Nuffield Trust Grant Report No. 1

Elderly People and the Boundary between Health and Social Care 1946-91

Whose Responsibility?

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Foreword by
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The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

Published by The Nuffield Trust
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ISBN 1-902089-39-1

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FOREWORD

Over the years the Nuffield Trust has had a marked impact on health care at the local level. In fact its original purpose was the co-ordination of hospitals and related local health services. The Trust played a key part in the Carnegie Third Age Initiative, supporting the health component under the leadership of Sir John Grimley Evans. Over the last nine years the Trust has demonstrated its commitment to community care with core funding for two academic units at Leicester and Glasgow. These two units have made a significant contribution to the scholarship in and around the issues of health and social care.

The present government's priorities also include focussing on the interface between health and social care. A number of new institutions and legal obligations have been created, including the duty to collaborate and pooling of funds between the NHS and local authorities. This Nuffield Trust publication by Paul Bridgen and Jane Lewis provides an insight as to why this may continue to be problematic.

The division between health and social care is far from simple in terms of what is actually provided. The social care provided by local authorities has always included both institutional and domiciliary care but the idea of "community care" (developed first in relation to the mentally ill and later in respect of elderly people) has increasingly come to mean shifting the balance in favour of the latter. However, health authorities have continued to view any provision outside hospital as community care.

As the authors point out, historical analysis carries no prescriptive power but can at least point to the extent to which the problems of the health/social care boundary are deep-seated. There is considerable political science literature which suggests that policy change is incremental and that past decisions have made constraining effect on contemporary choice. By placing policy developments in their historical context it is possible to identify longer term threats that tend to remain invisible when attention is confined to most recent developments.

Getting rid of the financial boundary between health and social care would make it much easier to address the issue of responsibility and what this historic study shows is the need for questions about the nature of provision to be addressed much more explicitly and to be given much higher priority.

John Wyn Owen CB
London: 1999

INTRODUCTION

The health/social care divide was built into the post-war settlement, which made health care the responsibility of the National Health Service (NHS) and free at the point of delivery, while social care was delivered by the local authorities, which were permitted to charge for it. The boundary between the two services has increasingly been recognised as a major policy issue during the 1990s. Indeed, the problems that result from it have grown more urgent as the proportion of frail elderly people has increased.[1] A number of issues have hit the headlines. Some of the most common have been protests by elderly people who must pay for nursing services delivered by local authorities that would be free under the NHS; the problem of so-called 'bed-blocking' by elderly patients in hospitals; and the seemingly incomprehensible boundary disputes between professionals, for example over 'the health versus the social care bath'. These examples are in fact illustrative of the main aspects of the divisions between health and social care: financial, administrative and professional. 'The boundary' is multi-dimensional.

In regard to the financial dimension, Britain, unlike most other European countries, funds health and social care differently. Health authorities are funded directly from central taxation; local authorities receive most of their money (approximately 80 per cent by the mid-1990s) from central taxation in the form of a grant, and raise the rest themselves from a local property-based tax. Some commentators have suggested that this funding separation, together with the fact that resources have often been severely limited, has encouraged both local authorities and health authorities to minimise their responsibilities.[2] In the case of local authorities, this temptation has been increased by the fact that the government grant for social care is not ring-fenced. Local politicians may well consider other priorities to be more pressing. The user experiences the differences in terms of a stringent income and wealth means-test that is administered in respect of social but not health care services.

The second part of the health/social care divide is administrative. At the end of the Second World War, local authorities were left with the responsibility for providing residential accommodation under Part III of the 1948 National Assistance Act, together with a range of domiciliary services, including home nursing and home helps. The 1946 NHS Act made the health service responsible for both acute and 'continuing' care. In 1974, when the NHS underwent its first major reorganisation, home nursing was transferred to the health authorities and the administrative boundary was thus drawn more tightly still between these and the local authorities. The definition as to what constitutes health and social care has therefore shifted over time. Since the late 1950s hospital doctors have repeatedly complained that their acute beds are 'blocked' by elderly patients, whom they suggest require social rather than health care. Local authorities, on the other hand, have protested that they are having to care for individuals with ever-greater degrees of infirmity. Meanwhile, as interest groups for elderly people have pointed out, individual service users have been caught in the middle of these disputes.

The third dimension is the professional divide. Numerous professional groups, including general practitioners, hospital consultants, hospital and home nurses, home care workers and social workers to name only the most obvious ones, are involved in the delivery of health and social care. Inter- and intra-professional rivalries and genuine disciplinary differences in approach have been and are rife. The problem of bathing cited above involves two different professional groups - nurses and home care workers - employed by two different authorities.[3] Under the 1946 NHS Act, hospitals were instructed to provide long-term care services for any elderly person in need of constant nursing and medical attention. However, this definition of the hospitals' role proved increasingly controversial not just for government concerned about costs, but for professionals too. Hall and Bytheway have suggested that hospital doctors have sought to limit the definition of health care in line with the prevailing 'acute ideology' in medicine and have thus tried to restrict entry to hospitals by controlling assessments of patients' needs.[4] On the social care side, local authority social services have tended to be residual in the post-war welfare state in terms of their client group, who are disproportionately poor, and in terms of the policy agenda. The status of the main professional group involved, social work, has been concomitantly much lower than that of medicine. Social workers fought to free themselves of medical control within the local authorities, which they accomplished in the early 1970s, and they have continued to be wary of the influence of 'the medical model'.

It is important also to note that the division between health and social care is far from simple in terms of what is actually provided. The social care provided by local authorities has always included both institutional and domiciliary care, but the idea of 'community care' (developed first in relation to the mentally ill[5] and later in respect of elderly people) has increasingly come to mean shifting the balance in favour of the latter. However, health authorities have continued to view any provision outside the hospital as community care.

But what is the story of the health/social care divide and why has it survived? The health/social care boundary has not been the subject of very much academic analysis. During the 1970s, there were a number of studies of joint planning (between health and local authorities) and of joint finance, in other words, evaluations of the policy of the day.[6] But we have little sense of how the problem of the boundary has been approached by policy makers over time, and whether, for example, the kind of issues that have reached the top of the policy agenda in the 1990s are new or not.[7] Our investigation, which is largely confined to central government's policy making, shows that it has always been hoped that 'a seamless service' would develop (although that particular term was coined by the Department of Health in introducing the 1990 NHS and Community Care Act).[8] The way in which the problem has been defined and in relation to which particular issue and which particular professional group has shifted over time, but our study reveals more by way of continuity than change.

The boundary was acknowledged as a policy issue from the inception of the NHS, particularly in relation to *institutional* care. It was defined in the late 1940s on the basis of the need for hospital or for local authority residential care. Prior to the setting up of the NHS, elderly people had to resort to either poor law or municipal hospitals where the standards of medical and nursing care for this group was often low. Thus access to care in NHS hospitals that was free at the point of delivery was highly regarded by patients and something that politicians did not wish to be seen to dilute. In the early 1950s, the problem of elderly people gaining admission to hospital was as politically sensitive as the issue of hospital discharge is today. Nevertheless, since the late 1950s policy has consistently edged towards limiting the role of the hospital.

We argue that the way in which the problem of the health/social care boundary has manifested itself in terms of the policy debate has been as a struggle over the respective responsibilities of health and local authorities. From the late 1950s, central government favoured the view of the Ministry's hospital division and medical department, as well as that of many hospital doctors that the number of geriatric beds should be limited. Drawing the NHS boundary more tightly around an acute-only hospital suited both policy makers concerned about costs and the professional inclinations of many hospital doctors. A lower bed norm for elderly patients was set in 1957 and this was confirmed by the 1962 hospital plan. However, the definitions as to what sort of need merited what kind of institutional care was not changed until the mid-1990s, which meant that local authorities could legitimately claim that they did not have any formal responsibility for borderline cases. In short, both health and local authorities endeavoured to avoid responsibility for what was, in the context of demographic change, a growing 'intermediate' group of people who were in need of nursing and/or medical attention on a very regular but not constant basis.

We argue that while central government was determined to reduce the number of geriatric hospital beds, it was not prepared publicly to admit that this would reduce the role of the hospitals in the continuing care of the elderly. There was a genuine hope that advances in rehabilitative medicine in particular would allow more people to be cared for with fewer geriatric beds, although the evidence of such advances was conspicuously lacking. To admit that the role of the hospitals was being reduced would have also been to admit that the local authorities had to do more, which carried financial implications. Local authorities had their own priorities, which in the case of institutional care, focused on upgrading the old Poor Law institutions (a matter of concern to central government as well) and relieving their own waiting lists for residential care. They were suspicious of any attempt to get them to do more in order to relieve the hospitals. It seems that this is one of main reasons why they were so slow to develop domiciliary services in the immediate post-war decades, fearing that this would enable infirm patients to be discharged from hospitals earlier.

The struggle over responsibilities between the two groups of authorities thus adversely affected service development for elderly people. Central government relied heavily on solutions that addressed only the professional divide between the two services, first exhorting professionals to co-operate and, by the 1970s, trying to impose new structures that would ensure co-operation. The political implications of addressing the administrative aspects of the boundary after the fight to establish the NHS were too great, besides which, the fudged nature of the responsibilities between the two services allowed for financial cost-shunting that was not wholly disadvantageous to governments eager to make cost-savings, even though it impeded service development.

The internal contradictions of a policy to shift more responsibility for the care of elderly people to the local authorities, without formally acknowledging any change in the responsibilities of either the health or local authorities, became severe by the end of the 1970s, but magically declined in the 1980s as a result of the massive, unintended injection of funds from the social security budget into private residential care. However, government could not let this way of solving the problem of the 'intermediate group' of elderly people needing care, which came about from a change in the regulations affecting social security, continue. The introduction of quasi-markets into health and social care with the 1990 NHS and Community Care Act gave a much larger administrative and financial role to local government in respect of community care, but closing the social security loophole brought the struggle over the respective responsibilities of health and local authorities back onto the agenda. Indeed, with the new transparency of the quasi-market, the disputes intensified.

Historical analysis carries no prescriptive power, but we can at least point to the extent to which the problems of the health/social care boundary are deep-seated, which we hope will also serve to clarify understanding of them. There is a considerable political science literature which suggests that policy change is incremental and that past decisions have an important constraining effect on contemporary choices.[9] By placing policy developments in their historical context, it is possible to identify longer term trends that tend to remain invisible when attention is confined to the most recent policy developments.

This study relies mainly on government records at the Public Record Office that relate to the policy debates between 1943 and 1966, and on published government documents for the later period. The debates between civil servants and ministers in the central health department (the Ministry of Health until 1968, the Department of Health and Social Security (DHSS) until 1988, and the Department of Health (DH) thereafter) were influenced to varying degrees by representations from the various actors involved in service provision and interest groups for elderly people, for example, the National Old People's Welfare Committee. The records show that the views of the British Medical Association and local authority representatives were particularly important.

References

1. On the growth of the elderly population since World War II, see Appendix 1. The numbers of over 80 year olds are projected to rise to 2.6 million by 2001. It should

be noted that the problems caused by the health/social care boundary are different for different user groups.

2. Giennerster H, Korman N, Marsden-Wilson F. *Planning for Priority Groups.* Oxford: Martin Robertson, 1983.
3. See Twigg J. Deconstructing the 'Social Bath': Help with Bathing at Home for Older and Disabled people. *Journal of Social Policy* 1997; 26, 2: 211-232.
4. Hall D, Bytheway B. The Blocked Bed: Definition of the Problem. *Social Science and Medicine* 1982; 16: 1985-1991.
5. The term was first used by the 1955-7 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. Cmnd. 169.
6. See Giennerster *Planning for Priority Groups;* and Wistow G. Joint finance and community care: have the incentives worked? *Public Money* 1983; 3, 2: 33-7.
7. The most useful account by Means and Smith charts the general development of services for elderly people but is not based on primary sources. See Means R, Smith R. *The Development of Welfare Services for the Elderly.* London: Croom Helm, 1985. Appendix Two provides a chronology of the most important dates with respect to the development of government policy on the boundary.
8. Department of Health, *Community Care in the Next Decade and Beyond Policy Guidance.* London: HMSO, 1990.
9. See for example, Heclo H. *Modern Social Politics in Britain and Sweden.* London: Yale University Press, 1974; and on the more recent theory of 'path dependency': Pierson P. *Dismantling the Welfare State?* Cambridge: Cambridge University Press, 1994.

CREATING THE GREAT DIVIDE BETWEEN HEALTH AND SOCIAL CARE

The creation of the boundary between health and social care was a side effect of the compromises made by the Labour minister of health, Aneurin Bevan, to secure his priorities in regard to the setting up of the NHS. His main concern was the establishment of a hospital service capable of providing uniform standards across the country, especially in respect of access to consultants.[1] This could best be achieved, Bevan believed, by nationalising the hospitals. However, such an option was extremely unpopular with local government and its supporters within the Cabinet.[2] To ease its acceptance, therefore, the Ministry guaranteed that local authorities would retain responsibility for domiciliary health services (such as district nursing and health visiting), together with the welfare functions they had held under the Poor Law (which was abolished in 1948). Thus, under the 1948 National Assistance Act local authorities were given responsibility for the provision of residential homes for older people, which, it was promised, would be transformed from forbidding poor law institutions into 'hotels'. The chronic sick would be cared for in hospitals rather than in these homes, which under the Poor Law had provided generally inadequate nursing and medical care.

There was disagreement among officials in the Ministry about whether such an administrative division was sustainable. Some suggested that conflict between NHS hospitals and local authorities would be reduced with the new structure because it entailed the abolition of the voluntary hospitals. Thus, one Ministry official contended that

> [because] the hospital system with which local authorities will be in contact will be a government system ... although occasions for friction will arise they will not be pursued or perpetuated as is often the case at present

> ... It seems probable that the mere existence of these two sets of services side by side will produce a day by day co-operation both in minor and major matters, and through that association will inevitably come the integration which is desired.[3]

Others were less optimistic. Scottish Office health officials believed that eventually local authority welfare services would have to be brought under the same administrative authority as the hospitals.[4] The division between hospitals and local health services was believed by some to be particularly unsustainable. One NHS official wrote in September 1945 in relation to the proposed tripartite structure: 'This can scarcely be defended. It would seem to be a corollary of the scheme that we should, later if not sooner, take over all the personal health services'.[5]

Once it was clear that, initially at least, a divided system was to be created, attention within the Ministry turned to the question of how the boundary should be defined and administered. Ministry officials decided that local authorities should be responsible for those in 'need of care and attention, [but] not ... constant medical and nursing attention', while hospitals should take responsibility for 'those in need of constant medical and nursing attention and those who are incapacitated by mental disorder'.[6] Thus the boundary was drawn above all in terms of *the need for different types of institutional care.* In a further commentary on this definition, one official explained that in relation to local authority residential care for the elderly:

> Maintenance in these homes and hostels will not include medical treatment of a kind for which a person would ordinarily be admitted to hospital, but a local

> authority should not of course be precluded from maintaining a sick bay or employing a residential nurse or from making arrangements with the local health authority to secure some domiciliary medical attention and nursing care for residents as might be provided for them by that authority if they were living in homes of their own.[7]

It was recognised, however, that such a definition was open to wide interpretation. There were, after all, large numbers of elderly people who needed constant nursing care but not constant medical attention, or who needed both, not all the time, but on a regular basis. Local authority representatives were particularly concerned about the definition. They feared a situation similar to that of the pre-war period when the municipal hospitals had largely been left to cater for the chronic sick, who had been excluded from the voluntary hospitals. If 'care and attention' was interpreted liberally under the new system, local authorities feared that they would once again be left with responsibility for the chronic sick, whose care was long-term and costly. They insisted, therefore, that the Ministry 'made perfectly clear that the local authorities [were] ... not under any obligation' in this regard.[8]

However, given the inevitable ambiguity of any needs-based definition, it was quickly apparent that the main issue would be: *who would decide where the patient should go for care?* Here the Ministry was absolutely clear. The need for hospital treatment could only be made on medical grounds and thus should be left to medical staff in the hospitals. This could also be justified on the grounds that hospitals had to be allowed to make decisions about how their beds were used. Unsurprisingly, given their concerns about access to hospitals on the part of the chronically sick, this decision was extremely unpopular with local authority representatives. They insisted that hospitals could not be trusted to make an objective assessment of need. 'There might be a tendency on the part of some hospital medical officers,' a local authority representative told Ministry officials, 'to restrict the admission of the chronic sick as much as possible'. For this reason he argued that 'a threesome committee of medical referees' should be established 'to lay down principles for admission'.[9] This would consist of one representative each from the regional hospital board (RHB) and the local authority, together with a 'neutral' referee, and would decide on the placement of all non-urgent cases.

The Ministry rejected the local authorities' proposal. Bevan told local authority representatives he could not accept that a hospital's decision on medical need 'should be subject to the jurisdiction of an independent tribunal'. Nevertheless, he reassured them that hospitals would be obliged to treat chronic, as well as acute, cases. In any case, he added, they had an interest in doing so because it was 'a matter of importance in medical education, since the student must receive instruction in all fields of medical work'.[10] These arguments did not convince the local authorities, who wanted more concrete guarantees, and ultimately they secured a small concession. The hospitals' power of decision was left intact, but local authorities were granted permission to undertake a 'periodic review' of the cases in residential homes. This would allow them to identify those for whom they believed hospital entry was necessary, but it would still leave the final decision to the hospitals. As will be seen, this concession was important because it allowed local authorities legitimately to disclaim responsibility for those elderly people they deemed to be in need of more than 'care and attention'.

Thus, the main focus for the Ministry in the 1940s was on establishing the general principle which determined the basis for the division between health and social care, and on addressing the issue of who should decide where those in need of care should go. The precise nature of the services that the health and social care authorities should provide did not become a policy issue. Rather, there was a general optimism about the future development of services on both sides of the boundary.

In respect of health care, some officials began to give consideration as to how the provision of care for the elderly and chronic sick could be improved in line with changes in thinking about the medical treatment of geriatrics. The pioneering work of Marjorie Warren at West Middlesex hospital was particularly influential. She had shown that early examination, investigation and treatment could achieve considerable results with elderly patients who might previously have been considered incurable.[11] The National Council for Social Services (NCSS) lobbied hard on this issue and found officials sympathetic.[12] The Ministry accepted the view that the pre-war system, which had often resulted in patients being dumped in large municipal wards where they received minimal treatment, would need to change. In future it was agreed that the emphasis should be on active and rehabilitative treatment. Patients should be taken into hospital early, where physiotherapy and occupational therapy, for example, would be made available. It was believed that prompt treatment of this kind would enable many elderly people to return quickly to their own homes or local authority residential accommodation. Only the most severely sick would have to be cared for in hospital chronic sick wards. However, the NCSS warned that if such a system was to work, the traditional lack of interest by the medical profession in these areas would have to be addressed. It would be necessary to 'educate the medical profession'.[13] Most important in terms of service development, domestic help from the local authorities would be essential if elderly people were to be enabled to stay in their own homes.

