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Service Provision for Visually Disabled Adults by Social Services Departments in Portugal and in England:

A comparative perspective

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Introduction

The aim of this article is to present the findings of a research carried out between 1999 and 2001 on service provision for visually disabled adults by Social Services Departments (SSD's) a comparison of Portugal and England. The research focused on visually disabled adults, including both blind and partially sighted people between the age of 18 and 65. It also focused on the service provision by Social Services Departments, i.e. the organisational structure for the delivery of social services by local authorities, for the visually disabled adults in those two countries.

The overall aim of this research was to identify and compare the service provision for visually disabled adults by SSD's by local authorities in Portugal and in England. More specifically, the research explored the differences and similarities in service provision between the Portuguese SSD and the English SSD in areas such as the quality of services, the duties and responsibilities towards visually disabled people and the role of the users' involvement and participation on service provision. In order to give an overall view of the quality of the services, the study has focused on the structure of the SSD, the service provision as well as statistical information such as expenditure and number of referrals. As far as the duties and responsibilities are concerned this research identified the pre-requisites for service provision and explained the SSD's duties and responsibilities in both countries. It also focused on the theoretical model (social or medical) that shapes the professional intervention of the relevant services. Finally, it pointed out the role of the users' involvement and participation in the planning and development of services.

The first part of this article looks into the design and methodology of the present research. More specifically it presents the research method used, which was a comparative case study based on a 'grounded theory' approach. It also presents some consideration in regards to data collection and analysis. In the second part, the literature review is presented and discussed. Relevant theoretical issues to this research such as visual disability, theories of visual disability, the differences between the Portuguese and the British welfare state, and previous relevant research on service provision for visually disabled adults in the Portuguese and English SSD are carefully examined and analysed. In the third part of this article, the main

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research findings are discussed by linking the theoretical discussion and the case studies to professional practice. The level and type of support that the Portuguese and the English SSD's offer visually disabled adults is identified and compared. Finally, in the fourth and last part of this article, the main conclusions of this research are highlighted.

Design and Methodology of the Research

Research Approach

This study had a qualitative orientation. The researcher aimed to gain an understanding of the service provision for visually disabled people by SSD in Portugal and England by exploring and describing each case and, then, confronting similarities and differences.

A comparative case study has been the research approach used in this study. Firstly, because it was felt that an insight into the research question would be possible by studying a particular social services department in each country. Secondly, one of the case study's strength is '*its ability to deal with a full variety of evidence documents, artefacts, interviews and observations'* (YIN, 1984: 20). Finally, the case study is, in many ways, ideally suited to the needs and resources of the small-scale researcher (Blaxter, Hughes and Tight, 1996: 66). Taking into account that it is very likely that nothing has been written on the research topic, an exploratory case study appeared to be the best option in terms of research approach. This particular case study, has undertaken a 'grounded theory' approach. This approach, developed by Glaser and Strauss (1967) is a process of constant comparisons where theory is 'discovered, developed, and provisionally verified through systematic data collection and analysis of data' (Strauss and Corbin, 1990: 23). With this perspective fieldwork and data collection were undertaken prior to the final definition of study questions and hypotheses (Glaser & Strauss, 1967; Ogawa & Malen, 1991; Yin, 1991; Yin, 1993).

As already mentioned, a single-case study was selected from each country. The cases were selected according to two criteria. Firstly, the cases were selected in terms of time and access to fieldwork, i.e. both social services departments in Portugal and in England were chosen because they were relatively easy to get to, welcoming to the research inquiry and where a prospective informant could be identified. Secondly and lastly, the author also tried to select a case from each country that could be representative of other cases in terms of service provision for visually impaired adults by Social Services Departments. The main disadvantage of using only a case study from each country is the difficulty of producing generalisations. While it may be true that generalisations in the present research will need some label such as 'small generalisations', nonetheless, it is possible to identify similarities and differences between the service provision for visually disabled adults by SSD in the two countries.

Data Collection

The methods used to generate the type of data that addressed the specific aims of this research were semi-structured interviews and analysis of documents. Firstly, documentary material regarding Community Care Plans and appropriate policy and/or operational documents concerning visual disability was requested to both SSD's and carefully analysed. Secondly, semi-structured interviews were conducted at strategic level with 'key informants' from management sector, one from SSD in Portugal and one from SSD in England. Moreover, at the operational level, two more interviews were conducted with one social worker in Portugal and one occupational therapist in England. Each interview lasted between 40 and 60 minutes and were audio-taped, transcribed and then analysed using a grounded theory approach (Denzin & Lincoln, 1994; Glaser 1967, 1992).

Data Analysis

For each case study initial data was collected, written up, and reviewed line by line, typically within a paragraph. Beside the paragraph, categories were generated and a list of them grew. These categories were reviewed and, consequently, a slightly more abstract category was attributed. Additionally, the data for each case study was analysed through triangulation by testing out information obtained from the semi-structured interviews to "key informants", against documentary evidence in order to confirm categories.

Lastly, a comparative analysis of the Portuguese and English case studies was developed by identifying and exploring the similarities and differences between them. It was not always clear whether the data were strictly comparable, since these two different countries used different definitions. Despite these concerns, at its best this method has been highly productive, making it possible to develop helpful typologies as a framework that could be the starting point to future researches on this topic.

Literature Review

Visual Disability

The experience of visual disability differs greatly from one person to another so it is unwise to treat visually disabled people in the same way. A minority of people are born visually impaired and, therefore, do not know life in any other way, while the majority acquire visual impairment, usually in later life (Bruce et al, 1991). Visual impairment can occur suddenly, for example as the result of an accident, or very gradually over a number of years. People who acquire a visual impairment may feel an acute sense of loss in certain areas of their lives and according to their lifestyles. They may, for example, greatly miss being able to read print or to do their shopping unaided. People who are visually impaired from birth or early childhood are unlikely to feel a sense of loss although they may be fully aware of the limitations society imposes upon them.

It is not easy to understand what visually disabled people can see because this will depend on their particular eye condition. Some visually disabled people can see small print but are unable to recognise a friend or see a street name or house number. Some people can see quite well in daylight but hardly at all at night, while for others this is reversed. Visually disabled people may have a restricted field of vision, for example tunnel vision or peripheral vision, and may or not be able to appreciate colour. The requirements of visually disabled people are, therefore, very diverse. Visually disabled people also have different degrees of vision from 'useful' vision to total blindness. Only four per cent of visually disabled people have no sight at all. Some visually disabled people know they will retain the sight they have while others must face the prospect of total blindness or the slow deterioration of their vision. Visual impairment can also be associated with unpleasant symptoms like pain, or other impairments such as deafness and learning difficulties (Walker et al, 1992). Nonetheless, most visually disabled people are not ill and it is important not to associate visual disability with illness.

