Introduction

This paper will attempt to discover the extent to which social work has been eclipsed in Europe. It will deal with the problem of defining social work and focus upon care functions of social workers within ‘greater Europe’ (see Giarchi, 1996). For the past fifty years Social work has aspired to the status of a profession. In both the UK and mainland Europe that status has been questioned. Since the advent of postmodernity the identity of social workers has been eroded within a plural, social care, complex. Even in the more northerly parts of Europe, social work no longer enjoys a monopoly of social care within state welfare systems, with the possible exception of Denmark. Other voluntary and health care agencies within the European continent have competed with social work and are steadily taking over its roles and tasks. This paper will ascertain to what extent social work in Europe has maintained its status and/or been made redundant, and to what extent it has been replaced by non-social workers in the voluntary or private sectors. The starting point is the lack of consensus over what social work is and stands for.

The lack of consensus in Europe as to the nature of social work

Since social work emerged it has been in search of an identity. Davies (1981) refers to social work as “maintenance” of society made up of many different tasks, but adds, “There is no such thing as the social work task; it is not even certain that there is any such activity as social work, in the sense that nursing, teaching and hairdressing, for example are self-explanatory terms” (p.3). Authors such as Davies refer to social work as essentially pertaining to the public sector. In contemporary Europe there is an increasing trend for social care agencies to be directed by health and a gradual shift from public to voluntary and private sectors. The government functionary may in fact be made redundant as many social work tasks are carried out by others.

Sheppard (1995. p.18) refers to the lack of consensus regarding the definition of social work:

“The definition of social work - of what it is centrally about - is not something which has traditionally commanded a great deal of consensus. Indeed this is an issue which has frequently not generated a clear answer at all.”

Although Sheppard presents the case for social work as having a special place within the paradigm of care and on the basis of its specific and significant role within care management, he identifies its vulnerabilities (1995. p. 54):

- “it is not even clear that a separate academic discipline, called social work exists.”; and
- “it is vulnerable to alteration from exactly those sources which have defined its roles(s) in the first place.”

The angst regarding social work prompted Melanie Phillips (1979) to state, “The major problem ... is that much of social work cannot be seen”.

Jeffries and Müller (1997) face difficulties in definition when they refer to the various titles used in Europe: ‘social worker’, ‘specialist educator’, ‘social pedagogue’, ‘community and/or youth worker’. Also, in the UK ‘social work’ is increasingly being operationalised by NVQ (National Vocational Qualifications) and variously accredited non-social workers within care management programmes. Care management purports to be a social work process but is de facto a money saving exercise. Countless older people are being means tested within a programme that has nothing to do with the holistic claims of social work theorists and a so-called caring profession.

In a comparative Euro-context, care management is not universal. The UK care management model is an American import. Over the years the social work task and knowledge base have generally been fashioned in accordance with various US models. These models have successively been adopted and then dumped. For example, there was US casework, US behavioural modification, US systems approaches and recently US care...
management. To a large extent the Anglo-Saxon global connection has isolated much of care intervention in the UK from the rest of Europe.

The impact of the market upon welfare has also weakened social work’s claim to professional autonomy, status and self-regulation resulting in deprofessionalisation or proletarianisation (Haug, 1975; Rothman, 1984). Tasks formerly done by social workers are being carried out by care coordinators and family aides.

Can social work survive as a distinctive profession? At best social work has been described as a semi-profession as in the heyday of social work (Etzioni, 1969). Greenwood (1957) in a seminal paper has listed the cardinal elements that are required for an occupation to merit the status of being a profession:
1. a systematic body of theory;
2. authority recognised by its users or clientele;
3. the sanction of the community;
4. a code of ethics; and
5. a professional culture.

Etzioni finds that social work lacks the full complement of these attributes. Toren (1969) states that when one or more of these are missing or is not fully realised, the occupation is deemed to fall short of full professionality and may more aptly be described as a semi-profession.

Hugman (1991, p. 6) in discussing professionalism based on the five elements says: “Whether or not professionals do possess an ethic which is not evident amongst non-professionals is unclear”.

However, it is very clear that the major professions have a written mandatory code backed by severe sanctions which strike erring professionals off the professional register, such as those of the BMA, the UKCC and the Law Society. Social work does not have an agreed code backed by such sanctions. They are wholly dependent upon local authority sanctions or the law, even with regard to sexual harassment. CCETSW in the UK has not risen to the occasion and filled this blatant ethical gap. The Code of Ethics of BASW (British Association of Social Workers) is no more than a set of edifying principles for its members. A mandatory ethic is essential if users are to feel safe in the hands of social workers.