These ideas were to inform the Ministry's policy on the care of the elderly by the early 1960s. However, in the 1940s, its main concern in the social care field was to improve local authority residential accommodation so as to remove the taint of the Poor Law. Domiciliary care was not seen as a priority by the Ministry in the 1940s. Indeed, there was considerable reluctance among officials to sanction the development of general domiciliary care for older people because of cost; concerns that it would impinge on family responsibility; and the belief that it was an ideal function for the voluntary sector.[14] There was also some confusion about whether the National Assistance Board (NAB) had a role in this area.[15]

The only statutory provision that was generally available to the elderly as an alternative to hospital care was local authority residential accommodation. The Ministry fully accepted that significant improvements were required in regard to both quantity and quality to make this service acceptable to the public, hence the 'hotels' that were promised in 1948. For this reason, officials believed that it was essential that developments by local authorities should qualify for a specific government grant. Bevan agreed. 'The plain fact is,' he argued, 'that without the inducement of grants we shall not get the local authorities to put their backs into the new scheme and, as time goes on, produce the better kind of hostels and services which we want'.[16] The Treasury, however, was not convinced. It argued that, despite the rhetoric accompanying the reform process, the services being offered under the new National Assistance Act were not new but were merely a continuation of those provided under the Poor Law. It also pointed out that the local authorities had gained a new source of revenue (i.e. charges) and that the poorest authorities would be assisted through the new block grant system.[17] Ultimately, these arguments were successful.

References

1. Bevan argued that nationalising the hospitals was the only way of achieving as 'nearly as possible a uniform standard of service for all.' He suggested that 'under any local government system ... there will tend to be a better service in richer areas, a worse service in the poorer'. He also argued that nationalisation would create a more rational administrative structure and was justified on the basis that approximately 70 per cent of NHS finance would be provided by central government. See Public Record Office (hereafter PRO) CAB129/3. CP(45)205. Memorandum by the Minister of Health: The Future of the Hospital Service, 5 October 1945. See also Webster C. *The Health Services Since the War,* vol.1. London: HMSO, 1988, pp.80-8; Klein R. *The Politics of the Health Service* London: Longman, 1989, pp.118-21; and Pater JE. *The Making of the Health Service.* London: Kings Fund, 1981, pp.108-13.
2. Herbert Morrision was Bevan's major opponent. See PRO CAB129/3, CP(45)227, Memorandum by the Lord President of the Council: The Future of the Hospital Service, 12 October 1945.
3. PRO MH80/33, Briefing memorandum, 28 February 1946.
4. See undated memorandum from Scottish health department in PRO MH80/47.
5. PRO MH80/34, official memorandum, September 1945.
6. PRO MH80/47, Undated memorandum on the abolition of the Poor Law.
7. PRO MH80/49, Boucher instructions to parliamentary counsel, February 1947.
8. PRO MH80/48, Meeting between Ministry officials and joint officers of local authorities, August 1946.
9. PRO MH80/48, Meeting between Ministry officials and joint officers of local authorities, 8 October 1946.
10. PRO MH80/48, Minister of Health meeting with local government representatives, 15 October 1946.
11. Brocklehurst JC. *The Textbook of Geriatric Medicine.* Edinburgh: Churchill Livingstone, 1983, pp.1005-6. See also Wilkin D, Hughes B. In: Phillipson C, Walker A. eds. *Ageing and Social Policy.* Aldershot: Gower, 1986, pp.170-73.
12. See PRO MH130/252, Messer to Nye, 24 October 1946. The Ministry was also influenced by Nuffield Foundation's Committee on the Problems of Ageing and the Care of Old People set up in 1942. See Webster C. In: Pelling M, Smith RM. eds. *Life, Death and the Elderly.* London: Routledge, 1991, pp.168-9.
13. Ibid.

14. Means and Smith, *The Development of Welfare Services for the Elderly*, pp. 97 and 242.
15. The Rucker Committee on the reform of the Poor Law, for example, thought the NAB should provide 'a general domiciliary welfare service' for the elderly and infirm. However, this idea came to nothing. The Committee's ideas can be found in paragraphs 82-88 of the Rucker Committee's Report. See PRO CAB134/698.
16. PRO T227/12, Bevan to Dalton, 9 October 1947.
17. Ibid, see, for example, Dalton to Bevan, 3 September 1947.

THE FIRST SIGNS OF STRAIN: PRESSURE FROM OUTSIDE THE HOSPITALS

The means of determining the boundary between health and social care in respect of individual cases that was set up in the 1940s was a fudge. In proposing a definition of need and the means by which decisions on care should be taken, the Ministry had tried to balance the interests of the hospitals with those of local authorities. The main result, however, was to give providers on both sides of the boundary the opportunity legitimately to disclaim responsibility for the care of some elderly people. With resources tight on both sides of the boundary, this was bound to cause problems. These were exacerbated by the failure both to provide a grant for the expansion of local authority residential accommodation and to encourage the development of domiciliary services.

It was not long before the new system came under pressure, largely as a result of the upsurge in demand that accompanied the setting up of a hospital service that was universally accessible. The first complaints came from general practitioners (GPs) about the difficulties they were experiencing in securing old people access to hospital beds. As a result of the semi-detached nature of their incorporation in the NHS, the role of GPs in the care of the elderly seems largely to have been ignored. However, for most older people, the general practitioner was the first point of entry into the NHS. As early as June 1949, the British Medical Association (BMA) reported that the GP service was coming under strain, largely because hospitals were refusing to admit elderly people. It asked the Central Health Services Council (CHSC) to consider the problems being created by this situation.[1] More dramatically, the Local Medical Committee for the County of London reported in 1951 that a number of old people had died during the year because hospitals had not granted them admission.

The Ministry accepted that there was a problem. In a letter to RHBs and hospital management committees (HMCs), George Godber, the deputy chief medical officer, admitted that 'hospitals fear that... old people would for long periods block beds urgently needed for acute cases'.[2] The Ministry's response was to set up the emergency bed bureaux in November 1951, which guaranteed hospital entry to urgent cases. However, nothing was done in respect of non-urgent cases.[3] This was despite a series of recommendations in the CHSC's 531949 report by the Standing Medical Advisory Committee on the issue.[4] These were dismissed by Ministry officials as 'platitudes of pious hopes'.[5]

However, pressure on the Ministry to change its position continued. The National Old People's Welfare Council (NOPWC), in particular, launched a campaign on the issue with the support of a cross-party group in the House of Lords and some local authorities. This crystallised into two main demands. First, a new type of provision - commonly known as 'halfway houses' - was proposed in order to fill the 'gap' between hospital and local authority provision. Second, appeals were made for changes as to who made the decision about where patients should go. The NOPWC wanted the appointment of a single officer with statutory powers to make the initial decision on whether an elderly person should go to the health or local authority for care.

'Halfway houses' were seen by the NOPWC as particularly appropriate for older people who were 'not hospital cases but who require more care and attention than can be provided normally in residential accommodation' and the 'continually fluctuating type of cases ... who are alternately sick and in need of hospital care and non-sick but in need of special attention'.[6] They were based on the idea that if the costs of caring for this group were shared between the NHS and LAs (an early proposal for pooling resources), the financial incentive to both health and local authorities to disclaim responsibility for these people would be ended. Some authorities (e.g. Middlesex County Council) had already experimented with 'halfway houses'. Ministry officials, however, were extremely reluctant to support them. They questioned the very idea that there was a group of people who lacked cover under existing provision. 'We have ... little or no evidence,' one official commented, 'that old people on the borderline between health and sickness are falling between two stools'. While some people were undoubtedly failing to secure admission to any type of provision, this was due to 'the unwillingness of the administrative authorities on either side to take responsibility for them'.[7] The Ministry also pointed to the administrative and financial problems raised by the idea of 'halfway houses'. In particular, would inmates be charged, given that they were in effect straddling the financial boundary between health and social care?

If, as the Ministry argued, the problem with the system was the unwillingness of both the health and local authorities to take responsibility for borderline cases, the idea of a single officer offered a potential solution. However, this raised once again the thorny question of who should make the decision on hospital admission, the issue which had caused so many problems between 1946 and 1948. Ministry officials had no intention of changing their minds on this matter. Thus, they opposed the single officer idea and argued that it would be seen as a return of the Poor Law relieving officer, who had been such an unpopular figure in the pre-war system. Moreover, it would be administratively unworkable given that the officer would have to be an employee of either the local authority or the RHB.[8] Neither of these arguments was particularly convincing. It was Bevan who probably let slip the most important reason for the Ministry's opposition to the idea of single statutory officer. He told a deputation from the NOPWC that it could lead to hospital authorities being 'responsible for persons who were not sick', which 'he did not want'.[9] In other words, the Ministry was not prepared to leave the decision on hospital admission of elderly people to an individual or body who might take a less restrictive view than the medical profession. This concern about the 'burden' being placed on hospitals was to become an increasingly significant feature of central government's approach to the boundary issue during the following thirty years.

In response to the problems that had emerged by the early 1950s, the Ministry took the view that the health/social care boundary was not a problem in and of itself. Rather, there was simply a need for increased provision on both sides of the boundary. More resources would allow hospitals to provide more annexes for the chronic sick and local authorities to provide more residential homes. However, it was conceded that resource constraints were likely to continue for the foreseeable future. In the meantime, officials suggested, it should be possible to overcome boundary problems by 'the exercise of humanity and common-sense by RHB and local authority officers alike'.[10] One official claimed that '[t]he only thing necessary was goodwill ... to make sure that everybody was catered for'.[11] As the NOPWC pointed out, however, and as some Ministry officials had already implicitly accepted, 'there was no active co-operation [between the two sides] because the authorities concerned could not see how they could co-operate'.[12] Both sides had a very strong interest in avoiding responsibility for cases about which there were any doubts.

References

1. PRO MH99/115, CHSC minutes, 21 June 1949.

2. PRO MH99/116, Letter by Godber to HMCs and RHBs, 19 January 1952.
3. See PRO MH99/116 for the setting up of the emergency bed bureaux.
4. The CHSC suggested that there should be more treatment at home by domiciliary services; greater use of convalescent homes; earlier and more active treatment of elderly patients; and the use of old isolation hospitals for housing the chronic sick. See PRO MH99/115, CHSC minutes, 21 June 1949.
5. PRO MH99/115, Clarke to Pater, 23 August 1949.
6. PRO MH130/266, Memorandum by NOPWC to Ministry, 23 March 1950.
7. PRO MH130/266, Brief for Minister on NOPWC deputation, April 1950.
8. PRO MH130/266, Pater notes on NOPWC memorandum, 15 November 1952.
9. Ibid.
10. Ibid.
11. Ibid.
12. PRO MH130/266, Meeting between NOPWC and Ministry officials, 17 November 1952.

While the major complaint of voluntary organisations, general practitioners and local authorities about the care of the elderly in the early 1950s was the difficulty in securing hospital admission, consultants warned that hospitals were becoming overwhelmed by older patients. They argued that this would get worse given the predicted rise in the proportion of elderly people in the population and would have negative effect on services for acute patients, which some consultants regarded as their core work.[1] Thus, some within the medical profession, particularly those linked with the emerging speciality of geriatrics, started to give serious attention to methods by which this 'burden' could be reduced. Their ideas were to influence the Ministry's approach to the problems created by the health/social care boundary.

Two developments in medical practice were regarded as especially pertinent. First, optimism grew among geriatricians about the possibilities of treating and rehabilitating elderly patients. As has been seen, these views had started to reach Ministry officials by the mid-1940s. By the early 1950s, they were more widespread and some hospitals had reorganised their geriatric services, dividing patients between assessment/acute rehabilitation and continuing care wards.[2] This was known as 'progressive patient care' and was regarded as the most efficient method by which patients could gradually be returned to a 'normal' level of functioning, measured according to physiological criteria or the ability to perform routine daily tasks, rather than the presence or absence of disease.[3] Second, in a linked development, views among the medical profession about the potential of care at home became more positive. Articles on the possibilities and benefits of domiciliary care became a regular feature of medical journals at this time.[4] Both these trends were further encouraged by similar developments in psychiatry, which were later reflected in the evidence given to the 1955-57

Royal Commission on the Law Relating to Mental Illness and Mental Deficiency.

By the mid-1950s, active treatment in hospital and care at home were becoming established as the panaceas that would reduce demand on the hospitals. As one geriatrician commented on the service most commonly associated with rehabilitation: 'there is a widespread belief that if only sufficient physiotherapy were available the geriatric problem would be solved.'[5] However, geriatrics as a medical speciality was far from strong, and it remained to be seen whether consultants would allow the transfer of funds to geriatrics that would be necessary to establish the necessary facilities for rehabilitative treatment. This issue was largely ignored in the mid-1950s. Instead, attention focused on the possible implications of such developments for hospitals' responsibilities: how far rehabilitative techniques and home care would allow a reduction in its provision for continuing care.

Some within the medical profession wanted a thoroughgoing re-definition of the health/social care boundary. For example, one leading medical academic suggested in 1952 that hospitals should only be responsible for patients requiring 'frequent medical attention and *skilled* nursing'. He argued that they should deal only with elderly people who required acute treatment or who could be rehabilitated. Anyone else should be cared for at home or in long-stay annexes, with local authorities taking responsibility for the latter.[6] This was an extreme view. Nevertheless, there was a consensus within the medical profession that local authority homes and domiciliary services should be expected to take responsibility for elderly people with far greater degrees of infirmity than had hitherto been the case. A report on geriatrics, published in 1955, also subscribed to this view. It emphasised, in particular, the potential of care at home and stated:

> (I)t should be the basic principle that the care of the elderly should be centred on the home and the general practitioner. The aim should always be to make any admission to hospital a temporary interlude only. To this end adequate domiciliary services of many kinds must be easily available, and the general practitioner must be able to command immediate support from the hospital and welfare services when the need arises.[7]

The report also suggested that there was a need 'for larger (local authority) homes for the infirm who require more care and attention' than was being provided by existing residential provision. The extent to which the BMA felt that hospitals would retain responsibility for long-term patients and the chronic sick was not made entirely clear. There was only a short section in the report on the provision of long-term annexes for the chronic sick, which concluded that these should continue to be provided by hospitals. In this respect the BMA's view differed from the more extreme proponents of 'acute-only' hospitals. Nevertheless, it reiterated that in respect of geriatric care, hospitals should increasingly focus their attention on acute treatment and rehabilitation. The Report concluded that '[t]he underlying principle should be that where admission proves to be necessary the stay in hospital should be regarded as a transient phase and discharge should be anticipated'.[8]

To ensure the practical implementation of this principle the BMA recommended that 'the practitioner who assesses priorities for admission to hospital beds for the assessment and treatment of the elderly should advise, through the medical officer of health, on admission on medical grounds to Part III accommodation [i.e. local authority residential homes]'. This meant that not only would the hospitals retain complete control over admissions to their facilities, but that their consultants would also have a say in admission to local authority provision. The report suggested - no doubt in anticipation of the local authorities' opposition to the plan - that this consultant could be jointly-appointed by the RHB and the local authority.

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3. Brocklehurst, The Textbook of Geriatric Medicine, pp. 1049-50. See also Jefferys M. In: Exton-Smith AN, Evans JG. eds. Care of the Elderly: Meeting the Challenge of Dependency. London: Academic Press, 1977.
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THE MINISTRY CHANGES GEARS: THE BOUCHER COMMITTEE AND THE POLICY SHIFT OF THE MID-1950S

A New Approach to the Boundary

The BMA's report prompted a major reassessment of policy on the health/social care boundary by the Ministry in the mid-1950s. During the late 1940s and early 1950s, officials had tried to steer a middle course in disputes over the respective responsibilities of hospitals and local authorities for elderly people. The main problem, they had argued, was a shortage of accommodation on both sides of the boundary. Given that no change could be expected in the short term, the system would have to be made to work by co-operation from both sides. All proposals for policy change were rejected. There was no need for a new intermediate type of residential provision; there was no prospect of improved domiciliary provision; the existing definition of care was defended; and the idea of a single officer was rebuffed.

In 1953, this policy of defending the status quo began to change. A debate began within the Ministry on how the problems created by the boundary could be addressed, based largely on the BMA's ideas. As a result, a three-part strategy was proposed. The first part involved reducing the non-acute role of hospitals in the care of older people. By implication, this involved a second set of measures to spell out the responsibilities of local authorities for residential provision and of hospitals for geriatrics. Here, the Ministry considered the option of re-defining the respective responsibilities of the two sets of authorities so as substantially to increase the nursing responsibilities of local authority homes. Consideration was also given to the BMA's proposal that hospital doctors should have a greater role in deciding where individual patients should go. The third part of the strategy entailed greater encouragement of the development of LA domiciliary services and of rehabilitation services in hospitals.

The most important documentary manifestations of this debate in the 1950s were the *Survey of Services available to the Chronic Sick and Elderly* (The Boucher Report), which provided the evidence on which the case for change was made (particularly in respect of the first part of the strategy on which the other two parts hinged) and two circulars (HM(57)86 and Circular 14/57) that accompanied the publication of the Boucher Report in 1957.[1] Ultimately, the issues raised by the debate were to have a major influence on the nature of the 1962 hospital plan and 1963 local health and welfare plan, and thus the subsequent development of services on both sides of the boundary.

The three-part strategy which emerged in the mid-1950s undoubtedly had the potential to reduce the problems created by the boundary between health and social care, had it been fully implemented in a co-ordinated fashion, albeit that this would have been on terms strongly favourable to the medical profession. It would, for example, have established a much clearer distinction between the respective roles of the hospitals and local authorities, with the former limited largely to the provision of acute care and the latter responsible, in collaboration with GPs, for all other types of care. Moreover, the notion of a central role for the medical profession in deciding which patients should go where would have substantially reduced the scope for local authorities to challenge the placement of individual patients in their care. However, the implementation of this strategy was to prove extremely problematic. Opposition both within and outside the Ministry to some of its basic elements was strong. As a result, implementation either did not take place or happened in an uncoordinated fashion.

There is evidence of the emergence at this time of a serious split between senior officials in the Ministry over policy regarding the health/social care boundary. The exact nature of this split is not entirely clear from the archival sources, but the main line of cleavage was between the hospitals division and the division dealing with local authority services. Moreover, it is also clear that many officials in the Ministry's medical department backed the hospital division's line, and that together this group gained an increasingly influential hold on Ministry policy in the early 1960s. These tensions were an important reason why the policy changes introduced after the 1950s debate failed to ease the problems created by the boundary and, if anything, made the situation worse.

The Ministry Investigates - and draws the boundary more tightly round the hospitals

There seem to have been two main reasons for the growing support among Ministry officials for a change of policy. The first was the persistent and growing concern about the rising cost of hospitals, especially given the realisation that a major building programme could not be put off much longer. The second was the powerful influence of the medical profession on some Ministry officials, especially those in its own medical department.

With regard to the first of these, Webster has suggested that 'the cost of the hospital service was the predominant worry' in the 1950s among officials searching for economies.[2] The sheer size of the budget as a proportion of overall NHS expenditure made it a tempting target for savings.[3] Moreover, the pressure was increased by repeated scrutiny from Parliamentary finance committees. The Select Committee on Estimates, for example, undertook three major reports on hospital costs between 1949 and 1957.[4] It seems likely that this pressure helps explain Ministry officials' desire to ease the 'burden' on the hospitals in respect of care for the elderly.