It is also important to realise that being visually disabled is just one attribute of the individual which interacts with all other attributes. An outgoing visually disabled person, may, for example, have different ways of coping than someone who is quiet and reserved. Visually disabled people, like other disabled people, are often stereotyped and thought of as a group. Although visual disability can be a very central experience, visually disabled people are as unique as all other people.

Visually disabled people are not confined to any particular group within society but are present regardless of gender, ethnicity, social class, sexual orientation and age. The experience of visual disability, may, however, be different according to these broad divisions. Visually disabled women may, for example, find themselves under particular pressures not to have children and may find it more difficult to obtain paid employment than visually disabled men because of sexist attitudes (Morris, 1991). Visually disabled men may, on the other hand, find it more difficult to ask for help because of the stereotyped 'macho' role of competence and power.

Ethnicity may also interact with visual disability giving rise to particularly oppressive experiences. It is well known that, because of racist attitudes, people from ethnic minorities are treated less well as patients and service users in the health and social services and find it more difficult to obtain paid employment (Begum et al, 1994). Visually disabled women from ethnic minority groups are in a particularly difficult situation as they may be coping with sexist, racist and disablist attitudes and practices. It is important, however, not to view these oppressions as adding one to the other. Morris (1991), Stuart (1993) and Begum (1994) point out that disabled women and disabled people from minority ethnic groups experience a unique form of oppression which is more than the sum of the parts.

Some visually disabled people are lesbian and gay and may have particular difficulties in establishing satisfying personal and sexual relationships. Visual disability makes social interaction difficult. This is not only because of the difficulty of recognising people and reading non-verbal cues, but also because of attitudes towards visual disability, difficulties in getting to social venues, unemployment and mobility problems, for example being unable to circulate at a social gathering (Shakespeare et al, 1996).

The majority of visually disabled people are over the age of 65 and may find themselves contending with ageism as well as disablism. They may be told, for example, that they can expect nothing more 'at their age' or that they must accept the inevitable consequences of degenerative disease. The resources made available for older visually disabled people tend to be less than for younger people even though coping with a visual disability may be more difficult because, for example, of reduced hearing or mobility.

Social class may also have an influence on how visual disability is experienced. Visual impairment is present among people of all social classes but, like most impairments, it is more relevant among people of low socio-economic class. This reflects the higher incidence of prematurity, birth trauma, infectious diseases, accidents and poverty and illustrates that impairment, as well as disability is, at least in part, socially constructed. The higher the social position a visually disabled person has within society the more able she or he is to remove the various social and environmental barriers. A person who is employed and receiving a high salary, for example, will be able to afford taxis to get about, will be able to purchase visual aids and equipment and may pay for some assistance, for example to do the gardening or decorate the house. Visually disabled people in this position tend to be in the minority, however, because only approximately 25% of visually disabled people of working age are in paid employment and the majority of visually disabled people are over retirement age (Bruce et al, 1991). The advantage of being from a higher social class does not only concern financial resources. The experience of a more privileged up-bringing and lifestyle including, for example, a good education and socialisation within a profession, tends to make people feel more confident about themselves and better equipped to demand their rights. They are less likely to be intimidated by professionals and are more likely to understand the workings of, for example, the Social Services Department.

Despite this diversity visually disabled people throughout the world share many common experiences of oppression and discrimination which are shared too with those with other impairments such as deafness, learning difficulties and language impairments. These oppressive experiences include discrimination in terms of education, leisure and employment, hostile attitudes, institutionalisation, poverty and lack of access to transport.

Theories of Visual Disability

There are numerous different theories of visual disability. At its broadest it can be argued that there are as many theories as there are human beings where 'theory' is an individual's understanding of visual disability. Even within this statement, however, there are more collective understandings, as evidenced by the very use of the term 'visual disability'. Furthermore, a distinction can be made between theories arising directly from the experience of visual disability, and those emanating from, for instance, professionals who work with visually disabled people. Another complicating factor is the differentiation between theory and action. What people believe and understand stands in complex relation to what they actually do. A final complication is the purpose of theories. To recognise this dimension of theory is to acknowledge that all theories have political import. There is no such thing as neutral theory. Every theory of visual disability speaks to the establishment of shared 'social understanding', justifies particular practices and policies, and is integral to the power relations between people.

Over the decades different explanations of disability have influenced the service development and the policy making for people with a visual disability. The most prevalent is the *individual or medical model* which categorises disabled people according to their sensory impairment. From this perspective *"disability is regarded as a product of biological determinism or personal tragedy, manifested in the material condition of the individual"* (Priestley, 1998). It is clearly medical and all paramedical sciences have to play a central role in enabling visual disabled people to have as active independent lives as possible and to reduce the symptoms (Oliver, 1988). Following this, as Oliver (1988) and Priestley (1998) stated, the other models, such as the *psychological or administrative*, have been implemented but all derive from the same biological determinism perspective and they produce oppressive medicalising outcomes.

The crucial development in theories of visual disability over the past twenty years has been the establishment of the *social model of disability.* Writers from a disability perspective argue that it is a disabling social environment and disability factors into the community which create disability and not the individual impairment. Disability is caused by social factors including discrimination and oppression which disabled people experience in the society (Oliver, 1993; Barnes, Mercer and Shakespeare, 1999; Croft and Beresford, 1996). From this a social analysis of disability has started, emphasising that disabled people can act for themselves in changing existing professional and societal definitions of disability. The social model criticises existing service provision, redefines the problem and attempts to create an alternative service structured and controlled by disabled people (Barnes and Oliver, 1995). Additional differences on the medical model and the social model are illustrated in the following figure:

Figure 1: Medical Model of Disability *versus* Social Model of Disability.

MEDICAL MODEL	SOCIAL MODEL
The problem of visually disabled people originate in their deviation from essential personal and social standards of normality.	The theory of normalisation with its emphasis on social integration and a valued life for people offer a participatory framework for services although it has been criticised about the dominant ideas of normality in society.
Visually disabled people are dysfunctional and need intervention and administration by able-bodied people.	Public concern about poor quality, paternalism and lack of responsiveness of welfare services.
Dependency: Inability to provide self-care due to functional limitations.	Engage visually disabled people more actively in their own affairs. Visually disabled people reject their representation by experts and redefine disability.
Disability is an issue of managing care.	Disability is an issue of civil rights.
Cure and care forms of intervention are administered within the rehabilitation and personal care services, respectively.	Disabled people try to influence the service providers about the control and delivery of service. Debates about the politics and control.
Community Care stress difference over commonality by focusing attention on specific impairment on individual experience.	Independent living stress commonality at the expense of difference but commonality is understood in terms of collective oppression.
Research projects are basically service led and provide reliable data to plan services based on official definition of the WHO[1] about disability.	Criticism of research based on official definition of disability - doing emancipatory research[2].

