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Social Service Provision System:
the Issues of Public-Private Partnership in UK, US and Korea

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Preface

Social service has of late gained increasing policy attention, and rightly so, because it is not only an industry with a great potential to create jobs, but also an effective response to new social risks such as population aging and birthrate declines. Korea's current social safety nets are oriented to providing cash-benefits to limited groups of people and thus lack the capacity to address more general issues of care service demand, disabilities, child development, and the employment conditions of the working poor. The strengthening of social services, therefore, has become a front-burner priority. In this effort, the role of private actors is no less important than that of the government.

According to a report released by Chungwadae (the Presidential Blue House) in April 2007, Korea's welfare expenditure has outstripped its economic expenditure since 2004. In 2006, in particular, the welfare expenditure took up 27.9% of the total government expenditure, dwarfing the 18.4% that went to the economic sector. The government's social service spending also has risen from 272.2 billion won in 2002 to 1 trillion 294.5 billion won, with an average annual increase rate of 36.6%. This, however, is not something to be proud of, as a report published in 2003 shows that Korea's social service spending as a share of GDP that year was lowest among all OECD members' at 0.3%, which accounted for 4.9% of its social expenditure, as compared to the OECD average of 8.1%.

Also, the changes that have taken place in the recent few years—the devolution of social welfare responsibilities from the central to local governments (2005), the social service voucher initiatives (2007), and the upcoming introduction of the Long-term Care Insurance (2008)—leave us with immense challenges concerning the roles of local governments, the composition of private non-profit and for-profit providers, and the marketization of social services.

This report brings together a number of papers. One is on Korea's social service policy and the others are those presented at the "International Symposium on Social Service Provision System: Issues of Public-Private Partnership in Korea," held on

December 11th, 2007 and organized by the Korea Institute for Health and Social Affairs (KIHASA). The lessons highlighted in these papers, drawn mostly from two pioneers in the area of social service, the US and the UK, are intended to provide guidance to those who make and implement social policy, who are in search of ways to best promote cooperation between the public sector, the private sector, and the civil society in the effort of strengthening social service in a rapidly changing socioeconomic environment.

We thank to the writers of the papers. Brian R. Munday of the UK, a world-renowned expert in his field, has served as the first director of the European Institute of Social Services. His paper herein is about the UK's approach to a mixed economy of social services and other European social service models. Steven R. Smith of the US, another foremost authority on social service policy who has served as the president of the Association for Research on Nonprofit Organization and Voluntary Action (ARNOVA) and who is currently a professor of public affairs at the University of Washington, discusses the privatization of social services and the role of the government. Jerry Friedman is Executive Director of the American Public Human Services Association. His discussion is on the US's welfare reform and privatization and the changes this has brought to the area of social services.

Our gratitude goes also to Dr. Hyekyu Kang and Dr. Se-Kyung Park of the Social Service Research Center at KIHASA, for their organization of the symposium and for their paper on Korea's social services. We are grateful to two other KIHASA researchers, Dr. Kyunghee Chung and Mr. Sang-yong Yoon, for reading the entire manuscript and providing sound editorial advice. We hope that the papers presented in this report can provide an opportunity for examining the experiences the world has had with the increasing trends of decentralization, privatization, and marketization in social services and for drawing implications for the improvement of Korea's own social services.

December, 2007

Yong Moon Kim, Ph.D.

President, KIHASA

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Chapter I SOCIAL SERVICE EXPANSION STRATEGY IN KOREA: NEW APPROACHES AND CHALLENGES

Hyekyu Kang[1] & *Se-Kyung Park*[2]

1. Introduction

Korea has undergone far-reaching changes in its socioeconomic patterns over the past 10 years. These changes have all along pushed up the demand for social welfare. The economic crisis of late last decade, during which Korea depended heavily on the bailouts from the IMF, spawned increases in the short- and long-term unemployed and the working poor. Korea became an "aging society" in 2000 and as of 2007 had 9.9% of its population over the age of 65. Statistics of various sources indicate that the country is aging at an unprecedented pace to become by 2020 an "aged society," where people over 65 take up more than 14% of its population. Its total fertility rate in 2005 was the lowest in the world at 1.08. These demographic changes are at play to make care for the elderly an increasingly difficult task for families.

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Table 1. Changes in Total Fertility Rate(TFR) and the Proportion of the Elderly

year	Total fertility rate[1)]	% of the population over 65 years old	Old Age Dependency Ratio[2)]
1975	3.47	3.50	6.00
1980	2.83	3.80	6.10
1985	1.67	4.30	6.50
1990	1.59	5.10	7.40
1995	1.65	5.90	8.30
2000	1.47	7.20	10.10
2005	1.08	9.10	12.60
2010	-	10.90	14.90
2015	-	12.90	17.70
2020	-	15.70	21.80

Notes: 1) The average number of children each woman in a population will have in her reproductive life.
2) Old age dependency ratio = ((population aged over 65)/(population aged between 15 and 64)) x 100.
Source: National Statistical Office, Korea, www.nso.go.kr.

Women's unpaid domestic labor was once an important source of welfare service in Confucian Korea. Social services as we know them today, such as child care, care and protection for the elderly and frail members, and emotional support, were part and parcel of the domestic duty of women in the household mothers, wives, daughters and daughters-in-law. More recently, however, as with the advance of industrialization come increases in women's education and labor force participation, their role and status in the family are undergoing significant changes. For example, during the period between 1970 and 2004, while the labor participation rate for men decreased from 77.9% to 74.8%, women's participation in the labor force increased from 39.3% to 49.8%. The college enrollment rate for women as of 2004 was 79.7%, only marginally lower than men's 82.8% (National Statistical Office, 2005).

Table 2. Trends in Women's Labor Force Participation and in Family Structure

(unit: %, person)

year	Women's college enrollment rate	Rate of female household heads	Rate of single-member households	Average number of household members
1975	-	12.8	4.2	5.0
1980	22.2	14.7	4.8	4.5
1985	-	-	6.9	4.1
1990	33.2	15.7	9.0	3.7
1995	-	16.6	12.7	3.3
2000	65.4	18.5	15.5	3.1
2005	79.7	19.5	-	2.9
2006	82.1	21.9	20.0	3.3

Source: National Statistical Office, Korea (2006), *Social Indicators in Korea*; National Statistical Office, Korea (2005), *Women's Lives by Statistics* (cites from Bong-joo Lee, et al., 2006)

Against this backdrop, the government continued its work into the first decade of the twenty-first century to strengthen and improve long-term care programs and such services for children as after-school programs and child care. In the process, new community-based social services were put in place for at-risk families, multicultural families and homeless people. Also, the coverage of social policy has extended to include the working poor and the near-poor, in addition to those living below the minimum subsistence level, and, as a result, the focus of social security is shifted from cash-benefit to service.[3] This paper examines such policy changes and the impact they are likely to have, and discusses what further policy steps Korea should take.

3) "Social welfare services" as stipulated by the Basic Law on Social Security are a form of benefit or "a series of activities provided for clients" that constitute, along with social insurance and public assistance, social security. This paper discusses social welfare services in general, which include social welfare programs, but not social insurance and public assistance. The focus of the discussion is on personal social services.

2. Rationale for the Policy on Korea Social Services

Care (long-term care and child care in particular) is a core social service that has become increasingly institutionalized in Korea since 2000, when the country's population aging was more rapid than in anywhere else and its fertility rate among the lowest in world. Korea's social service policy until the late 1990s was keyed to increasing welfare programs to meet people's traditional needs. After 2003, the year when the Participatory Government came to power, however, social services became more multifaceted and forward-looking so as to address emerging new social risks, not least population aging and birthrate decline. The implementation of the four major social insurance schemes[4] and the National Basic Social Security has brought a substantial improvement to in-kind benefits and social services. The recent improvement in social services was grounded in a number of factors.

The first was a growing need for a response to rapid socioeconomic changes. "Jobless growth" led to the increasing polarization of the labor market, which, in turn, widened gaps in both wage and employment between regular and non-regular workers, between large corporations and small-to-medium businesses, and between the manufacturing and service sectors. It was widely expected that low-fertility and population aging together would bring a decline in the economically productive population and dilute the quality of the labor force. The number of the economically productive population was forecast to peak in 2016. The average age of the economically productive population, which was 38 in 2005, would also rise to 41.8 in 2020 and to 43.1 in 2030.

Second, the traditional welfare system was seen as inimical to social solidarity. What were needed in these circumstances were proactive social protection mechanisms to keep the middle class from breaking down and the working poor from falling under the

4) National Pension, National Health Insurance, Industrial Accident Insurance, and Employment Insurance.

poverty line. Public assistance in this sense was seen as less than useful in providing route for exit from poverty and even as undermining work incentives, gradually hampering national productivity.

Third, that the traditional social services were way insufficient to meet the increasing welfare needs gained wide social recognition. Also among one of the widely held social views was that the social service provision system left much to be desired. Korea's social expenditure was kept at low levels. Furthermore, Korea's spending on social services as a percentage of GDP was 0.3%, the lowest among all OECD members' and its social service spending as a percentage of social expenditure was as low as 4.9%, as compared to the OECD average of 8.1%.

In terms of social service provision, both public and private providers are too insufficient to meet the existing demand. Worse still, little has been discussed as to how in a time of rapid social changes the responsibility for providing care should be shared among the government, the market, and the family. Most of current social services are institutionalized care in nature, whose most of target group is made up of low-income individuals. As a response, the government has increased the share of social policy programs in its overall expenditure, while at the same time introducing long-term care insurance and strengthening child care.

Voucher program is one of the market-conforming steps the government has taken to stimulate effective demand for social services. Anther case in point is its effort to create new private providers of available capacity. All this is in part due to the previous Participatory Government's bent toward social investment and in part a social response to changes in welfare demands.

The policy of social service is also an approach to the problem of employment. As the national economy was increasingly moving away from manufacturing, Korea faced employment woes. It was against this backdrop that the service sector was highlighted as an industry of much growth potential, which led the government to focus on increasing

jobs in social services. The government understood that job creation effect was three times bigger in services than in manufacturing (the employment inducement coefficient, or the number of workers required to create an added value of 1 billion Korean won, was 14.4 for manufacturing, 20.2 for the whole industry, and 24.3 for services), and that there was plenty of room in the service sector for new workers. In this regard, the government began working to promote sustainable social enterprises and create jobs with which to raise the quality of such social services as nursing, child-care, and healthcare (Presidential Committee on Jobs Strategy, 2006).

The government estimated in 2006 that the social service workforce fell short by 800 thousand workers, and forecast in a report that by 2010 about 400 thousand workers would be supplied by the private sector. The gist of the government's basic strategy for strengthening social services is to place emphasis on promoting private sector-driven supply by activating markets and also on making use of pubic resources to galvanize private markets and support the socially underprivileged. In the process, the government is working, first, to help underprivileged groups maintain their purchasing power (with an expansion of social insurance schemes and the introduction of voucher programs) and increase the supply of social services (by loosening or abolishing regulations and fostering and managing the workforce needed to provide services), and, second, to establish legal and institutional frameworks aimed at fostering social enterprises and providing quality social services at affordable prices.

As a result of these policy efforts, the number of social jobs has increased of late and best practice cases in this regard are coming into prominence, spurring further efforts in this direction. Such is demonstrated by the enactment in July 2007 of the Social Enterprise Support Act, the government's plan for favorable tax treatment for social enterprises, and other institutional improvements (including the implementation of the Long-term Care Insurance) underway to increase social service jobs in the third sector.

Still, however, Korea lacks the number of jobs in its social service industry as

compared to the developed world, which brings into attention the need for a more comprehensive policy effort. Furthermore, the government's policy on social service industry, oriented as it is to simply creating jobs, tends to give short shrift to demand analysis and how to improve the accessibility and quality of services. Jobs created this way are unlikely to be of decent quality, still less sustained.

Figure 1. Background Factors of Social Services Expansion in Korea

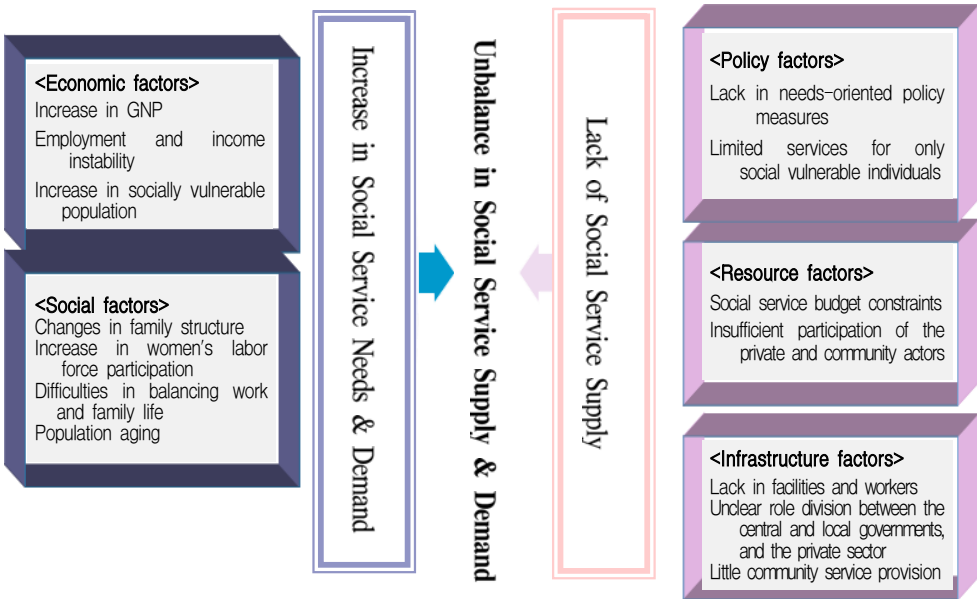
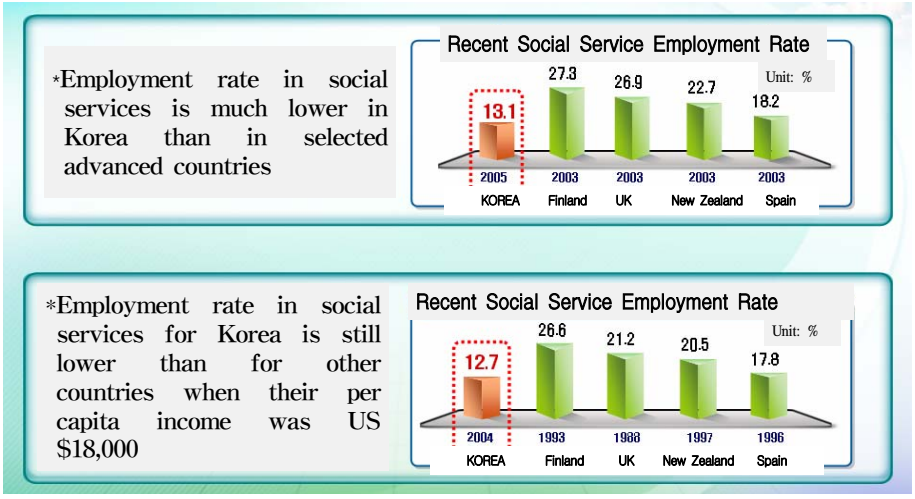


Figure 2. International Comparison of Social Service Workforce



Source: Ministry of Strategy and Finance, *Strategies for Strengthening Social Service*, 2006. 9.

3. New Social Service Policy: Contents and Implications

1) Social Service e-Voucher Programs

The Ministry of Health and Welfare has implemented the Social Service e-Voucher Project from 2007. The first of its kind in the country, the project provides welfare vouchers to senior citizens with disabilities and pregnant women. The project also encourages local communities to develop their own social services to meet various community needs by running their own service programs.

① Elderly Care Service

The Elderly Care Service was implemented in April 2007 to provide maintenance and rehabilitation services to old people with difficulties in daily activities. The voucher

service is intended to provide security to elderly population and stimulate the labor participation of family members, especially those who had to stay home and take care of their senile elders. Voucher services are provided to seniors over 65 and over based on household income[5] and health conditions. In the beginning of the project, every municipality was to have on voluntary home visitor institute and one self-support guardian institute. In 2008, the government allowed private facilities to participate in providing services, which include assistance in clothing, dining, washing, toilet going, and buying essentials.

In 2007, based on 27 hours per month, those with an income above the near-poverty level were charged 36,000 won for service fee, while those with an income below the near-poverty level were charged 18,000 won. The government provided a subsidy of ₩202,500 for each of those of the first category and 220,500 won for those of the second. From 2008, the government will increase its assistance service to 36 hours a month. For this service elderly individuals living above the near-poverty level will have to pay 48,000 won in addition to an amount of 270,500 won in government subsidy, whereas elderly people living below this level will be responsible for paying an out-of-pocket amount of 24,000 won(The government subsidy in this case is 294,000 won)

② Assistance Service for the Severely Disabled

The Severely Disabled Assistance Service was implemented to assist people with disability in daily activities and stimulate their social economic participation. The service is for people with 1st degree disability aged 6~65 of all income levels. Services include helping customers with clothing, washing, exercising, housekeeping and so forth. Based on disability levels, service hours between 20~80 hours are provided with 10~20% self-expense rate depending on their income levels. Like the Elderly Care Service, every state must designate more than 2 in-operation rehabilitation centers as voucher service

5) Only those with income below the 150% national average income level are allowed to apply

facilities to ensure competition, and the designated service facilities must recruit and train[6] their own service workers.

③ Mother-Infant Help Service

The Mother-Infant Help Service was implemented to provide health care to pregnant women and their new born babies, and to alleviate their child care cost. The two week home-visiting service is provided to families with income levels below the 65% national average income level. The two week service fee is 500,000 won, of which 48,000 is the client's out-of-pocket responsibility.

Table 3. Social Service e-Voucher Project

	Elderly Care Service	Severely Disabled Assistance Service	Mother-Infant Help Service	Community Service Innovation
Services	Maintenance and rehabilitation services	Providing assistances in daily activities	Health care and Financial assistance	Developing new social services based on community needs
Beneficiaries	Household income below 150% the national average income level (15,000 elderly population)	People with 1st degree disability of all income level (20,000 disabled population)	Household income below the 65% national average income level (43,000 mothers)	Household income below the national average income level (106,000 people)
Self- Expense	18,000~48,000 won/month	14,000~40,000 won/month	48,000 won/month	18,000~48,000 won/month
Service Hour	27~26 hours/month	20~80 hours/month	2 week	

Source: Ministry of Health and Welfare, 2007.

6) New comers are required to complete 40 hours of training.

④ The Community Service Innovation program

The Community Service Innovation (CSI) program was implemented to allow local communities to develop their own social services that reflect local needs and attributes. However, the overall examination and financing of the services still lie with the central government: Only after the central government's approval can the services be delivered. The central government recommends social investment programs especially services that focus on human resources and programs that help stimulate labor market participation. In 2007, all 280 programs were selected by the central government and out of 188 specific population targeted programs, 38% were child related services. Health care services, marriage immigrants' assistance services, care services for the disabled and etcetera took up the rest 60%. On the other hand, diverse organizations provided services, including private firms and universities, while the largest service providers were private welfare agencies and community rehabilitation centers which accounted for 45% of the total service facilities.

As part of the CSI program, the central government also provides two standard models as options for local governments. The first is the Child Obesity Prevention Management Service, which provides customized diet plans and physical training to obese children. Customers pay 10,000~40,000 won per month based on their income levels with 50,000~70,000 won subsidized by the government. The second model is the Cognitive Development Service for Children (Book Start). This program provides one-to-one reading mentorship and book rental services to children, as well as educational workshops to parents on proper book reading skills and how to develop a healthy parent-child relationship. Customers pay 8,000~14,000 won per month with 30,000 won provided as government subsidy. In 2007, two private facilities were selected by an open contest to provide the service.

The Ministry of Health and Welfare believes that the voucher program will bring high quality social service in Korea by instilling competition and marketization. The voucher program is regarded innovative as it differs from previous programs in several respects. First, the implementation of the electronic voucher system is believed to improve transparency. Customers are to purchase services by e-voucher cards, and every piece of information is signaled to the Center for Social Service Management, where every voucher services are monitored and managed. Second, in the new system even people with high income are also able to purchase the services. Unlike previous programs where service contents were often binary depending on incomes, in the new voucher program this separation no longer exists. In addition, beneficiaries are also able to enjoy services even after the subsidized hours at their own expense, bringing continuation to the program. Third, in the future service facilities will be able to set their own service fees based on different local economy, which is expected to stimulate market competition. Overall, the Ministry of Health and Welfare has high hopes on the consumer based E-voucher program, and plans to expand the program to other fields in the future.

