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# After Asylums and Orphanages

# After Asylums and Orphanages

Katren Rogers

LUND UNIVERSITY

DOCTORAL DISSERTATION

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Abstract
In this dissertation, I investigate the effect of partisan politics on the types of care policies that replaced asylums and orphanages between 1950 and 2015. Combining insights from the historical-sociological literature on party formation and theories of welfare politics, I formulate a theory of the partisan politics of care and apply it to two uniquely old care policy areas. While asylums and orphanages have widely been understood as institutions of social control, they also served a social care function, to substitute for family-based care. During the era of deinstitutionalisation, the care of people with chronic and severe mental illness and children who could not be cared for by their parents was shifted away from large, custodial institutions in countries throughout Western Europe, North America, Australia, and New Zealand. The deinstitutionalisation movement was shaped by changing scientific knowledge and ideas, professional specialisation, the lobbying of action groups against asylums and orphanages, and growing fiscal pressure. But asylums and orphanages could not simply be closed down. Governments were faced with choices about who should become responsible for the care of formerly institutionalised populations: the state, the market, the family, or voluntary providers. I demonstrate that these choices were decisively shaped by partisan conflict, not only over redistribution, but also over how society should be organised: around individuals or families. This study of the multidimensional politics of care policy contributes to theoretical debates in comparative politics about the dimensionality of party competition and how partisanship shapes welfare policy making over time. The empirical conclusions will also be of broader interest to scholars of the relationship between science and policy making.

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# After Asylums and Orphanages

Katren Rogers

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The most fanatical of individualists admits the existence of persons, such as infants or madmen, who, because they are incapable of knowing their own interest, and, in the strictest sense, unable to protect themselves, need the special protection or aid of the State.

A. V. Dicey, *Lectures on the Relation between Law and Public Opinion in England during the Nineteenth Century* (1905)

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# Chapter 1

# Introduction

Between the mid-nineteenth century and the interwar period, people with mental illness and children who could not be cared for by their parents were cared for, usually by the state, in asylums and orphanages. The individuals committed to asylums were then known as 'madmen' or 'lunatics', and children in orphanages sometimes called 'bastards' or 'foundlings', ostensibly neglected or abandoned by their parents. Like the language used to describe them, the conditions in which they lived and the treatments which they received seem harsh and foreign by today's standards. While the resident populations of asylums and orphanages were certainly not well looked after from the perspective of the present, they were cared for in the sense that daily needs which were understood to be important at the time, and which they were seen as unable to meet themselves, were provided for by public, or publicly subsidised services.

The solutions for caring for these groups of people were once remarkably similar in countries throughout North America, Western Europe, and Oceania (Australia and New Zealand), but since the Second World War these care policies have been dramatically changed. In 1965, Italian psychiatric hospitals housed 91 700 inmates (Donnelly, 1992, p. 88). Now, no large asylums remain. In 1933, there were 1 321 orphanages in the United States of America, each caring for an average of 115 children (Hacsi, 1997, p. 53). Today, there are none. While the nineteenth-century police stations, hospitals, and schoolhouses that developed as institutions of order, public health, and mass education alongside them still address similar social needs across advanced capitalist countries today, asylums and orphanages have all but disappeared from these parts of the world.

The deinstitutionalisation movement – defined as the shift from institutional to community care (Goodwin, 1997) – occurred between the end of the Second World War and the early twenty-first century. The large, custodial institutions which had provided a public alternative to care in the family were retrenched in the period during which state responsibility for many aspects of public welfare was expanding. Scull (1984) argued that post-war economic growth and the expansion of the welfare state *enabled* the process of psychiatric deinstitutionalisation.[1] But asylums and orphanages were not always replaced by alternative public services in the community. Indeed, Lerman (1984, p. 205) concludes that although 'community-based' care is rarely defined in the literature, it often refers to private – as opposed to public – facilities. When people moved out of large, custodial institutions and into smaller group homes or alternative forms of care, responsibility for providing care was perhaps more often shifted to voluntary organisations, to for-profit providers, or back to the families of formerly institutionalised populations. Despite the remarkable ubiquity of institutional care, there is great variety both among countries and over time in who became responsible for the care of people with mental illness and children who could not be cared for by their parents. This dissertation investigates how partisan politics shaped this variation in the care policy decisions that were made in twelve countries in North America, Western Europe, and Oceania between 1950 and 2015.

The reason we should be interested in the role of political parties is that, as I will argue, asylums and orphanages and the care policies that came after were welfare policies whose reform should be understood in the broader framework of comparative welfare politics. Although there are some important differences between asylums and orphanages and other types of welfare policies, we shouldn't see these custodial institutions as relics of a poor-law past, but as a form of care policy. Care policy determ-

[1] Scull uses the term 'decarceration' instead of 'deinstitutionalisation' because the latter has a much broader meaning in the social sciences. Other scholars have questioned the term deinstitutionalisation in light of evidence that some people were 're-' or 'trans-institutionalised' into aged-care facilities and prisons (Fakhoury and Priebe, 2007; Brunton, 2003; Thornicroft and Bebbington, 1989). Nevertheless, I use the term 'deinstitutionalisation' as it is so commonly used in the existing literature to refer to the gradual decline of both psychiatric hospitals and orphanages. In line with the existing empirical literature, I also use the term 'institutional care' to refer to care in large, custodial institutions and not the smaller residential facilities that sometimes emerged in their place.

ines the type of institution that is responsible for meeting the needs of people who are not expected to work: state, market, family, or voluntary actors. We know from the feminist social policy literature that most care is provided by women as unpaid labour in the home, but care policies can also substitute for unpaid care.

The eminent historian of ideas Michel Foucault and sociologists such as Scull (1984) and Cohen (1985) have highlighted the social control function of asylums and orphanages. But by reconsidering these institutions in historical perspective, I will show that they also functioned as care policies. These were public and publicly subsidised institutions that were actively used by individuals and families as a substitute for familial care. Although they had first emerged during the fifteenth to eighteenth centuries, both asylums and orphanages expanded dramatically in the mid-nineteenth century as public authorities increasingly took responsibility for their funding and administration. Unlike the subjects of pre-existing indoor relief, the people that lived in asylums and orphanages were seen as innocent, and institutionalisation as a means of improvement – a goal characteristic of other nineteenth-century public services (Ansell and Lindvall, 2021, p. 16). The Berlin city planner Herman Blankenstein designed the Karl-Bonhoeffer-Nervenklinik, featured on the cover of this dissertation, to look more like a monastery than a penitentiary. Insane asylums and orphanages were some of the earliest public services, and the antecedents of the welfare state.

Many of the welfare policies that emerged between the late nineteenth century and the interwar period were expanded in the decades following the Second World War, with variation in their development decisively shaped by struggles over redistribution. Although some social insurance programmes and public services such as schooling first emerged under authoritarian governments, there is little doubt that left-wing parties, with their close ties to organised labour, were singularly important for expanding the size and scope of the post-war welfare state. But during the same period that the state took more responsibility for other areas of human welfare, and at the same time as informal care became less available as more women entered the workforce, responsibility for the care of people with mental illness and children who could not be cared for by their parents was shifted from the state back to the family and to alternative providers.

To understand this puzzling trend, and the cross-national variation that has emerged in responsibility for care after asylums and orphanages, we need to go beyond the left–right conception of partisanship that is so cent-

ral for explaining the overall size and structure of the welfare state in the comparative welfare politics literature (for example, Huber and Stephens, 2001, p. 17; Esping-Andersen, 1990, pp. 29–32; Korpi, 1983, pp. 181–184). Unlike the pensions and social-insurance schemes that have been the subject of most of the classic welfare state literature, asylums and orphanages targeted a much narrower population with limited social and political capital, and they had a more marginal impact on overall levels of social spending. These policies were less important in the contest over the decisive median-income voter, and they were not principally concerned with the conflict between capital and labour. In order to understand the politics of the care policies that replaced asylums and orphanages, we need to consider drivers of partisan conflict beyond the issue of redistribution.

This dissertation formulates and applies a theory of partisan conflict over care policy that is based on cleavage theory, focussing on the class and religious divisions that shaped the ideologies of social democracy, Christian democracy, conservatism, and liberalism during the emergence of mass politics. Even in the period during which institutional care was dominant, between the mid-nineteenth century and the interwar period, partisan conflict was multidimensional. Alongside conflicts over redistribution, the ideologies of individualism and familialism divided pro-welfare Christian democrats from social democrats, and conservatives from liberals. These conflicts were played out over not just how much the welfare state should redistribute through public services, but who should provide those services: the state, the market, or voluntary providers, and religious or secular authorities (Ansell and Lindvall, 2021, p. 21). Although most industrial-era welfare policy change can be explained by conflict over redistribution, in the case of care policy, both dimensions of conflict are important.

The remarkable transformation of mental health care and child welfare services since the Second World War has been completely neglected by scholars who study the politics of welfare policy in the same period. The existing literature on deinstitutionalisation has suggested that institutional politics played a limited role in the shift, compared with broader structural explanations like technological, professional, and ideational change (Jones, 1993a, pp. 179–80; Rochefort, 1997, p. 124). Though there are few comparative studies of psychiatric deinstitutionalisation, and none to my knowledge of the decline of orphanages, such structural factors have likely shaped the common long-term trend away from institutional care in all Western countries (Goodwin, 1997, p. 27).

More contemporary care policies such as day-time child care and aged care have received attention in the literature on post-industrial welfare state politics, where there is growing recognition that conflict over these types of policies is more multidimensional than the left–right vision of partisanship in classic 'power resources' theories of welfare politics. A second, so-called 'socio-cultural' dimension of conflict has been conceptualised broadly in the existing literature, as dividing liberals from authoritarians, or cultural progressives from conservatives (Manow, Palier, and Schwander, 2018a, p. 6). This multidimensionality is depicted as specific to the post-industrial era, during which the salience of socio-economic conflict appears to have declined. But we know from the cleavage theory of Lipset and Rokkan (1967) that a second dimension of partisan conflict, with origins in religious cleavages, long pre-dates the identity politics of the post-industrial era.

Recent work by Rovny and Polk (2019) has begun to link the current literature on the dimensionality of party competition with cleavage theory by showing that the so-called 'cultural' dimension of partisan conflict is closely related to the religious cleavage of the late nineteenth and early twentieth centuries, even though explicitly religious content is often absent from contemporary politics. I refer to this 'non-economic' dimension simply as the 'second dimension' of partisan conflict throughout the dissertation, given the plurality of labels used in the literature and the fact that these types of conflicts – while they might be understood as mainly values-based today – were just as material as socio-economic conflicts when they played out in historical struggles for control over services, the most well-documented of which is education (Ansell and Lindvall, 2013; Van Kersbergen, 2009; Morgan, 2002).

I argue that a multidimensional conception of partisanship that draws together insights from the literature on historical religious cleavages and contemporary debates about cultural or values conflicts in politics can help us understand the politics of care policy during the periods of welfare state development and expansion, as well as today. I focus specifically on the aspect of religious or second-dimension conflict most relevant to care policy: ideals about how societies should be organised, around individuals or families. I argue that this second dimension of partisan conflict is a component of party ideology which, alongside socio-economic conflict, shapes the decisions that governments make about who should be responsible for providing care.

My theoretical approach also draws important insights from the feminist social policy literature, which has on the one hand elevated the concept of care in the comparative welfare state literature, and on the other hand drawn attention to the importance of explanatory factors beyond socio-economic conflict. In classic social policy texts, the welfare state was depicted as having *replaced* pre-industrial family-based care, in response to the social and demographic changes associated with industrialisation (Wilensky, 1975, p. 12). In the influential work of Esping-Andersen (1990), the family also played a marginal role. But feminist and feminist-influenced literature has shown that informal care continued to play an important role in welfare provision and, in particular, care arrangements. For instance, Pedersen (1993) and Skocpol (1995) argue that conflicts over policies directed toward the family and dependents were at least as important as the structure of the labour market and redistributive conflict for shaping the enduring institutions of the French, British, and American welfare states.

The main conceptual critique of welfare state theory made by feminist authors such as O'Connor (1993), Orloff (1993), and Sainsbury (1994) is that beyond the gender-neutral inequality between capital and labour that underpinned power resources theory and its central concept of 'decommodification', gender inequality also affects the gendered division of labour and the configuration of work, care, and welfare. Beyond the politics of socio-economic conflict between left and right, Lewis (1992), Gustafsson (1994), Pfau-Effinger (1998) and others have argued that cultural or values conflicts between different gender ideologies shape the types of care arrangements that emerge in different countries and over time. The connection between gender ideologies and religion is recognised by authors such as Morgan (2002) and Saraceno (1994). Morgan (2006) has shown that the nature of nineteenth- and early-twentieth-century religious conflicts had a lasting influence on partisan gender ideologies and variation in the development of work–family policies among countries.

In response to feminist critiques, Esping-Andersen (1999, pp. 51–5) has since introduced the term 'de-familialisation' to mainstream welfare state theory, to describe the relaxation of families' caring responsibilities by welfare policies which substitute for informal care. By understanding asylums and orphanages as care policies, we can think of the expansion of these early public services as a case of de-familialisation, and their decline as a shift in responsibility for care away from the state and to alternative providers. Shifts away from state responsibility have sometimes been la-

belled as a 're-familialisation' of care, but this dichotomous conception of family or state responsibility for care fails to capture the diversity of care policies and their implications for both gender equality and the generosity of welfare regimes (Eggers et al., 2020). Influential feminist scholarship has conceptualised contemporary care policy based on a division of care between state, market, family, and voluntary providers, each with distinct care logics (Daly and Lewis, 2000). Accordingly, I consider family care as just one among several possible choices of who could be responsible for care. Understanding asylums and orphanages as care policies allows us to describe the mental health and child welfare policies that came after as care policies which determine the type of institution that is responsible for meeting the needs of people who are not expected to work: promoting the responsibility of state, market, family, or voluntary providers.

The reasonably large number of mental health care and child welfare policy changes that have been made in the last seventy years, driven by the deinstitutionalisation movement, makes the reform of asylums and orphanages good cases for studying variation in policy areas where redistribution is not the single, dominant dimension of partisan conflict. Asylums and orphanages existed in all Western welfare states in the middle of the twentieth century and experienced significant reform despite making up a relatively small part of welfare budgets. They could not simply be closed, but were replaced by a range of alternatives to institutional care including new, smaller institutions like group homes for both children and people with mental illness, psychiatric wards in general hospitals, medications and other treatments provided through primary care and outpatient clinics, the expansion of foster care and adoption services, as well as new family welfare interventions. Successive governments since the 1950s have shaped the mental health care and child welfare systems that would come after asylums and orphanages.

One factor which complicates the task of understanding who became responsible for the care of formerly institutionalised populations is that the client population of mental health and child welfare services has changed since the age of asylums and orphanages. Asylums and orphanages were already diverse institutions. In some countries during the early twentieth century, asylums also cared for older people, or those suffering from alcoholism or epilepsy. Orphanages were typically home to not mainly 'true' orphans, but children with just one living parent, children who had been born out of wedlock, those from impoverished homes, with one or more

parents in prison or a psychiatric institution, or the children of people who were considered unable to provide appropriate care.[2]

During the era of deinstitutionalisation, the populations of custodial institutions shifted. Contributing to the deinstitutionalisation movement was a decline in *demand* for care, as parts of the formerly institutionalised population became encompassed within broader welfare policies that catered to much larger groups. For example, the introduction of widows pensions and benefits for families with children, as well as for single parents, dramatically reduced the demand for temporary care in orphanages due to poverty (Hacsi 1997, p. 216; O'Sullivan and McMahon 2006; Australian Institute of Health & Welfare 2001, p. 127). Alongside the emergence of geriatric psychiatry in the 1980s, new specific institutions emerged for the long-term care of older people, with or without neurological decline.

This decline in demand for institutional care was combined with a broadening of the population with which mental health and child welfare policies were concerned. The psychotropic drugs that were first used on patients in psychiatric institutions later became available to a much wider population. What we think of as 'mental illness' has expanded to include a range of conditions including anxiety and milder forms of depression. What we think of as mental health policy has broadened to include forms of health promotion and prevention including, for instance, the regulation of work–life balance. As child protection regimes have changed, so too have the grounds for intervention, or what is considered a dangerous environment or situation in which parents cannot care for their child.

There are three important considerations about how this changing target population relates to the object of study in this dissertation. First, it is important to clarify that I am explaining variation in policy decisions about who became responsible for care during the process of deinstitutionalisation, and not *why* deinstitutionalisation occurred or the outcomes of deinstitutionalisation. Outcomes are shaped by policy changes as well as demand for services and other changes within existing policy settings. Changing norms around out-of-wedlock childbirth and access to contraception, for instance, had a profound impact on the number of children put

[2]In colonial states such as Canada, the United States, and Australia, this often included the children of indigenous peoples, although separate institutions existed to fulfil so-called 'assimilation' policies too. It is worth noting that I do not consider policy changes relating to the child welfare policies which removed indigenous children from their families, because the politics of these decisions was shaped by a rather different set of objectives.

into substitute care. New scientific knowledge and technology also affected the care of people with mental illness and children who could not be cared for by their parents through the actions of professionals and providers within existing policy settings. The extension of mental health services to a wider clientele of patients with less severe conditions who could afford to pay for treatment even provided an important source of income for some service providers. I focus not on outcomes in terms of the ultimate distribution of responsibility for care among different types of institutions, but on the *policy decisions* that promoted responsibility for care by certain types of care providers.

Second, I should clarify the scope of the policies that I am interested in. I will argue in chapter 3 that asylums and orphanages can be understood as care policies, and it is therefore policies which replace their caring function that I am interested in. I consider the policies governing mental health services that meet the needs of people with chronic or severe mental illness who require assistance with the activities of daily living. I consider the policies governing child welfare services that meet the needs of children whose parent or parents have passed away or are otherwise unable to provide for their everyday needs. I capture policies that were designed to replace asylums and orphanages, and not those which served a wider purpose but may have indirectly affected the demand for institutional care. This means, for instance, that I include payments made to carers or foster families to enable them to provide care, but not wider social-assistance payments made to families to supplement household income.

Finally, it is important to consider the extent to which these changes in the target population might have affected the politics of these policy areas over time. With the emergence of new institutions for the care of the elderly from the 1980s, many policies which directly affected care for people with mental illness were actually wider policy decisions concerning the organisation of long-term care policies in general. But this expansion of the scope of mental health and child welfare policy has not, it seems, lead to a stronger group of interests surrounding care policies. Existing work on aged-care markets has shown that, while elderly voters and their adult children constitute an important electoral force, the needs of most older people are covered through pensions and social insurance, and care policies remain residual policies affecting clients and employees that have much less influence than those of broader-based public services such as education and health care (Gingrich, 2011, p. 178).

The dissertation aims to theorise the role of partisanship in care policy and explain care policy changes that affected the decline of asylums and orphanages. I take a more general and comparative approach than the existing empirical literature on deinstitutionalisation – which has tended to consider either asylums or orphanages in one or sometimes two countries, a single region within a country, or frequently a single institution and its community – by combining a quantitative analysis with comparative historical case studies. To draw more general conclusions from the rich existing empirical literature, I begin in the following three chapters by taking an historically informed but macro-causal approach to theorising and testing the role of partisan politics in care policy. What I mean by taking a macro-causal approach is that I ignore the specifics of context to treat political parties in all countries as being of comparable types based on party family, and I also ignore the distinctiveness of policy decisions to treat all policy changes as comparable events that can be classified by type. I then combine this analysis with a more historically and contextually rich comparison of policy changes over time in two very different countries – England[3] and Germany – in the qualitative chapters.

Chapter 2 outlines the theoretical framework for the study and the research design in detail. In this chapter I take what Mair and Mudde (1998) call a 'genetic approach' to identifying party families, drawing from the classical work of Lipset and Rokkan (1967) on the historical cleavages which shaped party formation. I specify the dimensions of conflict that structure party ideologies – both left and right, and individualist or familial. I draw out the implications of these ideological positions for partisan preferences about care policy, and therefore the types of policy choices that we should expect social democrats, Christian democrats, conservatives, and liberals to make. I review the relevant theoretical literature and identify the main theoretical contributions, before elaborating the research design.

In chapter 3, I introduce the two uniquely old care policies that I study. We might think of care policies, such as child care or aged care, as relatively new in the history of the welfare state, having expanded to support women's growing participation in the labour market. But by re-evaluating the historical function of asylums and orphanages on the basis of existing

[3] I refer to England rather than the United Kingdom throughout the dissertation, because these policy areas are governed by separate legislation in Scotland and Northern Ireland. Many, but not all, of the policy decisions I consider also applied to Wales.

historical research, I show that these are examples of care policies that are very old. I also review the empirical literature on deinstitutionalisation to identify important alternative explanations that will need to be addressed in the empirical chapters.

Chapters 4 to 6 constitute the empirical study of the effect of government partisanship on care policy changes since 1950. Chapter 4 considers variation in the types of mental health and child welfare policy decisions that were made in twelve countries in Western Europe, North America, and Oceania. Here, I test my theory of the partisan politics of care and take geographic and historical context into account to the extent that I use control variables for certain shared institutional characteristics and time periods.

In chapters 5 and 6, I trace policy debates over time in England and Germany, considering mental health and child welfare policies in turn. These chapters serve two purposes. On the one hand, they give confidence to the quantitative findings by providing evidence for key assumptions of the model, and by showing that my theory helps to account for patterns of policy change over time in two very different countries. On the other hand, they also allow me examine the role and salience of the different dimensions of partisan conflict over time. I look for evidence of how socio-economic conflict and second-dimension conflicts are reflected in the arguments that politicians make in parliamentary debates about the policy changes that I study. I show that considering disagreements among parties as two axes of ideological conflict helps us understand decisions made by different types of governments over time, as well as key differences between the two countries.

In the conclusion, I summarise the empirical findings and reflect on the differences observed between the two policy areas across the three empirical chapters, drawing out the implications for the relationship between partisanship and care policy as well as for future research on the multidimensional politics of care.

This study complicates the Whiggish depiction of the deinstitutionalisation movement as a process informed by changing scientific knowledge, professional developments, and a progressive shift in popular ideas across the Western world. While there is little doubt that the policy goal of shifting from institutional to community care was shaped by expert knowledge and ideational change – indeed, I find evidence that different types of political parties agreed on and collaborated toward the general aim of reducing institutional care – I show that the type of 'community care' that emerged

over time in place of asylums and orphanages was decisively influenced by government partisanship. In doing this, I address one of the key debates in the deinstitutionalisation literature, about whether community care meant care *in* the community (organised by the state) or *by* the community (motivated by cost savings) – and whether this was the result of poor policy implementation, or by design. Although my empirical work concerns variation in the mental health and child welfare policy changes that came after, these changes took place alongside and enabled the decline of asylums and orphanages. From my study we can therefore learn more about the process through which these institutions disappeared. This empirical contribution is relevant to much broader literature in political science that studies the relationship between science or expert knowledge and policy making.

The main theoretical contribution is to current debates in comparative welfare politics about the dimensionality of partisan conflict over time. My findings about the effect of partisanship on the care policy decisions that I study are consistent with wider theories of welfare politics. Social democratic parties promote state responsibility to a greater extent than all other types of governments, while conservative parties prefer private responsibility by the family or market. But parties of the centre and right also make distinct choices, supporting my claim that the politics of care policy cannot by reduced to a single, socio-economic dimension of conflict. Rather than being a distinctive feature of post-industrial welfare politics, I argue that multidimensional conflict was always more present in debates over care policy. The historical class and religious cleavages that contributed to party formation and ideology have had lasting impacts on the positions that partisan actors take in care policy debates throughout the second half of the twentieth century and to today.

# Chapter 2

# The partisan politics of care

This chapter outlines a theory of how government partisanship has affected care policy decisions since the Second World War. Its main argument is that, although the decline of asylums and orphanages occurred alongside the expansion of the welfare state, debates over care policies are not reducible to the socio-economic dimension of conflict which has dominated theories of partisanship in comparative welfare politics. Rather, partisan care policy preferences are also structured by a second dimension of partisan conflict that reflects ideas about how societies should be organised, around individuals or families. The ideologies of individualism and familialism divide Christian democrats from social democrats, and conservatives from liberals, and, like socio-economic ideologies, are rooted in the constellation of societal cleavages which shaped the major parties of government during the rise of mass politics. I argue that these ideologies have influenced partisan policy preferences and variation in care policy decisions throughout the twentieth century and beyond.

The theory presented in this chapter brings together insights from the historical-sociological literature on the origins and development of political parties with literature on the welfare state and social policy, and particularly its feminist critics. By combining these theoretical perspectives, I draw links between historical religious cleavages and contemporary debates about culture or values conflicts in politics, as well as gender ideologies, to formulate a more general theory of the effect of partisanship on care policy. I argue that care policies are particular types of welfare policy, targeted at non-workers, where multi-dimensional ideological conflict is more visible than in debates over core welfare policies such as pensions and social in-

surance, which are dominated by socio-economic conflict. My theory of the partisan politics of care should help us to assess the effect of partisanship on care policy changes since the Second World War, but it also makes a theoretical contribution to wider debates in comparative politics about the dimensionality of party competition and how partisanship shapes welfare policy making over time.

In the first section of the chapter, I trace multidimensional conflict over care policy to the class and religious cleavages which divided political parties during the rise of mass politics and the early development of the welfare state. I then consider the implications of these ideological divisions for care policy specifically, and outline my expectations about partisan care policy preferences. The third section of the chapter specifies the contribution that this dissertation makes to current theoretical debates, and identifies alternative explanations that will need to be addressed in the empirical study. The final section of the chapter describes the research design and methods that will be used.

# Two dimensions of party ideology

The major parties that have led democratic governments in advanced capitalist countries since the Second World War are divided on the question of who should be responsible for welfare provision. The important divisions between political parties are shaped by the societal cleavages which structured party formation during the nineteenth and early twentieth centuries. In the study of welfare policies such as social insurance, divisions among parties are often reduced to a single dimension or cleavage structure. Socio-economic conflict is at the centre of welfare politics in both T.H. Marshall's early conceptualisation (1950) and in influential theories that focus on the 'power resources' of organised labour (see especially, Korpi, 1983 and Esping-Andersen, 1990). Socio-economic conflict has dominated partisan theories of the welfare state, with parties' policy decisions being driven by class-based constituencies and competition for the median-income voter.

But current debates in the comparative welfare state literature have shifted away from this singular focus on socio-economic conflict, to emphasise the multidimensionality of party competition over welfare policy (for example, Manow, Palier, and Schwander, 2018). Recent work focuses on the multidimensionality of conflict in the post-industrial era, particularly over care policies such as child care and family benefits (for example,

Häusermann, 2018). The rationale for a 'new politics' of the post-industrial era is that demographic and social change and labour market restructuring have created new cross-class conflicts which divide socio-economic groups' interests in a way that affects both their policy preferences and voting behaviour (Häusermann, Picot, and Geering, 2013; Häusermann, 2010, p. 7). Whether divisions are between labour-market insiders and outsiders (Rueda, 2005), or the winners and losers of globalisation (Kriesi et al., 2008), scholars agree that class politics alone can no longer explain the partisan dynamics of welfare policy making.

This literature on post-industrial welfare politics has grown in response to the argument made by Paul Pierson that, since the 1970s, the explanatory power of left-right partisanship for predicting the path of welfare reform had waned. Pierson (1994) observed that the declining power of the organised working class did not appear to have heralded a retrenchment of the welfare state. The prominent explanation is that, as a result of the popularity of existing policies, right-wing governments are unable to implement significant welfare cuts, and, operating in a more constrained macroeconomic environment, left-wing governments are unable to resist cuts completely (Huber and Stephens, 2001). But a body of work has shown that left- and right-wing parties still pursue distinct reform strategies which affect the style of 'marketisation' (Gingrich, 2011), or 'social investment' (Morel, Palier, and Palme, 2012; Hemerijck, 2013) that is implemented. So while it would seem that other dimensions of conflict are increasingly important, distributive politics still plays a role in shaping policy decisions.

Although the post-Pierson, 'new politics' literature has been greatly concerned with the question of whether or not partisanship still matters, Pierson's argument was not that partisanship did not explain welfare politics but rather that power resources theory in particular could not explain the politics of retrenchment in an environment where the support coalitions for existing welfare policies are made up of wide and class-diverse constituencies of voters and interest groups (Pierson, 1996). Equally, I argue, power resources theory cannot explain the politics of policies which are not principally concerned with workers and which don't substantially affect overall levels of social spending, so are therefore not dominated by class-based conflict and competition for the median-income voter. Some of the recent work on multidimensional welfare politics supports the idea that certain dimensions of conflict matter for some types of policies more than others. A recent review of quantitative research on the effect of par-

tisanship on welfare policy finds that left-right partisanship matters most for class-related programmes like unemployment benefits and social insurance (Bandau and Ahrens, 2020). I argue that conflict over care policy has likely always been more multidimensional than conflict over core welfare policies such as pensions and social insurance, where the dominance of distributive politics means that the effect of partisanship can be described along a single, socio-economic dimension.

While social democratic parties of the left are singularly important in power resources theories of broader welfare state expansion, we know from the historical sociological literature on party formation that conflict between conservative, liberal, and religious parties was structured along multiple lines of conflict – between centre and periphery cultures, the church and state, and between landed elites and urban industrialists – as well as *and prior to* the socio-economic struggle. Distinct workers' parties of the political left emerged later, and were more alike that the alliances from which the other major parties were forged (Lipset and Rokkan, 1967, p. 21). The precise composition of party alliances around which conservative, liberal, Christian democratic, and social democratic parties were formed varied among countries, but it is possible to make some generalisations about the key divisions between these four party families which, I argue, should shape partisan preferences about care policy.

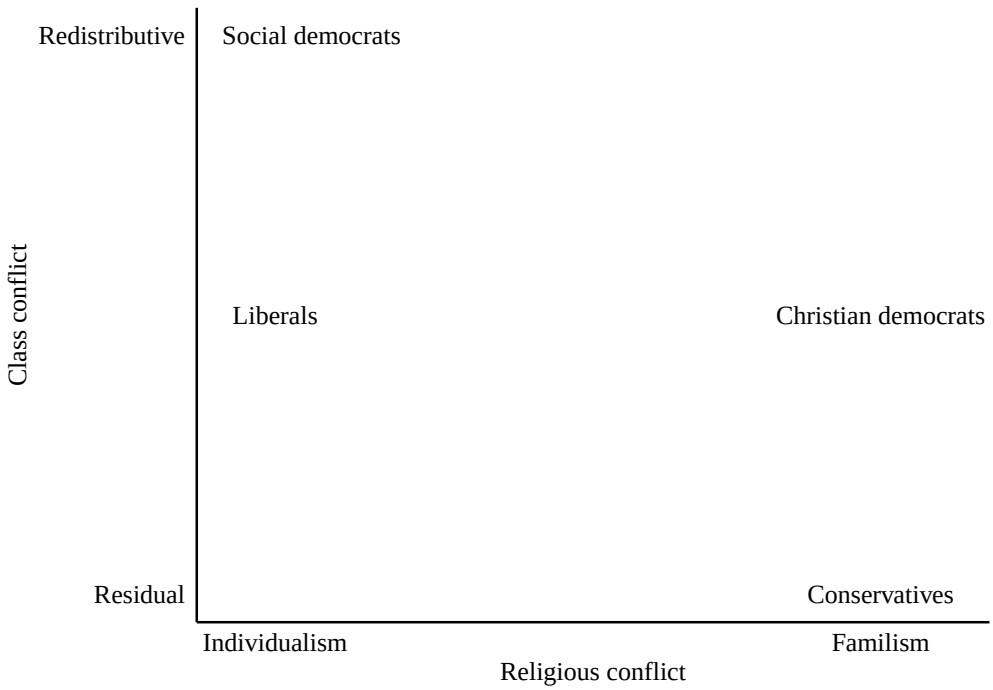
In Figure 2.1, I depict the four main party families according to their redistributive preferences and individualist or familial ideologies, shaped by the two dimensions of class and religious conflict. Preferences for high levels of redistribution on the one hand, or a more residual state on the other, are shaped by socio-economic conflict in line with the class interests of parties' foundational constituencies. On questions of redistribution (depicted on the vertical axis), social democratic parties emerging from workers' movements are most distantly divided from the conservative parties which originated with old regime elites who sought to defend the existing order against social upheaval (Ziblatt, 2017, p. 29).

Both liberal and Christian democratic parties can be placed toward the centre of the socio-economic dimension of partisan conflict, neither as embracing of redistribution as social democrats nor as in favour of a residual state as conservative parties, but for different reasons. Christian democratic parties became important forces for the expansion of the welfare state out of a desire to attract working class voters and a moral obligation to assist the poor, while liberal parties overcame a general opposition to

collectivisation to introduce social policies, either to attract support from workers or with secularising motives against a dominant religious opposition (Manow and Van Kersbergen, 2009, p. 4). Attracting the support of the middle classes, liberals were able to be more flexible about taxation and spending than conservatives, and they often worked in alliance with labour parties (Luebbert, 1991, p. 7).

A second dimension of partisan conflict divides Christian democrats from social democrats and conservatives from liberals. The ideologies of individualism and familism (depicted on the horizontal axis of Figure 2.1) were shaped primarily by religious conflict between the alliances which formed political parties. Christian democratic parties have their roots in nineteenth-century catholic associations, which were initially formed as apolitical organisations to defend against liberal anticlerical attacks, but evolved into mass parties separate from the Church (Kalyvas, 1996, pp. 71–4). In church–state conflicts, Christian democrats clashed with liberals and social democrats alike. Liberal parties comprised periphery

Figure 2.1: Dimensions of partisan conflict



cultures, dissident religions, and either industrialists or agrarians, emerging as alliances of diverse smaller interests in opposition to the powerful classes and dominant religious groups (Lipset and Rokkan, 1967, pp. 41–6).

Both Christian democratic and conservative parties privilege families as the foundation of society, but for Christian democrats the family has intrinsic and not just instrumental value. Christian democratic parties are distinctively shaped by catholic social doctrine and a philosophy of 'personalism' which, in contrast with liberal individualism, views people as flourishing in communities (Hanley, 1994, p. 4). While 'personalities', as distinct from individuals, can be fully realised through connections to groups of many kinds, the family is the elementary social unit which Christian democrats seek to uphold (Van Kersbergen, 1995, pp. 184–5). Influenced by Christian morals or in opposition to new commercial interests, conservatives aimed to preserve of the value of kinship connections over status attained though industrial enterprise (Lipset and Rokkan, 1967, p. 19). Families play an instrumental role for conservatives in preserving the existing social order. So that state intervention in the social order is curtailed, conservative parties prefer that welfare remain a private matter. Christian democrats prefer corporatist models of welfare provision based on the principle of subsidiarity, and compared with social democratic parties, place stronger emphasis on the male-breadwinner model and informal care by the family (Huber and Stephens, 2001, p. 185).

On the side of individualism, social democratic parties emphasise social rights and a decent standard of living for individuals, and their support for gender equality means that social democrats promote policies that relieve families of the responsibility for care (Armingeon, 2006, p. 107). The role of individualism in liberal thought long pre-dates the formation of liberal parties, but what made liberal parties liberal was the diversity of interests from which they were formed, and origins in commercial interests. Both contributed to a commitment to freedom and non-interventionism, and thus a preference for private welfare provision. Early in the twentieth century, liberals also supported welfare provision through voluntary organisations, not for their intrinsic value as communities of people (as for Christian democrats), but based on the principles of freedom of choice and association, and as an alternative to collectivised provision by public authorities or by socialist unions (Rothstein, 1992). But, fiercely divided over church and state, liberals were opposed to Christian democrats on whether the voluntary organisations that provided public services should

be religious. These historical origins shaped distinct partisan ideologies that have long shaped attitudes toward the role of different welfare providers.

The historical-sociological literature on party formation suggests that both socio-economic and religious conflicts structure the ideological differences between the major party families. This doesn't mean parties always compete on both dimensions, or that partisan governments always implement policies in line with their ideological predispositions, but in the following section I elaborate on why both dimensions of party ideology should more overtly shape decisions about care policy in particular.

## Care policy preferences

I argue that multidimensional partisan conflict is particularly important for understanding the effect of partisanship on care policy, because care policies are targeted not at workers, but rather dependents, or people who are not expected to work. Most welfare policies that are the object of study in the classic welfare state literature are either targeted at workers and retired workers, such as pensions and social insurance, or toward such a large part of the population that the level of expenditure on these policies makes socio-economic conflict and the politics of redistribution the central and dominant dimension of partisan conflict. But policies targeted at non-workers or dependents have different political implications. In this section, I turn to the feminist social policy literature to define care policy and identify how the politics of care policy is different from that of other welfare policies. On this basis, I outline my expectations about the care policy choices that partisan governments will make when they are in power.

The narrow focus of the classic welfare state literature on the needs of (male) workers and the role of organised labour in the expansion of the welfare state is well-documented in feminist critiques of the 1990s (for example, Pedersen, 1993, pp. 5–12; O'Connor, 1993; Orloff, 1993). It is also in this feminist literature that the concept of 'care' and the distinctive features of care policies have been elaborated.

The concept of care has diverse meanings, so it is important to clarify how I use it in this dissertation. I refer to care as a verb or activity rather than an emotional state, meaning 'to care for' rather than 'care about' someone, dimensions distinguished by Tronto and Fisher (1990). Dalley (1996, pp. 13–14) explains that 'the first is to do with the tasks of tending

to another person; the second is to do with feelings for another person'. Care as a social policy concept was developed in feminist scholarship to draw attention to the unpaid work performed by women within the family as a form of welfare provision. For instance, in her pioneering work, Ann Oakley argued that that the perception of women's informal care work as marginal in its contribution to the economic welfare of society was flawed, because the wider economy was dependent on reproductive labour within the family (Oakley, 1986 [1972], especially pp. 138–139). In early feminist contributions, care was specifically associated with work performed primarily by women in the family home (Waerness, 1978; Graham, 1983, p. 16). Theorists of the relational aspects of care still focus on care as a *private* and personal activity, arguing that care can only be provided by a person (Noddings, 2013, p. xiv; Bubeck, 1995, pp. 128-130).

But into the 1990s and 2000s, care as a concept in feminist social policy research was also applied to *public* services, such as day-time child care, which provided an alternative to care in the home and enabled women's access to the labour market (although as Leira highlights (1992, p. 164), women's labour-market participation was already well advanced by the time that state-sponsored child care was introduced in Scandinavian countries in the 1970s). This literature considers the political economy of care, and is concerned with the type of institution that was responsible for providing (and funding) caring activities in both public and private settings. The concept of 'social care services' was used by Anttonen and Sipilä (1996) to describe the range of care services provided publicly to strengthen the autonomy of women, explicitly *excluding* informal care. Empirically, the concept of social care services has been almost exclusively applied to day-time child care and aged care – policies largely emerging in the last quarter of the twentieth century (Sainsbury, 2013). But the universe of care policies can include social security and tax benefits, paid and unpaid leave, public services including residential and day care, and incentives for market provision (Daly, 2002).

The concept of 'social care' has also been used much more broadly by Daly and Lewis (2000) to describe the relations, contexts, and political economy of caring arrangements. Daly and Lewis define social care as 'the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out'. Social care in this context crosses the public–private divide, and the types

of institutions that can be responsible for care labour and costs can be the family, the state, the market, or the voluntary sector. The object of my study is not social care as a complex system, but more specifically the policy decisions which shape responsibility for care. I focus on what Daly and Lewis (2000) refer to as the 'trajectories of change' in the system of social care: whether there is more or less state, market, family, or voluntary-sector responsibility for care. The ultimate distribution of care is affected by a range of factors shaping the supply and demand for different care arrangements. I focus on *policy decisions* which shift more responsibility toward state, market, family, or voluntary actors for meeting the needs of dependent adults and children – or, care policies.

How do parties make decisions about care policies? Existing work on the behaviour of political parties in welfare policy making suggests that they choose policies not only in response to specific voter interests, but also as 'ideologues', playing to their core constituencies by enacting policies which are in line with institutionalised party ideals about welfare policy more broadly (Keman and Van Kersbergen, 2007, p. 29). A distinction is often made between the vote-seeking and policy-seeking behaviours of political parties (Strøm, 1990), but we can also think of this 'ideological' policy-seeking behaviour as parties implementing policies which align with the values of their core constituency in the pursuit of low-risk votes (Cox and McCubbins, 1986). These two impulses, to serve constituency interests or pursue institutionalised policy preferences, might result in similar observed outcomes when we study policies where the median-income voter is decisive. Because parties are organisations of interest groups, the policy choices that conform with parties' broad ideas will likely be consistent with those in the direct interest of their industrial-era constituencies. But when the median-income voter is not decisive, we should expect decisions to be based on partisan ideologies.

Because care policies are less costly than the broad-based programmes and services of the welfare state and targeted at non-workers, decisions about care policy do not appeal to the interest of the median-income voter, who is considered to be decisive in influencing the level of redistribution and generosity of the welfare state (Meltzer and Richard, 1981). Of course, policies for workers and non-workers cannot be completely separated. Aspects of policies targeted at those who are not expected to work are, directly or indirectly, also concerned with workers. Firstly, their eligibility requirements or 'categories of exception' come to define the legal

boundaries between worker and non-worker (Stone, 1979, p. 17). In addition, when alternative care services are provided, they free up informal carers – mainly women – for the labour market. Such policies may even be motivated or presented to voters with this goal in mind.

On the basis of partisanship theory, we should expect that the shift in focus away from the contest for the median-income voter leads parties to act as ideologues in care policy decisions, making the second dimension of partisan conflict more salient in care policy debates than those over other welfare policies. But a feminist critique of partisanship theory offers an alternative reason why these multiple dimensions should matter for care policy. The concept of the median-income voter, alongside that of the worker, is as Orloff (1993, p. 307) has argued 'explicitly gender neutral' and 'based on a male standard'. In other words, the model of partisan competition for voters along a single, socio-economic dimension where the median-income voter is decisive assumes that voters are economically active men. Apart from obscuring the varying citizenship rights of women, even where suffrage is universal, the 'gender blindness' of mainstream theories of partisanship in the welfare state also neglects women as a collectivity: their interests and political demands, as well as partisan competition for women's votes in particular. Morgan (2006) has shown that competition for female voters played an important role in the development of child care policies in Western Europe and America during the 1970s. She argued that party positions reflected both vote-seeking behaviour and gender ideology, shaped by the salience of religious conflict with other parties. More recently, Morgan (2013) argues that rising partisan competition over female voters since the 1990s has lead to an expansion of work–family policies in traditionally more male-breadwinner-oriented societies including the Netherlands and Germany. Naumann (2012) draws similar conclusions in her analysis of the development of child care policies over a longer period.

So while we have good reasons to expect that the socio-economic dimension of partisan conflict is less dominant when the (male) median-income voter is less decisive, the second dimension of partisan conflict is also likely to be more important in policy areas that disproportionately affect female voters. We should therefore expect parties to make decisions about care policy on the basis of their ideological position on both dimensions of conflict. Based on the constellation of cleavages which shaped the ideologies of social democratic, Christian democratic, conservative, and liberal parties,

and the expectation that governments will pursue care policies as ideologues, we can formulate a range of expectations about the choices that different types of parties will make when they are in power. Table 2.1 presents a stylised description of these expectations.

Let us begin by looking at the outcomes of state and voluntary provision to the far left and right of Table 2.1. Supporting both collectivism and individualism, social democratic parties should prefer state responsibility for care over all other types of provision, and to a greater extent than all other types of parties. Christian democrats will be less likely than social democrats to promote state responsibility, although they may favour state responsibility to a greater extent than liberals or conservatives. Christian democrats are most likely to promote voluntary responsibility for care. They prefer voluntary provision on the basis of both the direct role played by religious organisations in delivery, and the intrinsic value of voluntary organisations discussed above. Although liberals will also support voluntary providers as a form of private organisation, they will be concerned not to empower religious providers, so may not expand voluntary provision to the same extent as Christian democrats.

Table 2.1: Partisan policy preferences

| Party family | Outcome: Type of policy change | | | |
|---|---|---|---|---|
| | State | Market | Family | Voluntary |
| Social democrat | + | - | - | - |
| Christian Democrat | - | - | + | + |
| Conservative | - | + | + | - |
| Liberal | - | + | - | + |

*Comments:* The type of policy change reflects a policy promoting state, market, family, or voluntary responsibility for care. + indicates that the party will be more likely to prefer this type of policy change compared with other parties. - indicates that they will be less likely than other parties to pursue this type of change.

Turning to the middle outcomes in the table, social democrats and Christian democrats will be less likely than conservatives or liberals to promote market responsibility for care. Based on the socio-economic dimension of conflict, conservatives and liberals prefer private solutions and will be will be more likely to expand the role of for-profit providers, while both social democrats and Christian democrats favour collective responsibility for care. On the other hand, both conservatives and Christian democrats have familial values, so they should promote family responsibility for care to a greater extent than the more individualist social democrats or liberals.

# Theoretical contributions

By combining insights from the historical-sociological literature on the formation of political parties and feminist critiques of comparative welfare state theory, I contribute to theoretical debates in comparative politics about the dimensionality of party competition and how partisanship shapes welfare policy making over time. In particular, I question the extent to which the 'old' cleavages of class and religion have been transformed to shape a 'new' multidimensional politics of the post-industrial era, theorising instead that the *type* of welfare policy matters for the dimensions of party competition and ideology that shape decision making.

As discussed above, the main theories of welfare state expansion are unidimensional, focussed on the effect of socio-economic conflict, but both the historical-sociological literature on political parties and the feminist social policy literature have always emphasised other dimensions of conflict. Beyond Lipset and Rokkan's cleavage theory (1967), the role of religion in welfare politics has been well-documented in the work of Van Kersbergen (1995) and others on Christian democracy. Feminist research has drawn attention to the role of other non-economic conflicts, in the form of gender ideologies such as the male-breadwinner model (for instance, Lewis, 1992 and Gustafsson, 1994). Alternately, Pfau-Effinger (1998) refers to the male-breadwinner or dual-breadwinner models as gender *cultures*. Kremer (2007, pp. 70–71) has explored how this 'cultural dimension' of welfare politics shapes more specific 'ideals of care' which establish logics of appropriateness for working and caring arrangements. Although culture is positioned as distinct from policy or politics by these authors, Kremer (2007, p. 251) recognises that ideals of care can be shaped by partisan

actors who seek to legitimise or challenge existing policy settings. Morgan (2006, pp. 77–86) shows that predominant gender ideologies were actively promoted over time by dominant partisan actors, such as the social democrats in Sweden and Christian democrats in the Netherlands. Both Morgan (2006) and Saraceno (1994) argue that partisan gender ideologies are related to party's positions in historical religious conflicts.

But current debates on the dimensionality of welfare politics focus on *new* types of non-economic conflicts in the post-industrial era. This literature has developed from broader ideas in political science about the declining salience of socio-economic conflict. The seminal argument made by Inglehart (1977) was that an environment of affluence had engendered a 'silent revolution' among the post-war generations, from a political focus on economic concerns to 'post-materialist' values manifested in the new social movements of the 1960s and 1970s. Kitschelt (1994, pp. 9–27) described the non-economic dimension of conflict as a division between libertarian and authoritarian ideologies, reflecting a preference for self-organisation or paternalistic social structures respectively. This dichotomy has become known as the GAL-TAN (green/alternative/libertarian - traditionalism/authority/nationalism) dimension, following the terminology used by Hooghe and Marks (2009). It is also sometimes more generally called the 'socio-cultural', or simply 'cultural' dimension of conflict, dividing progressives from conservatives (Manow, Palier, and Schwander, 2018a, p. 6). Authors such as Bornschier (2010) have argued that the 'new cultural divide' helps to explain the shifting positions of social democratic parties to attract educated middle-class voters since the 1980s, and the emergence of parties such as green parties and the radical right.

Häusermann and Kriesi (2015) recognise that multiple dimensions of conflict have always been important, but argue that the 'old' cleavages of class and religion have been transformed. They suggest that on the one hand, as result of secularisation and globalisation, the cultural cleavage once shaped by religion is now structured by other issues that pit people with more local or 'particularist' cultural identities against those with more universalistic values. One example is the integration of migrants into the national social protection system. On the other hand, as a result of macroeconomic change, labour market transformation, and feedback effects from existing policies, the politics of redistribution is less about the overall generosity of the welfare state than the specific design of policies. The main claim is that voters' policy preferences and electoral choices have been

realigned by these transformations, resulting in a blurring of the conflict dimensions.

The recent literature on multidimensional welfare politics supports the idea that voters' policy preferences are determined by multiple dimensions of conflict. In a study of public opinion on welfare policy in western Europe, Garritzmann, Busemeyer, and Neimanns (2018) find that support for transfer policies such as pensions is highest among voters with a combination of traditional social values and left-wing economic attitudes, while social investment policies such as child are supported by voters with universalistic values across the class divide. Häusermann et al. (2022) show that while universalistic values are an important predictor of support for social investment policies, when we consider voters' relative support for different policies, the working class are less likely to prioritise social investment policies over transfer policies than middle class voters who have a more positive evaluation of their future economic position. In line with the focus on the post-industrial era, of particular interest are the welfare policy preferences of voters that support 'new' parties such as the radical right (Busemeyer, Rathgeb, and Sahm, 2022). Recent studies of the 'supply' side of politics have also focussed on the policy preferences of 'new' parties such as green parties (Röth and Schwander, 2021).

Realignment theory suggests that 'old' parties will either respond to the changing preferences of their core constituencies or shift their positions to attract new groups of voters, resulting in a restructuring of the political landscape. While there is evidence that parties of the left have changed their economic policy positions to appeal to middle-class voters, their welfare policy preferences have not necessarily been restructured by changes in their constituency. For instance, Gingrich (2011) shows that while both left- and right-wing parties have marketised aspects of welfare provision in recent decades, parties have still implemented the *types* of markets that empower their traditional supporters and allow them to pursue their core goals. For instance, in the case of the left, this means sustaining support for the welfare state. This suggests that even as electoral constituencies have changed, parties' core welfare policy preferences and are still structured by 'old' ideological differences.

Recent research in the partisanship literature has also questioned the extent to which competition between political parties has been restructured by 'new' cultural conflicts in the post-industrial era. Rovny and Polk (2019) have argued that the presence of cultural or second-dimension

conflict is closely related to the religious cleavage of the late-nineteenth and early-twentieth centuries. They show that even though the content of the second dimension has changed so that church-state conflict is no longer its central feature, political parties remain divided by contemporary cultural conflicts along similar lines as they were by historical religious conflicts. The question this raises is whether, and how, political parties have responded to changing voter preferences over time, particularly in policy areas where non-economic issues have always been more important or where the median-income voter was always less decisive.

I expect that while parties may seek office by changing the way they frame issues or elevating certain issues above others, their care policy preferences are shaped by more enduring ideological positions. Based on the historical-sociological literature on political parties, I argue that these ideologies have historical origins in the class and religious cleavages that contributed to party formation. While the recent multidimensional welfare politics literature has focussed on understanding partisanship in the post-industrial age, our understanding of the effect of partisanship in the period of welfare state expansion is still primarily based on unidimensional approaches. The power resources approach to partisanship was very effective for explaining the expansion of broad-based redistributive policies like pensions and social insurance, but based on feminist critiques of welfare state theory, we have good reasons to expect that second-dimension conflicts were always more important in conflicts over policies targeted at dependents rather than workers. That is, the *type* of welfare policy matters for the dimensions of party competition and ideology that we should expect to shape decision making. In this dissertation, by studying the evolution of much older care policies from at least as early as 1950, I am able to assess whether the effect of partisanship on *care policy* is also multidimensional in the decades of welfare state expansion immediately after the Second World War, and whether the decisions that partisan governments make are consistent with enduring ideologies shaped by class and religious cleavages.

There are important factors identified in the existing literature that might confound the relationship between government partisanship and care policy. Both the partisanship and welfare state literature suggest that the dynamics of multidimensional competition vary across countries. Rovny and Polk (2019) argue that in catholic countries where church–state conflict was stronger, left-wing parties also became more secular while right-wing

parties catered more to religious interests, leading to a closer association between the two dimensions of conflict. Similarly, Morgan (2006, pp. 67) finds that the strength of religious conflict and presence of religious parties led to the cross-cutting values cleavage, shaping partisan gender ideologies, being more salient in some countries than others (Morgan, 2006, pp. 67). Skocpol (1995, pp. 37, 56, 318) argues that the federal structure of the American welfare state and its two-party system contributed to the success of women's movements in garnering support for more maternalist welfare policies. I expect that the structure of partisan competition, constitutional structure, and the electoral system will affect the relative importance of each dimension of conflict across countries, so my research design will need to control for such factors, and allow me to show that the effect of partisanship is not only driven by variation among countries.

My contribution to this debate also speaks to an important assumption in this dissertation about how history matters. On the one hand, I argue that the class and religious conflicts of the late-nineteenth and early-twentieth centuries have had a lasting impact on policy outcomes. But, with an analytical focus on the agency of partisan actors, I do not argue that structural factors are deterministic of outcomes. Historical conflicts matter, not in a purely path-dependent fashion, but through the way that they institutionalise ideologies which shape the future policy preferences and decisions of partisan actors.

# Research design and methods

In this dissertation, I investigate whether and how partisan politics shaped variation in the policy changes that were made to two very old care policies: asylums and orphanages. In order to test whether my theory of the partisan politics of care can explain the general patterns in care policy decisions, I begin by conducting a quantitative analysis of care policy changes in twelve countries. I complement this with a qualitative, comparative study of policy changes in two quite different countries over time. The qualitative study gives confidence to the quantitative results by providing evidence for some of the main assumptions of the statistical model, showing that my theory helps to account for patterns of policy change over time in two very different contexts, and considering the evidence for relevant alternative explanations. It also allows me to explore how the two dimensions of conflict were reflected in parliamentary debates, and the extent to

which different types of ideological arguments were used over time.

Care policy changes are the main unit of analysis in the quantitative study, but because my ambition is to understand the impact of political parties distinct from structural factors that vary among countries, I select cases for the quantitative analysis at the level of countries and leverage variation in government composition over time to identify the effect of partisanship. I first aim to maximise variation on the dependent variable by choosing countries with different types of existing institutional care services, and different experiences of deinstitutionalisation – some early movers whose institutional populations peaked before 1970, and others considered laggard; some which made large, sweeping changes, others which favoured incrementalism, and some countries in between. This means that in the quantitative analysis the data panel is unbalanced by design, because I select countries based on the expectation that there will be variation in the number of policy changes that are made. Note that this strategy to maximise variation does not mean I select cases *on* the dependent variable, as I aim to explain the *type* of care policy changes that were made, and I do not know this in advance.

I also select cases with a mix of party competition environments. Six countries are effectively two-party systems with mostly majoritarian institutions, while the other half are proportional systems characterised by multi-party competition and typically coalition governments. Among the countries with two-party systems, half are characterised by competition between major social democratic and conservative parties (England, Australia, and New Zealand), and half by competition between liberals and conservative or religious parties (USA, Canada, and Ireland).[1] Among the multi-party systems, half have a strong history of Christian democratic leadership (Germany, Italy, and the Netherlands) while the others do not (France, Sweden, and Denmark).

The countries included in the study are also selected to represent different types of welfare state regimes, because the institutional factors which affect welfare regime classification may also shape both the composition of government and the propensity for state, market, voluntary providers,

[1] Although Ireland is not majoritarian, it scores under 3 on Lijphart's (2012) 'effective number of parties' measure, so I count it among the two party systems here. This is arguably less reasonable for recent decades, with the rise of new parties and latterly Sinn Féin, but for all of the period that I study either Fianna Fáil or Fine Gael held the majority of cabinet posts.

or families to take responsibility for care. I begin by considering the liberal, social democratic, and conservative worlds of welfare identified by Esping-Andersen (1990). This typology is widely used in the comparative welfare state literature and captures important aspects of class politics such as the strength of organised labour and the presence of corporatist institutions. However, the three-worlds approach has long been criticised for prioritising class conflict over other dimensions such as gender equality, and failing to account for the role of women in providing unpaid care (Orloff, 1993). These critiques are important for my case selection because gender inequality shapes the availability of family-based care, but more importantly it is underpinned by traditional gender norms which are deeply connected with the ideology of familialism.

Feminist analyses of gendered welfare regimes have grouped countries in myriad ways to demonstrate the limitations of Esping-Andersen's typology, but the approach with the clearest focus on familialism is the distinction that Lewis (1992) makes between weak, strong, and modified male-breadwinner models. Social democratic welfare states are typically depicted as weak male breadwinner societies, of which Sweden is an example in my study. Denmark, however, is typically placed together with France into the group of modified male-breadwinner countries with relatively high female labour market participation but more explicitly gendered tax and transfer policies (Sainsbury, 1999). The Netherlands, as well as Australia and New Zealand, are also considered modified systems, characterised by historically very low but fast-growing female labour market participation in the second half of the twentieth century, alongside the expansion of family benefits (Lewis, 2002; Nolan, 2003). The strong male-breadwinner countries include the liberal welfare states of England, Ireland, the USA, and Canada as well as the more familial countries of Germany and Italy.

Because I focus on national-level policy changes, I have chosen some federal and some unitary states. We might expect that federal countries were less likely to make national-level policy changes, but I find considerable diversity in the way that federal states handle these policy areas. For instance, child welfare services are the responsibility of the states in all of the federalist countries that I study, but in the United States the federal government has been quite active in legislating around child protection and adoption, as well as preventive programs designed to reduce the use of out-of-home care. In Canada and Germany, these types of policies were left up to the states until the 1990s, when, influenced by the United Na-

Table 2.2: Case selection by welfare regime type, timing of deinstitutionalisation, and key institutional features

| Welfare regime | Country | Deinstitutionalisation | | Constitution | | Electoral system | |
|---|---|---|---|---|---|---|---|
| | | Early-mover | Laggard | Federal | Unitary | Proportional | Majoritarian |
| Liberal | Canada | ✓ | | ✓ | | | ✓ |
| | England | ✓ | | | ✓ | | ✓ |
| | USA | ✓ | | ✓ | | | ✓ |
| | Australia | ✓ | | ✓ | | | ✓ |
| | New Zealand* | | ✓ | | ✓ | | ✓ |
| | Ireland | ✓ | | | ✓ | ✓ | |
| Conservative | Italy | | ✓ | ✓ | | | |
| | France | | ✓ | | ✓ | | ✓ |
| | Germany** | | ✓ | ✓ | | ✓ | |
| | Netherlands | | ✓ | | ✓ | ✓ | |
| Social democratic | Sweden | ✓ | | | ✓ | ✓ | |
| | Denmark | | ✓ | | ✓ | ✓ | |

*New Zealand is majoritarian for most of the period, but introduced proportional representation in 1996.
** For the period between 1950 and 1990, I refer to the policies of the Federal Republic of Germany.

tions (UN) Convention on the Rights of the Child, the role of the national government expanded (Haug and Höynck, 2012, p. 92). In Australia, however, the UN Convention had little influence on policy developments and we find just one national-level child welfare policy change, in 2009 (Katz, 2015, p. 221). Table 2.2 describes variation among the twelve countries in the study on each of the dimensions of case selection.

I study asylums and orphanages together because of their similarities in purpose, governance, and patterns of rise and fall. Emerging between the fifteenth and eighteenth centuries, asylums and orphanage grew in number and size during the nineteenth century across Western Europe, North America, and Oceania. They expanded at a similar time and with a similar purpose as other emerging public services, and after a peak in most countries in the third quarter of the twentieth century, both asylums and orphanages rapidly declined. These parallel transformations, which I discuss in some detail in Chapter 3, were likely shaped by the same factors, yet there have been few studies of these two policy areas together, and none which offers a common explanation for change.

Studying asylums and orphanages together also allows me to consider the effect of partisanship on care policy in two policy areas that are different in important ways – concerning both the types of service users, and existing policy settings. In distinguishing between welfare policies more broadly, and care policies specifically, I argue that the conception of service users as dependents or non-workers is important for shaping the politics of care policy. As care policies, asylums and orphanages catered to groups with different relationships to both the labour market and family. While I agree with authors who have argued that the boundaries between workers and those not expected to work not natural but constructed by policies (notably, Stone, 1979), it is reasonable to expect that infants and young children are more likely to be seen as dependent than adults with chronic or severe mental illness. Of course, even children were considered workers before the regulation of child labour, but that legislation such as the Factory Act 1833 came so early in the nineteenth century is only evidence of how especially subject to exemption from work children were. In addition, by the 1960s, the science of child development and child psychiatry, which showed that children had better outcomes when they were raised in a family environment, had gained merit in policy circles around the world. The fact that all types of governments may have had shared, non-ideological reasons to view the family as the ideal site for care in the

case of child welfare policy will help to shed light on the independent effect of partisanship on care policy choices.

Secondly, there were important differences in existing policy settings, or the types of providers that managed asylums and orphanages. Across most countries by 1950, the state directly provided a larger proportion of institutional care for people with mental illness than it did for children who could not be cared for by their parents. There was a much larger role for voluntary, and in particular religious, organisations in the care of children, and orphanages were often less centralised than asylums, with expenses controlled by financing mechanisms for local government. The larger existing role for the central state meant that the fiscal burden of the mental health services was higher than that for child welfare services in most countries. One of the assumptions of the post-Pierson welfare state literature is that the effect of left-right partisanship has diminished over time because the popularity of welfare policies combined with fiscal constraints make right-wing parties unable to dramatically cut spending while left-wing parties are unable to completely avoid cuts. Because I am interested in the role of partisan conflict – both socio-economic and second-dimension – over time, studying two policy areas that are subject from the outset to different levels of fiscal pressure will shed light on the response to fiscal pressure over time.