Sources: Priestley, 1998; Barnes and Mercer, 1997; Finkelstein and Stuart, 1996; Finkelstein, 1993; Oliver, 1993; Barnes, Mercer and Shakespeare, 1999.

Schon (1988) distinguishes in some detail between two models of professional development applied by professionals working with visually disabled people. Model 1, sometimes called the traditional model, involved the following action strategies for the professional providing social support: design and manage the environment so that the professional is in control of the factors which he or she sees as relevant; own and control the task; unilaterally protect self by, for instance, withholding critical information; and unilaterally protect others, particularly the client, from being hurt. Model 2, or the reflective practice model, is characterised by quite different action strategies: design situations in which all participants, particularly the professional and client working in partnership, participate in defining and controlling relevant factors; the task is jointly controlled; protection of self is a joint enterprise, orientated towards growth and bilateral protection of others.

The challenge to professionals who work with visually disabled people is to construct services and practices which respond to the viewpoint of visually disabled people. It means actively recognising and respecting the 'expertise' of users in relation to how they experience disability and their views on what they want and need. The implications of the social model for professional practice are evident: a shift of power to visually disabled people; the focus for intervention is the dismantling of disabling barriers and the creation of enabling environments; and, social support to visually disabled people is orientated to their rights to full participative citizenship (rights not 'special needs'). The discourse of needs focuses on the individual and the provision of social support which addresses, in theory, the individual's lack of capabilities to function within his or her particular community and society generally. By contrast the discourse of rights focuses on disabled people as a distinctive group within our society, who are denied their rights through institutional discrimination.

Portugal and Britain: Two different Welfare States

The ideology of welfare provision is an important aspect to the provision of services (Hardiker et al, 1991). From this point of view it is essential first to consider how the two 'welfare regimes' Portugal and Britain represent differently constructed types of welfare system. Nonetheless, a loose working definition is required to make comparison possible in the first place. Lena Dominelli works with a broader definition suggesting that '*The welfare state compromises those public and domestic relationships which take as their primary objectives the well being of people'* (1991: 9). A rather more limited definition was chosen as the starting point for the present research i.e. those policy areas generally associated with a relatively narrow use of the term 'welfare state', namely the involvement of the state in social security & social services; that is those in which states take on responsibility for providing a range of welfare services and/or benefits to their citizens (Cochrane & Clarke, 1993: 4).

This should not be taken to imply that direct state provision is a necessary or a defining characteristic of welfare states. On the contrary, according to Cochrane & Clarke (1993: 5), there is likely to be a 'mixed economy' of welfare, whose precise mix will itself be different in different countries, involving the state, the market, non-statutory organisations and networks of informal carers.

There are a number of difficulties in making comparison in welfare system. First of all, the welfare system in each country is unique in its national, social and historical context. Secondly, cultural values, economic forces, demographic factors etc. have influenced the structured diversity of each system (Ginsburg, 1992). Finally, increasing attention is being paid recently to the fact that social policies are not made by and within national states but they are also made by international organisations and supranational institutions (Burden, 1998).

There is not any meaningful explanation regarding the service provision for visually disabled people unless it is firmly set within the context of the Portuguese and British's overall collective provision for social welfare. It is the nation's perception of the value and the efficacy of government intervention in promoting individual welfare that stimulates the outcomes.

According to Ferrera (1996: 18) and Castles (1995: 292) the literature on comparative social policy has so far failed to include the south European welfare states systematically within its scope of observation. None of the great research efforts of the 1980s (e.g. Flora and Heidenheimer, 1981; Flora, 1986/87; Esping Andersen, 1990; Castles, 1989 and 1993a etc.) included Portugal in their samples. While before 1975 Portugal was poor, undemocratic, reported inadequate data and had just a few income maintenance programmes, after that the Portuguese welfare system developed substantially.

The Portuguese welfare state started approximately in 1935. Nevertheless, until 1974 the welfare provision consisted of compulsory social insurances for workers only. After the end of the dictatorship in 1974, the welfare provision became universal, i.e., for all citizens. However, after 1980 the Portuguese state was already in debt (Carreira, 1996). In contrast, the Nordic and Central European welfare states started at the end of the 19th century. Until 1945, the welfare provision consisted of compulsory social insurances for workers only. After the Second World War the welfare provision became universal. However, in the 70s these welfare systems were facing a crisis period due to an international economic recession (Carreira, 1996).

Consequently, the Portuguese welfare state has started when the Nordic and Central European welfare states were fully implemented and in a time of a worldwide economic crisis. Carreira (1996) considers that there are two main reasons for the lateness in the Portuguese welfare state. The first being the long period of dictatorship in Portugal[3]and the second the fact that Portugal only started its industrial revolution after the 1950's. Until then, Portugal was mainly an agricultural country.

As Ferrera argues the '*south European countries may well constitute a separate cluster in the universe of welfare states* '(1996: 18). They have common policy traits such as the 'rudimentary' character of welfare programmes (Leibfried, 1992), the influence of both Catholicism and Communism[4] in moulding these programmes, in a context where the traditional family still plays an important role (Castles, 1993b). However, for certain programmes the Portuguese welfare regime is far from being rudimentary mainly due to the influence of left governments after the revolution of the 25 April 1974. The Portuguese left has fought hard since the 1970s in order to promote broad welfare reforms in socialist directions. For example, cash benefits (especially pensions) constitute extreme versions of the 'transfer-centred model of social protection' typical of continental Europe (Kohl 1981, Esping Andersen, 1990; Kosonen, 1994).

The most distinctive trait of the welfare system in Portugal is the dualistic protection that it offers. As Ferrera points out '*On the one hand, the scheme (*of income maintenance) *provides generous protection (e.g. pensions) to the core sectors of the labour force located within the regular of 'institutional' labour markets; on the other hand, they only provide weak subsidization to those located in the so-called irregular or non-institutional market '*(1996: 19). However, this situation is changing gradually. For instance, the National Minimum Income Scheme for individuals and families with insufficient resources was introduced in Portugal in July 1997.[5] By contrast, the same scheme was introduced in Britain in 1948.

Another important trait is the welfare manipulation in Portugal that takes the form of political clientelism, i.e. favours exchanged for support to a public organization, such as votes for a given party (Ferrera, 1996: 25). Closely linked with the clientelistic model of social welfare in Portugal is the role of the family and family networks as the dominant route to employment and to wider social relationships. Family strategies and efforts aim to improve their members access to clientelistic clusters and discretionary benefits. Consequently, family is a central redistribution unit and a primary support for its members against unemployment, poverty and social disadvantage (Ferrera, 1996). Therefore, notions of individual responsibility and individual citizenship are novel, not only at the level of the state, but in the family centred culture.