2) Long-term Care Insurance

The Long-term Care Insurance will be implemented in July 2008, with the aim of replacing traditional family caregiving with professional long-term care, and thereby reducing preventable deaths among the elderly and helping them improve their bodily and mental functions and quality of life. Long-term care services will be financed from a number of sources including enrollees' contributions, the public purse, local government resources, and the out-of-pocket expenditures of service users.

Under the Insurance, the cost the service user has to pay will be reduced from between 1 million won and 2 million won to between 300 thousand won and 500 thousand won. The out-of-pocket cost as a share of the total cost under the Insurance is 20% for institutional service and 15% for in-home service. In addition, the opportunity

costs and labor loss of informal family caregivers can be reduced. Economic convenience is expected to rise with further increases in socioeconomic participation. The government says it expects that the introduction of the Insurance will have the effect of creating 40 thousand jobs for long-term care workers and nurses in the year 2008 alone.

Also, the number of local long-term care facilities will increase from 815 in 2006 to 1543 in 2008. Consequently, services in acute care, long-term care hospitals, and long-term care institutions will become more balanced and efficient.

Table 4. Financing sources of the Long-term Care Insurance

Contributions (50%)	- Collected together with National Health Insurance premiums - Contribution is the multiplication of health insurance premium by the long-term care insurance premium rate - The contribution as of 2008 is set at 3~4% of the health insurance premium and will be increased to 5~6% by the year 2010, when the target group will have been extended
Public purse (30%)	- The government is responsible for financing part of the cost of long-term care services as much as its budget allows
Out-of-pocket payment (in-home services 15%, residential services 20%)	- The recipients of National Basic Social Security benefits are exempted from out-of-pocket payment

The Long-term Care Insurance is viewed as a significant step forward in the development of social service in Korea, in that with it the responsibility of caring for elderly individuals with such geriatric diseases as dementia and paralysis, which formerly was in the hands of family members, will be shared with the state and society. But problems remain with the coverage, management and operation of the insurance system.

There is a plan in the pipeline to increase in a stepwise fashion the number of long-term care service users, from 85 thousand in 2008 (3.1% of the population over sixty-five) to 166 thousand in 2010 (9%), and to 200 thousand in 2015. But still the

real demand is unlikely to be met, as a study conducted in 2005 by the Korea Institute for Health and Social Affairs expects that the number of those over sixty-five with mild disabilities (530 thousand in 2005 and 58 thousand in 2007) will reach 650 thousand in 2010, which amounts to 12.1% of the age group.

The target Korea has set is way too low, as compared to Japan, where, when first implemented, its long-term insurance covered 12% of the population over the age of sixty-five, even considering that its population was more aged even then than Korea's now. Another problem is of what should be done for those aged under 65 with disabilities, whose demand for care is close in nature to that of their older counterparts. They remain excluded from the Long-term Care Insurance due to financial reasons. Also, as the responsibility for the management of the Insurance is left with the National Health Insurance Corporation and separated from the system of community-based social service provision, it can be difficult to deliver needed services in a holistic and continuous manner. An obvious concern here is that in such an environment, local governments can be held less responsible than they should be in service provision and therefore may become less committed to strengthening long-term care services in their areas.

3) Child-care Policy

As part of the Social Service Expansion Policy, investment in human resources is believed to be a key to Korea's low birthrate, population aging and growing socioeconomic disparity. Human Resource Investment programs are being carried out in line with other child welfare services with the objective of nurturing our children into productive and healthy adults[7]. In an effort to address the current challenges, the Korean government has gradually expanded child care services and community-based child

7) The total population in Korea was 48,456 thousand in 2007, with population under 18 estimated at 10, 705 thousand, accounting for 22.1% of the total population. While, children below age 5, the primary target group for child care services, were estimated at 2,832 thousand.

protection services through community child care centers.

① Child Care Services: Changes and Issues

Demographic changes caused by continuing falling birthrate and increase in women's labor market participation in the beginning of the twenty-first century has put great emphasis on the importance of social responsibility on child care. There is a growing consensus among people that the responsibility to nurture and foster our children not only involves the responsibility of individual families but the involvement of the general society. The enactment of Infant Care Act in 1991 and the continuous increase in government child care budget have put child care services at the center of child welfare policy. As a result of such efforts, the number of child care facilities has grown from 1,919 in 1990 to 30,856 at the end of 2007, more than a ten-fold increase. Simultaneously, the number of children using child care facilities has increased from 48 thousand to 1.1 million, and the number of people employed in child care facilities has increased to 170 thousand in 2007.

The First Policy Scheme of the National Childcare Support Policy in 2004, endorsed by the Presidential Committee on Aging and Future Society, especially served as the foundation for the expansion of public child care education and service provisions. The 2005 Second Policy Scheme of the National Childcare Support Policy succeedingly led the bases for the implementation of child care polices. During the Second Policy Scheme, metric data for standard child care and education cost were produced along side to supplement the implementation of the 2005 pilot program "Basic Subsidy Support System." Subsequently, in 2006 the Ministry of Gender Equality announced the "Saessak Plan" which reinforced the expansion of public child care facilities, and the promotion of basic subsidy provisions and financial child care assistance based on need and income levels. Moreover, the 2006 "Saeromaji Plan" by the Committee on Ageing Society and Population, further provided the ground for child care systems to develop in Korea by

assisting increased government budget in child care assistances and free child care services to children under 5, and child care facilities.

Table 5. Number of Child Care Facilities by category

	Public Childcare Facilities[1]	Welfare Agencies operated Childcare Facilities[2]	Private Childcare Facilities[3]			Home based Childcare[4]	Parents Cooperation Union[5]	Corporate Childcare Centers[6]	Total
			Sub Total	Non- profit Foundations	Individual				
1990	360	-	39	-	-	1,500	-	20	1,919
1995	1,029	928	3,197	22	3,175	3,844	-	87	9,085
2000	1,295	2,010	9,294	324	8,970	6,473	-	204	19,276
2005	1,473	1,495	13,748	979	12,769	11,346	42	263	28,367
2006	1,643	1,475	13,930	1,066	12,864	11,828	59	298	29,233
2007	1,748	1,460	14,083	1,002	13,081	13,184	61	320	30,856

Note: 1) State and Local government run childcare facilities(contracted out facilities included). Public child care facilities must accommodate more than 11 children aged 0 to 5 at all times.
2) Child care Facilities run by Welfare agencies endorsed by Social Welfare Services Act
3) Child care facilities run by private non-profit foundations and individuals, excluding home based child care, parents cooperation childcare union, corporate childcare centers. Private child care facilities are required to accommodate more than 21 children aged 0 to 5 at all times
4) Child care facilities run by individuals at homes or corresponding places. Home based child care are required to accommodate more than 5 and below 20 children aged 0 to 5 at all times
5) Child care facilities run by more than fifteen parents or guardians cooperate unions Parents cooperation union child care facilities are required to accommodate more than 11 children aged 0 to 5 at all times.
6) Child care facilities run by corperates with more than 300 full-time female workers or 500 full-time workers. Corporate childcare centers are required to accommodate more than 5 children aged 0 to 5 at all times and more than 1/3 of the attending children must be the children employees'

Sources: The Ministry of Health and Welfare, 「Child Care Statistics」, 2007.

Table 6. Number of Children attending Child Care Facilities

	Public Childcare Facilities	Welfare Agencies operated Childcare Facilities	Private Childcare Facilities[3]			Home based Childcare	Parents Cooperation Union	Corporate Childcare Centers	Total
			Sub Total	Non- profit Foundations	Individual				
1990	25,000	-	1,500	-	-	20,000	-	1,500	48,000
1995	78,331	77,187	93,225	591	92,634	42,116	-	2,388	293,747
2000	99,666	157,993	352,574	15,949	336,625	67,960	-	7,807	686,000
2005	111,911	125,820	608,734	56,374	552,360	129,007	933	12,985	989,390
2006	114,657	120,551	641,137	58,808	528,329	148,240	1,238	14,538	1,040,361
2007	119,141	118,211	668,390	55,906	612,484	177,623	1,444	15,124	1,099,933

Sources: The Ministry of Health and Welfare, 「Child Care Statistics」, 2007.

Table 7. Number of Child Care Workers

	Childcare Facility directors /admin.	Child Care teachers						nurses and food nutritionists	Social Worker	admin. staff	kitchen staff	Total[4]
		Sub Total	1st degree certificate[1]	2nd degree certificate[2]	3rd degree certificate[3]	special education teachers	thera-pists					
2000	19,276	43,219	22,921	20,298	-	-	-	817	-	898	6,531	75,720
2005	28,367	85,985	45,956	39,124	-	482	423	1,339	138	1,196	11,460	136,916
2006	29,233	105,484	56,384	40,362	7,124	656	508	1,634	123	1,194	11,304	156,309
2007	30,856	122,262	68,470	38,794	13,699	798	501	1,323	4,688	887	9,544	169,585

Note: 1) 2nd degree certificate acquirers who have worked in the field for more than three years and completed childcare training education or 2nd degree certificate acquirers with a master degree in childcare who have worked in the field for more than one year and completed childcare training

2) Two-year college or corresponding academic majored in childcare graduates or 3rd degree certificate acquirers who have worked in the field for more than one year and completed training education

3) High school or corresponding academic graduates who have completed education training in appointed childcare training centers

4) The total number of child care workers includes aggregated doctors(part-time doctors included) by 「Child Care Statistics」 and etcetera workers

Sources: The Ministry of Health and Welfare, 「Child Care Statistics」, 2007.

The recent child care policies have moved from its past institutional supplier based services to customer based services, providing a wider range of services to meet diverse social brackets and to alleviate growing child care burdens. The Korean government, as a result, is actively reviewing plans to gradually increase financial child care assistances, and to provide alternative child care allowances to families not using child care facilities. In addition, electronic child care vouchers are in plan as a new way to provide child care provisions, and more public child care facilities are to be constructed in socially deprived areas.

② Financial Child Care Assistances

As birthrate continues to fall, the number of children aged 0 to 5 using child care services are declining. However, contrary to this decline, the demand for child care services and child care service cost are on the increase, growing to become a huge burden in families' expenditure. To alleviate such problems, the Korean government is planning to expand financial assistances, child care provisions to families with more than two children from second child under 4 year olds, and free child care services to low income children under age 5 and children with disability.

③ Growth in Child Care Facilities and Child Care Assistance to the Socially Underprivileged

Public child care services are being expanded foremost in socially deprived areas such as in slums and in the countries where accessibility to child care services is much lower than in the cities Moreover, as women's participation in the labor market increases, corporate child care centers and a wider variety of services such as infant care, nighttime or holiday care, and care for children with disabilities concurrently is on the rise to meet the needs of working mothers.

④ Providing High Quality Social Services

Childcare center accreditation system is currently in operation to monitor and evaluate childcare facilities in Korea. The system was implemented to ensure high standards for child care facilities. The system was first implemented in 2005 as a pilot program and was officially operated from 2006. The childcare center accreditation system undergoes 4 process stages: application by the examined facility, self-evaluation, facility field inspection, and final evaluation by the Accreditation Deliberation Commission.

Furthermore, the government has implemented a government certificate system to ensure a safer childcare environment. Since 2005, by law every childcare teacher needs to possess a government-issued license in order to work in child care facilities and from 2006 the system was applied to childcare facilities directors as well. Through such systematic management, the government hopes to achieve high expertise levels and a safer service environment. Yet, despite such efforts, measures on health, nutrition, and safety should be further strengthened to reduce preventable diseases and accidents.

4) Community-based child protection services

The children of today enjoy more economic benefits and a healthier growth environment. However, as the traditional family structure is increasingly breaking down, they are exposed to more diverse developmental risks. As more and more families are disintegrated every year by divorces, and women's labor participation in rise, children are faced with much higher family uncertainty than in the past. With the current low birthrate at the side, the need for investment in human resources is gaining more attention. The sharing of responsibilities among the family, the society and the government is more important than ever to provide a healthy and safe growth environment and a level playing ground for children so that they can fully realize their potentials.

To resolve problems such as unbalanced nutrition intake, deprivation of educational

opportunity, safety accidents, poverty-related diseases poor children face in communities, it is important to have a comprehensive approach utilizing existing welfare infrastructures with community childcare centers. The 1,800 designated operating community childcare centers in June 2007 began from private run "Gongbubang activities," an afterschool tutoring curriculum in ghetto communities. In 2004 "Gongbubang activities" were reorganized into government managed public community child care centers by the Child Welfare Act revision.

Table 8. Number of Community Child Centers (March 2007)

Year	2004	2005	2006	2007
Number of community child centers	895	1,709	2,029	2,029
Government-sponsored community child centers (%)	454 (55.0%)	800 (46.8%)	902 (44.5%)	1,800 (89.0%)

Sources: The Ministry of Health and Welfare, 2007

Table 9. Number of Children using Community Child Centers (March 2007)

Year	2004	2005	2006
Preschoolers	1,564(6.7)	3,023(6.9)	4,133(7.0)
Elementary students	18,343(78.6)	34,617(79.0)	46,575(78.2)
Middle school students	2,880(12.3)	5,129(11.7)	6,846(11.6)
High school students	55(2.4)	958(2.2)	1,095(1.8)
Others(Marriage immigration children, school quitters e.t.c)	-	55(0.2)	523(0.9)
Total	22,842(100.0%)	43,782(100.0%)	59,172(100.0%)

Sources: The Ministry of Health and Welfare, 2007

Community child care centers are currently at a crucial transitional period. It needs to break out from its past plain meal services and afterschool homework tutoring to providing a wider quality service to satisfying individual needs. Community child care centers should focus on individual case studies to meet each child's individual developmental needs. Furthermore, for community child care centers to become strategic headquarters for effective countermeasures to poverty derived social service needs, it is vital that the government to establish a sophisticated structural supporting scheme. It is imperative that community based child care services to be well mediated and monitored, and its accessibility reinforced. In addition, it is equally important to establish a qualitative monitoring system so that a solid and professional social service foundation can be implemented in Korea.

4. The Korean Model of Social Services: Policy Implications and Challenges

Low birthrates, rapid aging, and vast changes in the structure of family have put the need for social responses to the fore. In this context, the current policies of decentralization, localization and "small government, vibrant market" are likely to affect the scope and structure of the social welfare service sector.

The recent few years saw new breeds of social policies. Starkly different in nature from the traditional social welfare services, these new policies are aimed at: increasing social service jobs voucher-based financing of a user support system institutionalizing a social insurance-type long-term care and institutionalizing social services for new groups in need. Such a change represents an effort to increase the quantity of social welfare services and improve their delivery and management in an environment characterized by decentralization, localization, tight budget constraints, and the limited managerial capabilities of central and local governments. The share in the cost of social welfare programs for which service users are made responsible is larger now than it was in the

past. Also, private investment is encouraged to add to the supply of social services.

Korea is in the face of a range of formidable challenges in these areas, not least of which are creating demand for social services, increasing the supply of services to meet the effective demand, raising the quality of services, and making the management of resources more efficient. The speedy decentralization of financing and delivery responsibilities also has left behind yet more challenges to work on and pull through.

As mentioned earlier, while in the past the main drawback of the existing social welfare service system was its limited scope and supply, Korea at present is in the middle of a much more complicated transition that calls for a multidimensional approach. At this juncture, more than a few things should be addressed. The marketization of social service may to some extent lead to: a decline in the use of services by low-income families and socially underprivileged groups; an increase in the number of unstable jobs in the social service sector; and increased anxiety among existing service providers over competition.

Also crucial to a successful transition of social welfare services into a new phase is to delve into ways to: foster a more consumer-oriented environment; reform social service delivery system; and reorganize the operational structure of provider organizations. Other overriding issues that require in-depth exploration are those pertaining to in what forms benefits should be delivered, how roles should be shared between the government, the market and the family, and what roles the public and private sectors should play to strike a balance in welfare mix.

In what follows, I would like to dilate on some of the changes and challenges at hand. They concern, first, the impact of the change in the method of financing for social welfare services (of which the expansion of voucher programs is a part); second, the impact of the marketization of social services, led by the newly implemented long-term care insurance; third, the reform of social service delivery system; and fourth, ways to best promote cooperation between the private and public sectors in the area of social

services.

1) The financing of social welfare services: expansion of voucher programs

Until the recent past, the government's support for social welfare programs took the form of subsidies that local governments could use to finance part of their operational costs. Such financial constraints confined the welfare programs largely to low-income families and socially underprivileged groups. Over the more recent years, however, much has changed in the way social services are financed. Now, social welfare service programs are more varied in function and ways of financing, as shown in the table below.

Table 10. Social Welfare Services in Korea: Financing Profile

Financing source		Budgets
Central government	Provider support	• Welfare services for children, senior citizens, disabled citizens, low-income families and homeless people (503.5 billion won)
	Consumer support	• Of the above figure, 180 billion won is allocated to four voucher programs (as of 2007) * Three care service programs (83.1 billion won) * Community Social Services Initiative Program (96.9 billion won)
Local government		• 67 projects handed over to local governments (1900 billion won, as of 2006) * "Decentralization grants (686.3 billion won) * Metropolitan cities (671.5 billion won) * Non-metropolitan municipalities (579.9 billion won)
Social insurance contributions		• Long-term Care Insurance (307.1 billion won)

Source: The Ministry of Health and Welfare(www.mw.go.kr); respective websites

Most of the nationally subsidized programs are now handed over to local governments. The responsibilities for the provision and budget management of the newly implemented

voucher programs, however, still lie with the central government. Here, local governments take only a limited part in financing. Also of note is the Community Social Services Initiative Program, via which the central government is to allocate budgets to local governments when they develop social service programs targeted to the needs of their communities.

Voucher programs allow each consumer to choose multiple providers and can be used by people of all income levels. These are considered more useful than provider support programs in that, with an appropriate budget allocated by the government, they can directly create effective demand. But problems may sprout up as service consumers make free contracts with any service providers of their choice. Other problems that are likely to arise include those concerning the employment conditions of social service workers and the marketization of social services that will be furthered with the introduction of voucher programs. The concern of some that voucher programs may undermine the publicness of social services is not something to be taken lightly. Nor can we slight the possibility that voucher programs may become increasingly dependent on the purchasing power of users and thus evolve into yet another source of social inequality.

As said earlier, most of social welfare service programs, and the fiscal authority thereof, are transferred to local governments. This implies that the central government is much more limited now than in the past in terms of capacity to finance new social service programs. Thus, the government has been fully aware of the need to raise the efficiency of the management of social service organizations. The new voucher programs can be seen as a step toward improving the delivery and structure of social service.

But Korea's social service industry is not much affected by economy of scale and has little room for profit-making. Thus, it remains to be seen whether for-profit firms in the private sector will voluntarily enter this industry. Whether, for that matter, a competitive environment will be created in the social service industry is equally unpredictable. All this leaves much to be done.

First, to get the most from voucher programs requires: effective quality management and monitoring; establishing mechanisms to protect the rights of users and ensure their access to services; setting the price of services at a level that would ensure service workers a decent wage; and building the capacity of services workers involved. These are prerequisites for not only voucher programs in particular, but social service programs in general. Setting prices right is highly important for keeping the service quality at a high level and creating good jobs. In price setting, service quality should be seen as a composite of costs for service labor, facilities and equipments, management, and operation.

Second, there is a potential risk of quality degradation if private providers are given too much leeway in setting prices and choosing what services to sell, or indulge in the cream-skimming practice of selecting under-informed consumers. This is of concern over not only voucher programs, but the supply of social welfare services as a whole. How to promote socially responsible non-profit agencies is an important question to work on.

2) Long-term Care Insurance and the marketization of social services[8)]

Implemented in July 2008, the Long-term Care Insurance is a contribution-financed universal program, a significant leap from its precursor which was tax-based, selective, and piecemeal. With this new program will come many important changes in the method of paying for services, the composition of supplier groups, and consumer decisions as to which services to use, as well as in the number of long-term care recipients.

The Long-term Care Insurance is believed to help create a market environment with increased providers (both in number and in types), higher competition, a broader range of consumer options, and higher-quality services. But given the risk-averse nature of private providers, service infrastructure may be unevenly distributed across different areas.