However, it would appear that the influence of the medical profession via the Ministry's medical department and from the BMA was the main reason for the Ministry's initial willingness to consider a change of policy. A firm link, for example, was established between the BMA's 1955 committee on geriatrics (see above, p.31/32) and the Ministry's medical staff. The BMA committee was set up in July 1953 and included two senior medical officers from the Ministry: J. Fenton as a sub-committee member and C.A. Boucher, as an observer.[5] Two months later, they were instrumental, together with Godber, in securing the establishment of the Boucher Committee by the Ministry's medical staff.[6]

The initial remit of the Boucher Committee was to 'investigate the facilities available under the National Health Service for the aged sick [and] ... examine the links between the National Health Service and Welfare Service.'[7] It was to do this on the basis of a survey of all the services for the elderly and chronic sick, with the exception of the mental hospitals, drawing on interviews with practitioners undertaken by the Department's regional officers during 1954 and 1955. It was then to submit recommendations for the extension of NHS services 'to meet present and future needs' and 'indicate lines of development along which closer association' between health and social care could be achieved. The Committee, as it was finally constituted, was dominated by the Ministry's medical staff, with only two relatively low-ranking lay representatives, and only one representative from the local authorities division. Its composition was therefore rather one-sided. Nevertheless, its conclusions were to strongly influence official policy during the following decade.

Despite the Committee's relatively anodyne remit, at least some of its members saw it as an opportunity to argue for a fundamental alteration in the Ministry's policy on the boundary, particularly in regard to limiting the role of hospitals. Once the survey of services for the chronically sick and elderly was completed, its findings were interpreted to suggest that the level of hospital provision was generally sufficient and that any problems were due to the inefficient use and distribution of beds. 'It cannot be assumed,' the Report concluded, 'that more hospital beds for the chronic sick are needed.'[8] Indeed, it continued:

> the number of beds ... in England and Wales is thought to be about sufficient in total, if they are properly distributed. Their efficient use depends on the strength of the rehabilitation service, the sufficiency of welfare accommodation for the infirm, and the adequacy of the local health authority services and of the voluntary services ... There should be much more effective liaison between the services concerned with old people.[9]

This conclusion was widely accepted in the Ministry - although, as will be seen, some officials in the local authority division were later to express doubts about its validity - and the Report was consequently used to legitimise a significant tightening in the role of hospitals. The Ministry's circular to RHBs that followed the publication of the Boucher Report in 1957 informed the boards that they could safely limit their provision for the chronic sick to 1.2 beds per thousand population (ptp), a figure based on the existing level of provision (as calculated by the 1954-5 survey of geriatric services). '(A)dmission to hospital,' RHBs were told, 'should always be a last resort and everything should be done to enable old people to stay at home'.[10] Thus it was proposed to recommend a definite limit on the number of elderly and chronic sick people entering hospital. The optimistic assumption of the 1940s that services on both sides of the boundary would eventually be expanded was abandoned.

To what extent did the evidence in the survey justify this policy change? Furthermore, how strong was the Ministry's commitment to the type of reforms in hospital and local authority care which it accepted were required in order to make this new policy work?

With regard to the first question, the text of the Boucher Report made it clear that there was no simple 'correlation between the number of chronic sick beds per thousand population and the adequacy of the service provided'.[11] However, it also presented evidence which strongly suggested that the need for hospital provision for the chronic sick was underestimated when the bed norm was laid down in the government circulars that followed the publication of the Report in 1957. Indeed, this evidence was downplayed in the Report's final conclusions, some of which were at odds with the tenor of evidence offered in the text.

The actual level of existing provision as established by the Boucher survey was 1.27 beds per thousand. The Ministry rounded this figure down to 1.2, and thus actually set a norm of 3099 beds below the existing level. This reduction could only be justified on the assumption that there were a large number of elderly people in hospital who should have been in local authority residential homes. This indeed was what the Boucher Report claimed in its conclusions. It suggested that there were 4,427 elderly patients in hospital who no longer required hospital treatment. It also suggested that there were only 1990 elderly people in Part III homes who required hospital admission.[12] However, in the body of the report it was made clear that the hospital figure had to be treated with caution. It was explained that

> [m]any of the patients regarded as fit for discharge were very frail and needed considerable help with dressing, feeding and toilet which was not always available outside the hospital ... The geriatric physician tended to overestimate their number because he thought in terms of those no longer requiring the full services of the hospital; yet a proportion would probably be unable to return home to independence even with the assistance of the domiciliary services; and a further group would require accommodation and staff of a type which the welfare authorities did not usually provide.[13]

Furthermore, there was considerable evidence to show that a large number of people, other than those in local authority homes, required a chronic sick hospital bed. The waiting list for such beds was 9,883 (almost 2,500 higher than the waiting list for Part III accommodation).[14] Even if only half of this number was assumed to be in genuine need the norm would have had to increase close to 1.4 beds per thousand population. In fact, due to 'difficulty of obtaining hospital admission', the Report found that there had been a 'considerable increase in the amount of nursing of the chronic sick at home, much of which was heavy and took considerable time'. This was confirmed by evidence which revealed the growing burden on district nurses and home helps.[15] With regard to the latter, it was suggested that 'the service was to a large extent masking the deficiencies of the hospitals', and that as a result, many home helps were having to work under 'intolerable conditions'.[16] In an attempt to ease the overall burden of home care for the chronic sick, some general practitioners had apparently sought 'admission of unsuitable cases to welfare accommodation in the belief that they would be transferred thence to hospital'.[17]

Finally, there was evidence to suggest that many chronically sick elderly people had been admitted to mental hospitals due to the unavailability of general hospital beds. In London, for example, the Report suggested that as many as 14 per cent of elderly patients in mental hospitals should have been in a general hospital. [18] It is clear, therefore, that a general hospital norm of 1.2 beds per thousand represented an extremely tough target.

Problems of Implementation

It was accepted in the Ministry that, if the setting of the target of 1.2 beds per thousand population was not to cause widespread disruption to the overall delivery of care, substantial reforms of hospital and non-hospital services were essential. The Boucher Report had highlighted the need for 'sufficient' Part III residential accommodation, 'adequate' local authority and voluntary sector domiciliary services, and a strengthened rehabilitation service in the hospitals.[19] Nevertheless, it was in these areas that the implementation of the post-1957 boundary strategy proved most problematic. There was conflict within the Ministry over the exact nature of the reforms required to bring about these changes. Even when there was consensus within the Ministry, there was often either strong external opposition to the policy process or doubts about the Ministry's ability to implement its proposals.

The proposal causing most controversy within the Ministry concerned the knock-on effects of a cap on hospital geriatric beds for local authority provision. Placing restrictions on hospital provision was bound to have implications for the type of cases seeking entry to local authority homes. Given the pre-war policy of the old voluntary hospitals in preventing the admission of chronically sick geriatrics and the persistence of complaints from GPs and local authorities since 1948 that NHS hospitals were continuing this practice, there must have been an expectation that the hospitals' response to a lower geriatric bed norm would be further to tighten their admissions procedures with respect to continuing care cases. This response was certainly anticipated by some members of the Boucher Committee. Even before the 1954/55 regional survey of provision had been completed, they proposed tightening the definition of the boundary to increase the responsibilities of local authorities for institutional provision. Thus, Boucher and, perhaps surprisingly, Aves (the chief welfare officer) proposed that

> [a]ged persons who [were] sufficiently infirm to require constant care and attention including maybe nursing supervision, but not nursing care, ... some of whom [were] bedfast should remain under local authority care, but should have the services of a consultant geriatrician made available if necessary ... [N]ursing attention might be needed even more than [could] be provided by the home nursing service, and ... no objection [should be made] to a trained nurse or a S[tate[E[nrolled] Assistant] N[urse] being appointed to the staff of a local authority home for old people, although it was anticipated that patients from outside requiring this type of accommodation would normally in the first place, be admitted to a geriatric unit ... [P]atients already in the home need not necessarily be.[20]

This would have represented a significant increase in the duties of the local authorities and made them responsible for residents with much greater degrees of infirmity. However, some on the Committee, including Godber, thought Aves and Boucher's proposal went too far. Godber was concerned that, despite the stipulation that residents would be visited by the hospital geriatrician, such a change would mean the abandonment of the 1940s commitment to end the Poor Law practice of grouping together the chronic sick in designated hostels with inadequate medical or nursing care. For this reason, he was highly suspicious of increasing the nursing responsibilities of local authority homes and proposed that they should rely solely on the home nursing service.[21] He felt that the number of bedfast residents in each home should be strictly limited. As was later to become apparent, the local authority division strongly supported this position (see below, p.57/58).

Ultimately, a compromise was agreed under which the responsibilities of local authorities were increased but to a much lesser extent than was implied by the Boucher Report. The 1957 government circulars made it clear that in large residential homes 'staff with nursing experience' could be employed to tend those who only had a few weeks to live.[22] Moreover, hospital authorities were informed that their responsibilities did not include *'all* medical or nursing care ... however minor the illness or however short the stay in bed'.[23] Nevertheless, given Godber's concerns, it was made absolutely clear to the welfare authorities that they were *not* expected to 'give prolonged nursing care to the bedfast'. The creation of 'separate infirmary wards' was also specifically discouraged.[24] Hospitals would still be expected to care for the long-term sick despite the 1957 bed norm.

Thus the circulars formally confirmed the responsibility of hospitals for continuing care. The responsibility of LAs was marginally increased in regard to nursing provision in their homes. These definitions were not formally revised until 1995.[25] Yet they left a large 'grey area' in respect of responsibilities for what in the

1940s had been termed the 'intermediate' groups of elderly people needing care. Moreover, privately Ministry officials accepted that setting the geriatric bed norm at 1.2 ptp would effectively amount to a reduction in non-acute role of the hospitals. With LAs still legitimately able to disclaim responsibility for the more infirm, unsurprisingly battles continued to be fought around this group.

There was also controversy in the Ministry over another aspect of the issue relating to the respective responsibilities of hospitals and local authorities. This involved the question of the administrative procedure for admissions to hospitals and local authority homes. On this issue the BMA had proposed (in its 1955 Report on geriatrics) the joint appointment by RHBs and local authorities of a consultant, who would classify patients according to their needs. This proposal would have ensured a clearer procedure to decide on difficult cases at a local level (albeit on terms favourable to the medical profession) in the absence of a more precise definition of responsibilities by the Ministry. The Boucher Report's conclusions ignored this idea, but it was picked up in the 1957 circular to RHBs, where it was proposed that geriatric physicians should have an advisory role in local authority decisions 'on the medical aspects of applications for admission to Part III accommodation from persons living in their own homes'.[26] Local authorities had consistently opposed such a move, fearing that hospital doctors would use their increased power to place more chronically sick people in Part III accommodation and there is evidence that the Ministry's local authorities division also opposed this in the mid-1950s. The 1957 circular to local authorities, which officials from the local authorities division drafted, reassured them that the new proposal did 'not in any way imply that all admissions to Part III accommodation should be via geriatric units or medically controlled'.[27] However, this statement merely increased the ambiguity of the proposal which, taken together with the fact that it was non-statutory and thus could be ignored by local authorities, reduced its usefulness as a means of easing the problems created by the dispute over responsibilities.

With regard to domiciliary services, there appeared to be more consensus within the Ministry on the need for change. The Boucher Report had suggested that these were 'the key to the problems stemming from an aging (sic) population'.[28] Nevertheless, even here problems existed which made the successful implementation of change questionable. The Ministry's language was cautious. For example the circular sent to local authorities stated:

> As regards the domiciliary health services, the survey indicates that in most areas they are adequate though they are under heavy pressure but that in some areas they are too thinly spread to provide an adequate standard of service. The Ministry *hopes* that as financial and other circumstances permit deficiencies will be made good where they exist.[29]

Policy in respect of domiciliary services relied on encouragement and exhortation. Moreover, the Ministry made no promise at this time of an increase in central government resources for domiciliary services. No commitment was made to extend their scope. Instead, local authorities were urged to improve the planning and co-ordination of the existing services to improve their effectiveness. Any extension would have to come from greater voluntary provision. The circular suggested to local authorities that the time was ripe 'for renewed contact between themselves and voluntary bodies working in the area with a view to further encouragement of voluntary help and efforts'. It continued: 'Only if such resources are properly utilised to supplement the work done through official channels can old people requiring help be provided with a service which it would be beyond the capacity of the statutory officers, whether health visitors or welfare officers alone to provide'.[30] What the circular ignored, however, was that the growth of voluntary sector services for the elderly had been disappointing in the early post-war years.[31] It was the mid-1960s before any major expansion took place, with the formation, for example, of Age Concern.

The main reason for this reticence about extending domiciliary services was financial. The Ministry's regional officials who undertook the Boucher survey were warned explicitly that resource constraints meant that they should take care 'not to urge extensions of local authority services which involved increased expenditure'.[32] The situation had become even tighter by the time the Boucher Report and its accompanying circulars were published in 1957. They coincided with a major Treasury retrenchment campaign which ultimately resulted in the resignation of the Chancellor of the Exchequer, Peter Thorneycroft. In these circumstances, the Ministry had little chance of securing resources for any improvement or extension of existing services, especially as it was also trying to make the case for a hospital building programme.[33] There was also continuing concern about increasing the role of the state in areas traditionally regarded as the responsibility of families.

There was in any case little evidence that local authorities were enthusiastic about domiciliary services. Many regarded the replacement of the old Public Assistance Institutions (PAIs), which continued to be used as Part III accommodation, as the overwhelming priority if new resources were to become available.

As Means and Smith have suggested, many local authorities believed that the potential of domiciliary services to serve as an alternative to residential accommodation was being exaggerated.[34] Thus, once the tight fiscal policy of 1957/58 began to ease, it was expenditure on local authority residential accommodation, rather than domiciliary provision, that received most attention.[35]

The Ministry also had doubts about its ability to secure the implementation of its proposals at the local level when it came to the issue of setting up geriatric units. As the Boucher survey and the 1957 circulars had made clear, the widespread establishment of such units practising rehabilitative care was essential if the 1.2 ptp. bed norm was to be achievable. Yet, the whole idea of specialised geriatric units remained a matter of intense controversy within the medical profession. As the BMA's 1955 report admitted 'whilst the extension of special geriatric units [was] advocated by many, others favour the treatment of the elderly in general wards'.[36] Enthusiasm for the specialism of geriatrics (if indeed it was accepted as such) was sporadic and, consequently, it seemed doubtful as to whether scarce resources would be re-directed towards geriatric medicine by RHBs. Indeed, Boucher felt the need to undertake a survey of geriatric provision in 1961 in an attempt to maintain interest in the idea.[37] Up to the mid-1970s the setting up of specialist geriatric units was to prove disappointing.[38] Again, the Ministry could only exhort.

Thus, while by 1957 a strategy for reducing many of the problems created by the boundary existed within the Ministry, internal departmental divisions meant that important issues were not agreed by all officials. This together with the limited power of the central department to affect local decisions made its full and co-ordinated implementation highly problematic. As a result, implementation of the Ministry's policy was one-sided. While it was accepted that geriatric provision by hospitals should be limited, there was no concomitant agreement that the responsibilities of local authorities for making provision for more infirm people in terms of residential and domiciliary care should be increased. The 1957 circulars represented only a limited attempt to make the definition of the respective responsibilities of hospitals and local authorities more precise. The change proposed to the admissions procedure of local authority homes, which might have eased the problems caused by this lack of precision, was ambiguous. Furthermore, any hope that an expansion of LA domiciliary care on the social care side and rehabilitation services on the health care side would make the 1957 policy workable, was undermined by the lack of commitment - both at central and local levels in the case of the former - to these forms of provision. There was a real risk, therefore, that instead of reducing the problems created by the boundary, the Ministry's change in policy would exacerbate them.

Evidence that matters did take a turn for the worse after 1957 was soon forthcoming. Complaints began to grow from local authorities about elderly patients in their residential accommodation whom they believed were in need of hospital admission. One local authority (Surrey County Council) was so concerned about the situation that it asked the Ministry's permission to provide a 100-bed nursing home for the chronic sick. It complained that '[hjospitals in the county were not providing long-stay annexes for the aged chronic sick who require prolonged nursing'.[39] General practitioners, too, complained that the situation was worsening.[40] It seems that many hospitals had interpreted the new directives, particularly the bed norm, as a justification for further limiting admissions of chronically sick geriatrics. More evidence to this effect was to become apparent in the early 1960s. However, as will be seen in the next section, the Ministry's preparation of the 1962 hospital plan resulted in the geriatric bed norm becoming more deeply entrenched.

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5. British Medical Journal supplement, 23 April 1955.
6. PRO MH130/266, Memorandum by J.Fenton, 9 September 1953. The full membership of the committee was: Sir Selwyn-Clarke (principal medical officer), Dr Maclay, Dr CA Boucher (medical officer), W.Aves (chief welfare officer), Lawson, H.M. Hedley (principal, hospitals and specialist services division) and J. McCree (principal, general practitioner services and local health services division).
7. PRO MH130/266, Memorandum by Fenton, 9 September 1953.
8. Survey of Services, p. 15.
9. Ibid,p.51.
10. PRO MH119/12, Circular HM (57) 86.
11. Survey of Services, p.15.
12. It was still anticipated at this time that an elderly person in a local authority home would be admitted to hospital if they became in need of more than 'care and attention' (i.e. prolonged nursing care).
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15. Ibid,pp.33-34.
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18. Ibid,p.47.
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20. PRO MH130/266, Third meeting of the Boucher Committee, 2 November 1953.
21. Ibid, Sixth meeting of the Committee, 15 February 1954; see also PRO MH99/157.
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31. See Bridgen P, Lowe R. Welfare Policy Under the Conservatives. London: PRO Publications, 1998, p.259. See also Townsend P. The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales. London: Routledge and Keegan Paul, 1964, p.397.
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33. The Ministry's negotiations with the Treasury are detailed in PRO T227/429,1168 and 1169. Its attempts to convince the Treasury of the need for a hospital capital programme are outlined in Webster, The Health Services Since the War, vol. 2, pp.92-109.
34. Means and Smith, The Development of Welfare Services for the Elderly, pp.266-8. Local authorities were concerned, in particular, about how elderly people at home would be cared for in the evenings and at weekends. With regard to home helps, there were also worries about staff shortages.
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40. Ibid.

A CO-ORDINATED POLICY AT LAST? THE HEALTH AND WELFARE PLANS OF 1962-3

In the early stages of his involvement with the preparation of A Hospital Plan for England and Wales (Cmnd. 1604) in 1962, Enoch Powell, the new minister of health, suggested that a major aim of the document was to 'show the links between [the Hospital service] and the rest of the health service'.[1] In order to reflect this aim, a separate section was included in the published plan commenting on its implications for the development of 'care in the community'.[2] The following year, a ten-year plan for the local health and welfare services (Health and Welfare: the Development of Community Care (Cmnd. 1973) was published to encourage development in this area. It appeared that the Ministry had finally established a co-ordinated policy on the purpose, development and delivery of hospital and local authority services.

Appearances, however, were misleading. In fact, hospitals policy dominated the planning process. The priority was to place a firm limit on the role of hospitals in order to reduce current costs and thus secure Treasury agreement to a ten-year expansion in capital expenditure. All other considerations took second place, including the health/social care boundary problems that had emerged in the late 1950s. *Health and Welfare* was a largely *ad hoc* attempt to encourage a complementary expansion of local authority services, particularly in the field of domiciliary care. However, Ministry officials recognised that they had insufficient resources (financial and managerial) to ensure that the scale and shape of the local authority developments were sufficient to match the changes proposed in the hospital plan.

