Section 1

Past and current influences on practice

Chapter 1

Historical perspectives from past to present

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Introduction

This chapter provides an historical perspective for present debates about the need for health and social care to support older people to remain in the community wherever possible. It starts by looking at the main source of community support for older people, namely family and kinship, and explores how the role of the family has changed from pre-industrial Britain through to modern times. This leads on to a discussion of the changing role of institutions and how this has lead onto a growing emphasis on the importance of care in the community. The chapter goes on to set these debates within the attempts of Labour governments since 1997 to modernise health and social care services for older people. It is argued that the speed of change has generated significant tensions and problems 'on the ground', and hence that section is called 'Modernisation muddles'. The chapter concludes by pulling together the main themes of each section and drawing out from these the main implications for nurses and other healthcare professionals working with older people in modern Britain.

Family, kinship and older people

Older people in pre-industrial Britain

In *The Long History of Old Age*, Thane (2005) starts her edited collection by challenging a series of myths related to older people in pre-industrial society. At the core of these myths is the view that there were few older people in these societies since life expectancy was usually around only 40–45 years. Equally strongly held is the belief that the very few who did survive into later life were all cherished by their families and communities alike. She points out that the low life expectancy of this period was driven by very high death rates at birth and during infancy. The majority of those who lived through their childhoods did not go onto die in their 40 s but rather stood a very reasonable chance of reaching their 60 s and beyond. As a consequence, over 10% of the population in England was over 60 in the 18th century.

Many of these older people would have received great love and care from their immediate families. However, this was not true for all, for at least three reasons. First, labour migration in search of work was highly common in the pre-industrial period, which often resulted in older people being left behind:

> Separation of families because of the movement around the country or the world is not, as is often thought, a fact only of modern life. In the distant past people did not always live out their lives in one place; and when they left, in the days before mass communications and mass literacy, links with home and family might be lost for ever. (Thane 2005: 9)

Second, many couples lost all their children at birth and during childhood. Consequently, there were no adult children available to support them in later life. The third point relates to economic tensions between the generations in pre-industrial societies. Authors such as Stearns (1977) and Sarti (2002) have explored tensions relating to the transfer of wealth in employment areas such as farming. As Botelho (2005) argues, ‘an aged parent’s continued control over both house and estate left the adult son in a state of prolonged dependency, either unable to marry at all or placing both him and his spouse in submission’ (p. 170).

Finally, veneration by the wider community was no more guaranteed than by the family. According to Thane (2005), old age per se did not generate respect but rather ‘people of any age earned respect by their actions or because their wealth and power enforced deference’ (p. 14). Poor older people were especially vulnerable – they might be looked after by their community, but equally they stood a strong chance of being largely ignored. Even those able to live with their children were likely to be dependent upon a household that was already in grinding poverty.

All of this raises the question of where these ‘golden age’ myths came from, especially in terms of this flawed belief in an organic community that cared for and respected all its older residents. Williams (1976) has claimed that ‘community’ is a crucial keyword in our society because of how it is used to explore major changes in culture and society. More specifically, he has traced how ‘community’ has been used from the 9th century BC to the 1970s as a mechanism to grieve for the passing of what is usually deemed to have been a much more organic and caring past. The biggest such fracture was caused by the Industrial Revolution, which encouraged a rather romantic view of community and family life in pre-industrial Britain.

Reflection points

- **What would it have been like to be old and poor in pre-industrial Britain? What would be the differences from now? What would be the similarities?**
- **What would it have been like to be old and rich in pre-industrial Britain? What would be differences from now? What would be the similarities?**

The impact of the Industrial Revolution

The late 18th and early 19th centuries saw massive changes transform Europe and North America through the combined impact of industrialisation, urbanisation and population growth (Cole and Edwards, 2005). The impact of all this on low-income older people was complex but often extremely negative. In many areas, although not all, it encouraged rural depopulation, with older people tending to be left behind to fend for themselves. Older factory workers were equally vulnerable when they 'lost their strength or became infirm or chronically ill and . . . could no longer keep up with the pace of the machine and the length of the working day' (Cole and Edwards 2005: 212). What happened to older people in such situations? One option was family support, but this was no less problematic in the 19th century than it had been in the previous two centuries. Younger kin may have migrated or been overwhelmed by responsibilities to their own children. As a result, such older people tended to try to stay at least on the margins of the labour market through part-time and casual work. Charles Booth, in his classic study of the *Aged Poor in England and Wales*, at the end of the 19th century found that 55% supported themselves through earnings and personal means, while 25% survived through a combination of earnings, parish provision, charities and support from relations (drawn from Cole and Edwards 2005: 236).