More recently, the Marxist and neo-Weberian commentaries upon what constitutes a profession focuses attention upon ‘power and control’. Contrary to this being a shift away from the five elements of a profession, it actually adds weight to the significance of the attributes listed by Greenwood, which are de facto features of influence and regulation. In discussing medical dominance, it refers to three forms of domination which an occupation can exert over others: subordination, limitation and exclusion. Abbott (1988) also refers to ‘structural control’ of dominant ideas within an occupation and also ‘structural control’ within realms of work such as the standards of service output and social work’s quality control.

As will be demonstrated by tracking the development of social work in Europe, the factors of structural control and subordination, limitation and exclusion have been eclipsed by pluralism in a postmodern Europe, when deconstructive forces have altered the shape of the Euroscape, social care structures and introduced a reconstructed panoply of alternative services.

Social work in Europe has been uneven and fraught with tensions. As will shortly be demonstrated, the disparities are so great that one cannot speak of Eurosocial work. There are social care agencies of various kinds some of which have statutory powers of one kind or another and few that are autonomous. Erichsen (1995, pp.188-89) says that there are professions which are an integrated part of the state itself and those which are not. Limitations have been exerted from outside upon the professions in most countries in Northern Europe (Abbott, 1988) and in the former Eastern bloc countries (Lorenz, 1994). Limitations have been exerted by the church in Southern Europe (Giacchi, 1996) and to a lesser degree in Central Europe. Limitations and constraints from both the market and the state have created cross-currents in which social work in Western Europe has been pulled in different occupational directions.

Lorenz (1994) refers to the different and confusing variety of social work within and between countries. When faced with social care activities we are often forced to ask, ‘Is this still social work? Is social work the right title for this activity?’ He concludes:

“No attempt at a definition of social work will be made since all such definitions are bound to be either so vague as to be all-encompassing and
meaningless or so subjectively biased as to omit crucial details.” (pp. 7-8)

Is it that social work is so nebulous that it defies definition? Even the core of social work is hard to establish both in its theory and its basic skills. Social work is a chameleon. In some countries social work is ‘client centred’ and in others it is ‘state centred’ (Harris, 1990). Social work is a fragmented entity, as the following exploration across the length and breadth of greater Europe will show, whatever its claims to being a recognisable and cohesive profession in the halcyon days of the welfare state in post-war Europe. Jones (1985, p.173) sums up the confusion over what precisely is ‘social work’:

“Even within countries, as any glance of the literature will confirm, social work can mean many different things to different people....How much more so, therefore, might one expect to encounter variations, contrasts, and above all ambiguities of usage once there is a switch from national to cross-national review”.

Whatever the claims of social work theorists, social work has never enjoyed a prerogative in social care. For example community nurses and occupational therapists have for some time been trained to provide holistic care. Their curriculum often overlaps that of social work students as does that of many voluntary agency workers. In addition, whilst Statutory social work is in the throes of massive deregulation in a postmodern Europe social workers are increasingly being employed within voluntary and private agencies where they no longer enjoy statutory powers. Also, judging from social and health care developments in Europe, line managed social work assistants at less than half of social work salaries are increasingly being deployed in place of social workers, especially in adult care. Such changes are undermining whatever status social work previously enjoyed.

The extent to which the profession of social work in Europe is in eclipse

For the tracking of social work in the European continent to be manageable the following account must of necessity be selective. The focus is not limited to EU countries.

Social work in Northern Europe
The claim to professionalisation of major caring professions has been most evident in Scandinavian countries (see Erichsen, 1995, pp.188 & 214-15). The major exponent of Nordic welfare has been Sweden. Its municipal social service system was established in 1862-63 (Ricknell, 1986, p.480). Social work has existed there for more than 60 years (Brauns and Kramer, 1986, p. 484). Approximately 15,000 professional social workers serve within the public sector - only 1,000 less than in the (much larger) UK. However, imperceptibly Sweden’s social work provision has been increasingly eclipsed by civil administration and management of budgets (Sundstrom, 1988, p.180). The Social Services Act (1981) had stated that: “Public social services are to be established on a basis of democracy and solidarity” (SFS, 1980/620, Section 1), however, the “contract culture” (Salvage, 1995, p.56) is increasingly taking over (Nilsson & Wadeskog,1988).