I begin in the next chapter by considering the history of asylums and orphanages, identifying their social function as care policies that substituted for family care. In chapter 4, I begin the empirical study by categorising policy changes made in the twelve countries discussed above, on the basis of whether they promoted the responsibility of state, market, family, or voluntary organisations for the care of formerly institutionalised populations. I then use logistic regression to examine the relationship between government partisanship and the types of care policy change that were made. Because I am interested in policy changes that were made to develop alternatives to institutional care, the time period covered captures the years when institutional populations peaked in all countries, except for orphanages in the United States, Sweden, and England (see Table 3.3 in the following chapter). In many countries, innovation in extramural care had begun before the Second World War, but was limited to localised experiments. England had introduced legislation enabling voluntary admission to asylums in 1930, but this did not in principle affect the type of institutions that were responsible for care. I begin my study in 1950

to ensure that all countries are on a 'level playing field' in terms of the utilisation of existing institutional capacity. During the wars, the terrible loss of life in central European countries was also extended to people in institutions, many of whom starved to death when resources were scarce (Goodwin, 1997, p. 9). The need to explore alternatives to asylums was potentially delayed until after the populations within institutions returned to their pre-war capacity and decisions had to be made about whether to expand the existing services or invest in alternatives.

The comparative historical analysis in chapters 5 and 6, which address mental health and child welfare policies in turn, have two purposes. The first is to give confidence to the evidence presented in chapter 4 about the relationship between government partisanship and care policy, by relying on two types of comparisons. The main causal leverage comes from the comparison of care policy changes over time within each country – England, and Germany. If a change in government partisanship affects the type of care policy change that is made, then the decisions made over time should be consistent with my expectations about the policy preferences of the party that is in power. The qualitative analysis addresses one of the limitations of the statistical analysis, which controls only for the welfare regime type and other institutional factors, and not individual countries, due to the relatively small sample.

In each chapter, I also make comparisons between the two countries. I select the two country cases of England and Germany because they are the most different cases in my wider sample on a range of important institutional factors. England has a national health service embedded in a liberal welfare regime where market solutions tend to play more of a role, while Germany has a national health insurance system and a corporatist welfare regime where voluntary organisations provide a larger number of services. England has a unitary constitution and two-party, majoritarian electoral system, while Germany is a federal country with a multi-party system of proportional representation. England and Germany are considered respectively leader and laggard in the implementation of deinstitutionalisation policy, and while in England institutional care was predominantly public, in Germany a mix of state and voluntary services existed. While the most-different system of case selection offers weak opportunities for causal inference, its principal strength is to demonstrate that a theory is helpful for understanding the relationship between cause and effect across different types of cases (Seawright and Gerring, 2008).

That England and Germany also have different major centre-right parties – conservative and Christian democratic, respectively – also allows me to investigate how my theory helps us understand differences between the two party families. The comparison also demonstrates that despite different levels of disruption to the party system, historical cleavages that shaped party families had an enduring influence. The British party system had developed in a democratic environment and remained relatively stable since its 'freezing' in the pre-war period, whereas in Germany political parties had not only emerged amidst the Imperial era and the interference of the Chancellor, but also experienced dramatic upheaval between 1918 and 1949. German historians mostly agree that the Social Democratic Party re-established itself around similar issues as during the Weimar era, while the liberal and Christian democratic parties were more disrupted (Kreuzer, 2009). Nevertheless, The Christian Democratic Union and Christian Social Union had connections to earlier catholic organisations and religious parties, and crystallised around traditional Christian values across the catholic–protestant denominational divide (Broughton, 1994, pp. 101–2). The liberal Free Democratic Party also attracted experienced politicians from earlier liberal parties, and socio-economic and religious cleavages are considered important for both party ideology and competition in the post-war era.

The second purpose of the qualitative chapters is to assess how the two dimensions of conflict are expressed in parliamentary debates when politicians make arguments to defend their policy positions. The main primary source materials are parliamentary debates and documents, which I introduce in more detail in the introduction to chapter 5. I categorise the arguments made by politicians based on the indicators listed in Table 2.3. By focussing not just on what political parties do but what they say, I am able to more directly address issues in current debates about the dimensionality of party competition in the post-industrial era. I examine the salience of each dimension of conflict for different types of parties in the two countries, and assess whether the role and relative importance of conflict dimensions – or their content – has changed over time.

Table 2.3: Indicators for ideological arguments

| Conflict dimension | Argument type | Indicator |
|---|---|---|
| Socio-economic | Redistributive | - Promote higher levels of government spending and public-sector employment.<br>- Frame policy solutions as providing equal access and quality of services for all citizens. |
| | Residual | - Promote lower levels of government spending, taxation, and public-sector employment.<br>- Frame policy solutions as being efficient or delivering services on the basis of need. |
| Second-dimension | Individualist | - Claim that individuals do better when they are not dependent on family relations; that individuals in need may not have families.<br>- Frame the family as something constructed by or dependent on public policy. |
| | Familial | - Claim that people do better when they are cared for by their families.<br>- Frame the family as a natural site of care, or as an independent social unit that should not be interfered with. |

*Comment:* Table lists the indicators for different types of ideological arguments, used in the qualitative chapters 5 and 6.

# Conclusion

In this chapter, I have outlined a theoretical framework and empirical strategy for explaining the types of mental health and child welfare policies that came after asylums and orphanages. These cases of care policy change can help us better understand the politics of care policy, and the role of political parties as actors shaping welfare policy more broadly. My central claim is that we should expect partisanship to shape care policy, not just on the basis of partisan conflict about whether or not care should be collectivised and publicly provided, but also based on competing visions of how society should be organised: around individuals or families. I argue that political parties are institutionalised collective actors, whose contemporary policy preferences are shaped by the historical class and religious cleavages that contributed to party formation. My work contributes to current debates in comparative politics about the dimensionality of party competition and the effect of partisanship on welfare policy over time.

In the following chapter, I re-consider the function of asylums and orphanages in historical perspective, justifying my consideration of these large, custodial institutions as types of care policy. I also review the empirical literature on deinstitutionalisation to identify potential alternative explanations that will need to be addressed in the empirical chapters, and outline the potential empirical contribution of the dissertation.

# Chapter 3

# The rise and decline of the first welfare state institutions

The first asylums and orphanages emerged in Western Europe in the fifteenth to eighteenth centuries. Confinement in these large, custodial institutions became the dominant form of care for people with chronic or severe mental illness and children who could not be cared for by their parents across the industrialised world from the mid-to-late nineteenth century until at least the interwar period, and in most countries well into the 'golden age' of welfare state. How can we understand these institutions at their zenith, and what do we already know about how and why they declined? These questions have so far been answered mainly by historians and sociologists, with a focus on specific national experiences on the one hand and broad processes of social change on the other. In this chapter, I show that asylums and orphanages can be understood as cases of welfare policy, and more specifically care policy.

In the previous chapter, I defined care policies as policies that determine who provides for the needs of people who are not expected to work, potentially substituting for family care. In this chapter, I review the historical evidence that asylums and orphanages fulfilled this social function. Unlike the institutions of indoor poor relief, nineteenth- and early-twentieth-century asylums and orphanages had humanitarian aims and provided for specific groups of deserving poor on the basis of desert and not punishment. Their objectives and increasingly centralised administration made them much more like the modern social policies of the developing welfare state.

To say that asylums and orphanages were care policies is not, of course, to suggest that the humanitarian aims of these large, custodial institutions were always fully met. We know that living conditions in asylums and orphanages were often very poor – just as contemporary aged care facilities do not always live up to our expectations for high-quality, personal care today. Equally, while there is evidence that it was mostly at the request of families that people were placed into in care, these decisions may have been made out of necessity, because families had neither the time nor the means to provide adequate care at home.

The social care function of asylums and orphanages existed alongside their function as mechanisms of social control that enabled the exclusion of deviant groups from society. Like other types of welfare policies, asylums and orphanages were simultaneously institutions of both care *and* control. While existing sociological accounts have framed deinstitutionalisation as a process entailing changing mechanisms of social control, by understanding asylums and orphanages as care policies this dissertation provides a complementary account of the policies that replaced their caring function.

In the first part of this chapter, I describe the rise of asylums and orphanages, showing that these policies were distinct from poor-law institutions in ways that make them much more similar to modern public services and the welfare state. I review the historical research which suggests that they fulfilled a social care function and were actively used by relatives as a substitute for family care. I also identify the key features of policy settings at the beginning of the period that I study, highlighting the main similarities and differences between the two policy areas.

In the second part of the chapter, I review existing explanations for the decline of asylums and orphanages and consider alternative explanations that will need to be addressed in this study. The existing literature has mainly been concerned with understanding what caused deinstitutionalisation as such, rather than variation in the care policies that came after. But the broad processes that drove the deinstitutionalisation movement – of economic and technological change, and changes in scientific knowledge and expert ideas – might also have shaped the patterns of care policy decisions that I study.

# From poor law to welfare state

Evoking mental images of the Dickensian workhouse, asylums and orphanages are associated with the systems of indoor poor relief that operated in Europe during the seventeenth to nineteenth centuries. But while the first asylums and orphanages emerged alongside or even before the first poor laws, they expanded as public services during the nineteenth century to care for specific groups of the so-called 'deserving' poor, with a reformist purpose that was distinct from the punitive principle of indoor poor relief. By the late nineteenth century, asylums and orphanages were care policies that provided for the needs of people who were not expected to work, substituting for family care. By re-evaluating the function of these institutions in historical perspective, we can identify the important features of pre-existing policy settings that may have shaped or constrained care policy decisions during the period of their decline.

As early as the fourteenth century, early hospitals throughout Europe had begun to admit 'mentally disturbed' people into long-term care (Mellyn, 2014, p. 193). At the same time, hospitals as well as nunneries and monasteries took responsibility for the care of orphaned or 'abandoned' children alongside other persons in need (Zmora, 2003). The first institutions specifically for the care of children emerged in southern Europe in the fifteenth to seventeenth centuries. They were privately administered, usually by catholic organisations, although the *Ospedale degli Innocenti*, established in 1419 in Florence, was operated by the powerful silk guild, to whom the task of caring for the innocent had been delegated by the city's general council (Khan, 2002). Both 'lunatics' (as people with mental illness were then known) and children were also often housed in almshouses or work houses.

Tables 3.1 and 3.2 list some of the first institutions that cared exclusively for people with mental illness or children who could not be cared for by their parents, in the twelve countries in this study. Although the administration of the institutions identified is not necessarily typical of the mix of services that would later emerge, institutions that were established later were more likely to be publicly administrated. Of those identified here, all of the institutions established after the 1760s were public, with the exception of the St Patrick's Convent in New Zealand, which had only been founded as a colony ten years earlier.

Table 3.1: Early asylums (listed by year)

| Country | First Asylum | Year | Administration |
|---|---|---|---|
| Netherlands | The madhouse at Zutphen | 1500 | Public |
| England | Bethlem Royal Hospital, London | 1547 | Public |
| France | Charenton, Val-de-Marne | 1701 | Religious |
| Italy | Ospedale di Sant'Orsola, Bologna | 1710 | Religious |
| Canada | Hôpital-des-Sœurs-Grises, Montreal | 1747 | Religious |
| Ireland | Magdalen Asylum, Dublin | 1765 | Religious |
| USA | Eastern State Hospital, Williamsburg, VA | 1773 | Public |
| Sweden | Danviks dårhus, Stockholm | 1788 | Public |
| Germany | Landes Irrenanstalt, New Ruppin | 1811 | Public |
| Denmark | Sct. Hans Hospital, Roskilde | 1816 | Public |
| Australia | Castle Hill Lunatic Asylum, NSW | 1811 | Public |
| New Zealand | Wellington Lunatic Asylum | 1854 | Public |

*Source:* Reproduced from Ansell and Lindvall (2021, p. 180).

Table 3.2: Early orphanages (listed by year)

| Country | First Orphanage | Year | Administration |
|---|---|---|---|
| Italy | Ospedale degli Innocenti, Florence | 1419 | Private |
| Denmark | Christian IV's Børnehus, Copenhagen | 1620 | Public |
| France | Hôpital des enfants trouvés, Paris | 1638 | Religious |
| Ireland | Dublin Foundling Hospital | 1730 | Public |
| England | London Foundling Hospital | 1739 | Private |
| USA | Bethesda, Savannah, GA | 1740 | Religious |
| Canada | Crèche d'Youville | 1754 | Religious |
| Germany | Findelhaus, Cassel | 1761 | Public |
| Australia | Female Orphan School, Sydney | 1801 | Public |
| New Zealand | St Patrick's Convent, Auckland | 1850 | Religious |

*Sources:* Gaughan (1939, p. 18), Ingrao (2003, pp. 74, 109), Jensen (2012, p. 19), Khan (2002), Prochner (2009, p. 95), Pugh (2007, chapter 1), Ramsland (1986), Scheutz (2017), Trattner (1974, p. 100), Ulbricht (1985), Viazzo, Bortolotto, and Zanotto (1994), Wodsworth (1876, p. 11).

The asylums and orphanages that existed before the mid-nineteenth century were often poor-law institutions in the sense that, prior to the laws on 'lunacy' and 'neglected children', they were governed by the laws on poor relief. However, some countries had distinct legislation that was older. Sweden's asylums were governed separately from local poor relief, as well as from regionally-organised general hospitals, from as early as 1787 (Ansell and Lindvall, 2021, p. 184). In France, the *orphelins* law of 1785 made the state responsible for all orphaned, abandoned, or neglected children, who were formerly known as *enfants trouvés* and presumed illegitimate (Fuchs, 1984, pp. 18–21). From 1801 the financial burden for their care lay with local authority hospices, which were not primarily institutions of poor relief but responsible for the care of the infirm on the basis of need, whether or not they could afford to pay (Weiss, 1983).

Early institutional care, mostly operated by private and religious organisations, addressed the problems of shame, scandal, and poverty. Orphanages cared not mainly for genuine orphans, but for illegitimate children conceived out of wedlock and abandoned anonymously at the 'wheel', a practice originating in Italy in the middle ages (Viazzo, Bortolotto, and Zanotto, 1994). At the *Inclusa de Madrid*, operated by the Brotherhood of Our Lady of Solitude and Anguish, the wheel continued to be used until 1927. Poverty had long been a reason for child abandonment, but the shame associated with illegitimacy, combined with poverty, drove the expansion of orphanages in the early modern period (Boswell, 1998, pp. 271–6). In Paris, the *Hôpital des enfants trouvés*, established by Vincent de Paul in 1638, accepted orphaned, abandoned, or criminal children (Ulbricht, 1985). In 1670 it become publicly administrated as part of the Paris *Hôpital general*, the great house of confinement in Foucault's *History of Madness* ([1961] 2006). Foucault suggests that while seventeenth-century confinement in poor houses and work houses was associated more generally with the prevention of begging and idleness, eighteenth-century asylums confined 'madmen' to evade the 'scandal' of unreason in the family and community (Foucault, [1961] 2006, pp. 141–2). It was also during the eighteenth century that, according to Scull (2015, p. 134), the stigma of having a 'mad' relative contributed to the expansion of asylums in England, leading increasing numbers of families to 'disembarrass' themselves of their care (Shorter, 1997, chapter 2).

By the eighteenth century, public institutions were established in connection with the differentiation of poor relief that had begun to take place

‘that separated the poor from the criminal, the insane from the foundling’ (Ulbricht, 1985, p. 234). The number of foundling homes expanded, especially in urban centres, and the new institutions that opened in northern Europe were increasingly likely to be publicly administered, or if privately operated, to work in cooperation with and be subsidised by local public authorities. The publicly run Vienna *Gebär- und Findelhaus* was established in 1784, associated with the general hospital, which also had an attached lunatic asylum, the *Narrenturm*. It cared for orphans, foundlings, and criminal children, as well as the children of impoverished mothers (Scheutz, 2017). The foundling hospital in Dublin, which cared exclusively for children from 1729, was administered by a board of local public and religious figures, employing primarily protestant but also catholic nurses (Wodsworth, 1876).

Institutions emerged in other parts of the world as they expanded throughout Europe. In the United States, orphanages almost never recorded children born out of wedlock as a category in their records, with most designating children as ‘orphaned’, ‘half-orphaned’ or ‘destitute’, the latter later sometimes described as ‘deserted’. But illegitimacy was still a common reason for admission. In 1903, the St Mary’s Orphanage of Providence housed 26 illegitimate children, about 18 per cent of its total population (Hacsi, 1997, p. 117). Institutions in Australia cared for so many children with at least one living parent that genuine orphans were listed in the records as ‘double orphans’ (Swain, 2014, p. 6). The first Female Orphan School in Sydney was administered by a board of public and private figures (Ramsland, 1986).

During the nineteenth century, asylums and orphanages were increasingly publicly funded and administered, and their expansion was coupled with increasingly public aims. When the asylums were taken into public control in Ireland in 1874, members of parliament argued that ‘lunacy [was] a national calamity, and should be a national charge and responsibility’, a problem that required a public solution distinct from the workhouse (Finnane, 1979, p. 33). Addressing the family problems of infanticide and neglect was seen as a way of increasing population levels and national strength in countries as diverse as Britain, France, Germany, and Russia (Cunningham, 1995, p. 128; Ulbricht, 1985). Orphanages also took on an increasingly reformist and educational role, in light of the ‘unfortunate’ status of abandoned children and in an effort to improve the lot of those whose families were unable to care for them (Miller, 2005). Asylums and

orphanages had taken on the character of other emerging public services, aspiring to the mental and moral improvement of the populations for which they provided (Ansell and Lindvall, 2021, p. 16).

It is this reformist quality, and the provision of indoor relief on the basis of desert and not punishment, which separates asylums and orphanages from the poor-law institutions that merely sustained their populations, but the centralisation of asylums and orphanages over the course of the nineteenth century was also distinct. By the mid-to-late nineteenth century, asylums and orphanages can be considered public services. Legislation making public authorities responsible for asylums was introduced in France in 1838, the Netherlands in 1841, and England in 1845 (Ansell and Lindvall, 2021, pp. 184–5). Many asylums that had initially been privately managed were from the nineteenth century publicly funded, and new public asylums expanded their capacity rapidly. By the year 1900, there were 3 000 residents in a single asylum in North London, compared with 2 500 across all of England at the beginning of the nineteenth century (Porter, 1987, p. 118). In the same period, asylum populations in France increased almost fivefold (Ansell and Lindvall, 2021, p. 173).

While many orphanages remained subsidised, privately operated institutions, the state often managed the placement or 'circulation' of children – for instance, from rural areas to the capital. Foundlings were commonly transferred to Paris from around France, and to Rome from other parts of Italy (Sá, 1992, p. 35). Public authorities took responsibility for orphanages in the Australian colony of New South Wales in 1833 (Bubacz, 2007, p. 280), in the American states from the 1870s, and the Canadian provinces from the 1890s (Swift and Callahan, 2006, p. 119). American orphanages housed 200 children at the beginning of the nineteenth century, or 0.01% of the youth population, growing to 126 600, 0.3% of youth, by 1910 (Downs and Sherraden, 1983). Legislation to regulate orphanages was not passed until 1905 in Denmark, where charitable organisations had taken responsibility for institutional and foster care from the seventeenth century (Melhbye, 1993, p. 39). By the beginning of the period that I study, most of the large Danish residential facilities were publicly administrated, but religious organisations had dominated out-of-home care until relatively late, and had already pioneered a wider variety of care arrangements than, for instance, in neighbouring Sweden (Sallnäs, 2000, p. 14).

Although the poor laws had increased the central state's involvement in the organisation of poor relief by setting a common standard, the bur-

den of care remained with local communities (de Swaan, 1988, p. 50). In contrast, asylums and orphanages were increasingly administered by regional and local governments, and subsidised with state funds, reflecting a collectivisation of care that is a marker of the emergent welfare state.

Since Marshall (1950) and Titmuss (1958), histories of the origins and development of the welfare state generally begin with the introduction of social insurance for work-related accidents, unemployment, and old age from the end of the nineteenth century. Social insurance is seen as the major structural break with the paternalism of the early poor-law era and the individualism of nineteenth-century liberalism, because it institutionalised a level of state responsibility for ensuring the living standards of workers (Flora and Alber, 1981, pp. 48–50). Insurance schemes guaranteed benefits to workers by collectivising the accumulation of savings (de Swaan, 1988, pp. 10). But the other important function of welfare states is the collectivisation of care for people who are not expected to work, or those in what Titmuss called 'situations of dependency' (1974, p. 87).

Asylums and orphanages were not only welfare policies, then, but more specifically they were care policies. They provided for the needs of dependents, or people who were not expected to work. The idea that these policies substituted for family care is not only theoretical, but also supported by broad historical evidence that across the industrialised world during the nineteenth and early twentieth centuries, it was most often at the request of families that people were admitted to asylums and orphanages. In the case of asylums, this occurred either 'voluntarily' where the law allowed, or more commonly through the mechanism of legally forced committal.

Using records of admission and letters between inmates and family members, Finnane (1985) shows that in both Australia and Ireland, although asylums played a custodial role for long-term inmates, the high turnover of short-term patients reflected the role of asylums in addressing familial conflict and temporary episodes of disruptive or dangerous behaviours. Individuals, especially men in their twenties and women in their forties, were incarcerated under involuntary committal laws and later released at the request of their families. In the Netherlands, the majority of patients between the 1890s and 1950s were admitted by relatives, on account of the danger or nuisance that they caused to their families (Vijselaar, 2005). At two asylums in New York, requests by families 'dominated' the forced committal process between 1843 and 1900 (Dwyer, 1987, p. 87). Similar patterns have been revealed in France (Prestwich, 1994), Ger-

many (Vanja, 2003) and in Australia and New Zealand (Coleborne, 2009). Orphanages, too, mostly cared for children who were not 'full' orphans, but predominantly children with at least one living parent who was unable to care for their child. Young children from impoverished families often stayed only a year or two in care (Hacsi, 1997, p. 221).

Historians offer a number of explanations for why families chose to turn, in increasing numbers, to institutional care. Shorter (1997, chapter 2) argues that changing relations within the family and the increasing intimacy of family bonds during the eighteenth century contributed to an desire to seek alternative care for mentally ill relatives. The stresses of industrialisation also led to the reconfiguration of caring responsibilities and, often, family breakdowns (Wright, 1997). Finnane (1985) suggests that the increasing willingness of families to admit relatives to asylums was in part due to the legitimacy that these institutions had gained by the last quarter of the nineteenth century through both the changing status and professionalisation of asylum doctors, and increasingly medicalised ideas about 'madness' as an illness.

The social care function of asylums and orphanages might feel at odds with our instinctive ideas about these institutions, shaped by powerful mental images of the heartless literary creations of Nurse Ratched and Mister Bumble. Indeed, we know that conditions in these institutions were often very poor. But the social function that these institutions served – to provide for those who were not expected to work, and to substitute for family care – is not incompatible with their other, more controlling, function.

The social control function of institutional care has been central in the existing sociological literature on asylums and orphanages. Custodial institutions have been depicted as forms of social control insofar as they segregate or change people and behaviours that are seen as deviant (Cohen, 1985, p. 1). Control of deviance through confinement was closely connected to the demands of industrialisation. Foucault explained in *History of Madness* ([1961] 2006, pp. 66, 73) that the workhouses that first emerged in early industrialising nations served to hide away the unemployed and protect against unrest until they were allowed to re-enter society as workers in times of crisis. On the other hand, the alienation of those who offended the moral concerns of the seventeenth and eighteenth centuries was more permanent (ibid, pp. 82, 155–6). It was not until the turn of the nineteenth century that the physician Phillipe Pinel – who is today considered one

of the fathers of modern psychiatry – espoused the curative properties of incarceration to 'tame the passions' of the madman (ibid, p. 480).

Andrew Scull (1984, pp. 26–8) asserts that the growth of institutions such as asylums and orphanages was driven by the need to distinguish the 'able-bodied poor' from non-workers and children, to ensure a healthy supply of labour. His argument builds on Marxist accounts of the welfare state, which explain that 'unproductive' services for non-workers, which do not directly enhance productive capacity, are funded by the state for their social control function (O'Connor, 1973, pp. 8-9). Cohen (1985) offers one of the few studies of institutions for people with mental illness and children in out-of-home care together. He depicts the closed, segregated institutions of the nineteenth to mid-twentieth centuries as exclusive and stigmatising (Cohen, 1985, pp. 16-17). He focuses only on the segregation of children convicted through the juvenile justice system, rather than the diversity of children housed in orphanages. This means he considers quite a small part of their clientele and misses the much more common temporary admissions to orphanages. Asylum admissions were also usually only temporary, although the average length of stay in both asylums and orphanages increased over the course of the nineteenth century (Finnane, 1985; Downs and Sherraden, 1983).

But even if the institutionalised were not destined for permanent segregation, the improving aims of asylums and orphanages could also be seen as a form of social control. This was the claim of the anti-psychiatry critiques of institutions in the 1960s and 1970s. Goffman (1968, pp. 361–370) argued that the interactions of nurses and attendants with inmates in wards were systems for behaviour modification that were ultimately based on moral judgements, but rationalised by the psychiatrist's medicalised power to diagnose and prescribe treatment. Szasz (1958, p. 509) went further to suggest that the diagnosis of mental illness was entirely subjective, the distinction between social deviance and madness being determined by the doctor's perception of the patient as an inferior subject.

For both Goffman and Szasz, the involuntary nature of confinement was central to the conception of containment as a form of social control, with patients judged by scientific experts to be deviant and requiring reform, rather than seeking treatment of their own volition (Goffman, 1968, p. 374; Szasz, 1975, p. 4). Although most inmates were interned by their families, it is likely that the decisions of these relatives were constrained by both economic realities and social norms. For instance, in the case

of orphanages, it was often not children but their families who were seen as deviant. Social reformers in the late nineteenth and early twentieth centuries had an interest in regulating the behaviour of parents, for those that violated child-rearing and family obligations were seen as inhibiting social progress (Althammer, Gestrich, and Gründler, 2014, p. 14). The number of illegitimate children in orphanages is testament to the role that these institutions played in reinforcing social norms.

Theorists of social control argue that deinstitutionalisation reflects not a decline in social control, but rather its expansion, from surveillance within institutions to more behaviourist modes of control that reinforce 'normality' in the community at large (Castel, Castel, and Lovell, 1982, pp. 331–2). They claim that the principle of 'community care' co-opts the family as an enforcer of norms that are still determined by psychiatric experts (Cohen, 1985, pp. 31–2, 48–9, 75–83).

While the social control function of asylums and orphanages is an important explanation for their rise, it doesn't paint the whole picture of the functions that these institutions fulfilled. The coercive or controlling aspects of institutional care existed alongside a nurturing, protecting, and improving function. This functional tension is also present in the wider programmes and services of the welfare state, as highlighted by Morgan and Orloff (2017). Understanding asylums and orphanages as care policies draws our attention to the ways in which these services were used by families as a substitute for family care, and demands an explanation for how this social care function was replaced as institutional care declined.

Decades before sickness insurance was introduced in Germany in 1883, asylums and orphanages had become well-established public services which substituted for care in the family. The number and size of institutions and the total populations within them, depicted in table 3.3, grew to a peak in most Western countries between the 1940s and 1980s, firmly in the 'golden age' of the welfare state. We should see asylums and orphanages as welfare policies, and the process which led to their decline as an instance not of the overdue abandonment of anachronistic indoor poor relief, but of changing welfare policy and, more specifically, care policy.

Despite remarkable similarities in the scale and and governance of asylums and orphanages by the turn of the twentieth century, there remained important differences in existing policy settings across countries, and across these two policy areas. Table 3.3 also lists the type of provider that delivered the majority of institutional care at the time that institu-

Table 3.3: Peak institutional populations and majority administration (listed by date of peak asylum population)

| Country | Asylums | Orphanages |
|---|---|---|
| England | 1954<br>State | 1948<br>State |
| United States | 1955<br>State | 1935<br>Religious |
| Ireland | 1959<br>State | 1970<br>Religious |
| Canada | 1962<br>Voluntary secular | 1965<br>Voluntary secular |
| Sweden | 1963<br>State | 1940<br>State |
| Italy | 1963<br>State | 1975<br>Religious |
| Australia | 1963<br>State | 1961<br>Religious |
| France | 1970<br>State | 1975<br>State |
| New Zealand | 1972<br>State | 1975<br>State |
| Denmark | 1972<br>State | 1957<br>State |
| Germany | 1975<br>State | 1977<br>Religious |
| Netherlands | 1984<br>Religious | 1969<br>Religious |

*Sources:* Brunton (2003, p. 83), Dekker et al. (2012, p. 41), Del Valle, Bravo, and López (2009), Donnelly (1992, p. 87), Durie (1999), Finnane (2009), Gilligan (2009), Goodwin (1997, pp. 86–7), Hardera et al. (2013), Jones (1993a, p. 161), Licursi, Marcello, and Pascuzzi (2013), Madianos (1994), Masson (2000, p. 567), Rochefort (1997, p. 225), Sallnäs (1995, p. 336), Sedgwick (1982, p. 221), Senate Community Affairs References Committee (2004, appendix 5), Socialstyrelsen (1982, p. 10), Søland (2015), Walsh and Daly (2004, p. 77), Weeke et al. (1986).

tionalised populations peaked. We can see that the primary responsibility for orphanages was much more varied among countries than for asylums. While the state was the main provider of orphanages in several countries in my study, voluntary providers and particularly religious organisations were much more likely to be responsible for the care of children who could not be cared for by their parents than for people with chronic or severe mental illness. Nevertheless, in all twelve countries, the state (at the national, regional, or local level) was responsible for regulating and funding institutional care – although the scale of public subsidies for voluntary and for-profit services varied.

This variation in the types of providers that were primarily responsible for institutional care at the end of the period of its dominance reflects different paths taken in the expansion of institutional care across countries and policy areas. It is likely that these different starting points had some effect on the care policy decisions that came after.

Considering first the differences between policy areas, the larger number of countries in which religious organisations were mainly responsible for providing orphanages suggests that second-dimension conflicts between religious and secular groups mattered in this policy area even before the period that I study, perhaps because children were more closely connected to family politics, or indeed because of the social-educational role that orphanages played. As noted in the previous chapter, church–state conflicts were particularly prominent in education policy. The relative scarcity of religious providers of asylums is also observed by Ansell and Lindvall (2021, 191–3). They find that the secularisation of asylums happened relatively early – in most countries, by the year 1800 – perhaps because of the relatively early centralisation of these services, or the relatively low salience of church–state conflict in this policy area.

Considering patterns across countries, there is much more homogeneity in the area of asylums. But it is not surprising that the only country in my sample where most asylums were run by religious organisations – even by the 1980s – was the Netherlands, where subsidised public services had been 'pillarised' on a sectional basis from the nineteenth century (Gijswijt-Hofstra, 2005, p. 26).

It is important that we take these existing policy settings into account when we seek to explain the care policy decisions that affected the decline of asylums and orphanages, because we could see a pattern of path dependence in responsibility for the care of formerly institutionalised populations.

Dominant providers – and, in particular, religious groups – may have had an interest in retaining control over the new types of services that replaced institutional care. In addition, their willingness and capacity to provide services may have made it attractive to governments to promote new types of care by the same providers.

Alternatively, the shift away from asylums and orphanages might reflect a deliberate effort to shift responsibility from these existing providers to others. Perhaps my focus on care policy *changes* will mean that I am less likely to observe changes that promote the responsibility of existing service providers, who could instead act to reduce the reliance on institutional care within existing policy settings. To help deal with these concerns, in the quantitative analysis I control for the type of provider that administrated the majority of asylums and orphanages when institutional populations peaked. But because the direction of their effect on policy changes is uncertain, the qualitative studies in chapters 5 and 6 will allow me to better assess how existing service providers may have played a role in policy debates.

It's also possible that the historical factors which contributed to the development of existing policy settings continued to shape care policy decisions during the period that I study. I say more about path dependence as a potential alternative explanation, and the steps that I take to address this, at the end of the following section on deinstitutionalisation.

## Deinstitutionalisation

The existing literature on the decline of asylums and orphanages has largely focussed on explaining why these institutions were closed, and there is much less existing research that seeks – as I do – to explain variation in what came after. Three of the best-known cases of psychiatric deinstitutionalisation are Britain, Italy, and the United States, whose major deinstitutionalisation policy initiatives were introduced by governments led by the Conservative, Christian Democratic, and Democratic parties respectively. Perhaps for this reason, the role played by political parties has not featured as an important explanation for when and why asylums and orphanages declined. In explaining deinstitutionalisation as such, the existing literature has suggested that institutional politics played a limited role compared with broader structural explanations like economic change,

and changes in scientific knowledge and ideas (Jones, 1993a, pp. 179–80; Rochefort, 1997, p. 124).

I argue that while these broad processes of change may have driven the deinstitutionalisation movement, the care policy alternatives which replaced asylums and orphanages – and enabled their decline – were likely shaped by partisan care policy preferences. That is, in the context of these common trends, politics still mattered for the outcomes that we observe. The drivers of the deinstitutionalisation movement are important for understanding the context in which the care policy decisions that I study took place, but it's also possible that these explanations for the decline of institutional care varied together with government partisanship, confounding any relationship with the types of care policy changes that were made. In this section, then, I review the existing literature on the drivers of deinstitutionalisation, and the very limited comparative work that has been concerned with what came after. I focus on the potential alternative explanations that emerge from this work, and the steps that I take to address them in the dissertation.

## Fiscal pressure

One prominent explanation for the decline of asylums and orphanages is growing fiscal pressure over time. This view was most influentially advanced by Andrew Scull, who argues that the fiscal crisis of the 1970s promoted a shift to cheaper means of sustaining institutionalised populations through the new transfer and insurance policies of the welfare state (Scull, 1984, p. 135). The Marxist argument goes that as the many programmes and services of the welfare state expanded in the context of an aging population – due both to increased living standards and the effectiveness of modern social policy – the generosity of welfare services began to put pressure on governments to reduce spending. In this eventuality, so-called 'unproductive' services both contribute to economic crisis, and become the target of restructuring when crisis occurs (see, for instance, Gough, 1979, pp. 138–41). Scull (1984, pp. 139) argues that 'rising costs more than any other factor' resulted in the closure of costly custodial institutions for the care of people with mental illness. Warner (1994, pp. 94–100) offers the complementary explanation that the closure of asylums was motivated by the desire to make institutionalised populations available for the labour market, but that higher levels of unemployment provided a

check on the swiftness of change in some countries.

There is debate about whether structural economic factors were the main driver of deinstitutionalisation. Authors taking a more comparative approach have already pointed out that the fiscal crisis of the mid-1970s occurred well after the population of asylums peaked in most countries (Novella, 2008, p. 309; and see Table 3.3 above). Goodwin (1997, pp. 57–9) shows that the demand for labour does not explain the timing of declining institutional populations across countries. The demand-for-labour explanation is also less helpful for understanding the decline of orphanages. By the second half of the twentieth century, child labour had been restricted across the advanced capitalist world, while the age of children that could remain in residential care was gradually being lifted to 18 and even 21 in some countries. Even if material concerns played a role in the decline of orphanages and the expansion of cheaper alternatives, peak institutional populations were even earlier in orphanages, long before the economic crisis of the 1970s.

It is also not clear that the alternatives to institutional care have actually proved cheaper than asylums and orphanages. Historically, alternatives such as family care or 'boarding-out' had been used alongside institutional care to save costs (Schmiedebach and Priebe, 2004, p. 456). But there has long been agreement among practitioners that adequate community care is at least as expensive as institutional care (Thornicroft and Bebbington, 1989; Weisbrod, Test, and Stein, 1980).

Nevertheless, many authors recognise that fiscal pressure played some role in policy decisions, particularly after the 1970s. Goodwin (1997, pp. 62-3) shows that the cost of services was a concern for governments in Canada, the Netherlands, and France, but he suggests that how this affected the use of institutional care and its alternatives. Lamb (1993) argues that an important driver of deinstitutionalisation in the United States was the *belief* among policy-makers that alternatives to institutional care would be cheaper. In the case of Britain, Jones (1993a, pp. 159, 192–3) asserts that this 'cost-saving' motivation was used opportunistically by politicians seeking simply to cut services – although she depicts changing scientific knowledge and technologies of treatment as the main catalyst for policy change (Jones, 1993a, pp. 179–80). A recent survey of psychiatric professionals in England, Italy, and Germany suggests that policy-makers perceived deinstitutionalisation as a cost-reduction strategy (Chow, Ajaz, and Priebe, 2019).

As a potential alternative explanation, growing fiscal pressure could be associated with both government partisanship and care policy changes. For instance, changing economic conditions and budgetary conventions in the neoliberal era might make both marketising policy changes and liberal or conservative governments more likely since the 1980s. In the quantitative analysis in Chapter 4, I include period effects and economic controls to account for growing fiscal pressure on the welfare state over time. In the qualitative chapters, I am able to more directly assess the extent to which fiscal pressure and cost saving played a role in care policy debates in England and Germany.

## Scientific knowledge and expert ideas

The second prominent explanation for deinstitutionalisation is that changing scientific knowledge in the twentieth century led to a shift away from institutionalisation as the primary means of caring for people with chronic or severe mental illness and children who could not be cared for by their parents. Changing scientific knowledge shaped the decline of asylums and orphanages through the influence of expert knowledge, both in policy circles and over public opinion. There are important differences in the effect that expert knowledge likely had across the two policy areas that I study, which need to be addressed in my analysis.

In the area of mental health policy, new expert ideas about the detrimental effects of institutionalisation came both from local initiatives conducted by asylum doctors and psychiatrists, and a more critical group of 'anti-psychiatry' experts. During the 1950s and 1960s, the work of British psychiatrists such as Russell Barton and Eric Cunningham Dax highlighted the negative impact of institutional practices and alienation on patients' possibilities for recovery (Finnane, 2009). The asylum doctor Maxwell Jones promoted more open forms of care known as 'therapeutic communities' on the basis of his own experiments with asylum practices (Jones, 1966). Similar trials were conducted locally in the Netherlands and Germany, and received increasing attention from the scientific community during the 1960s and 1970s (Schmiedebach and Priebe, 2004). In Italy, these local initiatives were harnessed by what began as the relatively fringe group of psychiatrists, *Psychiatric Democratica*, to directly influence policy change (Donnelly, 1992). Law 180 of 1978, which affected the immediate closure of all large psychiatric hospitals in Italy by 1980, be-

came the namesake of the group's founder, psychiatrist Franco Basaglia. At the same time, more fundamental critiques of medicalised psychiatry were made in Britain by R.D. Laing, who became one of the main figures of the popular anti-psychiatry movement (Crossley, 1998).

As anti-institutional ideas became more accepted in the scientific community, these experts influenced policy-making directly through offical inquiries and government commissions on mental illness, but expert ideas also shaped public opinion. Rochefort (1997, pp. 36-7) – one of the few political scientists to have published on the subject of asylums – argues that institutional care became misaligned with changing public opinion, shaped by both scientific and popular critiques. The work of Erving Goffman (1968) was well-known, and Ken Kesey's novel *One Flew Over the Cuckoo's Nest* was hugely popular upon release in 1962, before it was interpreted as a Broadway musical in the following year, and the acclaimed 1975 film directed by Miloš Forman.

In the area of child welfare policy, the critique of institutional care came earlier. Between the 1930s and the 1960s, there were a growing number of studies in child development and child psychiatry, influenced by Freudian psychology, which showed that children had better outcomes when they were raised in a family environment. In particular, the work of Burlingham and Freud (1944), John Bowlby (1952), and René Spitz (1965) gained merit in policy circles around the world, especially from the 1960s through Bowlby's work with the World Health Organisation (WHO) and the UN programme on child welfare (Mccall, 1999). There is evidence that these international networks of expert knowledge shaped reform across countries. For instance, in Spain, child welfare experts were influenced both by ideas of 'normalisation' originating in Scandinavia, and by theories of community-based social welfare propagated by Latin American authors (Casas, 1993, p. 198).

Jones (1993b, pp. 470–1) suggests that Goffman's depiction of the 'total institution' was also influential for shaping the ideas of child rights activists campaigning against orphanages in the United States. These groups argued that orphanages were both morally wrong and ineffective for dealing with the behavioural problems from which neglected children suffered. Although it was not until the twenty-first century that national inquiries revealed just how widespread the emotional and physical abuse of children in institutional care had been, revelations of shockingly poor conditions were also made public in Europe during the 1960s and 1970s (Hellinckx,

van den Bruel, and vander Borght, 1993, pp. 3–4).

The influence of anti-institutional ideas has been challenged by authors arguing that equally strong critiques of asylum conditions in both Europe and America during the late nineteenth and early twentieth centuries had failed to produce a policy shift at that time (Novella, 2008). Government inquiries expressing a preference for non-institutional care for children as early as the 1870s did not cause a substantial decline in institutional care either (Søland, 2015; Ramsland, 1986). But it seems likely that these ideas were more influential, at least in some well-known cases, in the context of the wider social movements of the late 1960s. The connection to more general protest movements is considered important in the case of Italian mental health reform (Donnelly, 1992, pp. 53–8), and in the United States the anti-asylum movement acted through civil rights litigation processes to shape policy change (Rochefort, 1997, pp. 125, 165).

Much of this expert and popular critique was anti-institutional in nature. While it likely contributed to the desire to shift away from institutional care in all countries, how should we expect these ideas to influence what came after asylums and orphanages – or, more specifically, the types of providers that became responsible for the care of formerly institutionalised populations? In the area of mental health policy, it is not clear that the scientific community promoted new types of care arrangements that should be provided by either the state, market, family, or voluntary sector in particular. But already by the 1960s, scientific studies of care for children were much more likely to promote family-based care. We should therefore expect that care policy decisions in the area of child welfare were more likely to promote family care regardless of the partisanship of government. The influence of these ideas may also have become greater over time, through international cooperation and agreements such as the UN Convention on the Rights of the Child.

I account for these important differences across policy areas in the quantititative analysis by allowing the probability of different types of care policy decisions to vary by policy area. I also control for the timing of policy decisions by using period effects. In the qualitative analysis, I am able to more directly assess how scientific knowledge and expert ideas were used by politicians in the policy debates, and whether different political parties agreed on the scientific evidence, or drew on competing expert opinions.

## Technology and professional specialisation

Alongside the influence of changing scientific knowledge and expert ideas are the two related explanations that changing technology and professional specialisation shaped the diversification of treatments for people who would formerly have been in asylums and orphanages. I distinguish these mechanisms from the broader influence of expert knowledge here because I do less in this dissertation to directly address the effect of these factors on the types of care policy decisions that were made, for reasons that I explain below. Nevertheless, technological and professional change are important context for understanding deinstitutionalisation, so I explain the arguments in the existing literature briefly here.

New technology is thought to have enabled extramural treatment – that is, treatment outside of large, custodial institutions – particularly of people with mental illness. The discovery of psychotropic drugs in the mid-1950s is considered the most important factor in the decline of mental hospitals in some of the key historical accounts of the process in the United States and Britain (Shorter, 1997, chapter 7; Jones, 1993, pp. 179–80). Although it is likely that the availability of alternative treatments played a role in the ongoing reduction of institutional care, Sedgwick (1982, pp. 221–4) has argued that the effect of drugs alone does not explain decisions to administer treatment in out-patient or alternative care settings. Sedgwick notes that even in France, where the tranquilliser chlorpromazine was first synthesised in the 1950s, and in Germany, where the pharmaceutical firms were particularly powerful, the decline in institutional populations came decades later (see also table 3.3 above). There is also no similarly watershed discovery in the technology of care for children, although the advent of oral contraceptives likely contributed to a decline in the number of unplanned children that made up a large part of the institutional population (Carp, 1998, p. 200). But orphanages, too, disappeared.

Another aspect of changing scientific knowledge was professional specialisation. It is widely accepted that the differentiation of both psychiatric patients and children in out-of-home care along the lines of increasingly specialised mental health and social work professionals contributed to the development of alternative services (aan de Stegge and Oosterhuis, 2018). In Western Europe and North America, it was from organisations of asylum doctors that the profession of psychiatry first emerged. Psychiatry became increasingly medicalised during the late nineteenth and early twentieth centuries as its practitioners increasingly shared knowledge and practices with

neurology (Abbott, 1988, pp. 294–300). The expansion of psychotherapy as a form of treatment used by psychologists, but also psychiatrists, saw these professionals expand their independent practices outside of the mental hospitals. Abbott (1988, p. 311) argues that, in the United States, the explosion of demand for psychotherapy during the 1970s was at least in part a response to the supply of psychologists, psychiatrists, and psychiatric social workers, whose services were partly covered by private insurance companies from the mid-1960s and by Medicaid from the early 1970s.

The nineteenth-century child reformers who operated orphanages did not develop the same level of professional identity as psychiatrists. This was despite their equally improving aims, to develop orphaned and neglected children and prevent their descent into delinquency and criminality (Pinchbeck and Hewitt, 1973, pp. 429–32). Staff were typically educators or amateurs before the profession of social work became recognised in the 1930s, not long before populations in orphanages peaked (Crenson, 1998, pp. 87–88, 199). In the 1920s and 1930s, orphanages in the United States became more treatment-oriented, increasingly staffed by professional social workers and taking on more children with behavioural difficulties (Hacsi, 1997, p. 46). It was thus with the closure of large institutions that expert treatment emerged as a function of the new or transformed smaller institutions (Jones, 1993b).

I do less in this dissertation to directly address the effect of these factors on the types of care policy decisions that were made. I consider it unlikely that technological change played an important role in shaping variation in the types of providers that took responsibility for care, either over time or across the two policy areas, and I do not expect that it had any influence on the types of governments that took power. But changing ideas and scientific knowledge, channelled through professional associations or scientific advisors could explain a relationship between partisanship and care policy if different types of political parties were the subjects of lobbying from *different* professional groups or received competing scientific advice. I can address the presence of competing scientific or expert claims in the qualitative chapters, but I am not able to systematically address the fact that political parties may have been influenced by the interests of specific professional organisations with which they had links. The relationships between relevant professional associations and political parties likely varied considerably among countries, so it is difficult for me to account for them in this study. While I am able to pay some attention to the role of

professional groups in England and Germany in my qualitative chapters, I cannot rule out this particular alternative explanation without conducting much more detailed case studies in a range of countries, which would need to be addressed in future research.

## National political cultures and path dependence

Although there is very limited comparative work on the decline of asylums and orphanages, some authors have suggested that national political cultures may have shaped when and how deinstitutionalisation occurred. Although often referred to as 'cultures' these cross-national differences are shaped by lasting institutional differences between countries that have affected, for instance, the relationship between the state and the family or the size of the public sector. In his comparative study of psychiatric deinstitutionalisation, Goodwin (1997) explains overall variation in the pace, timing, and 'style' of deinstitutionalisation in terms of the institutional ideologies of the liberal, conservative, and social democratic welfare regimes described by Esping-Andersen (1990). Table 3.4, reproduced from Goodwin's text, summarises his argument.

Goodwin depicts asylums as as a form of 'de-commodification', a term from the welfare state literature which refers to citizens' emancipation from dependence on the labour market (see Goodwin, 1997, pp. 102–12 for the extended argument summarised here). He consequently treats deinstitutionalisation as a kind of 're-commodification' of formerly institutionalised populations, forcing them to provide for themselves by re-entering the workforce. Goodwin argues that the liberal welfare regimes of the United States and England promoted rehabilitation early, motivated by the status of the market economy as the primary provider of welfare. He suggests that conservative welfare regimes were slow to deinstitutionalise because they tended toward maintenance of the status quo and were less likely to endorse the development of community services which encroached on the caring role of the church and family. In social democratic welfare regimes, he depicts the shift to community care as a relatively late move driven by the need to compete in the global market economy, but with less emphasis on re-commodification and higher-quality alternative services provided on the basis of social rights.

Table 3.4: Three worlds of deinstitutionalisation

| Regime type | Onset | Pace | Style |
|---|---|---|---|
| Liberal | Early | Fast | Emphasis upon rehabilitation. Poor quality of long-term services. |
| Conservative | Late | Slow | Emphasis upon maintaining the status quo. Minimum state provision based on the principle of subsidiarity. |
| Social democratic | Late | Fast | Emphasis upon social rights. Good quality services. |

*Comment:* Table reproduced from Goodwin (1997, p. 112), summarising his main argument about the association between welfare regime type and the timing, pace, and style of asylum deinstitutionalisation policy.

There are aspects of Goodwin's characterisation of the timing of reform in social democratic countries that I disagree with, that don't necessarily challenge his general claim that care was on the whole more residential for longer in Scandinavia, but given that his work is the only existing international comparative study of deinstitutionalisation it is worth taking the time to explain the differences here. The first is Goodwin's assertion that the mental hospital population peaked in Sweden in 1977, 14 years after I record it (see above, Table 3.3). This discrepancy can be attributed to the difficulty of sourcing data on asylum capacity that is consistent over time and across nations. The data that Goodwin uses refer to a global figure for bed capacity provided in both mental hospitals *and* general hospital wards – a total figure which continued to increase in Sweden long after the use of asylums as such had waned (Perris, 1987, pp. 200-201). Swedish researchers consistently point to the early 1960s as the turning point when populations in the large asylums began to decline (Meeuwisse and Sunesson, 1995, p. 19; Brinck, 1994). According to government sources, the population in mental hospitals peaked in 1963 (Socialstyrelsen, 1982, p. 10), after which treatment in general hospitals substantially increased in the short term (SOU, 1982, p. 4). However, it is certainly accurate that

Sweden continued to provide high levels of residential treatment capacity and that mental hospitals and rapidly growing psychiatric wards were at the centre of provision during the 1970s, with extramural care attached to these inpatient services (Svedberg, 2005, p. 369).

Secondly, Goodwin identifies the Netherlands as a social democratic regime and notes that, like Sweden and Denmark, little emphasis is placed on the family to provide care – unlike in conservative Italy, France, and Germany (Goodwin, 1997, p. 7). However, both its insurance-based health system and corporatist networks of service providers make the Netherlands much more like the conservative countries from the perspective of its institutional history, which is important if we think it is these structures that shape and constrain policy decisions. Although it has been argued that the Netherlands fits more into the social democratic regime type if we consider its high level of tax and transfer policy settings, and their relatively egalitarian outcomes, its institutional history is far less social democratic (Goodin and Smitsman, 2000). It is for this reason that, in my analysis, I treat the Netherlands as a conservative welfare regime.

Beyond these minor differences, there are two main distinctions between Goodwin's approach and mine – apart from the fact that I examine both asylums and orphanages. Firstly, Goodwin constrains the possible providers of care to two: public or private, state or market – where institutional care represents public responsibility and community care represents private responsibility for care. This dichotomous approach neglects the implications of non-institutional care by the family or voluntary organisations, and the possibility that asylums were themselves managed by non-state providers. While Goodwin views the rise of institutional care as de-commodification, I argue that it was a case of de-familialisation, on the basis that prior to being institutionalised the clients of asylums were not workers dependent on the labour market but non-workers dependent on their families. The decline of asylums is therefore as much a case of re-familialisation as re-commodification. The problem of non-state institutional care is less of a concern when thinking, as Goodwin does, about asylums alone. By the middle of the twentieth century, asylums were primarily 'public' services, although in some of the central European countries that Goodwin includes in his analysis this meant provision by voluntary organisations. But when we expand the analysis of care policy to think about orphanages also, it was more common for institutional care to be delivered by subsidised voluntary and religious organisations. It is

my claim that these differences in who provided services were important in political conflicts over care policies.

The second key difference between our approaches is that rather than focussing on the explanatory power of national welfare regimes, I concentrate on the effect of political parties as the agents of welfare policy change. Goodwin's approach captures the broad differences between welfare regimes, but it cannot account for more specific differences among countries – for example, the different ways that liberal countries supported the growth of community care. The United States introduced new federal subsidies to shift patients into smaller private nursing homes in 1966, while just four years later authorities in New Zealand established new publicly run outpatient services. New Zealand's initial strategy has more in common with Sweden, where publicly run outpatient care was developed in the 1970s, though managed not by the central state but county councils (Silfverhielm and Kamis-Gould, 2000). A focus on political parties also allows us to examine the differences in policy changes within countries, treating the evolution of care policy as a more dynamic process that is shaped by partisan conflict over time.

There is also some comparative work by sociologists which supports a link between the outcomes of deinstitutionalisation and national political cultures. Meeuwisse and Sunesson (1995, p. 36) observe that 'the institutional composition of the national or local welfare systems – whether they are market-dominated systems with residual welfare, institutional and universal systems, or familistic subsidiarity systems – seems to decide the outcome of deinstitutionalisation'. They develop a cross-sectional framework for describing alternatives according to the degree of hierarchy or social control, and the degree of integration or collectivised solutions to care (Meeuwisse and Sunesson, 1995, pp. 32-3). These authors take a sociological perspective, so are interested in the implications of deinstitutionalisation outcomes for the social inclusion and power of clients, whereas I am principally interested in who is responsible for care provision and how individual policy decisions are made.

Similarly, although not concerned with the decline of institutional care directly, literature dealing with variation in child welfare systems typically describes countries as having either a child-protection or family-service orientation, prioritising child rights and early intervention or parental rights and family-based support respectively (Fluke and Merkel-Holguin, 2019, p. 4). Gilbert, Parton, and Skivenes (2011) suggest that these different child

welfare systems are nested within national welfare state regimes, but not directly related to them. For instance, while conservative welfare states with a greater emphasis on the family tend to have child welfare policy settings with a family-service orientation, it is not clear that high levels of de-familialisation in the social democratic welfare states translate into less emphasis on family-based support, or that liberal regimes with low levels of de-familialisation prioritise parental rights.

I take steps to control for these nationally-specific political cultures in the quantitative analysis, but it can be complicated to dis-entangle the effect of partisanship from that of national political cultures because national political cultures are themselves shaped by the types of parties that frequently control government. The main evidence against this alternative, 'path dependency' explanation would be a finding that within countries over time, specific policy changes are in line with expectations for the types of governments that make them. This means that path dependency is most directly addressed in my qualitative chapters.

# Empirical contributions

The main empirical contribution of this dissertation is a study of the decline of asylums and orphanages together, explaining not *why* deinstitutionalisation occurred, but what came after. The mental health care and child welfare policies that replaced asylums and orphanages also enabled their decline, so my study will contribute to our understanding of the process through which these institutions disappeared. This is the first international comparative study, to my knowledge, of these two policy areas together. Lerman (1984) describes changes in mental health, child welfare, and juvenile justice institutions in the United States, but his causal discussion is limited to psychiatric institutions. Cohen (1985) discusses asylums and juvenile justice institutions, and Rochefort (1997, p. 225) offers a cursury comparison of asylums with orphanages in the United States and Canada. Although Scull (1984) views asylums and orphanages as similar systems of control, his explanation for change focuses on asylums, with analogies to prisons rather than orphanages. My empirical study can help to address one of the key debates in deinstitutionalisation literature, about whether policy change was motivated by fiscal pressure and the desire to save costs, or a more progressive response to changing scientific knowledge and ideas. But the empirical question of what role partisanship played, independent

of these structural drivers, is also of wider relevance to the broad political science scholarship that is concerned with the relationship between science and policy making.

One body of literature interested in the the relationship between science and policy has been concerned with the development of bureaucracies and the autonomy of the state from partisan actors. Traditionally, the bureaucracy were depicted as benign actors who helped to produce the social knowledge on which policy decisions were based. In the Weberian view of the bureaucracy, an increasing reliance on expert knowledge was an extension of the rationalisation of society (Weber, 1968, p. 1116). The process of 'scientification' began with the specialisation and professionalisation of disciplinary sciences with the growth of universities, and continued with the emergence of policy experts who were depicted as 'responsible' actors that mediated between scientific experts and policy-makers (Lasswell, 1970). In his pioneering work on Britain and Sweden, Hugh Heclo (1974) also presented a rather neutral view of bureaucrats as he argued that the information and analysis produced by civil servants had a more decisive impact on the development of pensions and social-insurance policies than the actions of political parties.

The now more influential perspective, advanced by Theda Skocpol, is that bureaucratic actions are not neutral or benign but also shaped by power, as the autonomous experts that inform policy decisions also act in their own self-interest (Skocpol, 1985, p. 15). The main argument is not that power and politics do not matter, but that expert knowledge significantly constrains the policy options available to partisan actors, by shaping the nature of the problems that policies should address (Rueschemeyer and Skocpol, 1996, p. 308). More recent work in this tradition suggests that bureaucratic expertise may prevent partisan actors from protecting favoured interest groups or constituencies, and lead to more compromised solutions (Dahlström, 2009). On the other hand, rather than promoting the interests of particular groups of voters, policies may reflect the interests of groups of experts and particular government agencies that are influential in the bureaucracy (Jenson, 2012).

A second body of literature on the relationship between expert knowledge and politics is concerned with more normative questions about the appropriate role for expert power. Some have argued that the scientification of society threatens the liberal-democratic principles of public discussion and representation (McCarthy, 1978, pp. 11–12). Theorists in this

tradition have explored ways of facilitating more deliberative forms of decision making in contemporary knowledge societies (for example, Fischer, 2009). Others depict the tendency of governments to 'depoliticise' issues, by deferring to scientific expertise and shifting functions away from elected officials, as a governance strategy to avoid blame for unpopular decisions (Burnham 2001; Flinders, 2002, p. 238). I contribute to the more empirical question of what the relationship between science and policy making is.

A third strand of literature interested in the influence of expert knowledge over policy is focussed on the diffusion of policies through expert networks and international institutions, or by policy learning (Dobbin, Simmons, and Garrett, 2007). Historians of social policy have long recognised that diffusion and policy learning played an important role in welfare state development (Briggs, 1961; Hennock, 1987). But the comparative welfare politics literature has only much more recently turned to theorise the role of international diffusion (Obinger, Schmitt, and Starke, 2013). It suggests that diffusion helps to explain welfare policy convergence over time, which has been highest in countries with similar institutions and especially among members of the European Union (Schmitt and Starke, 2011). Recent work has focussed on the role of international 'knowledge organisations' such as the OECD and the World Bank, in promoting particular social policy models and the practice of evidenced-based policy making (Jenson and Mahon, 2022; Mahon, 2019). But another recent contribution, examining international policy transfer during the phase of welfare state expansion, has shown that even highly influential ideas from abroad are not directly implemented, but must be translated to the national political and institutional context (Béland et al., 2022). Work on the diffusion of labour market policy suggests that the process of learning from abroad is also conditioned by the ideological positions of policy makers, which shape their prior beliefs about the potential outcomes and effectiveness of policy options (Gilardi, 2010).

While I do not make a theoretical contribution to this literature, my engagement with the existing empirical literature on deinstitutionalisation means that the empirical study will draw conclusions about the relationship between expert knowledge and policy making in these policy areas. I study two policy areas which have been the subject of many governmental commissions informed by local and international expertise, and where changing scientific knowledge is one of the main factors identified in the empirical literature as contributing to the process of deinstitutional-

isation. I therefore investigate the empirical question of whether and how partisanship matters for shaping policy in these cases where the potential for 'scientification' is very high.

## Conclusion

In this chapter, I have argued that asylums and orphanages were early welfare policies. Although they existed alongside indoor poor relief, in the nineteenth century they became public services designed to reform their populations, and had much more in common with modern public services and the emerging institutions of the welfare state. But unlike other early welfare policies, they served a narrow population of dependent people who were not expected to work, fulfilling a social care function by substituting for family care. Asylums and orphanages were the first care policies.

The existing literature on the decline of asylums and orphanages has focussed on explaining why these institutions disappeared, rather than what came after. This literature suggests that the deinstitutionalisation movement was driven by growing fiscal pressure, changing scientific knowledge, and professional specialisation, and that it was also shaped by different aspects of national political culture. I will address these broader factors as potential alternative explanations for the relationship between partisanship and care policy in the chapters that follow.

I study these two uniquely old care policies together in order to account for the types of policies that replaced their caring function. But the care policies that came after asylums and orphanages also enabled their decline, so my empirical study can tell us more about how these institutions disappeared. What was the role of government partisanship distinct from structural economic factors or changing scientific knowledge? This empirical question is of relevance not just to the narrow literature on deinstitutionalisation, but a much broader literature in political science that is concerned with the relationship between science and policy making.

In the following chapter, I commence the empirical study by classifying the types of care policy changes that were made to affect the decline of asylums and orphanages on the basis of whether they promoted the responsibility of state, market, family, or voluntary providers for care. I go beyond the existing explanations for the general decline of asylums and orphanages to offer an explanation for the types of care policy changes that were made to replace them.

# Chapter 4

# Patterns of care policy change

This chapter examines the relationship between government partisanship and the types of care policy changes that have been made since the Second World War in the areas of mental health and child welfare policy. It presents the results of a quantitative analysis of data on policy decisions that affected the use of asylums and orphanages as sites of care, collected from a survey of the secondary literature on deinstitutionalisation. I consider policy changes in twelve countries: Australia, Canada, Denmark, England, France, Germany, Ireland, Italy, the Netherlands, New Zealand, Sweden, and the United States of America. I explained in the previous chapter that these countries were selected because they vary on important characteristics that could shape government partisanship, the dynamics of partisan competition, and the availability of care alternatives, as well as the types of care choices that we might observe.

The existing literature on the decline of asylums and orphanages provides rich information on the country-specific experiences of policy change. Authors have defined the outcome of deinstitutionalisation – 'community care' – quite broadly, in order to capture the diversity of alternatives to large, custodial institutions. I use the detailed descriptions of policy changes in the existing literature to categorise policy changes based on the the type of care policy that they promote. I then examine whether governments that were led by social democratic, Christian democratic, conservative, or liberal parties were more likely to promote the responsibility of state, market, family, or voluntary organisations for the care of people who would otherwise have been institutionalised in asylums and orphanages.

The results are in line with the expectations of wider theories of comparative welfare politics, in that social democratic parties have a strong preference for state responsibility over that of the market, family, or voluntary providers. But parties of the centre and right have also made distinct – and, in some cases, surprising – choices. In line with my theoretical expectations, I find that Christian democratic parties favour voluntary responsibility, and that conservatives and liberals have a preference for market responsibility, but liberals also promote family responsibility for care.

This suggests that the motivations for expanding family responsibility are complex, reflecting either a preference *for* familialism or *against* state responsibility for care. A comparison of unexpected cases, where liberal governments promoted family responsibility, with more typical decisions by Christian democratic and conservative governments, supports this interpretation. Overall my results suggest that the politics of care policy cannot by reduced to a single, socio-economic dimension of conflict concerning whether there should be more or less public responsibility for welfare. Considering, too, the partisan ideologies of individualism and familism helps us to make sense of the patterns in policy choices.