8) The content summarized a section of Dr. Jea-eun Seok, "Changes and Policy Implications after the implementation of Long-Term Care in Korea; Financing, Service Administration and Social Service Market Development" article.

The risk of information asymmetry remains and so does the risk of reduction in options for consumers. Also remaining are the risks of market-failure related to excessive social costs that may arise in dealing with management and marketing risks.

Most salient among the changes that came with the Long-term Insurance is that the government's budgetary support to service providers is no longer all-inclusive, as it used to be, but paid in the form of insurance reimbursement for services provided. Before the implementation of the Insurance, service providers served as agencies for the government, providing arrangements to low-income individuals and socially underprivileged groups with budgets allocated from the public purse. Now that what matters most is what types of service should be provided in what quantity, client marketing becomes crucial for service providers.

In a market where the Long-term Care Insurance allows users to select the services they wish to purchase from providers, distinguishing public organizations from private non-profit ones, and private non-profit organizations from private for-profit ones, becomes increasingly irrelevant. As of June 2007, 77.5% of residential long-term care facilities and 88.2% of domiciliary care services were run by private non-profit organizations commissioned by the government, but more hospitals and for-profit organizations are expected to take part in this industry. Also, the distinction between free, paid, and reduced-price services has become a thing of the past. But in order for these changes to take hold and produce intended results, relevant infrastructure will have to be evenly distributed across different areas to an extent that presents consumers with options they can actually choose from to meet their needs.

Many of those who until recently have used long-term care facilities may now be made ineligible depending on their long-term care needs as assessed by relevant agencies. One of the efforts the Ministry of Health and Welfare, have made in this respect is the recent establishment of a domiciliary care system that can be used to provide voucher-based care services to elderly people with mild disabilities.

How to avoid future imbalance between demand and supply is one of the challenges the long-term care industry has to take up. Supply may outstrip demand in large cities with abundant resources. Small municipalities with constrained resources and low marketability, on the other hand, will need additional support from the central government, because these are the areas that are less likely to attract the investment of private-sector providers and more likely to face a demand that their existing supply capacities cannot keep up with.

As regards price control, the level of co-payment is as a rule set and made known to the public by the Ministry of Health and Welfare. What this means is a stringent price control in accordance with standard price lists, not unlike the case of Japan, with a loosening of labor market regulations. Cost reduction seems to be the prime aim of this change.

The role of local governments as stipulated by the Long-term Care Insurance Law is limited by and large to tasks having to do with establishing elderly care facilities and registering private facilities. Their authority needs to be expanded so that they can regulate to an extent the establishment of new private facilities with an eye to keeping balance between supply and demand. Local governments will also have to be able to provide continuum of care for elderly service users. Pivotal here is establishing a system by which to provide a wide range of arrangements, from preventive-care benefits to services for those with mild disabilities, who are largely excluded from the insurance coverage. Also, systems should be developed at the local level to monitor and assess the quality of long-term care services.

3) Restructuring the social service provision system

In a country such as Korea, where the demand for welfare services is rising at a rapid rate, the question of who, whether the public or private sector, should spearhead in social service provision is of secondary concern. More important is clarifying the roles

they each should play. The policy goal in this regard should be towards increasing the quantity of service provision and strengthening both the responsibility of public providers and the self-regulation of private providers.

As discussed earlier, many of the newly introduced social service programs are voucher-based. This implies that the basis of service providers, which the government has built with its continued support in their costs for labor and management, is narrowing. In this context, how to increase providers in areas with limited resources gains added importance.

It is important that private providers take part in the provision of social services, and this is where the concern over-maketization sets in. For an industry with little room for profit-making, consideration should be given to how best to build on the existing provision system which is led by private non-profit providers, that is to say, how to promote the participation of community-based social groups of different sizes, values, and accessibilities in the provision of social services.

The responsibility of civil servants in charge of social welfare at local governments should be extended to include－in addition to tasks involved with the provision of public assistance－policy planning, identifying needs, and managing casesand resources, not least in a time when resources are limited in every respect and the need for reform of community-based provision system is thinly understood at best.

5. Conclusion

An OECD member, Korea has achieved, amid highly dynamic socioeconomic changes, one of the most remarkable economic developments the world has ever known and, with this, seen its democracy mature to a great extent over the past 20 years. Now among the country's most important tasks is to have in place a social welfare system that befits the development it has attained. Particularly, as discussed earlier, the strengthening of

social services is put at the top of the national policy agenda as the care burden placed on society mounts with rapid population aging and falling birthrates.

Such a task is no easy feat, as it requires nothing less than an all-encompassing approach that addresses the steps that need to be taken with regard to the financing of services, the method of budgetary support, service providers, and the workforce, as well as the roles and responsibilities of the pubic and private actors. Korea is no welfare state and has no experience of one. Its current social service system is limited in terms of both public and private provisions. With the stepping stones such as its advanced IT infrastructures, innovative voucher programs, and the Long-term Care Insurance, how Korea will improve its social service provision system to meet the ever-increasing demand is something worthy of attention and anticipation.

Chapter Ⅱ THE PROSPECTS AND CHALLENGES OF WELFARE MIX IN SOCIAL SERVICE PROVISION SYSTEM

The UK's approach to a mixed economy of social services

by Brian. R. Munday[9)]

1. CLARIFICATION OF KEY TERMS

It is important at the outset to attempt to clarify the meaning of key terms, especially social services. This is a difficult task because of the considerable variations between countries in precisely what constitutes social services. For example, in one country they include cash payment or benefit services, while in another such services are specifically excluded. In fact the term 'social care' is internationally preferred to 'social services' because the latter is seen in some countries at least as associated with government provided services and so does not adequately represent the wide spectrum of care services and who provides them.

A further but helpful complication is that the term personal social services is widely used as a more precise and accurate term that the broader social services. As the writer has explained elsewhere (Council of Europe 2007)

> Personal social services (PSS) are normally provided for individuals related to their specific needs and circumstances, in contrast to standardized services provided to people as members of categories. People who are typically users

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> of PSS include elderly people and their carers, children and families, and people with disabilities. However, people with a variety of other needs and problems will use PSS, with differences between countries in who can and should use such services. Newer services for special groups have emerged such as people with HIV/Aids. Services are provided in different locations such as individuals' homes, in day centres and residential establishments. They are staffed by personnel including social workers, social assistants (or variations on this term), care managers, home-helpers, therapists, and kindergarten teachers. Organizations providing PSS may be: state - particularly local authority or municipalities; not-for profit non- governmental agencies; or commercial businesses. Services provided by third sector civil society organizations have become increasingly prominent in recent years.
>
> A recurring question concerns the extent to which PSS are distinct from or similar to services provided within health, education, employment and social protection services. This is reflected in changing organizational structures, ranging for example from separate local authority departments for PSS - the 'PSS are distinctive' model - to arrangements where PSS are seen as essentially services provided as part of a portfolio of services provided by health, social, protection, employment etc.' (p.2)

The shorter term 'social services' will normally be used in this paper for the sake of brevity and convenience. Other important terms such as 'mixed economy of social services' and 'privatization' will be discussed later.

2. KEY TRENDS AND CHALLENGES IMPACTING UPON SOCIAL SERVICES SYSTEMS

There is a clear international trend towards national systems of mixed economies of social services, with countries doing so from a rich variety of histories and political and economic systems. There are many factors influencing this international trend, some of which are outlined in this section. Naturally there may be considerable variations between countries in the extent to which these trends apply to them.

1) Globalisation

The term 'globalisation' is too often used rather loosely. It refers to phenomena such as: the deepening interconnectedness of societies internationally; the compression of time and space through increasing travel and electronic communication; and greater awareness of what is happening in other countries with possible implications for one's own country (See George and Wilding 2002).

The precise impact of globalization upon social services is uncertain but probably significant. Politically, there has been a move away from dominant ideologies, resulting in the lifting of political straightjackets on the form of countries' social services systems. Radical changes in the former communist countries are perhaps the best example. Economically, increasing international competitiveness constrains governments' expenditure in key areas such as social welfare. In relation to social services this results in governments seeking to reduce their costs by stimulating the contributions of other sectors the classic mixed economy scenario.

A very positive result of increasing globalization is a greater awareness of how other countries are dealing with similar social problems, leading to the selective adaptation of successful policies and practices. In Europe this process of cross-fertilisation in social policy is greatly facilitated by pan-European organizations such as the European Union. The Seoul symposium is a good example of this happening at the international level.

2) Demographic and Social Change

For many countries this is probably the most powerful driver towards newer, mixed systems of social services. In Europe, two well established demographic trends have considerable implications for social services, namely the trend towards ageing societies and the sharp decrease in birth rates. This latter is important because of its effect on the future availability of adult children to care for their dependent elderly parents.

A combination of demographic and attitudinal changes to family care will impact

heavily on the demand for formal social services in the 21st century. Certainly in Europe there is great concern over how societies will meet the ever increasing need and cost-for health and social care as people live longer and become more dependent in their older years.

An additional factor is the trend for more women the traditional family carers in most societies to enter the labour market and so become less available to care for dependent family members. The traditional family model has also changed with increasing numbers of one-parent families, couples living in non-married partnerships, and families affected by divorce and re-marriages. Past traditions and assumptions about reliance on informal family care may no longer apply, with significant consequences for formal social services.

3) Modernisation of Social Services

There is a clear trend in Europe for public services to be modernized and governed by similar principles and practices as are found in the commercial, business sector. This increasingly is the case in social services where funding constraints require these services to become more cost effective, publicly accountable and needing to show hard evidence of good service outcomes. Inspection, quality control and use of performance indicators are just some examples of the infiltration of business culture and methodology into the world of social services.

4) Rights and Choice for Users of Social Services

There is an increasing trend for people receiving major services (e.g. education, health, social services) to be seen as customers with rights and power, rather than as passive recipients of standardized services which are the only services on offer. Now the customer of such services no longer has to accept what is given, can exercise a degree of choice, and expects to be involved in decisions about exactly what services will be provided for him/her. There is less tolerance of bureaucratic convenience and tradition

and greater emphasis on the supermarket model for services. In this context the traditional power of the professional over the client is increasingly challenged. This cultural change affecting social services is more evident in some countries than others and can be very uncomfortable for service organizations and their staff.

3. THE PURPOSE(S) OF SOCIAL SERVICES SYSTEMS

The type of social services system adopted by a country will be governed by several factors. A fundamental consideration, prior to any decision about a particular configuration of a mixed economy of social services, is exactly what purposes and tasks that system is required to undertake in society. Lack of clarity and agreement on purpose can create serious problems for a social services system. Internationally, the 'menu' of purposes/tasks for social services includes

A. Provision of care and support: This is basic in all social services systems. Questions to be addressed are: to whom; in what circumstances; how; and by which sectors. Individual countries provide answers appropriate to their circumstances

B. Protection: Children, elderly people and people with disabilities may be vulnerable because of parental inadequacy, abuse or exploitation by other people. Society provides protection through social services.

C. Regulation: As countries adopt a more decentralized mixed economy of social services, regulation of quality and standards in the emerging market of services is necessary. This is a responsibility of government and its agencies. Regulation in the UK system is explained later.

D. Community development and care co-ordination: Social services involve much more than providing specific services to specific groups of citizens. This is because a) there are community care resources that need to be mobilized, and b) there is a limited availability of government services. All systems need to engage in this task

E. Social control: This purpose may be controversial and not always seen as a legitimate purpose of social services. It involves the enforcement of societal laws, norms, rules and procedures by people whose behaviour is defined as deviant and unacceptable. Examples are people who offend against the law, some seriously mentally ill people, and people who abuse alcohol and/or drugs.

F. Social integration: Within Europe considerable emphasis is given in social policy to address the widespread problem of social exclusion and the need for excluded groups to be better integrated into mainstream society. Social services may be expected to play a full part in implementing policies of social inclusion.

4. MIXED ECONOMIES OF SOCIAL SERVICES THE EUROPEAN PICTURE

As already indicated, virtually all countries adopt a version of a mixed economy which best suits their particular conditions. It is difficult to imagine any country that does not have some form of mixed economy as this would entail a complete absence of social services; or a total monopoly by one service sector. Even in former totalitarian regimes families, the state, work place organizations and families provided social care services, although not planned and coordinated to anything like the degree found in current mixed economies.

1) The Four Social Care Sectors

When analyzing and comparing social care systems attention is directed to how and why countries construct and give differential weight to the contributions of the four care sectors:

A. The informal sector: Social care that is provided freely but not necessarily always willingly by families, friends, neighbours, colleagues. This is difficult to quantify but remains the main source of social care in all countries although changing in quantity and type because of social and economic changes

B. The not-for-profit sector: This is frequently an extremely diverse and complicated sector, comprising a wide variety of groups and organisations. They may range from local self-help groups with no paid staff, to large social services agencies with substantial contracts from government to provide core services. This is the sector whose contribution governments seek to maximize in many mixed economies systems, mainly but not wholly for lower cost reasons

C. The state/government sector: This includes services provided by central, regional or local government. They may be provided by separate social services departments and/or as part of a larger department which includes other related services such as health or education

D. The commercial or for-profit sector: This is growing in size and importance in many countries, such as in the UK (see later). It can sometimes be difficult to distinguish between service organizations in this sector and some in sector 2. The criterion normally used is the use made of any surplus in the annual budget. For-profit organizations will pay dividends to share holders or profits will go to the owners of the company. With not-for-profit organizations the budget surplus must be invested in improvements to services

2) Models of European Social Services

In work on comparative social policy it is not sufficient just to formulate descriptions of different countries' services and systems (See Jones 1985). More can be learned by constructing models or typologies within which countries are grouped and compared according to certain characteristics. The work of Esping-Anderson (1990) has been seminal in this respect. Antonnen and Sipilia (1996) amongst others have built on the Esping-Anderson approach to construct 'models of European social services'(below) that helpfully take us beyond the traditional descriptive-case study approach in comparative social services work.

The discussion of the UK social services system in the second half of this paper is framed within the context of the European models. The writer is not aware of the extension of models of social services being made to other continents e.g. are there identifiable models of Asian social services that would be similar or significantly different from the European models?

A. The Scandinavian model of public services(Sweden, Denmark, Norway and Finland): This is the nearest to a classic 'welfare state' model of social services. It has been based on the principle of universalism with care and support services provided to vulnerable groups, paid for from general taxation and provided directly by government agencies. Informal care plays a major part in care but not so the not-for-profit and for-profit sectors. In most cases services are available as of right to those needing them. This model has been admired because of the range and quantity of services based on the universal principle. However, more recent economic and political changes have led to modifications of the model with less acceptance of universalism and a marked increase in interest in expanding the contribution of the not-for-profit sector in particular

B. The family care model: This is found in the Mediterranean countries of Greece, Spain, Portugal, Italy, Cyprus and Malta. In this model there is limited government provision of social services, with more emphasis on the Catholic tradition of families' responsibilities to care for dependent members. Well established not-for -profits make important contributions, while wealthier people tend to use for-profit services especially residential care. Italy has a greater supply of state services than in other countries in this model. Criticisms of this model refer to it's over reliance on women as carers; the low provision of rights for service users; and the geographical unevenness in the availability of services.

C. The means-tested, targeted model: This is not an altogether satisfactory title for this model. It is associated mainly with the UK and to some extent Ireland. Here the state increasingly withdraws from a traditional role of direct service provider; contracts

instead with providers from other sectors 'targets' services on people with the most severe problems or dependency levels, and people with least income. The not-for-profit and for-profit sectors play a major part in this model, with strong encouragement from government. The term 'privatization' is often associated with this model because of the substantial and growing involvement of commercial companies in providing care especially residential care.

D. The northern European subsidiarity model(Germany, Austria, Netherlands and less so France and Belgium): The subsidiarity principle inherent in this model states in its simplest form that the responsibility to provide care and support should be at the most local, informal level (i.e. the family). Responsibility and provision is only taken on by higher levels in society when lower levels are demonstrably unable to provide the necessary care and support. Therefore, not-for-profit organisations traditionally are the main providers of services, but with much of their funding coming from governments. The family has a strong primary responsibility, sometimes enshrined in the constitution and including a legal financial responsibility to pay for care of dependents.

These models should only be taken as approximations to reality, with often considerable variations between the countries grouped into any particular model. Models are also in danger of missing the dynamic nature of social services systems as, for example, in the more recent and rapid changes in Nordic countries. The writer has published work elsewhere (e.g. Munday 2003) on the major changes in social services systems in the former-Communist countries in Europe. Models need to be updated periodically to take account of the fluidity in social policy internationally, a fluidity strongly fuelled by the imperative for countries to learn from one another and develop their systems swiftly to deal with increasing and new demands.

5. SOCIAL SERVICES IN THE UNITED KINGDOM: FROM CHARITY TO A MIXED ECONOMY OF SERVICES

This discussion of the British system will concentrate mainly on the period 1990 to the present time. As any system needs to be understood in relation to what has gone before the main features of social services in earlier periods will be briefly covered.

The United Kingdom (UK) includes the countries of England, Wales, Scotland and Northern Ireland. In this paper the reference to social services in the UK will be to the systems in England and Wales as they are identical. Some important differences are found in Scotland (e.g. work with offenders in the criminal justice system are part of social services); and in Northern Ireland where social and health services are organized jointly through Health Boards. In the rest of the UK health and social services are organized separately although joint working is becoming increasingly evident. The issue of the integration or separation of health and social services was the subject of a European-wide study for which the writer acted as consultant(see Council of Europe 2007).

Local government social services in the UK have recently undergone a major reorganization. Previously services for adults and children and young people were integrated into one social services department. Now the services have been separated with those for children and young people moving into a local children's service that includes certain services previously part of education services. The following account concentrates almost wholly on adult social services in the UK.

1) From Charity to State Social Services

State provision in the UK goes back to the Poor Laws of 1834 which established a very basic even harsh system of welfare relief, acting as a 'safety net' for people with absolutely no other form of support. This was mainly a form of institutional care

illustrated so graphically in the novels of Charles Dickens. The regime in the infamous ‘workhouse’ was a strong disincentive to seeking state social support.

The enormous growth of charitable provision in social care in the second half of the 19th century can be understood in the context of the glaring inadequacies of state provision. NGOs in the children’s and young people’s fields such as Doctor Barnardo’s and the National Society for the Prevention of Cruelty to Children(NSPCC) were initiated in this period and continue today as major providers and campaigners for disadvantaged children. Many NGOs were started by evangelical Christian philanthropists of the time. It is important to note that, unlike today, there was very little public (state) funding for services provided by the NGOs.

Britain has a long and rich tradition of NGO involvement in social care, more so than many other European countries. Even in the 19th century there was a basic form of a mixed economy system, although unplanned and uncoordinated and with most provision increasingly made by the many NGOs. Because of the UK’s strong tradition of NGO provision it has been much better placed to develop a full form of a mixed economy than is the case, for example, with Nordic countries that do not have this tradition. Of course, this is even more so with former-communist countries in Europe where non-state organisations were mostly not permitted (Munday op cit)

The long period in the 19th century up to 1945 was characterized by gradual acceptance of state responsibility for provision in several welfare sectors: housing, health, income support, work-and social services. Legislation was introduced to provide a stronger foundation for funding and service provision, including an important legislative framework to legitimize the activities of NGOs in social care. However, public funding was still lacking.

The period 1945～79 saw the all important legislation in 1948 to establish separate local authority departments for children’s and welfare services. In the UK there are several levels of local government. It was and still is only the larger local authorities

that were given the responsibility, power and funding to provide social services. This period saw the biggest growth in state (local government) social services with an ever increasing number of trained staff employed to work with people with a wide range of social care needs. The emphasis from 1960 to the 1980s was very much on state rather than NGO or commercial services, with a major reorganization in the 1970s that integrated children's and adult welfare services into one new social services department in the major local authorities.

During this time NGOs and some commercial agencies continued to provide services but were somewhat overshadowed now by state services. This was reflected in the relatively low level of public funding for NGOs about 8% in 1979 (Hill 2000 p.312). So the balance in the UK's mixed economy of social services moved sharply in favor of the state sector in this long post-war period, influenced strongly by greater public awareness of the extent and nature of people's needs and problems; left-wing social policies; and favorable economic conditions. But much of this was to change under the impact of the world recession following the oil price crisis in the late 1970s, and the election of the right-wing Thatcher government in the 1980s.

