III. DETERMINING NEEDS

A. Defining "need"

Defining and determining need is easier said than done. It is not value-free, as who determines it, how it is determined and for what purpose it is done, will all affect the outcome. Neither the methods used to identify needs nor the concepts of social needs have been clearly defined. It is broadly understood that the ideologies of need will guide the methods of identifying need, thus directing the types of social services in meeting the need (Smith and Harris 1972). There are a few approaches in social services in conceptualizing need, from a person-oriented to policy-focused perspectives.

B. Types of needs

Maslow (1954) suggested that human needs could be structured into five categories in a hierarchy of ascending order of prepotency and probability of appearance: (a) physiological; (b) safety and security; (c) belonging and love; (d) esteem; and (e) self-actualization. With reference to service provision, it has been claimed that services should be geared to meet these needs, as social problems are the results of these needs not being met. Going along with this framework, Harvey (1973) has noted, from a policy point of view, nine areas of needs: (a) food; (b) housing; (c) medical care; (d) education; (e) social and environmental services; (f) consumer goods; (g) recreation; (h) neighbourhood amenities; and (i) transport facilities. While these definitions of needs are functional and do provide a loose boundary for what may be considered as need or no-need, they may not be able to differentiate the needy from the no-need groups. In this regard, Bradshaw (1972) has provided a methodology in making a 'real' need possible. His proposal was to first delineate four types of social needs, namely, (a) normative; (b) felt; (c) expressed; and (d) comparative, then to examine their presence in a given situation. The presence of all types of needs is equated to real need.

Normative need tends to be professionally defined and has a knowledge base. A desirable standard is set by professionals, policy makers or social scientists, against which the actual standard is compared. Those below the standard are said to be in need of support and special services. A good example is the intelligent quotient (IQ) which is used to indicate people with special needs (below a score of 80 is defined as moderately retarded). Social security entitlement is also normatively defined. People's need is measured against their assets. Only if the asset value is below a set amount, which is defined by policy makers, then eligibility results. Indeed the setting of the amount is not value-free, it is relative to the socio-political and economic situations, and may change from time to time.

A *felt need* is equated to what people want. It can be defined easily by asking service users or potential users what they wish to have. Hence, a felt need can be inflated by users' reference to their own high expectation (for example, a housing unit reaching a good private market standard). A felt need can be deflated by the potential users' ignorance or rejection of services (for example, many Asians often lack understanding of a personal counselling service and so reject it).

An *expressed need* is generally taken as equivalent to demand, as the unmet need. The notion is that one does not make a demand unless one feels the need. However, considering that people requiring social services are often those with fewer resources and education, they do not often voice their demands. Sometimes, well-justified collective demands, such as that for industrial safety, could easily be taken as political activity against the governments, hence, there is some reluctance for these needs to be expressed. Policy makers normally take it that 'no demand' means 'no need'. There are also cultural reasons as to why a need is not expressed (for example, wife and child abuse are believed to be fairly serious in several countries in the region, and yet, they have been taken as just within a family's business). Policy makers and professionals should be mindful that Asian families are likely to experience the same variety of problems as developed countries in the future.

Comparative need is measured by reference to a user already receiving the service in question. Therefore, a person is in comparative need if he or she has the same or worse characteristics as someone receiving the service. The concept also can be applied to districts (for example, district A provides free medical treatment while district B does not) or to countries. However, this method of comparison leaves two questions unanswered as only existing services are being compared. "What if there is a need for a new service?" "Does it also imply that the reference standard is faultless and no longer needs improvement?"

Bradshaw (1972) further proposed a taxonomy of need in which the four need-types, when considered in a reality need situation, were each need is assigned a plus sign (presence of need) or a minus sign (absence of need). Real need is defined as presence in all four standards. The taxonomy gives rise to 12 possible combinations (for example, ++++, ––––, ++––) which help in decision-making. However, in the Asia-Pacific region where many potential users do not feel the need for certain services (such as psychological counselling), or are reluctant to freely express their needs, the decision to provide the service or not is still left with policy makers and service providers.

Bradshaw's approach to need is a useful framework for policy-making and for analysing policy to the extent that political, economic and social factors can be taken into account in deciding needs and services. However, it does not provide a clear guide as to how needs can be assessed at operational levels, and for the quantification of various types of social services, for example if someone requires a two-hour home nursing.

C. Need assessment

Two crucial questions should be answered in the assessment of needs: “For whom?” and “For what types of need are people assessed?” The first question is to determine the unit and causes of need, while the second is about availability of services in terms of quantity and variety in matching the respective needs. A third question (“Where?”) can be added in the context of spatial proximity to services or facilities, or the distribution of such services, to meet identified needs.