Such strategies were, of course, not an option for those whose severe health and frailty problems meant that it was impossible to remain even at the margins of the labour market. Many of these were supported by families as best they could, but others became dependent upon the Victorian Poor Law system. The 1834 Poor Law Amendment Act stated that the 'able-bodied' should only receive relief in the pauper's workhouse, whose regime needed to be sufficiently harsh and demeaning to encourage people to find work. In theory, this should have meant that older people with health problems could access either relief from the Poor Law parish from outside the workhouse or relief within it in a form that lacked the deterrent features of the regime being offered to the able-bodied.

The reality of the Victorian workhouse is open to debate, with many stressing the boredom and regimentation rather than the cruelty of workhouse life (Crowther 1981; Cole and Edwards 2005). What is clear is that many pauper inmates were older people who were either victims of unemployment or just too frail to work, even though defined as able-bodied. Even those defined as ill often experienced a lack of segregation with the ‘able-bodied’ and hence were effectively dealt with as if they were paupers (Cole and Edwards 2005).

However, this rather gloomy picture needs to be balanced against the emergence of growing numbers of middle class older people in the 19th century with access to considerable material resources well into late life. For example, the growth in home ownership fostered independence since ‘homes, in addition to providing shelter and security for borrowing, can also be used to yield income from rent or taking in lodgers’ (Cole and Edwards 2005: 221). Indeed, a small minority continued to retain control over considerable personal wealth and were likely to be surrounded by a wide circle of family, staff and friends. The experience of later life in Victorian Britain demonstrated massive inequalities.

Reflection points

- **Imagine life in a Victorian workhouse. Are there any similarities with life in a 21st-century care home?**

The family care of older people in the 20th century

So far, this chapter has warned caution about assuming that families were always available to support older people in the past. Nevertheless, families have always been a key support to older people in times of difficulty and one upon which government has always relied as a key mechanism to reduce health and social care costs falling on the state.

A series of classic studies in the late 1940s and 50s were able to evidence the extent to which many older people were embedded in family and kinship relationships. These included studies in Wolverhampton (Sheldon 1948), Bethnal Green (Townsend 1957; Young and Willmott 1957) and Woodford (Willmott and Young 1960). The Bethnal Green and

Wolverhampton research was in traditional working class communities, and findings emphasised the nature of reciprocity in kinship relationships. Grandparents, and especially grandmothers, were often taking on a caring role for grandchildren in order to support their children. In return, children, especially daughters, were frequently the key source of care and support for grandparents when their health declined. In Woodford, a middle-class outer suburb of London, geographical and social mobility had changed rather than loosened ties between grandparents and the next two generations. Hence, the main difference between Woodford and Bethnal Green was that:

> help from the older generation is less common in Woodford than help to them. The real contrast with the East End is that there the generations live side by side throughout life and at every stage kinship provides aid and support . . . In the suburb help is much more one-way, the younger couple . . . receiving much less than . . . they give to parents who are widowed, infirm or ailing. (Willmott and Young 1960: 72)

As these studies were completed in the mid 20th century, it needs to be asked whether family and kinship relations have further moved on with a much diminished caring role for families.

Chris Phillipson and colleagues from Keele University revisited Bethnal Green, Woodford and Wolverhampton in order to research this crucial issue (Phillipson et al. 2001). They found that most older people remained engaged with family-based networks, with spouses and daughters being especially crucial to the provision of emotional aid and a wide range of services. Overall, they felt able to argue that: ‘The immediate family, then, offers an important protective role to older people: reassuring in times of crisis, playing the role of confidant and acting as the first port of call if help is needed in the home’ (p. 251).

Against this, their results showed how most older people no longer defined themselves solely through their families. Friendships and leisure activities are now much more important, as also underlined by other researchers (Spencer and Pahl 2006). Many older people now have significant resources at their disposal, and not just the minority as in the 18th and 19th centuries. However, they stress how this is not true of all older people, with a minority lacking the resources to pursue such lifestyles and hence likely to feel especially isolated and vulnerable to social change.

