

Growing Old in the City: Public Health and the Elderly in Leicester, 1948–74

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Introduction

Recently, historians and social policy analysts have begun to re-examine the experience of elderly people under the early National Health Service (NHS). However, while they have traced the evolution of policy in England and Wales as a whole, they have failed to explore the ways in which legislation was implemented at the local level.¹ This article examines how the elderly came to be included in local authority public health schemes, and it uses a case study of Leicester County Borough to compare policy with provision between 1948 and 1974. Firstly, it considers the rediscovery of old age during the Second World War and in the social surveys of the 1940s, and outlines the provision made through the 1946 NHS Act. Secondly, it traces official policy on local authority services, and examines how research by social scientists increasingly exposed the passivity of the Ministry of Health and the Department of Health and Social Security (DHSS). Thirdly, it points to links and disjunctions between the national and local levels through the case study of Leicester. Fourthly, the article concludes by suggesting that the theme of the elderly offers more general insights into the “decline” of public health in England and Wales between 1948 and 1974.

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¹ See Sally Macintyre, ‘Old age as a social problem’, in Robert Dingwall, Christian Heath, Margaret Reid and Margaret Stacey (eds), *Health care and health knowledge*, London, Croom Helm, 1977; Peter Townsend, ‘The structured dependency of the elderly: a creation of social policy in the twentieth century’, *Ageing and Society*, 1981, 1: 5–28; Anthea Tinker, *Elderly people in modern society*, Harlow, Longman, 1981, 3rd ed., 1992; Chris Phillipson, *Capitalism and the construction of*

old age, London, Macmillan, 1982; Robin Means and Randall Smith, *The development of welfare services for elderly people*, London, Croom Helm, 1985; Sarah Harper and Pat Thane, ‘The consolidation of “old age” as a phase of life, 1945–1965’, in Margot Jefferys (ed.), *Growing old in the twentieth century*, London, Routledge, 1989; P M Thane, ‘The debate on the declining birth-rate in Britain: the “menace” of an ageing population, 1920s–1950s’, *Continuity and Change*, 1990, 5 (2): 283–305; Roy Parker, ‘Elderly people and community care: the policy background’, in Ian Sinclair, Roy Parker, Diana Leat, and Jenny Williams, *The kaleidoscope of care. A review of research on welfare provision for elderly people*, London, HMSO, 1990; Charles Webster, ‘The elderly and the early National Health Service’, in Margaret Pelling and Richard M Smith (eds), *Life, death, and the elderly: historical perspectives*, London, Routledge, 1991.

Public Health and the Elderly before 1948

Interwar social surveys of London, Bristol, and York had shown that, despite the 1908 Old Age Pensions Act, many elderly people continued to live in poverty.² Yet they were not mentioned in the Chief Medical Officer's (CMO) annual reports until 1937 when Sir Arthur MacNalty, noting improvements in life expectancy, suggested that their living conditions deserved further study.³ During the Second World War the needs of this group began to attract more attention. Medical rest centres were set up for old people who were difficult to billet, and in 1940 hostels were established in evacuation areas, while the hospital surveys, which revealed that local authority infirmaries were filled with large numbers of chronic sick, stimulated the new specialism of geriatrics.⁴ Some local authorities, such as Ramsgate, used the 1936 Public Health Act to set up pioneer old people's clinics, and the CMO's report on the wartime period concluded of hostels for old people that "a similar provision has a definite place in the care of this type of patient after the War".⁵ New voluntary organizations emerged at this time. The National Corporation for the Care of Old People was founded in 1940, the Women's Voluntary Service (WVS) no longer dealt solely with mothers and children, and in some cities old people benefited from the Pacifist Service Units which had been formed to deal with so-called "problem families".⁶ In his study of wartime social policy, Richard Titmuss wrote that in the late 1940s the British people began to show "many symptoms of uneasiness about their treatment of old people before and during the Second World War", and although the evacuation of schoolchildren has attracted much debate, it is possible that the movement of elderly people was of equal significance.⁷

Certainly there were more social surveys of old people in the late 1940s, including the report of the Nuffield Foundation's Survey Committee on the Problems of Ageing and the Care of Old People, a study of the living conditions of old people in rural and urban areas, published in 1947. The survey acknowledged that domiciliary services and pensions could be more expensive than institutional care, but it argued that with them many old people could live independently in the community. The Nuffield Foundation found that some areas, such as Merseyside, had extensive district nursing and home help services run by local authorities and religious and voluntary organizations, but overall the report concluded that provision was inadequate, and it suggested that local authorities should provide old people's homes and a meals service.⁸ An important medical survey of the physical and mental health of old people, conducted by Dr J H Sheldon in Wolverhampton, was also

² H Llewellyn-Smith (ed.), *The new survey of London life and labour*, 9 vols, London, P S King, 1930–1935, vol. 3, pp. 15–16, 90, 188–92, 197–211; Herbert Tout, *The standard of living in Bristol. A preliminary report of the work of the University of Bristol social survey*, Bristol, J W Arrowsmith, 1938, pp. 44–6; B Seeböhm Rowntree, *Poverty and progress. A second social survey of York*, London, Longmans, Green, 1941, pp. 39, 70, 99.