The 1962 Hospital Plan

In the two years preceding the preparation of the hospital plan a major reorganisation of the Ministry of Health took place, which affected the development of policy in the early 1960s. This involved an important restructuring of the Ministry's divisional arrangements and significant changes of personnel in senior official positions. The hospitals division was split into three, with each new section forming a separate division organised on a regional basis and headed by an assistant secretary (the third-ranking official in the Ministry after the permanent and deputy secretary). Thus, the overall number of officials working on hospitals policy was greatly increased and the hospitals division's representation at senior policy-making levels was boosted. The most important change in personnel was the appointment of Bruce Fraser, a former Treasury third secretary, as the permanent secretary. He had been part of the Treasury's social services division during the 1950s, and had thus been involved in its attempts to control the rise in NHS expenditure.[3] These changes would seem in part to explain the increased determination in the department to push through the restrictive policy on hospital care for the elderly, which had been advocated by the 1957 circulars. The appointment of Enoch Powell as minister of health in July 1962 and the urgent need for a hospital capital building programme also pushed policy in this direction.

The Treasury was determined that in return for sanctioning an increase in hospital building, the Ministry should make real progress in reducing current expenditure. The Ministry acceded to these demands. It promised in July 1961 to limit the rise in hospital revenue expenditure to a maximum of two per cent a year.[4] To achieve this, officials considered short-term savings, such as increased charges, but also investigated what long-term savings could be made.[5] The Treasury was told that '[i]t was the convinced view of the Minister of Health that hospital running costs provide scope for savings; and ... there is no reason inherent in the hospital service why there should, on balance, be any net increase in hospital running costs from year to year'.[6] Thus, Powell decided in August 1961 to 'take ... on revenue expenditure ... a much more stringent line than has ever been adopted before in relation to hospital boards' revised estimates'.[7]

Given the high cost of long-term hospital care for the elderly, an obvious way in which these savings could be made was for hospitals to limit their role in the provision of non-acute care. Indeed, there is strong evidence to suggest that this was a major supplementary purpose of the hospital plan. This view is confirmed by the level at which the geriatric bed norm (the number of hospital beds provided per thousand of the elderly population) was set, the discussions that took place between Powell and senior officials about how this bed norm would be used, and Ministry debates on the question of hospitals' role in continuing care which took place during the preparation of the plan.

With regard first to the number of geriatric beds, it was decided early in the process leading to the plan, that the norm for future hospital provision for the elderly should be based on the 1.2 beds ptp figure laid down in the 1957 circular. This figure had already provoked criticism. The Welsh Board of Health and Scottish Office officials, together with local authority representatives, all complained in the late 1950s and early 1960s that the figure was far too low. The Scottish Office favoured a figure closer to 2 beds ptp.[8] Despite this criticism, the senior Ministry civil servants responsible for preparing the 1962 hospital plan decided that the number of geriatric beds should only be allowed to increase during the period of the plan in line with the expected rise in the elderly population. This would have given a figure of 1.4 beds ptp by 1975. As it turned out, even this small increase did not occur (see below, page 73).

Furthermore, there was also a change in the Ministry's policy on the implementation of the bed norm. Senior policy makers decided to adopt a much tougher approach than previously. Up to the early 1960s, those who had complained about the 1957 norm had been reassured that it was only meant as a guide and that there was room for local flexibility.[9] In June 1961, however, Powell and his senior officials agreed a more draconian policy. It was decided in discussions with the RHBs on the bed norm that

> initially, the object would be ... to clear up discrepancies, ascertain the reasons for local variations and the evidence held to justify them ... The Minister contemplated, at the next stage, we might need to do a good deal of persuading of Boards, to bring some of their figures - where no good reason could be discovered for regional variations - nearer into line with the standard.[10]

Thus, Powell and Fraser agreed between themselves that the figure was to be used to 'argue for reductions' in existing bed provision. It represented a 'maxifmum] ... for the purpose of reducing excesses above [it], not supplying deficiencies below'. Indeed, Powell hoped that eventually the norm might be modified downwards.[11] This new approach towards the bed norm was pursued vigorously once the various hospital boards had sent in their individual ten year plans. Those RHBs whose figures were in excess of the norm were put under considerable pressure to amend their plans.[12]

The news that the development of hospital geriatric provision over the next ten years would be based on the figure set in 1957 was met with widespread dismay. The County Councils Association (CCA), for example, complained in August 1961 about the inadequacy of the figure and questioned 'the findings on which it [was] based'.[13] The Executive Councils Association claimed that it would 'add to the difficulties which already exist in obtaining hospital accommodation for the elderly in many parts of the country'.[14] The local authorities' major concern was that the figure effectively implied that they would be expected to take an increasing responsibility for the care of the long-term sick. For example, the Association of Metropolitan Councils (AMC) complained in January 1962 that local authorities were being asked to 'make arrangements for the care of aged persons who are in need of constant nursing and medical treatment and who ought to be in hospital'. Rather than limiting their geriatric provision, the AMC argued that hospitals 'in making their ten year plans should allow for an adequate increase in the provision of accommodation for the aged and chronic sick ... local authorities must not be expected to accept automatically the residuary burden of responsibility for [this group]'.[15]

Nevertheless, in negotiations with local authorities, the Ministry denied that the underlying aim of the norm was to increase their responsibilities. Instead, officials continued to argue that given the implementation of an active treatment and rehabilitation policy in hospital geriatric services, the bed norm was more than sufficient. Such a policy, they suggested, made it possible to treat more people in the same number of beds. Thus, the freeze in geriatric bed numbers in relation to the rise in the elderly population, did not imply any overall change in the functions of the hospitals. Ministry officials insisted that they remained responsible for the continuing care of the chronically sick.[16]

However, despite this rejection of the local authorities complaints, by the early 1960s there seems to be a strong case for questioning the extent of the Ministry's commitment to the role of the hospitals in the continuing care of the elderly. Some officials had explicitly favoured a reduction in hospitals' functions in this area since the mid-1950s and their views had become increasingly influential in the early 1960s.

It was the Ministry's faith in rehabilitation and active treatment (together with the development of domiciliary care) that crucially underpinned the 1957 geriatric bed norm. A further survey of geriatric care was undertaken by Boucher in 1961 (in part to strengthen interest in geriatric medicine) and the subsequent report outlined the benefits of rehabilitative techniques in terms of patient turnover (i.e. the number of admissions divided by the number of beds on a yearly basis). However, it also raised important questions about who should care for those who could not benefit from rehabilitation. In particular, Boucher identified 'a category of patient,' who was very old and infirm and needed considerable assistance, including nursing. He claimed that this group was 'not really acceptable to hospital or welfare authority', but intimated strongly that such patients should be cared for by local authorities. He concluded that '[u]nless welfare authorities build realistic accommodation appropriately staffed, the hospitals will have to accept responsibility for long-stay ambulant residents'.[17]

Officials in the Ministry's local authority division had little doubt about the implications of this statement. They regarded Boucher's comments as an attempt to re-define the respective responsibilities of hospitals and local authorities set out in the 1957 circulars, without proper debate. Halliday, the assistant secretary in the local authority division, reminded his colleagues in the medical department and hospitals division that 'some of the observations [in Boucher's 1961 survey] affect the local authority and executive council services as well as the hospital service'. He continued: 'I am presuming that both ... divisions will be consulted before any final decisions are reached.' So far as the substance of the issue was concerned, Halliday made clear that on the basis of the 1957 definition of respective responsibilities, the hospitals were not fulfilling their required role. He questioned the extent to which they were 'genuinely trying ... to make provision in long-stay annexes to meet the needs of the elderly' as these had been defined in the circular of 1957. '[This is becoming a serious issue,' he continued, 'and I feel we ought to tackle it now and decide whether any guidance is needed for hospital and local authorities'.[18]

There seems to have been no response to Halliday's concerns. Instead, the assumption appears to have been made in the Ministry, particularly in the hospital divisions, that the non-acute role of hospitals was being reduced. For example, a brief prepared by Wallis, a hospital division official, for a House of Lords debate on the care of the elderly stated:

> It is the duty of the Hospital Service to care for patients who need active medical or surgical treatment or, at the very least, a considerable amount of nursing care. It is also responsible for rehabilitation and convalescent treatment of patients who have passed through the acute stage of illness but are not yet fit to return to their place in the community.[19]

No mention was made of long-term nursing care. On the basis of similar comments, Halliday observed at the end of the 1962: 'we are coming up increasingly against this view that hospitals only have a duty to *treat* the infirm ill.' 'They also have a duty,' he insisted, 'to care for those who need prolonged nursing'.[20]

It is also clear that Halliday believed that the geriatric bed norm had been set on the basis of this new approach to the hospitals' role and was thus too low. He observed that

> [t]he ratio was not produced in agreement with L[ocal] Authorities] Division ... when asked to comment, we always said the figure seemed to us to be too low. With the growing numbers of very old and very infirm people, this point will be thrust at us increasingly in the coming years. It seems to me that the onus must be on Hosps Div to prove that the suggested ratio is right.[21]

These concerns were largely ignored by senior policy-makers. The influence of the local authority division had declined after the reorganisation of the early 1960s. The bed norm was firmly established as Ministry policy.

To ensure that the norm did not cause a major decline in the overall level of care it was vital that the Ministry's commitment in the hospital plan to 'community care' was made a reality and that a co-ordinated pattern of local services was developed to make up for the reduction in the hospitals' role. This was meant to be the purpose of *Health and Welfare.* However, as the next section will show, there were a large number of obstacles to be overcome, not least the continuing dispute over the implications of the bed norm for the respective responsibilities of hospitals and local authorities.

The 1963 Local Health and Welfare Plan

It was widely accepted among senior policy-makers in the Ministry that the change in the role of the hospitals in respect of geriatric patients implied by the 1962 hospital plan would require a major expansion of alternative care services. Indeed, the RHBs had been told to assume that local authority services would be increased when they were asked to prepare their plans.[22] Enid Russell-Smith, the Ministry's deputy secretary, commented that it was vital that 'local authority developments keep pace with the expectations entertained of them.' 'A greater sense of purpose', she continued, 'needed to be instilled at the local level'. There had to be a 'general affirmation of community care'.[23] It was agreed that this should be achieved by the compilation of a separate ten-year plan for the local health and welfare services. This was the only way, suggested Fraser, to ensure sufficient 'impetus' on the part of the local authorities.[24]

A circular was thus drafted asking local authorities to outline their proposed developments during the following decade. This emphasised that care of the elderly should increasingly take place in the home and, consequently, that domiciliary services should receive priority.[25] At the same time, Ministry officials stepped up their pressure on the Treasury to agree to long-term financial planning to develop these services, particularly in respect of the loan sanctions that local authorities might expect over the next three or four years. They warned that without this, 'local authorities will never make progress with the preparation of their plans at the rate they should'.[26] The Treasury was initially reluctant, but as part of the deal which limited the rise in hospital current expenditure to 2 per cent in return for increased capital expenditure, it was agreed that expenditure on local authority health and welfare services (excluding mental health services) would be allowed to increase by 33/4 per cent a year. Moreover, in March 1962, the Ministry was also given permission by the Treasury to provide local authorities with 'planning figures' of approximately £20 million for future loan sanctions over the next three years.[27] This represented a significant increase on previous levels of growth, but from an extremely low base.[28] As will be seen, local authorities were extremely dubious about the reliability of the Ministry's figures.

Thus, the Ministry appeared to have a strategy in place to ensure that the development of local health and welfare services was adequate to cater for the reduced role of the hospitals. However, although the Ministry knew what it wanted to happen, this did not guarantee that its wishes would be met at the local level. Its power to affect the scale and shape of local developments was limited. It was unable to insist from the centre that local developments were co-ordinated with the hospital plan, but rather was reliant on the co-operation of local authorities. This was not forthcoming. As we shall see, continuing doubts among local authorities about the underlying objectives of the Ministry's policy on 'community care' soured negotiations on the local health and welfare plan.

As a result of these difficulties, the 1963 plan was hardly a 'national plan' at all. Rather, it was an amalgam of the individual proposals of local authorities compiled after a small amount of consultation with local hospitals.[29] The targets it contained consisted of averages of the local authorities' proposals, which hardly amounted to a rigorous assessment of future needs.[30] Moreover, rather than concentrating on domiciliary care as the Ministry had hoped, the major area of expansion proposed by the plan was in residential provision. Local authorities were keen to increase residential provision in order to reduce the waiting lists for this service and to improve its quality. They were less keen to increase domiciliary services which they believed were designed to provide hospitals with a means of either delaying the admission or speeding up the discharge of frail elderly people.

On the publication of *Health and Welfare* in 1963, the National Labour Women's Advisory Committee observed that there was 'no evidence of Government having given any leadership at all to the local authorities to assist them in working out their proposals'.[31] The documentary evidence suggests, however, that attempts were made in the Ministry to ensure a significant central input into the plan. Enoch Powell was keen for local service norms to be set in relation to the new more rigorous bed norm. He suggested that 'these ratios should then be built into the total requirements of staff and buildings for comprehensive community care.' 'The plans of individual authorities,' he continued, 'would be tested against these standards in much the same way as in the hospital plan'.[32] The problem was that the Ministry had no information on which to construct such a norm. It had done little research in this area and had insufficient time or, indeed, experience to undertake any before the date set for the plan's release. As one official admitted in relation to local authority homes: 'We have never pretended to know how many Part III beds per 1000 population are required to meet the needs of the area'.[33] J.P. Dodds, an assistant secretary in the Ministry and head of the local authority division, told a colleague that 'the fact that there is a norm for hospitals means ... that the rest of the aged ... will need to be looked after in the community *in some way.* It does not, however, point to definable separate norms for [each individual service]'.[34]

The reform of local government finance in 1959 also reduced the Ministry's power to affect decisions made at a local level.[35] The new general grant system, introduced mainly at the instigation of the Treasury, meant that one lump sum grant was paid by central government to local authorities rather than a number of specific grants for each individual service. This made it more difficult for the Ministry to target any increased money on one particular area:

the new resources would be swallowed up in the general grant and ultimately it would be left to local authorities to decide how they should be spent. Moreover, the general grant system also created suspicion in local authority circles about the reliability of the Ministry's expenditure figures. They questioned how valuable the promise of a 33/4 per cent increase in current expenditure was, given that the amount for health and welfare services was not ring-fenced within this general grant. The CCA was quick to remind the Ministry of this difficulty once the preparation of the local plan began. It warned in December 1961:

> The underlying assumption ... seems to be that because the Government will permit an extension of health and welfare services, local authorities will be in a position to extend them. There is still no mention of the most important and fundamental point that local authorities are concerned with many other services and that in deciding the rate of growth for the health and welfare they must also take into account what may happen in other services.[36]

The Ministry tried hard to influence the shape of the local authorities' development plans despite these limitations on its power to do so. During the preparation of *Health and Welfare,* the Ministry made clear that 'domiciliary health and welfare services should be developed as far as possible'. In contrast, it was lukewarm about the expansion of residential provision. It suggested that any proposal to expand Part III accommodation should be assessed in relation to the increase in provision of other forms of care.[37] The Ministry was reliant on the co-operation of local authorities for the implementation of these proposals. However, the chances of a co-operative relationship developing in the preparation of the plan were undermined by serious differences between the Ministry and LAs about its implications for the overall balance of care.

The local authorities feared that, when considered in conjunction with the hospital plan, the Ministry's proposals amounted to a change in the responsibilities of hospitals and local authorities in respect of geriatric care. The CCA, for example, questioned the references made by the Ministry to the proper role of hospital care. Ministry officials were informed that these were 'unsatisfactory', because 'it is quite wrong to suggest that if persons do not need *continual* nursing attention, they should be in an old persons' home'.[38] Its concern was so great that it asked for an explicit re-statement by the Ministry of the definition of respective responsibilities of hospitals and local authorities released by the department in 1957. However, the Ministry was not prepared to confirm or deny that its views regarding the respective responsibilities had changed, and it ignored the local authorities' request for a restatement of the 1957 definition.

Most notable was the emphasis placed by the Ministry on the development of domiciliary services. This represented a significant change of approach from the policy adopted after the Boucher Report in 1957, when it had been cautious about domiciliary care despite the enthusiasm expressed by the medical profession in the BMA's 1955 report on geriatrics (see above pp 32-3). Two factors, in particular were important in accounting for this shift. First, the 1955-57 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency had strongly endorsed the use of domiciliary services in its report published in 1957. This had led to the 1959 Mental Health Act, which the then minister of health, Walker-Smith had introduced in the House of Commons with a firm commitment to 'care in the community'. After this date, the Ministry's support for domiciliary services became more explicit and more frequent. Second, criticism of all forms of institutional care had begun to grow, particularly in the academic community.[39] Care of the elderly at home seemed to be an idea whose time had come.

However, local authorities viewed the Ministry's enthusiasm for domiciliary provision with suspicion. This was because it could be interpreted as a means of allowing the hospitals to restrict their role in respect of geriatrics. Local authorities feared that an expansion in domiciliary services might encourage hospitals to discharge elderly people with greater degrees of infirmity more quickly (or refuse them admission for longer) in the knowledge that the LAs would be less able to refuse to take responsibility for their care. Whereas local authorities had some role in negotiating the flow between hospitals and their residential accommodation, this was less true with regard to the flow between hospitals and home. This situation had been made apparent during the course of the 1954-5 regional survey, which found that a 'common criticism' of home nurses was that hospitals discharged elderly patients 'prematurely' into their care.[40]

These concerns were reflected in a long letter to the Ministry in which the CCA made clear that it regarded the emphasis placed on domiciliary care as an attempt to shift the costs of care from hospitals to local authorities. Such a move, it also suggested, reduced the overall standard of care. Like Richard Titmuss in his noted lecture on community care, delivered in 1961, the CCA understood that good community care was not cheap to deliver.[41] Thus, it complained:

> It is not accepted that it is universally agreed that the primary aim of services for the elderly is to help them

> remain in their own homes as long as possible. This doctrine can result in elderly people being kept at home at very considerable expense, by the provision of nursing, domestic help, night service and so on when their needs would be far better met by admission to hospital. Senile people can be kept at home, but for their own comfort and welfare they do need more or less continual care. This can be done by very considerable effort on the part of the local authority, but when all is said and done, the type of care that the old people really need is that of a residential establishment and because of the shibboleth of remaining at home as long as possible they are given second best.[42]

Given these concerns about the underlying aims of the plan, local authorities thus made clear that if the Ministry expected a major expansion in domiciliary services, better financial guarantees would be required. They warned the Ministry of the 'need for increased grant to take account of the expanding services of local authorities ... particularly in relation to some services (e.g. home helps) where [they] were more and more undertaking functions hitherto undertaken by the hospital authorities'.[43] They added that if this was not forthcoming, rather than being 'based on the anticipated demands for the domiciliary services, the plans would be founded upon realistic estimates of the extent to which the local authorities anticipate they can develop their services over the period ... taking into account ... the financial situation'[44] Indeed, the implication was that only the introduction of a specific grant for the expansion of domiciliary services would guarantee progress in this area. However, the Ministry was unable to offer any concessions in this regard. The Treasury was determined to prevent any relaxation of the general grant procedure and was, in any event extremely dubious about the Ministry's policy on domiciliary care, which it believed would ultimately prove to be more expensive than residential provision.[45]

As a result of the Ministry's failure to influence the development of the local plan, the completed document strongly reflected the views of the local authorities about the appropriate size and type of local health and welfare services. Thus, the area of greatest expansion proposed by the plan was in residential accommodation. Here it was proposed that provision should be increased over the next ten years from 14 places for every thousand of the population over 65 to somewhere between 18 and 22. In contrast, the plan's proposals for domiciliary services were conservative. It was proposed to increase the number of home helps only from 4.9 to 5.6 per thousand of the elderly population over a ten year period, while the rise in the number of home nurses would be even smaller - from 1.42 to 1.45.[46] This concentration on residential provision reflected the fact that most local authorities had long waiting lists for their homes and that many older people remained housed in pre-war PAIs, despite the 1940s commitment to abolish this form of provision. In short, local authorities regarded the local health and welfare plan as an opportunity for addressing the problems caused by the relative lack of investment in residential provision during the 1950s.