2) The New-style Mixed Economy in UK Social Services 1990～2007

The background to the major changes resulting from legislation in 1990 was the increasing number of older people requiring residential and home-based-care; and a funding system for residential care that was virtually out of control. An investigation and report leading to the legislation recommended major changes in the funding arrangements and most significantly changes in the roles of and relationships between the different sectors in the social services system. The legislation and what followed marked a watershed in the history of British social services.

Key features of the 1990 legislation that have shaped the form and operating style of social services to the present day were

A. In adult services a variety of home and community based care services should be developed to enable older and disabled people to live in their own homes for as long as reasonably possible. This was for two reasons. First, this is what people normally prefer for themselves; and, secondly, home/community based care should cost less than residential care.

B. A flourishing independent (i.e. private) sector should be supported, along with good quality public services. Responsibilities of all service agencies would be clarified, making it easier to hold them to account for their performance and to secure better value for taxpayers' money.

C. Local authorities would be required to develop a social services market by supporting its growth through direct funding and other means; and by using services of the independent sector where this represented a cost-effective service choice. Local authorities would need to show in future that they were spending a significant proportion of their budget on buying in external services.

D. The role of the local authority was to change progressively from that of the traditional main direct provider of services to one of acting as an enabling authority. Local authorities have a legal responsibility to ensure that certain services are provided for defined groups of citizens but they are not required to provide those services themselves. In future there would need to be a clear distinction between purchasers (or commissioners) and providers in the mixed economy of services. This change has had huge implications for British social services post-1990, providing the impetus and authority for what has amounted to a near complete revolution or cultural change in social services.

The report known as a government 'White Paper' that preceded legislation specified the ways and means by which local authorities would be able to develop and manage this new mixed economy of social services. These included;

• Clear service specifications and arrangements for tenders and contracts. Contracting

would now become a major activity for local authority social services departments

- Developing the external provider market, ensuring that no dominant monopolistic provider(s) emerged
- Identifying local authority in-house services suitable for externalization through a variety of devices

It should be emphasized that these near revolutionary changes in social services have taken place in the context of a more comprehensive policy and program to 'modernise' British public services across the board through use of principles and practices embedded in new public management. This process in the UK was started by Conservative governments and continued vigorously by subsequent Labour governments.

There has been strong opposition to aspects of the modernization of social services. It was seen as part of an ideologically-driven plan to privatize social services regardless of how appropriate this was in social services. The great fear was that there would be a proliferation of new commercial services, making large profits through providing services of dubious quality to vulnerable people who would not be protected through proper quality control and regulation systems. Fundamentally, the introduction of a 'market' in social services was mistaken as 'consumers' lacked both the purchasing power and choice of the supermarket shopper.

Alternatively, the development of a controlled, advanced form of a mixed economy was seen to have clear potential benefits: greater budgetary control; the targeting of resources on citizens most in need; a greater concentration on service outputs. The remainder of this paper examines what has actually happened since 1990 and how the outline blueprint in the White Paper and legislation has been transformed into some form of reality for British social services. Several key features of this transformation will be discussed

3) The Move from Public to Private Social Services

The 1990 legislation obliged local authorities to spend 75 per cent of new monies allocated to them on buying services from the not-for-profit (NFP) and for-profit (FP) sectors. This would apply primarily in the field of residential care for elderly and also for disabled people. In the 1990s there were big reductions in the number of publicly funded residents in local authority residential care homes, together with huge increases in publicly supported people in NFP and FP residential homes. Also, a new category of local authority funded resident appears post-1990 people in nursing homes who previously would have been in hospital care. As is quite obvious, the legislation gave a massive boost for the development of residential care in the non-state sectors.

Local authorities could also 'privatise' their domiciliary care services under the new arrangements but there was a reluctance to do so in the earlier period of the new legislation. That has changed in more recent years when there has been a substantial growth in private domiciliary care agencies providing services through contracts with local authorities and also directly to people funding themselves. These private domiciliary care providers are both NFP and FP organisations, with local authorities tending to favour contracting with the former in the earlier years because of concerns that service standards might be lower in the FP sector. The approach that has developed over time has been for local authorities to establish a list of 'approved providers' who meet key criteria such as service quality, financial viability and longer term sustainability. Approved NFP and FP providers are then invited to bid for local authority contracts. This system is not universal in that advertisements will appear in the Press inviting applications to provide domiciliary care services.

4) Privatisation

This term and its application to social services has been and remains controversial in UK social services. As Munday S (1996) indicates, there are three distinct aspects to

privatization policy

- A transfer of ownership from the public to the private sector
- Liberalisation: an attempt to permit and to promote competition in areas where previously there was no competition
- Franchising or contracting out: allowing and encouraging private firms to make bids to run services that were exclusively run by the public sector

Since 1990 privatisation in UK social services has involved all three aspects to varying degrees. As this writer has indicated elsewhere (Munday B. 2000). In the immediate post-1990 period there were financial incentives to set up fully or partially independent Trusts to take over responsibility for residential care homes. Trusts were often based in Housing Associations. Many local authorities saw this as preferable to selling elderly persons homes to the private sector because they retained some influence in the work of the Trusts. Trusts had the advantage of protecting residents' security of tenure, avoided staff redundancies, and local authorities were less exposed if Trusts ceased to operate.

An examples will be provided later of one such Trust. Competition between service providers has been progressively introduced within both health and social services. However, local authorities have not been obliged to practice compulsory competitive tendering of services because of particular considerations applying to these services that do not apply to other services for which local authorities are responsible e.g. collection of refuse. Therefore, the term 'quasi-markets' has been applied in the case of the UK mixed economy of social services, recognizing that a full market system is probably neither feasible nor desirable. Other terms such as a 'managed market' are used to reflect a system that remains in evolution rather than one that has experienced total revolution in its nature and style of operation.

5) The Changed Role of Local Authorities in Social Services

Reference has been made to how the role of local authorities was to shift away from being primarily the providers of direct services to that of purchasers or commissioners of services. This was never envisaged as a total change of role as local authorities were expected and have continued to provide certain services themselves. The government White Paper expected local authorities to continue to be able to provide services for people with high dependency levels or particularly challenging forms of behaviour. There was and still remains a concern that public provision in social care would come to resemble that of a much earlier era when it provided a basic 'safety net' welfare system for people who were too difficult or poor to be attractive to NFP and FP providers.

Some years ago a highly provocative and futuristic paper (unpublished) suggested that the logic of the 1990s changes in UK social services was that the staff in a local authority would be reduced to a small number whose sole task would be to negotiate and monitor contracts with the independent sector! These staff would not be social work trained but MBA graduates highly skilled in IT. This was, of course, a 'tongue in cheek' vision of the future, the more serious content being criteria to be used by a local authority to determine which services it should continue to provide, albeit on a more reduced basis than before

A. Services which a local authority has a legal duty to provide itself. In practice, these apply more in the field of children's rather than adult services. These services are relatively few in number
B. Services which the external market is unable or unwilling to provide to an acceptable standard or price(e.g. people with high dependency levels or problematic forms of behaviour)
C. Services where the external sector is vulnerable to unanticipated exits or even collapse, or where there is a danger of cartels e.g. in domiciliary care where the market has tended to be under developed and where there are several big suppliers

D. Where public expectation and consumer choice requires some continuing public provision. In some local authorities there remains a traditional view that residential care for older people should be available from the state as well as from the private sector. Politically it may be unwise to ignore this expectation.

Again, the role of the local authority as an 'enabler' in the mixed economy of social services has been mentioned. This includes a responsibility to help ensure that enough private providers of the necessary capacity, diversity and quality become available to provide the requisite services. A disastrous situation would arise where a local authority substantially reduced its own service provision capacity, only to find that its external market of providers was seriously deficient. So the local authority has a market development role, providing some pump-priming funding, expertise and other inputs to help external providers develop and become firmly established.

6) Service Specifications and Contracts

The nature of the financial relationship between local authorities and NFP social services providers has changed substantially since 1990. Previously local authorities provided annual grants to NFP organisations as a contribution towards their costs. Grants could be either small or large and tended to be for organisations providing services important to local communities and relevant to the responsibilities of the local authorities. Normally there was no formal contract in exchange for the grant.

Some non-contractual grants are still made but the norm now is for a contractual relationship between local authorities the commissioners, and NFPs the providers. The commissioners are required to demonstrate that they are obtaining 'value for money' through this new style of relationship with external suppliers. The term 'contract culture' has been used to characterize this changed relationship which has not been welcomed by many NFPs.

> According to Munday (2000) arguments for the move to contracting services include …reductions in costs increased efficiency; reductions in bureaucratic procedures; by-passing trade union restrictions and political patronage; increased user choice; and greater likelihood of innovative service arrangements. Arguments against contracting include: high administrative costs for both purchasers and providers; loss of traditional autonomy and independence of many independent agencies; lower wages and employment insecurity in provider agencies; reduced accountability and lower quality of services; less risk taking and innovation by external providers (p.273)

Local authority staff have become increasingly skilled in designing, executing and monitoring contracts with service suppliers. Service specifications are more tightly drawn, with requirements on suppliers' complaints procedures, equal opportunities policies, staff salaries and conditions of service. There is a concern for quality in a supplier's operations as well as their ability to provide at a competitive price. As mentioned earlier, local authorities attempt to guard against poor quality in their external suppliers by only inviting approved agencies to tender for contracts.

There are usually three types of contracts in social services

A. Block contracts which enable local authorities to buy access to services without having to specify exactly how many services for how many service users. Many suppliers also prefer this
B. Cost and volume contracts which specify the total cost of service to be supplied and the volume of service to be supplied e.g. exact number of users to be provided with the service. A difficulty arises when more or less services are provided than have been purchased
C. Cost-per-case contracts pay the agreed price for a unit of service per user after it has been provided. This is also referred to as 'spot purchasing' a term more associated with the Rotterdam oil market- of services tailored to the needs of

individual users. Administrative costs for both parties tend to be costly with this type of contract

Contracting is now firmly embedded as a key feature of the UK mixed economy of social services. It enables local authorities to fulfill their obligation to externalize a significant proportion of the services they are responsible for but which they do not have to provide themselves. Earlier concerns about unacceptable reductions in standards and quality of services as a result of contracting have lessened as commissioners have tightened up their quality requirements and monitoring systems. As is explained later, central national standards have been set for all suppliers to adhere to. One difficulty of contracting is that management/administrative costs have been higher than perhaps anticipated. Contracting gives considerable power and influence to local authorities in the mixed economy.

NFP agencies are less enthusiastic about contracting. It benefits larger, well resourced suppliers who develop a long term relationship with their commissioning local authorities. But even they often regret their loss of former independence they enjoyed under the previous annual grant system. The biggest losers are smaller NFPs who are either unable or unwilling to bid for contracts and also lose their previous local authority grants. As is explained below, it is the FP suppliers who are most enthusiastic about the post-1990 changes.

7) For-profit Providers of Social Services

Within Europe the UK is seen as probably having the fastest growing and largest FP sector in social services. The following basic statistics indicate the size of this sector in comparison with the local authority and NFP sectors(CSCI 2006).

- In adult residential care (non-nursing) the FP sector provided 177,992 places; local authorities 31,987 places; NFP 49,518 places. With nursing homes the dominance of the FP sector is even more marked

- In the case of domiciliary care there were 3,288 FP services; 787 local authority services; 402 NFP services.

FP providers certainly existed before 1990 but the main expansion of this sector has resulted from the marketisation of social services in the UK following the new legislation and subsequent policies and programmes to modernize UK public services. There have been several key features of this rapid expansion of the FP sector

A. Sale of local authority residential care homes: There were strong financial incentives in the early 1990s for local authorities to 'float off' some or even all of the residential homes they owned. Some were handed over to newly created NFP Trusts and other established NFP providers. Others were sold to FP commercial enterprises. Local authorities normally retained some residential homes for political reasons; because they needed to guard against failure in the external suppliers sector; and to provide a degree of choice for people entering residential care. Nevertheless, the sale of residential care homes provided lucrative opportunities for commercial providers.

B. Growth of small family-run business in residential care: The financial arrangements for residential care prior to 1990 led to a rapid growth in the number of residential care homes owned by private individuals as a business. Fee income was more or less guaranteed through the state funding system and this, coupled with the shortage of residential care homes nationally and an increasing proportion of elderly people needing residential care, led to the expansion of small residential care businesses. This growth has not continued to the same extent as eventually there was an over-supply in the market and funding arrangements were tightened, but very many residential homes are still owned by small family businesses.

C. Commercial companies in residential care: Post-1990 some large companies have seen the residential care sector as offering very good returns on investment. New companies have been set up and there have been mergers and take-overs. Commercial companies are attracted by the implications of the demographic figures and their ability

to control staffing and other costs when bidding in competition with other providers who are more constrained. Companies such as BUPA and Westminster Care are very active in the private health care sector but have moved substantially into private residential social care. Local authorities have been cautious over contracting with the FP providers because of fears over lower standards of care through cost-cutting. However, this reluctance has diminished as local authorities have become more experienced in contracting and increasingly rigorous systems of standards setting and inspection have been established. An increasing proportion of elderly people in residential care have to pay most or all of their own fees, meaning that FP providers are by no means entirely dependent on local authority business.

D. For profit domiciliary care: Local authorities have a responsibility to ensure that appropriate home-based care services are provided for people mostly elderly who are assessed as needing these services. Traditionally domiciliary services were owned and operated by the local authorities. Post-1990 these services have increasingly been externalized as the statistics above indicate, showing that the FP sector is numerically the biggest operator in this important service field. Again, cost control factors often work to the advantage of the FP services.

Limitations on space in this paper precludes discussion of the substantial involvement of the FP sector in social services for children and young people. Are FP providers better or worse that local authority or NFP providers in meeting or exceeding national minimum standards in residential and domiciliary care for older people? Critics of commercial care expect FP to have lower standards. There is some evidence for this in the CSCI report (2006) which compared service standards achieved by the three sectors across a wide range of indicators. The overall picture is that the NFP sector achieves high ratings than the other two in a majority of instances, with the FP sector regularly being third in ratings scores. However, differences in scores tend to be small in most cases.

8) Standards Setting, Regulation, Inspection and Quality Control

In the world of supermarket shopping the customer is regarded as king or queen. Competition between producers is fierce and the customer will buy elsewhere if the goods do not meet her/his requirements on quality and price. There are other safeguards built into food retailing to protect customers but generally the customer has choice and can choose to shop between different suppliers.

This model does not apply to anything like the same extent in social services. In the UK people with sufficient money can choose between several alternatives when they need to go into residential care. The same applies to a lesser extent with domiciliary care. But for people reliant to varying degrees on state support to pay fees their choices will be much more limited. They might like to go to a certain home but the local authority will only pay for them to go to another home where the fees are lower.

A second factor is that it is much more difficult for the 'customer' to know about the quality of different social services. The model of the well informed customer having the information and experience to judge quality and choose accordingly does not apply to anything like the same extent in social services. The UK now has a well established national system for licensing or registering social services providers who meet the necessary standards. Registered providers are then inspected on a regular basis to check quality of services as measured against a large number of service standards. The results of these inspections become public so that potential residents of a particular care home can access the latest inspection report and compare it with reports on other possible homes. This system includes inspections of local authorities' social services where a star rating system operates. National league tables are published comparing all local authorities that provide social services.

The Commission for Social Care Inspection (CSCI) was established by legislation in 2003 and is the single independent inspectorate for social care in England. The website of CSCI (www.csci.org.uk) states that: 'The remit of the CSCI includes the regulation,

review and inspection of all social care services in adult and children's services, in the public, private (i.e. FP) and voluntary (i.e. NFP) sectors.'

CSCI's role and responsibility in relation to local social care services include:

- Registering care services that have to meet national standards
- Inspecting services in all sectors and publishing subsequent reports
- Publishing performance ratings of local authorities' social services
- Investigating complaints. Any individual can complain to CSCI if they are unhappy with service delivered by a provider
- Taking enforcement action when services do not meet minimum standards

The UK has developed an increasingly effective system for setting and maintaining service standards in a mixed economy which relies heavily on providers in the non-state sectors. Of course problems still arise, vulnerable service users are sometimes exploited and badly treated but there are now better systems in place to ensure quality control in a field which is complex and difficult to regulate. Much depends on there being adequate funding for social services, a subject to which this paper now turns as the final but by no means least important topic.

9) Funding the Mixed economy of Social Services

Ensuring sufficient funding for social care in the UK is a continuing struggle in a context of increasing levels of need, rising public expectations of services, and strict constraints on levels of government funding for services. In the UK health services are free of charge at the point of delivery but that is not the case with social services. Means testing of service users is well established with an increasing proportion of users now paying all or part of the cost of their services.

Finance for social services comes mainly from the following sources:

- General taxation out of which central government makes an annual allocation to local authorities towards the cost of services for which they are responsible

- Local taxation, the amount of which varies between local authorities
- Payments made by service users themselves

In addition, NFP providers may receive funding from charitable Trusts that were established to make grants for specific purposes e.g. special services for disabled children. The European Union(EU) also has some funding programmes related to social services for which UK social services in all sectors can apply. This can be very useful for the development of new services and to support services in particularly socially and economically deprived areas.

In the UK and elsewhere the policy is to move the user of social services more towards the supermarket shopper model with cash in her/his hands to enable them to choose and pay for services that suit their needs and are affordable within their budget. In certain circumstances users are provided with 'personal budgets' to give them more power and choice in a market where state supported users have tended to be relatively powerless. The constraints on social services funding applies to varying degrees to all countries and is a major factor driving the strong trend towards mixed economies of social services. As already indicated, the UK is seen as an important case study because historically it has a substantial NFP sector; a flourishing FP sector; and a state sector that has been modernized to enable it to support and regulate the mixed economy of services.

6. CONCLUSION: FUTURE PROSPECTS FOR THE MIXED ECONOMY OF SOCIAL SERVICES IN THE UK

Cost effectiveness has become a dominant theme in the development of UK social services post-1990. Cost containment has become and will remain - a priority for social services across all sectors under the impact of trends outlined early in this paper. Social services receive a lower priority than health and education in governments'

spending plans, while to raise income tax to pay for more social services would be considered brave but very unwise politically.

Alongside the emphasis on cost containment there has been a welcome trend to require services to demonstrate their effectiveness by producing better outcomes for service users. This is now especially evident in services for children and young people where new organizational arrangements will need to show that their service configurations are designed to and actually achieve defined target outcomes for children and young people. The need for services to concentrate on producing good service outcomes will remain a marked feature of UK social services.

Other positive trends already underway will strengthen. Two related examples are the greater involvement by service users in decisions about what services are provided for them. Users are no longer passive recipients of pre-determined services in which they have had no say. The second example is the planned growth of enabling users to be allocated their own budgets to purchase services they choose. This is especially well developed in the Netherlands and has the potential to produce a major shift in social services funding, with less going from government directly into the services and more going directly to users themselves.

But achieving an adequate level of funding for UK social services will be the main preoccupation. Funding increases annually but so do the nation's needs for social care. The great concern is how to provide services of sufficient quantity and quality for the increasing proportion of elderly people in society. Means testing will probably become more stringent resulting in a greater proportion of older people paying for all or most of their care costs.

A final issue that is affecting many other countries is how to achieve and maintain adequate staffing levels in social services. When unemployment levels are relatively low as in the UK the modest rates of pay for basic care staff in residential and domiciliary services does not attract sufficient numbers. This results in greater use of temporary

agency staff which is costly. There are no quick solutions to this dilemma.

As is all too evident, in the UK there is likely to be even more reliance on services providers from the FP and NFP sectors, with local authorities the commissioners reducing their normally more costly in-house provision to the minimum and driving 'hard bargains' over rates they will be prepared to pay in contract negotiations. Much will depend in this scenario on what shifts take place in the balance of power within the mixed economy, with the possibility this may move more towards the two non-state sectors.

APPENDIX

Case Study: Kent Community Housing Trust

KCHT is a good example of the new-style NFP social services providers set up in the early 1990s, mainly to enable local authorities to take advantage of funding opportunities in relation to residential care for older people. The local authority initiated this new Trust as an independent body to take over responsibility for several residential homes previously owned by the local authority.

KCHT has expanded substantially and is now responsible for 19 residential homes for elderly people many suffering from dementia - in four local authority areas. In addition, it provides some day care facilities; a domiciliary care service for about 450 people; and special services for more than 1500 young people and their families. It has an annual budget of close to $30m. and employs around members of staff.