³ Ministry of Health, *On the state of the public health, 1937*, London, HMSO, 1938, pp. 29–32.

⁴ Ministry of Health, *On the state of the public health, 1939–45*, London, HMSO, 1946, pp. 187–9; R M Titmuss, *Problems of social policy*, London,

HMSO, 1950, pp. 374, 450–1; Means and Smith, op. cit., note 1 above, pp. 25–58.

⁵ J V Walker, 'A clinic for elderly persons', *Medical Officer*, 1945, 74: 103–4; Ministry of Health, *On the state of the public health, 1939–45*, London, HMSO, 1946, pp. 188–9.

⁶ Tom Stephens (ed.), *Problem families. An experiment in social rehabilitation*, Liverpool, Pacifist Service Units, n.d., pp. 37–42.

⁷ Titmuss, op. cit., note 4 above, p. 501.

⁸ The Nuffield Foundation, *Old people. Report of a survey committee on the problems of ageing and the care of old people*, London, Oxford University Press, 1947, pp. 4–5, 48–9, 51, 96, 164.

published in 1948. Sheldon found that 40 per cent of the old people in his sample had bronchitis, 14.8 per cent had difficulty in breathing, 55.4 per cent had rheumatic symptoms, and 40 per cent had trouble with their feet. In the case of eyesight, 30.6 per cent stated that their glasses were unsatisfactory, 35.7 per cent had not had their eyes tested for more than five years, and 10 per cent had obtained their glasses by gift or inheritance. Over half said that nursing and domiciliary help would be extremely useful at times of illness, and Sheldon concluded that chiropody, spectacles and hearing aids would make a great difference to their lives.⁹ Sheldon's revealing and detailed survey indicated the degree to which the elderly had been neglected by health services in the 1930s.

Despite this recognition of the problems of old age, the elderly benefited in only a limited way from the legislation of the late 1940s. The Ministry of Health claimed that the 1948 National Assistance Act "swept away the last remnants of the Poor Law", and that the old relationships of the workhouse would be replaced by one more akin to "that of an hotel manager and his guests".¹⁰ Yet the focus was very much on residential homes, and important clauses, such as those giving local authorities powers to give grants to voluntary organizations providing meals and recreational activities, were permissive. Many local authorities established Welfare Committees to administer the Act, but in general they had limited powers and little guidance, and their workforce and institutions still bore the imprint of the Poor Law.¹¹ Part III of the NHS Act, implemented in July 1948, also made little explicit provision for local authority services for old people, and while Sections 24–29, on health visitors, district nurses, ambulances, care and after-care, and home helps, were all relevant, only Section 29 specifically mentioned "the aged".

Progress and Patchwork, 1948–59

As Medical Officers of Health (MOHs) contemplated the loss of hospital administration and the future of preventive medicine under the NHS, some began to perceive that old age offered new potential for public health. They and others inspired by the emergence of social medicine increasingly advocated chiropody, health visitors, home helps, meals-on-wheels, and other services.¹² In 1947, the Ministry of Health encouraged local authorities and voluntary organizations to provide meals, and in 1950 the CMO suggested that MOHs should investigate the effects of loneliness, but in general their annual reports indicate that they were slow to come to terms with the needs of the elderly.¹³ The CMO noted that the

⁹ J H Sheldon, *The social medicine of old age. Report of an inquiry in Wolverhampton*, London, Oxford University Press, 1948, pp. v, 4–6, 19–20, 46–8, 69–71, 77–86, 116–27, 175–8, 194–7. See the comments by David Armstrong, *Political anatomy of the body. Medical knowledge in Britain in the twentieth century*, Cambridge University Press, 1983, pp. 85, 88–9.

¹⁰ PP 1950, XI (Cmd. 7910), Ministry of Health, *Annual report of the Ministry of Health, 1948–49*, 1950, p. 311.

¹¹ Julia Parker, *Local health and welfare services*, London, Allen & Unwin, 1965, pp. 106–9; E Younghusband, *Social work in Britain, 1950–1975. A follow-up study*, London, Allen & Unwin, 1978, vol. 1, pp. 195–6; Parker, op. cit., note 1 above, pp. 5–7.

¹² J L Burn, *Recent advances in public health*, London, J & A Churchill, 1947, p. 214; O A MacIver, 'What old people eat', *Social Work*, 1948, 5 (2): 159–63, on p. 162; Christopher Rolleston, 'Medical health services for elderly persons', *Medical Officer*, 1948, 79: 25–6; Thomas Ferguson, 'Aged sick nursed at home', *Lancet*, 1948, i: 417–19; S Leff, *Social Medicine*, London, Routledge & Kegan Paul, 1953, pp. 220–5.