In Finland the responsibilities of statutory, professional care have increasingly been devolved to the voluntary or private sectors (Alestalo & Uusitalo, 1986, pp. 242-3).

In Norway, municipal social services have had a relatively short history since 1949 (Hildeng, 1986, pp. 425-6). For many years personal social care was largely left to the Norske Kvinner Nasjonalrad, a voluntary womens’ organisation. The ethos of voluntarism is gaining status as social care is being sub-contracted to the voluntary sector.

In Iceland social work has only existed since 1957 and is the least Scandinavian devotee of the welfare state (Brauns & Kramer, 1986). Social work training has been weak: as late as the 1980s there was one full-time social work lecturer in the Icelandic university school.

Only in Denmark is the post-war notion of the welfare state maintained and public sector professional status of social work conserved. As early as 1937 the Danish school of social work offered a one-year programme. In Denmark today everyone seeking assistance at the municipality has a right by law to be seen by a social worker. But, for how long will the pre-eminence of statutory social work last? Even in Denmark a welfare mix is creeping in: 13% of the 5,200 social workers (socialraadgivere) are in the private sector (see Sørensen, 1986, p. 95).

Social work in Western Europe
The structure of welfare in most of Western European countries is synchronic (Svetlik, 1992, pp.
214-15), in which the welfare state orchestrates a mix of public and private services. In the past few years in varying degrees the dualism of state and market has whittled away the influence and authority of social work within a residual welfare system (see Means & Smith, 1994). Also, major disparities appear between mainland European social work and the UK - for example, UK social workers do not handle welfare benefits, whereas most in Europe do.

In the UK there are at least 16,000 social workers, a third of whom are not qualified (Sinclair & Williams, 1990. p.144). Indeed the number of the unqualified are increasing (Giarchi, 1996) as social work is sacrificed on the altar of savings and the secondment of assistant social workers onto university courses is decreasing. Local authorities’ cuts fall heaviest upon adult care and disability. Care of children is spared because of the fear of court action against failure to provide child care as long as the statutory powers of social workers remain. What would occur if the statutory mandate was taken away from social work, as well it might? After all the statutory role of social work is not universal. In the voluntary sector, Barnardos, the NCH Action for Children, NSPCC, Family Service Units, and Childrens Society have proven records in child care, as clearly do child psychiatrists, clinical psychologists, health visitors and school nurses. Child care is not the prerogative of social work. Is social work really indispensible?

In the UK, care management is fast becoming the management of costs (Giarchi, 1996). In fact, status in social work increases with the ability to cut back costs. In addition, health and social care workers dump costs upon each other on the basis of what each defines as social or health care (Abbot, 1992). Boundaries of responsibility and accountability shift when it suits the services in what have often become money-led enterprises. Since the introduction of the NHS and Community Care Act, 1990 the social work purchasers of care have enjoyed greater status than the providers of social care (Means & Smith, 1994; Giarchi, 1996).

The profession of social work is being affected by the new role of the GP within community care. The White Paper, The New NHS: Modern, Dependable, (1997), has enhanced the role of English and Welsh GPs yet more within Primary Care Groups in its ‘new third way’. To what extent will the lead role of social services be affected? The document states the department of Health “will integrate policy on public health, social care and the NHS” (7.3). The greater the significance given to the leadership and controlling role of GPs the less will be the professional status of social workers within the neighbourhood strategy. Johnson (1972.p. 58) points out that, “it is through control of the diagnostic relationship that the physician has maintained his pre-eminence”. The White Paper proposals are likely to increase that dominance.

The possibility of social and health care coming together is currently being discussed at conferences and seminars. Recently both counsellors and social workers have increasingly become part of that primary care (see Lankshear et al., 1998). Already in Somerset social workers and community nurses are under one authority. In Bath, housing and social services have the same Director. The coming together may strengthen the community strategy, but it may also greatly reduce the autonomy of social work as a profession. These measures, even the very suggestion, were unthinkable in the Seebohm era.

