

**MEMORANDUM SUBMITTED TO THE HOUSE OF COMMONS'  
HEALTH COMMITTEE INQUIRY: SOCIAL CARE  
OCTOBER 2009**

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**Summary**

- The principle that publicly funded health services, administered under the Poor Law, were free of charge but that charges might be made for social services administered by local authorities, was established in the nineteenth century. Independent, mainly voluntary (non-profit), organisations played a significant part in the provision of health and social care for older and disabled people, often collaborating with local and Poor Law authorities.
- This broad framework was carried forward into the post-war Welfare State. From 1948, all health services were 'free at the point of delivery'. Local authorities had responsibility for social care, either directly delivered or through independent institutions supervised by the local authority (LA), for which charges could be made.
- From the 1950s emphasis shifted from institutional to community care due to: client preference; belief that this improved the quality of life of older and disabled people; improved

medical knowledge and treatments; belief that community care was cheaper when demand for and costs of services were growing; continuous concern at inadequacy of community services and difficulty of defining and co-ordinating health and social care.

- The shift both to community care and to private sector provision accelerated in the 1980s for all of the above reasons, plus the government's preference for private sector provision. There were increasing charges for social care due to private sector charges and reduced public expenditure. Concerns did not diminish, and have continued despite government efforts through the 1990s and 2000s to improve community support.

### **Before 1939: Statutory Services**

Before the Second World War the only publicly funded social care for older and physically disabled people was through the Poor Law (named Public Assistance following the Local Government Act, 1929). From 1601, the Poor Law required each parish to levy rates to care for destitute people without family support. Those deemed unable to work due to old age or disability were regarded as deserving, but the level and type of care varied considerably locally and over time. At best, it funded a family member or a pauper woman to house and care for an older or disabled person or provided a regular weekly payment, clothing and health care to enable them to stay in their own homes. At worst, Poor Law 'relief' was extremely limited and stigmatizing.

The Poor Law was drastically amended in 1834 to withdraw relief from the 'able-bodied' (those deemed capable of work). If they were destitute they could be admitted to deliberately bleak and punitive workhouses. In theory, 'non-able-bodied' paupers- mainly older and disabled people deemed unable to work- should be allowed separate, more comfortable workhouse accommodation or granted adequate weekly benefits. Again, the practice was locally variable,

biased towards minimal provision. Generally, the 'non able-bodied' were not granted more comfortable accommodation and husbands and wives were separated. In the community they received minimal benefits in cash or kind (food, clothing). The reformed Poor Law rarely funded carers in the community.<sup>1</sup>

From 1885 free Poor Law health care was available to all who could not afford to pay for it, whether or not they received poor relief. Separate Poor Law hospitals were built and out-patient services expanded, due to growing awareness that sickness among the poor diminished their capacity for work, increased their dependence on public funds and spread infection in the community. Again, implementation was patchy: fastest in London and large towns.<sup>2</sup>

Public concern about the extent of poverty among older people, and recognition that many older people in severe need shunned the Poor Law, led in 1900 to a directive that Poor Law Unions should provide more comfortable, non-punitive separate accommodation for older people, where husbands and wives could share rooms. Again implementation was uneven.

Some mentally disabled people were separately cared for with public funding, though definitions of mental disability were uncertain and shifting (unmarried motherhood could still be a reason to place women in mental hospitals in the 1930s, homosexuality still in 1950s). By 1845 two-thirds of English and Welsh counties provided publicly funded 'asylums', often large and bleak. From 1845 this was required of all local councils. Patients who could afford it were charged, others were funded by Poor Law authorities, establishing the principle that publicly funded care not administered through the Poor Law could incur charges.

The Local Government Act, 1929, transferred all Poor Law powers to public assistance committees of local councils. In many places little changed, but, especially in larger towns, Poor Law hospitals were integrated with other medical services. This revealed the large numbers of older and disabled long-stay hospital patients, in often very bleak conditions, receiving little

medical care ,with no access to rehabilitative services ( e.g., following a stroke) which could enable them to leave and live in the community, or lacking a home or support in the community. This led to the expansion of geriatric medicine, focussed on rehabilitation and reducing the numbers of ‘bed-blockers’. This developed further after the establishment of the NHS.<sup>3</sup>