¹³ PP 1948–49, XVI (Cmd. 7734), Ministry of Health, *On the state of the public health, 1947, 1949*, p. 11; PP 1951–52, XV (Cmd. 8582), Ministry of Health, *On the state of the public health, 1950, 1952*, p. 160.

1951 census indicated that there were 5,990,100 men over 65 and women over 60 in England and Wales, but he simply listed the existing services and stressed the importance of co-ordination between statutory and voluntary agencies.¹⁴ Financial retrenchment was the predominant feature of this period; the Guillebaud Committee on NHS expenditure conceded in January 1956 that domiciliary services could be expanded only “as and when an increased proportion of the country’s resources is made available to the health and welfare services”.¹⁵ At the local level, health visitors and district nurses worked increasingly with the elderly, but their numbers grew slowly in the 1950s, and the Jameson and Youngusband reports failed to resolve the boundaries between health visiting and social work.¹⁶ Instead the burden was shouldered mainly by untrained home helps; in 1961, for example, there were 6,876 full and part-time health visitors, 52,427 full and part-time home helps, and 782 full and part-time home help organizers.¹⁷ Overall while the CMO reports showed an awareness of demographic changes, they tended to describe the services that had been provided, and they rarely addressed the question of need.

Despite the passivity of the Ministry, the new medical specialism of geriatrics grew quickly in the 1950s, and sociologists also increasingly turned their attention to the elderly. Numerous articles and books by pioneers such as Marjory Warren, William Hobson, John Pemberton, Ferguson Anderson and Nairn Cowan concluded from local surveys that more domiciliary services were necessary.¹⁸ In 1957, the social policy analyst B E Shenfield observed that nursing old people placed a heavy strain on families and district nurses, and she argued that domiciliary services would be relatively inexpensive. She recommended that local authorities should provide chiropody services, and she argued that inadequate voluntary services should not block better statutory provision.¹⁹ Peter Townsend’s case study of old people in Bethnal Green, also published in 1957, explored the role of the family at greater length. Townsend found that those who made the heaviest claims on the institutional and domiciliary services of the State generally lived alone, were unmarried and childless, and either had sons or were separated from their daughters. In 1955–56, only 6 per cent of the old people in the Bethnal Green sample were visited by home helps, while 43 per cent were helped by relatives and 8 per cent by

¹⁴ PP 1953–54, XV (Cmd. 9307), Ministry of Health, *On the state of the public health, 1953, 1954*, pp. 15, 193–5.

¹⁵ PP 1955–56, XX (Cmd. 9663), *Report of the Committee of Enquiry into the cost of the National Health Service*, 1956, p. 219, para. 652.

¹⁶ Ministry of Health, Department of Health for Scotland, and Ministry of Education, *An inquiry into health visiting. Report of a working party on the field of work, training and recruitment of health visitors*, London, HMSO, 1956, pp. vii–xi; Ministry of Health and Department of Health for Scotland, *Report of the working party on social workers in the local authority health and welfare services*, London, HMSO, 1959, pp. 94, 151–3, paras 350, 550–4.

¹⁷ PP 1960–61, XVII (Cmd. 1207), Ministry of Health, *On the state of the public health, 1960, 1961*, p. 150; PP 1961–62, XVII (Cmd. 1754), Ministry of Health, *Annual report of the Ministry of Health, 1961, 1962*, pp. 229–30, appendix VIII, tables K and M.

¹⁸ PP 1952–53, XV (Cmd. 9009), Ministry of Health, *On the state of the public health, 1952, 1953*, p. 172; Dennis H Geffen and M D Warren, ‘The care of the aged. A three-year survey of 189 cases referred to the Public Health Department of the Hampstead Borough Council’, *Medical Officer*, 1954, 91: 285–91; William Hobson and John Pemberton, *The health of the elderly at home. A medical, social and dietary study of elderly people living at home in Sheffield*, London, Butterworth, 1955; W Ferguson Anderson and Nairn R Cowan, ‘Work and retirement: influences on the health of older men’, *Lancet*, 1956, ii: 1344–7; A N Exton-Smith, ‘Terminal illness in the aged’, *Lancet*, 1961, ii: 305–8.