In the Republic of Ireland the Health Act of 1970 set up eight health boards under the Minister of Health within the Department of Health. These provide community care, employing social workers as well as community nurses known as public health nurses. The Health Board Areas serve populations of 100,000-120,000 people. They are responsible for three programmes: Community Care; General Hospital; and Special Hospital. The bulk of social workers are employed by health authoritiews within community care, which is headed by a programme manager who is usually a doctor. Kavanagh (1992. p.6) states:

“‘Ireland’s general public is not conscious of the existence of a distinct category of services labelled ‘personal social services’. This lack of perception stems from the way in which the personal social services are organised and administered. Personal social services are submerged in the ‘community care’ services’ which in turn are located within the general organisational framework of the health services’.

The home helps are attached to the public health nurses rather than to the social workers. Approximately 500 social workers serve the boards in the republic. In 1975 the Minister for Health stated, “my objective is to bring about a shift in resources in favour of community services, in the belief that this will lead to a better health service
overall” (Dail Debates, 1975). Central to this ‘health’ shift has been the dilution of the role of social work (Giarchi, 1996).

In the Netherlands the care system differs from that of the other Western European countries and is more asynchronic and akin to the corporatist model in Germany, Switzerland and Austria (Esping-Andersen, 1990) and to a lesser extent Italy. Steijger (1986, p.405) describes the social services as a decentralised network of agencies under the Ministry of Cultural Affairs, Health and Social Welfare (Ministerie van Welzijn, Volksgezondheid). The gravitational pull of health has weakened social work’s status; for example, home help (gezinsverzorging) is directed by district nurses, when it was once a social work responsibility. Also, a great deal of control is delegated to the voluntary and private sectors and the churches. The state has favoured private care and substituted it for the costly use of social workers.

In Belgium ‘service centres’ (dienstencentra) offer information, advice, financial assistance, meals leisure activities and personal hygiene in which social workers are assessors rather than providers (Moenaert, 1991. pp. 202-10). District carers (wijkziekenverzorgenden) are also part of the home help network. In the French communities of Belgium aide seniors and their equivalent, the bejaardenhelpster in the Flemish communities (Leaper, 1990), carry out tasks that UK social workers provide. In an attempt to bring the services together, Belgium as set up about 45 multidisciplinary Flemish Community co-operation initiatives (samenwerkingsinitiatieven) (Spinnewyn, 1990. p.97) in which social workers’ influence is dwarfed by that of GPs and home nurses.

In France, social care is provided by what is probably Europe’s most complex care system. Henrard et al. (1991. pp.109-10) refer to 780 services with 3,500 diverse types of care assistants (Leaper, 1991. p. 181). The complexity has led to confusion over boundary roles amongst the 34,000 or so who claim to be responsible for social care social work (Louatron, 1986). The following list illustrates the complex division of labour which segments what the French identify as ‘social workers’ (Louatron, 1986. pp. 44-45):
1. probation officers (délégué à la liberté surveillée);
2. special education experts (éducateur spécialisé);
3. teachers of special education (éducateur technique spécialisé);
4. pre-school teachers (éducateur des jeunes enfants);
5. kindergarten personnel (moniteur-éducateur);
6. medico-psychological aides (aide médico-psychologique);
7. social service assistants (assistant(e) de service social);
8. family counsellors (conseiller(e) en économie sociale et familiale);
9. social animators (animateur social ); and
10. female family helpers (travailleuse familiale).

The status of social workers further divides into two:

1. Public or semi-public status: civil servants, employees of local authorities, hospital or regional health insurance and family allowance agencies.
2. Private status: independent unattached social work based upon contract.

In addition, there are the CCAs (Centres Communaux d’Action Sociale), which Ely and Saunders (1992. p. 8) describe. The workers involved provide information, co-ordinate social action and deal with claims for financial support much of which would not be regarded in the UK as social work. Other social workers are employed within a wide variety of statutory and independent agencies providing either health or personal social care related to domiciliary services, within decentralised teams in 7 urban and 14 rural sectors (Leaper, 1990). Within such a diversified complex system it is difficult to identify a social work profession.