### **Before 1939: Voluntary and Family Care**

From medieval times residential care was provided for older and disabled people in almshouses and care institutions, run by faith organizations or other voluntary associations, often charitable and/or charging fees to those who could afford them. Particularly in the nineteenth century, voluntary visiting associations provided care in the community. Voluntary organizations, the Poor Law and local authorities often collaborated to maximize support for the ‘deserving poor’. It is impossible to quantify the extent of activity but it was unavoidably locally diverse and unable to meet all needs. Voluntary hospitals, especially numerous in London, provided free treatment to the poor, while charging others, but treated only ‘acute’ not ‘chronic’ conditions, hence the consignment of the long-term sick and disabled poor to workhouse hospitals. Particularly in the 18<sup>th</sup> and 19<sup>th</sup> centuries, private mental hospitals, generally fee-paying, developed. The voluntary sector, often collaborating with public authorities, was well-established in the provision of care before the Second World War.

Family care for older and disabled people in ‘the past’ should not be romanticized. Again, evidence is not systematic, but suggests that, then as now, families gave such care as they could.<sup>4</sup> At any time before the 1920s there was a high probability that older people would have no children living or available to provide care, due to high death rates, higher levels of non-

marriage/partnership than since the Second World War, infertility and high emigration rates of younger people.

### **Since 1939**

In 1955 187,000 people were registered as ‘substantially and permanently handicapped’. People over 65 were c. 10% of the population of England and Wales in 1951. There was concern about the high and rising proportion of older people and the resulting costs due to rising life expectancy and the pre-war fall in the birth-rate<sup>5</sup>. This concern diminished in the 1960s and 1970s due to the post-war rise in the birth-rate, only to return from the 1980s.

### **Statutory Care**

Wartime surveys revealed extensive ‘secret need’ among older people living in the community with minimal or no care. Inadequate, means-tested pensions had been available since 1908. Following the wartime revelations, more generous supplementary pensions were introduced. The campaigning group now known as Age Concern was founded in 1940 and put pressure on government for improved care for older people. There was heightened awareness of the needs of disabled people, whose numbers were increased by war service and bombing. This led in 1944 to the Disabled Person’s Employment Act, requiring employers of more than 20 persons to employ at least 3% from a newly instituted Disabled Persons Register. In 1946 the National Association for Mental Health (now MIND) was formed to campaign for better provision for the mentally disabled.

### **Care in the new Welfare State: the National Health Service and the National Assistance Board.**

The National Assistance (NA) Act, 1946, implemented 1948, abolished the Poor Law/Public Assistance and established the National Assistance Board (NAB), which took over its institutions and responsibility for means-tested benefits. However, all hospitals were absorbed into the National Health Service, also established 1948. Older and disabled people were divided into the 'sick', who were placed in hospitals (c. 90,000 people) and those needing 'care and attention' (c. 42,000) who were placed in residential homes, overwhelmingly former workhouses.

The NA Act required local authorities, under the control of the NAB, to provide residential accommodation for older and disabled people 'in need of care and attention which is not otherwise available to them'.<sup>6</sup> They were empowered also to register and inspect Homes run by charitable (non-profit) and private (for profit) organizations and to contribute to independent organizations providing 'recreation or meals for old people' or themselves provide these, or day centres, clubs etc.<sup>7</sup> Local authorities retained their established public health responsibilities, including for health visitors, home helps, child welfare clinics, though were not required to provide them. Whereas all NHS services were 'free at the point of delivery' local authorities could levy means-tested charges for residential and community social services, but not for services defined as 'health care', such as health visitors. They could also commission fee-charging independent services. The NAB funded residential care for those unable to afford charges.

A substantial role for voluntary action and personal payments, supplementing comprehensive basic services and protection for the poorest, was consistent with William Beveridge's vision of the new 'Welfare State'.<sup>8</sup> These principles were not explicitly endorsed by Attlee's government, but nor did they designate public social services 'free at the point of delivery' or discourage co-operation with voluntary agencies.

The NAB was responsible to the Minister of Health, but semi-independent and required to work also with the new Ministry of National Insurance, whose benefits it supplemented. The

National Assistance Act was piloted through the Commons jointly by the Minister of Health, Aneurin Bevan and the Minister of National Insurance, Jim Griffiths. The boundary between health care and social care was far from clear and could not easily be for older and disabled people. In 1966 the NAB was abolished and replaced by the Supplementary Benefits Commission. In 1968 this was absorbed into a new Department of Health and Social Security which replaced the Ministries of Health and National Insurance, where it remained until 1988, when a separate Department of Health was established. Responsibility for local government moved permanently from the Ministry of Health to a separate in department in 1951, further complicating the relationship between health and social care.