¹⁹ B E Shenfield, *Social policies for old age. A review of social provision for old age in Great Britain*, London, Routledge & Kegan Paul, 1957, pp. 168–71, 176–9, 190.

neighbours or friends, and Townsend concluded that “the family has the care of a far larger number of the infirm aged and chronic sick than all our hospitals, welfare homes and domiciliary services put together”. He estimated that in the country as whole, only 2 per cent of old people were visited by home helps, and he argued that the Ministry’s aggregate statistics disguised inadequacies in the provision of services. While the real focus of Townsend’s survey was changes in the role of the extended family, information hidden away in appendices and footnotes provided an important critical assessment of the coverage of domiciliary services for old people.²⁰

Although geriatricians and sociologists increasingly exposed the reality of provision, local authority services for old people continued to develop slowly in the 1950s, and within the Ministry of Health the issue of chiropody provides an interesting case study of policy-making in this period. While chiropody had not been mentioned in the NHS Act, the social surveys of the 1940s had revealed the need for this service, and in October 1948 Ministry officials concluded that chiropody could be provided more easily through local authority clinics than hospitals.²¹ Although motivated partly by a desire to save hospital beds, some Ministry officials suggested that local authorities should be allowed to provide chiropody under Section 28 of the NHS Act, estimating that the net cost for England and Wales would be £0.5 million. In August 1951, George Godber wrote that “we will have to face one day the need to provide chiropody for old people who for lack of it may be immobilized and so end in hospital”, and the Ministry quietly allowed local authorities, under Section 31 of the National Assistance Act, to contribute to chiropody schemes run by local Old People’s Welfare Associations.²² Nevertheless, voluntary organizations continued to press the Ministry to provide chiropody under Section 28, and new social surveys in the 1950s supported their arguments.²³ In January 1956, the Guillebaud Committee agreed that chiropody should be developed “when more resources become available”, but this continued to provide a convenient excuse for the Treasury.²⁴ Yet by the late 1950s the Labour Party included chiropody among its electoral promises, and in December 1958 the Ministry and Treasury reached a compromise that local authorities could provide a chiropody service in the next financial year. In March 1959, the Minister for Health stated that local authorities could arrange to provide chiropody under the NHS Act, and a circular was issued in April.²⁵ The Ministry had acknowledged in 1949 that chiropody was essential and cheap, but the Treasury had successfully overruled it until 1959 and delayed the introduction of local authority schemes by ten years.

²⁰ Peter Townsend, *The family life of old people. An inquiry in east London*, London, Routledge & Kegan Paul, 1957, pp. 190–4, 204, 210.

²¹ Burn, *op. cit.*, note 12 above, pp. 255–8; Sheldon *op. cit.*, note 9 above, pp. 71, 194–5; Public Record Office, Kew (hereafter PRO), MH 134/184: ‘Chiropody’, 14/10/48.

²² *Ibid.*, H K Ainsworth, ‘Chiropody Under the National Health Service’; *ibid.*, G E Godber to H K Ainsworth, 17/8/51; *ibid.*, D Emery to L C Watson, 24/4/53.

²³ *Ibid.*, D Ramsey to J M K Hawton, 1/6/51; R M Dykes, Fred Grundy and H B Lee, ‘Foot ailments in the general population. A survey conducted in the

Borough of Luton’, *Medical Officer*, 1952, 87: 223–7, 235–7; Henry Rosenstein and J E Barden, ‘The future of chiropody in the National Health Service’, *Medical Officer*, 1958, 100: 365–9.

²⁴ *Report*, *op. cit.*, note 15 above, pp. 206–7, para. 622; PRO T 127/666: R L Workman to F F Turnbull, 15/11/56.

²⁵ PRO T 127/666: A S Marre to F F Turnbull, 18/11/58; *ibid.*, cutting from *Daily Express*, 25/11/58; *ibid.*, ‘Chiropody. Note of discussion at the Treasury, 4/12/58’, 16/12/58; PRO MH 134/185: Ministry of Health, circular 11/59, *National Health Service Act, 1946. Section 28 chiropody services*, 21/4/59.

Crisis and Change, 1960–74

In the early 1960s, the Department of Social Administration at the London School of Economics provided an important critical perspective on social policy through its 'Occasional Papers in Social Administration' series, and many of these studies highlighted the inadequacies of local authority services for the elderly. In 1960, Kathleen Slack concluded from her survey of statutory and voluntary provision in London that while services had grown, "much, remains, however, that is incomplete and some services were noticeable only by their absence".²⁶ Other studies revealed more about the economic circumstances of old people. Dorothy Cole and John Utting, for example, found from their interviews with 1,078 old people in seven local case studies, that 12 per cent of the elderly, half as many as those receiving assistance, were entitled to help but not getting it, and they noted that state benefits determined the standard of living of a large proportion of old people. They estimated that in 1959–60, 2.5 million old people were living very near the poverty line determined by National Assistance standards, and they concluded that real hardship was staved off only through the efforts of family and friends.²⁷ Peter Townsend had briefly mentioned domiciliary services in *The last refuge*, and in the interim report of 1965, Dorothy Wedderburn and he were again critical of the complacency engendered by the legislation of the late 1940s. From their 1962 sample they estimated that nationally 4 per cent of old people were visited by home helps, 1 per cent received a meal at least once a week, and 7 per cent got chiropody treatment, but that small numbers were receiving more than one service. Their survey revealed dramatic regional variations in provision and a reservoir of unmet need, and Townsend and Wedderburn claimed that substantially more people than were receiving services felt they needed them or otherwise qualified for them. During illness, the main sources of help remained families and nearby relatives, and Townsend and Wedderburn concluded that "in illness and infirmity the role of the family in providing personal and household care dwarfs that of the social services".²⁸