According to many authors (Ferrera, 1996; Carreira, 1996; etc) the structural crisis of the Portuguese social protection will not be easy to overcome. In addition, the Portuguese welfare state has currently important external challenges stemmed from the process of the European Union and Monetary Union (Euro) and, more generally, from the increasing globalisation of the world economy. These developments are exerting pressures for budgetary discipline, bureaucratic rationalization and the containment of non-wage labour costs in order to maintain 'systemic' competitiveness. Therefore, as Ferrera states (1996: 31) they are increasingly forcing the Portuguese welfare state to restrict its social programme, thus jeopardising its chance of fully catching up with the rest of Europe.

To summarise, the Portuguese welfare state is characterized by a peculiar model of political functioning, which distinguishes it not only from the highly homogeneous, standardized and universalistic welfare states of northern Europe, but also from the more fragmented continental systems. In Portugal welfare rights are not embedded in an open, universalistic, political culture and a solid, weberian, state impartial in the administration of its own rules. Rather, it rests on a closed, particularistic culture. In addition, the Portuguese welfare state is characterised also by an absence of substantial social services, and a paternalistic and centralistic state tradition.

There is general agreement that Britain's classic welfare state was established between

1944 and 1948 with the adoption of Keynesian economic policy and Beveridgean social policy. Between those years, to a greater or lesser extent, political parties converged upon the belief that the welfare of the people is ultimately a collective responsibility of the sate (Morgan & Evans, 1993). According to Gladstone (1996: 14) the British classic welfare state had two main dimensions: full employment and extensive range of universal public services. A high level of personal taxation was the method labour used, as the means of realising their social objectives, between 1945 and 1970.

This period of the post-war settlement itself divides into two eras. The 1940s to the early 1960s was an era of austerity in material welfare terms, of great optimism about the benefits of the welfare state and of relatively little conflict and pressure over welfare issues. The period from the early 1960s to the mid 1970s, by contrast, saw a rediscovery of mass poverty, unprecedented expansion of welfare expenditure and the emergence of pressure groups and new social movements advocating a wide range of unmet welfare needs amongst poor people, elderly people, the black communities, women and so on. In the mid 1970s the welfare state in Britain was in crisis with unemployment standing at just under one million (Lowe, 1998: 1). This crisis in the welfare states was not peculiar to Britain but was experienced in all western industrialized countries. From 1974 to 1979 the Labour governments struggled to deal with the pressures from the 'welfare lobby' in the context of recession and inflation by inaugurating the transformation of the welfare state consensus.

The values of Thatcherism appeared after 1979 to continue to challenge the principles implicit in the classic welfare state. Nevertheless, as Gladstone (1996: 18) highlights, social expenditure continued to rise, the level of taxation increased and significant continuities with the past persisted. We can see, however, especially after the Conservatives' third election victory in 1987, new policy initiatives were introduced that have created a more market orientated welfare system. To Wilding (1992) the key facets of thatcherism were: challenge to collectivism, promotion of markets, new managerialism, cutting expenditure, reduced role for local authorities, changes in aims, purposes and values, centralization, mixed economy of welfare and regulatory sate. Many obstacles and forms of resistance from consumers, welfare professionals, the Treasury, local government and so on seriously thwarted this project.

According to the three-model explanation drawn up by Esping-Andersen in 1990 (Alcock, 1996: 175), Britain fits into the 'Liberal' welfare state model which is principally characterized by an emphasis on market based social insurance and the use of means-testing in the distribution of benefits. Levels of universal payments and forms of social insurance are modest and welfare is largely orientated towards a class of the poor, dependent on the state. The reason why benefits are limited or as said by Ruxton (1996) stigmatised is because this model assumes that higher levels of benefits will reduce incentives to work. Private schemes are encouraged for those who wish to go beyond the minimum and in some cases may be actively subsidised (Harder, 1997: 7; Ruxton, 1996: 36).

It is also appropriate to look at the work of Lorenz (1994: 22-28) because he considers different welfare models[6] which are combinations of Esping-Andersen's analysis and Leibfried's typology from 1992 (Alcock, 1996: 175). The 'Residual' welfare state, into which Britain fits according to this author, focuses on supportive measures outside the labour market, which makes the means test a pivotal device in ensuring both minimum subsistence levels and the willingness to work. To Lorenz (1994: 23) the universalism once envisaged by Beveridge[7] has in Britain given way to the dualism of state and market in insurance, housing, education and also in the privatisation of health and community care services.

Portugal and England: service provision for visually disabled adults by Social Services Departments

The review deliberately sought to identify systematic work of a research nature carried out by local authorities, as well as studies based in academic settings and independent research institutes, both in Portugal and in England. To the best of my knowledge, there exists no research that compares the service provision for visually disabled adults by SSD's in Portugal and England. It is also unlikely that a research had been carried in Portugal about the service provision for adults with a visual disability by SSD's. I could only find two Portuguese researches that relate broadly to my topic.

Francisco Branco (1990) has carried out a research about the relation between local authorities and social policy in Portugal. This author makes a valuable contribution in regards to the role of local authorities with the implementation of democracy in Portugal in 1974. This research is one of the most comprehensive pieces of literature about this topic. According to this author, the central government is the main provider of social services to individuals given that Portugal lacks an institutional framework enabling regional, municipal and voluntary agents to play a significant role in the development of social services. The civil society, through charity and voluntary organisations, also provide direct services to individuals and communities based on agreements with the Department of Social Security. Finally, the central government allocates insignificant powers, duties and scarce resources to local authorities in the social sphere (Branco, 1990: 186-189).

In regards to disabled people (including people with a visual disability) Social Services Departments have a duty to build or help financially other organisations to build equipments, such as centres for disabled people. They have also a duty to co-operate with local organisations in partnership with the central government in social programmes and projects (Decreto Lei No.159/99 of 14 September: 6301). To conclude, the value of this research was to highlight the minimal role of SSD's in Portugal in the provision of direct services to individuals. In fact, direct services are provided either by the central government or by the informal sector (family and friends) and local organisations, and SSD's only and main duty is to help financially those organisations.

The second research consists of a national survey to 142.112 disabled people carried out in 1998 by the *Secretariado Nacional Para a Reabilitação e Integração das Pessoas* *com Deficiência* . The aim of the research was to understand how disabled people viewed themselves as disabled, and how their impairments affected or not their roles in society, particularly in terms of behaviour, employment and social participation. The value of this research was to highlight the lack of rehabilitation services available to disabled people in Portugal. In regards to people with a visual disability aged 16 to 24 only 31,23% have or had access to rehabilitation services; aged 25 to 34, 20,41%; aged 35-44, 19,74%; aged 45 to 54, 13,99%; aged 55 to 64, 23,05%; aged 65 to 74, 21% and aged 75 and above, 13,88% (S*ecretariado Nacional para a Reabilitação e Integração de Pessoas com Deficiência*, 1998: 140).