In Luxembourg a cohesive social work profession is hard to find within the following ministries: Family Affairs, Labour, Social Security, Justice and Health (Roulleaux, 1986. p.394). Social care dates back to the middle ages and based upon religious values, from which has sprung the socio-medical and social help services. They operate within Social Communal Offices and Socio-Medical Centres and are inspired by a blend of vocationalism and voluntarism. The parity with social care roles elsewhere is difficult to establish. In fact, Hartmann-Hirsch et al. (1992. p.6) go so far as to say:

“To our knowledge, there are very few legislative texts which refer explicitly to social services”.
Social work in Central Europe

The case has been made to support the notion of a Central Europe within Europe’s geographic and historic heartland (Giarchi, 1996), consisting of Germany, Austria, Switzerland and the Czech Republic. This centre is federalist and corporatist. Historically, these countries occupy the geographic and rich economic core of mainland Europe (Lipset & Rokkan, 1969). Because the Czech Republic has only recently been liberated and established as an independent state it is not included here (see Giarchi, 1996 for Czech details). Because social care reforms will take 15-20 years to be fully developed within the European flux, aspects of Czech social work will be referred to when dealing with Slovakia in the next section (Castle-Kanerova, 1992. p.115).

In Switzerland social care is very much the responsibility of the private non-profit agencies, such as the Swiss Red Cross, Caritas and other church organisations. The principle of subsidiarity (as in Germany and in some Latin countries) is invoked, so that the people will only consult social workers as a last resort (Segalman, 1986. pp.107-8). Modena-Burkhardt (1985. p. 525) states that social services:

“have not shown their ability to get well organised and to articulate their demands clearly with regard to social work education and to professional social work”.

In Austria, as Hoffmann (1986. p.47) states, the ‘welfare worker’ has eclipsed the social worker. The history of social work there is not impressive. Indeed, Hoffman (1985. p. 47) observes that:

“there is no tradition of neighbourly help or partnership between donor and recipient. In such a place there was hardly a place for personal social services.”

The ‘care worker’ (Fürsorger) for many years catered for unmarried mothers and their children and only in the 1960s were social workers formally accredited by the state. Much of what would be regarded as community education in the UK is carried out by social work animators (see Lorenz, 1994. pp. 102-3).

Social work lacks cohesiveness as an autonomous entity in Austria. There are nine provincial legislatures with their own Social Assistance Acts with contrasting types of personal social services (Hoffman, 1986; Giarchi, 1996). In addition, social care is frequently carried out by the following NPOs (non-private organizations):

1. the Wohlfahrtsverbände, i.e. the social welfare organisations such as Caritas or Red Cross, which have both paid and volunteer labour;
2. the Vereine, i.e. the local associations, which may be affiliated or not to major or political organisations, run by both paid and volunteer labour; and
3. the grassroot groups and self-help initiatives, which are run and supported by volunteers only.

The NPOs often exploit the workers, who are frequently on part-time contracts. They are mainly untrained. In addition, NPOs are in competition, so that the possibility of joint or inter-agency action seldom occurs. Welfare grassroot agencies are usually run by political parties (Badelt & Pazourek, 1991. p.14).

The social services subcontract work to voluntary agencies. This is often carried out within largely decentralised neighbourhood systems, which also link with self-help groups. For example, in Lower Austria, personal social services consist of 74 different decentralised service stations most of which are sub-contracted non-profit organisations (Pohoryles et al., 1988. p.188-9). Another example of local ventures is provided by Integrierte Gesundheitsund Sozialsprengel (Integrated Health and Social Areas - the IGSS). It consists of an infrastructure of co-ordinated social and health care within small areas. Lastly, the federal authorities have initiated a nation-wide scheme to integrate the fragmented provision of care provided by GOs, NPOs and PMOs. Clearly, a discernible social work ethos is hard to find.

In Germany the social care system refers to ‘social welfare practitioners’ (Jeffries & Müller, 1997. p.326) rather than social workers. Their functions present diverse practices, as for example the ‘social pedagogues’. They do similar work to the ‘specialist educators’ (animateurs socioculturels) in France.

There are two branches of social welfare. Firstly, Sozialarbeit provides: financial support/assistance; probation; work with older people, the disabled, families; and public health. Secondly, Sozialpädagogik provides child protection, residential and community-based youth work. Both require different qualifications: the former is
acquired by means of a two-year course in further education (Fachschulen) ; the latter by means of a four year course in higher education (Fachhochschulen).

The complex nature and mix of orientations and lack of reliable data prompted Brauns and Kramer (1988, p.137) to say:

"More accurate statistics are available on the different species of cattle grazing in West German pastures than on the social workers employed by the various agencies."

The principle of subsidiarity (Jarré, 1991) exists here as in Austria and Switzerland. Clients first seek help from their families, churches, voluntary welfare organisations or co-operatives.