**1950s and 1960s: Moves towards Community Care.**

Few new Homes or hospitals were constructed until the late 1950s due to financial constraints. Surveys in the 1960s found deplorable conditions in both hospitals and Homes for older and disabled people<sup>9</sup>. The distribution between sectors of residential care for older people in 1960 is indicated in the following Table:

**Table 1**

**Number of Institutions and Homes of Various Types.**

<b>Type of Institution</b>	<b>Number of institutions</b>	<b>Number of beds</b>
Former public assistance	309	36,934
Other local authority	1105	36,699
Voluntary	815	25,491
Private	1106	11,643
<b>Total</b>	<b>3335</b>	<b>110,767</b>

Source: Peter Townsend *The Last Refuge* (Routledge 1964) p. 24.

There was a trend from the 1950s towards the replacement of in-patient with out-patient treatment for the mentally disabled, influenced by the increasing awareness of psychiatrists of the harmful effects of long-term institutional care for some people, and by the costs of institutions. In 1953 half of all NHS beds were occupied by people who were mentally ill or mentally disabled. The Mental Health Act, 1959, aimed to enable 'mentally ill people to live, as far as possible, in the community', but support services were limited.

The National Assistance Act 1948 (Amendment) Act 1962 encouraged local authorities to provide meals, recreational workshops and day centres for older and disabled people and they were required to draw up 10 year plans for health and welfare services 'designed to help them remain in their own homes for as long as possible'. Advances in medical knowledge and care enabled more older and disabled people to live in the community. It was also thought to be in their best interests and in line with their expressed preferences. And it was believed that community care was cheaper- an important consideration as costs rose. The Health Services and Public Health Act 1968 increased local authority powers to provide care services, including visiting, laundry, social work and wardens, to inform older and disabled people about services and to make adaptations to their homes . Provision of domestic help became mandatory. Charges could be made for these services. Local authorities could provide them directly or through independent providers. The Act came into force in 1971, when also Attendance Allowance was introduced for older and disabled people needing frequent attention or constant supervision if they were to remain in the community.

There was growing concern in the 1960s about the lack of co-ordination of health and social services. This led to the appointment of the Seebohm Committee on Local Authority and Allied Personal Social Services which reported in 1968 commenting that 'Although for many years it has been part of national policy to enable as many old people as possible to stay in their



own homes, the development of the domiciliary services which are necessary if this has to be achieved has been slow', partly due to the shortage of appropriately trained social workers. It recommended new, unified social services departments to assess local needs and resources and plan accordingly, taking account of and supporting the contributions of independent organizations, relatives and neighbours. The report stated: 'Services for old people in their own homes will not be adequately developed unless greater attention is paid to supporting the families who in turn support them...If old people are to remain in the community, support and assistance must often be directed to the whole family of which they are members'.<sup>10</sup>

### **1970s: Further Moves to Community Care & Problems Coordinating Health and Social Care**

The Local Authority Social Services Act, 1970, established a single social services department in each local authority, emphasizing the need for a co-ordinated and comprehensive approach to social care, supporting families, detecting need and encouraging people to seek help. The departments became responsible for domestic help, residential accommodation, meals and recreation services (for all of which charges could be made), registration of independent residential homes and social work support.

A succession of measures in the 1970s were designed to assist older and disabled people to remain in the community, partly impelled by activism by disabled people. The Chronically Sick and Disabled Act, 1971, required all local authorities to register disabled people and publicize services. It encouraged, but did not require or adequately fund, expanded community-based services such as home helps and day centres. Also, in 1971 Invalidity Benefit was introduced, supplemented in 1975 by means-tested Invalidity Pensions. In 1975 Invalid Care Allowance was introduced for people of working age (only) acting as care assistants to older and

disabled people, but not married women caring for close relatives (until 1986, following judgement by the European Court of Justice) ; or people above state pension age, the great majority of carers. The allowances were low in relation to average earnings. From 1976 Mobility Allowance covered such expenses as transport.