Regarding to the type of rehabilitation, the medical rehabilitation is the most significant followed by lower percentages of visually impaired adults that have or had access to special education, professional rehabilitation, labour integration and, at last, social rehabilitation. Firstly, only 28,32% of visually disabled adults aged 16 to 24 have or had access to medical rehabilitation, 28,11% to special education, 14,36% to professional rehabilitation, 12,47% to social integration and 10,92% to labour integration. Secondly, 42,08% of visually disabled adults aged 25 to 34 have or had access to medical rehabilitation, 32,61% to special education, 9,88% to professional rehabilitation, 6,73% to labour integration and 1,44% to social integration. Thirdly, 71,61% of visually disabled adults aged 35 to 44 have or had access to medical rehabilitation, 17,93% to special education and 9,33% to labour integration. Finally, 70,29% of visually disabled adults aged 45 to 54 have or had access to medical rehabilitation, 12,94% to special education, 6,99% to professional rehabilitation, 6,20% to labour integration and 2,06% to social integration (Secretariado Nacional para a Reabilitação e Integração das Pessoas com Deficiência: 176).

It can be seen that the medical model of disability is implicit in the research. Services for visually disabled people in Portugal are centred around the discourse of 'rehabilitation' in which disabled people are expected to learn new skills and strategies to maintain personal and economic self-reliance. In conclusion, the overall emerging picture from the research at this time is a concerning one in regards to measures of rehabilitation available to visually disabled adults in Portugal.

With regard to England, the National Assistance Act (1948) was designed to supply residential accommodation and other services for disabled people and to assist with their financial needs. A major recent piece of legislation is the 1990 National Health Service and Community Care Act. According to the White Paper Caring for People (1989), community care means providing services and support to everyone who is affected by problems of ageing, mental illness, or learning, or physical or sensory disabilities. This act affirms the value of a non-institutionalised and non-segregated lifestyle and the ideal that disabled people should make their own decisions and achieve their full potential. It acknowledges that services should be sensitive, flexible, and tailored to the needs of the individual. The act formulates a move away from service-led towards needs-led provision, where the needs of individuals determine what kind of services they receive.

Generally, the whole situation of community care has been transformed and this new legislation has established the partial privatisation of the welfare state. As a result there is a transfer of responsibilities from formal to informal provision and community care has been identified as being '*care by the community'* and not as *'care in the community'* (Clark, 1996; Symonds, 1998). Within this mixed economy care is provided by four main agencies: the sate, the voluntary sector, the private sector and the informal sector (family and friends). Consequently, the emphasis is firmly away from the state as provider (Symonds, 1998) as the professionals who assess the needs of visually disabled people are no longer the providers of the service which, in theory at least, may increase choice.

Assessment is still the gateway to services, however, and there is no automatic provision, but if a need is identified the local authority, through its Social Services Department, is legally obliged to provide it. A new breed of professionals called 'care managers' draw up a 'care plan' based on the assessment for each visually disabled person entitled to it. The care plan is, in theory, intended to ensure that the needs of individual visually disabled people are met. An important recent development in community care is direct payment to disabled people, including visually disabled people, whereby they can purchase their own care as they see fit (Zarb, 1995).

Another important development in this legislation is the introduction of users' involvement in the assessment and planning of the services through consultation. The National Health Service and Community Care Act 1990 creates an explicit expectation of users participation, firstly at case level and secondly at planning level (Connor and Black, 1994). Consequently, participation appears to be an important idea and an opportunity for visually disabled people to be involved in the planning and development of the services. It seems that there is a redistribution of power in service delivery and that disabled people have gained a more 'say' and control over their lives. As Beresford (1999) stated this development provides 'the starting point for broader action and thinking on participation and democratisation' (Beresford, 1999: 12). Nevertheless, many writers (Bewley and Glendinnimg, 1994; Macfarlane, 1996; Beresford et al, 1997) commented that there are limitations to the consultation procedures in the UK. These include:

§ People with sensory impairment may not be represented because there is a lack of information in accessible format;

§ Non users of services are not represented;

§ There is not any clarification to the question if representatives are selected or elected and by whom;

§ The agenda for planning meeting were set by those with statutory responsibility and upon guidelines set by central government;

§ Planning timetables should take into account the time which is required for these meetings;

§ The cost and distances required to travel should be considered as well as the physical accessibility of the venues;

§ Budgets restrains. Representatives usually are not paid in recognition of the time and energy they contribute.

This act does not, however, appear to have had a great deal of impact on the lives of visually disabled people. Services and resources are no longer a right but are provided at the discretion of the care manager who has the imperative to target services on those in greatest need. Recent reports detail the low priority afforded to visually disabled people by Social Services Departments as well as poor practice, weak inter-agency collaboration at the registration stage, and inadequate or inappropriate services (Lovelock et al, 1995; James and Thomas, 1996).

Lovelock (1995) was commissioned by the Department of Health to identify and review recent and current research to meeting the social support needs of visually disabled people, and to advise on future research priorities in this area. This author found several studies about service provision for visually impaired adults by SSD's in Britain, carried out either by specialist academic or independent research centres, or by SSD's or local (or small national) voluntary sector organisations. The main findings of the overall research carried out about service provision for visually disabled adults by SSD's are as follows (Shore, 1985; RNIB (Deaf-Blind Services Liaison Group), 1988; Best et al, 1987; DHSS, 1987a, SSI 1988b; University of Birmingham/Dept. of Social Policy and Social Work, 1995; Lovelock et al, 1995; RNIB/Scotland, 2000):

§ The needs of visually disabled clients have been accorded a low priority in relation to those of other clients of SSD's;

§ SSD's experience difficulties in maintaining and managing their register of blind and partially sighted people;

§ Specialist staff are scarce and have not fitted easily into the variety and often succession of operational and management structures which have been developed over the last few decades, although little attention has been given to this problem;

§ Visually disabled clients with additional disabilities do not fit easily into the service systems designed with reference to a single 'category' of client; also, any one local authority area is likely to have relatively small numbers in such special needs groups.

Many disabled people believe that the 1990 National Health Service and Community Care Act, like other previous legislation, is both paternalistic and dependency creating (Davis, 1994). Disabled people still have to go through a professional to attempt to acquire what other people may take for granted. Disabled people argue that money would be better spent in removing the social and physical barriers within society which prevent their full participation in everyday life. If the environment were adapted disabled people would be in a far better position to earn their own living which many people have found possible when they gain direct access to funding (Oliver and Zarb, 1992).