# Measurement

This section outlines the measures that I use for the dependent and independent variables in the quantitative analysis. I explain the types of policy decisions that I include in my dataset, and the indicators that I use to categorise policy changes as promoting state, market, family, or voluntary responsibility for care. I also motivate my use of a categorical measure of government partisanship, which classifies governments as being led by social democrats, Christian democrats, conservatives, or liberals.

## Measuring policy change

The outcome variable in the study is a categorical measure of policy changes that affected the use of asylums and orphanages. Policy decisions are coded based on whether they promoted the responsibility of state, market, family, or voluntary providers for the care of formerly institutionalised populations. The outcome data that I use is structured by country-year-policy area, so that for each policy area in each country for each year

between 1950 and 2015, I code whether or not a policy change was made, and if a change was made, whether it promoted the responsibility of the state, the market, the family, or voluntary organisations for care.

The sources that I use are authored by psychiatric and social-work practitioners, as well as sociologists and historians of psychiatry and social work. I also consult official policy documents written in English, German, and Swedish, such as green papers, white papers, and government reports, to triangulate my assessments of the secondary literature and confirm my judgements about the nature of the change where the secondary literature provides limited information about the indicators that I am looking for. I avoid where possible making judgements on the basis of explicitly political histories (there are in any case very few on the subject), in order to avoid potential confirmation bias from coding my dependent variable with the independent variable in mind. Appendix B lists the sources that I use to code each policy change. I also combat confirmation bias by using a clear coding strategy based on indicators which I view as evidence in favour of state, market, family, or voluntary responsibility.

My first step is to identify instances of policy change in the secondary literature. Policy changes in scope are all decisions which directly affected the use of institutional care in asylums and orphanages. For asylums, this can include the regulation of services for people with mental illness specifically, but also more general community-based care laws or benefits for people with long-term care needs in cases where people with a mental illness were eligible for such support. For orphanages, the scope is broader, because the children who were in institutional care were more diverse: these were children from poor or single-parent households, children whose parents were in situations which meant they were unable to provide care, and children who had been accused or convicted of crimes. This means that I include the regulation of adoption and foster care, child protection laws about the removal of children from families, laws which regulate what happens to children who are accused or convicted of crimes, as well as family services targeted at households perceived as vulnerable. I do not include broader-based policies which indirectly affected the demand for institutional care, such as benefits provided to all families with children to supplement household income. I also exclude policy changes that made more technical changes to, for instance, admissions and discharge procedures, or the powers to remove children from their families, where these did not directly affect the type of provider that was responsible for the care of

people with mental illness or children who could not be cared for by their parents.

I identify policy changes that are mentioned in at least two secondary sources. The reason for this is to focus on policy changes recognised by historians, sociologists, and practitioners as important, and to avoid giving equal weight to minor adjustments that are not consistently mentioned. One might think that there is a risk that this strategy will identify more policy changes in better-known cases and in English-speaking countries, but this doesn't appear to be a major concern. The average number of policy changes per country is 11.3, and the English speaking countries range from 15 (in England) to 5 (in Canada). The United States, by far the country with the largest number of sources covering both policy areas, has just over the average number of policy changes, at 12.

It is worth discussing my motivations for focussing on policy decisions rather than policy outcomes. Policy outcomes are often used as a proxy for policy change in the comparative welfare state literature because of the availability of time series data such as expenditure levels. The problems with using such outcome measures when we want to assess the effect of partisanship are well-documented in the literature on the so-called 'dependent variable problem' in comparative welfare studies. Firstly, policy outcomes can be affected by changes in demand for services as well as policy changes (Green-Pedersen, 2004). There is also a time lag between policy decisions and outcomes that is sometimes lengthy by design, for example if implementation is phased. This makes outcome indicators difficult to model consistently across national contexts (Pierson, 1994, p. 14). While it might make sense to measure outcomes if we want to understand the links between government partisanship and the broad patterns of welfare spending over time, if we are interested in the effect of partisanship on decision making in particular, it is preferable to measure policy decisions directly rather than using outcomes as the dependent variable.

It is also important to distinguish policy decisions from policy positions, which might be publicly stated but not necessarily adopted. This might seem obvious, but both mental health and child welfare are policy areas characterised by a large number of government commissions, reviews, and strategies. Documents associated with these processes often indicate a policy position prior to any government decision, but are interpreted in some of the secondary literature as policy changes. Most policy positions identified in the secondary literature are accompanied by decisions

with financial or regulatory implications. For example, the famous 'water tower' speech by the British Health Minister Enoch Powell in 1961 was associated with grants to local government the following year for the establishment of mental health services (Jones, 1993a, pp. 161-3). However, the *Progetto 80* report published in 1969 by the Italian Ministry of the Budget and Economic Planning – despite being oft mentioned in the secondary literature on deinstitutionalisation – was not a policy decision. Even though it condemned institutions for children and described a plan to reform provision, it lacked any associated funding or regulatory change (Ducci, 2003).

I only code decisions with financial or regulatory implications because these types of policy changes must go through an executive decision-making process and can therefore be considered government decisions. Decisions with financial implications have associated funding, which affect the national operating budget or public debt. Decisions with regulatory implications include new legislation, regulatory instruments, binding directives from the national executive, or formal agreements with other levels of government or non-government service providers. Financial decisions must represent new policies in order to count as policy changes. For example, in the case of the United States, I count the Community Mental Health Services Act 1963, which established grants for the initial construction of community mental health centres, as well as the 1965 amendment, because it expanded federal funding to staffing costs for professional and technical personnel. But I do not count the 1967 amendment because that Act was not a new policy, but rather appropriated the next phase of planned funding for existing services which had already been set aside in previous decisions (Rochefort, 1997, p. 61). Most of the policy changes that I code are legislative changes or new funding decisions, but there are also some agreements between different levels of government – for example, the Putting People First 'concordat' signed in England in 2007 by central and local government, the professional leadership of adult social care, and the National Health Service (Department of Health, 2007).

Commission reports, government strategies, and non-binding ministerial directives do not count as policy changes unless they are associated with financial decisions or formal agreements between different levels of government. For example, Sweden's 2006 strategy for the mental health services was underpinned by agreements signed with representatives of county (*Landstingsförbundet*) and municipal (*Kommunförbundet*) govern-

ment in 2005. There was also additional funding to assist with the development of services in the 2006 Budget which county councils and municipalities could access (PROP, 2005/06:1, pp. 47-8, 63). Likewise, the Action Plan for Mental Illness 2012–2016 was supported by an agreement between the counties and municipalities as well as national government funding (Socialdepartementet, 2013). Similar are the implementation and funding agreements among federal and state governments associated with Australia's first and second National Mental Health Plans in 1992 and 1998. I code both of these as policy changes, but not the third National Mental Health Plan in 2003, because this broad strategy document possessed neither an agreed implementation plan nor funding arrangements (Meadows and Grigg, 2007). I code all policy changes in the year that the regulatory or funding decision is made. Where there are both regulatory and funding decisions associated with the same policy change, I code the decision once, in whichever year comes first. I do this to avoid 'double-counting' policy changes.

Once I am satisfied that a decision mentioned in more than one secondary source is a policy change with financial or regulatory implications, I categorise the policy change according to whether it promotes state, market, family, or voluntary responsibility for care on the basis of the indicators described in Table 4.1.

Policy changes that promote state responsibility can include investments in the quality of existing public psychiatric hospitals, for instance by increasing staff-to-patient ratios, building additional capacity, or breaking large institutions down into smaller wards. But they may also include funding to build new, smaller residential facilities, sometimes called 'group homes'. For example, in Australia, the State Grants Lunacy Act of 1955 first invested in the quality of psychiatric hospital provision, before the Mental Health and Related Services Assistance Act of 1973 provided funding for the development of new, smaller residential facilities that were described as 'community-based' (Daniels, 2011; Australian Institute of Health & Welfare, 2001; Lewis, 1988). The important feature of policies promoting state responsibility is that care is delivered by public employees at any level of government.

Policy changes that increase market responsibility either subsidise for-profit providers or promote their expansion. For instance, this could include increasing the scope of public subsidies to include for-profit providers of psychiatric hospitals where they had been excluded before, as occurred in

Table 4.1: Indicators of responsibility for care

| Outcome | Indicators |
|---|---|
| State | – Increase in national funding for direct service provision by any level of government<br>– New investment in hiring and/or training care workers as public employees |
| Market | – Cash benefits to fund choice of private care services<br>– Regulatory changes enabling expansion of private providers<br>– New obligations on employers or for-profit insurance funds to fund private care services |
| Family | – Financial incentives for family to take on caring roles<br>– Expansion of preventive assistance in the family home<br>– Regulatory changes to prioritise placement in families over institutions |
| Voluntary | – Regulatory changes to enable or expand provision by non-government, not-for-profit providers<br>– Subsidies for non-government, not-for-profit providers<br>– Expansion of insurance-based services managed by not-for-profit organisations |

*Comment:* Table lists the indicators used to categorise policy decisions as promoting the responsibility of state, market, family, or voluntary providers for care.

Ireland in 1957, or creating new funding streams to subsidise private group home providers, as in England in 1979 (Walsh, 2017; Busfield, 1998).

Policy changes that increase family responsibility can include, in the case of mental health services, payments to family members to take on caring roles. Payments for family carers of people with chronic and severe mental illness are introduced in Australia in 1972, Italy in 1980, and Germany in 1994 (Daniels, 2011; Goodwin, 1997). They can also include regulatory changes to prioritise family care, for instance by only granting access to residential mental health services once opportunities for family-based support have been exhausted, as in England in 1990, or by increasing the barriers for the removal of children from families. In the case of child welfare policies, this category also includes new family services to prevent the separation of children from their families.

Policy changes that increase voluntary responsibility include new subsidies for voluntary providers to establish group homes or shared residences, as in the Netherlands in 1985, or to expand existing voluntary domiciliary services, as in France in 2005 (Gijswijt-Hofstra, 1998; Melke, 2010). The expansion of insurance-based services includes, for example, shifting long-term care beds from public mental hospitals into voluntary-run institutions such as general hospital wards in Germany (Puschner, Kunze, and Becker, 2006, p. 183). Where the existing institutional care services were delivered by voluntary providers, investments in their capacity or quality also reflect an expansion of voluntary responsibility, for instance in the Netherlands in 1950 (Schnabel, 1998, p. 35).

While the coding of policy changes was generally straightforward, it was at times more challenging. For instance, the distinction between state and voluntary responsibility is sometimes difficult in countries such as Germany and the Netherlands where the 'public' welfare system is organised mainly by not-for-profit insurance organisations. In these cases, where reforms prioritise services managed by the insurance companies I classify these as expanding voluntary responsibility, and where they expand tax-funded 'social assistance' services delivered by public providers I classify them as promoting state responsibility. More difficult coding decisions were legislation that could include more than one, or none, of my outcome categories. Two examples from Italian mental health policy come to mind. Law 142 of 1990 expanded subsidies for *both* voluntary and for-profit providers to deliver mental health care services, and Law 180 of 1978 significantly reorganised public mental health services without directly subsidising alternative fam-

ily, voluntary, or market providers. In these cases, I turn to government documents or publications by key lawmakers, where available, to identify the stated intentions of policy changes. In cases where I cannot find such sources, I look for evidence in the secondary literature about which type of provider expanded the most in the wake of the policy change. Although this blurs the distinction between the policy decision and its outcome, it is sometimes the best I can do. For robustness testing, I re-code these borderline cases to ensure that potential measurement error does not bias the results. I do not detect bias, but re-coding the Italian changes does reduce the statistical significance of observed differences between Christian democratic and conservative parties.

There are some types of policy decisions and potential outcomes that I don't include in my dataset. Firstly, I do not code any legislative changes relating to the child welfare policies which removed indigenous children from their families in colonised territories. Although reform in the late 1970s likely reduced out-of-home care for indigenous children substantially, it is my expectation that this was motivated by different factors than wider child welfare policy changes. The history of such policies continues to be told quite separately from that of decline of institutional care for non-indigenous children, and it is based on incomplete and missing records. In the United States, it is estimated that between 25 and 35 per cent of indigenous children were removed from their parents and placed into out-of-home care before the federal Indian Child Welfare Act 1978 sought to reduce this practice by making tribal courts responsible for determining cases of abuse or neglect on reservations (Myers, 2006, p. 99). In Australia, the Aboriginal Welfare Board was only obliged to take child removals through the courts after 1940, but official practice was not always followed and records of the aboriginal children removed from their families between the First World War and the mid-1970s are largely absent. It is estimated that some tens of thousands were removed as part of the policy of assimilation and what became known as the 'Stolen Generations' (Commonwealth of Australia, 1997). My exclusion of these policy decisions is not meant to minimise their significance in the history of child welfare policy in some countries, but is based on a recognition that they are shaped by very different political dynamics.

In addition, it is important to clarify that I focus on national-level policy decisions to ensure that my cases are broadly comparable, even though in many countries care services are organised at lower levels of gov-

ernment. I consider services that are delivered by employees of any level of government to be 'state' care services (as opposed to market, voluntary, or family care). I capture policy changes that affect locally or regionally administered services when the national or federal government makes a regulatory or financial decision, but I don't specifically code decisions to centralise or decentralise responsibility for care. It's worth reflecting on this exclusion because the decentralisation of services is an important trend during the era of deinstitutionalisation – particularly in the case of psychiatric services (Novella, 2008).

The decentralisation of mental health and child welfare services is strongly connected with the reorganisation of welfare services more broadly during the same time period. For instance, we see a decentralisation of mental health services from the central state to lower levels of government to align with the administration of health services in Sweden in 1967 and Denmark in 1976. Decentralisation of mental health care in Italy in 1978 was part of the decentralisation of the general health services. The decentralisation of child welfare services in France occurred in 1983, also part of a wider decentralisation of social services (Ullman, 1998, p. 112-7). In the United States, asylums were already run as 'state hospitals', but the allocation of funding for the new community mental health centres, while initially federal, was decentralised by means of a block grant in 1981, a funding mechanism used in a range of services to reduce federal control over state activities (Rochefort, 1997, p. 67-8). Even policies of 'sectorisation' which created new 'catchment areas' around which diverse services should be organised generally concerned services wider than just mental health. In England, the reorganisation of the National Health Service in 1974 created Regional Health Authorities which also became responsible for mental hospitals. French psychiatric sectorisation was first suggested in 1960, but legislated in 1970 as part of a shift in focus to more preventive approaches in health and social care.

The integration of mental health and child welfare services with broader welfare policies and the associated patterns of decentralisation are marked aspects of the process of deinstitutionalisation, but they are not my focus when I seek to identify the types of actors who become responsible for the care of formerly institutionalised populations. When considering the responsibility of the state, market, family, and voluntary providers, decentralisation is still important to keep in mind, because we know from the existing welfare state literature that decentralisation can be used as a

strategy to reduce public responsibility for services by shifting the financial burden and political consequences of retrenchment to lower levels of government (Pierson, 1994, pp. 16–17). These types of decisions are characterised by what Weaver (1986) called the politics of 'blame avoidance', meaning that decision makers aimed to minimise the implicit impacts of potentially unpopular decisions. This means that the 'true' purpose of decentralising policy decisions is open to interpretation.

For consistency and clarity, in this chapter I focus on coding the explicit aims of policy. This also means that I exclude two policy changes identified in the existing literature which constitute cuts to public services without explicitly expanding market, voluntary, or family responsibility for care (in Australia in 1977 and the Netherlands in 1982). I am able to say much more about how the politics of care policy interacts with the politics of decentralisation and potential blame avoidance strategies in Chapters 5 and 6, where I trace policy changes over time in England and Germany.

## Measuring government partisanship

The main independent variable in the study is partisanship, operationalised as the composition of government, and more specifically the composition of the executive. As is common practice in the comparative welfare studies literature, I use data on the proportion of cabinet posts held by social democratic, Christian democratic, conservative, and liberal parties, usually taking on the value of 1 in majoritarian systems or a fraction of the posts held in coalition governments (Huber and Stephens, 2001, p. 50). I follow the party family coding in Armingeon et al. (2020). Because most of the political parties that control the executive during the period that I study are large, long-existing parties, there is broad agreement on their classification in the literature, with the exception of the Irish political parties, which I discuss in relation to specific examples below.

All of the parties which controlled cabinet in the 12 countries in my study are classified as social democratic, conservative, liberal, or religious (which I treat as Christian democratic), with the exception of the Australian National Party, which Armingeon et al. (2020) code as agrarian. I treat the National Party as conservative on the basis of their long-term coalition with the Liberal Party of Australia (a conservative party, contrary to their name). The two parties are commonly considered one 'coalescence' in the terms of Sartori (2005 [1976], p. 166), and treated as a single

conservative party for the purposes of analysis (Budge and Keman, 1990, p. 209). Data on the proportion of cabinet posts held is taken from the Comparative Political Parties Dataset (Swank, 2018) for the years 1950 to 1992 and the Political Yearbook published by the European Journal of Political Research for the years 1993 to 2015.

I use this data to construct a categorical measure of the leading party of government, which takes on a value depending on the party family which holds the largest proportion of cabinet posts: social democratic, Christian democratic, conservative, or liberal. This is usually the same party as the head of government, but occasionally it differs.

I code the largest party rather than the head of government in these cases because it is more consistent with the continuous measure of partisanship that is commonly used, but I consider the impact of this coding strategy for the two cases where these governments make policy changes that appear in my dataset. During Merkel's first cabinet in Germany between 2005 and 2009, a grand coalition, the Social Democratic Party of Germany (*Sozialdemokratische Partei Deutschlands*, SPD) held 11 of the 21 cabinet posts. Despite holding the minority of cabinet seats, the Christian Democrats did hold the relevant portfolio of Family Affairs, Senior Citizens, Women and Youth. Recoding the partisanship of government to Christian democrat does not change the effect or statistical significance of any of the results that I interpret below. The first and second Kok cabinets in the Netherlands between between 1994 and 2002 had a majority of liberals in the cabinet posts across the People's Party for Freedom and Democracy (*Volkspartij voor Vrijheid en Democratie*, VVD) and Democrats 66. The VVD also held the portfolio for Health, Welfare, and Sport which included social services and youth care. Even though the VVD are an established liberal party, Democrats 66 are a newer party, considered potentially '*sui generis*' by Mair and Mudde (1998). Recoding the partisanship of government to social democrat, in line with the head of government, does not change the effect or statistical significance of any of the results that I interpret below.

In cases where cabinet posts are split evenly among party families, I code the leading party variable in line with the party of the head of government – for example, in the case of the Netherlands for the third Lubbers cabinet between 1989 and 1994, and the Rutte cabinets between 2011 and the end of the period. In the first case, the Labour Party also held the relevant portfolio for Welfare, Health, and Culture. In the second, the

relevant portfolio for Health, Welfare, and Sport was held by the Party for Freedom (*Partij voor de Vrijheid*, PPV), but changing the partisanship of government to liberal does not change the effect or statistical significance of any of the results that I interpret below.

The categorical measure of government partisanship is a preferable approach to the more common continuous measure in the modelling framework that I have chosen. Most of the existing quantitative studies of partisanship and welfare politics have used linear regression to test hypotheses about continuous outcome variables such as the level or annual change in welfare expenditure. The limitations of using such policy outcomes as dependent variables are discussed in the section above. My focus on explaining more directly the *type* of policy decision that is made leads me to a logistic regression framework appropriate for categorical outcome variables. In logistic regression, the relationship between the independent variables and outcomes is not linear, but rather varies across the values of the covariates.

In this framework it is less meaningful to consider the marginal effect of an increase in one party's cabinet share while holding other parties' cabinet shares constant, because in the real world the proportion of cabinet posts held by other parties must decline as one party increases. Investigating the marginal effect of one party being the largest party in cabinet as opposed to another party being the largest is more intuitive and substantively meaningful in relation to the observed data. In Appendix A, I show the results for two alternative models using the more common continuous measures of partisanship, excluding either the liberal or conservative party measure to deal with high multicollinearity. The results of these alternative models are consistent with those of the preferred categorical approach, but are a poorer fit for the data on the basis of fit statistics, and the substantive effects are much more difficult to interpret for the reasons discussed.

# Descriptive statistics

Let me begin by describing the main patterns in the data that I have collected. Of course, I am interested in the patterns by government partisanship, but in this section I also consider the distribution of the dependent variable over time and across countries and welfare regimes, because I expect the main alternative explanations for care policy change to vary on these dimensions.

## Patterns by government partisanship

To start, table 4.2 displays the frequency of policy changes by the leading party of government. One of the main assumptions of my theory is that all types of governments are equally supportive of deinstitutionalisation policy, so we should expect that all types of governments are equally likely to make some kind of policy change. We can see that all types of parties have a similar propensity to make changes, ranging from 9.2 per cent of country-years when governments were led by Christian democrats to 7.7 per cent of country-years led by Conservatives, with an average of 8.6 per cent. Given that the number of total policy changes is just 136, these differences are relatively small. Note that there is one observation for each policy area in each country year, with the exception of 2 observations for Italy in 1995, which are missing partisanship data because the Dini Cabinet was wholly made up of independent, extra-parliamentary experts.

Table 4.2: Frequency of policy changes by leading party of government

| | Leading party | | | | Total |
|---|---|---|---|---|---|
| | Social democrat | Christian democrat | Conservative | Liberal | |
| Policy change (per cent) | 39 (8.7%) | 28 (9.5%) | 39 (7.5%) | 30 (9.3%) | 136 (8.6%) |
| No change | 407 | 266 | 479 | 294 | 1446 |
| Observations | 446 | 294 | 518 | 324 | 1582 |

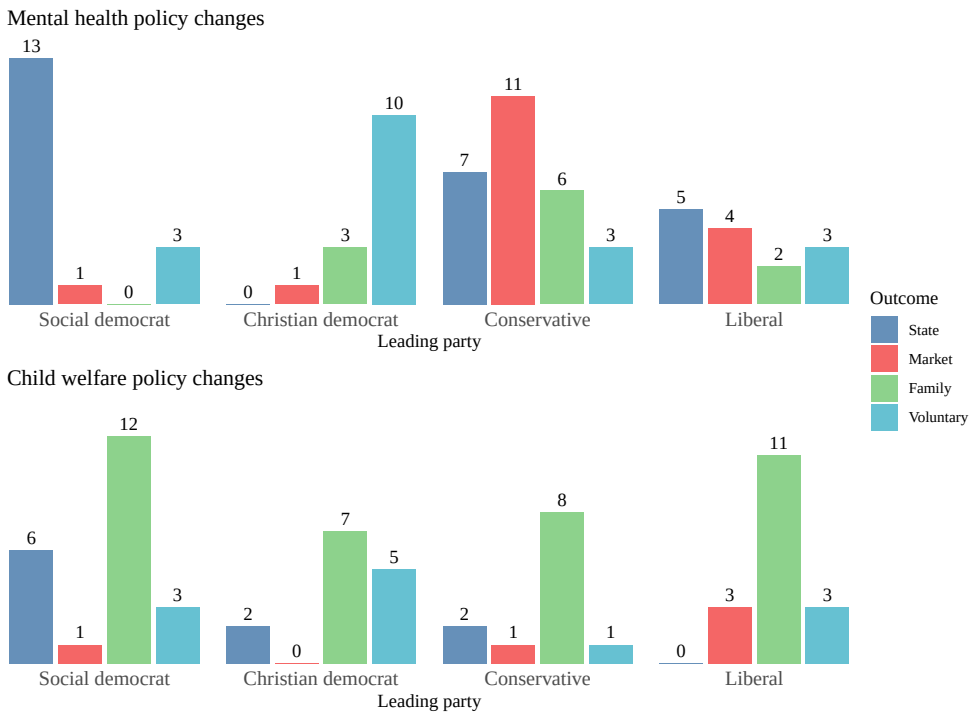
*Comments:* Table pools all mental health and child welfare policy decisions. Column percentages in parentheses. One observation is made in each country-year for each policy area (i.e. 132 observations per country). Two observations for Italy in 1995 are missing partisanship data because the Dini Cabinet was wholly made up of independent, extra-parliamentary experts.

Figure 4.1 describes the patterns in the data by government partisanship, by displaying the frequency of policy changes that promote state, market, family, or voluntary responsibility for care in each policy area (mental health or child welfare), grouped by the leading party of government (social democratic, Christian democratic, conservative or liberal). The charts are labelled with the frequency of policy changes at the top of each column. In total, there are 71 policy changes relating to mental health, and 65 relating to child welfare.

We can already see from the descriptive statistics that, in line with expectations, policy changes promoting state responsibility (coloured dark blue) are mostly made by social democrats, and those promoting voluntary responsibility (coloured light blue) are mostly made by Christian democrats. Most of the changes promoting market responsibility (in red) are made by conservative and liberal governments.

Policy changes which promote the responsibility of the family (in green) are more common for child welfare policy changes regardless of government partisanship. This is not surprising given that children are dependent on either family or out-of-home care and not supported to live independently in the same way that people with mental illness might be. It's also not surprising given that the science of child development and child psychiatry from the work of experts such as Burlingham and Freud (1944), John Bowlby (1952), and René Spitz (1965) showed that children had better outcomes when they were raised in a family environment. These ideas gained merit in policy circles around the world from the 1960s, in particular through the work of Bowlby with the World Health Organisation (WHO) and United Nations (Mccall, 1999). This means that all types of parties likely had shared, non-ideological reasons for supporting family care for children to a greater extent than for people with mental illness.

Figure 4.1: Policy changes in each outcome category, by type of government and policy area




*Comments:* Charts depicts the distribution of policy changes made in each outcome category by each type of government, according to policy area. The frequency is labelled on the corresponding bar.

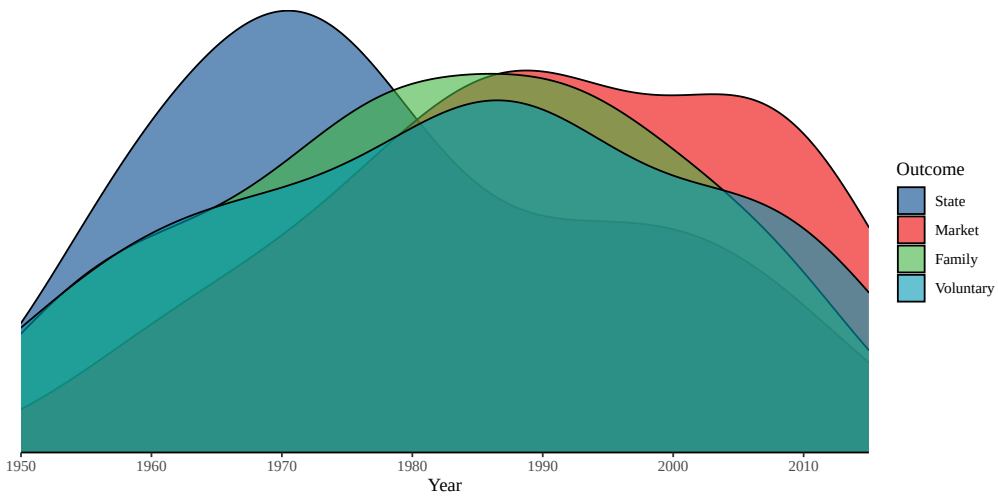
## Patterns over time

Non-ideological factors also play an important role in the patterns of outcomes that we observe over time. Alongside the science of child welfare, the other non-ideological factor that is raised in the literature on deinstitutionalisation is increasing fiscal pressure on the welfare state, as a result of the expansion of welfare programmes and demographic change. If the closure of mental hospitals was motivated by cost savings in response to fiscal pressure, we should expect that new policies reduced the responsibility, and the fiscal liability, of the state. Similarly, we might be more likely to see policy changes that promote care by market providers in later periods, alongside the privatisation of public services in general.

There are also reasons to expect an increase in policies promoting family responsibility over time. While the science of child development and child psychiatry supported family-based care from at least the 1960s, the transmission of scientific knowledge into policy through national professional networks and scientific advisors takes time, and countries increasingly learn from one another through international networks of experts, non-governmental organisations, and institutions such as the World Health Organisation (Dolowitz and Marsh, 2000). We also know from the literature on 're-familisation' in the welfare state that fiscal pressure can be associated with an increase in family responsibility for welfare provision, so an increase in family responsibility could also be related to growing fiscal pressure over time.

Figure 4.2 plots the distribution of each type of policy change over time using density curves, which measure the baseline probability of each outcome occurring over time based on the observed data. We can see that the frequency of policy changes promoting state responsibility (in dark blue) peaks around 1970 and declines sharply during the 1970s and 1980s, while other types of policy changes gradually increase. In particular, policy changes promoting family responsibility for care (in green) are most common in the 1980s and 1990s, and those promoting market responsibility (in red) from the 1980s to 2000s. The patterns in the data are consistent with the idea that factors such as changing scientific knowledge and fiscal pressure do have an effect over time, but we still observe all four types of policy changes throughout the period.

Figure 4.2: Density plot for types of policy changes over time



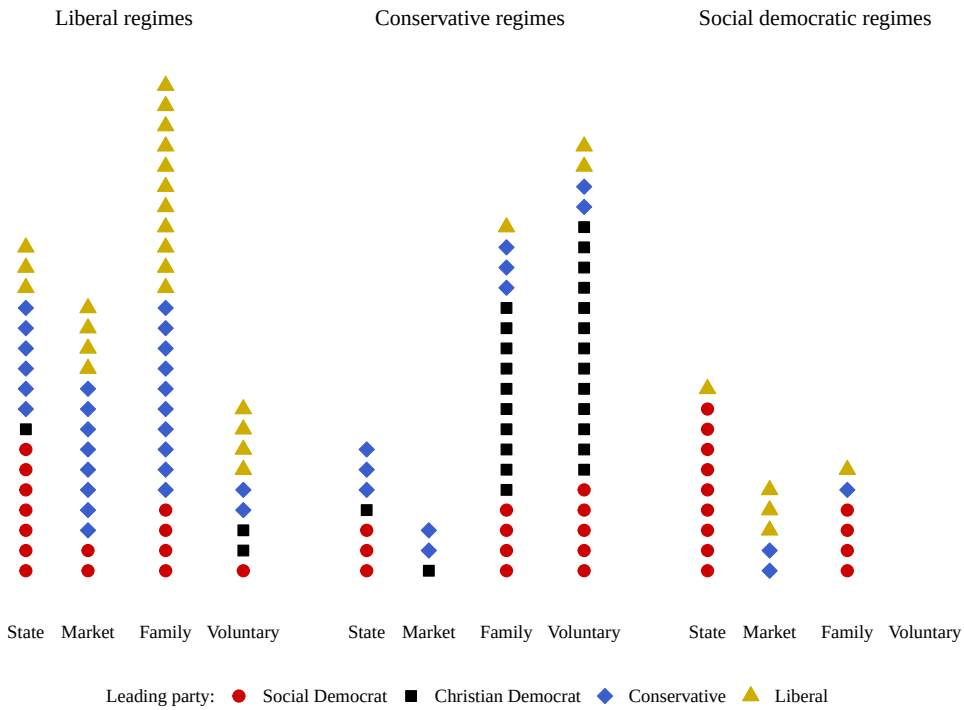

*Comments:* Plot displays the distribution of each type of policy change over time.

## Patterns by welfare regime type

There are also good reasons to expect that the type of welfare regime may affect the type of care policy change that is made. Because I select countries on the basis of a range of institutional factors, there are 6 liberal welfare regimes (Australia, Canada, England, Ireland, New Zealand, United States of America), 4 conservative welfare regimes (France, Germany, Italy, and the Netherlands), and 2 social democratic welfare regimes (Denmark and Sweden) in my sample. Figure 4.3 plots the number of policy changes in each outcome category for each of the three welfare regime types. Each point reflects one policy change, and the colour and shape of the points represents the type of government that made the change, led by a social democratic, Christian democratic, conservative or liberal party.

As we might expect, policy changes promoting voluntary responsibility are more common than other types of changes in conservative welfare regimes, but these changes (as well as those promoting family responsibility) are largely made by Christian democratic parties. Policy changes promoting state responsibility are more common than other types of changes within the social democratic welfare states, and almost all of these are made by social democratic parties. Even though there are more policy changes promoting market responsibility in liberal welfare regimes, the proportion of changes of this type (22 per cent) is similar to social democratic regimes (24 per cent). Privatisation of responsibility for care is much less frequent in conservative welfare regimes (just 6 per cent of policy changes).

Figure 4.3: Policy changes in each outcome category, by welfare regime and government partisanship




*Comments:* Plot depicts the number of policy changes in each outcome category in liberal, conservative, and social democratic welfare regimes. Note that there are 6 liberal welfare regimes, 4 conservative welfare regimes, and 2 social democratic welfare regimes in the sample. Changes made by social-democratic-led governments are represented as red circles; Christian democratic governments as black squares, conservative governments as blue diamonds, and liberal governments as yellow triangles.

# Modelling the type of policy change

In this section I use a multinomial choice model to investigate how the characteristics of governments – principally, government partisanship – affect the types of policy changes that they make. I do not model the propensity to make policy changes, for both theoretical and methodological reasons.

Based on the existing literature about the structural causes of deinstitutionalisation, I assume that all types of governments were equally inclined to make some kind of policy change in the second half of the twentieth century. This is supported by the descriptive statistics in table 4.2 above. Methodologically, although I am able to identify when a major policy change is made that is noted in multiple secondary sources, the absence of a policy change in my dataset only reflects the absence of a change in the historical record, or the absence of agreement among scholars that a change was important. I therefore only investigate what type of policy change is chosen when a change is made. The number of observations that I have for each country therefore depends on the number of major policy changes identified in the secondary literature. This ranges from 5 in Canada to 15 in the Netherlands and England, with a mean of 11.3. I pool all 136 observations and treat policy changes as the unit of analysis. The logistic regression framework has been shown to work well in small samples of at least 100 (Scott Long, 1997, pp. 53-4). It uses the method of maximum likelihood to estimate an s-shaped function of covariates around which we assume a logistic error distribution to make statistical inferences.

There are simpler logistic regression models than the multinomial model that can be used when the dependent variable can be reduced to a binary outcome, or when there are more than two outcome categories that can be ordered in some way. In one sense, deinstitutionalisation policy has often been considered (though not quantitatively) in binary terms, as either institutional or community care, or – for instance, in Goodwin's (1997) framework – as either public or private. As I argued in Chapters 2 and 3, this binary way of thinking about provision obscures both important variation in the types of services that came after asylums and orphanages, and important differences in partisan care policy preferences. The four categories of state, market, family, and voluntary services better capture the possible options that governments have when they decide who should be responsible for care.

It is also, to my mind, not possible to order the four categories of state, market, family, and voluntary responsibility for care in any meaningful way. We might think about these categories of care provision as, to varying extents, more custodial, interventionist, collectivised or generous, but they cannot all be ordered along any single dimension. State, market, or voluntary providers could all deliver equally custodial types of care. Services provided by publicly subsidised voluntary organisations could be equally as generous as those provided directly by the state. Even if the site of care is the family, it is not necessarily the case that the policy is less generous or interventionist than state alternatives. Monetary incentives for family-based care can be quite expensive policies, and the extension of support services into the family and use of the family as a care provider for formerly institutionalised populations has been described by Cohen (1985, pp. 78–79) as an expansion of social control into the community at large. And to what extent is care delivered by the market more or less collectivised than voluntary provision? Even if these outcome categories could be ordered, using a multinomial model when an ordered model would have been sufficient will return inefficient but unbiased results (Scott Long, 1997, p. 148–149). That is, the effects will be estimated accurately but the statistical significance may appear *lower* than if an ordered model was used. The multinomial model is therefore the more conservative approach, which minimises the risk of generating biased or nonsensical results from an ordinal model of an inherently nominal outcome.

The multinomial logit model carries with it a strong assumption that the probability of a particular outcome is not influenced by the existence of alternative options. The formal tests for this assumption are known to be unreliable, so it is important to ensure that the outcome categories are distinct enough that they are not substitutes for one another (Cheng and Long, 2007). I consider the so-called 'independence of irrelevant alternatives' assumption reasonable on the basis that the categories of state, market, family, and voluntary provision are logically distinct, and they are also statistically distinguishable with respect to the covariates in the preferred model based on a wald test for combining alternatives ($p<0.01$ for all pairs of alternatives). Robustness checks using modelling alternatives which do not impose this assumption, such as nested or mixed logit, are too demanding for this small sample.

In the preferred model I control for characteristics which could affect both the composition of government and the propensity for state, market,

or voluntary providers, or families to take responsibility for care. I use the liberal, conservative, and social democratic welfare regime types described by Esping-Andersen (1990) to capture a range of relevant institutional factors: the strength of organised labour, the influence of corporatism, and the significance of the state, market, or family as a welfare provider in general. Economic performance is also known to shape who governs, and could effect capacity to invest in public care services. I measure economic performance using data on expenditure-side Gross Domestic Product (GDP) per capita from the Penn World Tables (Feenstra, Inklaar, and Timmer, 2015). I also include dummy variables for coalition governments and federal governments, based on Armingeon et al. (2020), because the capacity of such governments to pass their preferred policies is likely constrained by the dynamics of negotiation with coalition partners and regional levels of government. I also include a measure of total women's labour force participation from OECD (2021) since 1970, and Olivetti (2013) for the earlier years. This is important because the availability of family care is influenced by the participation of women in the labour market, but also because labour market participation affects the voting patterns of women (Inglehart and Norris, 2000).

Recognising the inherent differences between the two policy areas that I study, I also include a policy area dummy coded 0 for mental health policy changes, and 1 for child welfare policy changes. I assume that there are important differences between the policy areas which have an effect on the types of policy changes that are made, but that the effect of partisanship does not vary across policy areas, so I do not interact these variables in the model. I expect all parties to promote more family care of children than people with mental illness, but do not have theoretical reasons to expect heterogeneous effects of parties' ideological positions across policy areas.

Because I focus on policy changes, it is important to recognise that the type of institution that has control over pre-existing institutional care could shape demand for particular types of policy change. The variable 'Institutions', takes on a value of 1 for state services, 2 for subsidised secular voluntary services, and 3 for subsidised religious services based on the preponderance of service providers in the year that institutionalised populations peaked. This measure varies by country and policy type. For a similar reason, I include for each policy change a binary measure of whether or not that particular type of policy change has been made previously in that country, in that policy area.

Finally, I take steps to control for confounding factors, either time-specific or nationally-specific, which might be related to both the type of policy change that is made and the type of government in power. I discuss these in detail in the section on Deinstitutionalisation in the previous chapter. I control for period-specific factors in the preferred model by including dummy variables for each decade, using the procedure recommended by Beck, Katz, and Tucker (1998). It is also likely that aspects of national political culture or institutional history make both particular types of policy changes and particular types of governments more likely to occur in certain cases because of path dependency. It is common to control for such contextual features which vary among countries but are constant over time by using country fixed effects and examining only the variation within countries. Because of the small number of policy changes made per country, this modelling approach is not possible with my dataset. However, controlling for the type of welfare regime means that the results are based on variation within these groups of 2, 4, or 6 country cases with very similar institutional features. I also estimate all of the models using clustered standard errors at the country level, which accounts for other country-specific factors that are correlated with the independent variables when it comes to inferring statistical significance.

## Results

Turning to the choice model, Table 4.3 displays the results of three models in which the base outcome category is state responsibility, and social-democratic-led governments are the reference category to which all of the government partisanship coefficients are relative. Model 1 includes only the leading party variable and the policy area dummy variable, coded 0 for mental health and 1 for child welfare. Model 2 controls for welfare regime as well as the range of controls described above, and model 3 (the preferred model) controls for period-specific effects by introducing decade dummy variables. Coefficients for all controls are reported in Appendix A. The raw coefficients presented reflect the effect of a change in partisanship on the log odds of each outcome occurring, so the substantive impact is difficult to interpret directly from this table. However, based on the sign and significance we can identify which changes in partisanship affect the likelihood of different types of policy changes, with reference to both the base outcome category and the partisanship reference category.

Table 4.3: Multinomial logit regressions on type of policy change

| *Relative to State* | (1) | (2) | (3) |
|---|---|---|---|
| **Market** | | | |
| Christian democrat | 1.6 | 2.9 | 3.3 |
| | (1.6) | (1.5) | (1.7) |
| Conservative | 2.6** | 3.3* | 4.4** |
| | (0.9) | (1.5) | (1.4) |
| Liberal | 2.8* | 4.5** | 7.0*** |
| | (1.1) | (1.5) | (1.8) |
| Policy area (1=child welfare) | 0.2 | 0.6 | 0.7 |
| | (0.7) | (1.3) | (1.5) |
| **Family** | | | |
| Christian democrat | 2.5** | 2.9* | 3.1** |
| | (0.9) | (1.2) | (1.2) |
| Conservative | 1.7* | 1.9 | 3.8*** |
| | (0.7) | (1.0) | (1.1) |
| Liberal | 1.8*** | 2.9*** | 5.9*** |
| | (0.5) | (0.8) | (1.4) |
| Policy area (1=child welfare) | 2.5*** | 2.8*** | 4.5*** |
| | (0.5) | (0.6) | (0.9) |
| **Voluntary** | | | |
| Christian democrat | 3.3*** | 2.6*** | 2.5* |
| | (0.8) | (0.7) | (1.1) |
| Conservative | 0.5 | 0.2 | 1.3 |
| | (0.8) | (0.9) | (1.1) |
| Liberal | 1.6** | 2.4*** | 5.3*** |
| | (0.5) | (0.6) | (1.3) |
| Policy area (1=child welfare) | 0.6 | 0.3 | 1.8* |
| | (0.4) | (0.5) | (0.7) |
| Welfare regime (1=Liberal) | | ✓ | ✓ |
| Other controls | | ✓ | ✓ |
| Decade dummies | | | ✓ |
| Observations | 136 | 136 | 136 |
| Log-likelihood | -147.1 | -125.2 | -103.2 |
| BIC | 348.2 | 309.3 | 265.4 |

Standard errors in parentheses
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

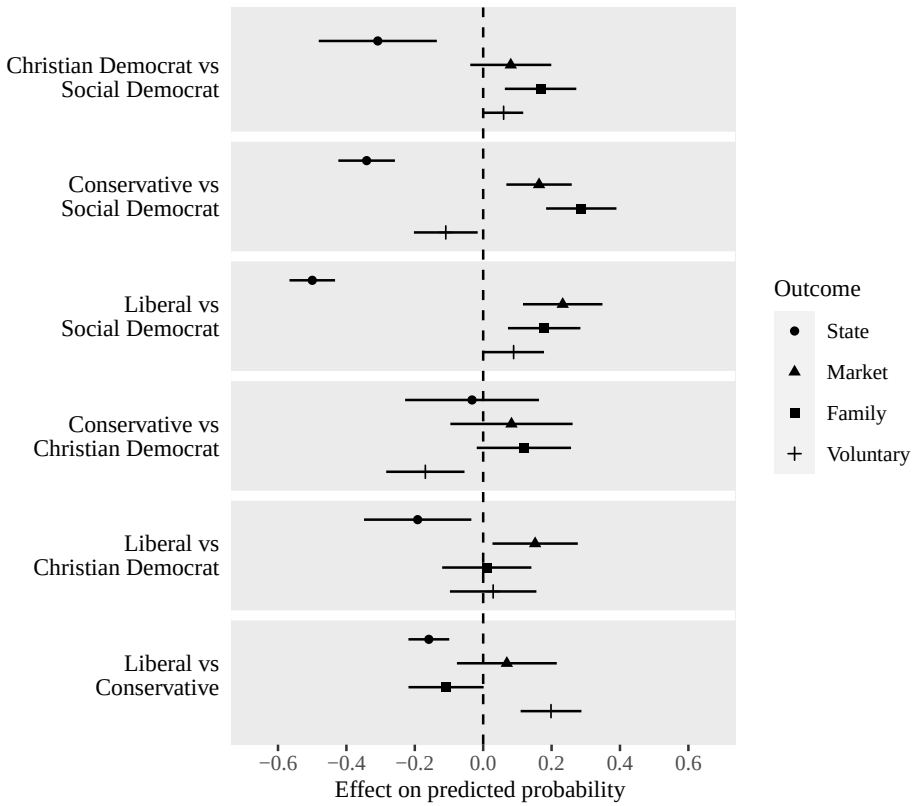
Many of the results support my theoretical expectations. Even after introducing institutional and economic controls in model 2 and decade dummies in model 3, it is clear that both conservative- and liberal-led governments are more likely to make policy changes that promote market responsibility than social democratic governments are to promote state responsibility. The three significant partisanship coefficients for the family outcome category suggest that social democratic governments prefer state responsibility over family responsibility to a greater extent than all other types of governments. Also in line with expectations, Christian democrats are more likely than social democrats to promote care by voluntary organisations rather than the state, even controlling for welfare regime characteristics which might make voluntary provision more likely (although the statistical significance is reduced). Liberals also prefer voluntary provision.

The size of the voluntary coefficient for liberal governments should not be directly compared with that for Christian democrats to assess the differences between these two types of governments, because both coefficients are relative to the base categories in this results table. Equally, at this stage the significant coefficient for liberal governments preferring family policy only indicates that liberal governments prefer family over state responsibility to a greater extent than social democratic governments, which is not surprising given that we expected social democrats to privilege state responsibility above all other types of policy change.

## The marginal effect of government partisanship

The most direct test of the effect of partisanship on care policy choice is to compare social democratic, Christian democratic, conservative, and liberal governments with each other by measuring the marginal effect of a change in partisanship on the probability of all possible outcomes. Figure 4.4 plots the average marginal effect of a change in government partisanship on the probability of each of the four outcome categories, along with a 90 per cent confidence interval. Because probabilities must sum to 1, the maximum possible effect would be 1. The effect size reflects the average change in probability brought about by a change in partisanship across the range of values that the covariates take on in the sample. The size of the effect can be compared with the average predictions for each outcome category, reported at the bottom of the figure, to give a sense of the substantive impact.

Figure 4.4: Average marginal effect of government partisanship




Average predictions: State=0.25 Market=0.16 Family=0.36 Voluntary=0.23

*Comments:* Average marginal effect reported with 90 per cent confidence intervals. A confidence interval which excludes zero (does not cross the dotted line) suggests that the change in government partisanship has a statistically significant effect on the probability of that outcome occurring.

We can identify the statistically significant differences between different types of governments by observing the average marginal effects with confidence intervals that do not include zero (do not cross the dotted line). The top three panels compare Christian democrats, conservatives, and liberals to social democrats again, but this time we are directly testing whether the change in partisanship induces a statistically significant difference in the probability of each outcome category occurring.

Immediately we can see that Christian democrats, conservatives and liberals have a much lower probability of making a policy change that promotes state responsibility for care than social democratic governments. Christian democrats have a higher probability of making a policy change that promotes family or voluntary responsibility, but are not significantly more likely than social democrats to promote market responsibility. The size of the significant effects is small, but substantive. For instance, a change from a social democratic to a Christian democratic government increases the predicted probability of policy change that promotes voluntary responsibility by 6 percentage points on average, from a base probability of 23 per cent. Also in line with expectations, conservatives and liberals have a higher probability than social democrats of promoting market responsibility for care, conservatives have a higher probability of promoting family responsibility, and liberals have a higher probability of promoting voluntary responsibility.

There are some unexpected results in the top three panels. Conservatives are also less likely than social democrats to promote voluntary responsibility for care. Based on their positions in the two dimensions of ideological conflict, I don't have clear expectations about either of these parties' preferences for voluntary responsibility. More surprisingly, even when comparing liberal and social democratic governments directly at the level of average marginal affects, there is still a significant difference in the probability of promoting family responsibility for care.

Turning to the bottom three panels, we are now able to compare Christian democratic, conservative, and liberal governments directly with each other. In line with expectations, conservatives have a lower probability than Christian democrats of promoting voluntary responsibility. Compared with Christian democrats, liberals have a lower probability of promoting state responsibility, and a higher probability of promoting market responsibility. Liberals also have a higher probability of promoting voluntary responsibility and a lower probability of promoting family respons-

ibility than conservative governments. Based on liberals' preference for private organisation, it is not surprising that we can't distinguish between the probability of changes promoting voluntary responsibility under liberal as compared with Christian democratic governments.

But there are also some unexpected results when we compare these three centre-right parties with one another. Firstly, liberals are less likely than conservatives to promote state responsibility. Secondly, Christian democrats are not significantly less likely to promote market responsibility than conservatives – although the effect is in the expected direction, and all of the marginal differences between these two parties are less precisely estimated because the two party types don't occur as leading parties of government within the same country (recalling that the model clusters standard errors at the country level). But most unexpectedly, given the theorised influence of individualist ideologies, liberal-led governments are not significantly less likely than Christian democrats to promote family responsibility for care. Taken together with the difference that we see between social democrats and liberals, liberals seem to have a clear and unexpected preference for family responsibility.

We have confirmed most of the expected patterns, with the exception of those regarding preferences for family responsibility. On the one hand, this could suggest that the dynamics of party competition mean that second-dimension conflict is important for distinguishing social democrats from Christian democrats and conservatives, and liberals from Conservatives, but not for distinguishing liberals from Christian democrats. But it might also suggest that the reasons for promoting family responsibility are complex, reflecting either a preference *for* familialism or *against* state responsibility for care. While social democrats promote family responsibility the least, conservatives and Christian democratic could do so to promote the role and value of the family as an institution, and liberals to reduce state responsibility for services. It is among conservative parties, where both motivations are present, that the relative preference for family responsibility appears strongest.

## Order of preference and outcomes

The above analysis of average marginal effects indicates that a change in partisanship effects the probability of different outcomes occurring. But the substantive impact of a change in partisanship – that is, whether or not the change in relative probabilities leads to a change in the most likely outcome – depends upon the predicted probability of each of the four outcome categories. In this section, I consider the order of preferences for each type of government, before turning to address the surprising findings concerning liberals' preference for family responsibility with examples.

The level of predicted probabilities estimated by the model will vary depending on the combination of values taken on by covariates. In other words, the type of policy change that we should expect depends on the wider contextual factors that we might observe in the real world. But to get an idea of the general patterns in parties' order of preferences, we can examine the predicted probability of a policy change promoting state, market, family, or voluntary responsibility for each type of government, holding all other variables in the model at their means.

Here, I consider parties' order of preferences for each policy area. Although I don't have theoretical reasons to expect that the *effect* of partisanship is different in mental health and child welfare policy, I do expect the *probability* of policy decisions promoting family responsibility for care in particular to vary across the two policy areas. I expect that all governments promote family responsibility for the care of children to a greater extent, because they also have shared, non-ideological reasons for doing so. Even if ideology makes them more likely to pursue certain types of care policy, these non-ideological reasons will affect their order of preferences across the two policy areas.

Figure 4.5 shows the predicted probabilities for each type of policy change by governments led by social democrats, Christian democrats, conservatives, and liberals, for each policy area separately. To predict these probabilities I hold the service area dummy constant (at 0 for mental health policy changes, or 1 for child welfare policy changes), the leading party variable at the the appropriate value, and all other variables in the model at their means. This figure does not isolate the effect of partisanship in the same way as the average marginal effects above. All of the other covariates are contributing to the predicted probabilities, but I am holding them at their mean levels. It is important to remember that there is no place in the world or time in history where all of the covariates would sim-

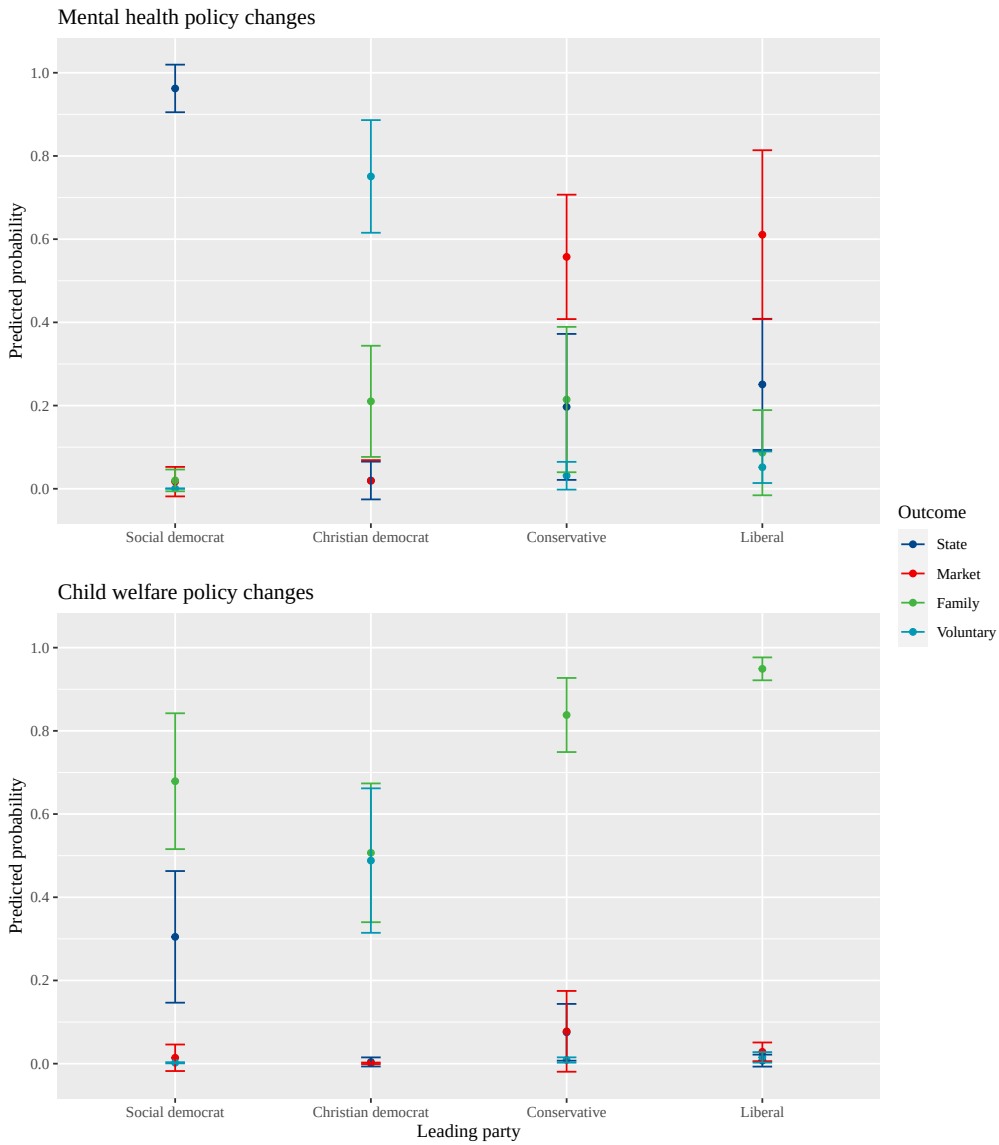
ultaneously take on the mean values that they have in the sample. That means that the predictions don't represent realistic probabilities that we would expect in any particular case. But this plot tells us about the clear patterns in the data.

In the upper panel, in the area of mental health policy, we can see that, in line with expectations, social democratic governments prefer state responsibility, Christian democrats voluntary responsibility, and conservatives and liberals are most likely to promote market responsibility for the care of people with chronic mental illness (the 90 per cent confidence intervals for state and market responsibility for liberal governments cross by less than 0.3 percentage points). It's also not surprising that Christian democrats have a preference for family responsibility over state or market responsibility. But even though we saw above that conservatives had the strongest preference for family responsibility relative to other types of governments, when all the other covariates are held at their means we can not distinguish between conservatives' order of preference for state, family, or voluntary responsibility at the ninety per cent confidence level.

In the lower panel, social democrats, conservatives, and liberals each appear most likely to make policy changes that promote family responsibility for the care of children, although unlike other types of governments, social democrats do have a clear second preference for state responsibility. In the area of child welfare policy, we can't distinguish between Christian democrats' preference for voluntary or family responsibility, but both are choices that match our theoretical expectations.

The differences in predicted probabilities between the two policy areas are broadly consistent with theoretical expectations. They suggest that shared, non-ideological factors play an important role in shaping all parties' preference for family responsibility for the care of children, but confirm that conservatives and liberals have a preference for privatisation, while social democrats prefer state responsibility, and Christian democrats voluntary responsibility, to a greater extent than other types of parties. Liberals, however, have a much higher preference for family responsibility than expected.

Figure 4.5: Predicted probabilities by policy area and leading party of government




*Comments:* Predicted probability for each type of policy change, by policy area and leading party of government, holding all other covariates at their means. Reported with 90 per cent confidence intervals. Probabilities across the four outcome categories for each type of government sum to one.

## Motivations for promoting family responsibility

To better understand the motivations of liberal governments for choosing family responsibility for care, let us now consider some examples of these types of policy changes. Some of the policy changes that don't meet my expectations are also not well-predicted by the model, meaning that neither the hypothesised role of partisanship nor the control variables in the model explain them. These are what we might think of as the 'least likely' cases, where the actual outcome was farthest from its predicted value.

The 'least likely' decision to increase family responsibility for the care of people with mental illness is the 2004 policy change in Canada, which established federal funding for assistance to carers in the family home. These services, known as 'home care', were for acute mental illness, in order to prevent premature or inappropriate admissions to long-term care services that would split up family units and incur greater costs to government (Forbes and Edge, 2009). The context for this policy decision is a federal country in which the national government has little involvement in mental health policy making. The 2004 decision was one of just three national-level mental health policy changes made by the Canadian federal government between 1950 and 2015. The first, in 1957, provided capital injections for the construction of community mental health clinics and psychiatric beds in general hospitals, while both the ongoing operating costs and governance of mental health services were left to the provinces, with mental hospitals excluded from the Hospital Insurance and Diagnostic Services Act of the same year (Gold, 1988). The rich literature on psychiatric deinstitutionalisation in Canada identifies that the majority of policy decisions were made at the provincial level, with the federal government removed from mental health policy despite the construction of a comprehensive national health system (Rochefort, 1997, p. 186).

During the 2000s, successive federal liberal governments began to take a more active role in mental health policy in Canada. In 2002, the government of Prime Minister Jean Chrétien, who had held the office since 1993, established a study by the Standing Senate Committee on Social Affairs, Science, and Technology into the state of the health care system in Canada and the role of the federal government. Its follow-up report on issues concerning mental health and mental illnesswas not published until shortly after the 2006 election, where, when outlining the benefits of community-based care, the committee identified that 'many community-based services can save money' (Kirby and Keon, 2006, p. 97). The 2004

initiative was part of a much larger Health Accord, which included home care as one of its five priority areas. Now connected with health policy at large, the new mental health initiative was shaped by the efficiency framework of the Health Accord, designed to address cost pressures in the overall health system. The mental health component has been described by practitioners as a 'tack on', considered inadequate to meet needs (Bartram and Lurie, 2017). Rather than a comprehensive policy to actively promote family care, the initiative to keep individuals in the care of the families was arguably motivated by cost saving.

Given that this poorly-predicted outcome is mainly explained by the desire to reduce public expenditure, and that most of the mental health policy changes promoting family responsibility for care are made after the fiscal crisis of the 1970s, we might ask whether all of them were motivated by cost saving. Given, too, that we don't see any social democratic parties making these types of changes in mental health policy, one might think that they can be explained by a single socio-economic dimension of partisan conflict, and that second-dimension conflicts simply don't matter.

Turning to some examples of more 'expected' policy changes offers some evidence against the alternative explanation that class conflict alone explains care policy decisions. The policy changes to promote family responsibility for care made by conservatives and Christian democrats were not only motivated by cost saving. Several of these changes introduced new, ongoing funding to promote family-based care. In Australia, Germany, and Italy the Social Services Act 1972, long-term care insurance (*Pflegeversicherung*), and care allowance (*l'indennità di accompagnamento*) respectively introduced cash payments for the family carers of people with mental illnesses to incentivise family members to take on caring roles. Although we see carers' payments introduced in a number of different countries to actively promote family care of people with mental illness, they are never introduced by social democratic governments in my sample. Some policy changes made by conservatives governments arguably combined cost-saving initiatives with a more direct promotion of family care. For instance, in the United States, the Omnibus Budget Reconciliation Act of 1981 slashed federal funding to community mental health centres by 30 per cent and established the Preventive Health and Health Services Block Grant, to be spent on preventive services to families (Rochefort, 1997, pp. 63–72). In chapter 5, I discuss the 1983 and 1990 policy changes in England, introduced by the Thatcher government, which arguably combined a cost-saving

agenda with an emphasis on the role of families as the primary source of care for people with chronic mental illnesses (Walker, 1997, p. 212).

These examples from the area of mental health policy lend some support to the idea that the motivations for promoting family responsibility for care are complex. These decisions might be made either to reduce public spending, or to actively promote care in the family. Both liberal and Christian democratic parties make these types of changes, but we see them much more frequently among conservative governments, who have ideological reasons both to reduce the size of the state and to promote the role and independence of the family.

Other unexpected outcomes – that is, policy choices that do not align with my theoretical expectations about partisan policy preferences – are well-explained by other variables in the model, so the model still predicts them correctly. For instance, in 1990 in Ireland, the coalition government of Fianna Fáil and the Progressive Democrats, led by Charles Haughey, introduced an allowance for the family carers of people with chronic mental illness. I code the Irish party families in line with Armingeon et al. (2020), where both Fianna Fáil and the Progressive Democrats are liberal parties. In 1990, Fianna Fáil held most of the seats in cabinet, including the Health and Social Welfare portfolios. The fact that the model predicts this policy decision correctly suggests that the other control variables help to explain it. Most notably, Ireland has relatively low female labour market participation, meaning that the availability of family care is high relative to other countries. In the full model reported in Appendix A, we can see that higher female labour market participation has a strong negative effect on the log odds of a policy change promoting family responsibility.