In the early 1960s the Ministry continued to stress the role of voluntary organizations, but its attempts to assess and plan services also became more rigorous and sophisticated. The Ministry claimed that the efforts of voluntary organizations reinforced the work of statutory bodies, and in 1962, at the National Old People's Welfare Council conference at Blackpool, the CMO argued that "the care of old people depends first and foremost on themselves and their families. . . . the chief source of support is always the family".²⁹ Under existing legislation, local authorities could contribute only to the funds of voluntary organizations, but the National Assistance Act 1948 (Amendment) Act of 1962 enabled

²⁶ Kathleen M Slack, *Councils committees and concern for the old. A study of the provision, extent and co-ordination of certain services for old people in the County of London*, Welwyn, Codicote Press, 1960, pp. 132–3.

²⁷ Dorothy Cole and John E G Utting, *The economic circumstances of old people*, Welwyn, Codicote Press, 1962, pp. 101–6.

²⁸ Peter Townsend, *The last refuge. A study of residential institutions and homes for the aged in England and Wales*, London, Routledge & Kegan Paul, 1962, pp. 394–9; Peter Townsend and Dorothy

Wedderburn, *The aged in the welfare state. The interim report of a survey of persons aged 65 and over in Britain, 1962 and 1963*, London, Bell, 1965, 3rd ed., 1970, pp. 11, 21–3, 29–43, 48–55, 68–70.

²⁹ PP 1960–61, XVII (Cmd. 1418), Ministry of Health, *Annual report of the Ministry of Health, 1960*, 1961, pp. 123–4; PP 1961–62, XVII (Cmd. 1754), Ministry of Health, *Annual report of the Ministry of Health, 1961*, 1962, pp. 8–9; National Old People's Welfare Council, *The elderly individual in modern society*, London, NOPWC, 1962, p. 73.

them to channel more resources and staff to voluntary bodies.³⁰ The Ministry's white paper, *Health and welfare*, published in April 1963, which complemented the Hospital Plan of the previous year, argued of voluntary organizations that "with the further development of care in the community, there is likely in future to be even more scope for them". Yet while it was unable to set out a minimum level of provision for domiciliary services for the elderly, *Health and welfare* did reflect a new emphasis on planning. The published plans revealed that between March 1962 and March 1972, local authorities intended to increase the number of health visitors by 2,338, home helps by 11,605, and district nurses by 2,086, and its assessment of provision per 1,000 population was an important innovation.³¹ There was progress in other areas; from the mid-1960s, the Ministry recommended that health visitors and district nurses should be attached to general practitioners, and the British Medical Association and Royal College of Physicians reports on the effects of hypothermia were circulated to local authorities.³² Moreover its own surveys revealed the true level of meals and home help services, and the new DHSS now accepted that "variations in levels of service—often wide—arise less from local assessment of need than from local operational practices and policies".³³

By the late 1960s, the *Health and welfare* plans were also looked at more critically. Jeremy Tunstall's study of the effects of social isolation concluded of *Health and welfare* that "the main fault of the plan is its failure to plan" and he argued that the Ministry merely asked local authorities what they would be doing in ten years' time and published the results.³⁴ Other observers of social policy developed more sophisticated analyses of provision and need. Bleddyn Davies, for example, applied the concept of "territorial justice", and his study, published in 1968, was one of the most authoritative. Davies, relating services to family care and housing conditions indices, found that standards of provision were not correlated with need, and that the degree of correlation was no greater in 1961 than in 1951. He concluded that local authorities' planned provision for 1969 and 1974 would not result in a higher correlation between standards and needs than in 1964, and that the inequality of standards was unlikely to be reduced. He argued that the success or failure of local authorities was judged by the quality and efficiency of the services they provided, and he pointed to the importance of attitudes inherited from the period before 1948, and to the relationship between local authorities and the Ministry. Davies concluded that services for children were much more sophisticated than those for elderly people, and he recommended that local authorities and the Ministry should develop methods of assessing need and organizing planning.³⁵

³⁰ PP 1962–63, XIX (Cmd. 2062), Ministry of Health, *Annual report of the Ministry of Health, 1962, 1963*, pp. 81–2; PP 1963–64, XV (Cmd. 2389), Ministry of Health, *Annual report of the Ministry of Health, 1963, 1964*, p. 26.

³¹ PP 1962–63, XXXI (Cmd. 1973), *Health and welfare: the development of community care. Plans for the health and welfare services of the local authorities in England and Wales, 1963*, pp. 44, 366–7.