Although KCHT is a NFP organization it is run according to modern business principles and practice, as is the case with similar organisations in the UK. The continuing success of KCHT depends heavily upon its ability to deliver on its existing contracts, to attract new social care business, and to do so with an adequate end-of-year budget surplus. Any annual surplus is used for the development of KCHT's services. Income is predominantly through contracts with local authorities who pay fees for agreed numbers of residents in the care homes; and people who pay directly for their care services. The latter are an increasing proportion of KCHT's service users. The work of KCHT is the legal responsibility of a Board of Trustees who are non-Executive Directors giving voluntarily of their time and expertise. The local authorities with whom KCHT

has contracts have representatives appointed as members of the Board.

KCHT has expanded its range of services in response to new or more urgent social needs in the community and opportunities to obtain service contracts with local authorities. It now works with young people aged 16 to 25 needing accommodation, advice on applying for financial assistance, and help with life skills and relationships. This service is designed to enable young people to develop self-confidence and the ability to move on to their own independent living.

A second service for young people and their families is a form of early intervention which aims to support families before a crisis is reached. Mediation, individual and group support is available to enable family members to identify strengths and difficulties and steps that can be taken to improve family relationships. These services are funded primarily through contracts with the local authority as part of a preventative strategy to avoid children and young people being taken into public care.

Chapter Ⅲ TRANSITION TO CONTRACTING REGIME: US SOCIAL SERVICES PROVISION SYSTEM

Contracting and its policy and practice implications

by Steven R. Smith[10)]

1. INTRODUCTION

It is almost accepted wisdom among many policy makers, the staff and volunteers in local social programs, and the citizenry in general that extensive devolution and privatization has occurred in American social policy in the last 20 years. Devolution has generally been defined as a shift from federal control and financing of social welfare programs to lower levels of government, nonprofit agencies, and local communities (See Alexander, 1999; Sosin and Smith, forthcoming). Devolution has roots, at least in part, in the New Public Management (NPM) which seeks to enhance the efficiency and effectiveness of public services through decentralization, greater entrepreneurship and more market-based approaches to addressing urgent public problems (Behn, 2002; Osborne and Gaebler, 1991). Devolution also is part of the push for a "New Federalism"that started with the Nixon administration as a way to shift federal responsibilities to state and local government. This effort continued with the Reagan Administration and its implementation of block grants and decentralization of the control and financing of some key federal social programs to the states (Palmer and Sawhill, 1982). This new federalism philosophy was further evident in the welfare reform law of

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1996. This law abolished the Aid to Families with Dependent Children (AFDC) program and created the Temporary Aid to Needy Families (TANF). As part of this landmark legislation, states were given more discretion on the design of their state TANF programs, although they were also subject to new federal regulations pertaining to work effort and time limits on the receipt of TANF cash assistance (Golden, 2005; Hacker, 2002).

Closely related to devolution has been the concept of privatization which also has many different meanings. In this context, privatization can be viewed as shifting responsibility for social programs from the federal government to the private sector broadly defined: individuals may pay more for services; private nonprofit and for-profit organizations are more prominent in providing services; and private philanthropy and earned income are more crucial components of the revenues of social welfare organizations. Social welfare services are more market oriented and commercial (Eikenberry and Kluver, 2004; Gilbert, 2004).

These twin concepts of devolution and privatization fit with prevailing views of the American welfare state. Wilensky (1965) argued that America lagged behind other advanced industrial countries in the development of its welfare state, calling America ″a reluctant welfare state.″ Gosta Esping-Andersen (1993) argued that America was a ″liberal″welfare state regime because it relied more heavily upon the market to finance and support key income maintenance programs such as the pensions and cash assistance to the disadvantaged. His focus in his comparative analysis of welfare states is direct government expenditures (Also, Alesina and Glaeser, 2004).

Many scholars have called attention to the inaccuracy of focusing on direct government expenditure as a way of analyzing a country's welfare state (Shalev, 1996; Hacker, 2002; Goodin and Rein, 2000; Smith, 2002). Private pension benefits for example can be subsidized and encouraged by government policy, so pensions are often a complex ″public/private mix″. Likewise, home care for the disabled may be provided by family members but it can be encouraged by government tax credits as well as direct

government payments.

In general, many prominent analyses of social policy especially in a comparative context have focused on income maintenance programs. Consequently, privatization and devolution are assumed to be occurring based upon trends in cash assistance programs rather than an analysis of social service spending and delivery.

In this paper, I argue for a more complicated view of the American welfare state based upon an analysis of the non-cash social service programs for the disadvantaged, disabled, and the elderly. These services include: welfare-to-work, child care, low-income housing, child protection, foster care, workforce development, mental health, community living for the developmentally disabled, substance abuse treatment, hospice care, and home health.

In this broad array of services, the often high profile politics of devolution and privatization have tended to obscure a fundamental transformation of American social services policy including the extensive growth of government contracting with nonprofit and for-profit social service agencies, the centralization of the financing at the federal level (especially through Medicaid) and the diversification in the tools by which government supports or encourages social programs in the public or private sectors. To be sure, the reliance on a mix of financing mechanisms for social services has been noted by many scholars and policymakers (Salamon, 2002; Howard, 1997; 2002; Gilbert, 1983; 2004; Hacker, 2004; Rein and Rainwater, 1986). However, the diversification of financing has significantly accelerated in recent years, with very important implications for the provision of services. Indeed, this diversification tends to mask the extent of public funding of local social programs and, simultaneously, the increased centralization of government funding for a broad array of social services.

Overall, the growth of contracting and other public funding of social welfare services generates pressure for more accountability and outcome evaluation. This pushes government to greater levels of regulation especially performance management that ties

government contract reimbursement to specific performance targets. Further regulation is likely. Yet, the diversification of policy tools combined with the devolution of the administrative responsibility for government programs has encouraged the growth of more partnerships and collaborations even among disparate types of service agencies. Thus, trends in the US mirror the two fundamental strands of the New Public Management (NPM): the desire for improved performance and the goal of shifting away from large public bureaucracies toward more flexibility and decentralization in public service delivery (Hood, 1991; Behn, 2003).

This paper will provide an overview of the development of government contracting, the diversification of government funding in the next section. The subsequent section focuses on the contemporary challenges faced for policy makers and social service agency staff and volunteers followed with a concluding section on the implications of recent developments for policy and practice. Throughout the paper, the primary focus is on nonprofit social service agencies which comprise the bulk of the social service organizations in the US.

2. THE FINANCING AND ORGANIZATION OF SOCIAL WELFARE SERVICES: GROWTH AND DIVERSIFICATION

In the early days of the American republic, local government, churches, and communities provided emergency assistance and support for individuals in need. The number of nonprofit social welfare organizations grew substantially in toward the latter part of the 19th century. For instance, some of the largest contemporary nonprofit organizations in social welfare such as The Salvation Army, Goodwill Industries, Catholic Charities, and Volunteers of America were founded during this period. Public support for the poor was at the local government level and focused on temporary care for the so-called undeserving poor. Overall, nonprofit organizations at this time depended upon cash and in-kind

donations and fees; thus most agencies did not receive public funding except for agencies in urban states such as New York. Even in this case though, the public funding tended to be a small part of an agency's funding (Smith and Lipsky, 1993).

In the late 19th century and early 20th century, the public institutional system for the mentally ill and developmentally disabled expanded significantly. New types of social service organizations were also founded at the local level usually with private funds. These agencies included settlement houses and child guidance clinics. However, the basic financing structure of social welfare services remained relatively the same: almost no federal funding; very limited state and local funding and little direct public funding of private agencies except for foster care and occasional emergency assistance (Also, Trattner, 1999; Crenson, 1998; Axinn and Stern, 2005).

This basic structure persisted until the 1960s. To be sure, the Depression led to a vast expansion of the federal role in social policy but on the services side, most of the funding was temporary and disappeared by World War II. In the early post-war year period of the late 40s and fifties, federal funding of social welfare service agencies remained very, very limited. Almost all spending on institutional services for the mentally ill, developmentally disabled as well as a host of other services such as foster care was from state and local government. It was, in the current parlance, a devolved service system. Nonprofit agencies relied upon private philanthropy and fees and public social welfare agencies were entirely dependent upon state and local funding (where it existed). Further, the network of social services was quite limited. Except for the very largest communities, social services were provided by longstanding agencies such as the Salvation Army, Goodwill, Catholic Charities, local churches, and state and local government agencies. The nonprofit agencies were typically supported by private donations.

Beginning in the 1960s, government funding of social welfare services increased sharply fueled by extensive federal spending through contracts on many new social and health programs including community action agencies, community mental health centers,

neighborhood health centers, and child protection agencies. In the 1970s, government funding essentially created a national network of mostly nonprofit drug and alcohol treatment program. Other community agencies receiving federal funds were battered women shelters, rape crisis programs, and emergency shelters for runaway youth. Overall government spending on social welfare services rose rapidly. For example, total government spending on a bundle of social welfare services including community action and child welfare rose from $1.1 billion in 1960 to $13.6 billion in 1980 (Bixby, 1999).

The vast majority of the newly funded and created services were nonprofit agencies. Some agencies were established agencies such as Catholic Charities but most of the new programs were provided by entirely new organizations dependent largely on government contracts. The reliance on nonprofit service agencies for service expansion was understandable given the existing service structure in the 1960s and 70s. As noted, state and local government provided a very limited amount of direct services mostly related to cash assistance and child welfare. But a network of voluntary agencies existed in local communities such as the Salvation Army and Catholic Charities with a willingness and proven record of providing services, although their ability to provide these services was greatly constrained by their dependence on private philanthropy and fees for services. Further, local government was often perceived negatively, especially in the 1960s. Many scholars, lay people, and policymakers were convinced that state and local government was incapable of providing equitable and adequate social welfare services, given the political and economic challenges that they faced (Lockard, 1971; Peterson, 1981).

Thus, the expansion of services in the 1960s and 1970s in the US occurred in the context of weak local government capacity, a lack of faith in local government, and a willingness of the nonprofit sector and the federal government to expand services through government contracts with nonprofit agencies (including the creation of entirely new nonprofit agencies reliant primarily on public funds). Significantly, the expansion of federal funding of social services led to a sharp shift in the funding mix of social

services. The percentage contribution of private philanthropy declined sharply, replaced by government contracts and grants.

Further, the percentage contribution of the federal government to total government spending on social welfare services rose rapidly. In 1960, the federal share of total government spending on social services was 36.6 percent. By 1980, the share had risen to 64.6 percent (Bixby, 1991, p. 13). This shift represented mostly new services as well as the substitution of state and local funding of existing programs. With this shift in revenue, state and local government and local service agencies developed close linkages and a shared interest in more federal funding. For instance, state government could claim credit for more funding for child welfare or job training but the fiscal burden of this funding did not fall upon them or the state's taxpayers. Social welfare agencies often worked closely with state government to access federal funding or to lobby for the appropriation of additional state funds for services. Significantly, the funding for services from the federal government was very fragmented with multiple funding streams with overlapping responsibilities and mandates. In short, the financing and regulatory structure put in place in the 1960s and thereafter has tended to promote service expansion. The new federal role, in addition to expanding the amount of money, transformed the political interests of state and local governments who now viewed federal funding as a political opportunity as well as a way of funding valued and needed services. Political entrepreneurship was encouraged as noted initially by Martha Derthick (1975) in her study of federal funding of child welfare services at the state and local level in the 1970s.

This promotion of service expansion and political entrepreneurship was evident in the wake of the major funding and regulatory changes enacted by the Reagan administration in the early 1980s. In 1981, President Reagan won passage of the OmniBus Reconciliation Act which reduced federal spending and regulations on many federal social and health programs and devolved responsibility for the administration of these programs, at least in part, to the states (Gutowski and Koshel, 1984). Many social welfare agencies

experienced sharp reductions in their government contracts especially agencies substantially dependent upon federal funding such as community action agencies, legal services, and workforce development programs.

Over time, though, government contract funding of many different types of social services recovered, and in many cases increased substantially. Many states and localities substituted their own funds for lost federal money or refinanced services to tap federal programs with increasing budgets such as Medicaid. This shift was particularly apparent with policy areas such as mental health, developmentally disabilities, child welfare, home health, and counseling. Many states and localities responded to emergent public problems such as community development, AIDS, low-income housing, homelessness, or immigration assistance with their own funding (GAO, 1984; 1995; Milroy, 1999).

In addition, new federal programs were created or the eligibility for existing federal funding was expanded. The first Bush administration initiated a sharp rise in federal spending on drug and alcohol treatment and prevention programs and child welfare services, for example. New funding was available for new or expanded child care, pre-school and foster care programs such as Headstart and AIDS-related services (Executive Office of the President, 2005, 260-261; House Ways and Means Committee, 1996, 695, 935). Nonprofit low- income housing agencies proliferated throughout the country, fueled in part by the federal Low Income Housing Tax Credit (LIHTC) program enacted in 1986. Changes in the federal Supplemental Security Income(SSI) program gradually broadened eligibility and resulted in a major increase in the number of recipients. For instance, the number of recipients rose from 4.1 million in 1980 to 6.6 million in 1996 (and a projected 7.3 million by 2008) (House Ways and Means, 2004, p. 3-54). Eligibility for SSI triggers eligibility for Medicaid, further expanding services and the incentive for state and local officials to shift financing from state financing to Medicaid, especially since eligibility for Medicaid financed services has also broadened

for many individuals.

This sharp shift to Medicaid funding for social welfare services in the last 25 years is evident in many social welfare programs. For instance, Medicaid is critical to funding services to the developmentally disabled, especially community based programs. In 1980, most government funding for services for the developmentally disabled were state dollars (primarily for institutional-based programs). But due to the Home and Community Based Services (HCBS) waiver program of Medicaid, state funding represented only 46 percent of community spending in 2002 (Rizzolo, Hemp, Braddock and Pomeranz-Essley, 2004, p. 8). Total public spending rose from about $8 billion in 1977 to $27 billion in 2002 (in 2002 dollars) (Rizzolo, et al., 2004, p. 44). Most of this spending is now devoted to community based programs that are typically provided by nonprofit community agencies.

To an increasing degree, Medicaid also funds child welfare, home care, hospices, counseling, residential foster care, drug and alcohol treatment, and services for the mentally ill (although the extent of coverage varies depending upon the state.) Indeed, even states that had resisted tapping Medicaid for many years increasingly rely upon Medicaid financing. Alabama, for example, has undertaken unprecedented improvements in its child welfare system using expanding support from Medicaid. In 1990, the state spent a total of $71 million, including $47 million in federal money. By 2004, though, total spending had risen to $285 million, with $179 million of it from the federal government. Medicaid funding was a key part of this federal funding, a source of funding that the state had not previously tapped (Eckholm, 2005).

With the changes in eligibility, the number of Medicaid recipients has risen rapidly --from 20 million in 1975 to almost 50 million in 2004 (House Ways and Means, 2004, p. 15-44; Behn and Keating, 2004, p. 843). Spending has surged especially in recent years. Total spending in 1995 was $159.2 billion and by 2003 it reached $275 billion (See Holahan and Ghosh, 2005). A more detailed look at the state level also reveals this rising importance of Medicaid. In 1993, Missouri had a total enrollment in Medicaid of

508,101 and total spending of $2.2 billion. By 2005, enrollment had reached 992,624 and spending had reached $6.2 billion (Holohan and Cohen, 2006). Over time, then, Missouri like other states, has shifted important costs such as the care for the disabled and foster care to the federal government through Medicaid which pays roughly half of state costs.

Federal financing also played a key role in the sharp expansion of government contracts for job training, child care, and other support services in the aftermath of the landmark welfare reform legislation of 1996, Temporary Aid to Needy Families (TANF). As part of this legislation, the federal government created new funding programs for services and gave greater administrative discretion to state and local governments to spend the new money. This discretion included new ability by local administrators to shift money from cash assistance to services. This opportunity was used extensively in the late 1990s when state governments were forced to impose strict new limits and regulations on the receipt of cash assistance from welfare. Due to these new regulations, many people lost their benefits.

The impact of the new welfare legislation on social service organizations was complex. Almost immediately, many of the clients of social welfare agencies lost their cash assistance. However, these same clients, to greatly varying degrees across the country, were eligible for additional services (funded in part with new federal grants) to help them seek permanent employment. Overall, the size and character of welfare rolls and the expenditure of funds on welfare related programs changed dramatically. A comparison of 1996 AFDC data and 2001 TANF data underscores this transformation: the number of families on welfare dropped 53 percent; the number of teen parents on welfare dropped by 50 percent; and the share of AFDC/TANF dollars spent on direct cash assistance declined from 73 percent to 44 percent (House Ways and Means, 2004, pp. 7-3, 7-4).

In short, federal funding for income maintenance support for individuals declined sharply. Yet, at the same time, federal support for welfare-related services rose significantly. Overall, the federal share of total human service spending increased in the

wake of welfare reform. Indeed, the federal share of total spending on income-tested service benefits, including welfare, climbed substantially. State spending on services dropped from $8.1 billion in 1995 to $4.6 billion in 2002 while federal spending rose $7.1 billion to $17.5 billion (in 2002 dollars) (House Ways and Means, 2004, p. K-6). A large percentage of this additional service funding was spent in support of social service programs, including day care, welfare to work, job training, and counseling.

This change is evident at the state level. For instance, in Wisconsin, funding for cash assistance to individuals dropped from $352 million in 1995 to $73 million in 1999 but total expenditures rose from $1.082 billion to $1.239 billion due to a big increase in federal service funding especially for child care (Boyd and Billen, 2003, p. 79; more generally, see House Ways and Means, 2004, p. 9-56). More generally, total federal expenditures on child care through TANF (including unspent funds) rose from $138 million in 1995 to $2.5 billion in 2003. And as further indication of the changing federal spending role, total federal expenditures on child care increased from $3.4 billion in 1981 to $27.3 billion in 2003 (in 2002 dollars) (U.S. Department of Health and Human Services, 2005).

The growth in government funding for private agencies for social services has shifted the financing of social services overall and in particular agencies from private philanthropy and private fees to government. Newer nonprofit organizations such as community mental health centers, drug treatment agencies, or job training programs are largely dependent on public funding. Older organizations tend to have a more diversified revenue mix but private philanthropy is a much smaller percentage of their budget as well.

The short and long-term outlook for government financing of nonprofit agencies is very unclear. Some welfare-related service funding has begun to decline. President Bush has proposed fundamental changes in the Medicaid program including a cap on expenditures that would have the effect of shifting a greater burden of the costs to the states and away from the federal government (Kaiser Family Foundation, 2005). Adding

to the uncertainty over future spending is the many and varied proposals pending in Congress to reduce spending. State governments have faced serious budget challenges in recent years, especially given the growth of major programs such as Medicaid (Behn and Keating, 2004). Some states such as Oregon, Missouri, and Tennessee have reduced eligibility for Medicaid for thousands of people, leaving them ineligible for many needed services. Although state revenues have recovered recently, the continued growth of programs like Medicaid, combined with declining federal assistance, is likely to squeeze state and local governments financing for social programs.

This uncertainty on government funding is likely to spur additional diversification of the tools employed by government to support nonprofit activity, especially since financing tools such as tax credits and deductions and fees for service tend to generate much less political opposition and controversy than direct grants and contracts. Given this shift in financing, it is particularly important to examine the impact of different types of financing on the operations of nonprofit agencies.

3. THE DIVERSIFICATION OF FINANCING

A critical component of the growth of government funding of social welfare services including the growing array of programs including many very specialized programs is the diversification in the policy tools used to support social welfare services. As noted by Salamon (2002), government has many different "policy tools" by which it can address public problems including direct grants, contracts, tax credits and deductions, bonds, loans, and regulation. This section profiles the significant shift away from contracts to a more diversified approach to funding social welfare services including widespread utilization of tax credits and deductions, bonds, and vouchers and quasi-vouchers such as Medicaid.

Before the 1960s, government funding of private social welfare agencies was relatively limited and tended to be restricted to certain services such as child welfare Typically,

public subsidies were provided with relatively minimal accountability requirements; nonprofit agencies were assumed to use the money wisely and efficiently, partly because many agencies were part of a web of local relationships that offered legitimacy and some measure of accountability to government. Also, state and local governments--the primary source of government funding--tended to maintain little capacity to monitor their grantees. Payments were not really contracts either but per diem payments based upon longstanding relationships between local government and particular social welfare agencies.