But we might also pause to consider the party-family coding of the Irish parties, given that their classification is notoriously difficult. The traditional two major parties in Ireland were divided in the early twentieth century over their positions in the civil war. Fianna Fáil's main rival, Fine Gael, is a Christian democratic party in my dataset, because its strong Catholic identity and electoral base among religious voters means that Armingeon et al. (2020) classify Fine Gael as religious. My theoretical framework expects liberal and Christian democratic parties to compete in second-dimension conflicts, so governments led by Fine Gael should be more inclined to promote voluntary or family responsibility. However, Fine Gael has typically governed in coalition with the Labour Party, and since the 1980s has pursued a more liberal social policy programme (O'Malley

and Kerby, 2004). I included Ireland because of its distinctive electoral institutions and party competition environment. Unlike other liberal welfare states, it has proportional representation for most of the period that I study (New Zealand only introduced proportional representation in 1996). Removing the Irish policy changes altogether has no effect on most of the results, but the average marginal difference between liberals and social democrats on family responsibility for care drops just below statistical significance at the 90 per cent confidence level.

Let's now turn to examples of policy changes promoting family responsibility for the care of children. As we might expect from the strength of the liberals' preference for family responsibility above, the model predicts most of these types of changes made by liberal governments quite well. Four of the eleven changes by liberal governments are made in Ireland, with its relatively low female labour market participation and nationally-specific party competition environment.

The 'least likely' change by a liberal government on the basis of the model is the 2005 Foster Care Reform in Denmark. It was passed by the government of Anders Fogh Rasmussen, a coalition between *Venstre*, Denmark's liberal party, and the Conservative People's Party, with *Venstre* holding a majority of cabinet posts and the relevant portfolio for Social Affairs. This policy change came during a period of reform under the new government which began with changes to the legal framework in 2001, but didn't directly affect service provision until the 2005 decision came into force, principally responding to the pattern of rapidly growing expenditure on child welfare and child protection interventions (Hestbæk, 2011, p. 134). The 2005 policy change strengthened preventive care for children in their biological families, increased the threshold for child removals, and prioritised family-based foster care over residential placements to a much greater extent than in the similar countries of Sweden or Norway (Jensen and Petersen, 2012, pp. 81–82). The reform also prioritised the use of 'kinship care', by a member of the extended family, which was subsidised at a lower rate than existing forms of foster care. It was planned that the proportion of children in this cheaper form of alternative care would be tripled and overall expenditure on out-of-home care substantially reduced (Hestbæk, 2011, p. 134). This unexpected promotion of family care by a liberal government was then also strongly motivated by a desire to cut costs and reduce the the size of government spending, in line with what we would expect on the basis of liberals' position in socio-economic conflicts.

# Conclusion

In this chapter I tested my theory of the partisan politics of care, which is based on how the class and religious cleavages that structured the formation of major political parties shaped partisan preferences about who should be responsible for the care of dependent persons. The quantitative analysis shows that, controlling for important factors like economic conditions, welfare regime characteristics, and the availability of family care, government partisanship makes a difference for the types of care policy decisions that governments make. It is likely that growing fiscal pressure and changing scientific knowledge meant that changes promoting state responsibility were more common in earlier decades, and those promoting family or market responsibility were more likely later. But despite these period effects, in any given time and place partisanship still makes a difference for the type of care policy that is chosen.

In line with wider theories of welfare politics, it is clear that social democratic parties prefer state responsibility over all other types of governments, while conservative parties prefer private responsibility by the family or market, but parties of the centre and right also make distinct policy choices about provision by non-state actors. When compared with conservatives, Christian democrats are more likely to promote voluntary responsibility, and liberals are less likely to promote family responsibility. But liberals do also choose to promote family responsibility, especially in the area of child welfare policy. In the 'least likely' cases where liberals chose to promote family responsibility for care, they were motivated to do so by a desire to reduce government spending. This supports the idea that the motivations for promoting family responsibility are complex, reflecting either a preference *for* familialism or *against* state responsibility for care. It is among conservative parties, where both motivations are present, that the preference for family responsibility, relative to other types of parties, is strongest. Examples of policy changes indicate that Conservatives and Christian democrats introduce policies that actively promote family care, even if these come at a cost. This suggests that socio-economic conflict alone cannot account for partisan differences. Christian democrats' preference for voluntary responsibility, even controlling for welfare regime characteristics, also suggests that historical religious conflicts matter for shaping parties' care policy preferences.

The findings from this chapter demonstrate that multidimensional partisan conflict helps explain patterns in care policy change, but it's also clear that changes in fiscal pressure and scientific knowledge over time, as well as nationally-specific dimensions of party competition, each affect the choices that governments make. In this quantitative analysis, I controlled for these and other confounding factors somewhat crudely in order to test whether the general patterns in care policy choices met the expectations of my theory.

To more effectively address their effects in context, and further scrutinise the alternative explanation that the effect of partisanship might be driven by a single, socio-economic dimension of conflict, in chapters 5 and 6 I trace changes in care policy preferences over time in England and Germany. These two countries have different health systems and welfare regimes, different constitutional and electoral institutions, different types of major centre-right parties, and different experiences of deinstitutionalisation policy, as leader and laggard respectively. In these two very different countries, I show that both dimensions of conflict matter for explaining variation in the care policy decisions that were made, both over time and between countries.

# Chapter 5

# Mental health policy in England and Germany

The statistical evidence presented in the previous chapter suggests that the type of government in power mattered for care policy choices during the era of deinstitutionalisation. These patterns exist even after we control for the availability of family care, the economic and political-institutional context, and enduring structural features of welfare state regimes that could shape decisions about who should be responsible for care. The macro-causal approach adopted in the previous chapter allowed me to demonstrate that these patterns hold across a range of cases, but it also meant treating similar countries, similar political parties, and the policy decisions within each policy area as commensurable. In this chapter and the next, I investigate how multidimensional ideological conflict can help us understand partisan care policy decisions in a more context-specific manner by studying the process of deinstitutionalisation over time in two countries – England and Germany – in detail. This chapter deals with mental health services, and the following chapter with child welfare services.

The purpose of this comparative historical analysis is, on the one hand, to give confidence to the statistical results by providing evidence for the assumption that all parties supported deinstitutionalisation policy, and showing that my theory helps to account for patterns of policy change over time in two very different country cases. Evidence of agreement on deinstitutionalisation as a policy goal could include jointly-sponsored bills or expressions of support for policy goals. Politicians may also make direct statements about the apolitical or bipartisan nature of reforms. I expect

parties to agree on deinstitutionalisation policy, but disagree about who should be responsible for care outside of large, custodial institutions. There are no liberal-led governments in England or Germany during the period that I study (although the liberals in Germany often govern in coalition with a larger party), but we can assess their positions by examining the arguments that they make in the policy debates and their voting behaviour on bills.

On the other hand, these chapters also investigate whether we observe the types of conflicts that I expect to drive partisan policy choices reflected in the policy debates in parliament. Do social democratic parties justify their policy positions with arguments in favour of a larger and more redistributive state, and to what extent are these positions challenged by more residual arguments from parties of the centre and right? Do conservative and Christian democratic parties make familial arguments in support of their preferred policies and do liberals and social democrats counter these arguments with more individualist positions? What is the role and salience of these different types of arguments over time?

I interpret the arguments made by partisan actors as being more redistributive or residual, reflecting the two poles of socio-economic conflict, and more individualist or familial, reflecting different positions in second-dimension conflicts. I explained the origins of these conflict dimensions, and introduced the indicators that I use for different positions, in Chapter 2. *Redistributive arguments* defend higher levels of government spending and public-sector employment, and frame policy solutions as providing equal access and quality of services for all citizens. On the other hand, arguments in favour of a *residual* state promote lower levels of government spending, taxation, and public-sector employment, and frame policy solutions as being efficient or delivering services on the basis of need.

Individualist or familial arguments focus not on the size of the state in terms of spending and public sector employment, but rather on the scope of the state's reach into the family, based on competing ideas about how society should be organised: around individuals or families. *Familial arguments* frame the family as a natural site of care, and claim that people do better when they are cared for by their families, or that the independence of the family from state intervention should be preserved. On the other hand, *individualist arguments* claim that individuals do better when they are not dependent on family relations, or that individuals in need may not have families, framing the family not as a natural social unit but as

something constructed by, or dependent on, public policy.

The analysis is based on a close reading of parliamentary debates around policy changes that affected the use of institutional care in England and Germany between 1950 and 2015. The main empirical material are the legislative debates in the parliamentary chambers and the policy documents tabled for these debates. One limitation of studying parliamentary debates and documents is that the material reflects how parties justify their policy positions publicly, but it does not necessarily reveal their underlying motivations. But if this evidence of *what parties say* over time is consistent with the patterns in *what parties do* – that is, the policy choices that they make – this gives us greater confidence that the dimensions of conflict that I expect to drive policy decisions matter in these policy areas. I am also able to assess which, if either, of these conflict dimensions is more important over time.

For each policy change, documents from the early stages of the legislative process offer a view of parties' initial positions. I consult the introductory statements made on the bills' first readings – that is, when they are introduced to parliament – and the policy documents that offer a government statement on the aims of a bill: white papers in England and government statements (*Stellungnahmen*) in Germany. These debates and documents reflect the government's position before a piece of legislation has entered the committee phase, where representatives from the parliamentary parties deliberate. The main debates on bills in parliament occur at the bills' second and third readings, after the committee phase and before the parliament votes on whether to pass the legislation. Documents from these later stages reflect parties' positions after any necessary compromises have been made, and they typically include discussion of the amendments proposed by opposition parties during the committee stage.

The main debates occur the Bundestag in Germany, and in both the House of Commons and House of Lords in England, where legislation can be introduced in both chambers. I interpret the arguments made by representatives of different parties, and identify the conflicts around which there is greatest contestation based on the areas of bills with which most interventions are concerned. I use the indicators described above and listed in Chapter 2 to identify the types of arguments that speakers make to justify their policy positions. To confirm the positions taken by individual members in the chamber, I also consult party manifestos for the most recent election, as well as a wider range of parliamentary debates on, in the

case of this chapter, mental health care.[1] The documents consulted are listed in Appendix C.

The more contextualised approach in these chapters allows me to more directly address the alternative explanations discussed in chapter 3. Firstly, although I controlled for economic conditions and growing fiscal pressure over time in the quantitative analysis, here I am able to asses the extent to which potential cost savings were important in policy debates, and how parties debated the impact of fiscal pressure in context. If external economic factors were the driver of policy choices, we might find that political parties agreed on care policies that they believed would reduce costs. If parties disagreed and took different approaches under the same fiscal constraints, this would support the idea that partisanship played an independent role. Secondly, I address how expert knowledge entered policy debates. Were policy choices motivated by the prevailing scientific evidence at any given point in time, and did parties broadly agree on the implications of expert ideas? Or did different parties interpret and use the same expert ideas in light of their own ideological positions? Thirdly, I address how existing policy settings or wider structures of the welfare state may have shaped care policy decisions in a path-dependent fashion.

I begin this chapter with a brief historical overview of the existing services for people with mental illness in England, where the state was mainly responsible for care (although there was a small private sector), and in Germany, where a mix of public and voluntary services existed. The following analysis of parliamentary debates in England and Germany in turn shows that despite these different starting points, and a high level of bipartisan agreement on the goal of deinstitutionalisation, policy decisions taken over time to promote the responsibility of state, market, family, or voluntary providers for the care of people with mental illness were decisively shaped by the ideological positions of the governments that were in power. I provide strong evidence for my assumption that all types of governments agreed on the policy goal of deinstitutionalisation, and I show not only that the patterns of policy decisions align with my expectations about partisan policy preferences, but that all types of parties made some

[1] I select this wider material by searching for debates that mention the terms 'mental health', 'mental illness', 'psychiatry', 'psychiatric', 'mental hospital', 'community care', and 'outpatient', in English, and 'Psychiatrie', 'psychiatrische' 'psychische', 'Landeskrankenhaus','Versorgung', 'Pflege', and 'Institutsambulanzen' in German, reflecting the changing language used to describe these types of services and clients.

arguments that were more redistributive or residual, and individualist or familial, to support their policy positions.

Toward the end of the chapter, by comparing policy changes in England and Germany, I demonstrate how my theory of the partisan politics of care can help us understand not only variation in policy decisions within countries over time, but also the distinct positions of the centre-right parties across countries, comparing the Conservative Party in Britain with the Christian democratic parties in Germany and the main liberal parties of both countries. Finally, I assess the main alternative explanations, considering first growing fiscal pressure, the wider structure of the welfare state, and changing scientific knowledge, which I controlled for in the previous chapter. I also consider one alternative explanation for which I don't have any statistical proxy: the influence of lobbying from professionals, providers, and users or advocacy groups. I show that none of these factors can account for the relationship between partisanship and care policy that I find.

## Asylums to 1950

Before turning to the period that I study, it's important to consider the development of the asylums systems in England and Germany, and how existing policy settings may have shaped care policy decisions after 1950.

Ninteenth and early-twentieth century asylums in England were predominantly state institutions, run by regional- and central-government actors. Prior to the nineteenth century, so-called 'lunatics' in England were often assisted in poorhouses or private madhouses such as London's infamous Bedlam. From the beginning of the nineteenth century, the public system expanded following the County Asylums Act of 1845, which mandated the construction of county-managed public institutions (Jones, 1993a, pp. 17, 60). In the same year, a new Lunacy Commission gained greater regulatory oversight of private institutions. The public asylums grew rapidly in the second half of the nineteenth century, so that by 1890 more than two-thirds of the 86 000 people who were registered as 'insane' resided in county institutions (Ansell and Lindvall, 2021, p. 173).

In the early twentieth century, alternative forms of care had already begun to emerge in England, but the public asylum system remained the dominant form of care. From the 1930s, outpatient psychiatric clinics were developed in general hospitals. Recognised by the Board of Control as a

valuable preventive treatment at the end of the First World War, their expansion had been encouraged by the Mental Treatment Act 1930 (Jones, 1993a, pp. 127, 132, 136). Nevertheless, most psychiatry remained in the asylums, and outpatient clinics served fewer than 1 per cent of approximately 150 000 registered patients. A further 1–2 per cent of patients were 'boarded out' to families under guardianship arrangements that had existed since the eighteenth century (Board of Control, 1932).

When the British National Health Service (NHS) came into force in 1948, the asylums were centralised and transferred from the Board of Control to the Ministry of Health (Jones, 1993a, p. 144). New central funding improved facilities in asylums, and local authorities acquired permissive powers to deliver preventive and aftercare services, both contributing to the steeper rise in voluntary admissions after the war. Local outpatient facilities quickly returned to pre-war levels of service, but, rather than being expanded as caring facilities in their own right, they facilitated admissions to the mental hospitals (Board of Control, 1951, p. 3). Although aftercare services were only nascent by 1950, the ability of local authorities to provide extramural services under the National Health Service Act (they were not obliged but merely permitted to do so at this stage) became important context for future policy decisions to expand alternatives to institutional care.

Overcrowding became a serious problem in English asylums during the 1950s, as voluntary admissions continued to rise and an increasing number of older patients were being committed. The Board of Control reasoned that this was due both to an aging population and the decline in the alternative care of poor-law institutions with the coming of the welfare state (Board of Control, 1954, p. 4). Despite this, in 1961, experts from the Ministry of Health and General Register Office, Geoffrey Tooth and Eileen Brooke, published a study which predicted that bed requirements were likely to substantially decline in the coming decades, as a result of improved treatment methods (Tooth and Brooke, 1961). The Health Minister would refer to this advice when announcing the introduction of deinstitutionalisation policy in England that same year.

Asylums in Germany were also predominantly state institutions by 1950, but their administration had been more mixed to the end of the nineteenth century. Municipal hospices for the chronically ill, including the 'insane', emerged in Germany during the seventeenth century, in typically very poor conditions where approximately one in four women, and

one in three men, died (Eghigian, 2000, p. 128). While the voluntary sickness insurance funds developed hospitals for the treatment of physical illness in large numbers during the middle of the nineteenth century, the German asylum system remained more fragmented. Administration was often private, or sometimes by the local duke or municipal authority, and, with only about 50 public and 20 private institutions in operation, provision was far less extensive than in England (Scull, 2015, pp. 193–4).

Nineteenth-century asylums in Germany had nevertheless modernised and taken on a more healing quality than the previous arrangements for similar patients in the earlier hospices. They came to be called *Heilanstalten*, or *Heil- und Pflegeanstalten*, denoted as places of healing where the 'curables' were separated from the 'incurables' (Vanja, 2003, p. 131). Following the unification of Germany in 1871, the asylums also became formally regulated by the federal states (*Länder*). From the 1870s to the First World War, university psychiatry clinics emerged as much smaller, urban teaching institutions that were quite distinct from the asylums, typically located in rural areas (Engstrom, 2003, p. 4). Private institutions were initially much smaller, providing for just 3 per cent of the asylum population in the mid-nineteenth century, but they grew rapidly in number and size to serve more than a quarter of patients by the year 1900 (Engstrom, 2003, p. 18). Many patients in private asylums were housed at municipal expense as demand for services grew. 'Boarding out' was also used to save costs, with patients moved from asylums into the care of their families or foster families (Schmiedebach and Priebe, 2004, p. 456).

The state, at the regional level, began to play a much larger role in the provision of asylums late in the nineteenth century. To meet rising demand, 133 new public asylums run by the federal states (*Landeskrankenhäuser*) were built between between 1880 and 1913, with the number of patients rising from 40 000 to 240 000. High death rates during the First World War saw this number fall to 170 000 in 1919, before rising to around 300 000 – 1.8 patients per bed – in 1929 (Siemen, 2012, pp. 16–18).

The overwhelming majority of patients were already being treated in public institutions by the time the National Socialist regime took hold, and asylums continued to be regulated by the federal states. During this period, tens of thousands of psychiatric patients whose conditions were classified as heritable were forcibly sterilised under the 1933 Law for the Prevention of Hereditarily Diseased Offspring (*Gesetz zur Verhütung erbkranken Nachwuchses*), and over 100 000 people with mental illness who

were deemed 'incurable' were later murdered under the secret program, *Aktion T4* (Siemen, 2012). Many of the patients who survived died of starvation (Schmiedebach and Priebe, 2004, p. 462–3). The scale of death meant that in the immediate post-war era asylums in Germany were under capacity, but in extremely poor condition.

The reduced occupancy of asylums in post-war Germany may have contributed to its relatively late move toward deinstitutionalisation, with no major policy changes made until the mid-to-late 1970s. It was overcrowding above all else that had drawn the attention of public authorities to the 'asylum question' in England during the 1950s and 1960s (Hopper, 2000). The responsibility of the federal states for the public asylums (*Landeskrankenhäuser*) would also be important context for future mental health policy decisions.

# England

Deinstitutionalisation policy was first introduced in England in the early 1960s, following the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, published in May 1957. The commission's principal recommendation was that mental illness should be treated in the same manner as physical illness, and that mental hospitals[2] should work together with local authorities on prevention and aftercare to reduce admissions and increase discharges where possible (Lewis, 1957).

The first legislation to come out of the commission's report was the Mental Health Act 1959, which was primarily concerned with methods of patient committal and discharge rather than treatment or service organisation. Although the Act made it possible for patients to be treated in general hospitals and reinforced the permissive powers for local health authorities to provide preventive and aftercare services, no additional funds were made available so the provisions remained little used (Means and Smith, 1998, p. 31). The bill had bipartisan support, but the principal objection raised by the Labour opposition was that it remained concerned with the technical aspects of admission, rather than service provision, and did not place any duty on local authorities to provide services (Hansard HC, 26 Jan 1959, v. 598, cc. 724, 821). The Health Minister Enoch Pow-

[2]The term 'mental hospital' becomes widely used in England from the 1950s, to describe the institutions that had previously been know as asylums.

ell's 'water tower' speech of 1961 was the first government commitment to winding back the asylums (Jones, 1993a, p. 159), although the policy was not funded until the following year.

In this part of the chapter, I trace parliamentary debates around seven major policy decisions in England which affected the use of asylums, listed in table 5.1. We will see that changing scientific knowledge informed ongoing parliamentary commissions into the mental health services, and that fiscal pressures and cost-saving concerns were at the centre of many of the parliamentary debates. I will show that parties agreed on the goal of reducing institutional care, but disagreed about who should be responsible for providing alternative care. Government partisanship mattered for the types of care policy changes that were made, and government ministers and members of parliament from both the major parties justified their policy positions using arguments that were more redistributive or residual, and individualist or familial, reflecting their expected positions in socio-economic and second-dimension conflicts.

Most of the changes made, between 1970 and 1990, conform to my expectations about partisan care policy preferences, with Labour governments promoting state responsibility for care and the Conservatives opting for market or family responsibility. But book-ending these changes are two perhaps more unexpected choices. In both unexpected cases, a compromise was made by the governing party on one of the conflict dimensions, but consistent with their position on the other.

Table 5.1: Mental health policy changes in England

| Year | Leading Party (PM) | Policy type | Policy or legislation title |
|---|---|---|---|
| 1962 | Conservative (Macmillan) | Voluntary | Hospital Plan |
| 1970 | Labour (Wilson) | State | Chronically Sick and Disabled Persons |
| 1976 | Labour (Callaghan) | State | Better Services for the Mentally Ill |
| 1979 | Conservative (Thatcher) | Market | Finance (Personal and Residential Services) |
| 1983 | Conservative (Thatcher) | Family | Care in the Community |
| 1990 | Conservative (Thatcher) | Family | Caring for People |
| 2007 | Labour (Brown) | Market | Putting People First |

*Comments:* Table lists mental health policy changes made in England between 1950 and 2015, indicating the leading part of government and prime minister (PM), as well as the type of policy change according to the classification system used in Chapter 4.

### The Conservatives' Hospital Plan and the voluntary services

The first policy change, made by a Conservative government in 1962, increased the responsibility of voluntary providers for the care of people with mental illness. The government encouraged local authorities to expand preventive and aftercare services under their existing permissive powers, but the funding mechanism incentivised the provision of care by voluntary bodies rather than the state. In early March 1961, at the Conference of the National Association for Mental Health, Health Minister Enoch Powell announced a plan to reduce capacity in mental hospitals by 50 per cent by the mid-1970s. Powell referred to the projections published by Tooth and Brooke (1961), and called on local authorities to participate in planning and building capacity to 'progressively accept responsibility for more and more of that care of patients which today is given inside the hospitals' (Powell, 1961).

The Labour opposition agreed with the general goal of deinstitutionalisation, but they had concerns about the pace of the process and disagreed with the government's technical justification. Raising the matter in the House of Lords the following month, the Labour Party's Lord Stonham called Powell's speech 'disastrous' and claimed it was based on the 'dangerous nonsense' that the demand for mental hospital beds would be halved within 15 years (Hansard HL, 26 Apr 1961, v. 230, c. 852). Stonham commented that, 'I know it is desirable to return mental patients to the community – wholly desirable, when safe to do so' (ibid, c. 867).

On 23rd January the following year, the Hospital Plan command paper was published to give effect to the new policy. It proposed a reorganisation of hospital services that was wider than psychiatric hospitals, but the most dramatic transformation was made of the mental health services. At first glance, the policy change would shift responsibility from the central government, which was responsible for funding and staffing the NHS asylums, to local authorities. Treatment for mental illness would be transferred into smaller clinics within or adjacent to general hospitals, and to local authority community-based services, so that 'there would be no place for many of the existing mental hospitals' (National Health Service, 1961, p. 8). The hospital building programme had been announced in the Conservative Party election manifesto for 1959, which stated that 'local authorities [would] be encouraged to develop their health and welfare services' (Conservative Party, 1959).

But when the Hospital Plan was realised, local authorities would not be expected to manage these services themselves, or take direct responsibility for the long-term care of the chronically mentally ill. The government aimed for a 'notable increase in the amount of home care' enabled by the new services, and the involvement of voluntary organisations in the provision of those services was framed as 'indispensable' (National Health Service, 1961, pp. 11–12). A large part of new residential accommodation for the elderly at the local authority level was already being delivered by arrangement with voluntary organisations (National Health Service, 1961, p. 11), and local authorities had been encouraged in a 1949 circular to work with voluntary agencies to provide occupational clinics for people with mental illness under their National Health Service Act aftercare powers (Welshman, 1999, p. 208).

As part of the consultation phase for the Hospital Plan, Powell had distributed circulars to the local authorities that urged them to expand the opportunities for voluntary services, and held a conference to coordinate the work of hospital authorities and local authorities with voluntary bodies (Hansard HC, 4 Jun 1962, v. 661, c. 98). In the debate on the Hospital Plan white paper in the House of Commons in June, the Minister made the objective of the Hospital Plan vis-a-vis the voluntary providers clear:

> This work of planning ahead for the community services provides for the first time the means of systematically extending the scope of the voluntary contribution to health and welfare (ibid, c. 158).

Although the two major parties agreed on the goal of reducing institutional care, they disagreed about who should provide the alternative services. When the Hospital Plan had first been debated in the House of Lords, Labour envisioned that the local authorities would become responsible for providing services directly, but argued that without adequate funding for staffing, 'the Plan would mean a crippling reduction in services' (Hansard HL, 14 Feb 1962, v. 237, cc. 517–21). They called attention to the lack of planning for staffing, in particular for psychiatrists and psychiatric social workers (ibid, c. 485). Concerns about the lack of operational funding were later raised in the House of Commons. Labour's Llewelyn Williams, who had served in the Committee on the Mental Health Bill, suggested that Powell's plan 'just [could] not succeed unless the local authorities are given resources' (Hansard HC, 4 Jun 1962, v. 661, c. 79). Williams argued that it was 'in line with Conservative philosophy' that

the redundant mental hospital facilities might fall into the hands of private providers (ibid, c. 80). Labour members repeatedly argued that voluntary providers would attract talent from the public sector, reducing both the size and the quality of public services (ibid, cc. 66, 80, 148, 159).

Labour's position that public authorities should be directly responsible for providing services was clear. Labour member Kenneth Robinson – who was also a former chairman of the National Association of Mental Health – had earlier been critical of the Mental Health Act 1959 for its inaction on services and lack of funding for local authorities, both publicly and in parliament (Robinson, 1959; Hansard HC, 26 Jan 1959, v. 598, c. 771). In concurrent debates on legislation concerning social-worker training, Labour peers in the House of Lords proposed an amendment to commit funding toward training to enhance local authority capability, but the government rejected the proposal (Hansard HL, 24 May 1962, v. 240; 26 Jun 1962, v. 241; 4 Jul 1962, v. 241). The Labour Party had actually attempted to have the Regional Hospital Boards written into the Mental Health Act 1959 as being responsible for planning and training staff for community services (Hansard HL, 26 Apr 1961, v. 230, c. 854). In the debates on the Hospital Plan, Robinson argued that, 'so long as the government remain determined that no Exchequer moneys are to be made available to local authorities specifically for the development of community services, or to social worker trainees... the expansion of these services in many areas will be almost imperceptible' (Hansard HC, 4 Jun 1962, v. 661, c. 55).

The disagreement between the Conservative and Labour parties about whether local authorities or voluntary organisations should take responsibility for care appears to have been much more strongly connected with socio-economic conflict than second-dimension concerns. The Hospital Plan provided capital funding to establish new facilities, but no operational funding for staff, instead encouraging local authorities to work with voluntary providers. Shifting responsibility for the provision of care to voluntary organisations implied lower public liability for ongoing operating costs. The government did not directly make residual arguments (those in line with a smaller state) to justify its Hospital Plan, but reducing state expenditure at the local level was part of its broader policy platform. Concerning all questions of ongoing finance, the Conservatives deferred to the position that local authority services could be funded from the block grants system established in the Local Government Act 1958. The Minister for Housing and Local Government described the block grant system as 'a

sounder system of local government finance which will make every local authority more anxious than ever to obtain value for money' (Hansard HC, 8 Dec 1958, v. 597, c. 37). This reading of the Conservatives' position is consistent with the argument by historian Kathleen Jones that the Hospital Plan was an opportunistic move to cut costs by a Conservative government that was committed to tax cuts, and a Health Minister who was a self-professed monetarist (Jones, 1993a, p. 159).

The arguments of the liberal members of parliament are consistent with what would would expect in terms of their position in socio-economic conflicts. The Liberal Party held just six seats in the parliament at this time and were not active in these policy debates. But the National Liberals, who had split from the Liberal Party in 1931 and been in a loose alliance with the Conservative Party since the 1950s, were supportive of the government funding strategy, making residual arguments in favour of voluntary sector responsibility. They argued that the expansion of community services should not result in local ratepayers bearing the costs of services, as they would do if local authorities took direct responsibility (Hansard HC, 4 Jun 1962, v. 661, c. 111).

Second-dimension arguments were not, however, absent from mental health policy debates during this period. The Conservative government justified the transition from mental hospitals to community-based services with more familial arguments, with Powell for instance arguing that assistance should be 'brought to the service of the patient as an individual and as a member of his family and social environment' (Hansard HC, 4 Jun 1962, v. 661, c. 158). This was consistent with the Conservative Party's position in earlier debates on the Mental Health Act 1959, where they argued that in the first instance, families should provide care to patients who no longer needed to be hospitalised, but that local authorities could arrange services in the event that families were unable (Hansard HC, 26 Jan 1959, v. 598, c. 721). At that time, Labour politicians had made more the individualist argument that public aftercare services should more pro-actively intervene to protect families (ibid, c. 722). They suggested that families could not be primarily responsible because 'we must not impose a strain on the family... we must attempt to adjust the family and the patient and be prepared to relieve the family' (ibid, c. 733).

Based on their familial arguments, and the statements in the Hospital Plan white paper that the new community services should ultimately allow more people to receive care in the home, why did the Conservatives chose

to encourage the development of voluntary services rather than incentivising family-based care? On the one hand, it is necessary to qualify that although the Hospital Plan finance scheme encouraged local authorities to work together with voluntary providers, the community-based services were broadly defined and could include domiciliary support services as well as residential homes. They certainly did not aim to preclude the expansion of increased family responsibility, and local authorities had the ability to fund social services through council rates.

But the decision appears to have been primarily motivated by a desire to limit the responsibility and the size, in terms of spending and personnel, of the state. By harnessing the existing permissive powers of the local authorities and the existing relationships between local authorities and voluntary providers in other social services, the Hospital Plan for the mental health services could reduce costs. The Ministry of Health had struggled to design a capital programme for general hospitals during the 1950s, in part because the majority of the agreed capital allocation was being used to upkeep and expand existing mental hospitals (Mohan, 2002, p. 105). The government therefore had pressing fiscal reasons to limit state responsibility for mental health care. But in the following decade, under increasingly severe economic constraints, successive Labour governments would nevertheless expand local authority capacity. The 1970s would be a time of significant bipartisan agreement on mental health policy, but nevertheless the partisanship of government made a difference for the extent to which the state – acting through local authorities – took responsibility for the care of people with chronic or severe mental illness.

## Labour in power and state responsibility at the local level

After thirteen years of Conservative rule, the Labour Party took power at the 1964 election with an ambitious plan for economic modernisation and investment in social policy. Under the leadership of Harold Wilson and James Callaghan, the Labour governments of the late 1960s and early 1970s would continue the policy of psychiatric deinstitutionalisation alongside a significant reorganisation of the health and social services.

It was not until the end of Wilson's second term that the first change to mental health policy was made, in 1970. Important context for the decision was the final report of the Committee on Local Authority and Allied Personal Social Services, chaired by Lord Frederic Seebohm and published in 1968. The Seebohm Report recommended the creation of a

social services department in each local authority where health, family, and personal social services could be jointly coordinated. These social services included care services both for people with mental illness and children who could not be cared for by their parents. Although a landmark piece of legislation from an administrative point of view, the Local Authority Social Services Act 1970, which implemented this main recommendation of the Seebohm Committee, did not make any direct changes to mental health service provision. The bill found support on both sides of the house, with the government also taking the opportunity to include the centralisation of social-worker training under a new national council, a policy that they had pressed for during 1962.

In the same month, another widely supported bill passed through Westminster, but bipartisanship on this occasion was more surprising. The Chronically Sick and Disabled Persons Act broke with the existing provisions, under the National Health Service Act 1946 and Mental Health Act 1959, that had given local authorities permissive powers to provide preventive and aftercare services. The new law would instead *compel* local authorities to provide services to the chronically mentally ill, and establish further central finance to for these activities. This was entirely consistent with the Labour Party's position between 1958 and 1962, that local authorities should be funded to directly provide new care services.

Introduced into the House of Commons in November 1969, the Chronically Sick and Disabled Persons Bill enjoyed such wide support in the parliament that, with limited amendments proposed by the Lords, it passed quickly back through the Commons on its third reading without debate. In the House of Lords, the main point of contention was the lack of a definition for chronic illness, on the basis of which services could be allocated. Conservative politicians made residual arguments in favour of a tighter definition. They were particularly concerned that resources should not be spread too widely, but rather they should be allocated on the basis of need (Hansard HL, 9 Apr 1970, v. 309, cc. 262; 265-6). Liberal Party members also made residual arguments with respect to local authority domestic help, arguing that 'there must be an overall saving if the introduction of such devices into the home were to defer sending a person into an institution' (ibid, c. 304).

It was perhaps the context of these debates, on the eve of the 1970 election, that meant the issue was not high enough of a priority for the Conservatives to seriously challenge Labour's expansion of the duties of

local authorities. But when Edward Heath's Conservative government took power in June 1970, they attempted to limit the cost of the Labour government's policy change by restricting local authorities' awareness of the new funding mechanism. The Conservatives delayed the implementation of the Act, which was planned to come into force in August. The Labour Party accused the government of having failed to either publicise the availability of further finance, or make the eligible population aware of the new services (Hansard HC 18 Dec 1970, v. 808, cc. 1790–2).

Labour members repeatedly questioned the government about the lack of progress on the Act, before the matter was finally addressed in the Lords just three days before the anniversary of its assent. The government instead announced a loan scheme for local authorities and made residual arguments to defend the new funding mechanism, suggesting that 'a relatively small expenditure of ratepayers' money to assist a disabled person to live in his own home is preferable to the much larger cost to the taxpayer of maintaining him in hospital' (Hansard HL, 26 May 1971, v. 319, c. 1167). They argued that the change would produce 'a very large net saving of money' (ibid). Around the time of the 1970 policy change, then, it appears that conflict between the two parties was still mainly socio-economic.

After the 1974 election saw another change of government, James Callaghan's Labour set out to further expand the role and capabilities of local authorities with regard to mental health care. Their election manifesto had made a specific commitment to investing in 'the community care services run by the local authorities, the most neglected of all the health services', including grants to bring hostels for people with mental illness up to standard (Labour Party, 1964). But the conditions for policy change were trying. The government was in the middle of implementing the National Health Service Reorganisation Act of 1973, which integrated the mental health services into the wider NHS and established Regional Health Authorities which were to collaborate with local authorities. In the aftermath of the 1973 oil crisis, unemployment was rising steadily while inflation was at over 20 per cent. The key issues in mental health policy debates had also shifted.

The mental health policy debates of the 1970s had become increasingly concerned with the treatment of people with mental illness who were detained for the protection of the public. In 1972, the Department of Health and Social Services (DHSS) began work on a review of the mental health services, and a Committee on Mentally Abnormal Offenders was

established to consider the legal recognition of mental illness and the appropriate treatment for people with mental illness who had been accused or convicted of crimes. Both delivered their final reports in 1975, the same year that the National Association for Mental Health, by then known as MIND, published its own report, *A Human Condition* (MIND, 1975). There was bipartisan support for enabling people with mental illness who did not pose a danger to others to live outside of mental hospitals, and providing secure hospital accommodation for those who were considered dangerous or had committed crimes. But policy change was constrained by the economic climate and political uncertainty.

This context contributed to a focus on minor policy adjustments with limited fiscal implications. On 1st May 1975, a Mental Health (Amendment) Act was passed which made minor changes to the Mental Health Act 1959 concerning the duration of compulsory detainment for the 'dangerous' mentally ill. The legislation made no changes to service provision, but while the bill was being debated, members on both sides of the House of Commons anticipated a wider debate on the mental health services that would follow the publication of the DHSS's final report and the government's white paper (Hansard HC, 27 Mar 1975, v. 889, c. 762). The white paper that was released in July 1975, *Better Services for the Mentally Ill*, was carefully framed as a strategic document that did not set out a specific policy programme, primarily because of ongoing budget constraints (The National Archives of the United Kingdom (TNA), CAB 129/184/10, 22 Jul 1975).

During this period, second-dimension concerns were increasingly raised by the Labour Party in debates on mental health policy. The *Better Services for the Mentally Ill* white paper made clear the Labour government's views on the role of the family. It made more individualistic arguments in favour of public responsibility for care in institutions for those who required it, and for those who did not, care in the community in the shape of short-stay and day-time care facilities to relieve families of the burden of care. The policy was framed as mitigating the negative social consequences of a reliance on family care:

> Living with people who have had or who are recovering from mental illness can place heavy strains on a family... the family can rapidly become socially isolated... they too may become virtually housebound, often giving up sources of income and interest (DHSS, 1975, p. 11).

The role of smaller group homes and day-care facilities was to 'relieve the strain on the client's family' (ibid, p. 52). A second justification given for public responsibility was that those who had been institutionalised, especially for long period of time, often had difficulty resuming family relationships or had lost their family ties (ibid, pp. 10, 49, 57).

Despite the earlier calls for a debate on the white paper itself, the subject of the mental health services was not given priority in parliament until the debates on the 1976 Budget Supply Bill. The government had proposed joint financing arrangements which would allocate central government operational funding for local authorities to expand extramural mental health services. This funding directly increased public provision of alternative care services, promoting the responsibility of the state.

In the debate, the Conservatives pressured the government to 'speed on' with changes to mental health services, evidence that both major parties supported deinstitutionalisation policy (Hansard HC, v. 904, 26 Jan 1976, c. 34). But they emphasised that public funding should be prioritised for secure units for dangerous offenders, and that the provision of extramural services should be left to private initiative, with the local authorities playing more of a coordinating role (ibid, c. 33). These secure units, while they replaced capacity in existing mental hospitals, could arguably be seen less as care policies than a form of incarceration for people who had committed crimes but required treatment for mental illness. That is, their social function was not to substitute for family care, but primarily a form of punishment under criminal law. Both Labour and the Conservatives supported state services to fulfil this role, but the Conservatives did not support new, publicly provided care services for people with mental illness.

Dr Gerard Vaughan, a medical doctor who had served as chief whip in Heath's Conservative government until 1974, spoke with authority on the opposition's stance:

> Local authorities should see themselves much more as identifying needs, showing people locally what should be done and how to organise themselves to do it, and then leaving other bodies, particularly the voluntary organisations, to get on with it (ibid, c. 32).

In this debate, both the government and opposition described a role for voluntary providers, but neither suggested actively expanding voluntary provision by increasing subsidies to these groups. Labour politicians depicted the voluntary services as an important supplement to public provision, particularly under the present fiscal conditions. They suggested

that voluntary organisations could 'relieve hard-pressed social service departments from at least some demands on their time' (ibid, c. 46).

But Labour politicians also expressed concern at the Conservatives' openness to *any* type of private initiative, including provision by for-profit providers. They described fears of 'a new class of Mr. Bumbles who have discovered that there is money to be made out of sick people in a certain category – the mentally ill' (ibid, c. 84). Labour members also criticised the focus of opposition on the provision of secure units (ibid, c. 95).

The Labour government prioritised public services, resulting in a relatively small expansion of services in light of the economic conditions. The joint financing agreement was eventually approved and 21 million pounds made available to local social service departments for new services. But the discussion on mental health policy was overshadowed by the wider debate on public expenditure, deepening economic crisis, and political instability. Within the Labour Party, factional conflict over the level of spending contributed to Wilson's resignation in March 1976, and the new Prime Minister James Callaghan was forced to take an International Monetary Fund loan that was conditional on substantial spending cuts.

The government began a review of the Mental Health Act 1959 to support more extensive change, beginning consultation in August 1976 and introducing a bill in late 1978. Although there was bipartisan support for further action on deinstitutionalisation, the reform would not be passed. The second-reading debate was held the following February, with subtle reference made in the Commons to 'parliamentary uncertainties' (Hansard HC, 2 Feb 1979, v. 961, c. 1847). In the intervening months, Callaghan's minority administration had endured a dramatic slump in public approval during the 'winter of discontent', when widespread strikes interrupted business and basic public services in the midst of bitterly cold and stormy weather. The debate took place just weeks after the largest single day of strike action in living memory, and one month before the controversial referendum on Scottish devolution that would ultimately lead to the Scottish National Party's withdrawal of support for the government and a successful motion of no confidence brought by Margaret Thatcher's opposition.

### Market and family responsibility during the Thatcher years

Following the March vote of no confidence, the Conservatives won a parliamentary majority in May 1979. During the Thatcher years, the level of bipartisan agreement on mental health policy declined as socio-economic

conflict between the two major parties intensified, and second-dimension concerns about the role of families – and in particular, women – in providing informal care were also increasingly raised.

The Conservatives' June budget made sweeping cuts to local authority operational funding which was set to affect the provision of the local authority mental health services. The budget also introduced a new funding stream which would fully compensate private mental hospitals for care, including for-profit institutions. This policy change is widely considered to have promoted the expansion of new for-profit residential services as an alternative to public care (Means and Smith, 1998, p. 50; Busfield, 1998, pp. 21–2; Walker, 1997, p. 199). When the Finance Bill was debated in the House of Commons, the Conservatives referred to the need to address mental health problems as a 'non-controversial' subject that would 'find great support and sympathy throughout the House', reflecting bipartisan agreement on the goal of deinstitutionalisation (Hansard HC, 27 Jun 1979, v. 969, c. 517–8). However, in contrast with earlier Labour policy documents, they described a role for government that was primarily focussed on investment in research rather than care services (ibid, c. 519).

The Labour opposition were strongly against market provision, and in ongoing debates they expressed a clear preference for public services, with voluntary, not-for-profit services depicted as a second-best alternative that should still be supplemental to public care. The government quickly came under pressure from Labour politicians, who questioned the Secretary of State for Social Services, Patrick Jenkin, about the growth of the private sector and the conditions of care that profit-oriented providers were offering (Hansard HC WA, 26 June 1979, v. 969, c. 160; HC, 5 Dec 1979, v. 975, cc. 495, 527–8). The Labour Party attempted to vote down the budget cuts that they argued would reduce the provision of public services at large, and personal and residential care services in particular (Hansard HC, 17 Jul 1979, v. 970, cc. 1392–95, 1403–4).

The 1979 policy change promoted private provision in the context of a 3-per-cent reduction in real expenditure on social services. The Conservative government stressed that this was not a policy of reducing mental health services, but rather expanding the role of new, more efficient providers in service delivery. Arguments in favour of a smaller, more residual state were also made in a letter that Jenkin sent to MIND, in which he wrote, 'where we differ from previous governments is not in our policies for the mentally ill and for the mentally handicapped but in our overriding determination

to secure substantial retrenchment in public expenditure' (Hansard HC, 19 Dec 1979, v. 976, cc. 683–684).

Redistributive conflict was at the centre of the debate between the two major parties in 1979. The Conservatives prioritised lowering expenditure, while Labour argued in favour of a strong public-sector workforce. The Conservatives saw the for-profit sector as a viable alternative to public services for developing the smaller-scale residential and outpatient services that the previous government had envisioned in its white paper *Better Services for the Mentally Ill*, while simultaneously decreasing public expenditure. The Labour opposition was against market responsibility for care because they doubted the quality of services that would be delivered by organisations with a profit motive, and because the private sector would drain skilled workers from the public system.

While the Conservatives expressed a clear preference for market responsibility, and Labour for state responsibility, neither party was opposed to provision by the voluntary services. When in government, Labour had depicted voluntary services as providing supplementary support to core public services, and when in opposition members of the party depicted the voluntary sector as a second-best alternative that was preferable to for-profit provision. Although the Conservatives' 1979 policy change expanded market providers, their funding scheme did not in principle exclude not-for-profit providers. Their preference was simply for services that were most competitive on cost.

During the 1980s second-dimension concerns were increasingly raised in mental health policy debates. It had already been clear in the Labour Government's 1975 white paper that they saw public services as relieving families of the burden of care, but during the second half of the 1970s the Conservatives had not made any arguments about the role of the family in mental health policy debates. This would change when they developed their own policy of 'care in the community', where greater emphasis was placed on the responsibility of individuals and their families. In July of 1981, the government released a white paper, *Care in the Community*, which argued that 'care in the community must increasingly mean care by the community... individuals helping themselves and their families' (DHSS 1981, p. 3).

Debates on the white paper had already begun as a narrow Mental Health (Amendment) Bill was progressed through parliament in 1982. The government framed it as an apolitical legislative change which did not deal

directly with the provision of care, but rather the limited legal aspects of patients' rights and protections on which all parties agreed: that people should only be detained in a mental hospital if their condition was 'treatable, that treatment against patient consent should be strictly limited, and that patients should have greater access to legal defence of their rights' (Hansard HL, 1 Dec 1981, v. 425, c. 935).

There were relatively few liberal politicians in parliament at this time, but they did weigh in on the debate. In 1982 the Liberal Party was working closely with the Social Democratic Party (SDP), and they were collectively known at election time as the Alliance, precursor to today's Liberal Democrats. The SDP had been formed after the resignation of the 'gang of four' Labour politicians, including former Minister of State for Health and Social Security, David Owen, in early 1981. In the debate on the Mental Health (Amendment) Bill, the Liberal Party supported the Conservative government's commitment to providing secure units, but opposed more extensive public commitments. But they also made a more individualist argument that suggested people with mental illness 'will be cured only when they are able to go out into the community and respond from their own selves' (Hansard HC, 22 March 1982, v. 20, c. 748).

Labour politicians also made individualist arguments, but used them to defend far more extensive public responsibilities. Members were concerned that the emphasis of the *Care in the Community* white paper on family responsibility would lead to an under-provision of services. This was consistent with the party's earlier position that individuals discharged from hospital often had few family ties and that those who did would place a burden on families that could lead to negative social consequences (ibid, c. 758). Consistent with their redistributive preferences, Labour politicians spoke in favour of an expansion of the public-sector workforce. While acknowledging that the bill was a step in the right direction, they argued that it must be coupled with a commitment to fund the training of social workers and 'the creation of an efficient social-worker workforce' (ibid, c. 699–700).

Workforce concerns were also at the centre of debates at the Mental Health (Amendment) Bill's third reading, where the shift to a more competitive partisan dynamic is evident. Whereas most mental health legislation to this point had been agreed through compromise within the parliamentary committees, in late 1982 disagreements between the government and opposition spilled into parliament. In an uncharacteristically

lengthy debate that ran through the night, the atmosphere of bipartisan support was shattered as members of parliament referred to the conflicting views held by the 'two different sides' of the committee (Hansard HC, 18 Oct 1982, v. 29, cc. 44, 50, 51). In line with promoting state responsibility for care, the Labour Party was committed to investing in more publicly employed social workers and expanding their statutory role, but their proposed amendments were defeated as the Liberal Party voted with the government.

Over the winter, the Mental Health (Amendment) Bill 1982 was incorporated into the existing legislation to form the Mental Health Act 1983, and in late spring an election was called, where the Conservatives stormed to a landslide victory.[3] The party's manifesto made clear commitments on community care and deinstitutionalisation. The section on public services, including the NHS and care policy, was entitled 'Responsibility and the Family', in line with the second of the Conservatives' five priorities 'to build a responsible society which protects the weak but also allows the family and the individual to flourish'. Here, the party promised to 'continue to return more choice to individuals and their families' (Conservative Party, 1983, p. 24). A more familial argument presented the family as the natural and most desirable site of care, stating that 'helping people to stay in familiar surroundings is the aim of our policy Care in the Community' (ibid, p. 28). The manifesto also made arguments against an active role for the state: 'Conservatives reject Labour's contention that the State can and should do everything... We shall promote closer partnership between the State and the private sectors' (ibid, p. 28).

During 1983, the government began to accelerate its hospital closure programme, while the Labour Party argued that closures were taking place before alternative services were provided, and that people could not rely on family care (Hansard HL, 29 Nov 1983, v. 445, c. 660; 4 Dec 1985, v. 468, c. 1314). The Conservatives more familial arguments to justify their policy, describing being 'discharged to home and family' as 'the most natural form of care in the community' (Hansard HL, 29 Nov 1983, v. 445, c. 679 ).

In the last months of Thatcher's prime ministership, the Conservative government would make another policy change to expand family respons-

[3]The SDP-Liberal Alliance had attracted 25 per cent of the popular vote, drawing large numbers of voters from the increasingly left-leaning Labour party, who saw their worst electoral performance since 1918.

ibility for care. The policy was informed by expert advice from a businessman, Roy Griffiths, who had been brought in to report on the managerial structure of the NHS. But Griffiths' main recommendation – to expand subsidies for voluntary and market providers of community care services – was opposed by both the government and the opposition. Both parties expressed their concerns in ways which reflected their socio-economic ideologies: Conservatives wanted to avoid increased spending, while Labour opposed private provision on the basis of equity concerns. But in the debates over the policy solution that was proposed instead, second-dimension arguments were equally prominent.

Griffiths' report on community care, published 1988, argued that the joint-financing arrangements for residential services which had been established by the Labour government in the 1970s had lead to an underutilisation of home-based or domiciliary assistance which was funded by the local authorities. The proposed solution was to make local authorities responsible for the entire budget and to expand the subsidisation of voluntary and private care providers. Griffiths was Thatcher's advisor, but his recommendation to increase local authorities' budgetary control and expand the level of funding available was so unpopular among government ministers that they initially tried to bury the report (Timmins, 2001, ch. 19). The 1989 white paper, *Caring for People*, and the resulting National Health Service and Community Care Act 1990 implemented many of the Griffiths Report's recommendations, with the notable exception of expanded subsidisation. Rather than expanding the subsidisation of care by private providers, the Act introduced a process for allocating assistance which would prioritise domiciliary support and promote care by the family. The psychiatrist Graham Thornicroft recalled that, 'a clear intention of the changes was to enable care managers to buy domiciliary support, rather than residential care where this was both more appropriate and inexpensive' (Thornicroft, 1994).

In anticipation of the government's white paper, a general debate on community care took place in the House of Commons in October, where the government stated that the bulk of community care would be provided by the family, and Labour and Liberal Democratic Party politicians made more individualist arguments against the reliance on informal care.[4] Conservatives made both residual and familial arguments, framing family care

[4]The Liberal Party had formally merged with the SDP in 1988 to form the new Liberal Democratic Party.

as ‘certainly the cheapest’ alternative, but also the option which upheld ‘the sense of duty that every family should feel towards its elderly or less fortunate members’ (Hansard HC, 17 Oct 1989, v. 158, c. 96).

Liberal members expressed concern that the policy on community care should not stand in the way of increasing the participation of women in the workforce, and that caring responsibilities should be duly compensated (ibid, cc. 61–2). The deputy leader of the Liberal Democrats in the House of Lords explained that ‘the burdens put on the members of the family may prove to be quite intolerable’ (Hansard HL, 29 Nov 1989, v. 513, c. 458). But while Liberal Democrats sided with Labour Party politicians on the strain that informal care placed on the family, making more individualist arguments in favour of formal care services, the two parties disagreed about how support services should provided. Labour favoured increased funding for local authority services, while the Liberal Democrats argued that local authority services would be too expensive, and that even local authority control over the contracts for voluntary and for-profit services would reduce the efficiency of service provision.

Familial arguments were made throughout the *Caring for People* white paper. The foreword commenced by stating that ‘the greater part of care has been, is and always will be provided by families and friends’ (Department of Health, 1989, p. iii). The ‘vital’ role of the ‘informal carer’ was repeated throughout (ibid, pp. 4, 5, 9, 83, 92). In parliament, the Conservatives made also residual arguments which called for the responsible use of existing resources, allocated on the basis of patient needs. They defended against the opposition’s calls for additional funding for local authority services, arguing that ‘the money has too often been spent by the wrong people in an inefficient way or on the wrong things’ (Hansard HC, 7 Dec 1989, v. 163, c. 547). This echoed their wider position on community care, expressed in the government’s Response to the Second Report from the Social Services Committee in 1985. There they had argued that ‘the aim [was] not to save money; but to use it responsibly’ (Department of Health and Social Security (DHSS), 1985, p. 2).

The environment for compromise heading into the committee stage was poor, as the white paper had been published less than a week before the bill was introduced (Hansard HC, 22 Nov 1989, v. 162, c. 116). At the second reading, Labour made more redistributive arguments as they criticised the government for their focus on cost savings (Hansard HC, 7 Dec 1989, v. 163, c. 542). The opposition were strongly opposed to the

internal market for care services that was proposed, on the basis that this would increase the role of private providers. One party member argued that 'the motivation behind [the bill] is financial and ideological', and that 'market forces do not lead to improved quality' (ibid, c. 559).

The Labour Party also made individualist arguments against the priority placed upon familial care. They highlighted 'the army of carers who are being exploited and overstretched' and argued that, 'there should be a commitment to seeking out carers, easing their burden, and recognising that they should not be pushed to the point of total exhaustion' (ibid, c. 543). As the debate continued, Labour members argued that 'changes in the pattern of community care are likely to affect women disproportionately. There is a danger that many women will be trapped into providing care for relatives and become a support safety net' (11 December 1989, v. 163, c. 708). Labour described the policy as 'a direct attack on the quality of life of many women in society, as women make up the vast majority of paid and unpaid carers' (ibid, 729–30).

The government made no compromise on their position to prioritise family care and restrict funding. Following a long first day of debate on the committee amendments at the bill's third reading, the government introduced timetable motions to restrict discussion in both the House of Commons and the House of Lords (Hansard HC 15 Mar 1990, v. 169, c. 494; Hansard HL, 18 Apr 1990, v. 518, cc. 1240–41).

Over the course of three terms, Margaret Thatcher's Conservative government had shifted responsibility for the care of people with mental illness away from the state and toward both the market and the family. Immediately upon entering government, they reduced the funding available for local authority hospices, and expanded subsidies for private, for-profit providers. They then increased the responsibility of the family for providing care, first by downsizing and closing hospitals and discharging patients into the guardianship of their families, and then by introducing regulations which forced local authorities to prioritise informal care and domiciliary assistance over care outside of the home for new patients. During this period, while socio-economic ideology remained important, second-dimension conflicts became much more salient in mental health policy debates. The Conservative government made more familial arguments about the fundamental role of family care givers and both the Labour Party and Liberal Democratic Party made more individualist arguments that the burden of care should not be placed upon families and, in particular, working women.

### New Labour's market turn

The Conservatives' hospital closures had continued during the early 1990s, and by the time Labour came to power in 1997, there was both growing concern about the level of care that was being provided to people with chronic or severe mental illness, and an increased political salience of the long-term care needs of a broader group of clients. In this context, which was arguably more favourable to new investments in mental health services, Tony Blair's Labour government would not increase direct provision of public mental health care services, but instead acted to expand the role of market providers in the name of patient choice.

The context of the late 1990s was favourable to new investments in mental health services. There had been a number of high-profile deaths from injuries inflicted by people with diagnosed mental illness during the term of the previous Conservative government, with media reports suggesting that the Conservatives were reluctant to provide public funding for new 'asylum-like' 24-hour care homes (Timmins, 1996). Labour had long opposed the Conservative government's policy of Care in the Community, speaking out against the speed of hospital closures and market-based alternatives in particular. The Labour Party made long-term care for people with mental illness and other needs a priority going into the 1997 election, making a manifesto commitment to improving community care under the policy area that they labelled 'older citizens' (Labour Party, 1997). People with long-term care needs as a result of mental illness were now included with a larger group of elderly clients with long-term care needs. Reflecting the new political saliency, a Ministry of State for Care Services was created within the Health Department, and in 2003 an independent Commission for Social Care Inspection was established.

During this period, the government and opposition collaborated on new legislation that was opposed by some of the main professional and providers' associations, as well as users' and advocacy organisations. Work began in 2002, with support from both sides of parliament, to make changes to the Mental Health Act. The proposed legislation was controversial because it contained new provisions for forced treatment – so-called 'supervised community treatment', known in other jurisdictions as community treatment orders. These measures were opposed both by voluntary providers and the Mental Health Alliance, a pressure group which included professionals and service users (Crossley, 2006, pp. 66–7; Pilgrim and Ramon, 2009, pp. 277). In November 2006, the bill was finally introduced

into the Lords as a narrow amendment to the 1983 Act, concerning only patients who posed a risk to themselves or to others, and it did not make any changes in responsibility for the provision of care (Hansard HL, 16 Nov 2006, v. 687, c. 19).

In parallel, the government was working to reform the organisation of mental health services. There were a number of independent reports published on the subject of service delivery and funding. The health-sector think tank, King's Fund, had commissioned a report led by Derek Wanless to investigate the demand for social care in England in the coming decades, and to make recommendations about how these services should be funded. *Securing Good Care for Older People* was published in March 2006, and recommended an increase in social care services based on a partnership model of funding, with costs shared between individuals and the state (Wanless et al., 2006, pp. 286–7). The Commission for Social Care Inspection, established in 2003, had also championed flexible funding models in their annual report, *The State of Social Care*, published in January 2007. Both organisations supported the system of 'direct payments' which had first been introduced to the wider local authority social services system in 1997. This meant that rather than services being provided or contracted directly by local authorities, clients would receive a cash payment which could be used to purchase services delivered by the local authority or other providers. The commission also proposed introducing 'individual budgets' for purchasing social services, which could be made up of funding from different entitlements.

These recommendations were put into effect in the Blair government's major change to responsibility for care in December 2007, initiated by the Putting People First concordat signed by central and local government, adult social care professionals, and the NHS. The main change was the introduction of a 'personalised budget' for adult social care – that is, an individualised direct payment that could be used to purchase the client's choice of services. The direct payments that had first been introduced in the late 1990s were dramatically expanded with the help of funding from a new Social Welfare Reform Grant from central government to local authorities that was included in the 2007 spending review (Department of Health, 2006, p. 83). The model was based on a similar scheme in Canada, which had been piloted in West Sussex and the London Borough of Tower Hamlets (Pilgrim and Ramon, 2009, pp. 281).

Crucially, although they expanded funding for social care services, Labour no longer prioritised local authorities as the first-choice provider. In opposition, they had been critical of the Conservative Party's NHS reforms, promising to 'end the Tory internal market' in their manifesto (Labour Party, 1997). The motivation given for Labour's policy change in the Putting People First concordat was that an aging population and changing family structures required an increase in social care services (Department of Health, 2007, p. 1). A more detailed government strategy had been provided in the white paper, *Our Health, Our Care, Our Say*, in 2006. The white paper stated that the government's strategy for health and social care was 'to put people more in control, to make services more responsive, to focus on those with complex needs, and to shift care closer to home' (Department of Health, 2006, p. 10). They also argued that the policy would deliver 'better value for money', referring to the two recommendations of the two Wanless Reports (ibid, pp. 10, 25).

While, on one hand, Labour had shifted away from its preference for state responsibility, their commitment to individualism and relieving families of the burden of care resulted in an expansion of spending that could be used for private care, and central government funding for these payments. *Our Health, Our Care, Our Say* also presented more individualist arguments about the burden of care placed upon family members who acted as full-time carers, leading to poor health outcomes for themselves and negative consequences for the wider family (ibid, pp. 16; 28.) The Labour government recognised that the closest forms of care were typically provided by family and friends, but stated that 'the needs of individuals go beyond what friends and family can cope with' (ibid, p. 79).

Labour were thus more open to a mixed market of care than they had been in the past, even mentioning value for money as a potential benefit of the Putting People First initiative (ibid, p. 10). But this shift in position was not simply a reaction to changing expert advice about how care services should best be funded. New Labour's shift to accommodate more centrist economic policy goals is well-documented (Bevir, 2000). A more centrist position in socio-economic conflicts meant that government was no longer the first-choice provider of services. But New Labour nevertheless increased spending on social care, on grounds that families could not be left to shoulder the burden of relatives' long-term care needs.

In contrast, the Conservatives continued to make more residual arguments in favour of lower levels of spending, suggesting that the local au-

thorities were spending too much and that efficiency benefits would need to be delivered by the personalised budgets (Hansard HC, 10 Oct 2007, v. 464, cc. 302; 312). The Conservatives had been reluctant to extend subsidies for private providers even when this strategy was recommended by the Griffiths Report in 1988, because of the cost. They were much more willing to rely on informal family support than the Labour Party would be, even after its shift to the right economically.

Second-dimension conflicts about the role of the family in providing care – which had become increasingly relevant in mental health policy debates in England since the mid-1970s – were therefore important for distinguishing New Labour from the Conservatives. The two parties reacted differently to similar expert advice during the 1980s to 2000s, reflecting different views about the role of the family, based on more familial or individualist ideological positions. These second-dimension conflicts would also play a role in mental health debates in Germany, where they would be arguably just as important as socio-economic conflicts between the two major parties over time.

# Germany

Psychiatric deinstitutionalisation was implemented later in Germany than in England. While psychiatrists in Germany were active in international networks that promoted social psychiatry, open care, and familial care, these ideas had little policy impact in Germany during the 1950s and 1960s (Schmiedebach and Priebe, 2004, pp. 464–465). It was not until 1971 that an Inquiry – the *Psychiatrie-Enquete* – was established to collect data on conditions in the mental hospitals. It was in the *Landeskrankenhäuser*, run by the federal states, that the majority of people with chronic and severe mental illness were housed. They were funded from a mix of statutory health insurance (raised mainly from contributions) and local authority social assistance (funded from central government grants and local taxes). The recommendations of the *Enquete* would enter the political debate in the following years, alongside newspaper reports of the inhumane conditions and abuses within psychiatric hospitals (Deutscher Bundestag (BT) Plenarprotokolle 07/12, 1 Feb 1973, p. 469; 07/52, 21 Sep 1973, p. 2962).

In this section, I trace parliamentary debates around seven major policy decisions in Germany which affected the decline of asylums, listed in table 5.2. Most of the changes conform to my expectations about partisan preferences, with governments led by the Social Democratic Party (*Sozialdemokratische Partei Deutschlands*, SPD) promoting state responsibility for the new outpatient services and care homes that would replace institutional care in the mental hospitals, and those led by the Christian Democrats increasing voluntary or family responsibility for care.