Social stations (Sozialstationen) provide social service care. They were established between the seventies and the eighties. In addition, within western regions there are religious centres, providing personal social care, known as the Evangelische Diakoniestationen (the Protestant centres) and the Katholische Sozialstationen (the Catholic centres). In Stuttgart, for example, there are 8 Catholic stations and 15 Protestant ones alongside the two Sozialstation der Arbeiterwohlfahrt (Workers Welfare social stations).

**Social work in Eastern European countries**

This paper subscribes to the view (see Giarchi, 1996) that the former Eastern bloc countries are best regarded as two clusters. Firstly, the swathe of Eastern Central European countries that lie off-centre consisting of Poland, Hungary and Slovakia. Secondly, Eastern European countries consisting of the former USSR, Bulgaria and Romania. Social care in these countries was referred to as 'welfare work' or 'rehabilitation' - neither the term 'social work' nor 'poverty' could be used because deprivation was a capitalist phenomenon (see also Lorenz, 1994, p.28). The old satellite countries are in transition undergoing massive socio-economic changes. The rejection of communist welfare has ushered in a state of anarchic welfare in which older bureaucracies have not yet been fully deconstructed and before reconstructed modes of provision have been put in their place. The tendency is for an anarchic market welfare model to emerge, favouring those with the ability to pay for social care. Social work is squeezed out as the voluntary and religious groups strive to fill the gap left by the retreating mega-welfare state.

In Slovakia and the Czechlands, organised social care has been minimal. Bolshevik brigades (subbotnicks) had taken over planned care. Bolting market systems onto old-system paternalistic systems after liberation is not likely to work. Hartl (1991. p. 38) describes clients as still "feeling blue" under the bureaucratic weight of the ancien regime, which was "rigid, sterile, autocratic, monolithic."

The possible emergence of social work in the former USSR will be fraught with immense difficulties. Professional autonomy even of medicine was deeply compromised by the autocratic state (Light, 1995. p. 29). The medical/health/social welfare services in effect constituted an industrial workforce subject to the specifications of the state machine. Any professional autonomy was ruled out. The Red Cross and the Red Crescent Societies vainly attempted to fill the gaps. In almost all the former Soviet republics, apart from a few cities such as Moscow there are no social workers as we understand the term. Manning (1992. p.39) refers to quasi-social work activities of doctors within polyclinics attached to local housing estates. The establishment of local personal social services is now on the CIS welfare agenda.

In Poland the Ministry of Health and Social Welfare runs both the health and social care services. In spite of the liberalisation of Poland progress has been hampered by splits and confusion. Hrynkiewicz (1991. p. 60) states that, “Agreement on social policy in Poland is extremely difficult - if at all possible”. Fallenbuchl (1991.p.114) comments that, “Poland has practically no sensible social welfare system”. Millard states (1992. p.131) that some of the former anarchic systems survive, in spite of market welfare.

State social care was never creditable in Poland (Selby & Schechter, 1982. p.72). The Polish Red Cross, the Union of Pensioners and the Disabled, the Polish Social Welfare Committee (PSWC), the Union of Disabled Veterans, the Warsaw Charity Association, the trade unions, and the Polish Scouts Association have attempted to fill gaps in social care provision. Much has been left to the local Catholic parish groups. In 1983 there were some 44,000 volunteers of various sorts as against only 9,500 social workers (Lorenz, 1994. p.118).

In Hungary welfare and health care have been
underfinanced for at least 30 years (Szalai & Orosz, 1992, p.162). From 1945 onwards, professional carers have had to rely upon tips described by Ferge (1991. p.143) as "money of gratefulness" and by Szalai and Orosz (1992. p.160) as "gratitude money". Social services have changed little since 1968 (Millard, 1992: 152). There are under 1,000 voluntary and state social workers in a country with millions of clients in need. Those who might loosely be referred to as social workers along with semi-skilled paid helpers come under the supervision of district medical officers and district nurses. The Hungarian report prepared for the UN World Assembly on Ageing (1982) stated that there were 16,000 home care service workers catering for older people of whom 14,600 were volunteers.