Reflection points

- **What role did older relatives play in your own upbringing?**

The future of the caring family

Families, and the place of older people within them, continue to evolve and change. Harper (2006: 157) stresses the continued emergence of ‘new family forms’ such as ‘reconstituted or recombinant stepfamilies, single parent families and cohabiting couples’, who now constitute around 25% of Western European families. The extent of familial obligations to say, for example, an elderly stepmother who has been diagnosed with cancer is unclear, while low fertility rates means that an only child may end up trying to support not only two elderly parents but also two elderly step-parents (Finch 1989).

Overall, Harper stresses how households and family networks are becoming smaller, and she argues that this means that spouses will need to play a much stronger role in the future than in the past. The role of daughters is likely to diminish, especially in terms of availability for full-time care because of the increased likelihood of them being in full-time employment. More of the responsibility for care is likely to fall on partners rather than the next generation.

Hovering over all of this is the imminent move into retirement of the cohort that is often called the ‘Baby Boomer generation’, namely those born in the late 1940s and the 1950s. These individuals will initially represent an enormous resource to society; they will be important consumers (Gilleard and Higgs 2000, 2005), as well as having much to offer civic society through volunteering and other related activity. However, as they continue to age and their own health deteriorates, they will place considerable pressures upon both their families/step-families and upon the state in terms of health and social care expenditure.

The welfare state, older people and the changing role of institutions

The impact of the Second World War

Local authorities had taken over responsibilities for workhouses in 1929, and these were renamed Public Assistance Institutions (PAIs). However, many PAIs remained large cheerless buildings that a growing number of reformers felt were in desperate need of investment and change (Means and Smith 1998). One criticism was that they continued to contain large numbers of older workers unable to find employment and hence did not deserve the taint of pauperism. There was also concern about how the 1929 reforms had allowed Poor Law infirmaries to be transferred to the public health committees rather than the public assistance committees of local authorities. This did encourage such hospitals to improve the healthcare on offer but often at the expense of being reluctant to admit older people with chronic health problems.

The resultant shortage of beds led to the development of very unsatisfactory conditions for older people in PAIs. Surveys in the 1940s presented the following picture:

> All are agreed that the reproach of the masses of undiagnosed and untreated cases of chronic type which litter our Public Assistance Institutions must be removed? Without proper classification and investigation, at present, young children and senile dements are 'banded together' in these institutions, along with many elderly patients whom earlier diagnosis and treatment might have enabled to return to their homes. (Nuffield Provincial Hospitals Trust 1946: 16)

In truth, such poor conditions had long been the norm, but it was only in the 1940s that reformers generated public and government concern. The reason for this seems to have been the impact of the Second World War.

The Second World War disrupted family and community support for all older people and not just those from poorer neighbourhoods (Means and Smith 1998). Older people needed to be evacuated from communities at risk from German bombing raids and they needed new accommodation when their homes were bomb damaged. However, perhaps even more importantly, support networks were undermined by sons being in the armed services and daughters increasingly involved in the war effort through such activities as working in the munitions factories. The ripple effect of this was even felt by middle- and upper-class households:

> The overriding claims of aircraft and munitions have swept the vast majority of maids, trained and untrained alike, into essential national war work. But total war has brought great sufferings and hardship to countless households: especially families which include the aged, the sick and young children. Family life among the middle and upper classes in this country has for generations rested largely on the assumption of domestic help of some kind being available. (Markham/Hancock Report 1945: 4)

The consequence of all this for better off older people was potentially dire, with some finding themselves in danger of becoming dependent upon PAIs, something which would have been unthinkable before the war.

In March 1943, the *Manchester Guardian* ran a story on a PAI visit to 'a frail, sensitive, refined old woman' of 84 years that was used to attack the regimentation of such institutions and the continued taint of pauperism:

> But down each side of the ward were ten beds, facing one another . . . On each chair sat an old woman in workhouse dress, upright unoccupied . . . There were three exceptions to the upright old woman. None were allowed to lie on their bed at any time throughout the day, although breakfast is at 7am, but these three, unable any longer to endure their physical and mental weariness, had crashed forward, face downwards on to their immaculate bedspreads and were asleep. (Samson 1944: 47)

The clear implication was that such conditions might just about be acceptable for working-class older people but certainly not for refined (middle-class) ones. The article led to a campaign for the reform of PAIs which the government agreed to tackle as part of post-war reconstruction.