When federal funding for social services increased sharply in the 1960s and 70s, many of the new federal and state contracts with private, mostly nonprofit agencies lacked stringent guidelines and regulations. Over time, though, federal, state and local agencies discovered that they now funding sometimes hundreds of agencies. In order to ″rationalize″ this system (Brown, 1983) and ensure the government agencies were maintaining accountability for the expenditure of public funds, the regulations governing government contracts are increasingly stringent, even to the point of government sometimes specifying the names of the clients to be served by the agency (Smith and Lipsky, 1993; Gronbjerg, 1993). Today, many government programs explicitly tie reimbursement for contract services to specified outcome measures through so-called performance contracting arrangements (Behn, 2003). Many states have also used third-party intermediary organizations such as managed care firms to manage various parts of their social welfare service system in the interests of controlling costs and achieving higher performance (Mahoney, 2000; Wulcyn, 2000; Courtney, 2000).

This change in substantive character of contracting has been accompanied by a shift away from a reliance on contracts to often complicated and diverse funding sources. In particular, an analysis of the financial statements of social service agencies, especially nonprofit service agencies would indicate a big jump in the percentage of their revenue earned from ″fees″. This terms refers to revenue collected from individuals and organizations (as opposed to directly from government through grants and contracts)

including: rent payments from residents in community housing programs; reimbursement from public and private health insurance programs; direct payments from clients; income from technical assistance services; tuition; the sale of goods such as meals from a café and special event ticket sales.

For social and health organizations, the very consequential shift in the last 20 years has been the increase in fee income from government. Two specific examples of the transformation of revenue streams for social welfare agencies vividly illustrate this shift. The first example is large multi-service agency is the state of Washington. This agency has a long history in the community and provides an extensive array of social and health services in the Puget Sound region. Its services include: home care, foster care, a homeless shelter for single men, emergency assistance, adoptions, and a residential facility for teen mothers.

This agency is a central component of the overall public service delivery system in the Puget Sound. Its services reflect this orientation as well. It is a faith-related agency but its services are available to anyone regardless of their faith; indeed ninety percent of its clients are not affiliated with the agency's denomination. They choose their clients based upon criteria established in government contracts. For example, its home care program relies entirely upon referrals from the state Department of Social and Health Services (DSHS) clients need to meet the state's criteria for admittance into the program. Many other agency programs are required to use state or city referral criteria. The agency is subject to many different state and federal regulations on wage and hour laws, union representation, immigration and citizenship, non-discrimination, access for the disabled, and Drug-Free Workplace rules. The agency has had to make extensive investments in a financial management system in order to track the agency's many revenue streams. Increasingly, the agency is required to track outcomes for its programs.

Overall, the agency has experienced significant budget growth in recent years. In fiscal year 1994, total income was over $43 million with approximately $37 million from

government. In fiscal year, 2003 (ending 30 June 2004), total revenue was over $63 million with up to $52 million from government through grants, contracts, and fee revenue from government including substantial reimbursement from Medicaid. Underscoring the complexity of the current funding environment, the exact percentage of government funding is almost impossible to discern without individually scrutinizing the myriad of client transactions. (Further, even the agency does not know how much of their funding is from Medicaid because the state is not required to inform the agency when it is reimbursed for services.)

Medicaid is an increasingly important as a funding source since the agency serves a primarily poor and disadvantaged population so many of its clients are Medicaid eligible, allowing the state to seek reimbursement from the federal government for approximately half the cost of service delivered by the agency to eligible clients. This shift for example in particularly noticeable in the foster care program offered by the agency which 25 years ago was financed primarily through state funds supplemented with some federal funding such Title XX. But today, the foster care services offered by the agency are primarily financed by Medicaid.

The shift away from direct contracts (and the growth of federal service funding) is evident in another way in the revenue profile of the agency. In fiscal year 2003, the agency received funding from several different funding programs within the federal Departments of Housing and Urban Development (HUD), Agriculture, Education, Health and Human Services, Justice, and Homeland Security (for emergency food and shelter) as well as the Corporation for National and Community Service (for foster grandparents and senior volunteer programs). Most of this federal money was ″pass-through″funds whereupon the funds were initially given to another public or private agency including the cities of Tacoma and Seattle, the state of Washington, the United Way of King County, and even other local nonprofit service agencies. Thus, the agency had dozens of contracts with multiple agencies as well as substantial fee income from public funding

sources such as Medicaid. These varied and complex funding arrangements require sophisticated management systems and infrastructure to manage.

The other agency example is a smaller agency, focused on providing services to the developmentally disabled. This agency was founded in 1971 by students at the University of Washington who were volunteering at a state institution for the developmentally disabled(At this point, most of the services for the disabled were provided through state-funded institutions). In 1991, the agency decided to focus on adults and since then has provided in-home case management and support services to developmentally disabled adults. In 1993, the total income of the agency was $365,000; the projected income for 2005 is $1.5 million, reflecting the growth in services of the agency and the overall increase in government funding for agency.

Currently, the agency gets close to 95 percent of its funding from state government. This funding is mostly in the form of fee income from the state; but most of this funding is Medicaid. (All of the agency's clients are SSI recipients, so they are eligible for Medicaid.) When it was founded, almost all of the funding was state dollars. But today, the agency relies upon Medicaid (which is reported as fee income). For the agency, the reliance on Medicaid has meant compliance with complex regulations that restrict the types of clients that the agency can serve and the manner in which services can be provided. Medicaid rates have also failed to rise sufficiently to keep pace with rising costs so the agency is sometimes simply not able to provide the amount of service to their clients that they believe is appropriate. This agency faces significant constraints in trying to diversify their programs or revenues. State regulations prevent the agency from offering vocational services in addition to their existing residential services. The agency has tried to increase its private fundraising in recent years, but the increase in private donations has not been sufficient to compensate for the failure of Medicaid to keep pace with rising costs and client need.

To varying extents, both agencies--as well as countless agencies throughout the country

also rely upon or utilize the growing number of tax credits for the benefit of their organization and/or their recipients. In the last 25years, Congress has enacted a wide array of tax credit programs including the Low Income Housing Tax Credit (LIHTC), the Work Opportunity Tax Credit (WOTC), the Earned Income Tax Credit (EITC), the Child and Dependent Care Tax Credit (CDCTC) and the Child Tax Credit (CTC). These credits are now a substantial cost to the federal treasury and play a major role in supporting access to an array of social services. These tax credits and others vary substantially in their benefit to low-income families and individuals (Burman, Maag, and Rohaly, 2005; Steuerle and Ball, 2006; Hamersma, 2005).

Their importance in supporting social programs is illustrated at both agencies. This agency provides services to developmentally disabled individuals who live in housing that is often built through the use of tax credits. Further, firms can take advantage of the WOTC to hire these individuals. The larger, multi-service has so many different programs that the agency, or its clients, benefits from almost all of these important tax credits. For example, it has extensive child care programs and it has built hundreds of units of housing through the use of the LIHTC.

Pressure on service agencies to diversify their revenue sources away from direct contracts has also encourage nonprofit service agencies to strive to raise more funds from individual and corporate cash and in-kind donations. Current federal law permits individuals to take a tax deduction for cash and in-kind donations if they itemize their tax returns. The deduction reduces the cost of giving from $1 to $1 t, in which t is the tax filer's marginal tax rate. In 2003, this deduction cost the federal treasury $37 billion (Ball, Carasso, and Steuerle, 2006). Many nonprofit agencies are aggressively raising money through capital campaigns, specialized in-kind donation programs such as car-donations, and new outreach efforts to corporations and wealthy individuals. The limitations of this strategy to raise private donations are numerous including intense competition among agencies for individual and corporate donors and a lack of

organizational capacity, especially among smaller organizations. Indeed, in the aggregate, total individual giving has hovered between 8 and 12 percent of total gross receipts for all nonprofit organizations (Bell, Carasso, and Steuerle, 2006). For many nonprofit social welfare agencies providing service such as mental health or substance abuse treatment, the percentage is even smaller.

One other noteworthy development in revenue diversification is the growing use of tax-exempt bonds by social service agencies. Large non-profit institutions such as hospitals and universities (as well as for-profits) have taken advantage of tax-exempt bonds for decades. These bonds help nonprofit organizations finance the cost of capital improvements such as a new construction or renovation. What is new is the growing use of tax-exempt bonds by smaller service organizations such as housing development organizations, child welfare agencies, and mental health centers. This increase in tax-exempt bond financing reflects in part the steady rise in the number of nonprofit social and health organizations, especially smaller community- based organizations. Most of these smaller organizations are undercapitalized so as they develop as organizations, they face substantial challenges in adequately funding their capital costs. This situation is exacerbated by the lack of financing for capital costs within government contracts. As a result, nonprofit organizations have turned to policy makers at the federal, state and local levels to help them address these important capital costs. For example, state housing finance agencies have helped support low-income housing development by issuing bonds. Also, some states such as Massachusetts, Washington, and New Jersey have created state agencies for economic development or housing development that offer tax-exempt bond financing programs for qualifying 501 (c) (3) organizations. For instance, Mass Development has provided tax-exempt bond financing to nonprofit human service organizations for building purchase and renovation. Often bond financing is combined with various forms of below-market rate loans (See www.massdevelopment.com for New Jersey, see www.njeda.com). In the state of Washington, the Washington Housing

Finance Commission has issued tax-exempt bonds on behalf of a wide variety of social, health and educational non-profits, including some relatively small community organizations (http://www.wshfc.org/bonds/npfacilities.htm). Tax-exempt bonds are an attractive financing option for nonprofit social service agencies since they can obtain sizable financing for their capital needs; few foundation sources of extensive capital financing exist by comparison, although some big national foundations have begun to offer programs specifically targeted to capital needs (Ryan, 2001). Targeted fundraising through capital campaigns can be a very labor intensive and expensive process that is especially difficult for smaller agencies to undertake. In sum, contracts remain the key strategy of government support for social service agencies. But increasingly, other revenue sources including Medicaid and other types of fee income play a sometimes major role in financing the operations of service agencies.

4. CHALLENGES FACING SOCIAL SERVICES AGENCIES

Privatization has thus produced an expansion in the number of agencies receiving government contracts and funds as well as a diversification of social services. However, it has also created new and different problems for policymakers, government administrators, and private agency staff and volunteers. These challenges are the focus of this section.

1) Pressure for Accountability and Performance Evaluation

Inexorably, privatization has created increasingly intensive efforts to hold private agencies accountable. This began, of course, with the initial build-up of government contracting with private social service agencies in the 1960s. Service agencies were expected to be accountable for their expenditure of public funds under their contracts. This accountability was in a line-item sense, however: were the public funds spent

according to the stipulations of the contract? This ″process″accountability typically involved reporting the number of clients served or meals delivered as well as a budgetary breakdown on the allocation of various expenditures. Government also tried to increase the likelihood that the on tract agency delivered a quality program by requiring staff and program standards even before any money was distributed.

Over time, though, many policy makers became disenchanted with this process accountability, arguing that it provided little evidence on the effectiveness with which programs were achieving their desired outcomes. Further, public grant administrators worried about the potential mismatch between public and nonprofit service priorities. As a result, public and private funders began to demand that service agencies measure their outcomes. Especially for nonprofit agencies, this shift to outcome evaluation involves a revolution in thinking and overall approach to service. It also requires new investments in management information systems and monitoring. Often funding for this management infrastructure is scarce, putting further financial pressure on many agencies.

Outcome evaluation further increases the competitive pressure on non-profits. In the past, non-profits were relatively assured that their funding would continue, barring any egregious problems. But many government contracts now tie reimbursement to performance, raising the specter that an agency could lose its contracts if it did not meet specific performance targets(Many welfare-to-work programs now have this requirement).

Financial uncertainty and competitive market pressure is due to the widespread restructuring of the contracts between government and private service agencies. In order to give government agencies greater control over private agency performance, governments have increasingly restructured contracts with social service agencies from a cost-reimbursement contract to a fee-for-service contract. Agencies have less predictability on their revenues since they will only be reimbursed through a fee structure when performance targets are reached.

The move to performance evaluation by government and private funders is part of

what many people regard as an overdue move to increase the accountability of nonprofit agencies, both in terms of specific program outcomes as well as more generally to their boards of directors and the community. As just one indication of this attention to performance, many larger agencies are implementing a ″balanced scorecard″that includes both financial and programmatic performance measures. Ultimately, the outcome of this attention to performance remains to be determined. Assessing outcomes of many social service programs is complicated and expensive. For some programs, it may be virtually impossible to evaluate outcomes given concerns about confidentiality and difficulties involved in tracking clients after they leave a service program. Also, public and private funders may find it difficult to use outcome data, however imperfect, to determine grant and contract decisions.

2) Managing the Government-Nonprofit Relationship

Despite the growth of for-profit social service agencies, most service categories are still dominated by nonprofit social welfare agencies. This section focuses on the government-nonprofit relationship given its special importance in understanding social services policy and practice in an era of privatization and devolution. Since the 1960s, government funding of nonprofit agencies has shifted from grants with relatively loose accountability to increasingly specific contracts and requirements. Also, government funding affects the operations of nonprofit organizations in many different ways with the specific effects dependent upon the type of service, the extent of professionalization, the origins and mission of the organization, and the character of the government-nonprofit relationship.

However, among nonprofit social service and health organizations, the response to government funding is rooted in the differing approach to services and clients taken by non-profits and government. Non-profits emerge out of a desire of a group of like-minded ″community″of people to address a problem or social need. Examples

include battered women shelters, neighborhood drop-in centers for youth, inter-faith homeless shelters, community health centers, and Lutheran Social Services. All of these organizations represent a "community," and as such, in their ideal type, feel a special obligation to their community of interest. Battered women shelters may view their obligation as primarily to any abused women in a given locality; community health centers may want to serve anyone in a community regardless of their specific problem; and a drop-in center may serve any adolescent who self-identifies himself or herself as troubled and in need of help. Responsiveness to a particular community is the guiding norm (Smith and Lipsky, 1993).

Government, by contrast, tends to approach services and clients from the norm of equity. The ever-present problem facing government officials charged with distributing funds or services is to justify why they provide services to one group rather than another, since government does not have the resources to serve everyone in need. In a democracy, groups can seek redress if they feel they are being unfairly treated; government officials are accountable to these groups and to the citizenry in general for their policy choices. Equity is a norm consistent with the need of government officials to treat groups and individuals fairly. Equity can be interpreted in a variety of ways, but in social and health services it usually means defining need in order to allocate resources by criteria deemed to be fair -- e.g. income, geographic location, and severity of illness or needs.

Because of their emphasis on responsiveness, nonprofit agencies may clash with government, especially in connection with contractual issues on policy matters relating to services, clients and staff. For instance, a program for troubled youth may prefer to serve any adolescent in the community; but government officials may believe its funds should only serve the neediest clients. Indeed, government staff may accuse the program of "creaming"-- or taking only the easiest cases and neglecting the so-called tough cases. Nonprofit agencies often respond to the creaming charge by arguing that they are only

providing services within their mission and in any case their services were never designed to serve difficult and expensive clients such as troubled youth. This same basic disagreement between government and non-profits can occur when nonprofit agencies favor certain groups such as co-religionists or local neighborhood children.

In addition to programmatic effects, government funding tends to affect the internal organization of agencies as well. Service agencies started through community initiative often lack, at least initially, a highly trained professional or administrative staff. Some of these agencies originally emerge from an unincorporated group of like-minded people concerned about a social problem. A clear separation between the board and staff is absent and many of these agencies do not have full-time executive directors. Government funding means accountability, which often requires these agencies to adopt new administrative procedures, add professionals, institute new financial management practices, and in some cases, modify existing physical structures. These organizational changes are often difficult to achieve because many smaller agencies do not have the financial resources. More generally, this is a key public policy concern because a disproportionate amount of the growth of the nonprofit sector in the last 20 years has been among these community-based agencies that after an initial, start-up phase must undertake complicated and sometimes expensive changes to their management and programs to abide by government expectations.

Administrative and programmatic restructuring in response to government funding is also apparent in other types of nonprofit agencies. More established agencies may sometimes be required to undertake expensive changes in their programs to comply with government contract regulations. For instance, when government funds arrived in significant amounts in the 1960s and 1970s, many agencies were already formal organizations with large boards and staffed by professional social workers and psychologists. Over time, new staff regulations were usually added and the client mix changed in a way which forced these agencies to hire more specialized staff; renovate

their physical plant; and change their client mix. (In part, these new regulations reflected the lack of attention to accountability, especially programmatic outcomes, by many non-profits.)

Some contract agencies are oriented toward government from their inception and may even be a spin-off from government, an increasingly common practice at the local level. These agencies then may be inclose agreement with government expectations from the beginning of the organization and as such, the organizational changes characteristic of agencies with roots in the community may not be evident.

This complicated, sometimes difficult relationship with government encourages nonprofit service agencies to mobilize politically especially through the formation of political coalitions to represent their interests. In general, these coalitions focus on issues of direct benefit to their member provider agencies, such as contract reimbursement rates and government regulations. There is much less incentive for these coalitions to become engaged in broader social welfare concerns such as workforce training, welfare reform and the need for low-income housing. In a sense, the intricacies and political sensitivities of the government-nonprofit relationship ″channel″the political activity of providers into areas that are materially affecting both parties.

Rethinking the relationship between government and non-profits remains one of the biggest challenges facing nonprofit service providers. The fate of these providers is tied to government policy but the political influence needed to change government policy, whether it is on funding levels or regulatory policies on contracts, is often wanting. Government officials, for their part, worry that any movement away from performance standards will undermine their effort to improve outcomes and reassure the citizenry that public funds are being spent wisely.

3) Revenue Development

A major challenge confronting non-profit and for-profit social service agencies at the present time is resource development. Part of the problem is related to the big increase in the number of social service organizations so competition for public and private dollars is much more intense. Further, public funding has increased as noted but it has often not kept pace with the rising costs of non-profits. Government contracts have been restructured as fee-for-service contracts, increasing the unpredictability of an agency's public revenue. Over time, government contracts typically do not keep pace with rising costs of the agencies so many agencies receiving government contracts are insufficiently funded and have to subsidize the services from other parts of their operation.

Many social service agencies are woefully undercapitalized. As a result, these agencies face enormous pressure to raise capital in order to compete effectively. The larger agencies have a greater capital base but much higher overhead; paying for this overhead has become increasingly difficult given the trend toward project-related funding by public and private funders.

The response of social service agencies to the challenge of resource development varies depending upon the type of organization. Nonetheless, a few broad trends are apparent. First, many agencies have greatly stepped up their effort to raise private donations: development officers have been hired; new board members with fundraising potential have been appointed; and executive directors are increasingly expected to be good fund raisers. Some of the larger agencies have created affiliate entities such as the "Friends of the Agency"to undertake special fundraising events and support campaign fund drives. In general, the big agencies with professional development staff, well-connected board members and staff, and resources for marketing and fundraising are in a much better position to compete for private donations than small or mid-sized agencies. Over time, one would predict that the big agencies will have a substantial edge in attracting qualified staff, new government contracts and private grants given their

ability to raise private funds.

The other ripple effect of the more competitive environment on private fundraising is the push to create endowments even among agencies of relatively modest size. As noted, many agencies are undercapitalized, having started in rented space and then obtained government contracts or foundation grants. This external funding only supported operations and was generally unavailable for capital expenditures, however. Now, many nonprofit human service agencies find themselves with aging physical structures, demands for improvements in technological capability, and intense competition with other non-profits(and for-profits in some cases) with much better capital positions. In addition, the project-driven character of public and private grants means that nonprofit agencies now have much less discretion to allocate grant funds. As a consequence, nonprofit human service agencies have a great incentive to build an endowment to provide the agency with unrestricted funding support and to improve the long-term capital position of the agency. The process of building an endowment can also have a number of positive marketing benefits for the agency.

Second, the stiff competition for public contracts and private donations has encouraged nonprofit social service agencies to tap earned income more extensively as a source of revenues. In the context of social services, fees and earned income can involve a variety of diverse revenue options: the payment of fees by individuals, public and private insurance companies, and corporations; selling services such as technical assistance or cookbooks, earning money from client-run businesses, such as a restaurant staffed by the disadvantaged; real estate development (including parking revenue); and selling food at a local festival. The fee revenue received by most non-daycare social service agencies, however, usually does not represent out-of-pocket client funds; instead it is often government or private insurance.