Thus, the local authorities' domination of the local plan seriously distorted the overall planning process of the 1960s. A reasonably large increase was proposed in the amount of residential provision, which could have eased some of the pressure on hospital beds. However, its effect was likely to be marginal so long as LAs were able legitimately to disclaim responsibility for the more infirm patients, preferring to use as much of their new residential provision as possible for people on their own waiting lists for whom they accepted an unambiguous responsibility. The failure of the plan to signal a major expansion of domiciliary services meant that any improvement in home care that did occur was unlikely to be sufficient significantly to reduce the demand from elderly people for hospital entry or to allow their accelerated discharge once they had gained admission.[47] The 'bed-blocking' controversy of the late 1960s and early 1970s tends to support this analysis of the two plans of the early 1960s, and it is to this controversy that we now turn.

References

1. PRO MH134/40, Powell to Butler, 20 December 1960.
2. *A Hospital Flan for England and Wales.* Cmnd. 1604. London: HMSO, 1962.
3. Fraser's involvement in the Treasury campaigns of the 1950s is detailed in PRO T227/744, 1118, 1119.
4. See Bridgen and Lowe, *Welfare Policy under the Conservatives,* p.274.
5. The importance of short-term savings by the Ministry as a method of financing the 1962 hospital plan has been emphasised by Timmins. See Timmins N. *The Five Giants: A Biography of the Welfare State.* London: Harper Collins, 1996, pp.208-213. In the event, the prescription charge was doubled, from 1 shilling to 2 shillings (lOp) and the NHS National Insurance contribution was increased. The importance of long-term savin
6. PRO 2SS21/786/01, Ministry of Health memorandum on NHS estimates for 1962/3, 14 December 1961.
7. PRO 2SS107/345/03A, Powell to Lloyd, 4 August 1961.
8. PRO MH99/120. In a letter to a Ministry official on 20 September 1959, Hughes, of the Welsh Board of Health, suggested that 'a figure well in excess of 1.2 per 1000 might be needed'. The Scottish Office informed the Ministry of their concerns on 3 March 1960.
9. See for example, PRO MH99/120, Shaw to Goodman, 25 June 1960.
10. PRO MH99/21, Memorandum on discussions with RHBs on bed norms, 30 June 1961.
11. Ibid, Powell to Fraser, 5 July 1961.
12. See for example the case of Leeds RHB in PRO MH130/33.
13. PRO MH134/40, CCA letter to the Ministry, 17 August 1961.

14. PRO MH99/162, Executive Councils Association letter to Ministry, 16 October 1962.
15. PRO MH134/41, AMC letter to the Ministry, 9 January 1962.
16. See, *A Hospital Plan for England and Wales.*
17. PRO MH99/163, Halliday memorandum, 3 November 1961.
18. Ibid.
19. PRO MH130/307, Draft brief for House of Lords debate on services for the elderly, November 1962.
20. PRO MH130/303, Note by Halliday on a letter from Yate to Paget, 22 November 1962. His italics.
21. Ibid.
22. See PRO MH134/40, Meeting between RHB chairs and Powell, January 1961.
23. PRO MH134/40, Russell-Smith to Fraser, 12 April 1961. The use of the term 'community care' became increasingly common during the late 1950s and early 1960s as a result of its use by the 1955-7 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency.
24. Ibid, Note by Fraser on the letter from Russell-Smith.
25. PRO MH119/16, *Circular 2162.*
26. Quoted in Bridgen and Lowe, *Welfare Policy Under the Conservatives,* p.274.
27. For the negotiations between the Treasury and the Ministry on the financing of the health and welfare plan, see PRO T227/1334, 1335 and 1336.
28. See Webb A, Wistow G. *Social Work, Social Care and Social Planning: Personal Social Services Since Seebohm.* Harlow: Longman, 1987, p.163. As will be seen, it was estimated in the 1970s that because of demographic change 2 per cent annual growth was required just to maintain existing service levels.
29. See Allsop J. *Health Policy and the NHS* London: Longmans, 1982, p.57; and Ham C. *Health Policy in Britain: The Politics and Organisation of the National Health Service.* Basingstoke: Macmillan, 1992, p.21.
30. Sumner G, Smith R. *Planning Local Authority Services for the Elderly.* London: Allen and Unwin, 1969, p.209.
31. Quoted in Means and Smith, *The Development of Welfare Services for Elderly People,* p.334.
32. PRO MH134/42, Memorandum by Powell, 17 May 1962.
33. PRO MH134/40, Briefing note on letter from County Councils Association, 22 August 1961.
34. PRO MH134/42, Dodds to Bavin, 16 March 1963. His italics.
35. Details of the reform of local government finance can be found in Raab CD. *The Reform of Local Government Finance in the 1950s,* forthcoming.
36. PRO MH134/41, CCA to Dodds, 21 December 1961.

37. PRO MH134/42, Long term Plan for Development of Local authority Health and Welfare Services: Notes for use in discussions with authorities, 2 April 1962.
38. PRO MH134/41, CCA to Dodds, 12 October 1961.
39. See for example, Townsend, *The Last Refuge.*
40. *Survey of Services,* p.34.
41. Titmuss RM, *Commitment to Welfare,* London: Allen and Unwin, 1968.
42. Ibid, CCA to Dodds, 17 October 1961.
43. Means and Smith, *The Development of Welfare Services,* p.266.
44. PRO MH134/40, CCA to Dodds, 17 August 1961.
45. See for example, PRO T227/1335, Dunster to Douglas, 28 April 1961. It is unclear what evidence the Treasury had to support this conclusion.
46. These figures have been calculated on the basis of the projected rise in the elderly population as indicated in the health and welfare plan (See *Health and Welfare,* p.13). The targets were not expressed in this way in the plan, but rather in terms of the overall population, the size of which was growing more slowly. Thus, the plan proposed that the number of home helps should increase from 0.54 to 0.73 per thousand of the population between 1961 and 1972, and that in the same period the number of home nurses should increase from 0.15 to 0.18/0.19 per thousand population. See *Health and Welfare,* paras.54-60.
47. This situation was accepted by Ministry officials. See, for example, PRO MH134/40, Note on letter from the CCA, 22 August 1961; and PRO MH134/41, Dodds to Dacey, 28 December 1961.

LOCAL AUTHORITY OR HOSPITAL FAILURE? THE 'BED-BLOCKING' CONTROVERSY OF THE LATE 1960s AND EARLY 1970s

After the health/social care boundary was established in the 1940s, the main concern that was expressed by GPs and LAs was about the lack of access to hospital beds for elderly people. By the late 1960s, the main concern was (the more familiar one) about the problems of discharging elderly people from hospitals. Hospital doctors tended to blame the lack of local authority provision, however this was far from the whole story. There is considerable evidence pointing to the failure to modernise hospital services in respect of geriatric care, which became additionally significant given the rising population of frail elderly people.

One consultant warned in the *British Medical Journal* in February 1969 that

> [h]itherto disaster has not overtaken us because acute ward and psychiatric sectors to which large numbers of elderly people ... are being directed have managed to speed up discharges of all types ... Those who practise acute hospital medicine have responded to the challenge by running ever faster ... But there is a limit to what the acute side can do and the time may come ... when it will grind to a standstill.[1]

This impression of an acute hospital sector overwhelmed by a rising tide of elderly people was supported by a large number of other commentators. Hazel, for example, reported that hospital beds 'are being blocked by the presence in the wards of elderly patients who do not require hospital treatment'. In common with most other observers, he blamed this situation on the lack of alternative non-hospital provision. The patients 'cannot return home,' he asserted, 'because of ... [the] lack of a home care programme'. Thus, the NHS was 'being overloaded by having to care for long stay patients who could more properly be dealt with by the local welfare authorities'.[2] The 'inadequate' provision of local authority residential homes was also blamed.

There is certainly some evidence to support this view. The proposed growth of local authority domiciliary services under the 1963 local health and welfare plan was modest in relation to the expected rise in the elderly population. Moreover, as Webb and Wistow have suggested, the subsequent rise in total spending on personal social services that occurred in the 1960s took place 'from a ludicrously small base'. Until the late 1960s, local health and welfare services were the smallest of the social policy programmes.[3] It was not until 1973/74 that any major increase of spending in this area occurred (see below, p.83). Nevertheless, some progress was undoubtedly made in the 1960s.[4] As Table 1 shows, contrary to the belief of some hospital consultants, there was a large increase in local authority residential places in the 1960s. In addition, legislation was passed in the late 1960s with the aim of encouraging a more rapid expansion of local authority services, mainly as a result of intensive lobbying by some politicians, academics and interest groups. The 1968 Health Services and Public Health Act provided local authorities with new permissive powers in relation to domiciliary services; gave them a duty to promote the welfare of elderly people; and made the home help service mandatory. This may be read as the Ministry's reaction to its failure to secure an adequate commitment to domiciliary care in the 1963 welfare plan. However, as Means and Smith have suggested, in many ways the process that led to this reform was indicative of the general lack of urgency which surrounded developments in domiciliary care. But, given the suspicion of LAs about the way in which domiciliary care might be used and the fears about its financing, central government had to proceed with a degree of caution. In any event, six years passed between the setting up in 1965 of the official body which advised the Government on the legislation and the final implementation of its proposals.[5]

Table 1: Places in Residential Homes for Elderly People 1959-1969

YEAR	Local Authority	All Provision
1959	62376	71412
1964	74691	85671
1969	89975	102536

Source: *Health and Personal Social Service Statistics, 1975* (London, HMSO, 1978); *Health and Personal Social Service Statistics, 1978* (London, HMSO, 1980).

There are good reasons for believing that the emergence of the controversy about 'bed-blocking' in the 1960s was as much or more the result of changes in the role of hospitals in respect of geriatric patients as it was the result of the failure to develop LA provision. In particular, there is evidence to suggest that the problems experienced at this time reflected the growing belief within hospitals that their role in the provision of long-term care could be reduced. We shall consider the degree to which the Ministry was responsible for this view. First, however, it is necessary to consider the nature of the change that took place in hospital provision.

The statistics in Table 2 show that the 1960s saw a significant fall in the number of geriatric hospital beds in relation to the size of the elderly population. While there was a 14 per cent increase in the elderly population, the overall number of hospital beds assigned for their use remained virtually static. It seems that hospitals were also putting much greater emphasis on short-stay provision by the

1960s. This view is supported by the 15.6 per cent increase in the number of annual discharges. It is possible that these developments reflected the growing influence in hospitals of the new speciality of geriatrics which, because of its emphasis on rehabilitation and active treatment techniques, was allowing more patients to be treated in the same number (or fewer) beds. However, while this may have been the case in some hospitals, there are strong grounds for doubting that this was occurring universally. Instead, it seems that in many areas there was a relative decline in provision without any accompanying change in the nature of the treatment received by elderly people.

Table 2: Average Daily Number of Beds for Geriatrics with Discharge rates in England and Wales 1961-1971

YEAR	Available	Occupied	Discharge
1961	56730	52989	149756
1962	57274	53685	154813
1963	57876	54373	158655
1964	57449	54817	157102
1965	57882	54783	158997
1966	58094	54859	167004
1967	58773	55571	165360
1968	59059	55494	178436
1969	56409	53021	166083
1970	57409	53595	171117
1971	57393	53725	173179
CHANGE	663	786	23423

Source: *The Annual Reports of the Ministry of Health* (1962-68); *and The Annual Reports of DHSS,* (1968-72).

The main evidence for this interpretation comes from the reports of the Hospital Advisory Service (HAS), which had a remit to investigate geriatric care facilities, together with those for mentally ill and disabled people. The HAS was set up in 1969 after a public scandal involving the ill-treatment of mentally disabled patients at Ely Hospital. Its investigations revealed the abject failure of geriatric medicine in many areas to gain recognition as a new speciality, together with the adverse effect this had on the level and standard of provision. The author of the 1971 HAS report warned:

> I must emphasise again that it does not seem from the visits made that Boards and Management Committees are paying sufficient attention to geriatrics. It is still usual to find that new hospitals are being planned with far too few geriatric beds, on the assumption that the geriatrician and other staff will be content to take over old and inconvenient premises vacated by other specialities ... Regrettably, it has been found that geriatric beds included in the early phases of some district general hospitals have been diverted for other purposes and in other areas geriatric beds have never been included at all in the planning.[6]

As a result of this neglect, geriatric care often took place in appalling conditions. In one area visited by the HAS, for example, provision was organised in a converted workhouse containing 200 beds: 'Patients have to be carried up and down stairs in chairs, the toilet doors are not wide enough to take a wheelchair, cubicle curtaining cannot be provided for all beds because of the window spacing, and only one or two wards have day rooms.'[7] The HAS was unequivocal in placing the blame for this situation on the medical profession. The author of the 1972 report stated:

> Hostility to geriatrics and to geriatric staff can be found at all levels in the hospital service and I am sorry to say that prejudice and lack of understanding occur amongst the most eminent in a Teaching Hospital as well as in the most isolated rural group. For example a Professor of (sic) a well known Teaching Hospital was heard to say that "medical students should not be contaminated by contact with geriatric patients". At another hospital the senior physician said "geriatricians are undesirable".[8]

As a result geriatrics was repeatedly undermined throughout the entire hospital service.

The neglect and low professional status of geriatrics inhibited the development of a modern geriatric service. For example, the HAS reported that medical students were discouraged from taking up the speciality and thus there was a general shortage of trained geriatricians. Even in those areas where a qualified geriatrician had been appointed, difficulties were experienced in establishing a service oriented towards rehabilitation. The general hostility to geriatrics meant 'that proposals put forward by the geriatrician within the Medical Advisory Committee [of the hospital were] ... automatically outvoted'. In other areas, where no geriatrician was in place, the appalling conditions made it impossible to appoint one. 'Is it surprising,' the HAS commented after visiting a particularly bad hospital, 'that there is difficulty in recruiting a geriatrician?'.[9]

These reports by the HAS throw a different light on the statistics regarding hospital geriatric provision in the decade after the 1962 hospital plan. In particular, they suggest that rather than indicating the development of a modern service based on the introduction of new medical techniques, the 1960s constituted a further period of neglect. It seems that the decreased emphasis on long-stay provision and the rise in the discharge rate were not predicated on any dramatic change in the treatment of elderly people.

What this would seem to suggest is that many hospital administrators interpreted the hospital plan as an indication that their responsibilities for geriatric care, particularly with regard to long-term patients, had been reduced, notwithstanding the fact that no public announcement to this effect had been made. Such an interpretation, while not justified on a strict reading of the text, was certainly a predictable response. The emphasis in the 1962 hospital plan on short-stay provision, home care and restrictions in bed numbers reinforced the belief (widespread in the medical profession) that hospitals should concentrate on acute care. Indeed, the plan's comments on long-term hospital care were cursory and ambivalent. In part, this reflected the fact that many Ministry officials did actually believe that the non-acute role of hospitals should be limited and it seems that these views filtered through to the hospital authorities. The Ministry's hopes that at least some reduction in long-term geriatric provision would be justified by the introduction of new medical techniques were largely disappointed. However, these hopes had always been overly optimistic. Officials were well aware of the difficulty geriatrics was having in establishing itself as a speciality and the Ministry had limited power to insist that hospital authorities set up modern geriatric facilities. Thus, setting so much store by them in the framing of the 1962 bed norm seems, at the least, to have been a major risk.

In any event, this lack of progress in hospital geriatric care provides an important alternative explanation to the lack of progress in local authority care for the growing problem of 'bed-blocking' in the late 1960s and early 1970s. Indeed, it was inevitable that the number of elderly patients occupying acute beds would rise given that there were inadequate facilities for their rehabilitation and that the overall number of beds per thousand elderly population had declined. Hospital doctors wanted to take less responsibility for long-term care. However, no change had been made in the definition of the respective responsibilities of hospitals and local authorities for long-term care, thus local authorities had every right to oppose this.

This analysis of bed-blocking as, at least in part, the result of failings in the hospital service was supported in the early 1970s by the HAS, which identified the failure of the medical profession to support the establishment of modern geriatric facilities as a particular problem. On the basis of its investigations, the service suggested that a substantial number of those who were assigned as 'disposal problems' or 'bed-blockers', suffered from 'complicated medical' conditions, 'many of which could be dealt with if a total approach to patient care [i.e. rehabilitation and active treatment] had been applied at the time of admission'.[10] In these circumstances, 'enlightened self-interest' should have ensured that 'acute specialities would welcome an effective geriatric service as the most certain way of keeping their own beds free of the increasing load of frail elderly dependent patients'.[11] Yet, it was not uncommon 'to find senior staff or committee members complaining about the failures of the geriatric department, [while] at the same time giving the staff neither the facilities, priority or status that they needed'.[12]

Later studies of 'bed-blocking' provided evidence to support the more general point that the controversy over this issue was dominated by the views of hospital doctors about hospitals' responsibilities for long-term care. For example, in a 1982 article tracing the history of the phenomenon and assessing hospital doctors' views, Hall and Bytheway concluded that the problem's 'significance ... is that it represents certain beliefs about the purpose of hospitals'. These beliefs were founded, they suggested, on the prevailing 'acute ideology' within the medical profession which emphasises length of stay (or throughput) as the main criterion of effectiveness. In these circumstances, 'it is unsurprising that people should feel unhappy at having the long-stay patient in their wards, and that this situation should be defined as "blockage".[13]

Whatever the interpretation of 'bed-blocking', its occurrence in the late 1960s and early 1970s seemed to indicate that the two plans of the early 1960s had not led to the co-ordinated development of services. Thus, attention increasingly focused on ways in which co-ordination could be improved. This was ultimately to lead to the joint planning initiatives of the 1970s. However, before considering these initiatives, it is first important to look at the degree to which concerns about the boundary impinged on the debates about the reorganisation of the NHS in the late 1960s and early 1970s, and how the subsequent reform, in 1974, resulted in a firmer administrative division between health and social care.

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A STRUCTURAL FIX? NHS REORGANISATION AND THE BOUNDARY

The Ministry's agenda in the decade after the mid-1960s was dominated by the issue of reorganisation. The 1968 Seebohm Committee on local authority and allied personal social services led to a major reorganisation of local health and welfare services with the formation of new personal social service departments headed by a director. The 1974 NHS Reorganisation Act meant that RHBs and hospital management committees were replaced by regional, area and district health authorities. The old tripartite structure was also abandoned, which had important implications for the nature of the boundary between health and social care. In particular, the administrative separation of health services from social care services was made more complete by the transfer of home nurses and health visitors from local authorities to the new area health authorities.