Reflection points

- **Imagine life as an older person during the Second World War. How well do you think you would have managed?**

Post-war reconstruction and services for older people

Overall, post-war construction went much further than just PAI reform and covered the insurance and benefit proposals of the Beveridge Report (1942), education, healthcare and social care (Glennerster 2007). In terms of PAIs, the introduction of pensions, unemployment benefit, sickness benefit and national assistance meant that older people should no longer need to seek institutional care because of their inability to find employment in the labour market (Macnicol 2006). However, in terms of this book and this chapter, the key change was the attempt to distinguish between the healthcare and social care needs of these older people who had previously all ended up in PAIs. Put crudely, the sick would be treated through a National Health Service (NHS) established through the 1946 National Health Service Act and their services would be free. The frail would be cared for in newly established Residential Care Homes under the 1948 National Assistance Act, and this service would be charged for by each pensioner paying 21 shillings a week from their new 26 shilling state pension to the local authority.

The new NHS was in fact composed of three different elements: a hospital sector; an executive council sector responsible for GPs; and a residual local authority sector that included district nursing, health visitors and midwives (this role was not taken away from local authorities until the implementation of the 1973 Health Services Reorganisation Act). In terms of hospitals, it remained true that the elderly chronic sick remained a low priority and hence a low-status medical specialism. Nevertheless, geriatric medicine pioneers such as Marjorie Warren, L.R. Cosin and Lord Amulree campaigned for improved care. All three were involved in a major British Medical Association review of geriatric medicine that was chaired by Dr Greg Anderson and that called for the following classification:

- The elderly
- The elderly and infirm
- The elderly sick
  - Senile sick
  - Long-term sick (potentially remediable)
  - Irremediable
- Elderly psychiatric patients
- Other special groups.

(Anderson Report 1947: 8)

The first group could manage in their own homes, while the elderly and infirm would either need family support or support through a Residential Care Home. The elderly sick could then be further classified so that active treatment and rehabilitation could be targeted at those most likely to gain from such input. Through such an approach, the elderly 'chronic sick' would no longer need to 'silt up' hospital provision.

As indicated, Residential Care Homes were established by the 1948 National Assistance Act. According to Nye Bevan, the Minister of Health:

> the whole idea is that welfare authorities should provide them and charge an economic rent for them, so that any old persons who wish to go may go there in exactly the same way as many well-to-do people have been accustomed to go into residential hotels. (Quoted in Means and Smith 1998: 139).

Such aspirations were not realised in the late 1940s and 1950s. There was a shortage of building materials after the war so new smaller residential care homes were not built – instead there was a continued heavy reliance upon the old PAI buildings, often with the same 'Poor Law' staff who received no additional training. Such homes received a withering attack by Townsend (1964) in *The Last Refuge*. He found that 57% of accommodation was in rooms with at least 10 beds, and that the older institutions were in a state of shocking disrepair while some staff retained 'authoritarian attitudes inherited from Poor Law days' (p. 39). This situation was not tackled until the Residential Care Home building 'boom' of the late 1960s, at which point nearly all of these old PAIs were finally closed down.

The health and social care divide

However, of most relevance to this chapter is the divide that had been created between health and social care. The 1948 Act referred to people 'in need of care and attention' but did not define what this meant. What soon emerged was massive conflict between local authorities and NHS hospitals. Local authorities complained that the NHS had a shortage of hospital beds for elderly people requiring medical treatment, and that as a result they were ending up in Residential Care Homes despite needing much more than just 'care and attention'. Hospitals complained that their beds were being filled up with older people in need of care and attention rather than active medical treatment but were being told by local authorities that either there were no beds or that the elderly person in question was too frail for a care home (Means and Smith 1998).

Huws Jones (1952) spoke of how large numbers of elderly people were stranded 'in the no man's land between the Regional Hospital Board and the local welfare department – not ill enough for one, not well enough for the other' (p. 19). The response of government was to provide detailed guidance in 1957 on respective responsibilities for the 'partly sick and partly well'. Hospital authorities were told they were responsible for:

- Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years;
- Convalescent care of the elderly sick who have completed active treatment but who are not yet ready for discharge to their own homes or to welfare homes;
- Care of the senile confused or disturbed patients who are, owing to their mental condition, unfit to live a normal community life in a welfare home. (Quoted in Means and Smith 1998: 184)

Local authorities, on the other hand, were told that Residential Care Homes should provide:

- Care of the otherwise active resident in a welfare home during minor illness which may well involve a short period in bed;
- Care of the infirm (including the senile) who may need help in dressing, toilet etc, and may need to live on the ground floor because they cannot manage stairs and may spend part of the day in bed (or longer periods in bad weather);

- Care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months). (Quoted in Means and Smith 1998: 183).