Professional practice with visually disabled people in England seems firmly rooted in the medical model of disability for example, it is the only form of impairment that requires medical certification before registration. Additionally, specialist services for visually disabled people are embedded in the discourse of rehabilitation.

Disabled people have gradually come together to campaign for change and a strong Disabled People's Movement has emerged (Campbell and Oliver, 1996). Many visually disabled people are active members of this movement. This Disabled People's Movement consists of organisations **of** disabled people, that is organisations which are controlled by disabled people themselves, although many welcome non-disabled allies. This is in contrast to organisations **for** disabled people such as The Royal National Institute for the Blind. Oliver (1995) points to growing evidence that a new kind of welfare state is emerging in England which will be based on rights, entitlements and consumer control.

Discussion about the main findings

Structure of the SSD in relation to the services provided to visually disabled people

The Portuguese SSD is one of the two sub-divisions of the Department of Education and Culture[8]. It is also a unified social service department which caters for the elderly and the disabled as well as children. By contrast the English SSD is divided into the following sub-departments: Adoption & Fostering, Asian Services, Childcare Information, Child Protection Committee, Domestic Violence, Elderly, Learning Disability, Mental Health, Physical Disability, Shared Care and Support Care. The Sensory Disability Services, which includes both hearing and sight disabilities, is part of the Department of Physical Disabilities[9]. We can see, then, that the structure of the SSD is remarkably different in both case studies, which confirms the emerging overall picture of the literature review.

Statistical background material

The Portuguese city chosen is one of the largest cities in the district of Lisbon with a population of about 190,070 in 1998 (*Ministério do Trabalho e da Solidariedade*, 1999: 4).[10] Furthermore, it is considered to be a multi-cultural city with a significant proportion of inhabitants from the former Portuguese colonies in Africa. Politically the council is run by the Socialist Party. According to a national survey carried out by the Secretariado Nacional Para a Reabilitação e Integração das Pessoas com Deficiência in 1998 there are 1402 blind or partially sighted people in this district. As stated by the professional interviewed no visually disabled adult contacted this SSD between January 1999 and October 2000.

The English city chosen has 486,400 inhabitants[11]. As in many British cities this northern city, too, is marked as a multicultural and multi-faith society. Politically the city has a Labour run council. National statistics indicate that there are 4,000 people registered within this district as blind or partially sighted. A national survey suggests that this figure represents only 25% of the people who could be registered. According to the Directorate of Social Services Business Plan 1999-2000, the Sensory Disabilities Services receive about 750 new referrals per year and up to 350 of these results in registration as blind or partially sighted. Although it seems that there are a significant number of referrals, the actual registration figures are much lower. The number of referrals per week are currently between 10 and 20 cases, and are actually increasing year by year. In addition, the great majority of blind and partially sighted people are aged 75 years and over.

Expenditure

It can be seen that the Portuguese SSD allocated 8.650.000 Esc (£27,680) to be spent on all types of disabilities (Plano de Actividades, 2000). As to the English case study this SSD allocated £647,900 to be spent on sensory services, which includes deafness, blindness, or both. Moreover, they also allocated £1,421,400 to spend on occupational therapy for both physical and sensory disability (Directorate of Social Services Business Plan 1999-2000). Although it is extremely difficult to make a direct comparison between the Portuguese and English expenditure in visually disability, it appears that the budget of the English SSD is significantly higher than the budget of the Portuguese SSD.

These findings confirm the research carried out in Portugal (Secretariado Nacional Para a Reabilitação de Pessoas com Deficiência, 1998) which highlighted the lack of rehabiliation services available to visually disabled people. Furthermore, in another research project Branco (1990) found that the central government allocates insignificant powers, duties and scarce resources to local authorities in the social sphere. Conversely since 1960 allocation of significant powers and duties to local authorities followed by real expenditure started to grow and SSD became the fastest growing area of British welfare (Lowe, 1999).

SSD's duties and responsibilities towards visually disabled people

With respect to the Portuguese case study, both interviewees stated that this SSD have the duty to fund projects from local voluntary organisations, which provide services for disabled people, through a programme called 'Programa de Apoio ao Movimento Associativo' (i.e. programme to support local voluntary organisations). However, these organisations are responsible for coming forward every year. Furthermore, this SSD can sometimes act as a partner in specific projects. In view of the above and as pointed out in the literature review, in regards to disabled people (including people with a visual disability) SSD's in Portugal have a duty to help financially other organisations to build equipments, such as centres for disabled people. They also have a duty to co-operate with local organisations in partnership with the central government in social programmes and projects (Decreto Lei No.159/99 of 14th September: 6301).

Conversely the English SSD have the duty to undertake an assessment of individual need, following the client's registration as blind or partially sighted which occurs at the hospital. Nevertheless, the registration process appears to be based on the medical model of disability and visually disabled people are characterised as dysfunctional and in need of intervention and administration from medical and social services. Moreover, it has emerged from both interviews with a specialist and the manager that some people may feel stigmatised being registered and perhaps refuse to be registered as possibly a sign of not facing up to their situation or may think that registration is not worthwhile. However, although being registered is a pre-requisite for receiving services, visually disabled adults can still have access to some services by SSD.

Professionals in England use a range of assessment tools and formats in order to ensure that their assessments are suitable for the situation in question (Business Plan 1999-2000). If there are any issues arising from that initial assessment, professionals may then go on further to do mobility or daily living skills assessments or possibly some aspects of social skills. The person must be seen as a whole. However, as pointed out by the specialist interviewed, while it may be true that the assessment is, in theory, intended to ensure that the person is seen as a whole and the needs of individual visually disabled people are met, in practice, there is not always adequate provision due to the lack of resources.

It seems, therefore, that although the assessment process introduced by the National Health Service and Community Care Act 1990 acknowledges that services should be sensitive and flexible to the needs of the individual, in the reality it is still a service-led assessment rather than a needs-led assessment. Many commentators (Bray and Preston-Shoot, 1995; Fisher, 1999) argue that the assessment is firmly under the control of the professionals, not of the service users and in the light of the services available. Thus, care managers tend to concentrate on 'normative need' that is need 'as assessed by professionals and experts' (Balloch, 1999: 19).

Comparing the two case-studies, it appears that the English SSD provides direct services to visually disabled people while the Portuguese SSD allocates the resources to other organisations in order to enable those organisations to provide services. Secondly, it seems that the Portuguese central government allocates insignificant powers, duties and scarce resources to local authorities for services to visually disabled people. On the contrary, the English central government allocates significant powers, duties and real expenditure to local authorities in this sphere. Finally, in both countries services are based on statutory provision, but in Portugal service provision by SSD's is limited because local authorities have a restricted role.