³² Ministry of Health, *On the state of the public health, 1967*, London, HMSO, 1968, pp. 162–3; PP 1966–67, XXXV (Cmd. 3326), Ministry of Health, *Annual report of the Ministry of Health, 1966, 1967*, p. 33.

³³ PP 1967–68, XXIII (Cmd. 3702), Ministry of Health, *Annual report of the Ministry of Health, 1967, 1968*, p. 30; Amelia I Harris, *Social welfare for the elderly. A study in thirteen local authority areas in England, Wales and Scotland*, London, HMSO, 1968, vol. 1., pp. 63–6; PP 1968–69, XXXII (Cmd. 4100), DHSS, *Annual report of the DHSS, 1968, 1969*, p. 26.

³⁴ Jeremy Tunstall, *Old and alone. A sociological study of old people*, London, Routledge & Kegan Paul, 1966, p. 270.

³⁵ Bleddyn Davies, *Social needs and resources in local services. A study of variations in standards of provision of personal social services between local*

Others now began to review the history of local authority provision for the elderly. Greta Sumner and Randall Smith, for example, had noted dramatic variations in both permissive and statutory services for the elderly, and their study, published in 1969, was based on surveys of twenty-four local authorities; eight in Scotland and sixteen in England and Wales. They provided a valuable summary of developments between 1945 and 1965, suggesting that in the 1950s services such as chiropody had been hampered by a lack of finance and staff, and that, while community care became a possibility in the early 1960s, progress at the local level was slow. Sumner and Smith argued that the Ministry gave local authorities little guidance on planning, there were considerable variations in local provision, and levels of services remained below the standards suggested by the Ministry. They also claimed that attempts to discover unmet needs were rare, and they argued that the ten-year plans had not altered local authority attitudes towards planning. Sumner and Smith concluded that between 1945 and 1965, local authority health and welfare services had evolved “piecemeal in response to expressed demand rather than as the result of any plan”, and they made a number of wide-ranging recommendations.³⁶

These debates about policy and provision culminated in the Seebohm report of 1968 which represented the first serious examination of local health and welfare services since 1948. The Seebohm committee was critical of local authority services for the elderly, and, while it conceded that some local authorities had made great efforts to develop services, it revealed striking regional variations in provision, and concluded that in many areas services were “underdeveloped, limited and patchy”. It found that domiciliary services had developed slowly and it argued that “this piecemeal and haphazard development is unlikely to use scarce resources to the best advantage even though some assistance may be given to a fortunate few”. The report found that home helps rarely discussed health matters with doctors in health departments, and it argued that health visitors could not become all-purpose social workers for general practice. The committee suggested that MOHs and geriatric physicians should link residential homes and hospitals, and it hoped that community physicians would have a wider and more responsible role. Nevertheless, its recommendation that local authorities should establish social services departments, one subsequently implemented in the 1970 Local Authority (Social Services) Act, reflected the triumph of the social work lobby over MOHs.³⁷

Despite Seebohm, surveys continued to indicate that the level of provision of some services remained unimpressive, and the Government Social Survey on the Home Help Service, for example, found that less than a third of areas had formal training schemes, and only a fifth of home helps had attended training courses. It found that the oldest age groups who were most likely to need home helps, knew least about the service, and estimated that to satisfy unmet needs the number of home helps would have to be doubled or trebled.³⁸ In general the annual reports of the CMO and DHSS continued to describe

authority areas, London, Michael Joseph, 1968, pp. 16, 158, 168–75, 210–14, 298–301. See also Bledwyn P Davies, Andrew J Barton, Ian S Macmillan, and Valerie K Williamson, *Variations in services for the aged. A causal analysis*, London, Bell, 1971.

³⁶ Greta Sumner and Randall Smith, *Planning local authority services for the elderly*, London,

Allen & Unwin, 1969, pp. 14–18, 29–48, 84–92, 244–54, 323–31, 347–59, 372–4.

³⁷ PP 1967–68, XXXII (Cmd. 3703) *Report of the Committee on Local Authority and Allied Personal Social Services*, pp. 90, 95–6, 118–20, paras. 293, 307–9, 376–80.