What this guidance did was to effectively begin to define the term 'in need of care and attention' and to do this in a way that placed greater responsibilities upon local authorities than they had originally assumed to have been the case.

This guidance is now over 50 years old. However, governments have continued to struggle to provide definitive guidance on 'what is healthcare?' and 'what is social care?', especially in the context of older people. Numerous further attempts have been made to tackle this issue 'for once and for all', but the boundary between the two has continued to shift, with local authorities being expected to provide services for older people at ever higher levels of dependency (Means et al. 2002). The Sutherland Report (1999) on long-term care was a Royal Commission set up by the incoming Labour government of 1997 to look at these issues yet again. The Majority Report of the Commission argued that no logical distinction could be made either between healthcare and social care or between those services which should be free and those which should be means-tested:

> Older people need long term care not simply because they are old, but because their health has been undermined by a disabling disease such as Alzheimer's disease, other forms of dementia or a stroke. As yet these diseases cannot effectively be cured by medical care but people suffering from them will require ongoing therapeutic or personal care of different kinds in order to enable them to live with the disease. In this regard, the only difference between cancer and Alzheimer's disease is the limitation of medical science. (Sutherland Report 1999: 67)

As a result, the Majority Report called for free personal care, but this proposal was rejected by the government on the grounds of the high cost of making social care free rather than subject to means-testing.

Post-war reconstruction in health and welfare services for older people was focused primarily on institutions: the hospital for the sick and the Residential Care Home for the frail. By the 1960s and 70s, this focus came under increasing challenge. Governments were becoming concerned about the high cost of hospital care especially for older people, and this encouraged the start of the long process of arguing the case for more investment in community-based health and social care services, while a number of commentators were criticising poor conditions in not only Residential Care Homes, but also long-stay hospital provision (Means and Smith 1998). The next section looks at some of the reasons why it took so long to achieve a genuine shift to Care in the Community.

Reflection points

- **Can you distinguish between what is healthcare and what is social care? What criteria are you using to do this?**

Towards Care in the Community

The slow development of community health and social care services

At first glance, there would appear few obstacles to a major shift to Care in the Community for older people in terms of both community health services and social care. The first section stressed how the role of the family in elder care has long been emphasised. Annual reports of the Ministry of Health in the 1950s and 60s nearly all made reference to the need to keep older people in their own homes for as long as possible. The rationale for this was well expressed by Vaughan-Morgan et al. (1952) when they argued that at home 'they are surrounded by the things and people they know and love', while at home they are also 'required to help themselves in a hundred ways, all calculated to stimulate their physical and mental processes and so maintain their interest in life' (pp. 19, 20).

So what were the blockages? One of these was the limited powers of local authorities under the 1948 National Assistance Act. This enabled them to provide Residential Care Homes for those deemed to be 'in need of care and attention', but it gave no general powers to promote the welfare of older people through social work services, day care or visiting services, while Meals on Wheels services had to be supplied by a voluntary organisation rather than directly by a local authority. They could supply home help/home care through the 1946 National Health Services Act, but this was not made a mandatory duty until the early 1970s. District nursing and health visiting were provided by local authorities through the 1946 Act, but their priority tended to be children and young families rather than older people, while major co-ordination problems existed with regard to how these services related to GPs. Gradually, the legislative weaknesses of the 1948 and 1946 Acts were tackled, and most of the required changes were in place by the early 1970s. This was followed by 2 or 3 years of rapid service growth, but this was brought to a shuddering halt by massive oil price rises and consequent public expenditure cuts. The boom years of the welfare state were over without a full investment in community services ever having taken place.

But why did it take so long to get these changes into place, and why was there such an initial emphasis upon institutions? This chapter will now look at one important factor, namely concerns about the relationship of welfare reform to family care. Townsend explains this in the following forceful terms:

> The failure to shift the balance of health and welfare policy towards community care also has to be explained in relation to the function of institutions to regulate and confirm inequality in society and indeed to regulate deviation from the central social valued of self-help, domestic independence, personal thrift, willingness to work, productive effort and family care. (Townsend 1981: 22)

Put more crudely, families might abandon the care of their elderly relatives to the state if institutional care was of high quality or if community services were readily available.

The years after the main post-war reforms saw much talk of a 'slackening of the moral fibre of the family' (Thompson 1949: 250) and the need to challenge the view 'that the state ought to solve every inconvenient domestic situation', resulting in 'a snowball expansion on demands in the National Health (and welfare) Service' (Rudd 1958: pp. 348–9). Rudd was a consultant physician, and his message, and that of many others, was that the primary responsibility for the care of sick and frail elderly people lay with the family and that this must not be undermined by the welfare reforms of the 1940s.