Services for visually disabled people

As pointed out by the Portuguese specialist interviewed, this SSD does not provide direct services to visually disabled people. Alternatively, they fund projects from local private and voluntary organisations that work directly with disabled people. Currently, there are five organisations in this district that work with disabled people, each organisation concentrates on the following disabilities: organisation No. 1 for disabled adults with cognitive, personal and mobility difficulties; organisation No.2 for children and young people with profound learning disabilities; organisation No.3 for families who have disabled children and/or adults in their family; organisation No.4 for young people and adults with hearing disabilities; and organisation No.5 promotes awareness of the difficulties faced by disabled people in the community. There is also a project which is being run in partnership with one voluntary organisation in the district. They provide practical support in the home, such as day care, specialist equipment, training and employment opportunities for all disabilities and child care for disabled children. In this district there is not yet an organisation which focuses specifically on visually disability but visual disabled people can have access to limited services provided by the above mentioned organisations.

According to the Business Plan 1999-200 the following services are provided to visually disabled adults by the English SSD: practical support in the home, such as day care; rehabilitation and therapy, which included packages of care which are part of a rehabilitation or therapy programme; specialist equipment and adaptation for sight loss around the home, e.g. symbol canes, etc.; respite care; permanent placements in residential or nursing home; accessible transport to allow access to services; training and employment opportunities; supported day activities, such as a day service for blind/partially sighted people; emergency call and telephone installations for disabled people, such as emergency call service; access to specialised information, e.g. holiday and recreational activities; social work support; care management, to adults whose primary need for services stems from their sensory loss; and supported housing, to support visually disabled adults to live as independently as possible.

To summarise the evidence suggests that in Portugal there is not a specialised service provision for visually disabled adults but a generic service for disabilities within a generic social services department. On the contrary in England the service provision is specialised based on the assumption that specialised social services are more able to address the specific needs of each group. In the British case study service provision is specific for visually disabled people. Furthermore, it appears that the service provision in England is much wider and comprehensive than in Portugal.

Partnership with other agencies

As mentioned previously this Portuguese SSD does not provide direct services to visually disabled people. In fact, all the services are provided through partnership with private and voluntary organisations in the district.

Through both documentary analysis and interviews it has been found that the English SSD works in partnership with independent and voluntary organisations as well as with other council departments, such as housing, health, etc. However, as highlighted by the manager SSD are the '*gate keeper and are able to send people to different directions'* . However, the specialist fears that '*the issues of visually impaired maybe addressed more and more away from local authorities into the private agencies which could be detrimental*". The mixed economy initiated by Thatcher is reflected in the National Health Service and Community Care Act 1990, which has established the partial privatisation of the welfare state. The main problem that derives from this legislation is that professionals who assess the needs of visually disabled people are no longer the providers of the services.

In Portugal the service provision for visually disabled adults in this SSD is based upon partnership with local organisations. Therefore, the service provision is totally dependent on partnership. In England although they work in partnership with several organisations, they also provide a number of significant direct services and are the gate keepers.

Specialists' role with visually disabled adults

The Portuguese SSD is a unified social service department and, therefore, has a generic approach towards social work. It is constituted by one manager with a social work background, 5 social workers and 3 psychologists. The main roles of this team are to identify the social needs in the community, to plan and organise a service provision in partnership with the local organisations, to allocate resources and monitor the service provision in the district. As a result those specialists do not work with individual clients but have an overview of all the projects run by local organisations. Although local organisations have some autonomy, their progress is monitored by this Portuguese SSD.

The Sensory Disability Services of the English SSD, which includes deafness and visually impairment, is constituted by 5 qualified social workers, 1 qualified BSL interpreter, 3 level 2 communicators, 2 rehabilitation officers, 2 x C&Gs, 1 NVQ level 3 business admin. The main responsibilities of the social worker are to undertake the assessment and to draw up the care plan based on that assessment for each visually disabled person entitled to it. In addition, the social worker as well as other specialists in the team are responsible for making referrals to other specialists or agencies. Counselling services may also be provided by social workers if they have attended a counselling course. The rehabilitation officer is also an important specialist in the team. This professional must have a Diploma in Visual Impairment Studies which has a mobility training component on one hand, and on the other hand a technical officer component, which is a sort of daily living skills and communications. Therefore, the rehabilitation officer assists the visually disabled individual with practical skills, such as daily living or mobility skills.

To sum up briefly the main difference between the two countries as far as the professionals' role is concerned is that the Portuguese SSD have a generic approach while in England professionals are specialised in visual disability issues.

Monitoring quality of services

As far as the Portuguese SSD is concerned the quality of the services provided by the local organisations is monitored through regular meetings not only with the senior management and professionals working in those organisations but also with the service users. As pointed out by the manager interviewed, the Portuguese SSD's concentrates on the following areas when monitoring the quality of the services provided by the local organisations: support of independent living in the community, development of training and work opportunities, removal of architectural barriers in the local communities and involvement of service users in the service provision and their feedback. Although we have obtained general information about monitoring the quality of services, we were unable to highlight the priorities as far as visually disability is concerned because there are not any specialised services for visually disabled people in this district.

The English SSD have set a number of realistic performance targets in their Business Plan 1999-2000 in order to develop their service provision, such as improving their timescales in providing equipment or recommended adaptations, and in responding to care management assessments. They also focus on extending the direct payments scheme, on increasing the range of living options and on obtaining service user feedback. Another important element for monitoring quality of services is the Directorate's formal Compliments/Complaints procedure that they have established in order to facilitate the service users' feedback on the services they receive. Additionally they have consultative committees with service providers, service users, their carers, representatives from the local community and staff. An example of a major exercise consultation is the 'Sensory Needs Review', with all local independent sector specialist sensory organisations involved, in addition to public meetings and the three user forums.

Overall in the Portuguese case study monitoring of the quality of the services is based on guidelines developed by each SSD and it appears to be less comprehensive. On the contrary in the English case study the guidelines appear to be provided by the central government through Best Value, Quality Protects, etc. and the quality of the services provided to visual disabled adults is monitored on a regular and systematic basis.

Users' involvement and participation on service provision

According to the interviews in both SSD's there is an interest in developing mechanisms to obtain information about the users' views. In addition, it appears that in both SSD's users' involvement is a crucial element in the development of user-led services.

In Portugal this has been established on an informal basis because the majority of the local organisations have been developed by service users themselves after 1975 as an attempt to enhance the limited services provided by the state. It appears, therefore, that service users in the Portuguese case study have a say in the planning and development of those organisations. Although in some cases this informal mechanism guarantees service users' involvement and participation, it might not be always the case because it depends on how powerful and influential the service users are.