In relation to the Ministry's policy on the boundary between health and social care, two main questions were raised by this reorganisation process. The first concerns what influence, if any, the problems caused by the boundary between 1946 and mid-1960s had on the Ministry's approach to the debates about reorganisation. Reorganisation of the NHS and local health and welfare services had, after all, occasionally been raised during this period as a possible way of addressing these problems. For example, the Guillebaud Committee on the cost of the NHS, which reported in 1956, had heard evidence in favour of a unitary authority for all services for the elderly, with overall responsibility resting either with the local authorities or the health authorities. However, it concluded that 'a period of stability' rather than 'radical changes in the structure of the NHS' was the 'right way of seeking to solve the undeniable problems which arise from (the existing) division of functions'.[1] Officials willingly accepted this conclusion. They believed that given the ferocity of the debate over the formation of the NHS, any attempt to re-negotiate the agreement reached between the medical profession and local authorities in the 1940s was liable to be intensely controversial and disruptive. Thus, in response to a 1955 request by North West Metropolitan RHB that services should be organised under a unitary health authority the Ministry replied that

> it is not thought that the hospital services for the treatment of the elderly chronic sick could be divorced from the hospital services for the community in general. Similarly, with regard to the local authority services, it is not thought that those for the elderly could in full be separated from those for the other local authority services, of which they are an integral part.

'Full and active' co-operation, it was insisted was the best way of minimising any difficulties.[2]

There is no evidence to suggest that the views of Ministry officials on this matter had changed by the early 1960s. The entry of reorganisation onto the political agenda was certainly not part of a strategy initiated by the Ministry in order to solve the problems caused by the existing administrative boundaries. Rather, the issue arose mainly as the result of external pressures for change and, as in the 1940s, officials saw their role in terms of facilitating a compromise agreement between the competing groups (i.e. the medical profession, local authorities, the Treasury, proponents of managerial reform, and the newly-emerging social work profession).[3]

Most of these demands for change were only indirectly related, if at all, to the problems caused by the health/social care boundary.

For example, the setting up of the Seebohm Committee in 1965 and the subsequent structural reform of local authority services appears mainly to have been the result of professional pressure by social workers.[4] The growing belief among many social workers in the essential unity of their subject - notwithstanding the administrative divisions in the organisation of their work - and the benefits which might accrue from greater professional cohesion was a major factor. The growing emphasis placed within social work on family or community-centred explanations for social problems, as opposed to the earlier concentration on individual failure, also implied the need for a new organisational structure (though not necessarily that proposed by supporters of professional unity).[5] Together with growing public concern about juvenile crime from the mid-1950s onwards, these developments led to calls for the more co-ordinated development of services for the family, perhaps under a strengthened children's department.[6] It was mainly as a result of these pressures, rather than any concern about boundary problems, that the Ministry agreed to set up the Seebohm Committee. Ultimately the Committee's recommendations were a major cause of the tighter administrative division drawn between health and social care as a result of the reorganisation process. By proposing the establishment of social service departments separate from local health services, the Committee made the transfer of these services to the new area health authorities established in 1974 almost inevitable.

The demands of the medical profession for the reorganisation of the NHS, on the other hand, *were* related in part to the problems caused by the boundary. Webster suggests that growing criticism from doctors about the administrative complexity of the existing structure, were an important reason for the setting up of the 1962 Porrit Committee, which began the profession's campaign for reform. The Committee's recommendations included the proposal that local authorities be stripped of all their health services and many of their welfare services, and that these be placed under a unified health board.[7] However, as Webster suggests, the Report also reflected the medical profession's 'deep-seated urge for extension of the medical empire'. It lobbied hard during the early 1960s for the implementation of the Report's proposals. As a result, by 1967 a full-scale debate was under way, with the local authorities lobbying the Ministry equally hard for their preferred option (i.e. a locally-organised service).

The Treasury was also a major participant in this debate. Its major aim was to improve the managerial efficiency of the NHS by the establishment of a stronger management structure. These concerns were ultimately reflected in the setting up of a working party on management efficiency as part of the reorganisation process and the publication in 1972 of the 'Grey Book', which advised the new health authorities on their management arrangements.[8]

With regard to the implications for the health/social care boundary, Ministry officials were mainly concerned to facilitate a compromise agreement in the face of these competing demands. Thus, in respect of the overall organisation of the NHS and local government services, the DHSS supported the medical profession's proposal that 'health' services, such as health visitors and home nurses, should be unified with the rest of the NHS, but rejected its calls for local government 'welfare' services to be similarly subsumed.[9] This proposal was generally acceptable to the social work lobby. Indeed, given that, as most commentators suggest, the main aim of the Seebohm Committee was to differentiate social work from the medical profession, such a transfer was welcome. It certainly made the case for the medical control (by medical officers of health) of the remaining local authority welfare functions untenable.[10]

However, the proposed separation of health and welfare services was strongly opposed by local authorities. Considerable efforts were made by the Ministry, therefore, to compensate them for their loss. Local authorities were promised that the administrative boundaries between health and social services authorities would be coterminous and that they would be favourably treated in the arrangements for dividing up the health and welfare services.[11] It was on the basis of the latter that local authorities retained responsibility for home helps, despite the fact that the BMA (and, indeed, home helps themselves) wanted them to become a health authority responsibility. The result of this compromise was to make the administrative and professional boundaries between health and social care more firm.

This brings us to the second question about the Ministry's attitude to the reorganisation debate. Once it was accepted that the new structural settlement would not remove the boundary, were any new efforts made to reduce its impact on service delivery? This raised once again the issue of co-ordination between local authorities and health authorities. In this regard, there were two main developments. The first concerned the territorial relationship between the new area health authorities and local authorities, which it was agreed should be coterminous. As Webster suggests, the 'principle of territorial congruity between health and social service authorities ... assumed the status of an unquestioned assumption' from an early stage in the reorganisation process in the mid-1960s. Coterminosity, as it was later to be called, 'was one of the few features destined to survive through all the twists and turns of the subsequent labyrinthine planning process'.[12]

The second development involved the strengthening of arrangements for collaborative planning between local authorities and health authorities. Where these existed at all, they had been established on an informal basis in response to repeated Ministry circulars urging co-operation. However, there was increasing evidence that such behaviour was the exception rather than the rule, even where contact had been made between the two authorities. The Seebohm Report observed, for example, that

> [N]either the evidence we have received nor the visits and discussions we have had convince us that any of [the] means for securing co-ordinated action work satisfactorily. Although the success achieved obviously varies in different areas, overall the impression is of very limited success despite the expenditure of much time and energy.[13]

This was confirmed by a 1969 survey of local authorities' implementation of the local health and welfare plan, which found that while 'plans were sometimes ... discussed with other bodies, such as hospitals ... the tendency was to plan each service separately, and without allowance for the possibility of substitution of one service or group of services for another'.[14] As has been seen in the previous section, this lack of collaboration contributed to the problem of 'bed-blocking'.

The Seebohm Report suggested a structural explanation for the failure of voluntary collaborative planning which was later to prove influential. It pointed out that 'the financial interests and regulations of local authorities and [the hospital service] do not always coincide'.[15] In these circumstances, the Report warned, there was no longer much hope that 'informal' co-operation between professionals on either side of the boundary would improve service delivery. Instead, it argued that the relationship between the local authority social services and the NHS need to undergo a 'reconstruction', adding that 'there is need for imaginative ideas for trying new approaches and a refusal to be satisfied with any particular method merely because it has always been used in the past.'[16]

It seems that this widespread evidence about the failure of the voluntary approach to collaboration across the health/social care boundary, together with the realisation that the new structural settlement would tighten the division between the two sides, finally convinced DHSS officials that a more active policy had to be introduced to improve the situation. By itself, coterminosity was held to be insufficient. In any event, in 1971 a DHSS working party was set up to examine the arrangements needed to secure collaboration between the proposed health authorities and the local authorities. It concluded that '[c]ollaboration cannot be left to depend merely on common boundaries. Services of mutual concern have to be identified and arrangements made between the authorities to plan, develop and operate them so that they satisfy mutual needs'.[17]

It was thus recommended that a new statutory machinery for collaboration be established. In particular it was proposed that:

- Area health authorities and local authorities should be required to set up joint consultative committees, comprising members from the two sets of authorities.

- Health and local authorities should have the power to provide each other with resources and make staff available for the use of the other authority.[18]

The proposals were subsequently incorporated into the legislation which reorganised the NHS.

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The introduction of statutory mechanisms for joint planning as part of NHS reorganisation in 1974, was one of a series of initiatives launched between 1972 and 1977 which sought to address the problems the Ministry had encountered during the 1960s in shifting the focus of care for the elderly and other vulnerable 'priority' groups from hospitals to local authorities. In 1972, the new social service departments (SSDs), set up as a result of the Seebohm Report, were asked to compile a ten year plan, on the basis of a compound growth rate of 10 per cent. In addition, new Departmental guidelines were established for LAs, which were established on the basis of research undertaken by or for the DHSS. These developments were undermined by an economic downturn in 1973, but a new attempt was made in the 1976 DHSS document, *Priorities for Health and Personal Social Services: A Consultative Document,* to shift resources to services for the 'priority' groups on the basis of a much lower growth rate.[1] This exercise was based on another set of guidelines which were again set independently of local authorities. A scheme of joint finance, by which health authorities were granted funds to finance the development of services by local authorities was also introduced in 1976.

Thus the aim of increasing the role of LAs in the care of the elderly (still without any change in the stated responsibilities of the hospitals for the very infirm) was spelled out more explicitly in the planning documents of the 1970s, alongside the Department's more pro-active planning for the development of LA services. In part, this reflected the degree to which 'community care' had become an accepted goal across professional boundaries. There was some recognition of the financial implications of this shift in the form of the new money for joint finance, but the amount allocated was small. Above all, the Department relied on promoting collaboration through joint planning. However, this was unlikely to be sufficient to overcome local authorities' not unreasonable suspicion of any shift in the responsibility for the continuing care of the elderly.

Health officials hoped that these initiatives would prove more successful than the two plans of the early 1960s in encouraging co-ordinated development, so as to ensure that the decreased role the hospitals were playing in the care of the elderly was accompanied by a more rapid development of LA provision, especially in respect of domiciliary care. The continuing problems arising at the health/ social care boundary such as 'bed-blocking', were interpreted as an indication that the efforts of the 1960s had failed. It was hoped that improvements in the planning procedures of the Department and the formalisation of joint planning at a local level would address the problems that had arisen in engineering the shift from hospital to local authority care.

What was ignored in the introduction of these new initiatives was evidence that some of the difficulties encountered in the 1960s were not the result of the administrative deficiencies of previous planning exercises but were in fact due to the central problem of continuing disputes between hospitals and local authorities about the nature of their responsibilities. This question was not directly addressed in the period between 1972 and 1977, and the disputes continued, which caused serious difficulties for the DHSS's planning initiatives during the 1970s. Most analyses of this period have concentrated on the difficulties caused by structural, procedural and professional differences between the two authorities.[2] In what follows, the way in which these affected the planning methods introduced by the DHSS in the 1970s are summarised and their limitations outlined before turning to the underlying issue of respective responsibilities, which has received less attention in the literature. We argue that the failure of planning had much to do with the old issue of whether the NHS or LAs should take responsibility for the large group of infirm elderly people in need of long-term nursing and sometime medical care.

More Directive Guidelines

The independently-researched guidelines provided to SSDs as part of the 1972 planning exercise represented the first real attempt by the DHSS to move away from planning based purely on past trends in development. As Webb and Falk have commented, the guidelines signalled the adoption of 'an active Departmental role in the planning process and indicate[d] one channel through which the Department [could] exercise a stronger influence'.[3]

This more directive approach was maintained after the 1972 plan was undermined by the economic downturn. Indeed, more sophisticated mechanisms, such as the adoption of a programme budget structure, were established within the DHSS which enabled officials to outline their planning aims more precisely.[4] These were used in the drafting of the 1976 'priorities' document, and were vital in giving some credibility to the DHSS's claim that its ultimate policy goal of shifting the focus of care from hospitals to local authorities remained, despite the fact that the annual growth rate for personal social services had been reduced to 2 per cent. Thus, for the first time, priorities for service development in respect of each client group were accompanied by expenditure targets for individual services. Within the 3.2 per cent annual increase in spending that was proposed on services for the elderly (which included both health authority and local authority provision), it was recommended that expenditure should be targeted on domiciliary services,[5] with a 6 per cent annual increase in spending on home nursing and health visitor services; a 3 per cent increase on chiropody services; and 2 per cent increase each on home help and meals services.[6] Priority was also given to the expansion of rehabilitation and active treatment facilities in hospitals. A transfer of resources from acute specialities to geriatric medicine was proposed, with the majority of these new resources to be used in developing 'acute geriatric units in general hospitals with immediate access to full diagnostic, therapeutic and rehabilitation facilities'.[7] To this end, the document recommended that 1,150 additional geriatric beds a year should be provided and proposed that 30 per cent of all geriatric bed provision should be in general hospitals by 1979/80.[8] In contrast, no expenditure target was set for local authority residential provision. Instead, it was proposed that this only be increased by 2000 places per year, a level of expansion which the DHSS conceded was insufficient to keep pace with demographic trends and would not allow former PAI institutions to be replaced.[9]

In addition to these immediate expenditure targets, long-term goals were also set out in the form of 'Departmental guidelines for standards of service'. For example, the ideal standard for the home help service was set at 12 per thousand elderly people. Only 6 per thousand had been provided in 1974 (the most recent year for which there were figures).

Both health authorities and SSDs were subsequently asked by the DHSS to construct plans for future development on the basis of both the targets set in the 1976 priorities document, and the work to be done by the elaborate new planning system.[10]

New Planning Structures, New Money

Joint planning was seen as complementary to the national guidelines in the encouragement of co-ordinated development, but the exact methods by which it could achieved were only vaguely set out in 1974. The DHSS thus decided as part of the introduction of the new planning system, to reaffirm its commitment to the idea and to outline in more detail how the process might work. It reiterated that '[t]he Secretary of State's aim was to encourage joint planning ... in which each authority contribute[d] to all stages of the other's planning, from the first steps in developing common policies and strategies to the production of operational plans'.[11] Moreover, it proposed that in addition to the Joint Consultative Committee (JCC) of members of local and area health authorities, which had been established in 1974, an additional tier of joint planning should be set up. This would take the form of Joint Care Planning Teams (JCPTs), made up of officers from the two authorities. The aim was to fully entrench joint planning within the structures of the two main planning bodies.[12]

To complement this more detailed picture of the structures it considered appropriate, the DHSS also announced in 1976 the introduction of joint finance. Under this scheme, area health authorities were allocated a sum of money which could be used to finance urgent expenditure by their associated personal social services department, 'where it [was] accepted by both health and local authorities concerned that this would yield a better return in terms of total care'.[13] The scheme was thus similar in principle to a specific grant. It was meant to circumvent the obstacles to the development of local authority services posed by the general grant system of local government finance (see above, p.61) In theory, joint finance money had to be spent on the personal social services, unlike the money provided to local authorities through the general grant.[14] The scheme also provided a means of transferring resources from the NHS to the personal social services at a time when resource constraints made it difficult to attempt to transfer resources from the NHS within the DHSS budget. Nevertheless, only £20m was initially assigned for the purpose of joint finance, and although this figure rose incrementally over subsequent years, the relatively small amounts provided for joint finance suggest that its main aim was 'to be the catalyst for progress in joint planning'.[15]

The Failure of Planning: 1976-80

(i) Mechanisms

The fiscal problems of the early and mid-1970s undermined the DHSS's more interventionist strategy for encouraging the co-ordinated development of health and local authority services. Despite the 1976 attempt to prioritise those services that would help to reduce the role of the hospitals (i.e. LA domiciliary services and hospital rehabilitation units in the case of elderly people), it was recognised by the Department that the reduction in the level of expenditure would mean that progress in this regard would be slow, particularly in relation to LA services. Indeed, in respect of services for the elderly, the publication of detailed expenditure targets was quickly regretted, and they were ultimately abandoned.[16] While overall spending by SSDs on the personal social services between 1975/6 and 1981/2 was ultimately to exceed the target set in 1976, the proportion spent on elderly people fell during this period.[17]

Furthermore, as commentators have shown, there were a number of problems with the DHSS's new initiatives regardless of resource problems.[18] First, it was not clear why the establishment of a more sophisticated set of guidelines and expenditure targets should be significantly more successful than previous sets of centrally determined targets in stimulating health and local authorities to develop their services in accordance with the Department's ideas.

Ultimately, the local bodies remained as free as they had been in the 1960s to spend the money provided to them by central government in any way they saw fit. Indeed, this was explicitly accepted by the 1976 'priorities' document, which stated that '[l]ocal priorities will naturally be affected by a range of factors - demographic, social and practical - peculiar to individual areas; and it is accepted that local plans will often not correspond to the order of national priorities proposed here'.[19] As Klein has commented, 'the DHSS's apparently solid policy targets dissolved under the acid of reservations ... In practice the language of norms turned out to be merely a vocabulary of exhortation'.[20] Consequently, as studies of health authority policy-making undertaken in the late 1970s showed, setting national priorities had only a marginal effect on local decision-making.[21] There was only a slight shift in resources within the hospitals in favour of geriatric medicine, for example.[22]

The second problem with the DHSS's strategy of the early 1970s concerned the idea of joint planning. As has been seen, the setting up of statutory mechanisms for this purpose during the 1974 reorganisation process reflected the Department's realisation that exhorting local authorities and health authorities to co-operate in service development was not necessarily sufficient. Nevertheless, the reform introduced in 1974 was, in many ways, very limited. As Webster has commented, the new structures put in place in 1974 were 'innocuous'.[23] It was far from clear how joint planning was meant to be achieved, even after the more detailed advice about the structure of the new bodies was issued in the DHSS circulars of 1976 and 1977. What was clear, however, was that the new structure had no executive functions.[24]

The limited nature of the joint planning reform reflected the fact that ultimately the Department still believed that 'goodwill' between the two sets of authorities was the best guarantee of co-operation. This was the view of the 1973 working party on collaboration, which had recommended the establishment of the new bodies. It had claimed that '[i]f there was a determination on both sides to work together many of the problems could be solved'.[25] This view was subsequently restated by the 1979 Royal Commission on the National Health Service.[26] Nevertheless, it would appear to have been mistaken. A 1984 DHSS working group on joint planning reported that

> joint planning showed promise in some areas but over the country as a whole these services had generally not developed as they should have done ... [T]here was a widespread sense of frustration that more had not been achieved ... While there is virtually unanimous intellectual assent to the importance of getting health and local authorities and voluntary organisations to work together, in practice progress has been disappointing.[27]

This conclusion was supported by Booth in his case study of joint planning during the mid-1970s in Calderdale. He found that

> there was a deep-rooted and sincere conviction among all participants from both sides of the JCPT that the main aim of developing a joint strategic approach to the planning of the health and personal social services is a desirable objective. There was also a considerable degree of unanimity about the potential benefits of such collaboration. However, participants were a great deal more cautious over whether the aim of forging partnership in planning matters of common concern was a realistic and attainable one.[28]

Joint finance too only was only partially successful. Many local authorities saw it as a bribe to incur further expenditure (when the joint funding ended) to which they would not otherwise have agreed.[29]

As a result of these problems, commentators analysed more closely the structural, procedural and professional impediments to joint planning.[30] The differences in the funding structure, planning cycle and decision-making process of the two authorities were once again identified as major problems and it was concluded that the mechanisms put in place in 1974 and 1976 had failed to overcome these obstacles. The situation was made more difficult still by the 1982 NHS reorganisation, which ended coterminosity between area health authorities and local authorities by abolishing the former. Differences in the perspective of the various professional groups operating within the two authorities had also created problems. These had been made worse by the fact that the introduction of joint planning had coincided with the setting up of the new post-Seebohm SSDs, in which a newly-established and self-confident social work profession was seeking to assert its independence.