Indeed, nonprofit social service agencies are substantially less dependent on client, out-of-pocket fees than they were in 1960 when many agencies relied on client fees for

over half of their revenue. Many nonprofit agencies find it very difficult to raise much revenue from client fees because most clients are poor or disadvantaged. In a sense, the lack of reliance on out-of-pocket client fees for most nonprofit social services should be viewed as a positive step in public policy. Forty years ago, nonprofit social service agencies were heavily criticized because of their failures to serve disadvantaged populations. Part of the issue in serving the disadvantaged at this time was the high dependence of nonprofit social service agencies on client fees and private donations. The growth in government funding since the 1960s has substantially changed this, permitting, and often requiring, nonprofit social service agencies to increase their service to poor and disadvantaged populations.

This is not to suggest that the shift to fee income even if it is not predominantly money directly from clients is unimportant. The structure of fee income means that non-profits are in an inherently more unpredictable and unstable revenue situation. Consequently, an indirect effect is to add further pressure on non-profits to be entrepreneurial and more business-like in order to be able to compete effectively in the new, more unstable environment.

Another potential source of fees is earned income from the sale of products and services. Gift shops and restaurants, for example, have allowed nonprofit arts and cultural organizations to boost their income significantly in the last 20 years. Earned income has also received broad attention in recent years as an outgrowth of the social enterprise ″movement,″which strives to meld the values of the nonprofit and for-profit sectors by building business ventures into employment and training or social service programs.

Despite the success of such organizations, most nonprofit social service agencies are not well-positioned to raise much earned income. A sizable number of nonprofit service providers, perhaps more than half, are small and undercapitalized with a very targeted market niche(Many small agencies do not even own any property). They also are very value-driven with very little interest (or capability) in expanding their earned income.

Also, many agencies do not have any service that they can profitably sell on the "market." For instance, an emergency shelter for youth really has no marketable product. Even nonprofit programs dependent upon client fees such as child care agencies do not really earn any significant amounts of money from the sale of other services. Surveys of nonprofit service agencies in recent years confirm this difficulty in raising funds from earned income sources.

4) Management Infrastructure

The growing complexity of the social service agency environment, and the escalating expectations of public and private funders for accountability and outcome evaluation, have placed vastly increased demands on the management infrastructure of service providers. For one thing, private social service agencies are pressed to invest in management information systems and improved technology in order to be able to respond to the greater demands for accountability. Performance contracts require the agencies to provide a lot of data on clients and programs. New accounting standards impose new record keeping requirements on non-profits. And the competition for funds means that nonprofit staff and boards need much better financial and program data in order to assess their present and future needs. The challenge for nonprofit social service agencies is that the expertise and resources necessary to adequately invest in new information systems is often in short supply. This is particularly true of smaller community-based agencies with roots in the informal sector.

Second, agencies face a big challenge in attracting qualified executive leadership. Historically, many executives "rose through the ranks"and were often trained as clinicians. Over time, they gradually assumed more and more administrative responsibilities. However, the emphasis on entrepreneurship and the increased external and internal complexity facing service providers calls for new types of executives, or at the very least new training and education programs to help executives cope with a very different

organizational environment. In recent years, many agencies have found it very difficult to attract top-notch executives given the tight labor markets and the problems of paying competitive salaries.

Third, the problems of attracting qualified staff and developing a sound management infrastructure is often exacerbated in nonprofit service agencies by inadequate board oversight and monitoring. Board members are often attracted to serving the board of a social service agency due to personal connections to the agency or a personal commitment to the agency's mission. But once on the board, these individuals find it very difficult to effectively monitor the work of the staff, particularly given the complexity of government performance contracts and the technical nature of many agency programs. Among smaller organizations, the problems with the board can often contribute to the already difficult challenges facing the agency in attracting and keeping qualified staff, raising private donations, and developing community and political support.

Fourth, many nonprofit service agencies, especially in the area of emergency assistance and relief rely substantially on volunteers for direct service contact with clients (even if their funding is often public or from foundations). But the competition for volunteers can be intense and many agencies find it increasingly difficult to engage volunteers in regular volunteering, especially with complicated services or with difficult client populations. Increased liability and accountability demands also make it more imperative to have a stable source of good volunteers. To effectively compete for volunteers in this environment, nonprofit agencies are being forced to devote more resources to volunteer management, training, and oversight.

Given the increasingly restricted character of public funding, finding the funds to invest in management infrastructure is a major challenge for social service agencies, especially the smaller organizations. This in turn contributes to management instability, which then encourages funders to press agencies ---notably the smaller agencies---to merge or collaborate. Also, many smaller nonprofits may be at a distinct competitive

disadvantage in relationship to for-profits hat often have greater access to capital, thus allowing them to invest in infrastructure to remain competitive for public funds.

5. IMPLICATIONS FOR POLICY AND PRACTICE

In the last 25 years, a fundamental transformation of social services has occurred. The wide ranging and ongoing debate about privatization and devolution has tended to divert attention from the realities of public policy and street-level practice as reflected in the organization and financing of social welfare.

At one level, "privatization" of a sort has certainly occurred. Hundreds of thousands of nonprofit and for-profit social welfare agencies have been established since the 1960s. In some policy areas such as developmental disabilities and mental health, a substantial shift has occurred from large public institutions to smaller, largely nonprofit, community-based programs. But most new agencies---whether in child welfare, job training, or low-income housing -- are providing services that were previously unavailable. Many of these organizations might have been at one time completely volunteer-led and financed, but eventually many of the organizations, especially in the social and health arena, received substantial public funding, especially through government contracts. These organizations and their programs represent an expansion of the American welfare state and a shift from private philanthropy to public funding.

Another perspective on privatization is to consider it a shift away from direct public grants and contracts. Nonprofit agencies such as community mental health centers that were funded through direct grants and contracts in the 1960s are now funded through a variety of different funding sources including fee for services through Medicaid and private insurance. (Indeed, he growth of Medicaid as a funder of social programs for a broad spectrum of the population with very diverse needs -- from residential treatment for children to outpatient drug programs to home care for the developmentally disabled

-- is one of the largely overlooked stories of the growth of government funding of social services.) Housing development agencies depend in part on tax credit revenues as opposed to direct grants for low-income housing.

Some fear that a shift to private agencies has been accompanied by an abandonment of public goals and objectives in favor of private goals. Whether true or not, most non-profits and for-profits receiving public funding, even in the form of fee for service revenue are very tied to public priorities and regulations. Medicaid eligibility, for example, and the rules governing reimbursable services are quite extensive and elaborate. Low income housing agencies must use these credits to serve eligible clients to the extent required by the programs, lest the entire project lose its tax credit eligibility. Many government contracts contain detailed performance measures and targets. Indeed, the continuing interest in the US (and elsewhere) in the New Public Management and its emphasis on accountability and performance measurement has encouraged governments at the state and local level (and private funding agencies) to tie ever more closely the programmatic outcomes of social welfare agencies to public priorities.

Importantly, the rhetoric of privatization also tends to minimize the need for additional public resources and thus creates major difficulties for advocates of social services and other social. The risks to service organizations of even incremental adjustments to key funding programs such as Medicaid or the LIHTC are largely neglected since the connection between these programs Medicaid and the health of many social welfare agencies is not immediately apparent.

Relatedly, the connection of the citizenry to its government over time can become attenuated as the funding and regulatory role of government becomes more complicated and private social service agencies assume a more prominent service role. Citizens are receiving an array of services that are subsidized directly and indirectly by government. But these nonprofit and for-profit agencies are not accountable to the citizenry in the same way as public agencies. In the case of nonprofit social welfare agencies, board

meetings are not open to the public; the board is usually self-perpetuating (rather than elected by the membership); most agencies have non-unionized employees with fewer job protections; and many agencies lack substantial infrastructure or community connections, undermining their ability to respond to citizen concerns.

Thus, the increase of public funding may actually lead to less citizen capacity or interest to mobilize around public concerns or the preservation of funding for particular service areas or even individual organizations. The lack of transparency (however inadvertent) around government funding mean that it is also much easier for government to make incremental cuts in service levels since it may not be obvious even to recipients of agency services that cuts are being implemented. For example, government can tighten eligibility or reduce the number of allowable visits that are often incremental but important reductions from previous service levels. In essence, the diversification of financing and funding may make service levels more politically contingent and more susceptible to cuts through administrative discretion.

The implications for equity and service adequacy of these financing trends are complex. Many social service organizations have expanded greatly in the last 25 years. Service levels for an array of programs, including hospices, home health, child care, community residential programs for the developmentally disabled, AIDS patients, and the mentally ill, job training programs for the disadvantaged are at or near record levels in terms of the number of publicly financed recipients. Indeed, many of these services receive levels of public funding that are significantly in excess of comparable programs in many other countries including countries with much more generous cash assistance programs. Yet, the decentralized character of social services in the US also means that overall trends such as increased federal funding for TANF, Medicaid, and other programs masks individual state and local variation (See for more detail, Golden, 2005). Individuals lacking eligibility for these individual programs may find it very difficult to obtain needed services since they may not earn enough to pay for important services

such as child care or job training from their own resources. This is likely to be a particular problem for disadvantaged who do not fit into a specific eligibility category. Or put another way, basic social welfare needs such as income and food assistance and emergency aid and shelter are very under-funded in the current environment which tends to emphasize support for specific categories of individuals with pressing needs such as the disabled.

Also, the increased role of nonprofit social welfare agencies in providing services means that services are more dependent on the capacities and location of nonprofit organizations. Government would be well-advised to regard their relationship with nonprofit service providers as a long-term relationship that requires ongoing investment and encouragement.

Finally, privatization and devolution in social services policy in the US proceeded initially through government contracts with primarily nonprofit social welfare agencies. Increasingly, these agencies are also supported through a mix of funding sources. This diversification of funding and the extensive role of contracts reflects several important characteristics of the social services policy in the US including administrative decentralization, major open-ended funding programs such as Medicaid, an important federal financing role, and many different potential funding agencies and sources. While these characteristics have tended to promote a long-term expansion of social services, it has also produced service fragmentation and less transparency in agency operations, leaving programs susceptible to shifts in political support and administrative cutbacks. Thus, policy makers and citizens interested in better performance and improved service adequacy should push for greater transparency and more openness in service agency operations in order to build more broad-based and enduring support for quality, adequate, and equitable social services.

Chapter Ⅳ TODAY'S PUBLIC HUMAN SERVICE WORKERS IN THE US

As a crossroads: The US human services system and the impact on its workforce

by Jerry W. Friedman[11)]

PREAMBLE

This paper was prepared to provide a practical description and a case study of the development of public health and human services policy and programs in the United States with special emphasis on emerging trends and an analysis of the impact on services as a result of the implementation of Welfare Reform in 1996. It concludes with a list of considerations as other governmental entities consider changes to their health and human services delivery systems. This paper was written from the perspective of a generalist human services administrator with the goal of raising critical operational questions and options derived from lessons learned over the course of the last several decades. Its primary intended audience is policy makers and practitioners responsible for administering health and human service programs.

1. INTRODUCTION

It is difficult to describe the delivery of health and human services in the United States as a system of care. It is a complex array of singularly focused programs delivered in multiple jurisdictions through public and private providers. Each program has different rules, regulations, and eligibility criteria.

In the United States, health and human services programs operate within a challenging array of dynamics that makes it unique in the realm of public administration. Some of

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these factors include the following:

- The goals are so very high to actually build a stronger society. Health and human services, especially public welfare, one of the few industries with the stated intent of literally putting itself out of business by eliminating poverty, hunger, hopelessness, etc.
- The failures are so visible. The homeless population found on the street corners of major metropolitan areas provides a constant reminder of the fact that, in spite of a substantial investment in the nation's safety net, a large number of people have been left out, left behind, and are not enjoying the bounty of a rich country.
- The resources available for health and human service infrastructure are often insufficient to complete the mission. Human services are not generally at the top of the priority list for new funding and, until recently, there has been little investment in new systems technology to support program and administrative requirements.
- Public human service programs conduct their business in the open. As required by public disclosure rules in conducting "the people's business," a mistake is likely to be reported on the front pages of the local newspaper. This is a challenge that private corporations and the business community generally don't face. Consequently, coupled with the difficulty in promoting success stories, this negatively affects the public image and confidence in managing programs efficiently and effectively.

It is important to note that the history of public human services in the United States was not the result of thoughtful planning. It seems as if Congress would discover a problem, allocate some money for that purpose, and presume that it was resolved. The net effect is a plethora of self-contained programs and agencies with redundant and costly administrative support systems and personnel rules. Often, these entities are forced to compete with one another for limited resources, pitting advocates against one another in a public arena. For clients, trying to navigate the public human services system can be cumbersome and confusing. For administrators of public human services, the

combination of categorical rules, funding restrictions and inconsistent bureaucratic oversight makes the programs seem almost unmanageable. The challenge of human service administration was compounded with the growth of entitlement programs in the 1960s and 1970s, increased services demand, class-action lawsuits, escalating public expenditures and public discontent. While benefit levels varied, the one constant among states was federally administered public health and welfare programs, including Aid to Families with Dependent Children, Medicaid and Food Stamps.

2. HISTORY AND CURRENT SYSTEM

While a number of pilot projects and experimentation has occurred throughout the United States since the passage of the Social Security Act in the 1930s, public human services has been administered as a categorical system since that time. Depending on one's perspective, there are certain advantages to problem centric categorical alignment, especially in terms of program advocacy, fund raising potential, and in the development of specialized clinical, treatment and case management expertise.

Also, if program administrative responsibility is limited to one specific area, it is easier to manage one categorical component rather than operate within an integrated management infrastructure. However, the categorical system also has distinct disadvantages including the fact that there is significant duplication and expensive redundancy within a categorical framework and the lack of a client centric approach is confusing and limits services access for clients.

Each state varies in terms of whether services are administered at the local level by local employees or by state employees out stationed in municipalities. In either case, states bear the primary administrative responsibility for compliance with federal rules and oversight. The degree to which state and federal matching monies are required also varies considerably among federal health and human services programs. Usually, a local

fiscal match is required in order to draw down federal funds. It should be noted that until the Great Depression of the 1930s, human services in the United States was primarily the responsibility of charitable and faith-based organizations and local governments. The federal government did not play a major role in the delivery of health and human services in terms of program development or financing. Instead, the federal role was evolutionary and lacked a systems approach or overview in the development stage of these programs. The challenge was further compounded by the fact that the federal bureaucracy is incredibly complex and the program oversight is vested in a number of different agencies reporting to different congressional oversight committees. Each operates as a self contained program without regard to each others rules which at times can be contradictory. With each federal program establishing new rules, regulations, and funding requirements, the tedious and challenging task of sorting through this complex array of categorical program requirements and financing fell to state and local health and human services administrators who, for the most part, were also aligned in a categorical fashion.

The 1970s and 1980s brought a significantly changing environment to the delivery of health and human services in the United States. Many public officials began to question the return on investment of the large outlay of federal expenditures to alleviate suffering through President Lyndon Johnson's"War on Poverty." This cry for public accountability and New Federalism that revised intergovernmental relationships led to the development of cost containment strategies and new ways of conducting business. There also was a growing acknowledgement that health and human services was a large business (usually one-third to one half of most state and local budgets) and needed to adopt modern business techniques and strategies to restore public confidence. It indeed is a "compassionate business", but a business nonetheless. Consequently, these municipalities, for the sake of better management and efficiency began to develop umbrella structures to bring order, uniformity, and consistency in the administration of these programs. For

many local legislators, the creation of a single health and human services organizational structure was viewed as an antidote to an administrative malady commonly referred to as "hardening of the categories."

To advance the rationale for the development of integrated service delivery, a compelling case for change could be made by examining the "real world" lessons learned from an uncoordinated categorical system.

- The categorical system was extremely confusing for clients, especially in terms of applying for and accessing services. With multiple intake points for services located within the same community, a revolving door of services emerged with the onus of self diagnosis and locating the right agency falling upon the client.
- The lack of a holistic approach to case management denied a family orientation, Singular-purpose agencies often missed the multiple needs of clients and families and the treatment plans were non-comprehensive and short sighted. The reality is that no single categorical agency can address all of the problems and needs within a dysfunctional family.
- With multiple intake processes, the potential for conflicting service plans for multiple problem clients arose. The lack of uniform case management planning and assignment of lead case responsibility gave rise to a breakdown of communication among staff and agencies and the potential for problem client dumping.
- The duplication and in the categorical system is extremely costly and inefficient. Multiple case managers, different intake processes and forms to collect the same information, and redundant administrative processes such as data processing, accounting, evaluation, etc., contributed to excessive expenditures for non-service delivery related activities and mounting discontent among public officials about the categorical structure and excessive administrative costs.
- The lack of uniformity and records keeping limited the ability to aggregate program and financial data across health and human service systems. This severely hampered

the potential for comprehensive planning, budgeting, and evaluation of the effectiveness and efficiency of the categorical system. To date, municipalities for the most part are still unable to generate unduplicated client counts or tally the costs of services per client or families served by multiple systems.

All of these factors led to a range of approaches by state and local governments to improve the coordination of service at the local level. While the options varied they generally fell into the following categories which are presented progressively in terms of difficulty of implementation:

1) Co-location

Essentially this houses multiple service providers at the same facility with the expressed goal of creating easier opportunities for clients to access services to address multiple needs and to create an environment for improved interagency communication. The advantages to this approach is that it does provide greater clarity for clients (a single place to obtain services), is fairly easy to implement, and is a relatively non-threatening method to improve communication and cost sharing among providers. However, the high cost of duplication and lack of uniform processes and leadership are not addressed under this model.

2) Adopting Uniform Procedures

Under this approach, categorical agencies retain most of their daily functions, including case management, but where possible uniform processes and procedures would be implemented for items such as intake forms, collection of common data elements, problem checklists, case closing reports, etc. The advantages under this initiative is that it's relatively easy to implement, can be incrementally applied, and it increases the potential to aggregate data for planning purposes. However, it doesn't eliminate the

interagency coordination challenges and doesn't track clients uniformly.

3) Lead Case Management

Under this model, a single lead case manager is assigned from among the categorical agencies to assume responsibility for case management. A process for selecting to lead case manager is assigned by presenting problem, first contact, severity of risk, etc. The single case manager tracks the case from intake to case closing regardless of the degree of involvement by the home agency. The advantages to this approach is that it doesn't dismantle the existing structure, provides a single worker for clients navigating the system, builds on existing strengths, and improves interagency communication. However, strong leadership and understanding of multiple agency procedures is required, extensive training is necessary, and categorical administrative redundancy remains.

4) Integrated Services

Under this model, all intake and case management services are consolidated under a central organization to serve all clients of the public health and human services system. The advantages are that it eliminates most of the duplication in the system, creates single leadership for accountability purposes, it is responsive to clients, and data can be aggregated for planning and evaluation purposes. The disadvantages are that it is a radical approach that deviates significantly from the categorical system, contributes to bureaucratic oversight problems, requires major investment in new systems (including a large investment in enhancing staff skill sets), and creates political and workforce challenges.

During the course of the past several decades, many state and local municipalities adopted variations on the above models to address the multiple challenges resulting from the limitations of the categorical system. Each is different and there is little uniformity among jurisdictions. Structural and organizational change is often met with significant resistance. Without mandate, and facing opposition from many sectors including labor

unions, advocates, the media, and especially the entrenched federal bureaucracy, these systems met with varying degrees of success and acceptance.

Unfortunately, few generally accepted service integrated best practice models exist for transfer among jurisdictions, especially as a result of the uniqueness of each municipality. The reality of public health and human services advocacy is that there is significant awareness of specific maladies such as mental health, developmental disabilities, domestic violence, etc. Therefore, a strong public voice exists to articulate their specific needs and advocate for more resources. However, while these programs are reliant on other health and human services delivery systems to a major extent, there is no specific advocacy for service integration. The fact is that the political will to undertake major structural and organizational change is severely limited. In addition, as most technology development funding is categorically restricted in the United States, until recently there has been little investment in services integration technology research and design. Hence, administrators of integrated programs are forced to retrofit categorical information technology systems into a coordinated framework.