The previous section outlined the classic community studies of Sheldon (1948), Townsend (1957), Young and Willmott (1957) and Wilmott and Young (1960). The picture that emerged from these was of the vibrancy of intergenerational family life rather than any slackening of moral fibre. This work was extended by Townsend when he explored *Old People in Three Industrial Societies* with international colleagues (Shanas et al. 1968) from a central concern to understand how support from the family intersected and meshed with support from the state. They concluded that health and welfare services do not conflict with family care: 'because either they tend to reach people who lack a family or whose family resources are slender, or they provide specialised services the family is not equipped or qualified to undertake' (Shanas et al. 1968: 129).

Gradually, governments began to see an expansion of community health and social care services as supporting the caring role of the family rather than undermining it.

Reflection points

- **How would you balance the responsibilities of the state and the family in the care of older people?**
- **Did we get the balance right in the past? Have we got it right now?**

Who should take the lead role in co-ordination?

The fact that community services were slow to develop did not stop endless debates occurring from the 1950s onwards about who should play the lead role in the co-ordination of such services. This has included numerous calls for both community health and social care services to all be under medical control rather than split between the NHS and local authorities. For example, the Gillie Report (1963) on *The Field of Work of the Family Doctor* claimed that the GP was 'the one member of the profession who can best mobilise and co-ordinate the health and welfare services in the interests of the individual in the community and of the community to the individual' (p. 9).

The restructuring of healthcare provision ushered in by the 1973 Health Service Reorganisation Act did take most healthcare functions away from local authorities but left them their social care or welfare functions. This left the GPs in a much stronger position to co-ordinate community health services on behalf of their patients, but in a very weak position with regard to social care input.

Indeed, by 1973, welfare services had been joined together with children's services and a range of other personal care services to create unified social services departments, which came into operation on 1st April 1971 as a result of the 1970 Local Authority Social Services Act. The 1970 and 1973 Acts had shown the continued belief in the need to distinguish between healthcare (GP, health visitor, district nurse, etc.) and social care (social work, home care, Meals on Wheels, etc.).

This resolution initially reduced pressure to establish a lead agency or profession across health and social care. The focus instead shifted to a range of mechanisms introduced by government to improve joint working across health and social services. The 1973 Health Service Reorganisation Act had established machinery for joint planning between health and local authorities through member-based Joint Consultative Committees. One of their main purposes was to plan for the rundown of long-stay hospitals and the encouragement of community-based services for a range of people including frail older people. Lack of progress led to the introduction of joint finance, a mechanism by which social services departments could, for a limited period, receive health authority funds to underpin community-based services for people leaving long-stay hospitals or to support people so as to avoid the need for future long-term NHS care (Means et al 2002: Ch. 5).

However, a key criticism of these types of initiative was that they involved relatively small amounts of money and hence impacted only at the margins of health and social care services. More specifically, the impact of joint care planning and joint finance was miniscule compared with the explosive growth of independent sector residential and nursing home care in the 1980s. This was initially funded through residents/patients being able to access social security benefits to pay for their care, and this enabled local authorities to close many of its residential care homes and hospitals to dramatically reduce its long-stay/continuing care beds. The scale of this growth was enormous. In 1979, 11,000 claimants in such homes were claiming only £10 million from the social security systems, yet by the early 1990s, 281,200 claimants were receiving £2.6 billion (Laing and Buisson 1994).

The Griffiths Review of community care and social services as the lead agency

Such developments were criticised not only because of the public expenditure consequences, but also because they were moving older people from one institution to another rather than supporting them to live in the community (Audit Commission 1986). There was also growing criticism of the continued failure to co-ordinate health and social care provision for older people (National Audit Office 1987). The then Conservative government invited Sir Roy Griffiths to carry out a review of the funding and organisation of community care.

Community Care: An Agenda for Action (Griffiths Report 1988) was widely expected to call either for social care services to move to health service control or for the establishment of a new organisation outside both the NHS and local authorities that would bring together community health and social care provision for the main community care groups, including older people. Instead, the review called for social services/local authorities to be given the lead agency role in community care, but to do this in a way that stimulated the provision of both care homes and social care services by the independent sector. The review also transferred responsibility for funding people in independent sector care homes to social services from the social security system, and hence effectively capped this major area of public expenditure.