But there is one policy change that runs against expectations. In 1999, under mounting fiscal pressure, the SPD departed from their long-term defence of state-run facilities to expand voluntary responsibility for extramural mental health services. On the one hand, the decision was certainly shaped by the voluntarist structure of the German health care system, which had been safeguarded by the Christian Democrats in particular over the years, but the policy was also defended by the SPD on the basis of their more individualist ideological position.

Table 5.2: Mental health policy changes in Germany

| Year | Leading Party (Chancellor) | Policy type | Policy or legislation title |
|---|---|---|---|
| 1976 | Social Democrats (Schmidt) | State | Amendment to Reich Insurance Order |
| 1979 | Social Democrats (Schmidt) | State | Model Psychiatry Programme |
| 1986 | Christian Democrats (Kohl) | Voluntary | Improving Ambulant and Semi-mural Care |
| 1990 | Christian Democrats (Kohl) | Voluntary | Hospital Staffing Directive |
| 1994 | Christian Democrats (Kohl) | Family | Long Term Care Insurance |
| 1999 | Social Democrats (Schröder) | Voluntary | Statutory Health Insurance Reform |
| 2012 | Christian Democrats (Merkel) | Voluntary | Psychiatric Remuneration Act |

*Comments:* Table lists mental health policy changes made in Germany between 1950 and 2015, indicating the leading part of government and chancellor, as well as the type of policy change according to the classification system used in Chapter 4.

### Social Democrats and state responsibility

During the early 1970s, the Christian Democrats were the main party speaking in favour of mental health policy change, from opposition, but by the middle of the decade there was agreement among all parties on the general goal of deinstitutionalisation. Since the publication of the *Psychiatrie-Enquete*'s interim report in 1973, the Christian Democrats, comprising the Christian Democratic Union (*Christlich Demokratische Union*, CDU) and its Bavarian wing the Christian Social Union (*Christlich-Soziale Union*, CSU), had been pushing the SPD-led government, in coalition with the liberal Free Democratic Party (*Freie Demokratische Partei*, FDP), to reform the mental health sector. They argued in favour of outpatient care in the image of the Dutch voluntary-provider-based model (BT Plenarprotokoll 07/67, 29 Oct 1973, p. 4052). At that time, the government responded that they were aware of the Dutch model and looking for opportunities to improve the efficiency of the German system (ibid).

When the *Enquete*'s final Report on the Situation of Psychiatry in the Federal Republic of Germany was finally published in 1975, politicians from the three major parties expressed support for its recommendations, evidence of agreement among the parties on the goals of deinstitutionalisation policy. The SPD and Christian Democrats both spoke in favour of reducing institutional care (BT Plenarprotokoll 07/203, 27 Nov 1975, pp. 14083, 14085). The FDP praised the integration of the psychiatric treatment with other health services, arguing that 'the ghettos of the large psychiatric hospitals could be thereby diminished, and psychological illness could become in the minds of citizens viewed as a perfectly normal disease' (ibid, p. 14087).

The first policy change in Germany in this period expanded psychiatric care in outpatient clinics by state providers. The SPD-led government modified the Reich Insurance Code (*Reichsversicherungsordnung*, RVO) – at that time, the foundational law of the German welfare state – to fund outpatient psychiatric clinics operated by the state psychiatric hospitals. According to the new Health Insurance Development Act (*Krankenversicherungs Weiterentwicklungsgesetz*, KVWG), general hospitals run by the voluntary health insurance companies would not be funded to open outpatient clinics or to dispense drugs to discharged patients with ongoing needs unless the responsible state committee found that public alternatives had been exhausted (Bundesgesetzblatt (BGBl) nr. 151, 30 Dec 1976, p. 3874). The small number of university outpatients clinics that already

existed for research purposes were also ineligible for the new insurance funding.

The KVWG introduced 'needs plans' (*Bedarfspläne*) as a cost containment strategy for outpatient services in the hospital sector in general, but contained separate clauses governing psychiatric care. The debate over the bill in the Bundestag showed that although there was agreement among the parties about the need for expanded psychiatric outpatient care, and for the implementation of the needs plans, the SPD and Christian Democrats disagreed about the priority given to the state psychiatric hospitals to provide outpatient care. The CDU/CSU argued that the government's proposal privileged state services and deprived the health insurance companies of influence over service provision. They favoured instead a mixed service-delivery model that would enable the voluntary hospitals to deliver services, underpinned by needs plans that would be negotiated among the federal states, and the associations of both the health insurance companies (*Landesverbänden der Krankenkassen*) and the statutory health insurance physicians (*Kassenärztliche Vereinigungen*). The CSU used their influence in the Bundesrat – the upper house, representing the federated states – to promote the alternative proposal.

In the debate in June 1976, the Bundestag erupted with each side of the house accusing the other of '*dirigisme*'. An SPD member scoffed that the opposition's 'white-blue proposal [was] marked by extensive dirigism', alluding to the colours of the Bavarian state flag to imply that it represented chiefly southern interests (BT Plenarprotokoll 07/253, 24 Jun 1976, p. 17976). The amendment requested by the Christian Democrats sought to give the associations of health insurance companies a statutory role in decision-making processes, and integrate psychiatric care into the statutory health insurance services provided in voluntary-run general hospitals (BT Drucksache 7/5429, 23 Jun 1976). The Bavarian Minister of State for Labour and Social Affairs, a qualified psychologist, argued that their proposal was 'rather just the opposite of *dirigism*' (BT Plenarprotokoll 07/253, 24 Jun 1976, p. 17981).

The 'dirigist' insult was levelled in the context of ongoing European integration, where Germany, along with France, was an important actor in shaping the economic and social model that would underpin cooperation in the region. The German concept of 'social market economy' was based on the doctrine of ordoliberalism, where the role of the state was to support the market by providing currency, fighting monopolies, sup-

porting a mobile labour market, and coordinating corporatist negotiation of social policies (Carlin, 1996, pp. 482–483). This vision competed with the French economic doctrine of *dirigisme*, which was based on more active state-directed investment, economic planning, and the establishment of state-owned enterprises as well as nationalisation in strategic sectors (Gillingham, 2003, pp. 26–33, 43–46). The label 'dirigist' was a politically charged insult at the time, which meant to be a proponent of an overly active role for the state.

The Christian Democrats framed the government's policy on outpatient funding as at odds with the principle of subsidiarity that underpinned the German economic and social model. They argued that by denying the health insurance companies an equal role, the government's proposal 'obviously [could] not be reconciled with the principle of partnership-based equal cooperation' (BT Plenarprotokoll 07/253, 24 Jun 1976, p. 17974). The CDU/CSU criticised 'the de facto elimination of one of the basic pillars of statutory health insurance law, the maintenance of the system of outpatient medical care by voluntary health insurance physicians' (ibid, p. 17983). The central role of the health insurance physicians or 'panel doctors' had been enshrined in the Law on Statutory Health Insurance Physicians 1955 (*Gesetz über das Kassenarztrecht*) (BGBl, nr. 513, 19 Aug 1955). If mental health was to be integrated with the wider health system, the Christian Democrats argued it should follow the same principles. They claimed that the government's proposal 'contradict[ed] the essential concern of the *Psychiatrie-Enquete*, namely to ultimately equate psychiatric treatment with other medical treatment in the eyes of the general public' (BT Plenarprotokoll 07/253, 24 Jun 1976, p. 17984).

The two major parties thus agreed that outpatient care should be developed, but disagreed about who should deliver these services. In contrast with England, where the Conservatives opposed state provision in favour of private initiative, the Christian Democrats in Germany opposed the priority given to state provision in favour of voluntary delivery and corporatist governance. This reflects the different dynamics of socio-economic conflict in the two countries. Germany did not have a distinct Conservative party in parliament that defended, as the Conservatives did in England, a smaller state. The development of the post-war German welfare state was shaped by conflict between the Social Democrats, who favoured an active role for the state, and the Christian Democrats, who were strongly committed to corporatism and the principle of subsidiarity, which implied a

lower level of redistribution. These two parties are closer together in socio-economic conflicts than the British Labour and Conservative parties, but nevertheless their ideological disagreement is evidenced in these debates.

In debates on the KVWG, the SPD made redistributive arguments for prioritising outpatient clinics attached to the state-run mental hospitals, to ensure equal access to services and expand jobs for specialists in the state sector. The 'red thread' of the government's policy, they argued, was 'to meet the claims of the insured and their families for a qualitatively and quantitatively equal outpatient medical care' (ibid, p. 17976). The FDP were in the governing coalition with the SPD, and voted in favour of the bill, with their deputy chairman explaining that it 'created the subsequent basis for a supply of state jobs' in outpatient services (ibid, p. 18339). The FDP's support for public-sector employment runs counter to my expectation that liberal parties should oppose state responsibility for care and make arguments in favour of a more residual state. But, in the case of Germany, the behaviour of the FDP often depends on their relationship with the larger parties. Later, when in coalition with the Christian Democrats, they would be more supportive of voluntary responsibility for care.

The second policy change made by Helmut Schmidt's government also promoted state responsibility for a new range of outpatient services. In the budget of September 1979, the federal government invested 470 million deutschmark over five years in the Model Psychiatry Programme (BT Drucksache 8/3101, 7 Sep 1979). This comprised federal funding for a new range of services including the training and employment of health care professionals as public employees, as well as new types of publicly provided residential facilities to promote rehabilitation and resettlement. The initiative was intended 'to make it easier for the federal states to develop facilities in the complementary and rehabilitative area in particular, and to contribute to more humane hospital care' (BT Plenarprotokoll 8/168, 12 Sep 1979, p. 13418). The programme went ahead in some states, but those controlled by the CDU/CSU refused to participate.

In wider policy documents at the time, the SPD's focus on prioritising state responsibility for service provision was clear, but the framing of policy shifted from principally redistributive arguments to a new focus on individual responsibility. In early 1979, the government issued a statement on the response to the *Enquete* Report in which it laid out the policy for reforming of the care of the mentally ill. The policy described a 'special duty of care' and 'great responsibility' for the federal states, municipal-

ities, and the local public social welfare providers, but another priority was '*Hilfe zur Selbsthilfe*', or 'helping people help themselves', through health education (*Gesundheitserziehung*). This focus on health education was consistent with the wider approach to public health policy in Germany. The engine of health education was the Federal Centre for Health Education (*Bundeszentrale für gesundheitliche Aufklärung*, BzGA) which had been founded in 1967 within the Federal Health portfolio. The BzGA worked with the federal states' ministries for work, welfare, health care, education, and culture, as well as their existing networks of community organisations, to address a range of public health policy areas that were not directly controlled by the German federal government.[5] From 1976, the BzGA had been running a health education campaign, People Like Us (*Menschen wie wir*), to counter discrimination against people with mental illnesses and other disabilities (BT Drucksache 8/3321, 6 Nov 1979).

Unlike in England, where the frame of individual responsibility was used by the Conservatives in connection with family responsibility for care, the focus on health education and individual responsibility in Germany did not imply that the family should provide *care* for people with mental illness. Health education was framed as a pathway to the identification of problems, to enable access to appropriate forms of care (BT Drucksache 8/2565, 13 Feb 1979, p. 8). The government's statement did not describe any responsibility for the family, or initiatives to subsidise or incentivise family-based care. On the contrary, in parliament, SPD politicians made individualist arguments to defend the policy, arguing that people will mental illness could not rely on family care.

The focus of the Model Psychiatry Programme was on expanding outpatient care and treatment alternatives, with a focus on the geographical distribution of resident neurologists, improving training for general practitioners, and coordination between different types of doctors and psychiatric professionals (BT Drucksache 8/2565, 13 Feb 1979, pp. 31–2). Patient needs plans were still to be overseen by the outpatient facilities at the state psychiatric hospitals. Although a working group of federal and state officials had recommended the establishment of inpatient psychiatric wards at general hospitals, which where managed by the voluntary health insurance companies, the government was reluctant. Instead, they stated:

[5]For instance, in the 1960s and 1970s, the BzGA had coordinated smoking cessation campaigns, and during the 1980s the response to HIV-AIDS (Elliot, 2015; Toppich, Christiansen, and Müller, 2001).

> ...in the foreseeable future the psychiatric hospital, despite the local and structural problems that are being successfully handled according to the reports of the federal states, will remain the core of inpatient care (ibid, p. 33).

When the government's statement was tabled in the Bundestag in October 1979, the government recapitulated its focus on individual responsibility and health education, but also made individualist arguments to support the policy. Jürgen Egert, who had founded the Berlin Psychiatry Working Group emphasised health education when he stated that 'the core problem, which is the prerequisite for improving the lot of the mentally ill, lies in the attitude of the population towards [them]' (BT Plenarprotokoll 8/177, 11 Oct 1979, p. 13935). The Federal Minister for Youth, Family and Health made a more individualist argument about the importance of developing the outpatient sector to 'open up opportunities for those families who often face a heavy burden by caring for their relatives at home (ibid, p. 13956).

Liberal politicians supported the focus on individual responsibility, but did not make particularly individualist arguments. An FDP member of the Committee for Youth, Family, and Health, supported the focus on health education, arguing that 'in the long term, the decentralisation and integration of mental health care into general medical care can only be achieved with the extensive consent of the population' (ibid, p. 13939).

There is also some evidence of policy learning, or at least awareness of psychiatric reforms abroad. The Minister quoted President Kennedy's speech to the United States Congress on the Community Mental Health Care Centers Act 1963, where he stated that 'the time has now come for a new and courageous move. New medical, scientific and social resources and knowledge are now available. The government of this country and individual citizens must be aware of their obligations in this area' (ibid, p. 13956). The SPD also referred to the 1978 decision to rapidly close the mental hospitals in Italy, posing the question, 'won't this perhaps push the problems back onto the individual's family, or lead to a new social isolation?... In Italy there is partly a family structure that is different from that in the Federal Republic of Germany. There are much larger families and a larger family group there, while with us the family has changed much more to the nuclear family due to the industrial revolution' (ibid, p. 13965). The latter reflected a more individualist argument, in line which my expectations about social democratic parties.

The Christian Democrats criticised the government's slow pace of reform, but there remained agreement across the parties on the general policy of deinstitutionalisation. The CSU criticised the 'tendency toward the entrenchment of the status quo against reform', and argued that 'a community-based psychiatry without psychiatric departments in general hospitals is not possible' (ibid, pp. 13932–3). Although the government was reluctant to integrate mental health services with the voluntary-run general hospitals, they clearly supported deinstitutionalisation. The Minister spoke of 'the goal of reducing inpatient treatment' (ibid, p. 13956), and another SPD member stated that 'the occupancy in hospitals must fall' (ibid. 13959). A member of the CDU concluded that 'there was no dispute about the problems across party lines. All of us, whether we are on one side or the other or in the middle of the house, believe that, in the field of mental and psychiatric care – with all the progress we have made – there are still large gaps' (ibid, p. 13968).

### Christian democrats and voluntary responsibility

In 1982, Schmidt's governing coalition fell apart, and following successive votes of no confidence in February and October, the Leader of the Christian Democrats, Helmut Kohl, succeeded Schmidt as Chancellor. Shortly after new elections in March, the Christian-Democrat-led government, in coalition with the FDP, limited federal funding for the Model Psychiatry Programme to the end of 1985, and set up a working group for further developments in the sector (BT Plenarprotokoll 10/68, 13 Apr 1984, p. 482). The Kohl government's goals in relation to mental health policy were to expand voluntary responsibility for mental health care, based on the principle of subsidiarity, and to integrate the treatment of mental illness with that of physical illness. They passed a number of laws to affect these objectives, but the principle policy change affecting service provision occurred in 1986.

The context for the 1986 policy change was pressure from the opposition to continue the Model Psychiatry Programme services. With the funding about the expire, the Social Democrats proposed a draft law to establish permanent funding for the services in the Reich Insurance Code (RVO). At the budget debate in November 1985, the SPD made a plea to the government 'to ensure that the mentally ill people can realise their claim to their human dignity' (BT Plenarprotokoll 10/178, 28 Nov 1985, p. 13510). The government responded that agreements had been made with

the participating federal states for regional follow-up financing (ibid, p. 13514), but the SPD were concerned that the cut in federal funding would lead to an under-provision of services that were not guaranteed in the RVO. The debate became heated when the chairman of the SPD parliamentary group for youth, family, women, and health, criticised both the health insurance funds and the government for their 'incomprehensible' unwillingness to increase spending in order to address 'conditions in psychiatry that are inhumane' (ibid, p. 13519). One CDU member was reprimanded by the house vice president for calling the SPD 'hypocritical', while the FDP also accused their former coalition partners of 'petty criticism' and 'small mindedness... relating in many cases to points on which the SPD was unable to achieve anything' (ibid, p. 13520).

The Social Democrats' proposal sought to maintain the system of rationing services through the state psychiatric hospitals, so that RVO funding would prioritise state-run outpatient clinics over independent services contracted through the state hospitals (BT Drucksache 10/3882, 25 Sep 1985, p. 3). The statutory insurance funds would cover the costs of new transitional facilities and vocational rehabilitation programmes, as well as social-psychiatric nursing services that had been established through the Model Psychiatry Programme. The Christian Democrats, with the support of the FDP, proposed an alternative bill which would fund outpatient and semi-mural clinics '*not only within* psychiatric hospitals, but also within separately recognised, independent psychiatric departments at general hospitals' which were primarily administrated by voluntary organisations (BT Drucksache 10/4533, 11 Dec 1985, p. 2, emphasis added). The government's bill excluded RVO funding for the new transitional facilities and vocational workshops. The Greens, who had won 27 seats in the Bundestag at their first appearance on the ballot in the 1983 election, refused to support either bill, describing both as 'inadequate and incompetent' (BT Drucksache 10/4557, p .1)

The Greens did not attend the sitting when the Social Democrats' Law for the Improvement of Care for the Mentally Ill (*Gesetzes zur Verbesserung der Versorgung psychisch Kranker*) had its second and third readings and was defeated. In this debate too, speakers referred to developments in the United States, France, Italy, and Great Britain (BT Plenarprotokoll 10/185, 13 Dec 1985, p. 14113). The FDP expressed regret that the Christian Democrat-governed federal states, with the exception of Saarland, had declined to participate in the Model Psychiatry Programme.

Their Minister of State responsible for European policy disagreed with the CDU/CSU's justification that 'the care of the mentally ill was a task of the states with which the federal government had nothing to do', but nevertheless expressed support for the government's proposal which would allow better access to voluntary outpatient services for those who had not had a stay in a psychiatric hospital (ibid, pp. 14114–5).

The debates around mental health policy in Germany were shaped by federalism and the principle of subsidiarity, particularly defended by the Christian Democrats. Although the Social Democrats prioritised state-run services, the principal disagreement in this debate was less about what type of provider should be responsible for care than which level of government should be responsible for the cost. The SPD argued that the government 'saw themselves as unable the follow [the SPD's] draft law because the sickness and pension insurance companies would have been burdened with the costs' of the supplementary services (ibid, p. 14116). This disagreement was echoed by the CDU's parliamentary secretary for the Ministry of Work and Social Order, who questioned that 'whether the statutory health insurance should finance such special facilities of a supplementary nature, or whether they don't belong to the health services borne by the federal states and municipalities' (ibid, p. 14118).

The Christian-Democrat-led government saw the federal states as the primary agents in mental health service delivery. In the government's 1985 review of health service provision, the section on psychiatric services praised the efforts and central role of the federal states and voluntary services in developing services independently of the previous government's Model Psychiatry Programme projects: 'The federal states have drawn up psychiatry plans and, in some cases, programs, and independent institutions have developed additional facilities and social psychiatric services as part of their work' (BT Drucksache 10/3374, 22 May 1985, p. 39). It continued by explaining that 'the planning ideas of the federal states are geared towards... needs-based and coordinated care for all mentally ill patients, and the principle of equality of mentally ill with somatically ill' (ibid, p. 41).

The government's Law for the Improvement of Outpatient and Semi-mural Care for the Mentally Ill (*Gesetz zur Verbesserung der ambulanten und teilstationären Versorgung psychisch Kranker*) was passed in January 1986. Related changes modified the RVO, laws governing health insurance for farmers, and the Federal Pension Act (*Bundesversorgungsgesetz*) so

that insured persons would have access to services provided by voluntary organisations contracted by the health insurance companies (BT Drucksache 10/6134, 9 Oct 1986).

Although the policy expanded voluntary responsibility for provision, it was framed using familial arguments. The new legislation specifically stated that 'nursing at home and domestic help should complement family care and provision' (ibid, p. 4). A related report on long-term care needs prepared by the Ministry for Youth, Family, and Health had stated that 'help should support the willingness to provide home care' (BT Drucksache 10/1943, 5 Sep 1984, p. 14). Although family carers were framed as playing a central role, the government recognised the need for voluntary outpatient services to support them.

The government also made familial arguments during the goal-setting phase of the wider Health Services Reform (*Gesundheits-Reformgesetz*) which commenced in 1988. The Health Services Reform would enable insurance companies to make cash payments to patients to purchase home-based voluntary care services, but the Christian Democrats argued that payments should not be made to relatives to compensate informal care, on grounds that this would intervene in the regulation of family life: 'care is often a joint effort of several people form the family relatives, neighbours or friends... it would not strengthen home care but would rather weaken the willingness to care in many families' (Drucksache 11/2493, 15 Jun 1988, p. 18). The Health Services Reform aimed to limit health insurance benefits to medically necessary services, strengthen individual citizens' responsibility for health care, and improve the profitability of services. The psychiatric services were not the focus, and no direct changes were made to responsibility for mental health care service provision, but most of the RVO was transferred to the Social Code and the law was modified so that mental illnesses would be treated equally with other illnesses, with 'health' interpreted to mean 'physical and mental health' (BT Drucksache 11/2237, 3 May 1988; Drucksache 11/2594, 28 Jun 1988).

The Health Services Reform and these related legislative changes provided the legal foundations for a further policy change that would expand mental health care within the general hospitals, run mainly by not-for-profit organisations, as opposed to the state-run psychiatric hospitals. The Psychiatric Personnel Ordnance (*Psychiatrie-Personalverordnung, Psych-PV*) – also known as the hospital staffing directive – was approved by the Bundesrat in November 1990, a month after reunification and just days

before the first all-German election since 1933. This type of regulatory instrument could be approved by the cabinet, and, owing to the timing, the matter was not extensively debated in parliament, where instead members discussed the need for structural transformation of services in the new federal states of the former German Democratic Republic (BT Plenarprotokoll 11/223, 12 Sep 1990, p. 17583). The federal government would subsidise the insurance companies for the immediate costs of the staffing directive (Bundesrat (BR) Drucksache 666/90, 26 Sep 1990, p. 2). The government had already included the change in its Social Report published in June 1990 (BT Drucksache 11/7527, 29 Jun 1990, p. 104). They were confident that the change had wide support from both psychiatrists and other professionals. The proposal was based on expert consultation made by the Ministry for Labour and Social Affairs (*Bundesministerium für Arbeit und Sozialordnung*, BMA) rather than the Ministry of Health.

An all-party commission has just delivered its final report on the structural review of health insurance, which recommended better integration of psychiatric services within general hospitals (BT Drucksache 11/6380, 12 Feb 1990, p. 134). When the report was debated in parliament, its SPD chairman explained that, 'the SPD parliamentary group was prepared to propose cross-party solutions because our health care system, as one of the main pillars of the welfare state, cannot tolerate party-political polarisation but rather depends on a broad consensus' (BT Plenarprotokoll 11/224, 13 Sep 1990, p. 17624). By this stage, the SPD appear to have accepted the integration of the mental health services within the structure of the wider health system, largely delivered by not-for-profit organisations. But the government and opposition remained divided over the question of finance. The FDP in particular made residual arguments against state funding for inpatient care. To applause from the government benches, the chairman of the Committee on Labour and Social Affairs, stated that they would 'not accept residential care being included in statutory health insurance' and instead wanted 'to strengthen private insurance' (ibid, p. 17632). On the other hand, the SPD expressed opposition to private, and particularly company-based, insurance (ibid, p. 17633). These arguments would reappear, and intensify, in the coming years as the federal government sought to address the growing need for long-term care.

### The era of health cost containment

After reunification, cost containment became an important goal of health system reform, with implications for the mental health services (Busse et al., 2017). During this period, both the Christian Democrats and the SPD shifted the *costs* of care away from the state to the voluntary health insurers, but the two parties made different decisions about who should be responsible for *providing* care. Back-flipping on their position from 1988, Helmut Kohl's government, in coalition with the FDP, would introduce new payments to family carers in 1994. Also reflecting a change of heart, in 1999 the Schröder government would make legislative changes to allow the general hospitals, run by the voluntary associations, to provide semi-mural care facilities (*Institutsambulanz*). Twelve years later, voluntary responsibility was again expanded, but this time by the Christian Democrats. They would introduce an internal market based on the reimbursement of mental health services chosen by patients, through a 'global treatment budget'. This was a similar mechanism to the personalised budgets introduced by Labour in England, but with voluntary insurance companies organising payments and delivering most of the services.

Carers payments were introduced as part of a law on long-term care insurance (*Pflegeversicherung*), the outcome of a decades-long debate which divided the SPD, the Christian Democrats, and the FDP. The policy included people with chronic mental and physical illness, as well as the elderly, which in the context of an aging population and growing need made it a highly salient and politicised area. The three parties disagreed on the one hand about the funding mechanism for long-term care, and on the other about the priority of, and rates of payment for, different types of services. The SPD supported a mix of tax and statutory insurance funding that would provide adequate levels of support to pay for residential care, while the Liberals opposed statutory entitlements and supported private insurance, but also favoured residential services. The Christian Democrats preferred a proportional funding mechanism based on earner contributions, and aimed to prioritise family-based care. After some years of deadlock, the Kohl government implemented statutory long-term care insurance which would incentivise informal care by providing payments and training to informal carers, and much more limited compensation for residential and professional services.

Long-term care insurance had been suggested in 1980 by the SPD, as one of several proposals from a federal-state working group that was set

up in response to the 1975 report of the Federal Ministry of Health, 'Care Needs of Older People' (*Pflegebedürftigkeit älterer Menschen*) (Forsbach, 2011, p. 218). Failing to make progress on a proposal before the 1982 election, the SPD tabled a draft bill for long-term care insurance from opposition in 1985. At that time, the Kohl government opposed statutory long-term care insurance, noting that private companies were already providing it. But by 1990, there was growing pressure from some of the federal states, whose social assistance systems were becoming overburdened with claims from people with long-term care needs (BR Drucksache 367/90, 28 May 1990). The Christian Democrat's manifesto for the 1990 election committed to providing security for long-term care (Christlich Demokratischen Union, 1990, p. 15).

Long-term care insurance was repeatedly raised by the SPD in debates during the first half of 1991, and in September they again proposed a draft law which would ensure that 'all those in need of care have the right to choose between outpatient and inpatient care' by providing either cash support for family carers or generous compensation for professional and residential services. The party made individualist arguments to support the bill, arguing that family members – especially women – 'have to bear the main burden of care' and that this 'overwhelmed the capacity of families' (BT Drucksache 12/1156, 18 Sep 1991, pp. 1–2). They also made redistributive arguments against private insurance, which they argued was 'not a socio-politically acceptable solution' because it would reduce access for low-income earners and reduce government control of the quality of services (ibid, p. 4).

The issue was discussed during a debate on the government's financial plan, where the three funding options presented were tax finance, statutory insurance, or private insurance. Both the Christian Democrats and the FDP were against funding through taxation (BT Plenarprotokoll 12/38, 5 September 1991, pp. 3124, 3129). The FDP were against any statutory support for residential care, and favoured a private insurance solution, as they had argued in earlier debates on the Psych-PV. The SPD were strongly opposed to private insurance, but were willing to support statutory insurance financed by higher employer contributions, based on a 'solidaristic financing concept' (ibid, p. 3157–8). The Christian Democrats, on the other hand, preferred a proportional earner contribution model.

In the debate on the SPD's proposal, the chairman of the party's social policy working group observed that while the government was trying to

push his party's proposal off the agenda, neither the FDP nor CDU/CSU had a majority in parliament that supported their preferred solution (BT Plenarprotokoll 12/65, 6 Dec 1991, p. 5547). The FDP made individualist arguments in favour of private insurance for residential care, suggesting that although families had long shouldered the burden of care, 'we know that the structures of living and family are changing in our society' so that formal care services were required. But, they argued, since the risk of needing long-term care was relatively small this should be privately financed (ibid, p. 5551). By this time, the Christian Democrats opposed private insurance as a long-term solution, and Heiner Geissler, the CDU's former secretary, recognised that 'the proposals of the SPD [were] closer to those of the CDU/CSU than what the Free Democrats [were] suggesting' (ibid, p. 5549).

Geissler had resigned as secretary before the 1990 election, after a failed challenge on Kohl's as leader of the party. Although he had become critical of his own party's inaction on 'the new social question' in Germany, he made a more residual argument against the SPD's proposal for long-term care insurance funded through employer contributions. Gerissler suggested that this would threaten the Christian Democrats' priority of 'enabling the competitiveness of the German economy' (ibid, p. 5548). He instead proposed financing long-term care insurance by having employees sacrifice one day of annual leave. Although this was not the party's policy at the time, Geissler would go on to play a key role in securing this historic compromise.

After two years of negotiations, the coalition government eventually proposed a bill guided by the principle that 'long-term care follows illness', so that people with private health insurance should also have private long-term care insurance, and those in the statutory voluntary system would have access to statutory insurance for both, with the new services funded by a one-day reduction in leave entitlements (BT Plenarprotokoll 12/183, 22 Oct 1993, p. 15820). The structure of the new entitlements incentivised home care over residential services. The combined value of cash benefits and in-kind assistance for informal carers was much higher than the maximum benefits for residential care, which would only cover about half the costs (Geraedts, Heller, and Harrington, 2000). Insurance providers would also deliver free nursing courses for family carers.

The CDU's former Minister for Health acknowledged the work of 'women, the wives, the mothers, the daughters and the daughters-in-law...

sometimes for years, often around the clock' providing care. She explained that it was for these women that the new entitlements were being established, to compensate for informal care and 'introduce the safeguarding of home care with the highest possible priority' (BT Plenarprotokoll 12/183, 22 Oct 1993, p. 15836). The CDU made familial arguments, describing the family as 'the nation's greatest caring service', but the priority of informal care was also defended on the basis of more residual arguments, 'to keep expenses under control' (ibid, p. 15820). Both the Greens and the SPD criticised the way that statutory entitlements had been structured to incentivise family-based care, arguing that women were being 'misused as a cheap stop-gap for underfunded long-term care insurance' (ibid, p. 15835).

Although both parties had been outspoken against private insurance based on redistributive arguments, once in government the SPD and Greens would respond to health system cost pressures by passing a reform to enable the expansion of private providers. Passed in 1999, the Reform of Statutory Health Insurance from the year 2000 (*Gesetz zur Reform der gesetzlichen Krankenversicherung ab dem Jahr 2000, GKV-Gesundheitsreform*) introduced the diagnostic-related group (DRG) funding mechanism and new contracting principles, but the mental health services were excluded from these cost containment strategies. Instead, the new law expanded psychiatric outpatient departments (*Institutsambulanzen*) in the general hospitals run by voluntary associations (Bauer et al., 2001).

This represented a shift from the SPD's earlier position that the state-run psychiatric hospitals should be the centre of psychiatric treatment and care when the outpatient departments were first introduced by the Schmidt government in 1976. In line with the wider reform's cost-containment focus, the government's proposal explained that the new services would 'reduce unnecessary hospitalisations for the severe mental illness and thereby the associated unnecessary cost burden' (BT Drucksache 14/1245, 23 Jun 1999, p. 57). The principle of 'outpatient before inpatient care' was applied to the entire hospital system, for the treatment of physical as well as mental illness (BT Plenarprotokoll 14/49, 30 Jun 1999, p. 4154). But the government were determined to ensure the quality of care, imposing new requirements on the health insurance companies to monitor standards of service.

Although this law has generally been assessed as contributing the ongoing marketisation of health services, at the time the opposition parties in Germany depicted it as a draconian policy of state planning. The debates

were very much focussed on the overall changes to health system funding and reporting, rather than the specific changes to mental health services.

The Christian Democrats criticised the way that budgets for inpatient, outpatient, and general practitioner services services would be set, in a top-down fashion, which they argued meant the 'health insurance bureaucracy' would ultimately determine the mix of care that was provided, compromising the potential cost savings and reducing the discretion of physicians and patient choice (ibid, pp. 4157–9). This was an argument about principles, but it was also about expenditure. The opposition claimed that the top-down budgets would actually lead to an increase in contributions, driving up non-wage labour costs for employers and leading to a higher level of overall expenditure than was necessary (ibid, p. 4158). The deputy chairman of the CDU/CSU group for health and social policy pronounced that 'the spirit of state control and paternalism runs like a red thread through all red-green laws' (ibid, p. 4158). A former member of the People's Chamber of East Germany went so far as to compare the law to the 'planned economy, centralised structures and sophisticated surveillance system' of the German Democratic Republic (GDR), suggesting that nostalgic GDR bureaucrats might celebrate that 'socialism at least in this area is experiencing a late success' (ibid, p. 4175).

The Christian Democrats favoured instead changes that would reduce patient contributions and increase patient choice of services (ibid, p. 4168). They argued that the government's budgeting strategy inhibited competition on price among insurers, and missed the opportunity for greater efficiency benefits from competition over services (ibid, p. 4169). The government argued that their proposal emphasised competition over service *quality* (ibid, p. 4178).

Identifying the types of arguments made by the Social Democrats during this period is complex, because although they directly justify the expansion of outpatient mental health care in general hospitals on cost-*saving* grounds, they also defend their budget mechanism on grounds of service quality, equality of access, and in the interests of protecting hospital employees. The SPD disagreed with the Christian Democrats' suggestion that quality, efficient services could be delivered by increasing the level of competition and choice, arguing that the health care 'market' was supply-driven and that supply decisions should also consider the interests of employees. They advocated 'the ability of everyone – service providers, employees and those insured by health insurance – to engage in dialogue' in

the budget setting processes (ibid, p. 4164). In the third reading debate, the SPD reiterated that 'the reform makes hospitals responsible, but not at the expense of the employees' (BT Plenarprotokoll 14/66, 4 Nov 1999, p. 5973). General hospital employees are largely employed by the not-for-profit sector in Germany, so this wasn't an argument in the interests of the public-sector workforce per se, but the opposition perceived the bill as increasing state control at the expense of private initiative, particularly that of physicians. To applause from the Christian Democrats, the FDP criticised the government, asking 'do you really want to abolish independent doctors and introduce state-employed doctors?' (BT Plenarprotokoll 14/49, 30 Jun 1999, p. 4168).

In wider debates, we find more individualist arguments made to justify outpatient care in the not-for-profit hospitals as opposed to informal care. While the Health Reform expanded general hospital responsibility for the care of people with mental illness, the Christian Democrats argued that wider budget cuts would reduce the provision of services by independent community-based organisations (BT Plenarprotokoll 14/71, 23 Nov 1999, p. 6455). The Federal Minister for Family, Seniors, Women, and Youth, was however adamant that the policy would not reduce voluntary services, as the government had prioritised rationalisation without cuts to long-term care. She defended the overall package as one which promoted the independence and employment of women (ibid, p. 6455–7).

The grand coalition that led Germany between 2005 and 2009 made no major changes to mental health service provision, although, under pressure from the federal states, in 2007 they did introduce new regulations for committal and release procedures as well as access to secure accommodation for individuals with mental illness who had been convicted of crimes. These changes were motivated both by a concern to protect the public, but also by cost pressures, because accommodation in a psychiatric hospital came at a lower cost than accommodation in prisons with specialist treatment facilities (BT Drucksache 16/1110, 31 Mar 2006).

The final major change to mental health services during the period that I study came under the coalition government of the Christian Democrats and the FDP, which came to power following the 2009 federal election. The Psychiatric Remuneration Act (*Gesetzes zur Einführung eines pauschalierenden Entgeltsystems für psychiatrische und psychosomatische Einrichtungen / Psych-Entgeltgesetz*) would incorporate psychiatric services into the DRG funding system for health services and enable new, integrated

treatment models which crossed the sectoral divide between inpatient and outpatient budgets (BT Drucksache 17/8986, 14 Mar 2012, pp. 27–28). In the parliament, the Christian Democrats made residual arguments, explaining that 'our goal is to create the conditions for a more efficient use of resources... Institutions with budgets that are too high must also be prepared for revenue reductions' (BT Plenarprotokoll 17/168, 22 Mar 2012, p. 19923). There was little debate in the Bundestag, as the grand coalition had agreed in the previous term that financing for cross-sectoral mental health services should be expanded, but the SPD did question whether the funding model did enough to encourage new cross-sectoral initiatives, because it maintained a global budget for mental health care controlled by the insurance providers (ibid, pp. 19923–4). The FDP supported the approach on the basis that it provided incentives to reduce inpatient treatment and would lead to cost savings (ibid, p. 19925). The law was passed without debate on its third reading (BT Plenarprotokoll 17/184, 14 Jun 2012, p. 22009).

None of the parties made particularly individualist or familial arguments in these debates, which were focussed on the funding mechanism. There was no question that the voluntary sector would take responsibility. However, responsibility for care had been an important enough question to warrant inclusion in the coalition agreement between the Christian Democrats and the FDP. In 2009, the new government had agreed that 'in order to give families the opportunity to better reconcile employment and the support of relatives in need of care, we want to develop better measures, through the economy and public care services in working hours, to promote the compatibility of care and work' (Bundesregierung, 2009, p. 92). This reflected a recognition that family care givers were simultaneously workers, and a significant shift from the CDU's 1993 tribute to the wives, mothers, and daughters working 'around the clock' to care for relatives. This shift might reflect a compromise between the Christian Democrats' and the FDP's competing positions on the role of the family. While electoral support for the Christian Democrats was declining, the FDP had won 15 per cent of the party vote at the 2009 election, their strongest ever result. They held a third of all cabinet positions, including the Health portfolio.

## England and Germany compared

So far in this chapter, I have considered the arguments that political parties made to justify policy positions in each country – England and Germany – over time. In this section, I compare the two countries, first to summarise how the different patterns in care policy decisions shaped care policy outcomes, and then to asses how the two dimensions of partisan conflict were reflected in parliamentary debates across these two countries with different constitutional settings and party competition environments.

First, let us consider the different outcomes in the two countries over time, in terms of the types of actors that became responsible for the care of people with mental illness. The shift from institutional to community care occurred earlier in England than in Germany, in part because there were higher pressures on the capacity of institutions in England, but also because in Germany during the 1970s the Social Democratic government defended the central role of the state-run psychiatric hospitals. While the first outpatient services promoted by the Conservative government in England in 1962 were run by voluntary organisations, those in Germany were established by the SPD within the existing state psychiatric hospitals. When the Labour Party came to power in England in 1964, they promoted state responsibility for the new outpatient facilities, by imposing a new duty on local authorities to provide services. These services were completely separate from the mental hospitals, which were managed by the NHS and devolved to the new Regional Health Authorities in 1974. Even as services outside of the mental hospitals were developed in Germany, funding mechanisms arguably perpetuated relatively high levels of inpatient care. From 1980, new state-run day hospitals and outpatient clinics received limited federal funding through the Model Psychiatry Programme, and after 1986 extramural services delivered by voluntary providers under the RVO received a lower rate of compensation than the psychiatric inpatient departments in voluntary-run general hospitals. When the RVO was transferred to the Social Code, voluntary-run services expanded relative to the state services, but the separation of inpatient and outpatient budgets – a legacy of the Social Democrats' earlier decisions to prioritise state responsibility – remained a barrier to the reduction of inpatient care.

In England, de-hospitalisation intensified during the 1980s following decisions by the Thatcher government, first to subsidise private providers of outpatient and smaller residential facilities, and then to prioritise in-

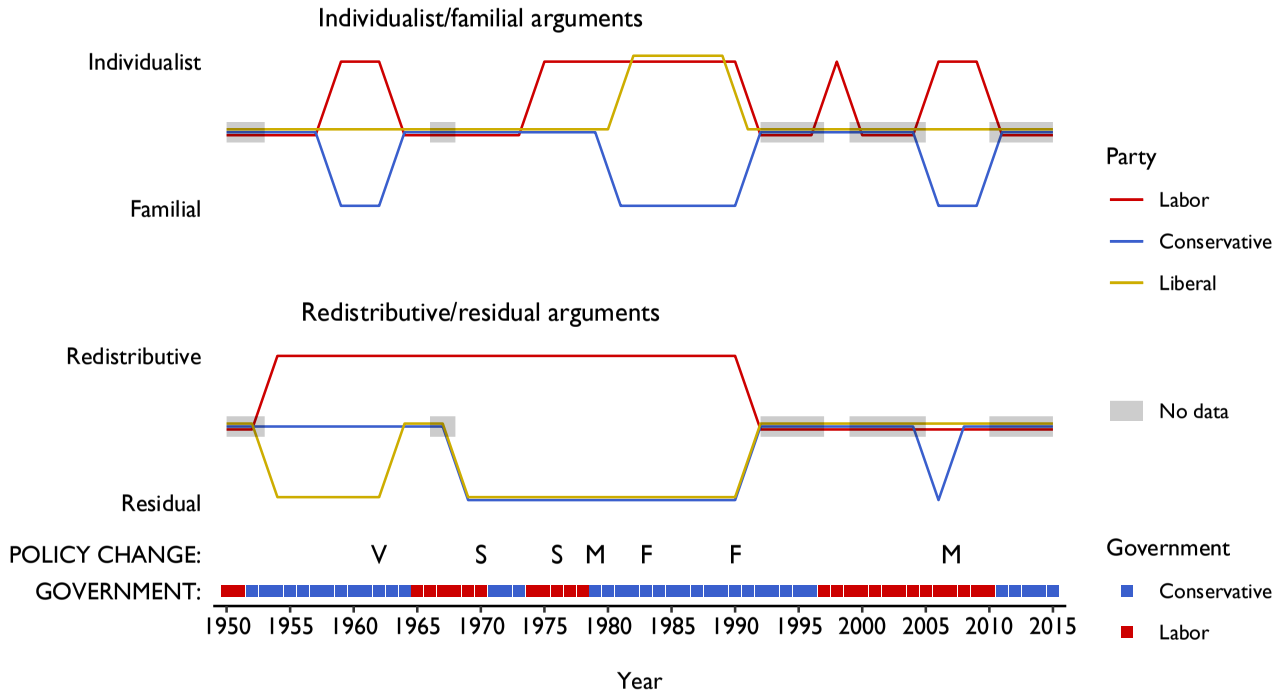
formal care with domiciliary assistance over local authority care services. In Germany, it was not until the wider health system faced significant cost pressures that the Christian Democrats turned to promote family responsibility for care, by giving the carers of people with chronic mental illness access to cash payments through the new long-term care insurance scheme introduced in 1994. Further policy changes in the 1990s and 2000s, made by governments led by both the Social Democrats and Christian Democrats, focussed on shifting incentives in the funding system to promote outpatient and integrated care models. For the Social Democrats, this meant increasing the role of voluntary providers relative to the state. During the 1990s the number and proportion of inpatient and long-stay beds declined more steeply within the federal states, both of the former Federal Republic and the former GDR (Salize, Rössler, and Becker, 2007).

Turning to the ways in which parties motivated their policy positions, figures 5.1 and 5.2 summarise the types of arguments made by social democratic, Christian democratic, conservative, and liberal parties over time in England and Germany respectively. In this section I discuss the significance of each dimension of conflict across the two countries in turn.

In both England and Germany, as we would expect, the Labour Party and SPD made redistributive arguments in favour of more public sector funding, employment, and responsibility for mental health care, but these types of arguments declined in both countries from the 1990s. In England, New Labour became more centrist in its economic policy orientation and made fewer redistributive arguments. Even when they expanded subsidies for social care they emphasised in the white paper the desire to achieve 'better value for money' (Department of Health, 2006, p. 10). When cost control became a priority after reunification in Germany, the SPD relaxed its emphasis on tax-funded services and public-sector delivery, and instead favoured higher employer contributions to insurance-funded services on the basis that this was a more 'solidaristic financing concept' (BT Plenarprotokoll 12/38, 5 September 1991, p. 3157–8). They directly justified the expansion of voluntary services in the Statutory Health Insurance Reform on cost-saving grounds, but also argued that the funding mechanism would maximise fairness, quality, and equality of access (BT Plenarprotokoll 14/49, 30 Jun 1999, 4164).

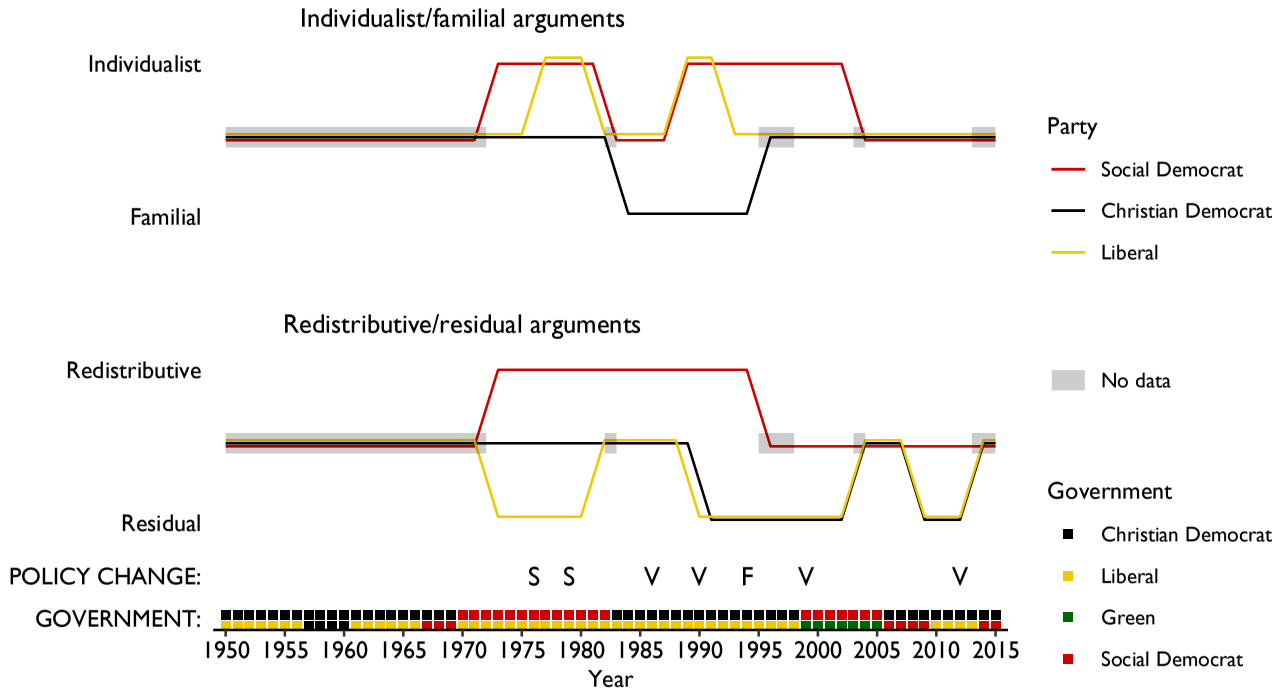
In England, both liberals and the Conservatives made residual arguments to reduce government spending, although these too declined toward the end of the period as socio-economic conflict between these parties and

Figure 5.1: Types of arguments made by parties in England in mental health policy debates over time




*Comments:* Figure displays types of arguments made by political parties over time, as well as the timing of policy decisions, where: S=state, M=market, F=family or V= voluntary responsibility. Primary sources are listed in Appendix C.

Figure 5.2: Types of arguments made by parties in Germany in mental health policy debates over time




*Comments:* Figure displays types of arguments made by political parties over time, as well as the timing of policy decisions, where: S=state, M=market, F=family or V= voluntary responsibility. Primary sources are listed in Appendix C.

Labour abated. In Germany, however, we see quite the opposite, with the Christian Democrats making fewer arguments to reduce the level of spending before 1990, but explicitly defending policies on these terms when cost pressures on the overall health system increased.

While socio-economic conflict was a central division between the two major parties in England, partisan conflict had a different character in Germany. The Christian Democrats were strong supporters of *collectivised* mental health care (and other forms of welfare) in line with a social market economy. They disagreed with the Social Democrats primarily on the question of the level of government that should be responsible for funding services and which actors should be responsible for coordinating them. It was not until after reunification that reducing the tax burden and overall levels of expenditure became a clear priority for the Christian Democrats. While they had been big supporters of the voluntary mental health services in earlier periods, they actually criticised the Social Democrats for expanding statutory entitlements to voluntary mental health services while removing the partial subsidy for more informal community-based care in 1990, on grounds of overall cost. The Social Democrats still opted for a collective solution, making individualist arguments in support of public care alternatives, but they accepted the integration of the mental health services with the wider health system which was dominated by the voluntary sector. The FDP, on the other hand, consistently emphasised the efficiency benefits of voluntary outpatient services.

Individualist arguments were frequently made by both the Labour Party in England and the SPD in Germany. While the liberal parties in both countries had made similar residual arguments to the Conservatives and Christian Democrats, they actually sided with the major left-wing party in making more individualist arguments. But liberals made these types of arguments less frequently than social democratic parties. In both England and Germany, the Labour Party and the Social Democrats made individualist arguments to support their own funding for state responsibility. By contrast, the main liberal party in both countries made individualist arguments in reaction to familial arguments by the Conservatives or Christian democrats, and in response to policy changes that prioritised family care.

But while individualist and familial arguments persisted as parties defended their policies in England during the 2000s, familial arguments have been virtually absent from German mental health policy debates in the

twenty-first century. This could reflect a compromise made within the second Merkel cabinet between the Christian Democrats' and the FDP's competing positions on the role of the family in providing care, in the context of declining support for the Christian Democrats and strong support for the FDP. The FDP's ideological position may have pulled the coalition government in a more individualist direction, which reduced conflict in parliament over the question of who should provide care. Both this pressure from the FDP and the shift in policy position were likely also shaped by wider electoral strategy as the Christian Democrats sought to cater to more working women. This strategy has been documented by Morgan (2013) in relation to family policy in Germany since the 1990s.

While this meant that second-dimension conflict between the two major parties waned in Germany, these conflicts actually became somewhat more important in England over time, marking the difference between the Labour Party and Conservatives as socio-economic conflict declined in the New Labour era. In both countries since the 1990s, cost pressures constrained the types of choices that the Labour Party and the SPD made, and the extent to which they argued in favour of a larger, more redistributive state. When forced by the economic climate to scale back state responsibility, second-dimension concerns played a role in how these parties motivated voluntary or even private sector responsibility for care over that of the family. In the concluding section of this chapter, I assess this the role of parties' ideological positions against competing explanations for the relationship between partisanship and care policy choice.

# Alternative explanations

This chapter has presented evidence from parliamentary debates and government documents which suggests that partisan ideology played a role the way that political parties motivated their care policy choices. But we have also seen that factors such as the economic climate and the structure of the wider health care and social services system were prominent in policy debates. Government decisions were also informed by expert advice about how mental health services should be funded and provided. In this section, I assess the extent to which these other factors may have driven the apparent relationship between government partisanship and care policy decisions.

In both England and Germany, and in the other cases covered in chapter 4, policy decisions to increase family or market responsibility were more common after the 1980s. We learned in chapter 3 that some scholars of psychiatric deinstitutionalisation have argued that fiscal pressure on the welfare state led governments to pursue these cheaper methods of care (Scull, 1984). It was also clear in policy debates in both England and Germany that cost pressures played an important role in policy debates. But it was still the Conservatives in England and the Christian Democrats in Germany that chose to expand family responsibility, by incentivising informal care and providing payments to family carers. Certainly in England, the Conservatives and Liberal Democrats explicitly argued that familial care was the cheapest. So was it simply cost pressures that drove these policy decisions, and would the Labour Party or SDP have made the same types of choices under the same fiscal conditions?

One indication that it was not only economic concerns that mattered is that both the Conservatives and the Christian Democrats also motivated these policy changes on the basis of familial arguments. But stronger evidence that second-dimension concerns shaped the outcomes that we observe are the rather different choices that were made by the Labour Party and SPD under similar fiscal constraints. When the Labour Party in England expanded subsidies for patients' choice of private care providers through the Putting People First concordat and Social Welfare Reform Grant, they argued that public subsidies for private care providers would alleviate families of the burden of care. This stood in stark contrast with the previous decision by the Conservatives to limit government funding for private providers (in order to reduce costs) and instead promote informal familial care. Even though Labour had turned to market responsibility as a cheaper solution than direct public provision, they were committed to providing public funding for care outside of the family.

Similarly, when the SPD were in power in Germany, they expand care in not-for-profit day hospitals and outpatient services because this was cheaper than long-term inpatient care in the state psychiatric hospitals, but they still made individualist arguments that collective care should be provided to promote the independence and employment of women who would otherwise be responsible for informal care. In contrast, just five years earlier the Christian Democrats introduced cash payments to support female caregivers to provide round-the-clock care at home through the long-term care insurance scheme. Even though decisions by all types

of governments were affected by cost pressures, social democratic governments chose policies that would reduce the reliance on informal caregivers while conservative and Christian democratic governments promoted it.

This evidence also suggests that while socio-economic conflict was very important in policy debates, the relationship between partisanship and care policy was not driven by socio-economic conflict alone. Socio-economic ideology can not explain the decisions that social democratic governments take when they *do not* promote state responsibility for care. When faced with cost pressures which constrained the expansion of state services, the Labour government in England and the Social Democrats in Germany chose market and voluntary responsibility for services respectively in order to alleviate the burden of informal care on family members, particularly women. Of course, the policy changes occur during a period when parts of the welfare state literature have suggested that the explanatory power of socio-economic conflict has declined. But conflict about how society should be organised – around individuals, or families – also helps us understand more enduring differences between the liberal parties in both England and Germany and the other major parties. Like Conservatives and Christian Democrats, liberals made residual arguments to reduce state expenditure and the tax burden, but like social democratic parties they made individualist arguments in support of residential, outpatient, and day hospital care services that substituted for family-based care.

Another factor which was clearly relevant in policy debates across the two countries was the structure of the wider health care and social services system, shaped by existing legislation and the federal constitutional structure in Germany. The role of existing institutions in policy debates begs the question of whether decisions about who should care for people with mental illness were shaped in a path-dependent fashion by what the existing literature on deinstitutionalisation has referred to as 'national political cultures' (Goodwin, 1997). We do find some evidence of this path dependency. In the wider sample in chapter 4, we saw that care policy changes promoting voluntary responsibility were most common in countries with conservative welfare regimes, where many of the health and welfare services are provided by voluntary organisations. And in this chapter we have seen that in Germany, even the SPD did not challenge the expansion of voluntary responsibility for care by the Christian-Democrat-led government in 1990, and indeed expanded voluntary responsibility further when they were themselves in power in 1999. But earlier, during the 1970s, the SPD

had prioritised state-run services for people with chronic or severe mental illness, and had fought against new psychiatric services in general hospitals until the mid-1980s. In supporting the 1990 change they explained that this reflected a 'cross-party solution' because the strength of the health care system depended on a 'broad consensus' (BT Plenarprotokoll 11/224, 13 Sep 1990, p. 17624). By this time, not-for-profit dominance and subsidiary governance, which had been most actively promoted by the Christian Democrats, had become a consensus on which wider health policy was based, and with the integration of mental health care into the wider health system this consensus extended to the type of provider that would be responsible for care services.

So did government partisanship play a role in shaping care policy decisions independent of national political cultures? The evidence presented in this chapter suggests that the decisions of the SPD in Germany had a decisive effect on the outcomes that we observe. By prioritising state responsibility early, they developed state-run outpatients clinics which expanded slowly and arguably stymied the pace of the transition from the large state psychiatric hospitals to extramural care alternatives. The SPD were not wholly responsible for the slowness of deinstitutionalisation, for it was conflict about whether voluntary organisations or the state should be responsible for providing services which drove Christian-democrat-led federal states to opt out of the Model Psychiatry Programme. The long-run consensus on the role of voluntary organisations did not emerge independently of government partisanship. Rather, it was actively shaped by the promotion of the voluntary services by the Christian Democrats, who controlled the government of the Federal Republic of Germany for the majority of years in the post-war era of welfare state expansion.

We have also seen that expert advice was raised in policy debates by all parties throughout the period that I study. A third possible alternative explanation for the types of care policy choices that governments made, discussed in chapter 3, is that changing scientific knowledge and expert ideas determined policy outcomes. The idea that who was in government simply didn't matter, because governments regardless of partisanship implemented the policy recommended by experts, is clearly contradicted by the evidence in this chapter. In both England and Germany, there was a high level of agreement on the scientific evidence, but parties interpreted expert advice in different ways and justified policy choices with reference to the types of arguments that reflected their ideological positions.

It is, however, possible that the party in government did make a difference, but not because of ideology. Rather, different parties may have acted in the interests of different professional or provider groups who actively lobbied different parties for their preferred policy. The existing empirical literature posits an important role for professional associations and advocacy groups in shaping deinstitutionalisation policy (Crossley, 1998). But even when parties had connections to particular organisations, they didn't always implement policies to their benefit. In England, the Labour politician Lord Stonham was president of one of the main voluntary sector providers of outpatient and day hospital services, the Psychiatric Rehabilitation Association, but he was also one of the most ardent supporters of public, local-authority-run services. And when parties had connections to the same types of interest groups, they still held different positions. Although members from both major parties in England sat on the board of MIND, Labour politicians were more supportive of directly subsidising voluntary providers. The National Health Service and Community Care Act 1990 was widely opposed by both public employees and voluntary providers, who together comprised the majority of the mental health care sector (Hansard HL, 3 Apr 1990, v. 517, c. 1264).

Policy changes were more often made in consultation with key professional groups in Germany, but we still see a difference in the approaches taken by different parties. The FDP and Christian Democrats were fiercely critical of the SPD's Statutory Health Insurance Reform from the year 2000 (passed in 1999) because of the priority that they claimed it gave to the interests of hospital workers and administrators. In Germany, the Christian Democrats more frequently defended the interests of the independent physicians, while the Social Democrats were accused of prioritising the interests of both public and voluntary hospital workers and administrators (BT Plenarprotokoll 14/49, 30 Jun 1999, pp. 4157, 4168). Social democratic parties in both countries were certainly more connected with public sector unions than other types of parties, and they often acted in their interests and made direct reference to these groups. In mental health policy debates in England, Labour Party members made frequent reference to public sector workers and their unions (for example, Hansard HC 11 Dec 1989, v. 163, c. 732; HC, 7 Dec 1989, v. 163, c. 550; HL 3 Apr 1990, v. 517, c. 1264). It is quite difficult to separate social democratic parties' connections to such organisations from their ideological positions, which are shaped by their *historic* connections to organised labour.

Based on the frequent references made to civil society groups in expert reports and parliamentary debates, it seems reasonable to conclude that these actors played a role in keeping deinstitutionalisation on the agenda (for all political parties), but based on my reading of parliamentary debates and government documents I do not find evidence that they systematically shaped the *type* of care policy changes that determined who would be responsible for care outside of asylums. This doesn't mean that professionals and providers didn't play a role in the type of care that was provided *within* existing policy settings. The changes already made by practitioners were recognised by policy makers in England (Hansard HL, 4 Jul 1962, v. 241, cc. 1251, 1304) and in Germany (BT Drucksache 10/3374, 22 May 1985, p. 39). Future research might explore the relationship between political parties and different types of experts in more detail.

# Conclusion

This chapter has traced parliamentary debates about mental health policy in England and Germany, demonstrating that governing parties made both more redistributive or residual arguments, and more individualist or familial arguments to support their policy positions. Socio-economic conflict played an important role in shaping the decisions of social democratic governments to prioritise state responsibility for care, and it was also an important motivation for conservatives and Christian democrats to promote policies that expanded the responsibility of non-state actors – the voluntary sector, the private sector, and the family – in order to reduce costs. In this chapter, as in the previous, we have seen that the motivations for pursuing family care in particular were not only based on familial arguments about the role of the family in providing care, but also motivated by cost savings. Second-dimension arguments were, however, relevant in policy debates and appear to have shaped the decisions that social democratic governments took when faced with fiscal constraints in particular. In the following chapter, I look for similar arguments in the parliamentary debates about child welfare policy changes in England and Germany.

# Chapter 6

# Child welfare policy in England and Germany

During the winter of 1962–3, peers in the British House of Lords spent some three sitting afternoons debating whether the first clause of the Children Bill should oblige local authorities 'to make arrangements for', 'to make available', or 'to provide' preventive assistance to families in order to reduce the extent of institutional care. This was more than a matter of semantics. The subsequent legislation enabled a shift in child welfare services toward a more preventive approach that aimed to keep so-called 'broken' families together. While the two major parties agreed that 'prevention [was] better than cure', its drafting brought out a major disagreement about the state's role in the protection and care of children and families. The Labour opposition wanted to establish that responsibility 'to provide' rested 'fairly and squarely' with the state, while the sitting Conservatives feared that a legal duty for the state to provide would not only reduce the possibilities to work through voluntary agencies, but also threaten the autonomy of families, leading to services being 'thrust down the throats of unwilling recipients' (Hansard, HL 4 Dec 1962, v. 245, c. 171; 24 Jan 1963, v. 246, c. 157). At stake was not just the question of how big and redistributive the welfare state should be, but clashing ideas about the nature of the family: as an independent unit of society that existed prior to and outside of state intervention, or one which was actively created, promoted, and protected by public policies.

This disagreement between more familial and more individualist ideological positions has been reflected in child welfare debates in both England

and Germany since the Second World War. Despite a high level of agreement on the scientific evidence that children did better when they were raised in a family environment, partisan governments in the two countries took distinct positions on the extent to which the state should shape, or intervene in, familial relations, and who should provide alternative care if the family was unable.

