HISTORY OF HEALTH AND SOCIAL CARE

Pat Thane

BEFORE THE WELFARE STATE

State Provision

- Old Poor Law, 1601. Local taxes provided health, social care, payments in cash or kind to destitute older and disabled people. Quality variable, normally minimal.
- Reformed Poor Law, 1834: workhouse for older and disabled people needing care, or small cash payments in the community.
- 1885 free hospital and out-patient health care for destitute.

BEFORE THE WELFARE STATE

Voluntary provision

- Free care in voluntary hospitals - but only for acute conditions. Little interest in old and disabled.
- Voluntary residential homes, free or fee-paying.
- Better-off cared for by servants. Common until World War 2.

1930s

- 1929, Poor Law transferred to local authorities: Public Assistance.
- Revealed large numbers of long-stay older and disabled patients, receiving minimal care
- Marjorie Warren, successful rehabilitation of older stroke victims etc. Returned to community, but few services if no family. Good family support for those with families.
- Growth of geriatric medicine, but low status.
- Discrimination against older and disabled, including in the welfare state.

World War 2

- Revealed need among older and disabled people living in the community with minimal incomes and care.
- Some improved services in wartime.
- And emergence of campaigning organizations.

Post-war Welfare State

- 1946 National Assistance Act: implemented 1948,abolished Poor Law/Public Assistance. National Assistance Board (NAB) took over means-tested benefits.
- Required local authorities to provide residential accommodation; to register and inspect voluntary and private care homes; provide or subsidize day centres etc. Weak regulation, poor social services. Required to levy means-tested fees for services.
- 1948 NHS: ‘free at the point of delivery’.
- Increased separation of health and social care.

Welfare State-2

- Beveridge: ‘social service state’ not ‘welfare state'. Believed in:
- ‘safety net’ of adequate basic services and benefits.
- Needs above minimum to be provided by individual saving or voluntary sector.
- Strong belief in voluntary sector.
- ‘Big State’ did not squeeze out the ‘Big Society’. Always a mixed economy of welfare.

1950s/60s

- Move to community care.
- 1966 NAB abolished, replaced by Supplementary Benefits Commission.
- Few care homes or hospitals built before late 1950s. Continuing poor conditions.

Care Homes 1960

Number of Institutions and Homes of Various Types

Type of Institution	No.	Beds
Former public assistance	309	36,934
Other local authority	815	25,491
Private	1105	36,699
Voluntary	1106	11,643
Total	3335	110,767

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

1960s

- 1962 local authorities required to draw up 10 year plans for health and welfare services to help older and disabled people stay in their own homes for as long as possible.
- Older and disabled people wanted this; and believed to be cheaper.
- Seebohm 1968: slow development of domiciliary services; need to support families to support older and disabled members.

1970s

- 1971: increased local authority powers to provide care services, adapt homes to assist independent living. Means-tested charges. Attendance allowance introduced.
- 1971 Chronically Sick and Disabled Act: required local authorities to register disabled people and publicize services. Entitlement to services.
- 1971 Invalidity Benefit.
- 1975 Invalid Care Allowance - not for most carers (married women caring for relatives and pensioners)
- 1976 Mobility Allowance.

1970s-2

- Reorganization of local government and NHS. Area Health Authorities.
- Local government and health authorities required to establish joint consultative committees and planning teams especially to integrate care of older and disabled. NHS funds could be used.
- Not very effective, partly because financial crisis and cuts.

1980s

- Faster move to community care.
- But increasingly targeted on most disadvantaged.
- Increased voluntary and private provision.
- Cuts to public funding.
- Increased costs to users of residential care and community services.