A unit of need refers to the person or persons under consideration. It could be an individual, a family, or a defined target group for a service. Determining the unit of need in policy is not a value-free process (Smith and Harris 1972), as it tends to reflect the ideologies of a government’s wish to deal with need at a certain level and in a particular manner. For example, the individual has generally been taken by industrialized countries, until recent years, as the basic unit of need. Hence, all policy and services tend to be designed to meet the needs at an individual level. This is not coincidental, as Western countries often place emphasis on the individual’s freedom, rights and respect for individual privacy. Services developed from this tradition tended to focus on needs at an individual level: direct help to individuals (for example, cash benefits per head and psychological support). Service organization also takes the form of matching the needs of a group of individuals with common characteristics (such as children and young people, women, older or disabled people), and makes little reference to a larger unit of need (such as the family or locality). However, there have been some practical and ideological changes in recent years to bring back “village communal” living in urban lives. Whether this is feasible remains to be seen but the intention already suggests a different mode of service organization. The trend is almost global in service types. For example, the development of certain out-patient clinics specializing in family medicine rather than in illness specialties; housing designed to allow nearby living of family generations rather than segregating the old and the young; and many social activities with a strong sense of family and community unity rather than being provided for the pleasure of individuals. So instead of the ‘lone’ individual being assessed for services, the individual is now sometimes placed back into the family and community contexts for assessment.

Having determined the unit of need, the causes assigned as the justifications for need follow a more or less philosophical stance. When an individual is taken as a unit, inadequacies in character are often the assigned causes, hence, services are given a treatment function (that is, to treat personal deficiencies). When the family is taken as a unit of need, interventions at the family level are called for, hence admitting that not all the faults are of the individual. When community or society as a whole is taken as a unit, structural defects come into focus, hence requiring structural changes to address structural causes of need (such as structural unemployment or changes in workforce requirements and retraining/reskilling). In reality, governments will have lists of needs addressing not just one but different units of need, giving rise to many services dealing with many needs.

In responding to needs, almost every government must have a range of services to meet a range of needs. To better match demands with needs, a matching mechanism must be put in place. Likewise, service-specific and target-specific (groups of people) protocols for assessments are not uncommon in developed and developing countries moving into a more bureaucratic government structure. These include standardized measures such as commonly agreed items on an aspect of need (for example, poor health indicates a need for health services) or a comprehensive assessment of a priority target group (such as elderly or severely disabled persons). However, the quantification of service provision (i.e. how many hours of nursing care is required) and its quality (that is, how good and appropriate the service) have been increasingly controversial topics in social service provision.

Who defines the real need is another pertinent question that requires consideration at this juncture. Traditional philanthropies in health and social care clearly refer to the middle-class "do-gooders" as the definers of need, according to what they might wish to give to the poor or how they might wish the poor to behave. This has had a tendency in the past to structure some services paternalistically, in a socially less-acceptable form to many recipients or target clients. There has been an implication of failure or lack of appropriate achievement in the receipt of some services, particularly those related to social welfare. In a developing country where a government might, for example, see a need or duty to educate its people in the hope of elevating the country's literacy rate, education may be taken as a universal service for all. A characteristic of the paternalistic doctrine is that some people appear to know users' needs better than the users themselves. Such an approach is increasingly challenged by many users and service providers, as people's knowledge about the services and their wish to participate in policy-making are increasingly evident. Thus, for measuring any needs or for designing services to meet needs, it has been acknowledged that a combination of perspectives, including users' expectations, service providers' views (especially those of frontline workers) and funders' opinions (usually but not always the policy makers) must be taken into consideration.

There is not any single and accurate measure of what may be an optimal duration of service provision. The provision of human services depends on many factors, including different user conditions, providers' skills and situations, interactions of the user and the helper, as well as the immediate environment affecting service delivery. Attempts used to be made to control inputs (such as staff-users ratios, capping maximum intake numbers and the like) but these have often been ineffective in matching needs with demands, as the services then have become service-led. This implies that for services which are made available only within office hours and adopt provider-specified service modes (for example, a user seeks employment but may be given job counselling instead), such services are not user-driven. Recently, new attempts to define the quantity and service types for needs of target groups have been on the increase. For example, the minimum data set on cognitive, physical and psychosocial aspects of care for older persons is used in the United States of America and Hong Kong, China, while a measure combining Independent Activities of Daily Living, Mini-mental State Examination and the Geriatric Depression Scale is used in

Singapore. However, there is not much evidence about the effectiveness or accuracy of these instruments compared with the old arbitrary methods used by frontline professionals. In this regard, the United Kingdom of Great Britain and Northern Ireland has been experimenting with a standardized approach to need assessment in elderly services for some five years and has recently relaxed the directive for a standard tool for need assessment. This is because standardized need assessment, though desirable in the care plan, is inevitably broad (hence, neglecting details of need), and could lead to professional obsession with very technical aspects of applications (such as the new training that has to be given to people using the minimum data set) and it could not replace the old means-tests. There seems to be greater consensus on the quality assurance for the intervention processes, for outputs and for outcomes.