Both local government and the NHS were reorganized in 1974, into larger, tiered units. One aim was closer integration of preventive and after-care services between the NHS (including GPs) and the local authorities. Local authorities took over certain services from the NHS, such as medical, including psychiatric, social work. The new local and health authorities were required to establish joint consultative committees to advise on planning and operation of services of common concern and were recommended to establish joint care planning teams. In 1976 joint financial arrangements were introduced to assist co-operation, enabling NHS funds to be used on collaborative projects with local authorities. Collaboration was never fully effective partly because the new authorities were not very successful and were reorganized again in the 1980s; and to financial constraints in the crisis of the 1970s.

In 1975 the White Paper, Better Services for the Mentally Ill, described the direction the Labour government wished to take, prefaced by a statement that little progress could be made until the economic situation improved. It emphasized the need to provide a comprehensive range of community services in place of mental hospitals, stating:

It will not normally be possible for a mental hospital to be closed until the full range of facilities described has been provided throughout its catchment area and has shown itself capable of providing for newly arising patients a comprehensive service independent of the mental hospital.<sup>11</sup>

Between 1970 and 1975 the population of mental hospitals fell from 107,977 to 87,321; that of mental handicap hospitals from 55,434 to 49,683.<sup>12</sup> There was concern that adequate community support services were not in place.

### **1980s and 90s: Faster Moves to Community Care and Private Sector Provision.**

The shift from institutional to community care moved even faster in the 1980s due to a government commitment to cutting public spending and its preference for private over public provision. In 1983 District Health Authorities were empowered to provide increased funding for services for people moving from hospitals to the community-funded local authorities or independent organizations to support people leaving hospitals. Local authorities were reluctant to take this up perhaps due to fear that it would ultimately increase their costs.<sup>13</sup>

A succession of documents in the 1980s emphasized the need to improve services for older and disabled people and promoted care and improved services in the community.<sup>14</sup> There were also acknowledgements, e.g., in the 1981 White Paper *Growing Older*,<sup>15</sup> that substantial numbers would continue to need institutional care, that good community care was not always cheaper and there was shortage of skilled carers, such as district nurses. A Report of the House of Commons Social Services Committee in 1985 criticized services for mentally disabled people, many of whom were older people. It wholly supported community care but was concerned that people were leaving institutions at a growing rate when there were inadequate community support services. It recommended that no-one should leave an institution without a community care plan. The 1986 Disabled Persons Representation Act attempted to give disabled people more input into policy-making at local level. It placed a duty on local authorities to assess the needs of disabled people for social services, take account of the needs and capacities of carers and inform disabled people about services. In the following year, the Audit Commission also criticized the

slow, uneven progress of community care pointing out that hospital care was still more generously funded than domiciliary care, which put pressure on local authorities to raise charges and devolve services to the independent sector if they were to expand. These concerns were reinforced by the Griffiths Report, 1988, commissioned by the Secretary of State for Social Services, which concluded: 'community care is a poor relation: everybody's distant relative but nobody's baby.' It had always been under-funded and there was still poor co-ordination between health and social services. Sir Roy Griffiths recommended, among other things, a clear framework for coordination between health and social services.

The 1989 White Paper, *Caring for People*, acknowledged these problems, reaffirmed the commitment to high quality community care, but put greater weight than before on the independent sector. It stated 'The Government will expect local authorities to make use whenever possible of services from voluntary, 'not for profit' and private providers insofar as this represents a cost effective care choice.'<sup>16</sup> Local authorities were encouraged to identify areas of their own work which could be 'floated off.' In 1990 the DoH stated that it was 'expected that local authorities will institute arrangements so that users of services of all types pay what they can reasonably afford towards their costs.' These charges varied locally and were rising

The National Health Service and Community Care Act, 1990, followed and attempted to implement these recommendations, without providing substantially increased funding, and, more vigorously than before, encouraged local authorities to become 'purchasing' (from independent agencies) rather than 'providing' authorities. It required social services departments to inspect services, establish complaints procedures and prepare Community Care Plans. Users became entitled to a Community Care assessment of needs.

Local authorities found it increasingly difficult to provide affordable care with the funding available to them. The number of private sector residential homes grew from 18,800 in

1975 to 119,900 in 1990.<sup>17</sup> Until 1980 voluntary sector homes received public funding from local authorities in addition to means-tested payments by the residents themselves. From 1980, means-tested board and lodging supplementary benefit allowances became available for residents of all independent sector homes, which encouraged the expansion of the private sector.