In this chapter, I interpret the parliamentary debates around policy changes that affected the use of institutional care for children in England and Germany between 1950 and 2015.[1] As in the previous chapter on mental healthy policy, I examine the justifications that members of parliament offer for their policy positions, to assess the role and salience of socio-economic and second-dimension conflicts over time. The reader will recall from the previous chapter that arguments in favour of a redistributive state defend higher levels of government spending and public-sector employment, and frame policy solutions as providing equal access and quality of services for all citizens. On the other hand, arguments in favour of a residual state promote lower levels of government spending, taxation, and public-sector employment, and frame policy solutions as being efficient or delivering services on the basis of need. Familial arguments frame the family as a natural site of care, and claim that people do better when they are cared for by their families, or that the independence of the family from state intervention should be preserved. Individualist arguments claim that individuals do better when they are not dependent on family relations, or that individuals in need may not have families, framing the family as something constructed by or dependent on public policy.

I begin this chapter with a brief historical overview of the existing services for children who could not be cared for by their parents, in England, where a mix of public and voluntary services existed, and Germany, where the voluntary sector was mainly responsible for care. The following analysis of parliamentary debates in England and Germany in turn shows that despite a high level of bipartisan agreement on the goal of deinstitutionalisation, partisan actors disagreed about whether state, market, family, or

[1] I consult the debates on relevant bills as well a a wider range of parliamentary debates on child welfare issues, that mention the terms 'child welfare', 'orphan', 'orphanage', 'children's home', 'community home', 'children's care home', 'boarded/ing out', 'foster care', 'guardianship', 'adoption', or 'looked-after children' in English, and 'Jugendfürsorge', 'Jugendwohlfart', 'Jugendhilfe', 'Jugendämter', 'Waise', 'Vollwaisen', 'Heimkinder','Waisenhaus', 'Kinderheim', 'Heimerziehung', 'Erziehungsheim', 'Adoption', 'Pflegekinder', in German.

voluntary providers should take responsibility for the care of children who could not be cared for by their parents, and they justified these positions using both socio-economic and second-dimension arguments. At the end of the chapter, I compare child welfare policy developments in England and Germany, and assess the evidence for alternative explanations. I show that a multi-dimensional perspective on partisan conflict allows helps to explain not only variation in policy decisions made within countries over time, but also the key differences in child welfare policy developments between England and Germany.

## Orphanages to 1950

Two features of the orphanage systems in England and Germany formed important context for the policy decisions that would follow in the period that I study. In both England and Germany, voluntary organisations played a greater role in the care of children than that of people with mental illness. Firstly, while voluntary providers were dominant in Germany, only about half of the orphanages were administered by non-state organisations in England, and the voluntary providers were predominantly religious. Secondly, although in both countries the types of children that were housed in orphanages – or the reasons that they could not be cared for by their parents – were diverse, institutions in England were more specialised by 1950.

Nineteenth-century orphanages in England had housed a mix of children with deceased or absent parents as well as children convicted of, or at risk of committing, crimes. By 1950, a more specialised range of residential and substitute care services existed for children who could not be cared for by their parents, but all of these institutions were considered together in deinstitutionalisation policy debates. National Assistance institutions managed by local authorities housed orphans and children left in care by their parent or parents, while separate institutions managed by the Ministry of Pensions housed war orphans. Remand homes and approved schools, formerly known as industrial or reformatory schools, housed children who had been convicted as juvenile offenders. The latter were largely run by voluntary organisations under the supervision of the Home Office (Gear, 1999, p. 11). In practice, the distinctions between institutions were not always fixed, especially in areas of the country where fewer services were available. For instance, children removed from their homes for care

and protection were sometimes temporarily placed in remand homes before being transferred to foster care or local authority orphanages (Hansard HC, 8 Mar 1951, v. 485, c. 643).

Although the voluntary sector was relatively smaller in England than in Germany, voluntary providers played an important role in England's relatively early deinstitutionalisation. The administration of services was almost an even mix of private and public by the beginning of the period that I study. Of approximately 120 000 children in substitute care, a little over half were cared for by local authorities, about 40 000 were in the care of voluntary providers, and almost 20 000 overseen by private, for-profit organisations (Masson, 2000). The first moves away from institutional care were the initiative of voluntary organisations within existing policy settings. Alternatives such as smaller group homes or foster families were widely used by voluntary organisations by the 1950s. Approximately 65 per cent of children in care were in residential institutions, with the remaining 35 per cent 'boarded out' in foster care (Lynch, 2020). Foster care and adoption (the latter also known as guardianship) had been publicly regulated since 1926, but were managed by voluntary and private organisations. While the first public institutions closed in Manchester in 1956, the number and proportion of children in public residential care nationwide actually slightly increased between 1959 and 1966 (Home Office, 1967, pp. 6). During the same period, numbers fell dramatically in the voluntary sector, from 17 000 children to 10 000 children, where larger homes had closed and smaller homes opened (ibid, p. 12).

The voluntary sector had played a much greater role in the provision of German orphanages since the late-nineteenth century. In eighteenth-century Germany, public foundling homes were developed to care for orphaned and illegitimate children, to prevent infanticide and to promote population growth, but under pressure from moral opponents these institutions declined, and by the nineteenth century the care of orphans and other children who could not be cared for by their parents was mainly by voluntary, religious organisations (Ulbricht, 1985). By the turn of the twentieth century, a child welfare system had been developed, codified in the 1922 Child Welfare Act (*Reichsjugendwohlfahrtsgesetz*), with services primarily delivered by voluntary providers that received public funding from municipalities (Wolff, 1997). Adoption was legalised in 1900, but its use (as in France and other southern European countries) remained relatively low compared with adoption rates in England and Scandinavia (Mignot, 2019,

p. 10). Fostering had been practised in Germany during the nineteenth century, but became more common after 1922 as local authorities found it cheaper than funding institutional care by the voluntary organisations (Mouton, 2005, p. 550). In both England and Germany, then, foster care had been the preferred alternative to institutional care trialled by the existing providers. This innovation would be important context for policy decisions after 1950.

Orphanages in Germany were more mixed institutions than those in England, caring for orphans and half-orphans, as well as children up to the age of 14 who had committed crimes (Dünkel, 2008, p. 226). During the National Socialist era, the legislation governing the municipal system of care was subordinated to the 'Führer Principle', which saw many voluntary child welfare organisations nationalised and custody become more punitive (Wolff, 1997, p. 214). Because of the diverse reasons that children could not be cared for by their parents, in both England and Germany debates on substitute care for children were shaped by both social policy and public order concerns. Child welfare policy changes during the 1950s to 1970s were motivated not only by a desire to implement deinstitutionalisation, but by a concern with the rise in what was known as 'juvenile delinquency' since the end of the war (Hansard HL, 20 May 1953, v. 182, c. 668; BT Plenarprotokoll 1/205, 23 Apr 1952, p. 8853). Debates around the care policies that would replace orphanages were also linked with emerging day-time child care services because orphanages and children's homes had been used as a form of care by single working parents, both during the nineteenth century and in the decades after the war.

In the aftermath of the Second World War, the number of orphans and half-orphans had dramatically increased in Germany, so the problem of inadequate institutional care for children was much more pressing than for people with mental illness, where, as describe in the previous chapter, large numbers of residents had perished during the war. In the immediate post-war years, thousands of German children were adopted internationally (Mignot, 2019, p. 18). Child migration was a feature of post-war child welfare policy in both England and Germany, but it affected less than one per cent of the children in care in both countries.

# England

By the mid-1950s in England, the scientific wisdom which informed departmental reports and parliamentary committees was that children developed best when they had strong primary carer relationships, and that family care led to better outcomes than an institutional environment. Both parties agreed on and accepted the general principle of deinstitutionalisation, supported by the numerous government commissions and reports that informed child welfare policy making throughout the second half of the twentieth century.

In this part of the chapter, I trace parliamentary debates around five major policy decisions in England which affected the use of orphanages, listed in table 6.1. We will see that legislation was mostly passed with bipartisan support, but when in power Conservatives prioritised family autonomy and responsibility for care, and at least during the second half of the twentieth century Labour governments expanded the mandate of the state to both actively shape family relationships and directly provide alternative care in new, smaller institutions. We will find that despite supporting a role for voluntary, and particularly religious, providers, the autonomy and responsibility of the family was the Conservative Party's priority. Although Labour also accepted the scientific evidence on the benefits of family-based care, they saw a far greater role for the state in shaping and protecting the family that was at odds with the Conservatives' vision of society.

Table 6.1: Child welfare policy changes in England

| Year | Leading Party (PM) | Policy type | Policy or legislation title |
|---|---|---|---|
| 1963 | Conservative (Macmillan) | Family | Children Act |
| 1969 | Labour (Wilson) | State | Children and Young Persons Act |
| 1975 | Labour (Wilson) | Family | Children Act |
| 1989 | Conservative (Thatcher) | Market | Children Act |
| 2008 | Labour (Brown) | Market | Children and Young Persons Act |

*Comments:* Table lists child welfare policy changes made in England between 1950 and 2015, indicating the leading part of government and prime minister (PM), as well as the type of policy change according to the classification system used in Chapter 4.

## Prevention and family responsibility

The first major policy change shaping the use of institutional care in England after 1950 was the Children Act 1963, which allowed local authorities to fund preventive family assistance, leading to an increase in care in the family and a decline in residential care (Bullock and Parker 2014, p. 12; Littlechild and Meffan 2012, p. 94).[2] The context for the 1963 policy decision was a high level of agreement among political parties about the need to reduce institutional care of children, and promote family or family-like care as an alternative.

The work to implement this shift had already begun prior to 1950, when Clement Attlee's Labour government had passed the Children Act 1948, which prioritised foster care as the preferred solution for children who could not be cared for by their parents (Wilson and Petrie, 1998). On the one hand, the 1948 Act expanded a form of care – foster care – that had already been favoured by the voluntary organisations that were reducing institutional care within existing policy settings. But it was also based on new scientific ideas in the study of child development, which had informed the 1946 Report of the Care of Children Committee, chaired by Dame Myra Curtis. Lynch (2020) argues that the Curtis Report established landmark principles for out-of-home care which prioritised the emotional care of the individual child. There was a high level of agreement between the major parties that the family was the preferred site of care, but disagreement about how and by whom services should be provided, both to prevent the removal of children from their families, and to substitute for family care when required.

The 1948 Act was passed alongside a range of legislation that aimed to establish a new role for the state in the post-war era, which was being referred to by politicians as the 'Welfare State'. The large number of debates on child welfare policy issues during this period reflected the importance of this policy area within the emerging social services. Although the 1948 Act promoted family-based care by expanding the use of foster care by local

[2]There were a number of legislative changes relating to child welfare services during the 1950s, but none made substantial changes to the use of custodial care. The Adoption Act 1950 consolidated legislation from 1926, 1939, and 1949. Following the 1954 Report of the Departmental Committee on the Adoption of Children chaired by Sir Gerald Hurst, the Adoption Act 1958 and Children Act 1958 made changes to the regulations and procedures for adoption and foster care, but no changes were made to the responsibility for care services.

authorities, the post-war Labour government also expanded the power of public authorities in the child welfare system. It gave local government children's committees the authority to assist struggling families, subsidise voluntary services, or, in cases of suspected cruelty or neglect, to remove children into state care. Substantial investment was also made into in the training of professional carers (Hansard HL, 25 Mar 1952, v. 175, c. 957).

The Conservative Party was returned to power in 1951, and while they supported many aspects of the state's new welfare role, including the National Health Service, they took objection to an activist state in the area of child welfare. In the House of Lords, the Conservatives argued 'that the state's action in fostering the family should be action at a distance' (Hansard HL, 20 May 1953, v. 182, cc. 680–1). This reflected their view of the family as an independent social unit, or a more familial position in second-dimension conflicts in my theoretical framework. But they also challenged an active role for the state on the basis of a more residual socio-economic perspective. A Conservative peer expressed that, 'I do not think that the present structure of the social services is designed primarily as a method of redistribution of the nation's wealth... I do not think it is one of the primary objects for which the social services exist' (ibid, c. 690).

Liberals at this time focussed on the potential efficiency benefits of new policies to reduce child neglect and promote family cohesion. One liberal peer referred to a pamphlet printed by the Children's Officers' Association, entitled 'Cruelty to Children', quoting that 'a tithe of the money spent on maintaining neglected children in institutions apart from their parents could provide, throughout the Kingdom, a first-class family service that would considerably reduce the incidence of neglect' (ibid, c. 700). Liberals were thus, like Labour, more open to intervention in the family, but they supported it on the basis of a more residual socio-economic position.

The Children Act 1963, introduced by the Conservative government, would shape the terms of the new family services. As a Conservative government policy change promoting family responsibility, it reflects a typical case in my theoretical framework. It aimed to reduce the number of children removed from their families for protection from abuse or neglect, as well as those being brought to court by their parents as 'beyond control'. Large numbers of children who would formerly have been institutionalised should instead be assisted to remain in the care of their families. The Act was based on the recommendations of a 1960 report on the question of juvenile delinquency and the operation of the children's courts, prepared

by the Committee on Children and Young Persons, and known (after the committee's chair) as the Ingleby Report. At the second reading debate on the Children Bill, Lord Ingleby highlighted the themes of the report, 'that prevention is better than cure' and 'that parental responsibility must be made paramount' (Hansard HL, 20 Nov 1962, v. 244, cc. 828–9).

The heart of the debates at both the second and third readings in the Lords, as well as in the House of Commons, was on the the first clause, the prevention clause, which was to be repeatedly re-drafted through tabled amendments over the coming months. The government's original version stated that 'it shall be the duty of every local authority to make arrangements for such advice, guidance and assistance to be available, as far as practicable, as may promote the welfare of children by diminishing the need to receive children into or keep them in care'. This drafting retained scope for voluntary organisations to act as providers of preventive services and did not oblige the local authorities to intervene in cases of suspected abuse or neglect. The Conservative Minister of State for the Home Office explained that 'the major object of the major clause of this bill is to help parents to help themselves and, through themselves, their children. It is to ensure, in fact, that the responsibilities of parents are not necessarily handed over to public authorities' (ibid, c. 814).

The Conservative government supported a role for voluntary, religious providers in delivering preventive services. At a time when the role of the state in relation to the new social services was still in the making, clergy peers in the House of Lords argued that the Church 'must send its own members into the welfare services and it must actively collaborate with the statutory social worker' (ibid, c. 834). Conservative politicians expressed support for the role of the voluntary and religious organisations in both the House of Lords and the Commons (Hansard HC, 27 Feb 1963, v. 672, cc. 1295, 1334). The responsible Under-Secretary of State for the Home Department emphasised that 'the local authority is to be free to seek assistance from the various voluntary organisations, some of whom already have valuable experience in preventive work' (ibid, c. 1271). In contrast with the mental health policy debates of the same period, where the Labour party were more supportive of voluntary agencies as a second-best alternative to state care, the Conservatives were far more supportive of voluntary child welfare services. This is consistent with the parties' positions in religious conflicts, because the voluntary organisations caring for children were predominantly religious.

Conservatives also made familial arguments which emphasised parental responsibility and minimal intervention by the state. The Parliamentary Secretary to the Ministry of Health expressed that 'the aim of it all ought to be to make the family independent and able to stand on its own feet... I do not believe that any public authority ought to intervene or interfere in private family affairs unless it is really necessary' (ibid, cc. 1332–3). The role of these familial arguments was to speak out against state intervention in the family, but they did not preclude the role of religious organisations in providing preventive services.

The question of the independence of the family, or second-dimension concerns, was less salient in arguments made by liberals, who instead focussed mainly on socio-economic arguments. They made clearly efficiency-based arguments in favour of preventive action, stating for instance that it was 'far more expensive, from an economic viewpoint, to take into care than to pay the not very big sum needed to keep the family together' (Hansard HL, 20 Nov 1962, v. 244, c. 824).

On the other hand, both socio-economic and second-dimension concerns were important in arguments made by Labour politicians. The role of more redistributive arguments, in favour of the expansion of local authority services, was to enhance the overall quality of services and equality of access to services, as they argued that the voluntary services were not of an equal standard. The Labour Party campaigned for the transfer of the voluntary-run approved schools to the Education or Social Services Departments and additional public investment in the training and employment of staff (Hansard HL, 20 Nov 1962, v. 244, cc. 842, 851–53; HC, 27 Feb 1963, v. 672, c. 1293). They also called for additional central government funding for local authority facilities (ibid, c. 1301). Labour also opposed the Conservative Party's focus on the responsibility of the family on the basis of this more redistributive argument about expanding the capabilities of local authorities. They argued that so long as responsibility was 'divided between the family and the public authority, the public authority can all too easily shuffle out of its responsibilities' leading to poorer quality local authority services (Hansard HL, 20 Nov 1962, v. 244, c. 817).

But Labour's main objection to the Children Bill was based on their view that the state should ultimately be responsible for shaping and supporting families, which the Conservative party saw as an intervention into family autonomy. The Labour Party would not support the bill as drafted, and unsuccessfully requested an amendment that would change the

wording of the first clause to read that 'it shall be the duty of every local authority *to provide* such advice, guidance and assistance'. Labour peers argued that 'the proposed amendment would not exclude local authorities from cooperating with suitable voluntary agencies in the work involved, but it would ensure that responsibility for positive action rested upon the local authority itself' (Hansard HL, 4 Dec 1962, v. 245, c. 164). They challenged the government's preference to leave preventive work to the voluntary, primarily religious, organisations. In the Commons, they insisted that 'voluntary bodies will augment the work of local authorities and not replace them' (Hansard HC, 27 Feb 1963, v. 672, c. 1285).

The arguments that the major parties made to support their positions on the drafting of the Children Act 1963 reflected enduring positions that had been expressed in debates since the early 1950s. Even despite agreement on the aim of reducing institutional care and – based on scientific advice – increasing the role of family care, the major parties were divided in arguments not only about the size of the state, but the nature and autonomy of the family. Although the Labour Party certainly supported more extensive investment in the public sector to support its role as service provider, their alternative wording of the Children Act 1963 prevention clause would have no direct effect on the funds available for workforce expansion. Their principal concern was to codify an active role for the state in shaping the family, while the Conservatives acted to preserve the autonomy of the family as an independent social unit.

### Labour expanding the state's mandate

When the Labour Party entered government in 1964, the broader political context meant that child welfare policy was not initially high on the agenda. The policy change that would eventually be made in 1969 would expand the role of public authorities in providing both preventive family assistance and directly managing new out-of-home care facilities. In contrast with the 1950s and early 1960s, child welfare policy was not a central issue for either of the major parties at this time, and there was relatively less contestation in parliament of the state's role as a provider of care.

Child welfare policy was hardly debated during Harold Wilson's first term. Wilson won just a four-seat majority in October 1964, and his party's fortunes had turned in the context of a troubled economy, with the cost

of living the central issue for voters.[3] Labour promised new investment in social services in their election manifesto, but their main focus was an ambitious plan for economic modernisation (Labour Party, 1964). Nevertheless, a slim, 14-page white paper was published in August 1965 which would leave a lasting impression on the treatment of juvenile delinquency, by introducing the idea of the family court. *The Child, the Family and the Young Offender* proposed taking children and young people under the age of sixteen out of the criminal court system and merging the voluntary-run approved school service with a comprehensive residential system for children who could not be cared for by their parents (Home Office, 1965).

Frustrated in parliament, Wilson called a snap election in 1966 which would deliver an increased majority and a new mandate for social policy change. The Committee on Local Authority and Allied Personal Social Services, chaired by Lord Frederic Seebohm, was tasked to review local authority personal social services and make proposals for an effective family service (Jones, 2020, p. 47). Its final report, published in 1968, recommended the creation of a social services department in each local authority where health, family, and personal social services could be jointly coordinated. In the midst of the devaluation criss, internal Cabinet-room politics delayed progress on the family service legislation and led to the production of a second white paper by the new Secretary of State for the Home Department, James Callaghan.

Although consultation had been conducted on the basis of *The Child, the Family and the Young Offender*, the 1968 white paper *Children in Trouble* informed the Children and Young Persons Bill, which was introduced into the house of Commons in the new year (Hansard HC, 11 Mar 1969, v. 779, c. 1193). The extent of residential care had reduced somewhat in the five years since the Children Act 1963. The Seebohm Report showed that about 54 per cent of the 69 000 children in care were fostered out, but a further 150 000 children were being helped in their own homes (Jones, 2020, p. 64).

The Children and Young Persons Bill would bring together the system for juvenile offenders and other children in care, in an effort to extend local authority preventive work to children who had committed minor crimes,

[3]According to national opinion polling, 72 per cent of respondents reported cost of living as an important issue for the election, followed by education, housing, and pensions at 29, 27 and 25 per cent of voters respectively (Butler and King, 1965, p. 128).

and thereby reduce the number of children taken into care for this reason. In addition, the legislation would shift responsibility for the care of juvenile offenders away from the voluntary-run approved schools under the purview of the Home Office, into a single care system overseen by the new Department of Health and Social Security and administered by the local authority children's committees (Davis, 1981). Some 10 000 children then cared for by voluntary organisations would be transferred into the care of public authorities, and, along with the 20 000 already in public residential care, transferred from large institutions to new, smaller community homes (Hansard HC, 11 Mar 1969, v. 779, c. 1181). The bill also restricted the growing number of private foster agencies and provided additional support for the training and employment of child care officers (ibid, c. 1185).

The Labour Party used primarily redistributive arguments to justify the responsibility of public authorities to provide both preventive services and care facilities. In the first instance, state responsibility was justified on grounds of improving the quality and equality of access to services. Callaghan explained that that bill aimed 'to ensure as nearly as we can real equality for all children of all classes and backgrounds' (ibid, c. 1116). Consistent with their position in 1962–3, the government argued that non-government substitute care was not providing an equal standard of care for all. Callaghan recognised that 'a very considerable contribution has been made over the years in a great many approved schools... [but] the results are uneven (ibid, c. 1183). Further, he argued against private responsibility, stating that 'the powers of local authorities to protect foster children are in some respects inadequate. The number of privately placed foster children has grown considerably in recent years' (ibid, c. 1186).

Labour also made a more redistributive argument in favour of local authorities' power to decide on the appropriate response to children convicted of minor crimes. Callaghan explained that 'the family of the middle-class child, his school, his social background, all the factors that surround his whole life, are there to provide facilities to support and correct him where it is necessary' (ibid, c. 1191). He argued that the Children and Young Persons Bill aimed to prevent poorer children from coming before the courts where other children would not usually (ibid, c. 1294). Consistent with their earlier position on expanding the size of the public sector, Labour politicians raised the need for investment in local authority staff and training, as well as additional public capital expenditure to provide the new community homes (ibid, cc. 1213, 1224, 1269).

The Conservative opposition, in contrast with their position during 1962–3, did not devote much time to defending the role of the voluntary services as an alternative provider, and their arguments against state intervention were not explicitly about the autonomy of the family. Their focus was on challenging the role of local authorities in making decisions about whether or not a juvenile offender should be taken into care, expressed as a 'fundamental objection to state intervention in a juvenile's life through an executive rather than a judicial body' (ibid, c. 1215). Moving to protest the bill's second reading, the Conservatives stated that 'in point of fact this is largely a civil servants' measure and we suffer more and more in this House by government of civil servants by civil servants for civil servants' (ibid, c. 1197). This was neither an explicitly familial argument, nor did they make residual arguments directly objecting to the requisite increase in spending on public employees.

The Conservatives' focus on the bill's proposal to shift responsibility for decisions about child removals away from the courts can be understood in the context of the party's effort to elevate law and order as a political issue. Although the Conservatives had long defined themselves as the party of law and order, the issue had not featured in any party's election manifesto since the Second World War, until the Conservative Manifesto of 1970 (Morgan and Downes, 1997). The Conservatives positioned themselves as 'tough on crime' in contrast with the permissiveness of the Labour government in the context of rising crime rates. They argued that 'urgent action [was] needed to check the serious rise in crime and violence', and attacked the the Labour Party for attempting to 'shrug off' its responsibility in this area (Conservative Party, 1970). The centrality of the judicial aspect in the debates that took place in 1969 reflected the Conservatives' increasing focus on the issue of law and order at that time.

There was relatively little debate over the creation of new community homes in the place of voluntary-run approved schools. This may have reflected the clearer role that the new white paper ascribed to the voluntary services, perhaps the result of intermediate consultation. The earlier white paper from 1965 had left the involvement of voluntary organisations up to the local authorities, reading that 'the Home office will welcome the continuing interest and support of voluntary workers in its own training establishments; and there is no reason to doubt that the local authorities will be equally glad to enlist voluntary help' (Home Office, 1965, p. 13). *Children in Trouble*, on the other hand, made clear that 'the Govern-

ment attaches great importance to the further development of partnership between public and voluntary bodies in meeting these needs, and the public system will therefore include both local authority and voluntary homes' (Home Office, 1968, p. 12). Nevertheless, the role and status of voluntary establishments would ultimately be decided by the local authority joint planning committees (ibid, p. 14).

The bill allowed community homes to be run in three forms: as local authority homes delivered directly by the state, as 'controlled homes' with local authority finance and managerial control but voluntary staff, or as 'assisted homes' delivered by the voluntary organisations with local authority representation on the board and at least half of available places reserved for children taken into care by the local authority. The local authority was thus responsible for the planning of community homes and involved in managing all three forms of care (*Children and Young Persons Act 1969*, cl. 35–6). In the Commons, Callaghan expressed the hope that 'the excellent facilities provided in establishments now run by voluntary organisations as approved schools or voluntary homes [would] through partnership with the local authorities, become available to them... while preserving for the voluntary organisations a part in the management of these establishments' (Hansard HC, 11 Mar 1969, v. 779, cc. 1182–3).

It was not until after the committee stage, in the House of Lords, that Lord Jellicoe made an intervention defending the status of the voluntary services. He said, 'I trust that this Government, who have done so much in other fields to dry up the springs of voluntary effort, will here at least do all they can to give real scope and elbow room to the voluntary body' (Hansard HL, 19 Jun 1969, v. 302, c. 1146). The Conservatives twice attempted to insert an amendment, supported by the Approved Schools Association, to refer to the community homes as 'community homes and schools', but the point was quickly conceded on both occasions (Hansard HC, 9 Jun 1969, v. 784, c. 1166).

The debate in the Lords reflected some conflict between the two major parties about the autonomy of the family. Conservative peers were concerned that nowhere in the bill was a responsibility placed upon the parents (ibid, c. 1174). Speakers for the government, on the other hand, welcomed the state 'co-opting the responsibilities of parents and the family' in order to encourage families to seek help (ibid, cc. 1199–1200). The deputy speaker and government whip summarised the government's view on an active role for the state in protecting and promoting the family:

> There is nothing in this bill, I believe, that will undermine the responsibility of parents. The point is to assist, to support, to strengthen and to help the parents in the upbringing of their children (ibid, c. 1208).

The Children and Young Persons Act was passed with bipartisan support in October 1969, reflecting a high level of agreement among parties on the goal of deinstitutionalisation. Along with the Local Authority Social Services Act, which made changes to community care for mental health to further implement the Seebohm Report's recommendations, the legislation passed by the Wilson government gave the state a new mandate for the provision of care facilities and services (Littlechild and Meffan, 2012, p. 94). Though informed by expert advice from the Seebohm Report, the expansion of the role of public authorities as direct providers reflected Labour's expressed preference for the responsibility of the state for care. Perhaps because of the wider political context and the relatively low politicisation of child welfare policy, there was relatively little contestation over who should provide care.

### Adoption as a family-based alternative

Child welfare policy remained a low-priority issue in the early 1970s, as Edward Heath's Conservative prime ministership was marked by international economic crisis, domestic industrial disputes, and the escalation of the Troubles in Northern Ireland. When Wilson was returned as Prime Minster in 1974, the Labour Party continued its programme of child services reform, with a focus on adoption. Like earlier legislation, the policy change was informed by the recommendations of an ongoing departmental committee that received evidence from a range of experts and professional associations, and it resulted in the expansion of adoption as a family-based alternative to institutional care. The Labour Party had accepted the scientific evidence that children did best when raised in a family environment since as early as the Children Act 1948, so this policy change – which runs counter to my expectations about social democratic parties' preferences – might be seen as chiefly driven by expert ideas, and not partisanship. But, in expanding the responsibility of adoptive families for the care of children who could not be cared for by their birth parents, the Labour government also expanded the capabilities of the public sector by creating

a professional public adoption service, and increased the power of the state to intervene in family life.

The creation of a public adoption service was a Labour Party initiative. The Departmental Committee on the Adoption of Children, chaired by Sir William Houghton, had been established under the Labour government in July 1969 (Hansard HC, 24 Jul 1969, v. 787, c. 2112). In its final report, published in 1972, the Houghton Committee recommended increasing coordination of the sector by establishing a central public adoption service, clearer procedures for fostering and adoption, and greater powers for local authorities to intervene to protect children (Home Office and Scottish Education Department, 1972). Labour's David Owen had introduced a private member's bill to implement the changes during Edward Health's prime ministership, but the legislation did not progress. Following the 1974 election, Owen led the consultation phase for the Children Bill 1975, as Minister of State for Health and Social Security.

The Children Bill was framed by the government as having two main purposes. On the one hand, it would seize the opportunity of unmet demand from couples who wanted to adopt, to provide more appropriate family-based care for children who were in institutions. On the other, it would clamp down on the expansion of private, for-profit adoption agencies. Adoption had been regulated since 1926 but predominantly privately organised, and although the number of adoptions had grown substantially to a peak of 24 800 in 1958, the rate had declined during the 1960s (Keating, 2009, p. 206). The Lord Chancellor introduced the Children Bill into the House of Lords in January 1975, stating that it was designed to address the problem of some 7 000 children in residential care run by local authorities and voluntary organisations, 'who were thought to need permanent substitute families' through fostering or adoption (Hansard HL, 21 Jan 1975, v. 356, c. 18). The proposed legislation would expand access to family care, but on the basis of greater regulatory power for the public authorities. It transferred oversight of children's residential, fostering, and adoption services from the local to central government in England and Wales, to create a public adoption system run by professionals who would be trained and employed by the state. The Labour government stated that the new system would restrict the operation of private agencies which, they argued, did not put the interest of the child first (ibid, c. 42). As they had done in earlier discussions of private fostering agencies, Labour questioned the quality of provision by organisations with a profit motive.

The Conservatives in the House of Lords commended the bill and emphasised its cross-party support, evidence of agreement on the principle of deinstitutionalisation. But although they agreed with the goal of increasing family-based care, Conservatives spoke against the level of responsibility that the Children Bill conferred on state actors. In particular, they objected to the right given to public authorities to dispense with the consent of biological parents and place children into alternative care. They made few explicitly familial arguments about the rights of 'natural' parents, but instead argued against the increased power of public authorities, suggesting that the new responsibilities would instil significant decision-making power in individual social workers (ibid, cc. 87–90). As the bill progressed through the committee stage, they disputed local authority power to revoke parental rights, and argued that the same powers that applied to approved voluntary agencies should apply to local authorities (Hansard HL, 13 Feb 1975, v. 356, c. 1488; 6 Mar 1975, v. 357, c. 1424).

In other debates during the period, Conservatives defended the ability of religious organisations to progress deinstitutionalisation policy without the interference of the state. The Labour government had introduced new land sales legislation to enable the profits of sales from the closure of children's institutions to be directed through the local authority to fund alternatives services. In the Commons, the Conservatives defended the burden on churches who would no longer be able to sell land 'on the free and open market' to fund new initiatives. They suggested that 'the Labour party does not want all those facilities. It wants the whole thing municipalised and state-controlled' (Hansard HC, 29 Apr 1975, v. 891, c. 265).

The Conservative Party successfully lobbied the government to protect some of the independence of the voluntary sector, with a compromised amendment negotiated that would restrict the removal of children from the care of voluntary organisations, but retain the right of removal by local authorities without parental consent (Hansard HL, 5 Nov 1975, v. 365, c. 1265). Despite the conflicts that I have highlighted, the debates generally signalled the intent of both major parties to craft bipartisan legislation that would place the best interests of children at the centre of the child welfare system. The Children Act 1975 and Foster Children Act 1980 were later consolidated into the Child Care Act 1980, with no additional changes to service provision or the responsibility for care (Ball, 1998, p. 166).

Although the policy choice to expand family responsibility for care clearly reflected the influence of scientific knowledge and expert ideas, the

Children Act 1975 that was passed by the Labour government established a professional public adoption service that would likely not have been created by a Conservative government, had they been in power. The Conservatives favoured voluntary responsibility and defended the independence of religious organisations in particular. They also opposed the expansion of public-sector capability to which Labour was committed. The conflict between religious and secular values was certainly relevant to the Conservatives' defence of voluntary organisations, but second-dimension concerns were more implicit in Conservatives' arguments against the expanded role for the state, which also implied greater public sector employment and investment in training. In these debates, then, the independent role of more familial or more residual arguments is less clear. In a policy area which the Lord Chancellor recognised was fundamentally about 'the state entering into the delicate field of family relations', the two dimensions of partisan conflict were closely connected.

### Conservative expansion of private provision

The coming to power of Margaret Thatcher signalled a general intensification of partisan conflict in British politics, and this conflict would enter the area of child welfare policy in the late 1980s, when the Conservatives repealed the powers of local authorities that had been established by Labour in 1975, and created a new funding stream to expand private, for-profit children's homes.

The decade had begun with a bipartisan initiative to enable the registration of for-profit children's homes, which the Labour Party was concerned were going completely unregulated. The Children's Home Act 1982 enabled the registration of market providers, but it did not promote their expansion. Owing to the close cooperation of the major parties in drafting, the bill progressed through the committee stage to its third reading without any amendments. One Labour member commented that 'there has been a tremendous degree of cooperation both in the House and in the Department of Health and Social Security' (Hansard HC, 22 Apr 1982, v. 22, c. 523). Peers in the House of Lords used the occasion of the bill's passing to celebrate the recent birth of Charles, Prince of Wales, though the responsible Parliamentary Under-Secretary of State for the Department of Health and Social Security, though it 'worth saying that it is unlikely that the new Prince will end up in one of these homes' (Hansard HL, 22 June 1982, v. 431, c. 915).

The atmosphere of cooperation disintegrated over the following months and years. The House of Commons Social Services Committee produced a damning *Children in Care* report in early 1974, prompting the government to set up an Interdepartmental Review of Child Care Law. This type of review process involves consultation with experts, but it is lead by civil servants rather than politicians, so unlike the parliamentary select committees does not include representation from all the parliamentary parties. The political climate was heightened while the review was being conducted by five widely publicised deaths of children at the hands of their caregivers between 1984 and 1987, where local authority social services departments were found culpable of having failed to prevent the tragedies. In 1987, local authorities in the northern county of Cleveland were found to have falsely removed large numbers of children on grounds of suspected sexual abuse (DHSS, 1987b).

The Government's 1987 white paper, *The Law on Child Care and Family Services*, aimed to promote the care and upbringing of children within their families by repealing the responsibility of local authorities established by Labour in 1975 and giving birth parents more rights to continue to be involved in their children's care (DHSS, 1987a, para. 35). The Conservatives implemented this change in the Children Act 1989, along with changes to service provision that would expand the responsibility of market care providers. The introduction of the Children Bill would await the split of the Department of Health and Social Security into two separate departments by order of the the Privy Council in In July 1988. The Children's Office was moved to the Department of Health, and the Children Bill was introduced into the House of Lords in November.

Although it was repeatedly framed by the government as a non-political bill, the Labour Party's objection to the expansion of market providers caused the most debate. At the second reading, Labour members spoke out against market responsibility for services on grounds of inferior quality, and made arguments in favour of a larger and higher-quality public sector workforce. They made more redistributive arguments in favour of expanding quality public services, expressing concern about the lack of sufficient funding for the training of public social workers (Hansard HL, 6 Dec 1988, v. 502, c. 520). During the committee stage, the opposition requested a large number of amendments to regulate private homes (Hansard HL, 23 Jan 1989, v. 503).

Although the tone of the debate at the second reading had been 'happily entirely on non-party lines' (Hansard HL, 6 Dec 1988, v. 502, c. 528), in February, the government and opposition clashed on the role of private organisations. The Conservative Lord Chancellor summarised that:

> [Labour had] made it quite clear that in their view there is no place for private children's homes using secure accommodation, and that such provision should be confined to establishments provided by central and local government (Hansard HL, 16 Feb 1989, v. 504, c. 336).

When the bill was debated in the Commons, the speaker placed a restriction on the length of speeches. Labour members spoke out against private provision on grounds of inferior quality, and made more redistributive arguments in favour of equal access for all children (Hansard HC, 27 Apr 1989, v. 151, c. 1121). They suggested that 'the Government are afraid that if they ensure the provision of services for all children, somehow that will undermine the family' (ibid, c. 1181). At the final reading in late October, the proceedings were repeatedly interrupted by questions about the resignation of the Chancellor of the Exchequer that morning. The debate descended into a fight about the extent to which the bill had been adequately debated, as the front bench emptied to deal with the leadership crisis (Hansard HC, 26 Oct 1989, v. 158). The Children Act 1989 was passed the following day.

Just as during the the debates on the Children Act 1975, the role of Labour's redistributive arguments was to critique the quality of the service delivered by for-profit providers and defend the expansion of public sector capability on grounds of equality. The Conservatives did not make clearly residual arguments to the contrary, but disputed the claim that market services were of inferior quality (Hansard HL, 16 Feb 1989, v. 504, c. 336).

The use of second-dimension arguments in the debate on the Children Bill 1989 was more surprising, because both Conservative and Labour politicians made some more familial arguments about the family as a natural unit of society. When Conservatives made familial arguments, they did so with reference to the framing of the recent election manifesto, emphasising individual and family responsibility (Conservative Party, 1987). The Lord Chancellor stated that 'the fundamental concept in this area of law is no longer to be expressed variously in terms of rights, duties, authority or even powers of parents, but simply as parental responsibility' (Hansard HL, 6 Dec 1988, v. 502, c. 490). On the other hand, when

Labour politicians made familial arguments they referred to the sanctity of the family in the International Convention on Human Rights, and an active role for the state to protect the family. Support for universal human rights in particular is consistent with social democratic ideologies of individualism and equality. Labour's David Ennals commented that:

> It is in my view a happy coincidence that this Second Reading debate comes just a few days before the 40th anniversary of the United Nations Declaration of Human Rights which lays down the basic principles that the family is the natural and fundamental group unit of society and is entitled to protection by society and the state (ibid, c. 529).

Some members of the Labour Party also expressed concern using more individualist arguments about the absence of family ties for some children leaving care (ibid, c. 511). But in these debates they mainly relied on redistributive arguments to challenge the expansion of private providers and lack of investment in public services to care for children who could not remain, or be placed, with families.

During the 1980s, the two major parties continued to agree, in line with prevailing scientific ideas, that the family was the ideal site of care for children, but they were clearly divided on the question of what types of providers should manage children's homes for those who could not remain, or be placed, with families. The expansion of for-profit providers by the Conservatives was not supported by Labour, and would likely not have been enacted in this period had the Labour Party been in power. Socio-economic ideology was at the heart of this conflict, as reflected in the redistributive arguments made by Labour in the debates. The Labour Party had also begun to use a new language of human rights to defend the state's responsibility to guarantee the well-being of all children, which was distinct from the language of family responsibility used by the Conservatives, but second-dimension conflict played less of a role in child welfare debates during this period than it had during the 1950s and 1960s.

### New Labour's market turn

Compared with the Labour governments of the 1960s and 1970s, and their time in opposition during the 1980s, there was a distinct shift in the types of arguments that Labour politicians made to support policies when they

returned to government under the New Labour brand in 1997. During the Blair years, they made some redistributive arguments in favour of equality of access, but no longer explicitly defended the expansion of spending and public-sector employment in child welfare services. While Gordon Brown was Prime Minister, redistributive arguments virtually disappeared from these policy debates, as the Labour Party embraced the private provision of services. The debate around who should be responsible for care became less ideological and more technicalised, with the advice of social policy experts increasingly referenced in the parliamentary debates. There had long been strong agreement between the parties that the family was the preferred site of care, and under existing policy settings the vast majority of children who would formerly have been in institutional care were already looked after in families.

Under New Labour, the only policy change which affected responsibility for the care of children that could not be cared for by their parents occurred in 2008. When Tony Blair's government first entered office, policy changes were limited to the workings of the foster care and adoption systems. They sought to increase the permanency of foster placements as well as adoption rates from foster care, affecting the type of family care that was provided rather than the balance of responsibility for care among the state, the family, and voluntary and private providers. Neither the Adoption Act 2002 nor the Children Act 2004 directly shaped the use of institutional care, and the legislation built on a trend of increasing numbers of children being adopted from foster care that had already commenced in the years prior to the 2002 Act (Department for Education and Skills, 2003, pp. 9). White papers from this era still reveal some evidence of redistributive arguments. For instance, the 2000 white paper, *Adoption, A New Approach* identified widespread variation in local authority adoption practices as one of the central problems with the existing system, arguing in favour of more equal levels of service provision and access (Department of Health, 2000).

The context for the policy change that would be made in 2008 was an integration of children's homes regulation within the education system, and pressure from both the Conservatives and Liberal Democrats to improve the care system. In 2004, local authority education and children's services were integrated as the Department of Education and Skills became responsible for the legislation governing community homes. With education as one of the key priorities in Labour's 2007 election manifesto, the Department of Education and Skills had a mandate for reform. In December, the

Secretary of State for the Education portfolio, newly minted as the Department for Children, Schools, and Families, released a Children's Plan which laid out goals for schools and children's services, including increasing the role of the Office for Standards in Education, Children's Services and Skills (Ofsted) in setting and monitoring standards of care (Hansard HC, 11 Dec 2007, v. 469, c. 173). The Plan also proposed an expansion of investment in preventive services that was justified with a broadly redistributive argument, 'to ensure all families benefit' (Department for Children, Schools and Families, 2007, pp. 17, 22).

On the eve of the Children and Young Persons Bill's first reading in the House of Lords, the opposition parties challenged the Brown government on why the issue of looked-after children had not been brought to parliament earlier. In 1996, John Major's Conservative government had initiated a Health Committee report on looked-after children, but on its publication in 1998 the issue was not picked up as priority by Blair's cabinet (Hansard HC 25 Mar 1998, v. 309, c. 419). Labour foreshadowed the arguments that would be made in the coming debates on the Children and Young Person's Bill when they responded that there was 'no political advantage in being ideological: [we] do not care who delivers the appropriate level of care to looked-after children. It could be the private sector or the voluntary sector... or perhaps a reformed local government department' (Hansard HC, 13 Nov 2007, v. 467, c. 590).

The Children and Young Person's Bill was justified in line with the principles of flexibility and continuity, supported by the evidence on effective public services and children's services, rather than along ideological lines. The responsible Parliamentary Under-secretary explained that 'the aim is to establish whether, by giving social workers more freedom and flexibility in their work, they can deliver a more personalised service and create more continuity for children in care.' (Hansard HL, 26 Nov 2007, v. 696, c. 1043).

The bill would allow local authorities to contract out children's homes and preventive services to third parties, leading to expansion of the private sector (Bullock and Parker, 2014). The changes aligned with the principle of 'partnership' that also underpinned the Local Government and Public Involvement in Health Act of 2007. This legislation, supported by the government white paper *Strong and Prosperous Communities*, promoted greater flexibility in the types of public, voluntary, and private providers from which citizens could choose to access services (Department for Com-

munities and Local Government, 2006). 13 per cent of the 60 000 children in care – by this time conventionally referred to as 'looked-after children' – were in residential care, these figures having remained approximately the same since the year 2000 (Hansard HL, 26 Nov 2007, v. 696, c. 1043).

The new language of human rights was also present in the arguments made by Labour politicians in the House of Lords. The government emphasised the aspects of its consultation process that involves the wishes of children directly, and Labour peers were concerned to ensure that contracting procedures would mean that all organisations interacting with children – public or private – would uphold the individual rights of children as guaranteed in the UN Convention on Human Rights (ibid, c. 1059).

The tone of the interventions from partisan peers was largely agreeable. One Labour peer remarked that 'There [had] been an inspiring unanimity of mind and spirit' in the debate (ibid, c. 1083). In line with earlier arguments against local authority responsibility, the Conservative Party supported 'having groups of social workers undertaking work with children in care that is commissioned by, but independent from, the local authority' (ibid, c. 1048).

The most disputed area of the bill was its proposal for 'social work practices', but concerns came from cross-benchers and individual peers, rather than falling along party lines. Social work practices were care services provided by 'an autonomous organisation, whether a voluntary or community sector organisation, a social enterprise or a private business... commissioned by local authorities' (Department for Education and Skills, 2006, p. 35). These agencies would be contracted to achieve placement outcomes, and could retain any surplus as profit or for reinvestment when the return to home or adoption had taken place (ibid, p. 36). The main opponents of the introduction of private social work practices were the cross-benchers and one Liberal Democrat, who expressed concern that 'there is a danger of these services creaming off the best professional social workers and offering them better pay and conditions, while nearby local authority services suffer' (Hansard HL, 26 Nov 2007, v. 696, c. 1054). One Labour peer spoke to similar workforce concerns, arguing that the model would reduce financial flexibility for the local authorities and that 'there [was] no evidence that [social work practices] will resolve the issues of recruiting and retaining social workers or for this model being better than empowering foster carers or key workers in children's homes' (ibid, c. 1064). The Liberal Democrat's spokesperson for education, science, and technology,

however suggested that, 'we have no objection in principle to developing contracting-out procedures, and we recognise that this accords very much with the Government's vision of local authorities' children's services as commissioners of services and not providers of services' (ibid, c. 1088).

Despite at least some concern from within the Labour Party, the government acted quickly to begin expanding private providers in the sector. While the bill was still at the committee stage, the Secretary of State entered into a contract with Serco Limited for the development of Sure Start children's centres to deliver preventive services to families, in anticipation of the enabling legislation (Hansard HL, 21 Jul 2008, v. 703, c. 112WS).

The Labour Party had abandoned its position on the duty of local authorities to provide services, which they had defended at length in 1962–3. When questioned about the absence of such a duty in this bill, the responsible under-secretary argued that 'when read with existing legislation, there will in effect be a requirement on local authorities to provide a range and level of services appropriate to the needs of children in their area and to facilitate the provision of services, including accommodation, by others' (Hansard HL, 26 Nov 2007, v. 696, c. 1098).

Labour turned to a more technicalised defence of the 2008 legislation, referring repeatedly to the social policy experts who it seemed had virtually drafted the legislation. The social work practices working group was chaired by Julian Le Grand, an influential 'third way' economist and advisor to both Blair and Brown, who had just published his book *The Other Invisible Hand: Delivering Public Services through Choice and Competition* (2007). In the committee debate on the social work practice clauses, Le Grand was referenced no fewer than seventeen times (Hansard HL, 8 Jan 2008, v. 697, c. 292GC).

Familial arguments still played a role for the Conservative Party, to advance the use of kinship care. The opposition pressed the government on why rates of familial foster care were so low in Britain, making the argument that kinship care was always a superior alternative (Hansard HC, 8 Oct 2008, v. 480, c. 313). The Conservative Shadow Minister of Health and Children, who had proposed and defended an amendment to prioritise kinship care, nevertheless expressed his party's support for the bill: 'We need innovation in this aspect of public service because, at the end of the day, it is not the ownership of the provision of service that matters, but the welfare of the children' (ibid, c. 374).

Up to the 1990s, decisions on child welfare policy had largely reflected my theoretical expectations about partisan preferences. The Labour Party favoured state responsibility for care with the exception of the Children Act 1975, which expanded the use of adoption and foster care but nevertheless increased the role and power of state actors to intervene in family life and govern the alternative care sector. These state powers were repealed by the Conservative government in 1989 in favour of a more familial approach which preserved the rights of birth parents and expanded market responsibility for alternative care. Although the major parties agreed that families were the ideal care provider for children, they nevertheless disagreed about the appropriate powers of the state in acting to promote and protect, or intervene in, the family. The Conservative Party expressed a preference for market responsibility for care, based on the argument that for-profit services were more efficient than the public sector. In opposition during the 1980s, the Labour Party spoke out against market responsibility for services on grounds of inferior quality, and made arguments in favour of a larger public sector workforce that would underpin more equal outcomes and a more redistributive state.

When New Labour departed from type and turned to expand private sector responsibility for care in the late 1990s, they departed too from the enduring redistributive and individualist arguments that had been made in support of earlier policies, moving toward more technicalised justifications for policy decisions. This was in line with the party's emphasis on evidence-based policy-making, or implementing 'what works' (Labour Party, 1997). Expert advice had long informed child welfare policy making, but in this period the government leaned more directly on expert opinion to justify policy, and ideological arguments played less of a role. There was agreement between the two major parties that the family was the preferred site of care, and in this later period a shared pragmatism regarding the question of who should provide additional services to the relatively small number – though still thousands – of children who remained in residential care.

## Germany

There were fewer federal initiatives to affect the care of children who could not be cared for by their parents in Germany, where orphanages and foster schemes had long been managed by local authorities. However, following the constitution of the Federal Republic of Germany in 1949 and reunification in 1990, major legislation which re-established the responsibilities of the local authorities also determined the types of care services that could be provided, and by whom.

Each of these changes, listed in table 6.2, was made by a Christian-Democrat-led government. Although no policy change was made while the SDP controlled the cabinet, the party actively pursued an expansion of state responsibility when Helmut Schmidt was Chancellor. They failed to pass the reform as a result of conflict with their coalition partners, the FDP, and strong opposition from the Christian Democrats. In the parliamentary debates, we will find that both socio-economic and second-dimension conflict between the three main parties stymied progress on deinstitutionalisation policy in the years between reforms.

Table 6.2: Child Welfare policy changes in Germany

| Year | Leading Party (Chancellor) | Policy type | Policy or legislation title |
|---|---|---|---|
| 1953 | Christian Democrats (Adenauer) | Voluntary | Child and Youth Welfare Law |
| *1979* | *Social Democrats (Schmidt)* | *State* | *(failed) Youth Welfare Reform* |
| 1990 | Christian Democrats (Kohl) | Family | Child and Youth Services Act |
| 2007 | Christian Democrats (Merkel) | Voluntary | Early Assistance for Parents and Children |
| 2011 | Christian Democrats (Merkel) | Family | Federal Act on the Protection of Children |

*Comments:* Table lists child welfare policy changes made in Germany between 1950 and 2015, indicating the leading part of government and chancellor, as well as the type of policy change according to the classification system used in Chapter 4. Note that the 1979 policy in *italics* was an attempted policy change.

### Voluntary responsibility in the post-war period

The debates on the amendment to the Federal Child Welfare Law in 1952–3 revolved around similar issues as the debates on the Children and Young Persons Act 1969 in England: who should hold the power to decide when to intervene in families. Although in England this had been a debate about the role of executive versus judicial powers, in Germany the major parties clashed over whether public or voluntary actors should decide. Compared with the Conservatives in England, the main right-wing party in Germany, the Christian Democrats, were more open to active intervention to strengthen the family, but by voluntary actors rather than the state. The Social Democrats took a similar position to the Labour Party in England, defending the state – or its local authority representatives – as both the primary decision-makers and providers of child welfare services. The SDP recognised a role for voluntary providers, who managed a far greater proportion of services than the voluntary sector in Britain, but they nevertheless defended state administration and investment in public sector capability.

In the early 1950s, child welfare services were pushed onto the political agenda by the opposition party, the Social Democrats, in debates on the reform of juvenile justice regulations. While the Adenauer government sought to make minor adjustments to youth sentencing and probation, the Social Democrats drew attention in parliament to the living conditions of 1.5 million children who had lost one or both parents, and the concomitant rise in juvenile delinquency (BT Plenarprotokoll 1/205,23 Apr 1952, p. 8853). The SPD's deputy chair on the Bundestag's Child Welfare Committee, indicated that her party would support the proposed changes in the Juvenile Court Act, but called for action on changes in the Federal Child Welfare Law (*Reichsjugendwohlfahrtsgesetz*) to more effectively address the problems (ibid, pp. 8852–3).

The major parties agreed broadly on the goal of deinstitutionalisation. The CDU chair of the committee had earlier accused the SPD of taking a polemical stance on youth issues, but the two parties would work closely on developing the wider changes that would eventually be brought to parliament in late 1952. One FDP member expressed the general tone of agreement among the parties when she said, 'I believe that, given that all parties are interested in achieving the best for the youth, a law will come about that all of us will approve of' (BT Plenarprotokoll 01/228, 10 Sep 1952, p. 10308).

The 1953 amendment to the Child Welfare Act re-established municipal responsibility for the youth welfare offices, which had been implemented in 1922 and revoked during the National Socialist era. It also expanded the role of voluntary agencies by enabling local youth welfare offices to delegate their activities to voluntary associations, and by giving non-government representatives majority membership on the local youth welfare committees which would make decisions about local care arrangements. The Christian-democrat-led government's main emphasis was to establish these services as a 'clear self-government task', a phrase to which the CDU committee chair repeatedly referred (ibid, pp. 10303-4).

The bill spent some nine months with the Child Welfare Committee and Local Government Committee, with debate between the government and the SPD centred around the composition of the local child welfare committees, who would hold the power to decide when to intervene and what services to provide to children and families. The government defended majority representation of the voluntary associations, based on the principle of subsidiarity (BT Plenarprotokoll 1/273, 18 Jun 1953, p. 13515). The Minister for the Interior described 'the voluntary associations' right of co-determination [as] an essential part of this amendment' (ibid, p. 13517). The Christian Democrats' coalition partner, the FDP, also supported voluntary control, but on the basis of more residual, efficiency-based arguments. Using the example of the railways and post, they argued that delegating decision-making authority to skilled professionals resulted in more efficient services.

The SPD did not dispute the principle of subsidiarity, but argued that the proposed structure of the child welfare committees, with majority of voluntary association membership, would 'deprive' the municipalities of their 'necessary duty of responsibility'. At the bill's first reading they argued that the municipal youth welfare offices should be answerable to a federal body for youth policy with the power to make budgeting decisions (BT Plenarprotokoll 01/228, 10 Sep 1952, p. 10306). Even after the committee stage, the SPD maintained that majority state representation on the child welfare committees, as well as a federal organ responsible for child welfare, was necessary to legally establish state responsibility for deciding what type of care was to be provided, even if voluntary organisations were primarily responsible for service provision. Their argument was that 'the voluntary welfare organisations and child welfare associations are also reliant on the allocation of public funds, and when the public has made funds

available, then they must also have the possibility of controlling in which manner and ways these funds have been spent' (ibid, p. 13534).

The SPD used redistributive arguments to defend greater responsibility for public and parliamentary institutions in the field of child welfare, in order to promote equality of service provision and access. For example, they opposed the part of the legislation which would allow child welfare committees to delegate 'groups of activities' to voluntary associations or individuals, on grounds that this would create an unequal provision of service throughout the country. The Social Democrats made a redistributive argument against the delegation of large responsibilities to voluntary actors, suggesting that 'it would lead to a fragmentation and a big gap in youth work; because the good and efficient youth welfare offices would not delegate, while the youth welfare offices that are financially weak or uninterested would make use of this opportunity and assume that savings can be made through the delegation' (ibid, p. 13522).

At this time, the SPD did not challenge voluntary responsibility for providing care, given that local youth welfare offices run by voluntary organisations already existed. There was also agreement between the two major parties that the ultimate responsibility for raising children rested with families. The Minister explained that 'in the first instance the family has responsibility. But at the moment in which the independent work of a family fails, public assistance kicks in' (ibid, p. 13517).

The Christian Democrats were more open to intervention in the family that the Conservative Party in England. They saw a role for the wider community, and specifically voluntary organisations, to strengthen the family and support children in the event of family breakdown. A CDU member stated that, 'we help the youth more when we integrate them in the family, when we strengthen the family, so that the youth are included in their community'. They continued by explaining that youth workers should offer assistance 'when the family is not enough for the young person' (ibid, p. 13531).

During the 1950s, there was relatively little disagreement between the major parties over the role that voluntary providers should play in both alternative care services and preventive assistance to families. The major parties agreed on the principle of deinstitutionalisation, and the priority for family care, but the role of redistributive arguments for the SPD was to defend a greater control of services by elected local authorities and the federal government on grounds of equality. There were fewer familial argu-

ments from the Christian Democrats, who were more open to intervention to strengthen the family, but they defended voluntary responsibility based on the principle of subsidiarity.

### The dynamics of partisan conflict in the years between reforms

The Federal Republic of Germany made no major policy decisions to affect the use of institutional care for children between 1953 and 1990. On the one hand, this reflected the fact that child welfare services were devolved to local authorities, and, during the 1950s and 1960s, the declining salience of child welfare policy issues at the federal level. On the other hand, when the issue of institutional care regained prominence during the late 1970s and early 1980s, the absence of federal policy decisions reflected increasing tensions between the parties and the inability to form a stable coalition that agreed on the shape that child welfare reform should take. In broader debates related to child welfare issues, the parties became increasingly combative, particularly after the Social Democrats became the leading party of government in 1969. They were divided in both socio-economic and second-dimension conflicts, over how big and redistributive the welfare state should be on the one hand, and the nature of the family on the other.

Already in the 1960s, the Christian Democrats had begun to use more familial arguments in child welfare policy debates. The Youth Welfare Act 1962 consolidated the policy decisions already made in 1953 with no direct effect on responsibility for care. The origins of the new Act were in an amendment introduced in late 1960, where the Christian Democrats restated their commitment to the independent decision-making power of the child welfare committees, and used familial arguments to justify the law. As the keynote speaker for the government, the chairman of the Committee for Family and Youth Issues, stated that:

> The family is the natural environment for the upbringing of young people.... help for children must first and foremost be help for the family (BT Plenarprotokoll 03/135, 9 Dec 1960, p. 7727).

The SPD criticised the government's position, making more individualist and redistributive arguments. They described the Christian Democrats' 'interpretation of the parental right' from the constitutional Basic Law as 'absolutely arbitrary', and suggested that it made the responsible local authorities 'mere night-watchmen' (ibid, pp. 7729, 77231). Instead, they

made a more individualistic argument that the system 'violate[d] too the right of young people to equal treatment', on grounds that 'the facilities and operations of the independent providers and associations depend on their own fund-raising' (ibid, p. 7734). The SPD called for an increase in public funding, arguing that the law did not provide enough resources to meet needs in the community and was at risk of overburdening the voluntary service providers, which offered different levels of service (ibid, p. 7732–4).

At this time, the FDP were no longer in the governing coalition, as after the 1957 election, Adenauer had formed a government with the short-lived conservative Germany Party (*Deutsche Partei*, DP). Absent any political obligation to a senior coalition partner, the members of the FDP spoke their mind, arguing that 'what the government draft aims to achieve is, instead of equal treatment, a superiority of associations over state organisations' that would weaken the independence of social work professionals (ibid, pp. 7735–6 ). The FDP's priority was that partnerships between local authorities and voluntary organisations should enable social workers to have more decision-making power in individual cases and to shape the direction of service development, based on the more residual argument that this was in the interests of both service effectiveness, and efficiency (ibid, p. 7736).

During the committee stage, the SPD made an effort to strengthen the responsibilities of the local authorities as direct providers of services. They proposed an amendment that would ensure public, secular facilities such as youth homes 'must be established' (*errichten muß*) upon a vote of parents in the community (BT Plenarprotokoll 03/164, 29 Jun 1961, p. 9504). The SPD objected to the government's 'unclear' wording, which stipulated that youth welfare offices should refrain from establishing public facilities where voluntary services were available, but that if parents did 'not want to make use of the existing independent youth welfare agencies, the youth welfare office has to ensure that the necessary facilities are created' (*hat zu sorgen dass... geschaffen werden*) (ibid, p. 9511). As in England, what might seem like semantic issues could not be resolved in the all-party committee rooms and instead consumed debate time in the parliament, because these disagreements were heavily burdened by competing visions of the state and society. In both countries, the social democratic parties did all they could to ensure that the state had a legal responsibility to provide, and not only fund or coordinate, services.

The SPD continued to make individualistic arguments in support of state intervention as they entered into government with the Christian Democrats, in the first Grand Coalition of the Federal Republic. When the first Report of the Committee for Family and Youth Issues was debated in parliament in 1967, the SPD argued that 'due to the structural change from the large to the small family, which is the norm of our time, [the family] is subjected to severe burdens of various kinds' (BT Plenarprotokoll 05/124, 11 Oct 1967, pp. 6302). They continued that 'the changed situation of the family requires new and increased support from the state and society', not least because of the relatively small but increased participation of women in the labour market (ibid, pp. 6302–3). The SPD called for additional state funding for child welfare services and emphasised the inadequate upbringing afforded to children being raised in institutional care: 'The home children are still today the stepchildren of society' (ibid, p. 6304).

In the early 1970s, child welfare policy receded from the federal agenda. The Grand Coalition had fallen apart over a currency revaluation proposal, and after the 1969 election Willy Brandt formed a coalition government with the FDP. The government appointed a Commission on the Reform of Child Welfare Law in 1970, and the Social Report of 1971 made plans for social insurance funding for children in institutional care (BT Plenarprotokoll 06/135, 23 Sep 1971, pp. 7895). But the government had a wide-ranging domestic policy goals, a controversial new foreign policy of *Ostpolitik*, and a narrow majority to work with. As FDP members defected to the Christian Democrats, Brandt was almost toppled in a vote of no confidence, but in the election that followed the 1972 Olympic Games the Social Democrats were returned to power as the largest party in the Bundestag, supported by the FDP. Their domestic reform programme substantially increased spending on social insurance, social assistance, and particularly education.

At this time, second-dimension arguments about the nature and role of the family reflected the different ways that the two major parties interpreted and used the dominant scientific evidence about the importance of primary carer relationships child development. The Report of the Commission on the Reform of Child Welfare Law was published after Helmut Schmidt had succeeded Brandt as Chancellor of the social-liberal government. It was the CDU/CSU parliamentary group that initiated a discussion in parliament by submitting a draft law to amend the Child Welfare Act. In his appeal to the government, the 100 000 children living in insti-

tutional or foster care were the first group of vulnerable children to which Dietrich Rollman, regional chairman of the Hamburg Christian Democrats, referred (BT Plenarprotokoll 07/173, 22 May 1975, p. 12087). In defending the family as 'the ultimately irreplaceable site of children's growth and development', Rollmann stated:

> We say this not on grounds of ideology, but because it is the experiences of life and the knowledge of science itself that have helped the family, repeatedly pronounced dead in recent years, to a Renaissance (ibid, p. 12090).