(ii) Responsibilities

However, there is also strong evidence to suggest that the failure of the new mechanisms was linked to the continuing unease and suspicion over the respective responsibilities of LAs and the NHS for elderly people. No attempt had been made by the DHSS to redefine the responsibilities of the health and local authorities since 1957, and the Department continued to deny that the now more explicit policy of shifting the balance of care represented a change in the non-acute role of the hospitals. Nevertheless, as has been seen, there is strong evidence to suggest that a reduction in the role of the hospitals had been an important policy aim since the early 1960s. Certainly, policy was interpreted in this way on both sides of the health/social care boundary.

The main proposal of the 1976 'priorities' document relating to NHS long-term care was the idea of 'community hospitals', which, the Department suggested, should be built to replace the existing long-stay hospital annexes. However, this did not represent an increase in provision but rather the replacement of pre-war facilities. Moreover, the Department's enthusiasm for the scheme appears to have been lukewarm at best. It intimated strongly that 'slow progress' was likely to be made in this area and that improvements in existing facilities might have to suffice.[31]

Ambivalence about the hospitals' role in the long-term care of the elderly was also evident elsewhere in the document. The analysis of 'bed-blocking', for example, accorded almost exactly with that offered by the medical profession. It was stated that

> Inadequate domiciliary services cause misuse of hospital beds and unnecessary demands for residential places ... Health authorities find that hospital beds are blocked by patients who could be discharged if domiciliary or residential care or suitable [sheltered] housing were available. As a consequence, other patients cannot be offered the prompt hospital treatment and rehabilitation which could lead to their own early return home.[32]

Evidence that 'bed-blocking' was also a result of the failure of hospitals to fulfil their responsibilities in respect of long-term patients (see above, pp.70-78) was ignored. Moreover, repeated emphasis was given throughout the document, to the benefits of reducing the average length of hospital stays. The Department suggested this could save £26m a year in 'hotel costs', even with a relatively small reduction in the average period of stay.[33] Finally, there was no explicit statement in the document as to the definition of responsibilities of hospitals and of local authorities for the care of long-stay elderly patients.

Thus, the situation remained the same as it had been for the previous 25 years with both sides able to disclaim responsibility for the large 'intermediate' group of elderly people who required long-term nursing care. Booth suggested that in Calderdale this lack of 'agreement on [the] crucial issue [of] the proper division of responsibilities and functions between health and personal social services' made strategic planning 'impossible'.[34] The situation was particularly difficult with regard to services for the elderly. Here, Booth found that '[a] lack of agreement on appropriate criteria for admission to hospital or residential accommodation has precluded any discussion of the overall pattern of care which should be provided by the two authorities. One officer commented, "there's no clear agreement really on who should do what".[35]

Disagreements in Calderdale centred on the issue of 'bed-blocking' and it is possible to see how the new mechanisms for joint planning foundered in face of this issue, which in turn spoke to the fundamental problem of the definition of respective responsibilities. The health authority side saw the problem of bed-blocking as the result of inadequate local authority provision. Thus, joint planning was seen as a method for ensuring that the local authority side 'accept[ed] its share of the responsibility for the care of the elderly'.[36] As Booth suggests, the result was that the emphasis was put 'rather pointedly on getting the local authority to give greater priority to services for the elderly and on giving doctors a greater say in who use[d] them'.[37] The focus of collaboration was slanted in favour of the health authority's interests. This immediately provoked a negative response from the local authority, which claimed that its level of provision for the elderly was above DHSS guidelines. It regarded increasing accommodation for children as the main priority. Despite the setting up of a special sub-committee to discuss these issues, the problems proved largely irresolvable. Continued differences over responsibilities and priorities meant that the whole process became 'stuck in a rut'.[38]

It seems likely that these continued disagreements between health and local authorities over their respective responsibilities for the care of the elderly were also responsible for the failure of SSDs to give the expansion of domiciliary services for the elderly priority in the 1970s. Local authorities continued to be strongly resistant to spending money on services which they believed were designed to reduce the responsibilities of hospitals.

As a result of the disappointing response to the DHSS's strategy, faith in central planning began to decline in the late 1970s. The move away from planning was accelerated by the election of a Conservative government in 1979 determined to reduce public expenditure and ideologically opposed to state intervention. Thus, during the 1980s, faith in planning was abandoned and there was a major change in the approach to delivering both health and social services.

References

1. DHSS, *Priorities for Health and Personal Social Services: A Consultative Document* London: DHSS, 1976.

2. See for example Glennerster, *Planning for Priority Group;* Webb and Wistow, *Social Work, Social Care and Social Planning.*
3. Webb and Falk suggested that '[t]he guidelines were developed ... from existing trends and examples of "good practice"; from research studies which have examined the extent of need as well as the present performance and likely future utility of particular branches of the personal social services; from admittedly arbitrary guesswork in areas of service where our knowledge is poor; and from judgements of what is administratively, economically and politically feasible to expect local authorities to achieve in the future. See Webb A, Falk N. Planning the Social Services. *Policy and Politics* 1974; 3, 2: 40.
4. On the development of a programme budget, see Banks GT. In Booth T. ed. *Planning for Welfare,* Oxford: Basil Blackwell and Martin Robertson, 1979.
5. *Priorities for Health and Personal Social Services,* para. 11.
6. Ibid, para. 5.
7. Ibid, para 4.21 and 5.13. It was not made clear which acute specialities the DHSS had in mind. Services for the mentally ill were also to benefit from this transfer of resources.
8. Ibid, para. 5.22-3.
9. Ibid, para. 5.5.
10. See, DHSS, *The NHS Planning System.* London: DHSS, 1976; and DHSS, *Circular LASSL (77)13* London: DHSS, 1977. See also Webb and Wistow, *Social Work, Social Care and Social Planning,* pp.146.
11. DHSS, *Circular HC(76)18* and *LAC(76)18.* London: DHSS 1976.
12. See, DHSS, *The NHS Planning System.*
13. Quoted in Glennerster, *Planning for Priority Groups,* p.21.
14. In fact, 19 per cent of joint finance was being spent by health authorities on their own schemes by the mid-1980s. See Wistow G, Hardy B, Turrell A. *Collaboration Under Financial Constraint: Health Authorities Spending on Joint Finance.* Aldershot: Avebury, 1990.
15. Webb and Wistow, *Social Work, Social Care and Social Planning,* p.145.
16. See, DHSS, *Priorities for the Health and Social Services: The Way Forward.* London: DHSS, 1976; Webster, *The Health Services Since the War,* p.609; and DHSS, *A Happier Old Age.* London: DHSS, 1978.
17. Webb and Wistow, *Social Work, Social Care and Social Planning,* p.175.
18. For example Glennerster, *Planning for Priority Groups;* Webb and Wistow, *Social Work, Social Care and Social Planning;* and Klein, *The Politics of the National Health Service.*
19. DHSS, *Priorities for Health and Personal Social Services,* para. 17.
20. Klein, *The Politics of the National Health Service,* p.128.
21. See, for example, Hunter DJ. *Coping with Uncertainty* Chichester: Research Studies Press, 1980; and Brown, *Reorganising the National Health Service.*

22. Glennerster, *Planning for Priority Groups,* pp.24-5.
23. Indeed, Webster dismisses joint planning as 'primarily of value as a protective measure, demonstrating to sceptics in the debates on the reorganisation Bill that the Government was taking countervailing measures to prevent health authorities and local authorities from drifting apart in provision of services to the many client groups requiring their joint participation'. *The Health Services since the War,* pp.495-6.
24. The DHSS stated categorically that 'the role of JCPTs is advisory not executive'. See DHSS, *Circular HC(76) 18.* London: DHSS, 1976.
25. A *Report from the Working Party on Collaboration on its Activities to the end of 1972.* London: HMSO, 1973.
26. Booth TA. Collaboration between Health and Social Services: Part I. *Policy and Politics* 1981; 9, 1: 23-49. See also Booth TA. Collaboration between Health and Social Services: Part II. *Policy and Politics* 1981: 9,2: 121-156.
27. DHSS, *Progress in Partnership: Report of the Working Group on Joint Planning.* London: DHSS, 1984.
28. Booth, 'Collaboration between Health and Social Services', p.41.
29. See Nocon A. *Collaboration in Community Care in the 1990s.* Sunderland: Business Education, 1994.
30. See Glennerster, *Planning for Priority Groups;* and Wistow G. *Community Care Planning. A Review of Past Experience and Future Imperatives.* London: DH, 1990.
31. DHSS, *Priorities for Health and Personal Social Services,* para.5.25.
32. Ibid, para. 5.10.
33. Ibid, para. 4.22.
34. Booth, 'Collaboration Between Health and Social Services', p.46.
35. Ibid, p.46.
36. Ibid, p.35.
37. Ibid, p.37.
38. Ibid, p.224.

An Unanticipated Solution: The Expansion of Private Residential Care

The new Government indicated its desire fundamentally to alter the nature of community care policy in line with its aim to reduce the role of the state as early as 1981. Thus, it explained that in future community care would not be regarded just as 'care in the community', but would also involve more 'care by the community'. In particular, families would be expected to accept a greater level of responsibility.[1] The new approach to community care policy was accompanied (and was partly explained) by a reduction in government expenditure on the personal social services.[2]

A desire to control public expenditure was also the main influence on the new Government's approach to the NHS. The Conservatives sought to limit the annual rise in health spending by making the service more efficient. Thus, it was argued that the growing demands on the NHS (not least by the increasing number of elderly people) could be met by squeezing more out of existing resources.[3] A 'managerial revolution' was launched on the back of the 1983 Griffiths Report, with the aim of increasing accountability and productivity. Hospitals were expected to increase the number of patients they treated despite the limitation placed on their spending. The level of 'throughput' thus became a major criterion for successful performance. Unsurprisingly, given these concerns, the new Government continued to emphasise the short-stay role of hospitals in the care of elderly. In Growing Older, for example, hospitals were reminded that '[sjcarce resources [could] be wasted if a hospital stay is unnecessarily prolonged'.[4]

This combination of policies was bound to exacerbate the problems caused by the health/social care boundary in respect of services for elderly people. With hospitals under even greater pressure than previously to keep the average length of stay as short as possible, and the growth of local authority services slowing down, it was likely that disputes about the correct placement of service-users would increase. The prospects for joint planning in these circumstances seemed even worse than they had been in the 1970s, notwithstanding the fact that joint finance was made more generous in the early 1980s in the hope of stimulating greater joint planning efforts.[5]

Table 3: Average Available Geriatric Beds in England, 1980-1994/5 (thousands)

	1980	1982	1984	1986	1988/9	1990/1	1992/3	1994/5
Geriatric Beds	57	57	57	56	53	46	40	37
Discharges/ Deaths	268	302	356	405	419	N/A	N/A	N/A

Source: *Health and Personal Social Services Statistics, 1975, 1978, 1984, 1985, 1992, 1996* (London, HMSO, 1976, 1980, 1984, 1985, 1992, 1996)

Yet, while there continued to be some complaints from hospitals in the mid-1980s about 'bed-blocking', the issue did not achieve the prominence that might have been expected. This was all the more remarkable in view of the fact that in a predictable response to the new efficiency drive, hospitals began from the mid-1980s to reduce their provision of geriatric beds (see Table 3). The main explanation for this apparent conundrum was a minor and largely unnoticed change in social security. A small alteration in the discretionary payments element of supplementary benefit (designed to tighten procedures) had the unintended consequence of allowing claimants who were lodgers to claim the full board and lodging charge plus an amount to cover personal expenses. Those who could claim this benefit included the residents of private residential and nursing homes. Given the budgetary pressures on health and local authorities, it was not long before they started taking advantage of this change to shift the location of long-term care for elderly people into the private sector using social security funding. By the mid-1980s, the sum spent on this benefit had risen from £10 million to £500 million and a flourishing private care sector had been created.[6] Largely as a result of this loophole, hospitals were able to dramatically reduce the average length of stay of patients and substantially increase the level of throughput.[7] By the end of the decade, they had begun actively reducing their level of geriatric bed provision. The expansion of private sector residential care cut across the underlying problem of the ill-defined responsibilities of local and health authorities, which we have argued to be fundamental to understanding the nature of the health/social care boundary in the post-war period. However, the huge cost implications of this social security change meant that this solution was unlikely to prove permanent.

A Paradigm Shift in Service Delivery: towards Quasi-Markets

The burden of residential care costs on the social security budget, together with growing concerns about stagnation in the development of local authority services, pushed the policy of community care back on to the political agenda. A 1985 House of Commons Social Services Select Committee report on the state of community care was followed a year later by a damning survey of developments by the Audit Commission.[8] The Government responded by setting up an inquiry chaired by Sir Roy Griffiths. It reported in 1988, and its recommendations were to form the basis - albeit with important amendments - of the 1990 NHS and Community Care Act.[9] This legislation was to have important implications for the health/social care boundary and was ultimately to force the government to issue a detailed definition of the respective responsibilities of hospitals and local authorities for the long-term care of the elderly, the first since 1957.

The main focus of the Audit Commission report *(Making a Reality of Community Care)* was domiciliary and day services, which was in keeping with the view that care at home was preferable to institutional care. It concluded that these services were seriously inadequate for three main reasons:[10] the 'perverse incentives' provided by the social security system for the development of residential services, which the Audit Commission proposed should be removed; the widespread 'confusion' over responsibilities for the provision of the various community services between health authorities and local authorities; and the structural, procedural and cultural obstacles in the way of joint planning. With regard to the question of responsibilities, the Audit Commission proposed that the confusion could be ended only if responsibility was vested in some form of unitary authority. With regard to services for elderly people, it suggested that the best way of doing this was by the establishment in each area of a single budget which would receive contributions from health authorities and local authorities. This would be overseen by a single manager who would purchase services, as appropriate for the needs of individual elderly people, from public or private agencies.[11] This proposal was typical of the Audit Commission's view that the obstacles in the way of joint planning made it largely unworkable as a method of co-ordinating the delivery of community care.[12]

However, while the Audit Commission's report addressed the issue of confused responsibilities in respect of the provision of community-based services for the elderly, it ignored the question of hospitals' responsibilities for the long-term care of older people.

This was an important omission because the Audit Commission's proposals were likely to increase the controversy about this issue. It recommended that the social security loophole be closed, which would remove the option of shifting long-stay patients out of hospital wards and into the private sector. If this happened, the pressure on hospital acute beds and, thus, complaints of 'bed-blocking' were likely to increase. The Audit Commission appears to have assumed that the problem would be solved by the expansion of domiciliary and day provision.

The 1988 Griffiths Report was far clearer on the question of hospitals' responsibilities. Griffiths stated early in the report that the most 'radical' proposal would be to 'spell out responsibilities, insist on performance and accountability and on evidence that action is being taken'.[13] True to his word, he provided the clearest definition of hospitals' responsibilities for long-term care since the mid-1950s. He suggested that their main responsibility was 'the provision of health care', which 'in broad terms' involved 'investigation, diagnosis, treatment and rehabilitation undertaken by a doctor or by other professional staff to whom a doctor has referred the patient'.[14] Elderly people should only be in hospital if they needed *'both* medical supervision and nursing care to be available throughout twenty-four hours'. In short, Griffiths was very much in sympathy with the long-standing demand of many in the medical profession that hospitals should concentrate solely on acute care.[15] He recommended that all other services (including nursing and residential homes and domiciliary services) should be commissioned by local authorities, who would receive a specific grant (set at 40 or 50 per cent of agreed local spending) for this purpose and would be treated as the lead authority for community care. However, this grant would only be supplied once local authorities had submitted community care plans that were judged by central government to provide evidence of collaborative planning and the promotion of a mixed economy of care. This amounted to a general acceptance of the ad hoc developments evident since the mid-1980s. But whereas hospitals had been able to reduce their responsibilities for long-term care by using the loophole in the social security system, in future the shift of patients out of the hospital would occur in a more controlled fashion as financial responsibility was transferred to local authorities.

The central health department had always been loathe to address the issue of the respective responsibilities of hospitals and local authorities for the long-term care of the elderly. It had repeatedly refused to amend the definition released in 1957. It had continued to claim that the policy of limiting hospital geriatric provision did not mean a change in hospitals' responsibilities for long-term care. Its response to the Griffiths Report revealed that this was still the case in the late 1980s. Rather than accepting Griffiths' move towards defining the role of the hospitals in terms of acute care, the DHSS maintained the position it had held to for the previous 30 years. Thus, in *Caring for People*, the Department's 1989 white paper on community care, it stated:

> The key functions and responsibilities of the health service as a whole remain essentially unaltered by the proposals in this White Paper ... [I]t is the responsibility of health authorities to ensure that the health needs of the population for which they are responsible are met ... [They] will remain responsible for the health care needs of those people who also have a need for social care. Such people may well have special needs for health care, whether for primary care or acute hospital care or for long-term care.[16]

It was further stated categorically that '[w]here people require continuous care for reasons of ill-health, it will remain the responsibility of health authorities to provide this'.[17]

However, there are good reasons for questioning the value of this commitment. No attempt was made to give it any material substance by reversing the decline in hospitals' long-term care provision that had begun to take place in the late-1980s. The Department merely stated lamely that any decision on the need for 'an increase or a reduction in the level of continuous care' would have to be made on the basis of local circumstances after consultations between health and local authorities. However, no resources were set aside for this purpose.

The value of the commitment was further undermined once the details of the 1990 NHS and Community Care Act were released.[18] Many aspects of the reform appeared directly to contradict the idea that the NHS had a continuing care role. Local authorities were now designated as the 'lead' agencies for community care. Social care was conceptualised in relation to the problems of social security and of the NHS; service delivery in and of itself was not at the forefront of government thinking. The more pronounced shift towards increasing the responsibility of local authorities was the product of a 'pincer movement' led by the new-found concern to curb social security spending and the old ambition of drawing a tighter line around the NHS as an acute care service.