The one common thread within the health and human services community in the United States during that time was that federal entitlement programs, i.e., welfare cash benefits, food stamps and Medicaid generally operated from within the same uniform rules base. At that time there was also significant public, media and political dissatisfaction with welfare entitlement programs and increasing sentiment for change. Reforming entitlement programs emerged as a national campaign issue with President Clinton's promise to "end welfare as we know it." While state and local governments operated from vastly different structures as articulated above, if there was potential for significant change, by necessity it would emerge from reforming the entitlement programs in the US.

3. THE OPPORTUNITY

In 1996, all of the factors that gave rise to a public demand for reform of federal entitlement programs culminated in the passage of the PRWORA (Personal Responsibility and Work Opportunity Reconciliation Act), commonly known as the welfare reform. This represented the most significant change in U.S. social policy since the passage of the Social Security Act in the 1930s. Essentially, this law ended the federal welfare entitlement program in favor of giving block grants to states with capped expenditures and a lifetime cash benefit time limit. The former AFDC (Aid to Families with Dependent Children) program, which insured each person living below specified poverty levels with a minimum cash benefit, was replaced with TANF (Temporary Assistance to Needy Families), with emphasis on the word "temporary."

The legislative focus was clearly on personal responsibility, providing both positive and negative consequences based on client behavior. While the law contained broad outcome measures with penalties and incentives, for the most part states had considerable flexibility to design their own programs, including the composition of their own workforce. It should be noted that welfare reform actually evolved over the previous decade by the granting of more than 40 state waivers from federal rules. These jurisdictions approached the federal government with experimental projects promoting local solutions to welfare dependency. Many of these successful field-tested programs were translated into the new law.

One of the most significant aspects of the new law was a provision that states submit comprehensive plan to describe their TANF implementation strategy. This was one of the first times that interagency planning through a multi-disciplinary process was required. It forced a level of thoughtful interaction among categorical programs that continued throughout the first decade of TANF. While categorical human services plans were

previously required for most health and human service components, they were in effect compliance documents that lacked a full program overview.

The TANF plan, however, involved a variety of programs such as public welfare, child care, food stamps, child support enforcement, child welfare, employment security, etc. This comprehensive approach mandated a participatory process in the form of public hearings and an endorsement of the governor. Given the comprehensive nature of this exercise, many jurisdictions approached the budget process in a more strategic manner to better leverage and manage funds. It was a significant step toward breaking down traditional categorical barriers and enhancing interagency communications.

Initially, there was considerable concern that reducing federal oversight would result in a "race to the bottom" among states to limit safety net programs for people living in poverty. The law restricted eligibility for certain populations such as legal immigrants, able bodied adults without dependent children and convicted drug dealers. In reality, concern never materialized and many states actually used local monies to restore benefits to newly ineligible populations, especially food stamps for legal immigrants. A federal law was actually amended to permit the states to purchase federal food stamp coupons for this purpose. There was also concern that monies initially intended to provide a minimal standard of living in the form of welfare cash benefits would be diverted to non-health and human services purposes. There was further concern that the strong workforce attachment model contained in the law couldn't be sustained by local employment and economic conditions in the event of a fiscal downturn. Each state plan required a provision that addressed many of these contingencies.

By almost all accounts, the formula contained in PRWORA of establishing broad program goals and empowering communities to achieve them is a success. While it was not a panacea, the first decade of welfare reform produced the following results:

- Welfare caseloads declined by 60 percent. An unintended consequence was that Food Stamp caseloads, which were relatively unrelated in terms of eligibility, also declined

significantly during this period.

- Non-custodial child support collections doubled. The new law invoked strong performance criteria on states in areas such as paternity establishment and child support enforcement. It also provided new tools in terms of data matching and interstate collections.
- More than 1.5 million welfare recipients gained full-time employment and were removed from the welfare rolls. This not only helped people gain financial independence, but restored personal dignity and created positive role models and instilled a work ethic for their children.
- Hundreds of thousands of safe child care slots were created to care for the children of working TANF parents. One of the ongoing debates in the child care arena is whether the program goal is to provide economic support for working families or a child development opportunity for children with more rigid quality standards. States have approached this issue differently because of the program cost differential.
- Teen pregnancy among the welfare population was reduced by one-third. Many states incorporated family planning, parenting classes, marriage and family formation, etc. into their TANF Program to take advantage of incentives created by the new law.
- A national Electronic Benefits Transfer program was implemented for the distribution and administration of nutritional benefits in the form of Food Stamps. This technology platform also served as the framework to incorporate cash benefits, child care payments, and child support distribution into the system.
- Child poverty rates declined, reversing a two-decade rising trend.

It is important to note that these results were achieved without any additional federal financial support above the base level block grant amount established a decade earlier. From a public policy standpoint one of the major unanswered questions resulting from welfare reform was how to define success. The debate is whether the purpose is to

lower caseloads and reduce expenditures for income maintenance, or to reduce poverty by increasing ones prospects for self sufficiency and eliminating reliance on other human service programs. While earnings from work coupled with other benefits clearly provided financial advantages over welfare subsidy, many TANF clients found that their status changed from welfare recipient to that of the working poor. It should be noted that during the first dozen years of welfare reform, the federal minimum wage was never adjusted to account for inflation and the rising costs of goods and services. While many states did adjust their minimum wage requirement, it was not embraced as a matter of national public policy. In fact, the reauthorization of TANF actually stalled in Congress due to efforts to attach a minimum wage increase to the bill. While PRWORA clearly embraced a work first model, many states also invested TANF funds in providing on-going education and training opportunities to increase longer term career employment prospects. One very significant incentive was the Earned Income Tax Credit which used the federal Income Tax structure to provide incentives to workers with low wages via tax rebates.

4. LESSONS LEARNED

The first decade of welfare reform provided valuable lessons to guide other human service program development. Some of the most significant lessons from a policy development perspective are:

- There was a compelling case for change. Welfare dependency was simply a bad investment strategy.
- There was both an economic and moral imperative to reform the Public Welfare System. In addition to a societal obligation to protect the most vulnerable, there was an obligation to help people realize their maximum personal potential.

- Personal responsibility and reciprocity are good public policy, e.g., cash assistance in exchange for work preparation and job search activities. This policy reinforced the notion that there are consequences to personal behavior and that quid pro quo is a reflection of societal norm.
- People need to be personally invested and have a say in their own solution in order to have good outcomes. "Nothing about me without me" became the standard operating case work principle.
- Government alone cannot fix poverty and welfare dependency. It requires a partnership among the public, private, and business sectors. As incentives for hiring welfare clients created a good business strategy, doors that were traditionally closed to recipients of government benefits opened up. Public welfare administrators began to market the advantages to potential employers of hiring former welfare clients. These included customized job training, ongoing casework support, transitional medical and child care benefits, allowances for tools and special equipment, tax credits, transportation subsidies, etc. In this instance, good public policy and good business practice converged.
- Services coordination and integration is essential, especially with lifetime limits on welfare. Critical personal maladies such as mental illness, drug addiction, abuse, illiteracy, etc., need to be addressed if clients are to become work-ready. There is a general acknowledgement that people generally didn't apply for welfare benefits simply because they are poor. The core dynamics leading to that situation of destitution need to be addressed in order to interrupt the welfare cycle.
- Generally, the best service delivery models are developed at the local level in communities knowledgeable about local resources, economic, and social conditions. The devolution that occurred at the federal level also cascaded to the local level from states, especially in county administered jurisdictions.

- Multiple strategies such as asset development, tax policy, rules against predatory lending, financial planning, etc., are necessary components to helping people successfully achieve self sufficiency.
- Good outcome data are essential to promote good policy development and make necessary program corrections and improvements. Good data also helps tell the human services story in order to project a positive public image about the societal investment in self-sufficiency programs.

There was one other critical lesson learned from welfare reform. For decades, the general public complained about the failure of the welfare system. However, PRWORA demonstrated that it was failed policy and not a failed workforce. Under the prior AFDC Program, clients with earnings had their cash grant levels reduced by an amount equal to that of their wages. In addition, other critical programs like Food Stamps and housing subsidies were also lowered to offset an increase in personal earnings. When coupled with the incidental costs necessary to support work activities such as child care, transportation, work tools, etc., most low wage earners on welfare found themselves negatively impacted financially after obtaining employment. When clients were penalized and worse off for trying to be productive, that's failed policy. When that changed and states created grant subsidy levels that provided incentives for work that resulted in an improved quality of life for families, the bureaucracy changed almost overnight. Welfare offices throughout the country were transformed to workforce centers, reinforcing the message of self-sufficiency and the virtues of employment. The human service workforce embraced this new philosophy and there is evidence that similar dynamics are beginning to penetrate other systems, especially child welfare and Medicaid (health care) services at the state level with a renewed focus on prevention, wellness and incentives for positive client behavior. As occurred with welfare programs a decade earlier, state public child welfare administrators and Medicaid directors are seeking federal waivers and

experimenting with alternative service delivery strategies.

This major change in legislation also provided a catalyst for rethinking the categorical organizational model and tradition of having core services provided exclusively by public employees. In order to meet work participation rates and other requirements of the law, new partnerships and contractual relationships were formed. For decades, governments contracted with private providers, both profit and non-profit organizations, for specialized services, treatment and residential care. But, until the advent of welfare reform, the notion of privatizing core services was extremely rare. Since that time however, government as a contractor for welfare benefit delivery has emerged as a viable major initiative.

5. FUTURE CHALLENGES AND TRENDS

During the past decade, almost all states redirected monies previously spent on cash benefits into other programs designed to promote self-sufficiency and strengthen families such as child care, child welfare, health screening, parenting programs that strengthen family formation, employment support services, transportation, etc. It was a period of great creativity and experimentation within states, including the development of different workforce service delivery models. These included privatization, contracting with private non-profit organizations (including faith-based entities) and implementation of new computer programs and call centers to automate and expedite the application process. The requirement for job placement services also contributed to new opportunities for partnerships and contractual arrangements with employment service providers. Other challenges such as public workforce recruitment, retention and retirement, and a political effort to reduce the size of the government payroll contributed to a review of public staff capacity needs and development of alternative service delivery models. The impact of this mix of private and public, union and non-union, rural and urban, contracted and

volunteer staff on the performance of the human service system has yet to be fully evaluated, but it is safe to say that it has been met with varying degrees of success and public acceptance.

In the United States, the largest and most aggressive efforts to privatize core services occurred in Texas and Indiana. There are positive and negative lessons to be learned from both of these well intentioned experiments. The Texas effort has been significantly scaled back since the initial conceptual design due to system failures and mounting public and political pressure. This model called for a substantial reliance on computerization to provide intake services through the Internet and automated call centers. It called for the reduction in the public workforce of thousands of employees and the elimination of several hundred local welfare offices throughout the state. There was an aggressive and perhaps unrealistic timeline set by the state legislature. While improved client access, a simplified and streamlined application process, and expedited benefit delivery were stated goals of the privatization effort, cost containment was also a main driver of the initiative. The project called for the replacement of a 25-year-old computer legacy system and relied substantially on a consortium of vendors. The project was piloted in two counties in Central Texas, including the State Capitol, and was highly visible with much media attention.

Ultimately, the inability to generate timely and accurate benefits on the new system, a severe reduction in experienced workers who left for other jobs in light of the announced layoffs, and the inexperience and poor training of the contracted workers led to a decision to abandon the effort. There also were significant performance issues on the part of the prime contractor. The Indiana effort, while in the early stages of implementation, has met with better success in the pilot sites. This effort, which benefited from the prior Texas experience, was driven more out of compelling need for program change than a stated desire to contain costs. The Indiana workforce, which was protected by a strong labor union organization, performed poorly under Welfare Reform

and had the lowest rate of caseload reduction in the country - only 6 percent as opposed to the national caseload reduction average of 60 percent. Their model called for subcontracting the entire welfare eligibility and case management effort, including automation. The administration was very clear about their performance objectives and contract terms and conditions in awarding the contract to a coalition of vendors. This project evolved after a state reorganization that carved out child welfare services into a new state cabinet level department which is operated by state employees. This enabled the Indiana Human Services Department, sanschild protective services, to focus intensely on this change effort. In reviewing the privatization experiences of both projects, there are significant lessons to be learned. These include the following:

- It is important to be clear about the strategic direction and core competencies. Project designers need to precisely articulate what problem is being solved and what are the resources necessary to make it happen. The core competencies necessary for the Indiana effort were clearly stated at the onset - Policy Development, Contract Management, and Technology.
- Providing protection for a changing workforce is essential to effect a smooth transition. The Indiana effort insured each state employee a job with the new contractor with comparable compensation and benefits for a specified period of time. Consequently, the attrition levels, vacancy rates, and program disruption kept to a minimum.
- Keep reasonable expectations about the amount of change that the system can reasonably withstand. The Texas model attempted to change state policy, reorganize, change business processes, and replace a large computer system simultaneously. The Indiana effort was more incremental in its approach to program change.
- Build and rely on an experienced leadership team that has fully embraced the initiative. Relying on civil servants who may ultimately be replaced through privatization creates a difficult climate in order to create change. Resistance, either

overt or covert, can be anticipated with this degree of change in a well-entrenched bureaucracy.

- Transparency and communication is key to a successful privatization effort. Workers impacted by the change need to be advised at each step in the process, including both successes and failures. The public message is especially critical with constant reinforcement of the program goals and rationale.
- It is important to do it right, not necessarily fast. In many major public administration change efforts, especially computer conversion, there is a tendency to implement prematurely in order to meet deadlines which are often imposed by state legislators or federal officials who are not involved in the daily nuances of project management. This pressure, especially that brought by media attention, can mount to the extent of even stripping functionality out of the system in order to achieve project time compliance. If delays are required in order to effect a smooth transition, the justification must be clearly articulated. Many well-designed projects are jeopardized due to premature implementation and insufficient testing.
- The decision to use outsourcing options should be guided primarily by client service considerations, whether they meet the agency's business needs, and finally, if they are cost-effective. In this instance, the "what" is more important than the "who."Utilizing private-sector flexibility, non-public research and development resources, and competitive pricing can provide clear advantages under certain circumstances. However, these must be balanced against all of the political, historical, and legal requirements associated with this critical public service.

Based on all of the recent changes in public policy, privatization efforts, and new management and technology approaches, it appears that the future of the human service workforce is at a crossroads. If contracting and privatization are to continue to expand, administrative core competencies will need to shift from program supervision to contract

management, project management, outcome (not process) evaluation, and operational and contingency planning. A viable backup plan needs to be in place if the private sector is unable to fulfill the requirements of the contract. The risks are greater if the public workforce is no longer available as a result of the privatization initiative. If automation and Internet applications are to make benefit processing less labor-intensive, the political and financial will must exist to replace legacy systems with more agile and nimble applications. This has not become a mainstay in the industry's computer application development process. The challenge of recruiting workers into the profession in a competitive market with higher-paying opportunities, and succession planning for management, and mid-management jobs must be addressed in the universities and human resource departments. The loss of institutional knowledge due to an aging workforce and high turnover within upper management are also a major issue. A recent workforce study conducted by the American Public Human Services Association indicated that nearly one half of the state Child Welfare Administrators in the United States have less than two years of experience.

In addition, the nature of human services delivery is undergoing change and innovation that to a large extent is altering workforce philosophy. Case management today is more client centered (individual versus service based), strength based as opposed to deficit focused, and involves families to a greater extent in the case disposition process. Workers are more community centered in their service provision approaches (not just geographically, but also from a cultural appropriateness and informal supports perspective), are more client outcome focused rather than process oriented, and tend to work more effectively in teams to solve multiple problems. There is stronger reliance on technology and virtual offices, telecommuting and alternative work schedules are becoming the norm. This implies an improved supportive infrastructure and new management techniques to allow for creativity, innovation and to embrace non-traditional partnerships.

Finally, as a matter of federal public policy, the lessons learned from welfare reform have yet to fully permeate other human service programs and translate into a systematic operating philosophy of state and local empowerment. Ironically, Congress seems to be moving in the opposite direction, which is seriously affecting the credibility of future block grants. The reauthorization of TANF has resulted in more prescriptive program rules and stronger federal oversight with substantial penalties for failure to meet process activity goals. The fear is that these rules will divert monies invested in other human service programs as previously mentioned. Further, current legislative proposals would prohibit non-government employees from administering food stamp nutritional benefits. This inconsistency and lack of a clear federal policy standard negatively affects intergovernmental relations and the future of continued reform.

Ultimately, this leads to an analysis of the factors that contribute to the development of effective public policy and the steps necessary to evaluate program effects. Since the loss of program flexibility due to the passage of TANF Reauthorization, the National Policy Council of the American Public Human Services Association has been working on a more proactive approach in identifying social issues and developing policy positions to lead to improved program goal achievement.

The following represents the Policy Council's consensus on the elements that contribute to better program outcome success. Too often, public administrators fail to make the distinction between compliance and policy development. In either case, however, policy must be grounded in operational reality. Ultimately, policy is what is done, not what is written. Therefore, policy should be primarily an operational tool and effective communication between policy and practice functions is essential to good programming. This implies a participatory process involving all parties affected by the change, especially training, information technology and finance.

The conveyance of policy must also be clearly understood by the end users. Field testing and mid-course correction based on experience rather than theory is needed to

balance a tendency toward rigidity and to create a program safety valve against unanticipated consequences. Also, there is no need to reinvent the wheel. Capturing best practices and lessons learned is more efficient and mitigates risks. Correspondingly, policy must remain contemporary and obsolete and obscure rules need to be periodically purged. In measuring welfare reform against these standards, one could conclude that for the most part this major change in social policy met this effectiveness criteria.

However, there is one other critical factor that fell short, which seriously affected the effort in a negative manner. That is, policy needs to be data-driven to the extent possible, both in terms of making the case for change and in evaluation effectiveness. Ultimately, in a democracy, policy is driven by political forces. The best antidote for public policy developed purely by ideology, anecdote and innuendo is solid, objective data and evidence-based practice. Unfortunately, in the case of welfare reform, this did not happen. Instead, human service administrators learned the perils of relying primarily on federal data reporting requirements to define program success.

These data are generally the bureaucratic means to report to Congress, and not client-outcome measures. Given the intense focus on designing new state welfare to work strategies and the variation among states, data collection became a secondary consideration to program implementation. The critical lesson learned from this experience is that human service planners and researchers need to identify those data elements essential to measure client outcomes first and then, if necessary, add those elements identified for reporting compliance. To do otherwise severely inhibits the ability for practitioners to define program success and measure against it. It is perhaps one of the most important lessons to be learned from welfare reform in the United States and should be a prime consideration in all future health and human services planning.

6. CONCLUSION

The positive and negative lessons learned from the U.S. welfare reform experience, especially in terms of the workforce impact, creates a learning opportunity for other countries interested in rethinking the welfare mix and developing new social service models. In the midst of this sea of change, emerging technology, modernization and privatization, the following trends and observations based on the US experience are offered for consideration:

☑ The need to improve the coordination and integration of services will continue to emerge.

☑ The need to grow community partnerships and promote volunteerism will expand - it adds capacity and engages the community.

☑ The need for technology that is more nimble, can interface with other systems, and can program changes more easily is essential.

☑ Wellness, prevention, and early intervention approaches will continue to be developed, especially in the health care and child welfare arenas.

☑ Prudent management, modern business practices, and public accountability are required in conducting "the peoples business."

☑ Consumerism and client choice will continue to be embraced as both good public policy and good business.

☑ The demand for improved quality control, program integrity, outcome measurement and fraud detection will continue and expand. Ultimately, in the public's eye, we are only as strong as our weakest link and fraud, waste and abuse drags down the entire system.

☑ Public administrators should articulate a "return on investment" approach in justifying their programs and budgets. Human services need to be promoted as an investment in a stronger society. This implies the use of better evidence based data.

☑ To remain competitive, public human service agencies will need to invest in their strongest asset-their workforce. This requires staff development and promotion opportunities in addition to appropriate and competitive compensation.

In addition to these factors, perhaps the most important is to always maintain the client focus. Human service professionals must never lose sight of the noble goal of providing a safety net for people in need, protecting those that are the most vulnerable, improving the quality of life for those with disabilities, and helping people maximize their personal potential to achieve self-sufficiency. Behind all of the forms, regulations, manuals, policies and procedures is a real person in pain, suffering, feeling hopeless or destitute. All trends in social service delivery, management, organizational development, technology, etc., should be created and implemented solely in support of this honorable mission.

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the Issues of Pubic-Private Partnership in UK, US and Korea

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