Rollmann referred to the evidence on the importance of primary carer relationships for child development, which had been recognised in the commission's Family Report and acknowledged by the government. His statement makes clear his own awareness that the primacy of the family – and, in particular, he emphasises, the role of the mother – was entirely in line with the Christian democratic ideology of familism. Rollmann spoke strongly against the government's education policy, which promoted the higher education of women to 'permit a real decision between employment and non-employment', arguing that 'the mother's freedom of choice, if it is exercised in favour of professional activity, is in practice a decision against the toddler... we stand for the right of the toddler to his mother' (ibid, p. 12091). He likened the situation of children in day-time child care to that of children in residential homes. For the Christian Democrats, the child development studies of Sigmund Freud, Rene Spitz and John Bowlby confirmed the importance of the party's male-breadwinner view of the family. With the backing of this science, the government's education policy was framed as a threat to the family, and thus to the foundation of society.

In countering Rollmann's address, the Minister for Youth, Family, and Health, Dr. Katharina Focke, presented an entirely different view of the family, which was actively shaped and supported by public policy. She stated that, 'family policy would be very simple if the family, with a clear definition or even fixed position in society, existed', but that as a result of its various forms and changing nature, 'the family would not be viable without society and its services for personal prosperity, social security, public goods, education, leisure, to name just a few'. She also emphasised that a goal of the government was 'equal opportunities within the family' (ibid, p. 12092–3). This meant a redistributive state that would equalise opportunities for different families across society, but also ensure that 'within the family, everyone has their rights' (ibid, p. 12093).

In more clearly redistributive terms, as Dr. Focke escalated her defence against 'the unjustified attacks, allegations, and insinuations' of the opposition, she argued that achieving more equal opportunities for the groups of vulnerable children that Rollmann had identified 'require[d] a redistribution of income... and that is what we want'. Further, she explained that equality among individuals within the family meant equality between women and men: 'today no longer a legal, but primarily a social, problem... the relationship between them in the family cannot be fundamentally different' (ibid, p. 12096). This heated exchange demonstrates how both redistributive and individualistic arguments were used by the Social Democratic Party to defend their family and social policies.

Although the Christian Democrats criticised the government's disruption of the family through their wider education and social policies, they were not opposed to redistributive family assistance or preventive services for struggling or single-parent families. They supported both family benefits and additional allowances for single parents (ibid, pp. 12119, 12127). Despite strong divisions over the state's role in shaping the family, the German Christian Democrats were thus closer to the Social Democrats in redistributive debates than the Conservative Party were to the Labour Party in Britain.

Arguments in favour of a more residual state in Germany came instead from the liberals. In the debate on the second Family Report, the FDP, despite being in government with the Social Democrats, made arguments in favour of a more residual state which offered assistance on the basis of both efficiency and need. They argued that family care should be prioritised 'if the child would be better off with the birth parents or a single parent with the same financial expenditure from the public authorities' and that, 'we should help where it is really necessary and not give everyone something according to the watering can principle, which is not enough for everyone in the end' (ibid, p. 12119). But alongside these arguments in favour of a more residual state, the FDP made a more individualist argument that emphasised the individual rights of all family members, arguing that, 'a healthy family can only exist if all members of this family have rights and responsibilities, and not if the husband and children have rights and women alone have responsibilities' (ibid, p. 12132).

The salience of both socio-economic and second-dimension arguments increased in policy debates during these years, and they were used by political parties broadly in line with my theoretical expectations. The

SDP clashed with the Christian Democrats on the nature and role of the family, and largely agreed with the FDP that social policy should promote the flourishing of all members of the family as individuals. The FDP's more residual view on the size of the state and social spending was also apparent, and would present problems for the governing coalition as the Social Democrats set out to increase the role of public authorities as direct providers of services in the late 1970s.

### The Social Democrats' attempt to expand state responsibility

During Schmidt's second term, care policy became more politically salient and hotly debated by the major parties, and during this time the Social Democrats attempted to expand state responsibility for the care of children who could not be cared for by their parents. A brief discussion of this attempt is relevant, because there were no cases of successful policy changes that increased state responsibility for the care of children in Germany throughout the period that I study. As we saw in the previous chapter, the Schmidt government had successfully expanded state responsibility for the care of people with mental illness in 1976 and 1979. But their attempt to do the same for children was frustrated by both the fiscal prudence of their coalition partners and the opposition Christian Democrats, who were committed to both the expansion of family-based alternatives, and the priority of voluntary child welfare organisations over public services.

There were two major disagreements between the government and the Christian Democrats, concerning, on the one hand, the relative responsibility of public and voluntary organisations for service planning and delivery, and, on the other, the forms of substitute care that should be available. The SPD sought to expand public responsibility for care services including children's homes. They agreed with the CDU/CSU on the goal of reducing the use of institutional care, but suggested that 'it must be a question of developing open pedagogical and therapeutic help as an alternative' (BT Plenarprotokoll 08/172, 20 Sep 1979, p. 13702). The SPD wanted to incentivise improvements in residential care so that homes resembled more family-like environments, and to promote the development of 'other open living forms' – that is, more family-like, less custodial group homes (BT Drucksache 08/3108, 10 Aug 1979, p. 55). The Christian Democrats, on the other hand, were deeply committed to the priority of voluntary providers, and strongly preferred family-based care alternatives, including

preventive services, foster care, and adoption, to any form of residential care.

In 1979, the government proposed a law to reform youth welfare which would give public authorities majority decision-making power in the local youth welfare committees responsible for providing services. These authorities would be empowered to delegate tasks to the independent and voluntary services (BT Drucksache 08/3108, 10 Aug 1979, p. 15). The government justification for their bill argued that while 'upbringing in the family – or at least in a form that comes close to the upbringing in the family – should, if possible, be preferred to education in large institutions', institutional care and other forms of living (such as group homes) were still a necessary alternative in the event of parental death or absence leading to family breakdown. The SPD argued that regulations should incentivise improvement the internal structure of these environments (BT Drucksache 08/3108, 10 Aug 1979, pp. 54–5).

Although the stated aims of the bill included 'securing the priority of independent providers', the opposition viewed the changes as a threat to the principle of subsidiarity. The Christian Democrats used their strength in the Bundesrat to strike down the government draft, and the party's alternative proposal was debated in the Bundestag the following year. They claimed that the government's proposal had violated the 'priority of the independent child welfare providers over the public providers' (BT Plenarprotokoll 08/219, 23 May 1980, p. 17634). The Christian Democrats also strongly preferred family-based care alternatives, and their alternative proposal did not include any provisions for institutional care or other forms of living such as group homes. During this period, they had repeatedly pressed the government to increase the use of family-based alternatives, by increasing the parental rights of foster parents and increasing state subsidies for foster care (BT Plenarprotokolle 08/151, 10 May 1979, p. 120120; 08/155, 18 May 1979, p. 12387).

The government's fifth Youth Report, published in 1980, had contained only a vague recommendation for the development of a framework which might shape guidelines for foster care arrangements, stating that 'a push for the expansion of foster care is only possible with intensive research into the problems of this area and in combination with controlled practical experiments' (BT Drucksache 8/3684, 20 Feb 1980 pp. 42–3). In the first instance, they awaited the results of the federally-funded day-time child care (*Tagesmütter*) trial, which would assess the affect of substitute

care on intelligence and social-emotional skills (BT Plenarprotokoll 08/219, 28 May 1980). Instead, plans were made to expand the development of municipal adoption agencies and the possibilities for foster children to be adopted into more permanent care arrangements (BT Drucksache 8/3684, 20 Feb 1980 pp. 43).

The plans for adoption reform did not make it onto Schmidt's legislative programme before the governing coalition collapsed as FDP members defected to support the CDU's Helmut Kohl in a constructive vote of no confidence in October 1982. The social-liberal coalition had already begun to fracture after the election in October 1980, where the FDP improved their share of the popular vote by 2.7 percentage points to 10.6 per cent. In their election manifesto and coalition talks, the party had called for cuts to social expenditure to curb inflation, which was by then persisting despite rising unemployment (Freien Demokratischen Partei, 1980; Dittberner, 2010, p. 50). Although compounded by foreign policy disagreements and the electoral threat of the rising Green Party, it was the dispute over the size of the social budget that drove this crack between the Social Democrats and the FDP (Dittberner, 2010, p. 51).

### Familial care in a united Germany

Helmut Kohl would govern for the next sixteen years, managing the unification of the Federal Republic and the Democratic Republic, and shortly after introducing a new Child and Youth Services Act. During the 1990s and 2000s, Christian-democrat-led governments would promote the responsibility of the family for care, by expanding preventive and family support services and later lifting the threshold for the removal of children from their families. They would also expand the responsibility of voluntary providers to deliver a new range of semi-mural care services, in addition to their management of the existing children's homes. Throughout this period, the Christian Democrats used more familial arguments to justify legislative changes.

In January 1989, the government began preparing a new Child and Youth Welfare Act (*Kinder- und Jugendhilfegesetz*). Its focus was to improve services for children, youth, and struggling families, to establish a legal basis for new 'outpatient' and 'semi-mural' forms of care in addition to fostering and institutional care, to 'promote upbringing in the family', and to 'strengthen the protection of the functions of independent providers' (BT Drucksache 11/5948, 12 Jan 1989, p. 2). The legislation preserved

the decision-making power of the youth welfare committees, with majority voluntary membership, over the mix of services offered (ibid, p. 22).

When the bill was debated in parliament following consultation with the federal states, the CDU chairman of the Committee for Youth, Family, Women, and Health, described an environment of 'constructive cooperation' and 'broad consensus', but recognised that 'one of the criticisms was the alleged family-centricity of the law' (BT Plenarprotokoll 11/203, 28 Mar 1990, pp. 15846–7). The CDU justified the preventive focus of the bill using both familial and residual arguments, suggesting that prevention would both reduce 'intervention in the family', and also prevent 'cost intensive out-of-home accommodation, furthermore avoiding dependence on social welfare and entry into criminality' (ibid, p. 15847).

Both the Social Democrats and the Greens were strongly critical of the family focus, and, along with the FDP, made individualist arguments. The SPD's children's spokesperson suggested that it might be not ideology but 'delusion', that made the Christian Democrats 'believe that the family is still in the position to solve all of life's problems' (ibid, p. 15860). The SPD argued that although the law was named the Child and Youth Welfare Act, the child was absent. The party's amendments would attempt to insert children and adolescents, and not just their legal guardians, as the subjects of entitlements in the bill (BT Drucksache 11/6806, 27 Mar 1990). In parliament, they argued that 'the family centring has provoked an unnecessary conflict between the family and the child', and made the more individualist argument 'that the child is an independent legal subject' (BT Plenarprotokoll 11/203, 28 Mar 1990, pp. 15846–7). The FDP defended the concept of parental rights on grounds that it did not preclude children's rights, but nevertheless made a more individualist argument about the independent right of children to an adequate upbringing, ensured by the state independently of the child's parents (ibid, pp. 15851–2, 15861).

The red-green government of the late 1990s and early 2000s did not make any major changes affecting children in substitute care, with their child welfare programme focussed on the expansion of day care. After the 2005 election, the Social Democrats and Christian Democrats entered into Germany's second grand coalition, in which they shared cabinet places equally after having won 34 and 35 per cent of the vote respectively. The Family, Seniors, Women, and Youth portfolio was held by the Christian Democrats' Ursula von der Leyen, and the party maintained a policy of family care first. Nevertheless, as part of the coalition agreement with

the SPD, the party committed to a policy change, eventually enacted in 2007, that would provide federal government subsidies to voluntary organisations for new projects such as secure semi-mural facilities (*Tagespflege*) to supplement institutional care (Bundesregierung, 2005, p. 99).

The programme for 'Early support for children at risk' (*Frühe Förderung für gefährdete Kinder*) was a small part of the government's much wider policy programme for a 'family-friendly society', with family policy appearing fifth in the group of eleven priority areas in the coalition agreement (Bundesregierung, 2005, p. 11). The programme included an increase in family allowances, child care places, and parental leave, and the high-level goals of family policy were expressed in clear familial arguments. These focussed on increasing both the birthrate, and the responsibility that families took for the care of children and older individuals requiring care:

> Too few children are born in Germany. We want more children in families and more children in society. In the family, people learn to take responsibility for themselves and others. Families are the basis of a free community... The multi-generational family offers the opportunity to take responsibility for one another. We will develop models of how several generations can live together and take responsibility for one another (Bundesregierung, 2005, p. 11).

However, the Early Support for Children at Risk programme, later re-dubbed 'Early Assistance for Parents and Children' (*Frühe Hilfen für Eltern und Kinder*) actually increased the responsibility of voluntary organisations for children from vulnerable families. It aimed to strengthen 'the guardianship and protection mandate of the national community' by engaging civil society groups to create 'go-structures', or more proactive interventions that did not require families to reach out and 'come' to services (Bundesregierung, 2005, p. 98). In 2007 the National Centre for Early Assistance (*Nationale Zentrum Frühe Hilfen*) was created to direct the new federal funding toward services run by voluntary organisations. The additional resources enabled voluntary child welfare organisations to execute new capabilities to remove children that they judged to be at risk of harm from their families. These capabilities had been established in the 2005 Law on the Further Development of the Child and Youth Welfare System (*Kinder- und Jugendhilfeweiterentwicklungsgesetz*) (Haug and Höynck, 2012, p. 92). Following the introduction of the Early Assistance

policy in 2007, the number of children removed from their families into the care of voluntary organisations increased by 14 per cent in just two years (BT Drucksache 16/13803, 20 Jul 2009, pp. 2, 10).

Government policy statements on the initiative combine arguments that had previously been made by each of the SPD and the CDU. For instance, increasing the birth rate had been among the Christian Democrats stated interests in family policy since 1975, while, in line with the SPD's earlier positions, there was also reference to 'strengthening the capability and self-responsibility, from traditional families through to blended, step- and single-parent families' (Bundesregierung, 2005, p. 95).

However, in wider child welfare debates in this period, the two parties' distinct positions are more clearly identifiable. In the debate on the twelfth Child and Youth Report published in 2006, the Social Democrats made redistributive arguments in favour of the proactive intervention, arguing that it was particularly important to develop services for children growing up in 'socially disadvantaged' and 'desperate' families that were less likely to seek out assistance (BT Plenarprotokoll 16/22, 9 March 2006, pp. 1630, 1639). They also made individualist arguments, suggesting that children, especially from 'desperate' families, needed to 'see that there is also a world outside of the family', and that 'in terms of gender policy, women's lopsided bond to the household and child-rearing must be overcome. Family policy must further improve the balance between work and family' (ibid, pp. 1639, 1642). On the other hand, the Christian Democrats emphasised other family policies designed to increase the birth rate and care in the family, stating that 'for us, there is no substitute for the intact family' (ibid, pp. 1626, 1640).

Residual arguments came not from the CDU/CSU but the FDP, who were anxious to begin the scheduled discussion on tax reform, and argued that initiatives to support children and families should not be funded by the proposed increase in the value-added tax (ibid, pp. 1628–9). While making residual arguments, the liberals sided with the SPD on gender politics, mocking the CDU's support for 'the conservative family image of the single-earning husband' (ibid, p. 1649). Although it stood in contrast with the Christian Democrats' position of 'family care first', by increasing the power and funding of voluntary organisations to proactively intervene in struggling families, the 2007 policy choice was a reasonable compromise between the two governing party's positions. It would strengthen the protective role of the 'national community' (*staatliche Gemeinschaft*), while still leaving

the primary decision-making power and care work to voluntary organisations. The early intervention strategy was well in line with the SPD's new vision of the 'preventive social welfare state' (*vorsorgende Sozialstaat*) expressed in the party's Hamburg Programme (Sozialdemokratischen Partei Deutschlands, 2007).

The family policy reform programme is considered one of the successes of the second grand coalition, which failed to act in other priority areas such as health care and labour market policy, largely due to the two major parties' contradictory policy positions (Zohlnhöfer, 2009). Even in family policy, at least concerning care of children who could not be cared for by their parents, we can see that the two parties made contrasting ideological arguments. In the summer of 2009, the government began work on a draft Child Protection Law, but was unable to come to an agreement before the October election. The two parties disagreed on the role of the child welfare committees, and the legal rights of children. The Social Democrats wanted specific recognition of children's rights, distinct from their parents, in the constitutional Basic Law.

Angela Merkel would return to the chancellorship following the 2009 election, this time together with the Christian Democrat's traditional coalition partner, the FDP. The election was called in favour of a 'bourgeois' government just two hours after the polls closed. Once again the coalition agreement included plans for family policy, including a new Child Protection Act that would focus on 'low threshold services' to assist families (Bundesregierung, 2009, p. 97). Early in the new year, the SPD parliamentary group called on the government to introduce a law for the protection of children, taking into account the UN Convention on the Rights of the Child and the Charter of Fundamental Rights of the European Union (BT Drucksache 17/498, 22 Jan 2010). The FDP 'warmly welcome[d]' the suggestions for more direct preventive action by the state (BT Plenarprotokoll 17/19, 28 Jan 2010, p. 1660). Although most parties agreed, the Christian Democrats expressed frustration at what they called the SPD's 'hypocrisy', suggesting that they had prevented the same legislation from being passed the previous year. In parliament, the CDU continued to make familial arguments, emphasising that 'the family has to be protected and strengthened... it is also about protecting parental rights' (ibid, p. 1658). The 2011 change significantly increased the barrier for interference with parental rights and child removals by the child welfare committees, focussing on parental support to promote care in the family (Kindler and

Borrmann, 2012, p. 168). The SPD abstained from the vote in parliament on grounds that there was insufficient funding for local authorities to employ and train the professionals that would be required to deliver the policy, criticising the governments wider Budget cuts (BT Plenarprotokoll 17/136, 27 Oct 2011, p. 16147).

The policy changes made by the Christian-democrat-led governments in the 1990s and 2000s were in line with my theoretical expectations, promoting family and voluntary responsibility for care. Although they had previously focussed on expanding the responsibility of the family, when in coalition with the SDP, new voluntary services were established. The SDP's support for voluntary services reflected a long-standing recognition of the role of the voluntary services in the area of child welfare policy. Unlike in England, and despite the 'third way' shift of the Social Democratic Party under Gerhard Schröder, the major parties continued to make both socio-economic and second-dimension arguments to support their policy positions during this period.

# England and Germany compared

So far in this chapter I have considered how changes in the partisanship of government over time shaped child welfare policy changes in England and Germany in turn. In this section, I compare the two countries. First, let us consider the different deinstitutionalisation outcomes in the two countries over time, in terms of the types of actors that became responsible for the care of children who could not be cared for by their parents. As discussed at the beginning of this chapter, before 1950 orphanages in both countries were run by a mix of providers. In England, public institutions looked after the largest proportion of children who could not be cared for by their parents, although there were also sizeable voluntary (largely religious) and private sectors. In Germany, voluntary providers were more dominant.

The shift from institutional to community care occurred earlier in England than in Germany, in part driven by the independent decisions of voluntary providers to prioritise foster care during the late 1950s and 1960s, but also as a result of policy changes made in the 1960s and 1970s. Most community care meant family care, enabled by the expansion of fostering in 1963 by the Conservative government, and adoption in 1975 by the Labour government. But new, smaller, state-run community homes were also developed to replace the local authority institutions in England, following

the 1969 Children and Young Person's Act. By the 1990s, 89 per cent of children who could not be cared for by their parents were in foster homes, and the remaining 6 500 were looked after in public group homes (Hansard HL, 21 Dec 2000, v. 620, c. 830, 842).

In Germany, alongside the Church-run orphanages, the minority of institutions for the care of children that were run by the state came increasingly under the operation of voluntary child welfare organisations – both secular and religious – after the Child Welfare Act 1953. The independent shift from institutional to foster care by these voluntary organisations progressed much more slowly than in England, perhaps because the voluntary services in Germany were, as in other areas of welfare policy, the heart of the 'public' welfare system, and therefore much more generously subsidised than the independent voluntary services in England. Although I found evidence of cross-party agreement in the Bundestag that the use of large, custodial institutions should be reduced, no major policy decisions were made to affect this change in Germany before 1990. As I have shown, this was not simply because of the devolution of responsibility for child welfare services to local authorities. Child welfare policy was on the federal agenda during the late 1970s and early 1980s, but tensions between the parties and strong disagreement about the types of alternative care that should be promoted by the federal government prevented the formation of a stable coalition for child welfare reform. In 1979, the Social Democrats attempted to develop new, smaller, state-run community homes similar to those which by that time dominated the residential care system in England, but the legislation was not passed. The FDP opposed the increase in spending, and the Christian Democrats strongly preferred family-based care alternatives.

After 1989 in England, the remaining residential care system was increasingly privatised, first by the Conservatives in 1989, and then by Labour in 2008, but residential care was and remains the fate of a very small proportion of looked-after children. The predominance of family care had already been established in England by end of the twentieth century. Conversely, it was not until 1990 that the first major policy action to expand family-based care was undertaken in Germany, by legislating the priority of foster care and providing new preventive services to vulnerable families. Residential care in smaller institutions run by voluntary organisations remained the fate of the majority of children who could not be looked after by their parents (Wolf, 2008). In 2007, voluntary responsibility was actually

expanded further through the Early Assistance for Parents and Children initiative implemented by the grand coalition. Although, in 2011, the Christian Democrats reduced the power that had been granted to voluntary organisations to remove children from their families, the child welfare system in Germany today remains an even mix of family-based care and voluntary residential care.

Turning to the way that parties motivated their policy positions, figures 6.1 and 6.2 summarise the types of arguments made by social democratic, Christian democratic, conservative, and liberal parties over time in England and Germany respectively. In both countries, as we would expect, the main social democratic parties made redistributive arguments in favour of more public sector funding, employment, and responsibility for child welfare, but there are three major differences between the two countries that reflect the changing dynamics of partisan conflict over time.

Firstly, although I find some evidence of arguments in favour of a redistributive or residual state in both countries, socio-economic conflict between the two largest parties was more salient in child welfare policy debates in England than in Germany. The Labour Party in particular consistently made redistributive arguments in favour of state responsibility for care, on grounds that voluntary and particularly private, for-profit services provided an uneven standard of care. They defended the expansion of the public-sector workforce to meet the needs of children who could not be cared for by their parents. These arguments were countered by the Conservative Party, who argued in the 1950s and early 1960s that redistribution should not be the purpose of the new social services, which should be provided on the basis of need, and with an active role for the Church.

Even when the Labour government introduced measures to increase the responsibility of the family for care in 1975, the Conservatives spoke out against the expanded regulatory role of the state and the funding of new adoption services through the sale of properties managed by religious providers. Conflict between the two major parties was particularly high around the passing of the Children Act 1989, which formulated local authority responsibilities on the basis of need and required the local authorities to facilitate care provision by private providers. While the Conservatives viewed the private providers as more efficient, Labour spoke out against market responsibility for services on grounds of inferior and uneven quality, and argued instead that the training and employment of public social workers was needed to meet the bill's aims.

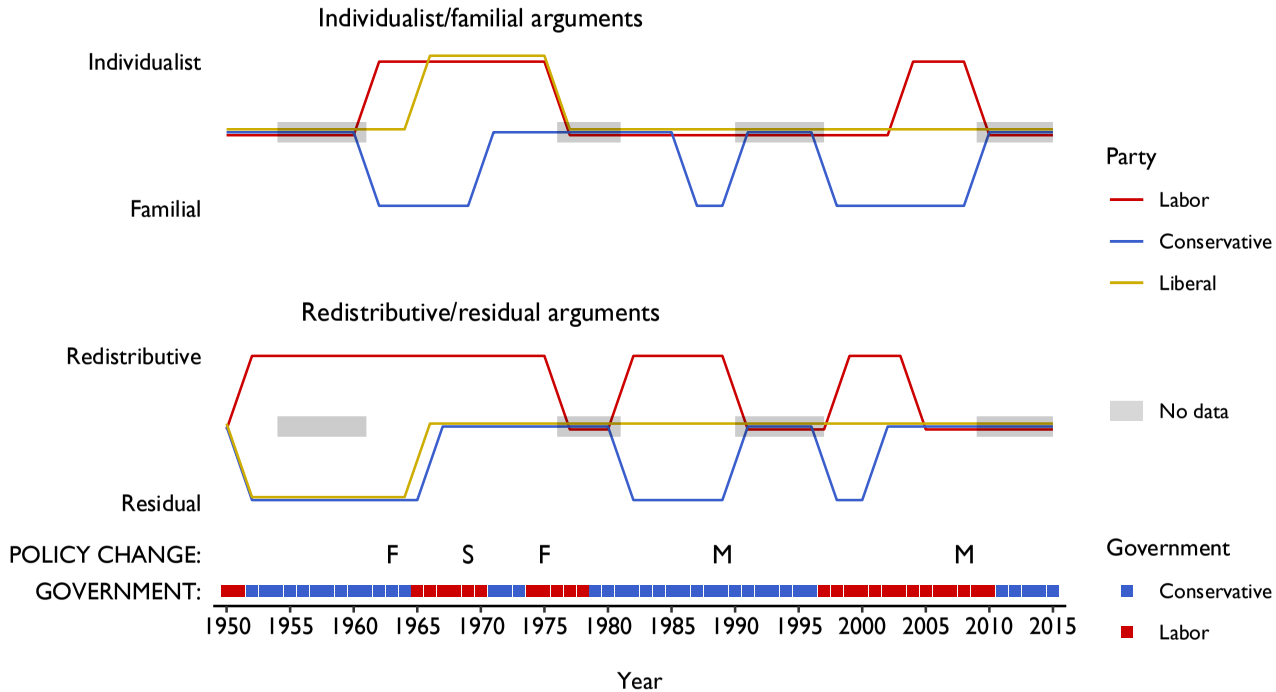
In Germany, socio-economic conflict between the Social Democrats and the Christian Democrats was less prominent, consistent with the fact that the Christian Democrats were strong supporters of a more coordinated social market economy and, in particular, redistributive social assistance to struggling families. During the 1950s, the Social Democrats took a similar position to the Labour Party in England, defending the state – or its local authority representatives – as both the primary decision-makers and providers of child welfare services. But they made fewer redistributive arguments in favour of expanding the public-sector workforce and state responsibility for service provision than the British Labour Party in later periods. this may have been due to the growing societal consensus in Germany around the principle of subsidiarity and the role of voluntary associations in the welfare state in general.

Residual arguments in Germany came not from the major centre-right party, but from the liberals. The redistributive arguments that the Social Democrats did make were countered by the Free Democratic Party. The FDP consistently emphasised the efficiency benefits of preventive services, and when the Social Democrats attempted to expand state responsibility for care when in coalition with the FDP, the junior party aimed to ensure that the law would protect the role of the voluntary providers and contain the expansion of public bodies.

Secondly, while socio-economic conflict over child welfare policy declined somewhat in England after 2000, it actually became more prominent in Germany in this recent period. It was not until the late 1980s and 1990s that the German Christian Democrats began to emphasise the cost savings that could be achieved through preventive services and imposing cost controls on the child welfare committees. Although the Social Democrats did not prioritise changes to child welfare policy when they were in power in the early 2000s, they increasingly made redistributive arguments in favour of public responsibility for services when they were in opposition. On the other hand, by the 2000s, in England, wider socio-economic conflict between the Conservatives and the Labour Party had declined as New Labour took a rightward turn toward public choice and the marketisation of public services, also affecting the child welfare services.

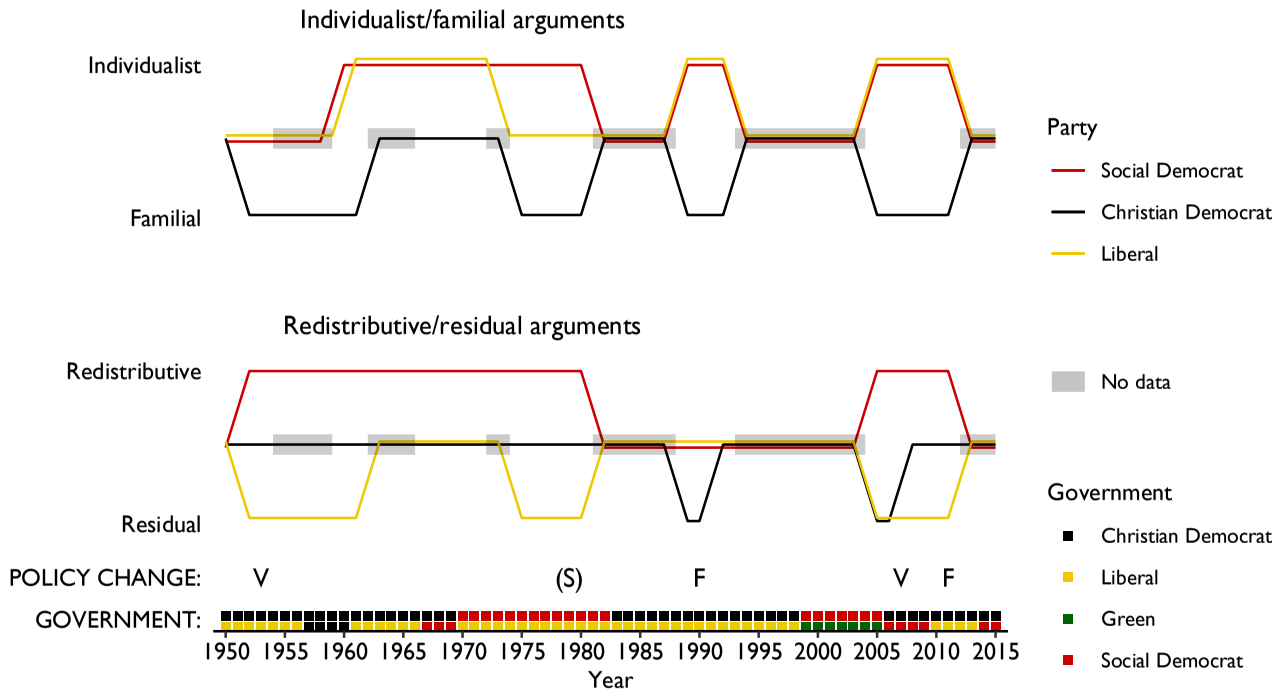
Thirdly, second-dimension conflict between the two major parties was more salient in child welfare debates in Germany. Familial arguments were frequently made by both the Conservatives in England and the Christian Democrats in Germany. But while the SPD consistently countered these

Figure 6.1: Types of arguments made by parties in England in child welfare policy debates over time




*Comments:* Figure displays types of arguments made by political parties over time, as well as the timing of policy decisions, where: S=state, M=market, F=family or V= voluntary responsibility. Primary sources are listed in Appendix C.

Figure 6.2: Types of arguments made by parties in Germany in child welfare policy debates over time




*Comments:* Figure displays types of arguments made by political parties over time, as well as the timing of policy decisions, where: S=state, M=market, F=family or V= voluntary responsibility. Note that the 1979 policy in brackets (S) was an attempted policy change. Primary sources are listed in Appendix C.

arguments with individualist arguments in Germany, the British Labour Party made few individualist arguments after 1975. In Germany, at least in the area of child welfare policy, this second dimension of conflict was stronger. While the FDP had opposed the Social Democrats in making arguments in favour of a residual state, they actually made similar individualist arguments to the major left party. The FDP defended children's rights distinct from those of their parents, and women's rights to be free from the burden of care, while speaking out against the Christian Democrats' vision of the male-breadwinner family as the solution for all social problems.

The differences between the liberal parties in the two countries should not be overstated on the basis of Figures 6.1 and 6.2. In England, the Liberal Party, and later the Liberal Democrats, were simply not very involved in child welfare policy debates. On the other hand, in Germany, as junior coalition partners in most governments, the FDP were quite involved in these policy debates. Their participation in both Social-Democrat- and Christian-Democrat-led governments likely also contributed to the slower pace of reform in Germany. The proportionality of the German electoral system meant that more compromise had to be made across multiple dimensions of conflict than in majoritarian England.

It is also worth reflecting briefly on the character of the arguments made in policy debates on child welfare policy, in comparison with those made in mental health policy debates. The character of socio-economic arguments across the two policy areas was quite similar. Social democratic parties made arguments in favour of expanding the public-sector workforce and state provision to ensure equality of access to services, and equal quality of services throughout the country. Conservatives, liberals, and at times Christian democrats made arguments in favour of reducing costs, increasing the efficiency of services, and restricting the expansion of public-sector employment.

But the character of second-dimension arguments varied across policy areas. We saw in the previous chapter that individualist arguments made by social democrats and liberals were primarily about relieving the family – and particularly, women – of the burden of care of people with chronic and severe mental illness. But in child welfare policy debates, individualist arguments were also concerned with the role of public policy in shaping the family. Many of the children who were in orphanages and the substitute care arrangements that replaced them were not children without families,

but children with one or more living parents who were unable to care for them. Political parties agreed that children should be cared for by their parents, but they disagreed about the role for the state in shaping the relationships between parents and children and determining what an appropriate family environment was.

This is exemplified by the debate in England on the Children Act 1963, where the Labour Party argued that it should be the duty of local authorities to promote the welfare of children to prevent the need for substitute care, while Conservatives argued that the responsibilities of parents should not be handed over to public authorities (Hansard HL, 20 Nov 1962, v. 244, c. 814). The Conservatives' 1963 policy change allowed local authorities to fund preventive assistance in the family, but this assistance would be provided to willing families, on a voluntary basis, with the state acting 'at a distance'. Similar disagreements were observed in debates on proposed amendments to the Child Welfare Act 1975 in Germany, where the Christian Democrats defended the family as 'the ultimately irreplaceable place of children's growth and development', while the SPD argued that 'the family would not be viable without society and its services for personal prosperity, social security, public goods, education, leisure' (BT Plenarprotokoll 07/173, 22 May 1975, pp. 12090, 12092–3).

The character of these arguments was different, but they reflected the same underlying conflict between the parties about the organisation of society. For conservatives and Christian democrats, the family is a foundational social unit whose functions should not be subject to state intervention. As discussed in Chapter 2, leaving families to perform their caring function has intrinsic value for human flourishing within catholic social doctrine, and instrumental value for the preservation of the traditional social order from the perspective of conservatives. Conversely, for liberals and social democrats, it is a function of the state to shape the roles and relationships within families, to enable all individuals to flourish. The arguments made in these care policy debates reflect a clash of ideologies, or ways of seeing the world, that have roots in the historical religious cleavages that contributed to party formation and continue to structure second-dimension conflicts between the major parties of government.

## Alternative explanations

This chapter has presented evidence from parliamentary debates and documents that is consistent with the claim that partisanship shaped care policy choices. Christian democratic governments promoted voluntary and family responsibility for care in Germany, and conservative governments promoted family or market responsibility for care in England. Social democrats promoted state responsibility in England, and attempted to do so in Germany. In England, the Labour Party introduced legislation which promoted the responsibility of families by expanding adoption and foster care, but in doing so they also dramatically expanded the role and power of state actors to intervene in family life and govern the alternative care sector. These findings suggest that despite bipartisan agreement on the general goal of reducing institutional care, the process of deinstitutionalisation and the transition to 'community care' was still politicised. It is possible, however, that the apparent relationship between partisanship and care policy choices is driven by factors other than party ideology.

The parliamentary debates on child welfare policy suggest that fiscal pressure and the economic climate played less of a role in the type of care policy that was promoted than it did in the case of mental health care – although these factors appear to have affected the legislative priority given to child welfare reform. But we have seen that scientific knowledge and the structure of the wider social services system were influential in policy debates. In this section, I consider whether the patterns that I observe in the type of alternative care that was promoted were actually driven by changes in expert knowledge that contributed to the wider deinstitutionalisation movement, or lobbying from different professional or provider groups. I also consider how national political cultures and the wider structure of the social services system may have shaped policy decisions in a path-dependent fashion.

If changing scientific knowledge and ideas were the driver of care policy choices, then we should expect that either the types of care policy choices promoted by different parties were the same at a given point in time, or that the decision-makers were relying on different scientific evidence or advice. The evidence presented above shows that in parliament, parties disagreed over who should be responsible for care and did not promote the same types of policy changes. In England, the Conservatives fought against the Labour Party's expansion of state power to intervene in family life in

1975, and when they came into office, repealed these changes. In 1979, German Social Democrats failed to introduce a change that would expand state responsibility, partly because the Christian Democrats opposed the policy and used their power in the Bundestag to thwart the bill.

The parties' different positions were not informed by different bases of scientific evidence. We have seen that from 1948 in England and from 1957 in Germany, child welfare policy changes were informed by bipartisan parliamentary standing committees that collected a common evidence base to inform policy decisions. When the Bundestag debated the report of the Commission on Child Welfare Law Reform in 1975, the major parties accepted its evidence from the child development studies of Anna Freud, Rene Spitz, and John Bowlby, but they interpreted and used this common scientific evidence in line with their pre-existing ideological commitments. While the Christian Democrats interpreted the science in line with a male-breadwinner vision of the family, and saw support for the mother to remain primary carer, the Liberals and Social Democrats argued that 'it [did] not matter that the child only has one caregiver' but rather that the quality of care was such that, in a well-staffed children's home, 'the children receive the necessary loving attention from caregivers who are regularly present' (BT Plenarprotokoll 07/173, 22 May 1975, pp. 12120–2). Neither party disputed the science, but they viewed its implications through an ideological lens.

It is also clear that the types of policy changes made in England and Germany were quite different, despite decision-makers in both countries referring to the same scientific experts such as Freud and Bowlby. Lawmakers were also well aware of developments in other countries. For instance, when the first Report of the Committee for Family and Youth Issues was discussed in the Bundestag, members made reference to the both the English Youth Service Reports and the American Robins Report (BT Plenarprotokoll 05/124, 11 Oct 1967, pp. 6272–3).

One policy change that might be explained by expert knowledge is the British Labour Party's 2008 decision to encourage local authorities to contract-out children's homes and preventive services to third parties from the private sector, justified in line with the principles of flexibility and continuity, and supported by new evidence on effective public services and children's services, rather than along ideological lines. But changing, or different, scientific knowledge does not explain the relationship between partisanship and care policy across the era of deinstitutionalisation.

Even if different science did not drive the patterns that I observe, it is possible that decision-makers from different parties were the targets of lobbying from different groups of service providers, professional associations, advocacy organisations, or other civil society groups, and that their policy choices actually reflected the influence and preferences of these actors rather than party ideology. Individual politicians were active in civil society organisations, and members of parliament sometimes referenced the interests of specific non-government organisations in debates. However, I don't find evidence in the parliamentary debates that particular service providers, professional associations, or other civil society groups systematically lobbied different parties to drive the patterns in child welfare care policy decisions that I observe. In Germany, the CDU's Maria Stommel, who was also vice-president of the Family Association of German Catholics during the 1970s, actually bemoaned the weakness of lobby groups for the interests of children in substitute care, 'because they have too few active members and too few sponsors who support their work' (BT Plenarprotokoll, 07/173, 22 May 1975, p. 12118). Nevertheless, future research might also explore the relationship between political parties and different types of civil society organisations in more detail.

It is clear that the wider structure of the social services, and some of the activities of service providers within existing policy settings, shaped the available options that policy makers had for care policy, but partisanship still affected the actions taken by sitting governments. The use of foster care and adoption by voluntary-run orphanages in England arguably set an example for the growth of these family-based alternatives within the public system as an alternative to institutional care. Nevertheless, when the Labour government did so in 1975, they also expanded the public-sector workforce by creating a public, professional adoption and foster care service. The powers conferred on local authorities were opposed, and later repealed, by the Conservatives. In Germany, the Social Democratic Party accepted a dominant role for voluntary providers in delivering child welfare services, based around the existing voluntary youth welfare offices. Although they attempted to create new state-run 'open living' homes in 1979, they ultimately supported the expansion of similar voluntary services when in coalition with the Christian Democrats in 2007. In the comparison of child welfare policy reform in England and Germany above, we saw that the actions of governments were constrained by the wider institutional characteristics of each country, too, with the compromises necessary within

German coalition governments slowing the pace of reform. Although the legacies of previous policies and the institutional characteristics of each country clearly mattered, policy changes were not completely determined by these factors in a path-dependent fashion. Partisan actors shaped the trajectory and ultimate outcomes of child welfare reform.

# Conclusion

This chapter has traced parliamentary debates about child welfare policy in England and Germany, demonstrating that governing parties made both more redistributive or residual arguments, and more individualist or familial arguments to support their policy positions. The patterns of care policy change over time are consistent with my theoretical expectations about how partisanship shaped care policy. I have shown not only that both dimensions of conflict were present in parliamentary debates in both countries, but that a multidimensional perspective on partisanship helps us to understand the main differences in child welfare policy reform between England and Germany.

The earlier and more dramatic shift to family responsibility for the care of children who could not be cared for by their parents in England was enabled by a high level of agreement between the major parties on the goal of deinstitutionalisation, and a relatively lower level of conflict on the second dimension of conflict after 1970. The strong role for voluntary responsibility in Germany mirrors the responsibility that voluntary organisations play in other areas of the welfare state, reflecting the principle of subsidiary promoted by the Christian Democrats in particular. This made the Social Democratic Party of Germany less likely, and less able, to expand the role of state providers, reflected in the relatively lower level of socio-economic conflict observed between the two major parties on child welfare policy matters. The relatively laggard development of foster care and adoption as alternatives to institutional care in Germany was shaped, instead, by much stronger disagreement on the second dimension of partisan conflict, manifested in the persistent clash between individualist and familial visions of society.

# Chapter 7

# Conclusion

This dissertation set out to address whether, and how, partisan politics shaped variation in the care policy choices that affected the decline of asylums and orphanages. There have been a large number of mental health and child welfare policy changes since the Second World War, as governments throughout Western Europe, North America, and Oceania made decisions to reduce the use of institutional care. The deinstitutionalisation movement was shaped by changing scientific knowledge and ideas, professional specialisation, the lobbying of action groups against institutional care, and growing fiscal pressure. Decisions to reduce the use of asylums and orphanages involved choices about who should instead be responsible for care. I have shown that these policy changes were not benignly shaped by expert knowledge, and they weren't just a response to fiscal pressure or purely socio-economic conflict either. The ideologies of individualism and familialism, shaping debates about whether or not care should be provided by families, also structured the care policy preferences of partisan actors. The partisanship of government affected decisions about who became responsible for the care of formerly institutionalised populations, and disagreements between political parties were played out across these two dimensions of conflict.

In chapter 2, I outlined my expectations about how partisan politics shapes care policy decisions, combining insights from the historical-sociological literature on the origins of political parties with theories of welfare politics. I theorised that, because the target population for care policy is a relatively less powerful group of people who are not expected to work, care policy decisions are not as decisively shaped by the contest

for the median-income voter as other types of welfare policies. I argued that partisan care policy preferences are structured by two dimensions of ideological conflict: socio-economic conflict, rooted in class cleavages, and second-dimension conflict, with origins in religious cleavages. Divided in both socio-economic and second-dimension conflicts, I expected social democrats to promote state responsibility for care, while conservatives preferred market or family responsibility. But as the ideologies of individualism and familialism also divided liberals from Christian democrats, I expected liberals to prefer market responsibility rather than family care, and Christian democrats to favour care by the family or voluntary providers.

In chapter 3, I introduced the two policy areas for the empirical study, positioning asylums and orphanages, and the mental health care and child welfare policies that replaced them, as cases of care policy. Drawing from existing historical literature, I re-evaluated the function of asylums and orphanages in historical perspective. I showed that while asylums and orphanages have widely been understood as institutions of social control, they also fulfilled a social care function, to substitute for familial care. Although asylums and orphanages existed alongside earlier forms of indoor poor relief, in the nineteenth century they became public services with a similar purpose to the emerging institutions of the welfare state. I reviewed the existing empirical literature on deinstitutionalisation, identifying potential alternative explanations for the relationship between partisanship and care policy. Growing fiscal pressure, changing scientific knowledge, and the influence of 'national political cultures' were each addressed as potential confounding factors in the empirical parts of the dissertation that followed.

In chapter 4, I tested my theory of the partisan politics of care using a quantitative approach, by categorising care policy changes in twelve countries according to whether they promoted the responsibility of the state, the market, the family, or voluntary providers. The analysis showed that, controlling for important factors like economic conditions, welfare regime characteristics, and the availability of family care, government partisanship affected care policy choices. I found, in line with the existing comparative welfare state literature, that social democratic parties promote the responsibility of the state to a greater extent than all other types of parties. But parties of the centre and right also make distinct choices, supporting my claim that the effect of partisan politics is multidimensional. Even though family responsibility for care was more common in the child welfare policy

area, social democrats were still more likely than other parties to promote state responsibility, Christian democrats more likely than others to promote voluntary responsibility, and conservatives and liberals more likely than other parties to promote market responsibility.

The most unexpected result was that liberal governments preferred family responsibility to a similar extent to Christian democrats, even though I expected these parties to be divided in second-dimension conflicts about the nature and role of the family. But in cases where liberals chose to promote family responsibility for care, they were motivated to do so by a desire to reduce government spending, while conservatives and Christian democrats actively promoted care by the family, even if it came at a cost. This suggests that the motivations for promoting family responsibility are complex, reflecting either a preference *for* familial care or *against* state responsibility. It is among conservative parties, where both motivations are present, that the relative preference for family responsibility is strongest.

Chapters 5 and 6 gave confidence to the quantitative findings, by showing that my theory helps explain the evolution of mental health policy and child welfare policy in two quite different countries over time, and providing evidence for one of its main assumptions: that all political parties agreed on the goal of reducing institutional care. I also showed that a multidimensional perspective on partisan conflict can help us understand some of the important differences between care policy outcomes across countries.

Comparing England with Germany, the main difference in mental health policy outcomes was that in England, both the family and market providers played a much larger role from the 1980s, as a result of the reforms of the Thatcher government in reaction to the expanded role for local authorities that had been developed by the previous Labour governments. In Germany, the Christian Democrats mainly promoted voluntary responsibility for care, and it was not until the wider health system faced significant cost pressures after reunification that they turned to expand the role of informal family carers. The main difference between the two countries in child welfare policy was that the shift from institutional to community care occurred earlier in England than in Germany as a result of policy decisions made in the 1960s and 1970s to expand family responsibility through foster care and adoption, as well as the development of new local-authority-run group homes by the Labour government. Although the Social Democratic Party of Germany tried to make a similar change in 1979, their attempt was frustrated by their liberal coalition partner's concerns about the cost of state

responsibility, and an opposition that strongly preferred family-based care alternatives. Though the FDP were on the side of the Christian Democrats in socio-economic conflicts, they did not share the Christian Democrats' view of the family as the natural site for care, and with the two in coalition together, it was not until 1990 that the first major policy action to expand family-based care was undertaken.

The second purpose of these chapters was to address *how* partisanship shaped care policy decisions by looking for evidence of socio-economic and second-dimension arguments in parliamentary debates about care policy changes. In the case of mental health policy in chapter 5, socio-economic conflict played an important role in shaping the decisions of social democratic governments to prioritise state responsibility for care, and it was also and important motivation for conservatives and and Christian democrats to promote policy choices which expanded the responsibility of non-state actors – the voluntary sector, the private sector, and the family – in order to reduce costs. But second-dimension conflict also mattered, in particular for explaining the decisions of social democratic governments under fiscal constraints, to expand voluntary or private providers rather than shifting responsibility for care onto the family. In both England and Germany, social democrats motivated these decisions on the basis of individualist arguments.

In chapter 6, we saw that the earlier and more dramatic shift to family responsibility in England was enabled by a relatively lower level of second-dimension conflict over the nature and role of the family, especially after 1970. The relatively lower level of socio-economic conflict observed between the two major parties in Germany, on the other hand, reflected the established role for voluntary provision, actively promoted by the Christian Democrats, which constrained the Social Democrats' ability to expand the role of state providers.

The distinct role of each dimension was not always clear in individual policy decisions. Take, for example, the debates on the Children Bill 1975 in England, discussed in chapter 6. Arguments made against the responsibility of the state may have reflected opposition to redistribution or opposition to intervention in the family. But a multidimensional perspective on partisan conflict helps account for the general patterns in care policy decisions over time and among countries.

This dissertation has shown that ideological conflicts shaped by the class and religious cleavages that contributed to party formation have had

lasting impacts on the positions that partisan actors take in mental health care and child welfare policy debates, and the care policy decisions that they make when they are in power. While partisan politics had an independent effect on care policy choices, the qualitative chapters of the dissertation showed that outcomes also depended on the fiscal climate, the influence of expert knowledge, and the wider institutional environment including existing policy settings and the electoral system.

Before turning to its main contributions, I should recognise that this study of the relationship between partisanship and care policy changes has not been exhaustive. One aspect of the relationship that has not been adequately addressed is the connection between political parties and particular groups of providers, professional associations, and advocacy groups. A closer study of these relationships, using material beyond parliamentary debates and documents, would deepen our understanding of how and why political parties promote particular types of care policy.

The main empirical contribution of the dissertation is a study of the decline of asylums and orphanages together, explaining not why deinstitutionalisation occurred, but what came after. What have we learned about the process of deinstitutionalisation, and about the relationship between partisanship and care policy, by studying these two policy areas together?

I studied mental health and child welfare policy changes together because of the shared historical function of asylums and orphanages to substitute for family care, and their similar patterns of rise and fall. But there were also important differences between the two policy areas. Under existing policy settings in 1950, the state directly provided a larger proportion of the existing institutional care for people with mental illness than it did for children who could not be cared for by their parents, so the fiscal burden of the mental health services was relatively higher. As the process of deinstitutionalisation saw psychiatric services increasingly integrated with the wider health services, sector-wide cost pressures and spending reviews also affected the context for policy change. Comparing my findings across the two policy areas gives some insight into the effect of fiscal pressure on policy decisions.

This is relevant to one of the main empirical debates in the deinstitutionalisation literature, concerning whether the process was driven by changing scientific knowledge and ideas, or ultimately motivated by cost savings. Based on his Marxist analysis of psychiatric deinstitutionalisation, Scull (1984) argued that rising costs were the primary motivating factor.

The role of fiscal pressure remains central in current debates on the causes of deinstitutionalisation, with a recent survey of psychiatric professionals in England, Italy, and Germany suggesting that cost-reduction was an important driver of policy decisions (Chow, Ajaz, and Priebe, 2019).

By studying mental health and child welfare policy together, we can see that fiscal pressure did shape policy decisions and the arguments that partisan actors made to defend their policy positions over time, but that the response to fiscal pressure was conditioned by party ideology. The major centre-left parties in both countries frequently made arguments in favour of an expansion of public-sector spending and employment, in both policy areas until the 1990s. In the policy area where the potential for fiscal savings was smaller – child welfare – arguments to reduce the cost of services and the size of the public sector were made less frequently by parties of the centre and right. For these parties, the relatively lower potential for cost savings appears to have reduced the political salience of socio-economic arguments. But even in the policy area where socio-economic arguments were less salient, centre-right governments did act to limit expenditure – for instance, when the Thatcher government repealed the expanded duties of local authorities in the public adoption system introduced by Labour in 1975. Individualist and familial ideologies also mattered for the decisions made by different parties under similar fiscal constraints. In the area of mental health policy, the British Conservative Party reduced expenditure by placing more responsibility upon families, while the Labour Party acted to subsidise private care providers.

Throughout the three empirical chapters, we also observed differences between the two policy areas in the role of scientific knowledge. One of the main arguments in the psychiatric deinstitutionalistion literature, favoured by Jones (1993a) and Rochefort (1997), is that expert ideas and scientific knowledge were the main drivers of change, through their influence on either technology, public opinion, or policy-making more directly through government inquiries. Considering the decline of both asylums and orphanages together showed that changing scientific knowledge was important for mobilising parties across the political spectrum to reduce the role of institutional care, but that the types of alternative care policies that parties supported were decisively shaped by their ideological positions.

In both policy areas, there were a large number of government inquiries and commissions, and a high level of agreement between political parties on the scientific evidence that was presented as well as the general goal

of deinstitutionalisation. The starkest difference between the two policy areas, observed in Chapter 4, was that family responsibility for care was much more common in the case of child welfare policy. All types of governments were more likely to promote the responsibility of families for the care of children, because they agreed on the science of child development, which showed that children had better outcomes when they were raised in a family environment. Considering parliamentary debates on the two policy areas in Chapters 5 and 6, we saw evidence that all parties had shared, non-ideological reasons for supporting family care for children to a greater extent than for people with mental illness. Already in the 1950s, representatives from different parties in England made reference to scientific ideas about the importance of a family upbringing in child welfare policy debates. In Germany, when family policy entered the remit of the Committee on Youth Issues and it began producing an annual Family Report, the work of child psychiatrists such as Bowlby and Rene Spitz was also referenced in parliamentary debates.

Political parties nevertheless disagreed about the types of care policies that should replace institutional care. Even though they agreed on the science, political parties interpreted its policy implications in line with their pre-existing ideological positions, and used ideological arguments to justify their policy choices. When the British Labour Party expanded family responsibility for care in 1975, they did so by establishing a professional public adoption service that would expand access to family care, but on the basis of greater regulatory power for the public authorities to remove children from families and place them in appropriate adoptive families. In Germany, the SDP were more resistant to familial policy changes in spite of the evidence about child development. Although they did not dispute the science, in debates they interpreted the evidence in line with their values by arguing that local authority homes for children could be provided in a way that met children's developmental need for a consistent primary carer.

These empirical findings will be of interest to scholars of the relationship between science and policy making. My findings are consistent with the idea that partisan actors play an active role in translating expert knowledge into policy problems based on their pre-existing ideological positions (Gilardi, 2010). There is also some evidence in my empirical study of 'depoliticisation', or deferring to expert knowledge, as a strategy by governments (Burnham, 2001). In the policy areas that I have studied, it is only in recent decades, when the political salience of certain ideological

arguments has declined, that parties have reached for 'evidence-based' justifications for policy. I have shown that while both fiscal pressure and expert knowledge shaped deinstitutionalisation, partisan actors played an independent, and decisive, role in the care policies that came after.

The main theoretical contribution of the dissertation is to current debates in the comparative welfare politics literature about how the dimensionality of partisan conflict may have changed over time. The main argument of the literature on multidimensional welfare politics is that as a result of secularisation, labour market transformation, and the policy feedback effects associated with mature welfare states, the conflict lines around which voters' preferences are structured have been transformed, resulting in a realignment of voter-party linkages and a restructuring of party competition (Häusermann and Kriesi, 2015). One important claim is that the 'new left' have shifted rightwards in socio-economic conflicts under conditions of fiscal pressure and in order to attract more educated middle-class voters.

My findings are broadly consistent with this claim. In both mental health and child welfare policy debates, there were changes in the salience of socio-economic arguments over time. Growing fiscal pressure reduced the scope for expanding public-sector employment by investing in new state-managed services, and the willingness of the major centre-left parties to make these types of arguments. Under increasing cost pressures in the 1990s and 2000s, both the Labour Party in England and the SPD in Germany reduced their use of redistributive arguments in policy debates when they were in government. In response to fiscal pressures, New Labour became more centrist in economic policy, reducing socio-economic conflict between the two major parties in England. The Schröder government in Germany was also more centrist when in power, but the SPD made redistributive arguments in the 2000s from opposition.

Despite this shift in rhetoric, both Labour- and SPD-led governments increased funding for both mental health and child welfare services during this period. But rather than being provided directly by the state, these services would be delivered by voluntary or for-profit providers. Governments justified their choices on the basis that they would provide better value for money while ensuring the quality and equality of access to services. While the use of redistributive arguments by the major centre-left parties declined, the liberals, conservatives, and Christian democrats continued to make residual arguments during the same period. We actually

saw in increase in the number of more residual arguments made by the Christian Democratic Party in the 1990s and 2000s.

These changing patterns over time do not appear to have been driven by purely fiscal concerns. As discussed above, comparing the two policy areas, socio-economic conflict appears to have been more salient in policy debates on the mental health services, which were subject to higher cost pressures. The relatively higher fiscal pressure facing the mental health services did not lead to fewer redistributive arguments from the British Labour Party or the Social Democratic Party of Germany, at least until the 1990s. During the fiscal crisis of the mid-1970s and into the 1980s, social democratic parties made redistributive arguments in both government and opposition. It was only from the 1990s that these parties reduced their use of redistributive arguments when in government. This suggests that fiscal pressure alone did not reduce socio-economic conflict, but that changes in electoral strategy from the 1990s reduced the willingness of the major centre-left parties to make redistributive arguments.

These findings are consistent with the claim in the existing welfare state literature that the electoral role of socio-economic ideology for 'new left' parties appears to have declined. But rather than reflecting a decline in the relevance of left-right partisanship, my findings support the argument made by Gingrich (2011) that parties have responded to fiscal constraints by pursing policies that engender broad electoral support but allow them to pursue their core welfare policy goals. Gingrich (2011) shows that left-wing parties have criticised private insurance schemes and enhanced state control over costs through funding mechanisms, while right-wing parties have differentiated benefits and expanded private finance. I find that, in contrast with the marketising reforms of the Conservatives, the Labour Party's expansion of personalised budgets for mental health care in England were designed to introduce competition and give service users choice without resorting to private finance. Private social work practices were strictly commissioned by local authorities with enhanced regulatory capabilities. In Germany, the SPD's Statutory Health Insurance Reform also retained strong central financial controls to ensure equality of access. All of these policies acted to strengthen collectivised care.

Their wider economic policy positions, shaped by electoral strategy, meant that the policy choices of social democratic parties deviated from their traditional preference for expanding the public sector from the 1990s. But their decisions were still consistent the parties' expected second-dimension

preferences. Both Labour and the SPD continued to make individualistic arguments in support of subsidising voluntary or market providers. Labour's decision to marketise mental health service delivery in 2007 still stood in contrast to the two prior policy changes made by the conservative Thatcher governments in 1979 and 1983, which actively promoted care in the family. Likewise, the Social Democratic Party of Germany argued that their policies prioritised 'rationalisation' alongside the independence and employment of women.

Electoral strategy may also have played a role in the German Christian Democrats' framing of their policy decisions after 2009, with the stated aim in their coalition agreement with the FDP 'to promote the compatibility of care and work' (Bundesregierung, 2009, p. 92). This is consistent with the argument made by Morgan (2013) that competition not for the median-income voter but for female voters, in the context of increasing female labour market participation, led the Christian Democrats to pursue more generous parental leave and day-time child care policies. The realignment of political constituencies therefore appears to have affected the electoral relevance of both socio-economic and second-dimension arguments for particular parties, and the way that they justify their policy positions.

A related claim in the post-industrial politics literature is that the importance of socio-economic conflict, and therefore the relative salience of second-dimension conflicts, has changed over time (Kitschelt, 1994). My findings suggest that although second-dimension conflicts may have become more salient in some countries and policy areas, they have always been more relevant in others. In England, second-dimension arguments have become relatively more salient than socio-economic arguments – particularly in mental health policy debates – since the 1990s. But debates about the nature and role of the family, and the role of the state in intervening in the family, had always been important in child welfare debates in England, and in both care policy areas that I have studied in Germany.

What does appear to have changed over time is the *content* of the second dimension of conflict. Early in the period that I study, the content of second-dimension conflicts was sometimes more explicitly religious – for instance, where it shaped attitudes to voluntary service provision across the two policy areas. In mental health policy debates in England, the Labour Party were more supportive than the Conservatives of directly subsidising voluntary agencies as a second-best alternative to public provision.

Conservatives, on the other hand, were more supportive of voluntary child welfare services, where, unlike in the case of mental health services, the voluntary organisations caring for children were predominantly religious. In Germany, voluntary responsibility was clearly the first preference of the Christian Democrats in both policy areas, even though most of the voluntary mental health services providers were secular. The Christian Democrats were also more open to active intervention to strengthen the family, but by voluntary community actors rather than the state. The difference between the Christian Democrats and Conservatives' preferences across the two policy areas is consistent with the intrinsic value that Christian democrats placed on voluntary organisations, on the basis of catholic social doctrine. In more recent decades, a language of universal human rights has entered arguments in parliamentary debates on both policy areas, but rather than shaping a new or transformed second dimension of conflict, it has been incorporated into the existing structure of partisan competition and is used by social democratic and liberal parties to support individualist policy positions.

The content of second-dimension arguments also varied across policy areas. In mental health care, individualist arguments made by social democrats and liberals were primarily about relieving the family – and particularly, women – of the burden of care, but in child welfare policy debates, individualist arguments were often about the role of public policy in shaping or intervening in the family. The scientific evidence about the effect of primary carer relationships meant that, in child welfare policy debates, there was more agreement on the family's role as an ideal carer. But partisan disagreement about the nature of the family and how society should be organised was still structured along the same lines as religious conflict. These findings are consistent with the argument by Rovny and Polk (2019) that contemporary second-dimension conflicts are closely related to the much older religious cleavage of the late nineteenth and early twentieth centuries, even if the content of second-dimension conflicts has changed. My findings suggest that partisan conflict over these policy areas is no more multidimensional in recent decades than it was during the period of welfare state expansion.

The existing post-industrial welfare politics literature compares the multidimensional dynamics of contemporary welfare policy-making with uni-dimensional theories of industrial-era welfare state expansion that are based on the analysis of broad-based pensions and social insurance policies.

There is strong evidence that when it comes to policies such as pensions, partisan policy preferences have been restructured along the socio-economic dimension of conflict by labour market transformation and the differentiation of workers according to skill level and occupational class (Häusermann, 2010). There is also strong evidence in the wider literature on post-industrial politics that the emergence of 'new' political parties has been enabled by shifting voter demand in the new 'culture wars' (Bornschier, 2010). But I have shown that in policy areas targeted at dependents rather than workers and therefore not dominated by redistributive conflict, while the wider electoral relevance of certain types of ideological arguments may have shifted, the core policy preferences of the 'old' political parties are still structured along similar lines today.