On the contrary in England users' perspectives on service provision has been established through legislation (National Health Service and Community Care Act 1990). According to the information obtained through the interviews, professionals consider users' involvement to be of paramount consideration. Although it was mentioned in the interviews that visually disabled clients can refuse services, this does not necessarily mean that they actively contribute to the assessment of their needs. Moreover, one of the limitations of this research is that service users were not included in the sample, and, therefore, their perspective has not been obtained.

To summarise it appears that generally in Portugal service users are more actively involved in the planning of services because of the deficit of legislation and subsequent lack of services. On the contrary, in England because services have been well established through statutory provision, professionals play an important role in the service provision.

Social model versus medical model of disability

As it appears from both case studies professional practice with visually disabled people seems routed in the medical model of disability. Services for visually disabled people in both countries appear to be embedded in the discourse of rehabilitation as they focus on minimising the negative effects of impairment and not in removing social and environmental barriers. In addition both SSD's tend to intervene mainly at a personal level and lesser at a more structural and organisational level to challenge the disabling barriers that prevent visually disabled people from participating fully in society.

Conclusion

It is argued that any meaningful explanation regarding the service provision for visually disabled people by SSD's should be set within the context of the Portuguese and British welfare state. It has emerged from the literature review that there are significant differences that shape both welfare states. Portuguese welfare state started developing after 1975 while the British welfare state was established at the end of the 19th century. Moreover their structure is based on different welfare models. The Portuguese welfare state is characterised as a 'rudimentary' welfare state. In other words, welfare rights in Portugal are not embedded in an universalistic culture, there is an absence of substantial social services and a paternalistic and centralistic state tradition. Another distinctive trait of the Portuguese welfare state is the dualistic protection that it offers. On the one hand, it provides generous protection to those located within the regular of 'institutional market'. On the other hand, it only provides limited protection to those located within the non-institutional market. By contrast the British welfare state has been influenced by liberal welfare regimes and by social democratic models. The social democratic model is characterised by the principal of universality and the state provides universalistic services, premised on equal opportunities and full employment. The liberal welfare model has made an attempt to minimise direct intervention by the state and it depends on marked based social insurance approaches.

There is also a difference in the service provision for visually disabled people in both countries because these SSD's are structured differently and they exist within different economic social, cultural and political framework. Whilst SSD's in Portugal have a minimal role in the provision of direct services to individuals, SSD's in England are the main providers of services to individuals and became the fastest growing area of welfare since the late 1950s. It has been found that the Portuguese central government allocates insignificant powers, duties and scarce resources to local authorities for services to visually disabled people. In Portugal all services are provided through partnership with voluntary organisations and SSD do not provide direct services. On the contrary, the English central government allocates significant powers, duties and expenditure to local authorities which are the gate keepers. In Britain, within the mixed economy, there is a variety of service providers (SSD, independent and voluntary organisations and other council departments) and, therefore, visually disabled clients can potentially decide which service provider they want to use. Additionally in Portugal there is a generic SSD whilst in England service provision is specialised in many different social areas and client groups.

Evidence suggests that the service provision in England is better developed, more comprehensive, based on specialised service provision and has a long and well established history. On the contrary in Portugal the welfare state has been established quite recently and service provision by local authorities is limited only providing weak subsidization to visually disabled people. However, in England gaps in the service provision have been identified in areas such as, waiting list, staff levels, counselling services, supported housing and community centres. The lack of resources is also obvious in the lack of training facilities for visually disabled people to embrace the new technologies. Moreover, it has been found that in Portugal there are fewer opportunities for independent living, training and employment opportunities, counselling services, and respite care. It appears that those services are underdeveloped because the family unit is a primary support for its members against unemployment, poverty and social disadvantage. Although on the one hand this may have some advantages, on the other hand it is an obstacle to the development of appropriate services for visually disabled people.

Both SSD's appear to monitor the quality of the services provided. However, in Portugal the monitoring seems to be less formal than in Britain. As far as England is concerned guidelines are provided by the central government and monitoring is carried out on a more systematic basis.

With respect to users' involvement and participation in the service provision both SSD's have an interest in developing mechanisms to obtain information about users' views. In England this is a statutory requirement established by the National Health Service and Community Care Act 1990. In Portugal this has been developed on a more informal basis because many local organisations have been established by service users themselves. In fact Portuguese service users gained power and influence in service provision by establishing their own organisations after dictatorship. However, their power gradually diminished as these organisations started to be funded by the central government and SSD's. As a result these organisations are increasingly run by professionals although service users still participate in the planning and development of services. Therefore, it seems that in Portugal service users are more actively involved in the planning of the services due to the political, cultural and historical context within which mechanisms of involvement and participation have been developed. Nevertheless, it appears that users' involvement is a field for further improvement in both countries. Furthermore, users' groups advocate that their involvement in the planning of the services is more reliant on consultation than on participation. It is proposed that the 'reflective practice model' mentioned in the literature review might best acknowledge users' involvement and participation in the service provision because both professionals and service users work in partnership.

Although significant knowledge has been obtained through both case studies, documentary analysis and literature review, there are still some areas that need further exploration, such as statistical information on qualifications, employment rates, independent living and quality of life. In addition, further research is needed in order to understand the role of gender, ethnicity, social class, sexual orientation and age on the experience of visual disability in both countries. It is also important to ascertain the users' views on the quality of the services they receive as well as their views about their involvement and participation in the service provision. Overall the researcher would like to consider this exploratory case study as a prelude to more detailed research to be undertaken on this area in order to recommend policy changes.

Notas

[1] Oliver suggests that the current definition of the World Health Organisation emphasizes that disability is reducible to the individuals. According to this definition: "a) impairment is an abnormality in function; b) disability consists in not being able to perform an activity considered normal for a human being" (cited in Chadwick, 1996: 26)

[2] Oliver suggests that disability research can be an alternative to the existing research theory and methods. Emancipatory research is based on the social model of disability and takes into account the social barriers that produce disability (Barnes and Mercer, 1997).

[3] From 1928 to 1974.

[4] This may seem a contradiction but in Portugal the presence of strong and deeply socialist/communist sub-cultures has made a significant contribution towards shaping the Portuguese social policies.

[5] Legislation No. 19-A/96 dated 29 June 1996.

[6] The Scandinavian model, the Residual model, the Corporatist model and the Rudimentary welfare model.

[7] The Beveridge Report in 1942.

[8] This information was obtained from the Portuguese Council's website.

[9] This information was obtained from the British Council's website.

[10] The total population of Portugal is about 10 million people (EIU Country Report 1st quarter 2000).

[11] The total population of the United Kingdom is about 59 million people (mid-year official estimate 1997).

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