These recommendations were to subsequently feed into the White Paper on *Caring for People* (Department of Health [DH] 1989) and then the 1990 National Health Service and Community Care Act, the community care elements of which were implemented on 1st April 1993. The White Paper set out the main responsibilities of social services as the lead agency; these included:

> Carrying out an appropriate assessment of an individual's need for social care (including residential and nursing home care), in collaboration as necessary with medical, nursing and other caring agencies, before deciding what services should be provided. (DH 1989: 17)

Such assessments were to be carried out by care managers who were likely to be, but not necessarily, social workers.

These reforms had not returned control of community health services such as district nursing to local authorities, but it had placed them in 'the driving seat' in terms of co-ordination at both the authority level (through community care plans) and at the level of the individual client (through care management). A crucial justification for these changes was that older people define their core needs in social rather than medical terms through their emphasis upon quality of life and retaining independence. However, would this new arrangement between health and social care last any longer than previous ones?

Long-term conditions and health as the lead agency

From the outset, it became clear that social services could attempt to influence health, but that it had few levers by which to encourage it to deliver healthcare in a way that integrated with its community care provision at both the strategic and individual levels. Not only this, but there was still no clear way forward for deciding 'what was healthcare?' and 'what was social care?' Health and social services continued to argue about who should supply what services for individual clients.

The 1990s, also, saw the issue of hospital discharge and bed-blocking emerge as a high-profile political issue. Increasingly, health blamed social services for these delays, a view that the Labour government of 1997 supported:

> On one day in September last year, 5,500 patients aged 75 and over were ready to be discharged but were still in an acute hospital bed: 23% awaiting assessment; 17% waiting for social services funding to go to a care home; 25% trying to find the right care home; and 6% waiting

> for the right care home package to be organised . . . The 1948 fault line between health and social care has inhibited the development of services shaped around the needs of patients. (DH 2000: 29)

The quotation is taken from *The NHS Plan*, which expressed the desire to establish Care Trusts as ‘new single multi-purpose legal bodies to commission and be responsible for all local health and social care’ (p. 73).

Although a small number of Care Trusts for older people have emerged, these never took off as a popular way forward because of the legal and practical complexities in setting them up. Instead, the main thrust of government policy became strengthening the (lead) role of health, to the detriment of social services. More specifically, the focus has shifted to the long-term health conditions of older people rather than their social care needs. For example, *Supporting People with Long-term Conditions* (DH 2005) stressed the discomfort and stress experienced by the 17.5 million people with a long-term condition, but then focused down on how 5% of inpatients, most with long-term conditions, accounted for 42% of all acute bed days. The new model claimed to offer a new systematic approach to the care of patients with such conditions, with a view to significantly reducing the number of inpatient emergency beds. This is to be achieved through targeted health intervention via a new system of case management provided by experienced nurses who are to be called community matrons. The community matrons are:

> likely to have caseloads of around 50–80 patients with the most complex needs and who require clinical intervention as well as care co-ordination. They will work across health and social care services and the voluntary sector, so that this group of patients received services that are integrated and complementary. (DH 2005: 16)

Healthcare provision now seems of more importance to government than social care, with the nurse as case manager replacing the social worker as care manager (Means et al. 2008: Ch. 5). Time will tell whether this arrangement proves any more robust than the community care reforms of the early 1990s.

Reflection points

- **Should the nurse or the social worker take the lead in the care co-ordination for older people? How do you justify this view?**

Modernisation muddles

The need to modernise public service has been a mantra for recent governments. The reasons for this are complex, but one influence has undoubtedly been a fundamental change in the general population in terms of the quality of services they expect to receive. Older people are no different in this respect. Earlier in the chapter, we looked at the future of the caring family in the 21st century. This will see the ageing of the 'Baby Boomer' generation who will expect to have a much greater say over their own healthcare than older people in the past. It is inevitable that healthcare systems will need to change in order to meet these increased expectations.

Few commentators would therefore argue the case for no healthcare reform at all. The real question is whether this desire for change has almost spun 'out of control' and hence become counterproductive. Within the space of this chapter, it is impossible to cover the sea of policy announcements, policy changes and organisational restructuring that has impacted upon health and social care under recent Labour governments. The 1997 government started by outlining broad modernisation plans for local authorities (Deputy Prime Minister 1998), social services (DH 1998) and health (DH 1997); and went on to embrace White Papers, National Service Frameworks and an almost endless stream of policy documents. In addition, there has been the growth of increasingly different policy frameworks in England, Scotland, Wales and Northern Ireland as a result of devolution. For example, Wales has free prescriptions but England and Scotland do not (although Scotland plans to implement free prescriptions from April 2011). Scotland has free personal care, England has rejected it, while Wales wishes to introduce it but cannot afford to do so.