The broader implication for the comparative welfare politics literature is that theories of partisanship should consider both the vote-seeking and policy-seeking behaviour of political parties, or, in other words, both their electoral strategies *and* core policy preferences. While electoral strategies may be affected by social-structural changes, I argue that parties' core policy preferences are shaped by the lasting ideological effects of much older societal cleavages. Parties act as ideologues in the care policy areas that I study because the target population are a relatively narrow group of people who are not expected to work. The partisan dynamics that I observe may also be borne out in other care policy areas, including those that emerged much more recently than asylums and orphanages. For instance, in the case of aged care policy, even though the elderly are a larger population, the group requiring long-term care is smaller and has weak political power. But because of the breadth of the population to which day-time child care applies, and the strong connection between child care and women's labour market participation, child care policy could be driven more strongly by vote-seeking behaviour.

Welfare politics has long been multi-dimensional, but the role and salience of each dimension of conflict depends on the nature and electoral implications of each policy area. This makes the partisan politics of care policy distinct from other welfare policy areas. I argue that the dimensions of partisan conflict that shape the core policy preferences of the 'old' political parties can be traced to the class and religious cleavages that contributed to party formation, which have had lasting effects on party ideology and welfare policy making.

# Appendix A: Full and alternative models

Table 7.1 reports coefficients for all control variables used in the multinomial choice model in Chapter 4. Table 7.2 compares the results of the preferred model (model 1 here) with two alternatives using the more common continuous measure of partisanship which takes on a value between 0 and 1 representing the fraction of the cabinet posts held. Including this measure for all four party types induces high multicollinearity, so one parameter must be excluded. Model 2 excludes the measure for conservative parties, and model 3 excludes the measure for liberal parties. The coefficients in models 2 and 3 represent the effect on the log odds of each outcome category of a one unit shift in the partisanship measure, or from zero per cent of cabinet seats to 100 percent. Both models report the effect on the log odds relative to the outcome category of state responsibility.

Remembering that in model 1 the base government partisanship category is social democratic leadership, the significant negative coefficients for social democratic cabinet seats in models 2 and 3 are consistent with the results obtained using the preferred categorical approach. On the basis of the information criterion (BIC) reported at the bottom of the table, models 2 and 3 are a poorer fit for the data, and the effects are much more difficult to interpret. It is less meaningful to consider the effect of an increase in one party's cabinet share while holding other party's cabinet shares constant, because in the real world the proportion of cabinet posts help by other parties must decline as one party increases. Investigating the effect of one party being the largest party in cabinet as opposed to another party being the largest, is more intuitive and substantively meaningful in relation to the observed data.

Table 7.1: Full multinomial logit regressions on type of policy change

| | | (1) | | | (2) | | | (3) | |
|---|---|---|---|---|---|---|---|---|---|
| | Market | Family | Voluntary | Market | Family | Voluntary | Market | Family | Voluntary |
| CD | 1.6 | 2.5** | 3.3*** | 2.9 | 2.9* | 2.6*** | 3.3 | 3.1** | 2.5* |
| | (1.6) | (0.9) | (0.8) | (1.5) | (1.2) | (0.7) | (1.7) | (1.2) | (1.1) |
| CON | 2.6** | 1.7* | 0.5 | 3.3* | 1.9 | 0.2 | 4.4** | 3.8*** | 1.3 |
| | (0.9) | (0.7) | (0.8) | (1.5) | (0.9) | (0.9) | (1.4) | (1.1) | (1.1) |
| LIB | 2.8* | 1.8*** | 1.6** | 4.5** | 2.9*** | 2.4*** | 7.0*** | 5.9*** | 5.3*** |
| | (1.1) | (0.5) | (0.5) | (1.5) | (0.8) | (0.6) | (1.8) | (1.4) | (1.3) |
| Policy | 0.2 | 2.5*** | 0.6 | 0.6 | 2.8*** | 0.3 | 0.7 | 4.5*** | 1.8* |
| | (0.7) | (0.5) | (0.4) | (1.3) | (0.6) | (0.5) | (1.5) | (0.9) | (0.7) |
| WFR=2 | | | | 2.6* | 2.8*** | 2.5*** | 5.4** | 6.6*** | 6.3*** |
| | | | | (1.2) | (0.7) | (0.7) | (1.8) | (1.4) | (1.4) |
| WFR=3 | | | | 0.7 | -0.3 | -14.9*** | 1.7 | 3.9*** | -11.6*** |
| | | | | (1.8) | (0.7) | (1.1) | (2.0) | (1.0) | (1.0) |
| GDP p.c. | | | | 0.0 | -0.0 | -0.0 | -0.0 | -0.0*** | -0.0*** |
| | | | | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) |
| Coalition | | | | -2.9* | -2.7*** | -0.9* | -6.4** | -7.1*** | -4.5** |
| | | | | (1.2) | (0.5) | (0.5) | (2.3) | (1.7) | (1.5) |
| Federal | | | | -0.4 | -0.6 | -0.9 | -0.7 | 2.1** | 1.2* |
| | | | | (0.8) | (0.5) | (0.5) | (0.9) | (0.7) | (0.5) |
| FEMLAB | | | | 2.1 | 3.5 | 6.4 | -5.5 | -16.5** | -9.0 |
| | | | | (3.2) | (4.2) | (4.2) | (9.3) | (5.7) | (4.6) |
| INST=2 | | | | -1.6 | 0.9 | 1.3 | -3.4** | -1.8* | -0.8 |
| | | | | (0.9) | (0.9) | (1.0) | (1.1) | (0.8) | (1.0) |
| INST=3 | | | | -1.2 | -0.0 | 0.7 | -2.2 | 0.2 | 0.9 |
| | | | | (2.5) | (1.0) | (0.9) | (2.5) | (1.0) | (0.9) |
| PREV | | | | -0.3 | 1.1* | 0.2 | -0.3 | 1.2 | 0.1 |
| | | | | (0.8) | (0.5) | (0.7) | (0.9) | (0.7) | (1.0) |
| 1960s | | | | | | | -0.6 | 2.8 | 3.5* |
| | | | | | | | (1.1) | (1.6) | (1.6) |
| 1970s | | | | | | | 1.7 | 5.7* | 5.8** |
| | | | | | | | (1.7) | (2.6) | (2.3) |
| 1980s | | | | | | | 4.3 | 9.5* | 9.2** |
| | | | | | | | (3.2) | (3.9) | (3.2) |
| 1990s | | | | | | | 4.5 | 14.3** | 12.2*** |
| | | | | | | | (3.0) | (4.5) | (3.4) |
| 2000s | | | | | | | 6.3 | 19.4** | 18.6*** |
| | | | | | | | (5.0) | (6.3) | (5.3) |
| 2010s | | | | | | | 9.6 | 25.3*** | 25.2*** |
| | | | | | | | (6.1) | (7.5) | (6.4) |
| Constant | -2.3* | -2.1*** | -1.4* | -5.4** | -3.4*** | -3.5** | -2.2 | 4.9* | 3.5* |
| | (0.9) | (0.5) | (0.7) | (2.0) | (1.0) | (1.2) | (4.0) | (2.1) | (1.8) |
| Observations | | 136 | | | 136 | | | 136 | |
| Log-likelihood | | -147.1 | | | -125.2 | | | -103.2 | |
| BIC | | 348.2 | | | 309.3 | | | 265.4 | |

CD=Christian Democrat; CON=Conservative; LIB=Liberal; WFR=Welfare regime; FEMLAB= Female labour market participation; INST=Institutions; PREV=Type of policy change made previously.

Table 7.2: Alternative models using continuous partisanship measure

| | (1) | | | (2) | | | (3) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Market | Family | Voluntary | Market | Family | Voluntary | Market | Family | Voluntary |
| CD | 3.3 | 3.1** | 2.5* | | | | | | |
| | (1.7) | (1.2) | (1.1) | | | | | | |
| CON | 4.4** | 3.8*** | 1.3 | | | | | | |
| | (1.4) | (1.1) | (1.1) | | | | | | |
| LIB | 7.0*** | 5.9*** | 5.3*** | | | | | | |
| | (1.8) | (1.4) | (1.3) | | | | | | |
| Policy | 0.7 | 4.5*** | 1.8* | 0.2 | 4.2*** | 1.5* | 0.2 | 4.2*** | 1.4* |
| | (1.5) | (0.9) | (0.7) | (1.4) | (0.8) | (0.7) | (1.4) | (0.8) | (0.7) |
| WFR=2 | 5.4** | 6.6*** | 6.3*** | 3.9* | 5.3*** | 4.7*** | 3.7* | 5.2*** | 4.7*** |
| | (1.8) | (1.4) | (1.4) | (1.9) | (1.3) | (1.2) | (1.9) | (1.3) | (1.2) |
| WFR=3 | 1.7 | 3.9*** | -11.6*** | 1.2 | 3.1** | -12.9*** | 1.3 | 3.2** | -12.8*** |
| | (2.0) | (1.0) | (1.0) | (2.1) | (1.1) | (1.1) | (2.1) | (1.1) | (1.2) |
| GDP p.c. | -0.0 | -0.0** | -0.0*** | -0.0 | -0.0** | -0.0*** | -0.0 | -0.0** | -0.0*** |
| | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) | (0.0) |
| Coalition | -6.4** | -7.1*** | -4.5** | -5.1* | -6.3*** | -3.9** | -5.1* | -6.4*** | -4.0*** |
| | (2.3) | (1.7) | (1.5) | (2.1) | (1.6) | (1.2) | (2.2) | (1.6) | (1.2) |
| Federal | -0.7 | 2.1** | 1.2* | -0.7 | 1.8** | 0.9* | -0.6 | 1.8** | 1.0** |
| | (0.9) | (0.7) | (0.5) | (0.7) | (0.6) | (0.4) | (0.7) | (0.6) | (0.4) |
| FEMLAB | -5.5 | -16.5** | -9.0 | -2.2 | -12.1* | -5.7 | -2.4 | -12.3* | -5.5 |
| | (9.3) | (5.7) | (4.6) | (8.5) | (5.3) | (4.0) | (8.5) | (5.3) | (3.9) |
| INST=2 | -3.4** | -1.8* | -0.8 | -2.8*** | -1.6* | -0.6 | -2.8*** | -1.7* | -0.6 |
| | (1.1) | (0.8) | (1.0) | (0.7) | (0.8) | (0.9) | (0.7) | (0.8) | (0.9) |
| INST=3 | -2.2 | 0.2 | 0.9 | -1.8 | -0.2 | 0.6 | -1.7 | -0.2 | 0.8 |
| | (2.5) | (1.0) | (0.9) | (2.3) | (0.8) | (0.9) | (2.2) | (0.8) | (0.9) |
| PREV | -0.3 | 1.2 | 0.1 | -0.5 | 1.1 | 0.0 | -0.4 | 1.1 | 0.0 |
| | (0.9) | (0.7) | (1.0) | (0.9) | (0.7) | (0.9) | (0.9) | (0.7) | (0.9) |
| 1960s | -0.6 | 2.8 | 3.5* | -0.2 | 3.1* | 3.7* | -0.2 | 3.1* | 3.7* |
| | (1.1) | (1.6) | (1.6) | (1.0) | (1.4) | (1.6) | (1.1) | (1.4) | (1.6) |
| 1970s | 1.7 | 5.7* | 5.8* | 1.7 | 5.4* | 5.2* | 1.7 | 5.5* | 5.2* |
| | (1.7) | (2.6) | (2.3) | (1.7) | (2.6) | (2.1) | (1.7) | (2.6) | (2.1) |
| 1980s | 4.3 | 9.5* | 9.2** | 3.9 | 8.7* | 8.4** | 4.0 | 8.8* | 8.4** |
| | (3.2) | (3.9) | (3.2) | (3.1) | (4.1) | (3.2) | (3.1) | (4.1) | (3.2) |
| 1990s | 4.5 | 14.3** | 12.2*** | 3.7 | 12.8** | 10.9*** | 3.8 | 12.9** | 10.9*** |
| | (3.0) | (4.5) | (3.4) | (2.9) | (4.6) | (3.2) | (2.9) | (4.6) | (3.2) |
| 2000s | 6.3 | 19.4** | 18.6*** | 4.7 | 16.9** | 16.3*** | 4.9 | 17.2** | 16.4*** |
| | (5.0) | (6.3) | (5.3) | (4.4) | (6.4) | (4.8) | (4.4) | (6.4) | (4.8) |
| 2010s | 9.6 | 25.3*** | 25.2*** | 6.7 | 21.4** | 21.2*** | 6.9 | 21.5** | 21.3*** |
| | (6.1) | (7.5) | (6.4) | (5.4) | (7.4) | (5.7) | (5.4) | (7.4) | (5.8) |
| SD (continuous) | | | | -3.6* | -3.5** | -1.3 | -5.6** | -5.3*** | -4.2** |
| | | | | (1.5) | (1.2) | (1.4) | (1.9) | (1.4) | (1.4) |
| CD(continuous) | | | | 0.7 | 1.9 | 3.9 | -1.1 | 0.4 | 1.1 |
| | | | | (2.8) | (2.0) | (2.0) | (2.5) | (2.0) | (1.7) |
| LIB (continuous) | | | | 2.2* | 1.7* | 3.1** | | | |
| | | | | (0.9) | (0.8) | (1.0) | | | |
| CON (continuous) | | | | | | | -2.1* | -1.8* | -3.1** |
| | | | | | | | (0.9) | (0.8) | (1.0) |
| Constant | -2.2 | 4.9* | 3.5* | 0.3 | 6.0* | 2.8 | 2.6 | 7.8** | 5.8** |
| | (4.0) | (2.1) | (1.8) | (3.7) | (2.6) | (2.1) | (4.0) | (2.8) | (2.0) |
| Observations | | 136 | | | 136 | | | 136 | |
| Log-likelihood | | -103.2 | | | -108.1 | | | -108.0 | |
| BIC | | 265.4 | | | 275.1 | | | 275.0 | |

SD=Social Democrat; CD=Christian Democrat; CON=Conservative; LIB=Liberal; WFR=Welfare regime; FEMLAB= Female labour market participation; INST=Institutions; PREV=Type of policy change made previously.

# Appendix B: Outcome variable coding and sources

Table 7.3: Mental health policy changes

| Country | Year | Policy type | Policy or legislation title | References |
|---|---|---|---|---|
| Australia | 1955 | State | State Grants Lunacy Act | Australian Institute of Health & Welfare (2001); Lewis (1988, p. 77). |
| Australia | 1972 | Family | Carer's Payments | Australian Institute of Health & Welfare (2001); Daniels (2011). |
| Australia | 1973 | State | Mental Health and Related Services Assistance Act | Australian Institute of Health & Welfare (2001); Lewis (1988, p. 79). |
| Australia | 1993 | State | National Mental Health Plan | Gerrand (2005); Whiteford (1993). |
| Australia | 1998 | Market | Second National Mental Health Plan | Meadows and Grigg (2007); Rosen (2006). |
| Australia | 2006 | Market | Fourth National Mental Health Plan | Carter, Burke, and Moore (2008, p. 10); Rosen (2006). |
| Canada | 1957 | State | Hospital Insurance and Diagnostic Services Act | Goodwin (1997, p. 46); Gold (1988); Williams and Luterbach (1976). |
| Canada | 2004 | Family | Health Accord | Bartram (2017); Dyck (2011). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| Canada | 2013 | Market | Housing First | Bartram and Lurie (2017); Shera and Ramon (2013). |
| Denmark | 1959 | State | Psychiatric Hospital Expansion | Weeke et al. (1986); Kastrup et al. (1976); Strömgren (1985). |
| Denmark | 1975 | State | Sectorisation | Bennett (1991); Licht, Gouliaev, and Lund (1991); Søgaard, Godt, and Blinkenberg (1992). |
| Denmark | 1998 | State | Amendment of Mental Health Act | Bauer, Okkels, and Munk-Jørgensen (2012); Hayward (2007). |
| Denmark | 2007 | Market | Social Services Act | Bauer, Okkels, and Munk-Jørgensen (2012); Fersch and Jensen (2011). |
| England | 1962 | Voluntary | Hospital Plan | Welshman (1999, p. 211); Jones (1993a, pp. 161–3). |
| England | 1970 | State | Chronically Sick and Disabled Persons | Welshman (1999, p. 214); Jones (1993a, pp. 185–8). |
| England | 1976 | State | Better Services for the Mentally Ill | Busfield (1998, pp. 21–2); Means and Smith (1998, p. 49). |
| England | 1979 | Market | Finance (Personal and Residential Services) | Busfield (1998, pp. 21–2); Means and Smith (1998, pp. 49–50); Walker (1997, p. 199) |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| England | 1983 | Family | Care in the Community | Busfield (1998, pp. 21–2); Means and Smith (1998, p. 49); Jones (1993a, pp. 206–9). |
| England | 1990 | Family | Caring for People | Thornicroft (1994); Jones (1993a, pp. 235). |
| England | 2007 | Market | Putting People First | Gheera (2009); Pilgrim and Ramon (2009). |
| France | 1955 | State | Mental Hygiene Centres | Coffin (2005, p. 238); Mangen and Castel (1985, pp. 119–20). |
| France | 1968 | State | Amendment to the Lunacy Act | Henckes (2009, p. 172); Goodwin (1997, p. 71); Mangen and Castel (1985, p. 123). |
| France | 1970 | State | Sectorisation | Coffin (2005, p. 239); Barres (1987, pp. 140–1); Demay (1987, p. 74). |
| France | 1975 | Market | Handicapped Persons Act | Winance, Ville, and Ravaud (2007); Melke (2010, p. 76). |
| France | 1984 | Voluntary | Global Budget | Goodwin (1997, p. 49); Barres (1987, pp. 141); Mangen and Castel (1985, pp. 128, 131). |
| France | 2005 | Voluntary | Mental Health Plan & Disability Act | Melke (2010, p. 166–7); Henckes (2009). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| France | 2007 | Market | Sheltered Housing | Melke (2010, p. 158–62); Verdoux (2007). |
| Germany | 1976 | State | Amendment to Reich Insurance Order | Goodwin (1997, p. 89); Mangen (1985, p. 98); Bauer et al. (2001). |
| Germany | 1979 | State | Model Psychiatry Programme | Schmiedebach and Priebe (2004); Cooper (1987). |
| Germany | 1986 | Voluntary | Improving Ambulant and Semi-mural Care | Tester (1996, p. 18), Haerlin (1987). |
| Germany | 1990 | Voluntary | Hospital Staffing Directive | Puschner, Kunze, and Becker (2006, p. 183); Kunze, Becker, and Priebe (2004); Bauer et al. (2001). |
| Germany | 1994 | Family | Long Term Care Insurance | Geraedts, Heller, and Harrington (2000); Goodwin (1997, pp. 49, 100). |
| Germany | 1999 | Voluntary | Statutory Health Insurance Reform | Salize, Rössler, and Becker (2007); Puschner, Kunze, and Becker (2006, p. 183); Bauer et al. (2001). |
| Germany | 2012 | Voluntary | Psychiatric Remuneration Act | Koch-Stoecker and Driessen (2017); Schmid, Steinert, and Borbe (2013). |
| Ireland | 1957 | Market | Voluntary Health Insurance | Walsh (2017); Prior (2017). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| Ireland | 1966 | Voluntary | A Vision for Change | Kelly (2019, ch. 5); Walsh (2017). |
| Ireland | 1984 | Voluntary | Planning for the Future | Kelly (2019, ch. 6); Walsh and Daly (2004); Walsh (1985, p. 165). |
| Ireland | 1990 | Family | Carer's Allowance | Daly (2019); Prior (2017); Cousins (1994). |
| Ireland | 2001 | State | Mental Health Act | Kelly (2019, ch. 6); Walsh (2017). |
| Ireland | 2006 | State | Community Mental Health Teams | Kelly (2019); Walsh (2015, ch. 7). |
| Ireland | 2010 | State | National Clinical Programme | Kelly (2019); Walsh (2017, ch. 7). |
| Italy | 1978 | Family | Law 180: Basaglia Law | Carta, Angermeyer, and Holzinger (2020); Foot (2015); Donnelly (1992, pp. 72–3); Crepet (1990); Maj (1985). |
| Italy | 1980 | Family | Law 11: Care allowance | Courbage, Montoliu-Montes, and Wagner (2020); Shorter (2007). |
| Italy | 1990 | Voluntary | Law 142: Municipal Organisation | Goodwin (1997); Tester (1996). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| Netherlands | 1950 | Voluntary | Asylum funding | Schnabel (1998, p. 35); Giel (1987). |
| Netherlands | 1961 | Voluntary | Psychiatric wards | Oosterhuis (2005, p. 84); Furman (1965, p. 5). |
| Netherlands | 1968 | Voluntary | Exceptional Medical Expenses Act | Gijswijt-Hofstra (1998, p. 52); Weijers (1998, p. 176). |
| Netherlands | 1971 | Voluntary | Hospital Facilities Act | Goodwin (1997, p. 21); Giel (1987). |
| Netherlands | 1982 | Voluntary | Health Care Facilities Act | Breemer ter Stege and Van Heugten (1986); van der Grinten (1985). |
| Netherlands | 1985 | Voluntary | Exceptional Medical Expenses Amendment: Semi-mural facilities | Gijswijt-Hofstra (1998, p. 57); Schnabel (1998, p. 35). |
| Netherlands | 1989 | Market | Exceptional Medical Expenses Amendment: Private providers | Schnabel (1998, p. 34); Tester (1996, p. 67). |
| Netherlands | 1994 | Voluntary | Healthcare Renewal Fund | Schene and Faber (2001); Gijswijt-Hofstra (1998, p. 77). |
| New Zealand | 1961 | State | Psychiatric Services in Public Hospitals | Brunton (2005, 2003). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| New Zealand | 1969 | Family | Mental Health Act | O'Brien and Kydd (2013); Coleborne (2009). |
| New Zealand | 1971 | State | Asylum funding | Brunton and McGeorge (2017); Brunton (2005). |
| New Zealand | 1974 | State | Hospital and Related Services | Brunton and McGeorge (2017, p. 273); Kemp (1991). |
| New Zealand | 1992 | Market | Mental Health Act | O'Brien and Kydd (2013); Barnett and Newberry (2002). |
| New Zealand | 2010 | Voluntary | Integrated Care | Brunton and McGeorge (2017, p. 283); O'Brien and Kydd (2013). |
| New Zealand | 2012 | Family | Improving Mental Health and Well-being | Brunton and McGeorge (2017, p. 291); Mental Health Commission (2012). |
| Sweden | 1967 | State | Public Works Bill | Perris (1987); PROP (1967:1). |
| Sweden | 1982 | State | Mental Health and Medical Care Act | Maycraft Kall (2004, p. 23); Arvidsson and Ericson (2005). |
| Sweden | 1991 | Market | Ädelreform (Local Government Act) | Bergmark, Bejerholm, and Markström (2017); Maycraft Kall (2004). |

Table 7.3 continued

| | | | | |
|---|---|---|---|---|
| Sweden | 1995 | State | Psychiatric Care Reform | Stefansson and Hansson (2001); Silfverhielm and Kamis-Gould (2000); Brinck (1994). |
| Sweden | 2006 | State | National Psychiatry Co-ordination | Melke (2010, p. 74); SOU (2006:100); PROP (2005/06:1, pp. 47-8, 63). |
| Sweden | 2013 | Market | Action Plan for Mental Illness | Bergmark, Bejerholm, and Markström (2017); Socialdepartementet (2013). |
| USA | 1963 | State | Community Mental Health Centers Act | Grob (1994, p. 257); Rochefort (1997, p. 59). |
| USA | 1965 | Market | Social Security Act | Scull (1984, p. 322); Levine (1981, p. 70). |
| USA | 1966 | Market | Medicaid for Private Nursing Homes | Goodwin (1997, pp. 13, 99); Mechanic and Rochefort (1990). |
| USA | 1975 | Market | Community Mental Health Centers Amendment Act | Grob (1994, p. 284); ; Levine (1981, p. 70). |
| USA | 1981 | Family | Omnibus Budget Reconcilliation Act | O'Connor (1998); Rochefort (1997, pp. 63,72). |
| USA | 1986 | Market | State Comprehensive Mental Health Services Plan | Davis et al. (2012); Goodwin (1997, p. 11); Rochefort (1997, p. 135). |

Table 7.4: Child welfare policy changes

| Country | Year | Policy type | Policy or legislation title | References |
|---|---|---|---|---|
| Australia | 2009 | Family | Family Support Programmes | Katz (2015); Fernandez and Atwool (2013); Babington (2011). |
| Canada | 1994 | Voluntary | Community Action Program for Children | Swift and Callahan (2006, p. 137); Gough, Shlonsky, and Dudding (2010). |
| Canada | 1998 | Family | National Child Benefit Supplement | Swift and Callahan (2006, p. 134); Gough, Shlonsky, and Dudding (2010). |
| Denmark | 1958 | State | Child Care Act | Sipilä et al. (2019); Melhbye (1993, p. 39). |
| Denmark | 1964 | State | Child Care Act | Jensen and Petersen (2012, p. 85); Melhbye (1993, p. 39). |
| Denmark | 1976 | Family | Social Security Act | Jensen and Petersen (2012, p. 85); Melhbye (1993, p. 40). |
| Denmark | 1985 | Market | Collective Care and Ship Homes | Hestbæk (2011); Melhbye (1993, pp. 36, 40). |
| Denmark | 1992 | Family | Social Welfare Act | Hestbæk (2011, p. 133); Melhbye (1993, p. 42). |

Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| Denmark | 2005 | Family | Foster Care Reform | Jensen and Petersen (2012, pp. 81–2); Hestbæk (2011). |
| England | 1963 | Family | Children Act | Bullock and Parker (2014, p. 12); Holman (1988). |
| England | 1969 | State | Children and Young Persons Act | Littlechild and Meffan (2012, pp. 94, 104); Davis (1981). |
| England | 1975 | Family | Children Act | Masson (2000); Ball (1998). |
| England | 1989 | Market | Children Act | Wilson and Petrie (1998); Bullock (1993). |
| England | 2008 | Market | Children and Young Persons Act | Bullock and Parker (2014); Littlechild and Meffan (2012). |
| France | 1959 | Family | Decree 58-101: National Health and Social Affairs Administration | Grevot (2006, pp. 153–4); Jovelin (2012). |
| France | 1966 | Family | Adoption Law | Bolter and Seéraphin (2019); Mignot and Depledge (2015, p. 763). |
| France | 1975 | Voluntary | Children's Act | Barral (2007, p. 211); Grevot (2006, p. 115); Corbillon (1993, p. 60). |
| France | 1984 | Family | Child Care Act | Jovelin (2012, p. 153); Grevot (2006, p. 167). |

Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| France | 1989 | State | Prevention of Abuse of Children Act | Jovelin (2012, p. 154); Grevot (2006, Appendix C). |
| France | 2007 | Family | Child Protection Reform | Jovelin (2012, p. 154); Bolter and Seéraphin (2019, p. 81). |
| Germany | 1953 | Voluntary | Child and Youth Welfare Law | Witte et al. (2019); Wolff (1997). |
| Germany | 1990 | Family | Child and Youth Services Act | Hardera et al. (2013), Kindler and Borrmann (2012, p. 168), Colla-Mueller (1993, p. 87). |
| Germany | 2007 | Voluntary | Early Assistance for Parents and Children | Haug and Höynck (2012, p. 92), Wolff, Biesel, and Heinitz (2011, pp. 184–5). |
| Germany | 2011 | Family | Federal Act on the Protection of Children | Haug and Höynck (2012), Kindler and Borrmann (2012, p. 168). |
| Ireland | 1952 | Family | Adoption Law | Skehill (2004, pp. 256, 267); Shanahan (2005); Gilligan (1993, p. 119). |
| Ireland | 1953 | Family | Health Act: Boarding Out of Children | Skehill (2004, pp. 284, 290); Gilligan (1993, p. 123). |
| Ireland | 1974 | Voluntary | Care of Deprived Children | Skehill (2004, pp. 69); Gilligan (1993, pp. 121, 126). |

Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| Ireland | 1988 | Family | Adoption Act | O'Brien and Mitra (2018); Shanahan (2005); Gilligan (1993, p. 131). |
| Ireland | 1991 | Family | Child Care Act | Burns et al. (2012, pp. 149–50); Gilligan (1993, pp. 123, 130). |
| Ireland | 2014 | State | Better Outcomes Brighter Future | Burns et al. (2012, pp. 148); Fernandez and Atwool (2013). |
| Italy | 1965 | Family | Family Group Homes | Vecchiato (1993); Ducci (2003, p. 6). |
| Italy | 1967 | Family | Law 431: Adoption | Licursi, Marcello, and Pascuzzi (2013); Bertotti and Campanini (2012, p. 205). |
| Italy | 1975 | Family | Law 151: Family Rights Reform | Bertotti and Campanini (2012, p. 205); Ducci (2003, p. 9). |
| Italy | 1977 | Voluntary | Law 616: Guest Homes | Mignot and Depledge (2015); Vecchiato (1993, pp. 142–4). |
| Italy | 1983 | Family | Law 184: Adoption and Foster Care | Mignot and Depledge (2015); Vecchiato (1993, pp. 144–7). |
| Italy | 1989 | State | Law 272: Residential Care Standards | Ducci (2003); Llorente et al. (2003). |

Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| Italy | 1997 | Family | Law 285: At-risk Families | Licursi, Marcello, and Pascuzzi (2013); Bertotti and Campanini (2012, p. 206). |
| Italy | 2001 | Family | Law 149: Foster Care Expansion | Licursi, Marcello, and Pascuzzi (2013); Bertotti and Campanini (2012, p. 213). |
| Netherlands | 1953 | Family | Foster Children's Act | Bakker (2019); López et al. (2019, p. 176). |
| Netherlands | 1955 | Voluntary | Child Care and Protection Boards | López et al. (2019, p. 176); Dekker (2016). |
| Netherlands | 1989 | Voluntary | Youth Care Act | Hardera et al. (2013); Strijker and Knorth (2007); van der Ploeg (1993). |
| Netherlands | 1995 | Family | Youth Care Agencies | Hardera et al. (2013); Dekker et al. (2012, pp. 63, 68); Strijker and Knorth (2007, p. 2). |
| Netherlands | 2005 | Voluntary | Youth Care Act | Hardera et al. (2013); Dekker et al. (2012, pp. 68–70); Strijker and Knorth (2007, p. 2). |

Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| Netherlands | 2007 | Family | Welfare Act | Noordegraaf and van der Veer (2012, p. 224). |
| Netherlands | 2011 | Voluntary | Youth Care Act | Dekker et al. (2012, p. 101); Noordegraaf and van der Veer (2012). |
| New Zealand | 1955 | Family | Adoption Act | Blake and Coombes (2016); Dalley (1998, p. 336). |
| New Zealand | 1957 | Family | Foster Care Subsidy | Fernandez and Atwool (2013); Dalley (1998, p. 245). |
| New Zealand | 1973 | Family | Sole Parent Benefit | Dalley (1998, p. 217); Kamerman and Kahn (1997, p. 280). |
| New Zealand | 1975 | Family | Children, Young Persons, and their Families Act | Fernandez and Atwool (2013); Dalley (1998, pp. 275–9). |
| New Zealand | 1984 | State | Family Home Operations | Hyslop (2017); Dalley (1998, p. 327). |
| New Zealand | 1989 | Voluntary | Children, Young Persons, and their Families Act | Hyslop (2017); Dalley (1998, pp. 317, 336). |
| Sweden | 1981 | Market | Care of Young Persons Act | Healy, Lundström, and Sallnäs (2011, p. 256); Andersson (1993). |

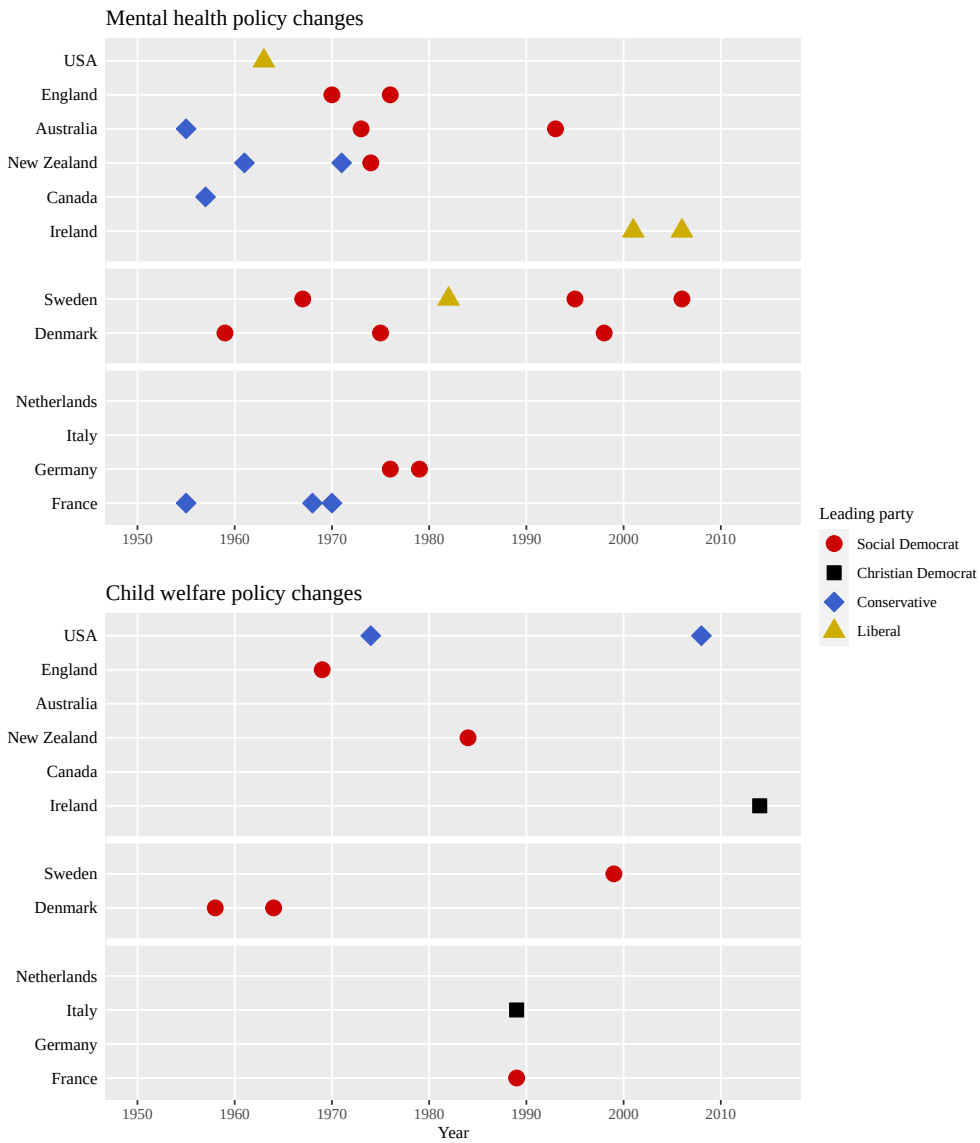
Table 7.4 continued

| | | | | |
|---|---|---|---|---|
| Sweden | 1990 | Family | Care of Young Persons Act | Nygren, Naujanienė, and Nygren (2018); Svensson and Höjer (2012, p. 70); Andersson (2006, pp. 177–8). |
| Sweden | 1998 | Family | Kinship Care | Andersson (2006); Hessle and Vinnerljung (1999, pp. 178). |
| Sweden | 1999 | State | Homes for Care and Accommodation | Andersson (2006); Hessle and Vinnerljung (1999, pp. 180). |
| Sweden | 2001 | Family | Social Services Act | Nygren, Naujanienė, and Nygren (2018); Svensson and Höjer (2012, p. 66). |
| USA | 1961 | Family | Aid to Families with Dependent Children | Hacsi (1997, p. 216); Jones (1993b). |
| USA | 1962 | Voluntary | Social Security Act | Myers (2006, pp. 86–7); Pine (1986). |
| USA | 1974 | State | Child Abuse Prevention and Treatment Act | Myers (2006); Jones (1993b). |
| USA | 1978 | Family | Adoption Reform Act | Carp (1998, p. 276); Pine (1986). |
| USA | 1980 | Family | Child Welfare Act | Myers (2006, p. 100); Berrick (2011, p. 24). |

Table 7.4 continued

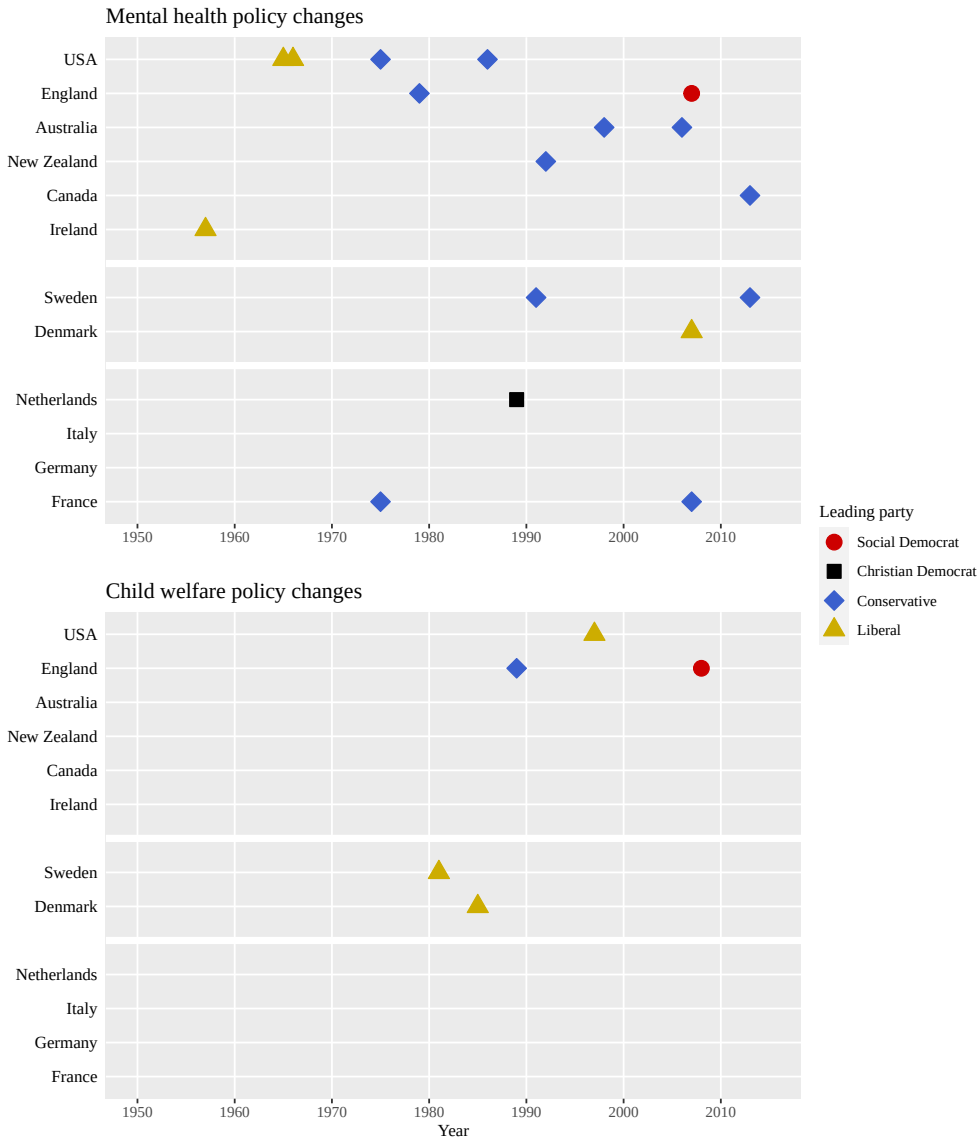
| | | | | |
|---|---|---|---|---|
| USA | 1984 | Family | Aid to Families with Dependent Children | Hacsi (1997, p. 48); Jones (1993b). |
| USA | 1993 | Family | Family Preservation and Support Initiative | Berrick (2011, p. 24); Schene (2006, p. 89). |
| USA | 1997 | Market | Safe Families Act | Myers (2006, p. 102); Berrick (2011, p. 25). |
| USA | 2008 | State | Fostering Connections to Success | Berrick (2011, p. 27); Schelbe (2011). |

Figure 7.1: Policy changes promoting state responsibility for care



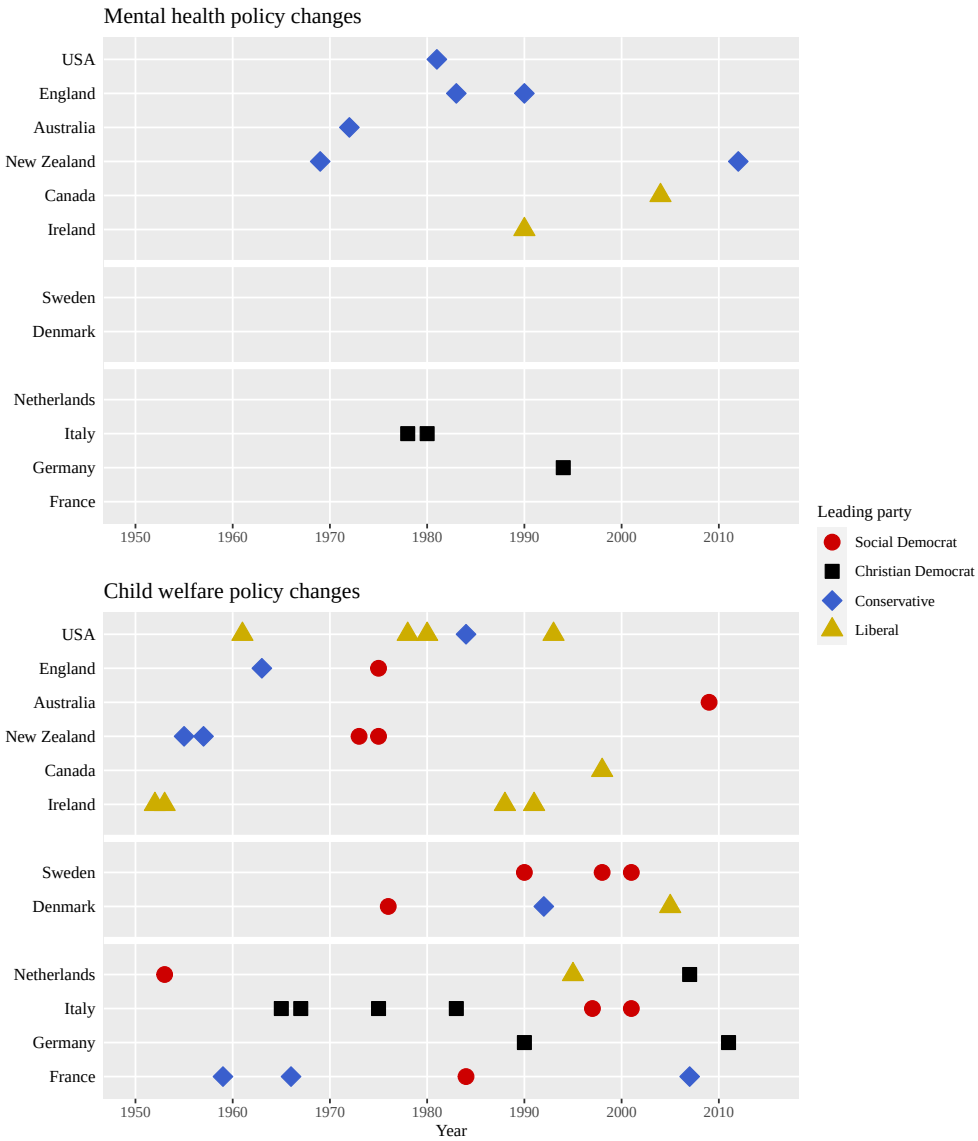

*Comments:* Charts plots all of the policy changes promoting state responsibility, by policy area and country over time. The shape and colour of the observations indicates the partisanship of government, and countries are arranged by welfare regime.

Figure 7.2: Policy changes promoting market responsibility for care



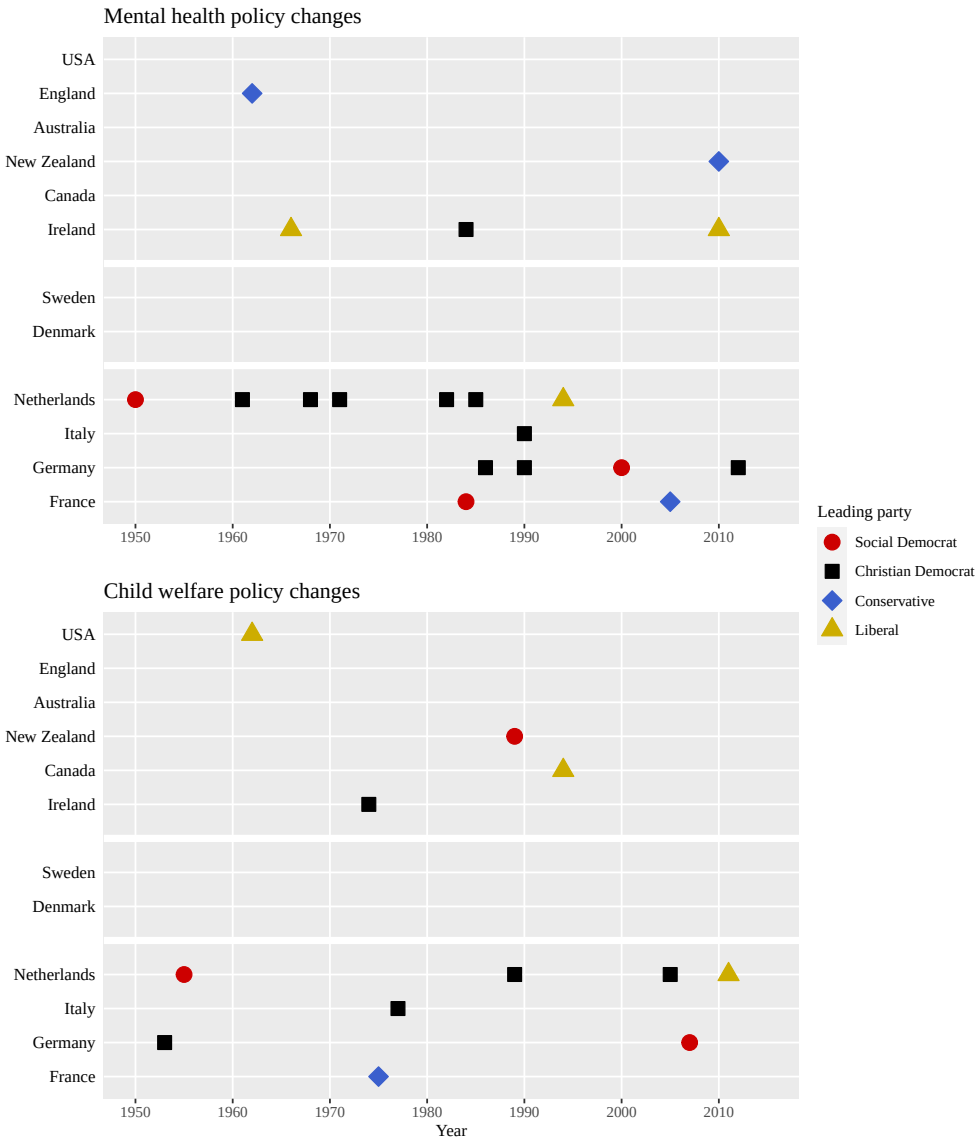

*Comments:* Charts plots all of the policy changes promoting market responsibility, by policy area and country over time. The shape and colour of the observations indicates the partisanship of government, and countries are arranged by welfare regime.

Figure 7.3: Policy changes promoting family responsibility for care




*Comments:* Charts plots all of the policy changes promoting family responsibility, by policy area and country over time. The shape and colour of the observations indicates the partisanship of government, and countries are arranged by welfare regime.

Figure 7.4: Policy changes promoting voluntary responsibility for care




*Comments:* Charts plots all of the policy changes promoting voluntary responsibility, by policy area and country over time. The shape and colour of the observations indicates the partisanship of government, and countries are arranged by welfare regime.

# Appendix C: Primary sources

## Chapter 5 – England

### House of Commons debates

Mentally Sick (Care and Accommodation), Hansard series 5, vol. 523, 19 Feb 1954, cc. 2293–2379.

Local Government (Grants), Hansard series 5, vol. 597, 8 Dec 1958, cc. 34–161.

Mental Health Bill, Hansard series 5, vol. 598, 26 Jan 1959. cc. 704–840.

National Health Service, England And Wales, Hansard series 5, vol. 644, 11 Jul 1961, cc. 220–350.

Hospital Plans, Hansard series 5, vol. 661, Monday 4 Jun 1962, cc. 31–160.

Mental Health Service, Hansard series 5, vol. 708, Friday 19 Mar 1965, cc. 1646–1719.

Local Authority Social Services Bill, Hansard series 5, vol. 796, 26 Feb 1970, cc. 1406–1520.

Chronically Sick And Disabled Persons Act, Hansard series 5, vol. 808, 18 Dec 1970, cc. 1789–1809.

Chronically Sick And Disabled Persons Act, Hansard series 5, vol. 817, 21 May 1971, cc. 1664–1758.

Mental Health Act Patients (Release), Hansard series 5, vol. 875, 26 Jun 1974, cc. 1692–1700.

Mental Health, Hansard series 5, vol. 889, 27 March 1975, cc. 755–766.

Mental Health Services, Hansard series 5, vol. 904, 26 Jan 1976, cc. 30–104.

Mental Health Act (White Paper), Hansard series 5, vol. 951, 13 Jun 1978, cc. 817–819.

Bills Presented, Hansard series 5, vol. 959, 29 Nov 1978, cc. 450–456.

Mental Health (Amendment) Bill, Hansard series 5, vol. 961, 2 Feb 1979, cc. 1847–1896.

Written Answers: Old People's Homes, Hansard series 5, vol. 969, 26 Jun 1979, c. 160.

Finance Bill, Hansard series 5, vol. 969, 27 Jun 1979, cc. 464–590.

Public Services, Hansard series 5, vol. 970, 17 Jul 1979, cc. 1392–1439.

Psycho-Geriatric Services (East Surrey), Hansard series 5, vol. 974, 26 Nov 1979, cc. 1070–1080.

Public Expenditure, Hansard series 5, vol. 975, 5 Dec 1979, cc. 443–574.

Health Services Bill, Hansard series 5, vol. 976, 19 Dec 1979, cc. 649–769.

Mental Health (Amendment) Bill Lords, Hansard series 6, vol. 20, 22 Mar 1982, cc. 696–768.

Social Report, Hansard series 6, vol. 29, 18 Oct 1982, cc. 41–51.

After-Care, Hansard series 6, vol. 29, 18 Oct 1982, cc. 158–163.

Disabled People, Hansard series 6, vol. 62, 29 Jun 1984, cc. 1292–1331.

Caring For The Carers, Hansard series 6, vol. 96, 1 May 1986, cc. 1120–1150.

Community Care, Hansard series 6, vol. 158, 17 Oct 1989, cc. 32–116.

National Health Service And Community Care, vol. 162, 22 Nov 1989, c. 116.

National Health Service And Community Care Bill – 1st Allotted Day, Hansard series 6, vol. 163, 7 Dec 1989, cc. 489–569.

National Health Service and Community Care Bill, Hansard series 6, vol. 163, 11 Dec 1989, cc. 681–770.

Community Care, Hansard series 6, vol. 163, 12 Dec 1989, cc. 604–606, 834–845.

National Health Service And Community Care Bill, Hansard series 6, vol. 169, 15 Mar 1990, cc. 685–728.

Lords Amendments – Supplemental, Hansard series 6, vol. 175, 27 Jun 1990, cc. 320–334.

Mental Health Services, Hansard series 6, vol. 322, 8 Dec 1998, cc. 145–158.

Mental Health Bill [HL], Hansard series 6, vol. 687, 16 Nov 2006, c. 19.

Health and Social Care, Hansard series 6, vol. 464, 10 Oct 2007, cc. 298–313.

Caring for the Elderly, Hansard series 6, vol. 496, 15 Jul 2009, cc. 365–411.

## House of Lords debates

The Law Relating to Mental Illness, Hansard series 5, vol. 207, 19 Feb 1958, cc. 813–880.

The Hospital Service, Hansard series 5, vol. 230, 26 Apr 1961, c. 851–873.

Health Visiting And Social Work (Training) Bill, Hansard series 5, vol. 240, 24 May 1962, cc. 1123–1162.

Health Visiting And Social Work (Training) Bill, Hansard series 5, vol. 241, 26 Jun 1962, cc. 862–911.

Working Of Mental Health Act, 1959, Hansard series 5, vol. 241, 4 Jul 1962, cc. 1236–1340.

The Younghusband Report on Social Workers, Hansard series 5, vol. 221, 17 Feb 1960, cc. 74–91.

The Hospital Service, Hansard series 5, vol. 230, 26 Apr 1961, cc. 851–873.

The Hospital Plan, Hansard series 5, vol. 237, 14 Feb 1962, cc. 473–581.

Health Visiting and Social Work (Training) Bill, Hansard series 5, vol. 240, 24 May 1962, cc. 1123–1162.

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# Chapter 6 – Germany

## Bundestag debates

Beratung des Mündlichen Berichts des Ausschusses für Fragen der Jugendfürsorge (33. Ausschuß) über den Antrag der Fraktion des Zentrums betr. Vorlage eines Gesetzentwurfs zum Schutze der heimat- und berufslosen Jugend, Plenarprotokoll 1/109, 10 Jan 1951, pp. 4141–4142.

Erste Beratung des Entwurfs eines Gesetzes zur Änderung des Reichsjugendgerichts gesetzes, Plenarprotokoll 1/205, 23 Apr 1952, pp. 8851–8859.

Erste Beratung des Entwurfs eines Gesetzes zur Änderung von Vorschriften des Reichsjugendwohlfahrtsgesetzes, 01/228, 10 Sep 1952, pp. 103001–10308.

Zweite und dritte Beratung des Entwurfs eines Gesetzes zur Änderung von Vorschriften des Reichsjugendwohlfahrtsgesetzes, Plenarprotokoll 1/273, 18 Jun 1953, pp. 13530–13537.

Zweite und dritte Beratung des Entwurfs eines Gesetzes zur Änderung des Reichsjugendgerichtsgesetzes, Plenarprotokoll 1/273, 18 Jun 1953, pp. 13537–13539.

Erste Beratung des Entwurfs eines Gesetzes zur Änderung und Ergänzung des Reichsjugendwohlfahrtsgesetzes, Plenarprotokoll 03/135, 9 Dec 1960, pp. 7723–7744.

Zweite und dritte Beratung des Entwurfs eines Gesetzes zur Änderung und Ergänzung des Reichsjugendwohlfahrtsgesetzes, Plenarprotokoll 03/164, 29 Jun 1961, pp. 9544–9548.

Erste Beratung des Entwurfs eines Gesetzes zur Änderung und Ergänzung des Gesetzes für Jugendwohlfahrt, Plenarprotokoll 05/124, 11 Oct 1967, pp. 6267–6309.

Beratung des Sozialberichts 1971, Plenarprotokoll 06/135, 23 Sep 1971, pp. 7865–7900.

Beratung des Berichts der Bundesregierung über die Lage der Familien in der Bundesrepublik Deutschland – Zweiter Familienbericht, Plenarprotokoll 07/173, 22 May 1975, pp. 12085–12163.

Zweite Beratung des Entwurfs eines Gesetzes über die stufenweise Einführung eines Familiengeldes (Bundesfamiliengeldgesetz), Plenarprotokoll 08/151, 10 May 1979, pp. 12072–12123.

Fragestunde – Zulässigkeit der Anrechnung von Kindergeldzahlungen auf das Pflegegeld, Plenarprotokoll 08/155, 18 May 1979, p. 12387.

Erste Beratung des vom Bundesrat eingebrachten Entwurfs eines Gesetzes zur Verbesserung der Jugendhilfe, Plenarprotokoll 08/172, 20 Sep 1979, pp. 13698–13710.

Zweite Beratung des vom Bundesrat eingebrachten Entwurfs eines Gesetzes zur Verbesserung der Jugendhilfe, Plenarprotokoll 08/219, 23 May 1980, p. 17632–17669.

Beratung der Großen Anfrage der Fraktion der SPD – Soziale Lage von Familien und Kindern, Plenarprotokoll 11/165, 6 Oct 1989, pp. 12532–12548.

Fortsetzung der zweiten Beratung des von der Bundesregierung eingebrachten Entwurfs eines Gesetzes über die Feststellung des Bundeshaushaltsplans für das Haushaltsjahr 1990 (Haushaltsgesetz 1990) – Einzelplan 15, Geschäftsbereich des Bundesministers für Jugend, Familie, Frauen und Gesundheit, Plenarprotokoll 11/179, pp. 13790–13807.

Zweite und dritte Beratung des von der Bundesregierung eingebrachten Entwurfs eines Gesetzes zur Neuordnung des Kinder- und Jugendhilferechts (Kinder-und Jugendhilfegesetz – KJHG), Plenarprotokoll 11/203, 28 Mar 1990, pp. 15846–15864.

Aussprache zur Erklärung der Bundesregierung, Plenarprotokoll 12/6, 31 Jan 1991, pp. 95–224.

Befragung der Bundesregierung (Bericht zur Frage weiterer Maßnahmen der Frauenförderung in Beruf, Familie und anderen Bereichen), Plenarprotokoll 12/20, 17 April 1991, pp. 1268–1274.

Beratung der Unterrichtung durch die Bundesregierung Der Finanzplan des Bundes 1992 bis 1996, Plenarprotokoll 12/102, 8 Sep 1992, pp. 8662–8710.

Zweite und dritte Beratung des von der Bundesregierung eingebrachten Entwurfs eines Gesetzes zum qualitätsorientierten und bedarfsgerechten Ausbau der Tagesbetreuung und zur Weiterentwicklung der Kinder- und Jugendhilfe (Tagesbetreuungsausbaugesetz – TAG), Plenarprotokoll 15/179, 3 Jun 2005, pp. 16883–16896.

Antrag der Fraktion des BÜNDNISSES 90/DIE GRÜNEN – Neue Chancen und Perspektiven für Kinder und Jugendliche in Deutschland, Plenarprotokoll 16/22, 9 March 2006, pp. 1625–1642.

Antrag der Fraktion der SPD – Kinderschutz wirksam verbessern: Prävention im Kinderschutz optimieren – Förderung und frühe Hilfen für Eltern und Kinder stärken, Plenarprotokoll 17/19, 28 Jan 2010, pp. 1656–1665.

Erste Beratung des von der Bundesregierung eingebrachten Entwurfs eines Gesetzes zur Stärkung eines aktiven Schutzes von Kindern und Jugendlichen (Bundeskinderschutzgesetz – BKiSchG), Plenarprotokoll 17/118, 1 Jul 2011, pp. 13693–13708.

Zweite und dritte Beratung des von der Bundesregierung eingebrachten Entwurfs eines Gesetzes zur Stärkung eines aktiven Schutzes von Kindern und Jugendlichen (Bundeskinderschutzgesetz – BKiSchG), Plenarprotokoll 17/136, 27 Oct 2011, pp. 16137–16149.

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Entwurf eines Gesetzes zur Änderung und Ergänzung des Reichsjugendwohlfahrtsgesetzes, Drucksache 03/2226, 14 Nov 1960.

Schriftlicher Bericht des Ausschusses für Familien- und Jugendfragen (10. Ausschuß) über den von der Bundesregierung eingebrachten Entwurf eines Gesetzes zur Änderung und Ergänzung des Reichsjugendwohlfahrtsgesetzes, Drucksache 03/2854, 15 Jun 1961.

Entwurf eines Gesetzes zur Änderung und Ergänzung des Gesetzes für Jugendwohlfahrt, Drucksache 05/1723, 6 Jun 1967.

Unterrichtung durch die Bundesregierung – Sozialbericht 1971, Drucksache 06/2155, 12 May 1971.

Unterrichtung durch die Bundesregierung – Bericht über die Lage der Familie in der Bundesrepublik Deutschland (Zweiter Familienbericht), Drucksache 07/3502, 15 Apr 1975.

Gesetzentwurf des Bundesrates – Entwurf eines Gesetzes zur Verbesserung der Jugendhilfe, Drucksache 08/3108, 10 Aug 1979.

Unterrichtung durch die Bundesregierung – Bericht über Bestrebungen und Leistungen der Jugendhilfe (Fünfter Jugendbericht), Drucksache 8/3684, 20 Feb 1980.

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Antwort der Bundesregierung auf die Große Anfrage der Franktion der SPD – Soziale Lage von Familien und Kindern, Drucksache 11/5106, 30 Aug 1989.

Gesetzentwurf Bundesregierung – Entwurf eines Gesetzes zur Neuordnung des Kinder- und Jugendhilferechts (Kinder- und Jugendhilfegesetz – KJHG), Drucksache 11/5948, 1 Dec 1989.

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Antrag Fraktion der CDU/CSU, Fraktion der SPD – Gesundes Aufwachsen ermöglichen - Kinder besser schützen - Risikofamilien helfen, Drucksache 16/4604, 7 Mar 2007.

Beschlussempfehlung und Bericht des Ausschusses für Familie, Senioren, Frauen und Jugend (13. Ausschuss) zu dem Antrag der Fraktion der CDU/CSU und der Fraktion der SPD – Gesundes Aufwachsen ermöglichen

- Kinder besser schützen - Risikofamilien helfen, Drucksache 16/5695, 15 Jun 2007.

Antwort der Bundesregierung auf die Kleine Anfrage der Fraktion FDP – Stand der Bindungsforschung und bindungsorientierten pädagogischen Arbeit in der Bundesrepublik Deutschland, Drucksache 16/6895, 31 Oct 2007.

Antwort der Bundesregierung auf die Kleine Anfrage der Fraktion der FDP – Die Entwicklung der Inobhutnahmen durch die Jugendämter, Drucksache 16/13803, 20 Jul 2009.

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Antwort der Bundesregierung auf die kleine Anfrage der Fraktion BÜNDNIS 90/DIE GRÜNEN – Stand der Umsetzung des Koalitionsvertrages zwischen CDU, CSU und FDP im Bereich Kinder und Familie, Drucksache 17/2698, 4 Aug 2010.

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