³⁸ Audrey Hunt, *The home help service in England and Wales*, London, HMSO, 1970, pp. 5–8, 23–8.

the expansion of domiciliary services, claiming dramatic increases in the number of old people visited by health visitors, more district nursing and night care, and the appointment of geriatric health visitors linking community nursing services, GPs and hospitals.³⁹ Yet the debate on provision and need did have some effect on the DHSS. Section 13 of the Health Services and Public Health Act of 1968 replaced Section 29 of the 1946 NHS Act; it compelled local authorities to provide a home help service, and gave them general powers to provide laundry services for people who were visited by home helps.⁴⁰ In April 1971, Sections 13 and 45 of the 1968 Act were brought into force, and at the local level the new Social Services Departments took over responsibility for the home help service, and for meals and other recreational activities for old people.⁴¹ By September 1973, there were 6,212 health visitors, 10,217 district nurses and 38,095 home helps (full-time equivalents); 79 per cent of health visitors and 77 per cent of district nurses were attached to general practitioners, and 86 per cent of the visits of home helps were to the over-65s.⁴² The DHSS claimed that all local health authorities provided chiropody, that 595 chiropodists were employed, with another 436 working on a sessional basis, and that 4.5 million treatments were given to over 1 million people; from April 1974 all chiropody services were taken over by the new Area Health Authorities.⁴³

Growing Old in the City: Leicester, 1948–74

Having charted official policy on local authority health services for the elderly in England and Wales, this article will now consider to what degree services organized through Leicester County Borough's Health Committee followed or deviated from the national model. The Ministry of Health always regarded Leicester as a progressive local authority, and under its MOHs the city had built up impressive public health services in the years before 1948. By then, Leicester was a reasonably affluent Midlands city, with prosperity based on the hosiery, boot and shoe, and light engineering industries, and its population was 285,181 at the 1951 census; Dorothy Cole and John Utting, who included the city as one of their case studies, concluded that by the early 1960s Leicester was "a microcosm of the affluent society".⁴⁴ The city's demographic trends, like those of other urban areas, included increasing numbers of old people, with the number of men aged over 65 and women over 60 increasing from 17,777 in 1921, to 38,840 in 1951, and to 47,970 in 1971. As a proportion of the total population, men aged over 65 and women over 60 represented 7.59 per cent in 1921, 13.62 per cent in 1951, and 16.88 per cent in 1971.⁴⁵

³⁹ Ministry of Health, *On the state of the public health, 1969*, London, HMSO, 1970, p. 149.

⁴⁰ PP 1968–69, XXXII (Cmd. 4100), DHSS, *Annual report of the DHSS, 1968*, 1969, p. 20.

⁴¹ PP 1971–72, XV (Cmd. 5019), DHSS, *Annual report of the DHSS, 1971*, 1972, pp. 32–3.

⁴² PP 1974, V (Cmd. 5700), DHSS, *Annual report of the DHSS, 1973*, 1974, pp. 26–7, 63–4.

⁴³ *Ibid.*, p. 28; PP 1974–75, XI (Cmd. 6150), DHSS, *Annual report of the DHSS, 1974*, 1975, p. 38.

⁴⁴ Cole and Utting, *op. cit.*, note 27 above, p. 8. See also David Nash and David Reeder (eds),

Leicester in the twentieth century, Stroud, Alan Sutton, 1993.

⁴⁵ General Register Office, *Census of England & Wales 1921. County of Leicester*, London, HMSO, 1923, p. 29, table 14; General Register Office, *Census 1951. England and Wales. County Report. Leicestershire*, London, HMSO, 1954, p. 47, table 21; Office of Population Censuses and Surveys, *Census 1971. England and Wales. County Report, Leicestershire*, London, HMSO, 1973, part I, p. 16, table 8.

In the interwar period, Leicester's old people had benefited from the general expansion of local authority public health services, but they received little real attention until after the Second World War. In his plans for reconstruction, written in December 1942, the city's MOH, Dr Kenneth Macdonald, noted that Hillcrest, the former workhouse, was "situated in most unsuitable surroundings", while the Nuffield Provincial Hospital Trust's surveyors noted that "the surroundings are gloomy and although the wards are slightly better than the average accommodation for the chronic sick, they cannot be regarded as satisfactory".⁴⁶ Macdonald assumed that Hillcrest would be redundant in the new welfare state, and in an article published in 1948, he included old age among those aspects of public health which he claimed had potential for MOHs.⁴⁷ Following the National Assistance Act, the city appointed a new Welfare Committee to deal with residential homes, and the Health Committee stretched Section 47 so that the MOH could include old people among the cases that he recommended for compulsory removal to hospital. In general however, it was voluntary organizations, such as the newly-established Leicester Old People's Welfare Association, which filled the gap with its fifteen Evergreen Clubs; the Health Committee was represented on the Association's committee and it sent delegates to the parent organization's third national conference in London in November 1948.⁴⁸

In general, little was achieved for the city's elderly people in this early period, apart from services for diabetics, an area in which Leicester was an important pioneer. Dr Joan Walker had worked in the Emergency Medical Service in Leicester during the War, but in 1945 she began a clinic for diabetics at the Royal Infirmary and this became her main professional interest. She argued that the clinic could diagnose and treat diabetics, teach patients and their families good diabetic care and dietetics, educate nursing staff, organize and co-ordinate welfare work, and promote research, and she envisaged it as "the hub from which these other interests radiated".⁴⁹ Her visit in 1950 to the Mayo Clinic in Rochester, Minnesota, was an important influence, as she was able to compare American and British facilities. In particular, she realized that health visitors could be used to teach diabetics in their own homes, and Leicestershire and Leicester appointed health visitors for this purpose in 1950 and 1953.⁵⁰ Walker claimed that the patients did not resent the intervention of the clinic-based health visitors, and she argued that her system saved time, often overcame the patients' resistance to insulin, and reduced the number of admissions

⁴⁶ Leicestershire Record Office (hereafter LRO): DE 3277/116: Health Committee minutes, 9/4/43, p. 711; PRO MH 77/11: 'Hospital survey. Sheffield and East Midlands area. Report', A57.