In terms of health, England has seen among other things:

- the restructuring of health authorities and primary care trusts
- the emergence of foundation trusts
- the introduction of numerous milestones and targets
- the development of new approaches to commissioning and purchasing healthcare services
- fundamental changes in approaches to remuneration and workforce mixes
- a shift in emphasis to healthcare provision in the community rather than the hospital.

Equivalent changes in social care have included the break-up of social services departments into Children's Services and Adult Social Care

Services, the growing emphasis upon direct payments and personal budgets, as well as the same emphasis upon both milestones and workforce change.

The most coherent explanation of what the government is trying to achieve is probably to be found in *Our Health, Our Care, Our Say*, the White Paper on community services (DH 2006). A key thrust is that GP practices and primary care trusts would have a major focus on commissioning, with money increasingly following the patient, a process called practice-based commissioning. It is stressed in the White Paper that this requires close working with local authorities, especially if broader well-being and public health objectives are to be met. A cynic might conclude that the subsequent new *Commissioning Framework for Health and Well-being* (DH 2007) has many similarities with community care plans introduced as a result of the Griffiths Report (1988) (see above), but with health/primary care trusts rather than social care now very much in control. However, what is certain is that the health reform agenda of the government (and of the Conservative and Liberal Democrat parties) seems to guarantee a continued landscape of change at the levels of both policy and practice.

Means et al. (2008) argue that one consequence of all this change has been a growth in the gap between the formal objectives of policies and what is actually happening on the ground. They hence refer to 'modernisation muddles, in which managers and field-level staff struggle to keep pace with the demand for policy change and the ever increasing flood of directives, guidelines and indicators' (p. 250). This is a critical issue especially in terms of front-line staff since many older people will judge their healthcare in terms of how they are treated by those professionals with whom they have most contact. Nearly everyone enters a healthcare profession from positive motivations, but the impact of endless change and disruption can be a sense of feeling undervalued and hence the encouragement of what Lipsky (1980) called 'street level bureaucracy' (see also Hoggett et al. 2006). In other words, front-line staff end up offering the very opposite of person-centred care.

Reflection points

- **Have you been affected by a major reorganisation at work, and if so, how did this affect you and your colleagues?**

Conclusion

The noted historian Anne Digby (1989) has stressed that history does not respect itself precisely, ‘yet, on a broader front, certain policy issues, dilemmas, problems and choices do recur in social welfare’ and hence ‘to forget the past record of these events is to force each generation to relearn what should already be known and thus make future developments less satisfactory than they might be’ (p. 1). Hopefully, this chapter has supported Digby’s perspective on the importance of historical perspectives on today’s policy and practice dilemmas in the work of nurses and other health professions with older people.

The chapter concludes by drawing out three important themes. First, governments have always stressed the importance of family care for older people, and care in the community policy has usually been predicated upon the need to maintain the lead role of informal care rather than this being substituted by the state. Research evidence has consistently shown that children are committed to supporting their parents as their health declines, but that the nature of this changes as families themselves continue to evolve.

Second, governments have been continuously concerned about the high costs to the state of health and social care for older people despite the fact that older people have often been what used to be called ‘a Cinderella service’ in terms of their low priority for health and social care resources. This seems to often leave older people presented as some kind of threat or problem, especially to the health service, and also vulnerable to dependence upon poor quality services. Thus, the Boucher Report (1957) was based upon a 1954/55 survey of hospital and care home provision for older people and underpinned by concern around the high costs of hospital care for older people, while 50 years later policies on long-term conditions (DH 2005) seem to have been driven by exactly the same anxiety.

Finally, British provision for older people has been underpinned by this continued assertion that it is possible to make a distinction between free healthcare and means-tested social care services. It has been demonstrated how this health and social care boundary shifts over time, as do views about the respective roles of nurses and social workers, and of healthcare agencies and social care agencies. The present emphasis is upon the pivotal role of nurses/community matrons and supporting older people in the community. This places a major responsibility on nurses to try to ensure that these responsibilities are carried out in a way that supports older people to maintain their independence and social lives rather than just treating them in terms of their long-term illnesses.

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