Much of the confusion over this issue could have been reduced if some attempt had been made by the DH to define what it meant by health care and social care. However, this did not happen. The Department accepted that in some individual cases there might be difficulties in drawing 'a clear distinction between the needs of an individual for health and for social care'. But faith was once again placed in collaboration between health authorities and local authorities as a method of resolving these problems. It was 'critically important for responsible authorities to work together', the Department suggested.[19] However, no attempt was made to address the obstacles to collaboration, which numerous commentators had emphasised during the 1970s and 1980s. For example, unlike the Griffiths' report, which had attempted to link joint planning to resource allocation through the provision of a specific grant, the 1990 Act merely obliged local authorities to 'consult' other authorities (health authorities, family health service authorities and housing authorities), voluntary organisations, users and carers in the production of community care plans. The House of Commons Social Services Committee was not alone in remaining unconvinced that this would prove sufficient.[20]

The interpretation of the 1990 Act by those in the NHS soon became clear. As Lewis and Glennerster have suggested, NHS officers regarded it 'as good grounds for getting rid of their long-term care responsibilities as soon as possible'.[21] All the evidence suggests that continuing care provision continued to be cut regardless of the DH's 1989 commitment.[22] Richards, for example, suggests that some health authorities stopped providing any continuing care beds at all.[23] Eventually, these developments forced the Department of Health publicly to accept that the 1990 Act had led to a reduction in the responsibility of hospitals for long-term care, notwithstanding its earlier claims to the contrary. The immediate catalyst was a 1994 report by the Health Service Commissioner into the case of seriously brain-damaged patient, for whom the local health authority had refused to accept responsibility. The Commissioner found that in refusing to spend resources 'on patients of this type' the health authority was failing to fulfil its duties. In response to the widespread publicity this case created, the DH released a new guidance on NHS responsibilities, its first detailed statement on this matter for almost 40 years.[24] The ostensible aim of this guidance was to reinforce the Commissioner's finding that the NHS retained long-term care responsibilities. 'Continuing in-patient care' was identified as one of the range of services which the NHS should provide. However, four eligibility criteria were set out for this service. It would be available:

- where the complexity or intensity of patients' medical, nursing care or other clinical care or the need for frequent not easily predictable interventions requires the regular supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team (in most cases interventions might be weekly or more frequent);

- where patients require routinely the use of specialist health care equipment or treatments which must be supervised by specialist NHS staff;

- where patients have a rapidly degenerating or unstable condition which means that they will soon require specialist medical or nursing supervision;

- where patients have finished acute treatment or inpatient palliative care, but their prognosis suggests that they are likely to die in the very near future.[25]

The 1995 guidance gave an overt commitment to continuing care as an integral part of the NHS. But in comparison with the definitions of responsibility provided by health officials in the 1940s and 1950s, the new guidance clearly represented a significant restriction of the NHS's role. The emphasis placed on 'specialist' care was a new departure, which, as one commentator suggested, indicated 'that basic nursing care for chronically, but not acutely ill patients, is no longer to be regarded as part of a "comprehensive" national health service'.[26] To a large extent, however, the guidance merely represented a retrospective acceptance of a situation that had been developing steadily since the mid-1950s. It took almost 40 years for health officials to acknowledge publicly that a major implication of their policy was that the role of the hospitals would be restricted. Pearson and Wistow have pointed out that this policy has been 'silent, if not surreptitious'[27] but, as this investigation of the history of policy development has shown, health officials privately acknowledged such a change for much of the intervening period. Ironically their failure openly to confront it also served to impede the development of domiciliary care services.

References

1. *Growing Older.* Cmnd. 8173. London: HMSO, 1981, para.1.9.
2. The 1979 Expenditure White Paper indicated cuts of 6.7 per cent for 1980/81 compared with expected spending levels for 1979/80. See Webb and Wistow, *Social Work, Social Care and Social Planning,* p. 164.
3. Klein R. *The New Politics of the National Health Service.* London: Longman, 1995,p.l31.
4. *Growing Older,* para. 8.3.
5. See Wistow et al, *Collaboration Under financial Constraint.*
6. For more details on the change in social security, see Lewis J, Glennerster H. *Implementing the New Community Care* Buckingham: Open University Press, 1996, pp.3-5; see also Land H. In: Gabe J, Calnan M, Bury M. eds. *The Sociology of the Health Service.* London: Routledge, 1991, pp.210-2.
7. Between 1982 and 1994, the average length of stay fell by more than a third, while throughput increased by 80 per cent. See Wistow G. Coming Apart at the Seams. *Health Services Journal* 1995; 105, 2 March: 24-5.
8. Audit Commission. *Making a Reality of Community Care: A Report by the Audit Commission.* London: HMSO, 1986.
9. DHSS, *Community Care: An Agenda for Action.* London: DHSS, 1988.
10. *Making a Reality of Community Care,* p.2.

11. Ibid, pp.49-59.

12. Ibid, pp.56-60.

13. DHSS, *Community Care,* para.20.

14. Ibid, para. 6.12.

15. Ibid, para 4.13. Griffiths was generally very explicit in his support for the idea of acute-only hospitals. However, he clouded the issue somewhat by stating that, while long stay hospitals were not in general the right setting for elderly people, or those who were mentally ill or had a mental handicap, there would be 'a continuing need for some long-stay facilities'.

16. *Caring for People.* Cmnd. 849. London: HMSO, 1989, para.4.2.

17. Ibid, para.4.20.

18. On the 1990 NHS and Community Care Act, see Lewis and Glennerster, *Implementing the New Community Care.* Also Wistow A *et al. Social Care in a Mixed Economy.* Buckingham: Oxford University Press, 1994; and Means R, Smith R. *Community Care.* Basingstoke: Macmillan, 1994.

19. *Caring for People,* para.4.2.

20. House of Commons Social Services Committee, Eighth Report. Community Care Planning and Cooperation. London: HMSO, 1990, pp.580-1.

21. Lewis and Glennerster, *Implementing the New Community Care,* p.16.

22. See for example House of Commons Health Committee, First Report. Long-term Care: Future Provision and Funding. London: HMSO, 1995, paras. 16-20.

23. Richards M. *Community Care for Older People.* Bristol: Jordans, 1996, pp.18-19. Richards suggested that there was a 30 per cent cut in long-term care beds between 1990 and 1996.

24. See DH, *Circulars HSG(95)8 and LAC(95)5.* DH: London, 1995.

25. Richards, *Community Care for Older People,* p. 30.

26. Ibid, p.31.

27. Pearson M, Wistow G. The Boundary between Health and Social Care. *British Medical Journal* 1995; 22 July: 208.

CONCLUSION

The health/social care boundary problem comprises a large number of issues; there are indeed many boundaries. However, the historical record shows that at the level of central government the most important source of controversy in regard to elderly people since World War II has been the respective responsibilities of the NHS and of local authorities. Furthermore, the long struggle over this issue has had important knock-on effects for the development of services for this group, particularly in respect of domiciliary care.

In the mid-1990s, the Department of Health was forced to address this issue explicitly for the first time since the 1950s. The dramatic fall in the number of geriatric beds, which had begun in the mid-1980s and accelerated following the passage of the 1990 NHS and Community Care Act, meant that the Department had little option but to acknowledge publicly that the role played by hospitals in the care of the elderly had been reduced. However, although the decline in hospital provision has been particularly rapid in the recent past, the change may be seen as the culmination of a process that has been occurring since the mid-1950s. From that time to the early 1980s, provision of geriatric beds remained static in absolute terms and fell in relation to the elderly population. As we have shown, health officials actively encouraged this trend. Indeed, from the setting of the geriatric bed norm in 1957, this increasingly became a basic assumption of central government's policy. No attempt has been made since to reverse this relative decline, although some effort was made in the mid-1970s to boost the number of acute geriatric beds in general hospitals.

Despite the clear articulation of a basic assumption in the files of the central health department that hospitals would do less and local authorities more in respect of care for elderly people, ministry officials argued that the relative reduction in the provision of beds was consistent with the definition of the respective responsibilities of hospitals and local authorities. Health officials justified this claim mainly on the basis of new ideas within geriatric medicine, such as the development of rehabilitation and active treatment techniques, which they argued reduced the need for long-stay hospital provision and thus allowed the same (or more) people to be catered for in a reduced number of beds. Local authorities repeatedly challenged this view. They were convinced that the relative decline in hospital provision implied an increase in their responsibilities.

This investigation has shown that, on the basis of the documentary evidence, the local authorities appear to have had a strong case. It is clear that a large number of health officials in the 1950s and 1960s privately accepted that a relative reduction in hospital beds would increase the responsibilities of local authorities. Indeed, in the 1950s some officials wanted to make this shift explicit. At this time, the policy appears to have been conceptualised as part of a genuine attempt by a group of officials, mainly based in the medical department of the old Ministry of Health, to ease the problems of the health/social care boundary that had begun to occur, albeit on terms strongly favourable to the medical profession. These problems had arisen largely because of disputes between hospitals and local authorities about the placement of what was identified as an 'intermediate' group of elderly people,[1] who, some voluntary organisations suggested, were not covered by the definition of responsibilities in the 1946 Act. The aim of officials was to make it clear that local authorities were responsible for these people.

However, this strategy was resisted by a number of senior officials, particularly those in the Ministry's own local authority division.

They opposed any increase in the nursing responsibilities of local authority homes, mainly because of the continuing shadow cast by the Poor Law. As part of the abolition of the Poor Law in 1948, a major improvement in long-term provision for elderly people had been promised. Many officials were therefore extremely reluctant to do anything that could be construed as watering down this commitment. This was to remain an important, though diminishing, constraint on policy for some years. Thus the definition of responsibilities published in 1957 provided for only a marginal increase in the nursing responsibilities of local authorities. Nevertheless, a limit was placed on hospital geriatric provision.

This policy informed the drawing up of the hospital and local health and welfare plans in the early 1960s, despite the evidence that few hospitals had modern geriatric facilities, and that large sections of the medical profession opposed their introduction. Local authorities were more than willing to increase their residential accommodation, for which long waiting lists existed. What they did not want to see was an influx of elderly people from the NHS. This fear also explained why they were reluctant to increase their domiciliary provision, which they believed would result in the discharge of more dependent elderly people from hospitals.

Thus while the plans of the early 1960s placed a firm limit on geriatric beds, the expansion of alternative services was inadequate. The result was that disputes over the care of the 'intermediate' group of elderly people intensified in the late 1960s. Complaints about 'bed-blocking' by hospitals grew more common as the number of elderly people occupying acute beds increased. Local authorities, on the other hand, claimed that they were having to cater for people with ever-greater degrees of infirmity. In this argument, health officials backed the hospitals. Evidence that 'bed-blocking' was also caused by deficiencies in the hospital service, caused particularly by hospital consultants' resistance to the establishment of modern geriatric facilities, was ignored. Instead, a further attempt was made in the 1970s to encourage co-operation across the health/social care boundary and an expansion in local authority services using joint planning and joint finance. This was undermined by economic problems and the growing realisation that profound structural, procedural and professional obstacles made shifting the focus of care for elderly people and other vulnerable groups from hospitals to local authorities a difficult exercise. The fudged definition of respective responsibilities was the direct manifestation of this set of issues.

Why were officials so reluctant publicly to acknowledge the increase in the care responsibilities of local authorities that were implied by the limit placed on geriatric bed provision? There are a number of possible explanations. Early on, the 'policy inheritance' of the Poor Law was an important piece of the policy making conjuncture. A second explanation is that officials were genuinely convinced that developments in geriatric medicine would make it possible to reduce the role of hospitals without any implications for local authority provision. However, little attempt was made to investigate the true potential of rehabilitation and active treatment. Nor was much done to address the known hostility of the medical profession to the provision of services in this area. Rather, officials repeatedly relied on exhortation, despite compelling evidence from the reports of the Hospital Advisory Service that this had little effect.

It seems probable therefore, that financial and political considerations, particularly as they related to the NHS were the most important factors. The dominant view within the central government department was that of the health service and the medical profession. With regard to financial considerations, from the 1960s the priority was saving money in the hospital sector, hence the emphasis on short-stay provision and the encouragement of a freeze on geriatric beds. However, any public acknowledgement that this policy involved an increase in local authorities' responsibilities in respect of more infirm elderly people would have provoked immediate demands from LAs for a transfer of resources far in excess of anything that was proposed. With regard to political considerations, any public acknowledgement of a shift in responsibilities would have led to accusations that the scope of NHS care had been reduced and that elderly people were being forced to pay for their care. [This accusation was levelled at the DH after the release of the 1995 guidance.]

Up to the 1990s, health officials were able to avoid this major area of controversy because the decline in the number of hospital geriatric beds was gradual. However, with the change in social security regulations in the early 1980s and the entry of large numbers of elderly people into private nursing homes, this decline became rapid by the end of the decade. The full implications of the change were masked initially by the fact that most of the costs of private provision were met by the Department of Social Security. However, once this provision was made the responsibility of local authorities under the 1990 NHS and Community Care Act, the withdrawal of the hospitals from the long-term care of the elderly became visible. In the context of a more transparent market-oriented system, the responsibilities of the different authorities began to be tested in the courts. Policy in respect of the health/ social care boundary has been consistent in terms of drawing the line ever more tightly around the hospital as an acute care service.

Finally, it is worth reflecting on the implications of our research findings for the late-1990s debate on policy regarding the health/ social care boundary, even though, as we pointed out at the beginning of this report, history has no prescriptive power. In retrospect it is possible to see that two major problems resulted from the health/social care divide. The first was the extent to which service development was *distorted* by the conflict over responsibilities that followed the creation of the boundary. Both health and local authorities had every incentive to limit what they did about the growing 'intermediate' group of elderly people needing care. The reduction in the part played by the hospitals was not addressed openly, and so local authorities adopted a defensive position, which involved resisting the development of services that might increase their burdens. Crucially, this slowed the development of domiciliary care. Until 1995, when the issue could no longer be avoided, the division of responsibilities was fudged. Efforts to introduce greater clarity with the 1995 guidelines, at a time when the division between health and social care had become tighter, has not surprisingly resulted in more appeals on the part of users. Thus it is essential that the administrative and financial dimensions of the boundary be addressed.

Indeed, these issues have been raised more frequently over the last decade as the health/social care divide became more visible. The main alternatives have been identified first, as 'unification' (of health and local authorities), which addresses the administrative divide. However, the nature of local government reform in the mid-1990s, which resulted in a wide variety of local authorities with responsibility for social care, made this an even more distant prospect. The 1998 discussion document, *Partnership in Action,* explicitly rejected any move towards unification: 'We do not intend to set up new statutory health and social services authorities'.[2] It may nevertheless be possible to achieve some degree of unification as a by-product of the rapid changes that have taken place in health and social care 'markets'. In some places, integration has already begun in primary health care settings,[3] an idea that also found favour in the Minority Report of the Royal Commission on Long Term Care.[4] However, the history of post-war social policy has shown a tendency for policy makers to reach for the 'organisational fix' (particularly in respect of the NHS) as a way of dealing with problems. This has not been conspicuously successful. In the case of the health/social care boundary, it is probably more important to tackle the financial divide. It is this that has played such a major part in stimulating the battle over responsibilities.

A second set of proposals have focused on the financial boundary. The 1998 white paper on social services advocated the pooling of resources, first suggested by the Audit Commission more than a decade ago, as part of a larger effort to promote 'partnership' and to bring down the 'Berlin wall' between health and social services.[5] The New Labour Government seems to have put its faith in pooling, together with lead commissioning by one agency and a measure of integrated provision by, for example, primary health care groups. Given the history of joint finance in the late 1970s, pooling is likely to prove difficult. Its prospects would certainly improve dramatically if the recent proposal of the Royal Commission on Long Term Care to finance social care (other than for board and lodging costs) out of taxation were to be implemented.

The administrative and financial dimensions of the health/social care divide have become entrenched. It is therefore little wonder that practitioners as well as government have tended to fall back on a third form of solution that addresses the professional divide by some form of collaborative working.[6] In its 1998 discussion document, the government referred to a 'vision of joint working' at all levels.[7] There is a case for arguing that whatever the structural incentives to collaborate, there would still be a boundary issue of some kind, certainly in the minds of professionals. As Janice Robinson has commented: 'In the new climate of partnership, it would be nice but naive to expect the boundaries that hinder integration to disappear'.[8] However, as we have seen, successive governments have put their faith in first in 'goodwill' on both sides of the boundary, and then in a more directive approach to joint planning and joint working. By itself, this approach is unlikely to prove sufficient; battles over responsibilities would continue.

There is, however, a second problem that may be seen to have resulted from the health/social care divide and which must be addressed regardless of what is done about the structural dimensions of the boundary. That is the issue of what is to be provided for elderly people. In a very real sense, this was what the battle over responsibilities was about. However, in large part because the nature of the struggle was never openly acknowledged, so the question *'what kind of care?'* never reached the top of the agenda. The nature of social care provision in particular has always effectively been treated as some kind of residual, discussed in relation to some other issue (usually hospital provision), but rarely in and for itself. Parker has commented on the way in which the meaning of 'community care' has been changed to suit new policies making it possible for a 'hotch-potch of policies and practices' to be invested with a 'spurious sense of integration and consistency'.[9] The population of frail elderly people has increased (and will continue to increase), with the result that the numbers of those people termed 'intermediate' in the 1940s have become much larger. If the hospital is to become more of an acute-care-only institution, then there is an urgent need to re-think the other kinds of care available for elderly people. Bringing back convalescent homes, for example, is one possibility, but much more attention to the whole nature of social care provision is needed. Getting rid of the financial boundary between health and social care would again make it much easier to address the issue, but what this historical study shows is the need for questions about the nature of provision to be addressed much more explicitly and to be given much higher priority.

References

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6. See for example, King's Fund, *The Future Organisation of Community Care.* London: King's Fund, 1997.
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Table 4: The Population of Elderley People 1931-1991 (thousands)

	1931	1951	1961	1971	1981	1991
AGE						
60-64	1848.6	2366.8	2942.7	3133.8	2826.1	2759.0
65-69	1419.3	2020.7	2183.3	2646.9	2722.5	2678.0
70-74	976.7	1578.3	1694.5	1957.4	2319.1	2171.1
75-79	560.0	1020.9	1174.4	1300.7	1644.0	1800.9
80-84	252.3	491.5	662.7	772.8	929.1	1214.4
85+	107.6	217.5	329.3	462.4	575.5	838.3
TOTAL	5164.5	7695.7	8986.9	10274.0	11016.3	11461.7

Source: OPCS, 1991 Census. *Historical Tables, GB* (London, HMSO, 1993).

APPENDIX TWO

CHRONOLOGY

1946	National Health Service Act
1948	National Assistance Act
1953	Boucher Committee formed in Ministry of Health
1955	Report of BMA's joint sub-committee on Geriatrics
1957	*Survey of Services available to the Chronic Sick and Elderly* (The Boucher Report)
	Circular HM(57)86 to hospital authorities and *Circular 14/57* to local authorities on their respective responsibilities following the Boucher Report
	Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency
1959	Mental Health Act
1962	*A Hospital Plan for England and Wales* (Cmnd. 1604)
1963	*Health and Welfare: the Development of Community Care* (Cmnd. 1973)
1965	*Circular 18/65* partially updates *Circular 14/57*
1968	*Report of the Committee on Local Authority and Allied Personal Social Services* (The Seebohm Report)
	Formation of Department of Health and Social Security (DHSS)
1969	Formation of Hospital (later Health) Advisory Service (HAS)
1974	National Health Service reorganisation
	Introduction of joint consultative committees (JCCs)

APPENDIX TWO

CHRONOLOGY

1976	*Priorities for the Health and Social Services: A Consultative Document*
	Introduction of joint finance
1978	*A Happier Old Age*
1979	Report of Royal Commission on the National Health Service
1981	*Growing Older* (Cmnd. 8173).
1982	National Health Service reorganisation
1983	The Griffiths Inquiry into National Health Service management
1986	*Making a Reality of Community Care: A Report by the Audit Commission*
1988	*Community Care: An Agenda for Action* (The Griffiths Report)
	Formation of Department of Health (DH)
1989	*Caring for People* (Cmnd. 849)
1990	National Health Service and Community Care Act
1995	*Circular HSG(95)8 and Circular LAC(9S)5* on long-term care responsibilities of hospitals