By the late 1980s services were increasingly targeted on the most disabled, to cut costs, and by 1990 it was becoming difficult for older and disabled people to access help with tasks such as cleaning and shopping if they did not have intensive care needs and could afford private services. Services were still highly variable across authorities. There was evidence of much unmet need, most commonly for home helps and chiropody.

Further measures sought to assist community care: Disability Living Allowance from 1992 ; the Carers (Recognition and Services) Act, 1995; the Mental Health (Patients in the Community) Act, 1995; the Disability Discrimination Act, 1995; the Community Care (Direct Payments) Act, 1996 which enabled local authorities to make payments to disabled people to assist them to buy community services according to their needs. The Disability Rights Commission (DRC) was established in 1999 and since 2007 has been absorbed into the Equality and Human Rights Commission. Nevertheless, in 1998 another Audit Commission report, *Home Alone: the Housing Aspects of Community Care* again criticized the inadequacy of community, especially housing provision, recommending improvements, with examples of good practice. The criticisms were repeated in another Audit Commission Report in 2000 *Forget Me Not: Mental Health Services for Older People*. This recommended that local authority health and social services departments should work more closely together and submit annual joint plans. Again, it found wide local variation in the provision of services, and often patchy and uncoordinated support for users and their assistants.

Further measures since 2000 have sought to improve support for older and disabled people in the community and their carers, including the Carers and Disabled Children Act 2000, amended 2004; the Special Educational Needs and Disability Act, 2001; the Private Hire Vehicle Act, 2002 and the New Deal for the Disabled, all consolidated in the Disability Discrimination Act 2005 followed by the Disability Equality Duty (DED), 2006.

Family care has continued to be vital for the survival in the community of many older and disabled people. Assertions about declining family responsibility over time are not supported by research evidence.<sup>18</sup>

## **Conclusion**

The current system of division of social from health care, commissioned and funded by local authorities, subject to means-testing and charging came into being in 1948, with roots in the pre-war system. Over the period since 1948, especially in the 1980s and 1990s, responsibility for the care of older and disabled people shifted from institutions to the community and from the public to the independent sector, while charges rose. Despite well-meaning statements and efforts by successive governments, criticisms of under-funding of social care and poor integration of health and social care have continued.

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<sup>1</sup> Pat Thane *Old Age in English History* ( OUP, 2000), 165-193

<sup>2</sup> M.A.Crowther *The Workhouse System, 1834-1929* ( Batsford 1981)

<sup>3</sup> Thane , 436-457.

<sup>4</sup> Thane, 287- 307, 407- 435.

<sup>5</sup> Pat Thane 'The debate on the declining birth-rate in Britain: the 'menace' of an ageing population, 1920s-1950s' *Continuity and Change* 5 (2), 1990, 283-305.

<sup>6</sup> National Assistance Act 1948, Part III, Section 21 (1) and (2).

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<sup>7</sup> Ibid. Section 29 (1), (2) and 31.

<sup>8</sup> William Beveridge *Voluntary Action* ( London, 1948).

<sup>9</sup> E.g. JH Sheldon *Report to the Birmingham Regional Hospital Board on its Geriatric Services* , Birmingham Regional Hospital Board, 1961. P. Townsend *The Last Refuge* ( London, Routledge 1964). Barbara Robb *Sans Everything* ( London, Nelson, 1967).

<sup>10</sup> Home Office *Local Authority and Allied Personal Social Services* ( Report of the Seebohm Committee) , (London, HMSO, 1968), 96.

<sup>11</sup> Better Services for the Mentally Ill, (London : Department of Health and Social Services , 1975) para 11.5.

<sup>12</sup> In-Patient Statistics, (London: DHSS, 1975),5,7.

<sup>13</sup> Anthea Tinker *Elderly People in Modern Society* ( London, Longman 1992 ), 99

<sup>14</sup> Ibid. 97

<sup>15</sup> Ibid. 98

<sup>16</sup> Ibid. 170

<sup>17</sup> AH Halsey & J. Webb eds *Twentieth Century Social Trends* ( London, Macmillan, 2000), 526.

<sup>18</sup> Among others: H.Qureshi and A. Walker *The Caring Relationship* London, Macmillan, 1989); J. Finch *Family Obligations and Social Change* ( Oxford, Polity, 1989); *Ageing and Society* . Special Issue, Family Support for Older People , 10 (11), 2006.