Even well known histories of Europe such as that of Roberts (1980) have said little about contemporary Bulgaria - a comprehensive history of 1,052 pages with only a couple of lines written in passing on Bulgaria. Its neighbour Romania is linked with the general malaise and socio-political chaos facing Bulgaria. More than the Friendship Bridge (between the Romanian city of Giurgui and the Bulgarian city of Ruse) links the two countries. The two nations share many post-Communist problems: both nations are 'uncivil societies' The Romanian regime shows every sign of being an "uncivil administration" rather than a civil one, to use Rose's (1992. p.5) distinction. In both Romania and Bulgaria the lack of resources and continuing deprivation suggest that they are 'third world countries in Europe'. Personal services have not fitted into the old Communist ideologies, nor are they prioritised within footloose welfare systems, where limited resources exists for those prepared to pay for care, such as provided by the prophylactoria, run by private enterprise and trade unions in Bulgaria.

Social work in Southern Europe
In Italy by the end of the 1970s, secularisation of the nation separated out welfare from Christian charity (Ferrera, 1986. p.393). Care had been discretionary and paternalistic (Cavallone, 1986. p.357). However, subsidiarist Catholic policy and family centred social priorities remained. A corporatist and asynchronic system (Svetlil, 1992. p.215; Giarchi, 1996. p.27) has passed responsibilities to local authorities where 'closer to people' campagnilismo (local parish action) and famiglialismo (family care) are dominant. Thereafter, client participation (clientelismo) and populist control have been encouraged by political parties (partitocracia). Within this socio-political cauldron social work has been politicised. The political element brought about a split between northern and central Italian schools of social work. The notion of one-to-one intervention and casework came under fire swayed by the influence of parties to the left. In the political battle the Association of Italian Schools of Social Work was dissolved in 1973. Even the term 'social worker' was replaced by operatore sociale in some places, and in others by 'social assistant' (assistente sociale). The abolitionists reasoned that social intervention was not the sole prerogative of social work, but was also carried out by psychologists, sociologists and health workers (Cavallone, 1986. p.359). Today sociologists and psychologists are part of the local agenzia sociale.

Social services within communes are usually run by an assessore (alderman), who is appointed by the Council. Social work accountability is paramount hence the assessore receives users on two mornings a week at his office. Settling disputes and receiving complaints are major duties of an assessore. The regions each have their own peculiar social service structures. For example, in Tuscany social services usually have a full-time appointed co-ordinator, akin to the Director’s post in Britain. The social work profession has been criticised in Italy within academia and by the media, because it was seen to fulfil a function of social control or policing, rather than providing care for the needy.

The corporative nature of welfare is characterised by voluntarism and vocationalism (Giarchi, 1996). Voluntary agencies in Italy are run by Caritas, St. Vincent de Paul, Society of Egidio Bullesi, or parish groups and various small social solidarity co-operatives. Donati and Colozzi (1986. p.75-95) describe them, basing much of their analysis upon a nationwide investigation into 7,024 voluntary associations by Colozzi and Rossi (1983). On the basis of their remarks, there are three recognisable types of welfare mix.

Firstly, there are agencies which supplement the welfare state. They reflect its universalist values and are non-selective. These voluntary agencies constitute the other arm of welfare and social care. For example, when the social services close down in the middle of the day and at weekends, the voluntary sector takes over (see Depaoli, 1986. p.54).
Secondly, there are agencies which uphold the rights of everyone to health care and social relief, but also the right to choose between welfare mixes, some of which may be bought from private or co-operative welfare agencies.

Thirdly, there are agencies which are inspired by the Christian concept of care such as Caritas. The Catholic voluntary sector (motivated by vocationalism) is the largest provider (Depaoli, 1986), which generally conserves democratic individualism. Some examples are the Egidio Bullesi Society, which builds villages for younger families; Caritas and ACAP ('Associazione Cultura e assistenza Popolare - ‘People’s Culture and Welfare Association’); the St. Vincent de Paul Society, the Daughters of Charity and the Caterina Volpicelli carers.

In Spain the first school of social work was founded in 1932 in Barcelona by a Catholic women’s committee (Poch & Andreu, 1986. p.451), but it took another 16 years before it was incoroporated into universities (Poch & Andreu, 1986. p.454). The Constitution states that all citizens have the right to social services. Casado (1992) describes the nature and extent of personal social services. The Comunidades Autonomas are endowed by the Spanish Constitution with exclusive authority for provision of social aid (assistencia social), which is equivalent to social services as generally understood in Europe.

First stage social work is variously named in the Comunidades, such as: First Aid Social Services (Servicios Sociales de Atencion Primaria); Basic Social Services (Servicios Sociales de Base) or Community Social Services (Servicios Sociales Comunitarios). Whatever names they are given, these intake services consist of small offices, which may serve a whole district, several municipalities or just one municipality. They can serve anything from 5,000 to 25,000 people, but often only have one qualified social worker who works alongside other specialist professionals and a back-up adminstrative staff. Social work for families (unlike the UK, Northern and Central European countries) is minimal (Casado, 1992. p.9). There is faith in the family to provide care and protection. In contrast, social workers based in factories are only 1% fewer than those based in social care assistance in health establishments (Poch & Andreu, 1986. p.453). The syndicalist system and trade-union structure are an integral feature of Spanish life. They have eclipsed social work provision. Caring co-operatives are very active in Spain.

Community care has been minimal (Estivill, 1984; Casado, 1985; Rossell & Rimabau, 1989) and according to Spinnewyn and Cabrero (1991. p.169), home help resources are not supported and run by social services, but by social security, by Catholic services, by town councils, by regional government, by private agencies and by three other undefined voluntary organisations. About 38% of day centres are provided by private non-profit organizations (Spinneywn & Cabrero, 1991. p. 168; Lishman et al., 1993. p. 16).

In Portugal social workers are called ‘social service technicians’. PSSIs (Private Social Solidarity Institutions), which are patronised by social security, receive state support, have autonomy and a private budget, and carry out social action activities for older people assisted by organised volunteers. There are many different types of organisations within the PSSI. There are social solidarity associations, social action volunteer associations, mutual benefit associations, social solidarity foundations and lastly the Irmandades da Misericordia. Unions, federations and confederations make up the heterogeneous spectrum of voluntary non-profit agencies. Many of the associations are run by the Church.

In Greece the Ministry of Social Welfare is responsible for social care. However, basic social care is minimal. Lorenz (1994. p.26) points out that the welfare state in Greece is rudimentary. There are some 2,680 social workers in 264 municipalities and 5,774 communities, as described by Hunter (1986. p.44). These are maintained by directly elected councils. They can establish local health and social services. Health and social care services are provided by the one centre. Voluntary centres for older people are known as the KAPI (Greek initials standing for Open Care Day Centres) which have been integrated into the formal public community care system (Amira, 1990. pp. 73-4). Each KAPI centre has a doctor, a social worker, a physiotherapist, an occupational therapist, a visiting nurse and a home assistant (Malikiossi-Loizos, 1986. p. 23). When care services operate, they are usually coupled with health and nursing services, the Greek Red Cross, Greek Orthodox Church, Red Cross and Foundation of Volunteers (Teperoglou, 1980).
The status and involvement of social work in the former Yugoslavia defies description because of internal wars. Its social welfare and health system were once compared favourably with those of the more democratic states of Europe (Kavar-Vidmar, 1980, p.162; Pesic and Jovanovic, 1986; Ruzica et al., 1991, p.85). However, the systems now lie in ruins.

In Albania (that socialist ‘stray’ in Southern Europe) there could hardly be an eclipse of social work, for the simple reason that social work never really emerged in a country where there has been a lack of state services for vulnerable groups (Sjöberg, 1991, pp. 115-27; Pashko, 1991. pp.128-46).

In Malta the island’s ‘closer to people’ social care has been inspired by subsidiarity and corporatism. Health services dictate provision and alliances. Social workers do not regulate home help; they come under the wing of nursing and are known as ‘health assistants’. The Director of Social and Family Welfare is responsible for providing personal social services (Vella, 1990; Ministry for Social Policy, 1990). The statutory sector is to a large extent eclipsed by the voluntary sector - there are eight major non-social work, voluntary organizations serving older people (Trois, 1988, p.53). Caritas is relied upon to run Malta’s ‘Good Neighbour Schemes’ serving housebound people or the quasi-housebound (CPA, 1989. p.103).

Cyprus, at the other end of the Mediterranean, has minimal social work provision. Its four areas of work (child care and family welfare, public assistance and services for the elderly, community work ,and youth protection and development) (PIO, 1992, p.173) are largely served by voluntary and private agencies. Again, the Orthodox Church steps in to provide social care.

Conclusion

Having tracked social care within Europe, it is clear that there is considerable evidence that social work as a profession or as an identifiable occupation is hard to find. In many countries it has never really existed. In a seminal statement Clarke (1996, p. 49) doubts whether there ever was ‘a social work’. Where it has been created, particularly in the more northern and western European countries, it is, to use a Harden (1992) expression, increasingly being eclipsed within the ‘contracting state’.

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