⁴⁷ E K Macdonald, 'The fragments that remain', *Medical Officer*, 1948, 80: 185–7.

⁴⁸ LRO DE 3277/116: Health Committee minutes, 23/1/48, p. 254; LRO: Leicester Health Committee, *Report of the MOH, 1954*, Leicester, 1955, pp. 59–60; LRO: Leicester Old People's Welfare Association, *Annual report 1948–49*, Leicester, LOPWA, 1949, p. 6.

⁴⁹ Hugh Trowell, 'Diabetes Mellitus death-rates in England and Wales 1920–70 and food supplies', *Lancet*, 1974, ii: 998–1001; E R Frizelle, *The life*

and times of the Royal Infirmary at Leicester. The making of a teaching hospital 1766–1980, Leicester, Leicester Medical Society, 1988, p. 209; PP 1966–67, XXXV (Cmd. 3326), Ministry of Health, *Annual report of the Ministry of Health, 1966, 1967*, p. 26; Joan B Walker MSS, Clinical Sciences Library, University of Leicester, 'Chronicle of a diabetic service', 4/86, p. 8; interview between Joan Walker and the author, Lyme Regis, 18/11/93.

⁵⁰ Walker, op. cit., note 49 above, pp. 29–30, 47, 58–9; LRO DE 3277/119: Maternity and Child Welfare sub-committee minutes, 9/9/53, p. 50; interview between Yvonne Cox and the author, Leicester, 9/12/93.

to hospital.⁵¹ In some respects the scheme fell short of her original expectations as not all health visitors could acquire the specialist knowledge and experience, and there was opposition from doctors who felt that health visitors should be working as nurses in hospitals. Nevertheless, Walker's survey of health visitor records for 1950 and 1953 demonstrated that 97 of the 113 elderly diabetics were still living in their own homes, and she concluded that once relatives were trained, diabetic patients were happier and better cared for at home than in institutions. She recommended co-ordination between diabetics and family doctors, health visitors working as liaison officers, short stays in hospital to relieve relatives, education in hygiene, showers and foot baths, and occupational therapy at home.⁵² In July 1953, a Ministry of Health circular provided local authorities with basic guidelines on the development of services for diabetics, and some subsequently copied Leicester's innovations.⁵³

More generally in the 1950s, Leicester slowly began to provide some services for the city's old people through health visitors and district nurses. Section 24 of the NHS Act had extended the duties of health visitors to people suffering from illness and to the prevention of infectious disease, and while the MOH was premature in writing in 1948 that "the health visitor can become the social worker of the future", in the early 1950s the training of health visitors improved and their work widened to include older children and adults.⁵⁴ The Health Committee also took over the District Nursing Association in January 1954, and it increased the number of nurses from 45 to 48, provided a daily service, and established four nursing homes in the city. By 1958, provision for the elderly was an important aspect of the work of district nurses, and visits to the over-65s represented 42 per cent of the total cases and 58 per cent of the total visits.⁵⁵ While one of the important features of the 1950s was financial retrenchment, Leicester did spend more on these services than other County Boroughs; in 1956–57, for example, £93 4s on health visiting and £146 18s on district nursing per 1,000 population, against the County Borough averages of £71 13s and £119 19s respectively.⁵⁶ Yet the number of health visitors and district nurses in Leicester, at around 28 and 45 respectively, remained fairly static through the 1950s, and the changes in their work raised the question of their relationship to social workers.

While there was little increase in the number of health visitors and district nurses, Leicester had begun a home help scheme in November 1946, and this expanded rapidly in the early 1950s so that there were 236 home helps by December 1952.⁵⁷ In 1952, the MO for Maternity and Child Welfare wrote that "the home help has been called 'the missing

⁵¹ Joan B Walker, 'Field work of a diabetic clinic', *Lancet*, 1953, ii: 445–7, on p. 447; *idem*, 'Sociological implications of diabetes', *Br. med. J.*, 1955, ii: 318–19; *idem*, 'Chronicle of a diabetic service', op. cit., note 49 above, pp. 56, 91; *idem*, *Chronicle of a diabetic service*, London, British Diabetic Association, 1989, p. 31; interview between Joan Walker and the author.

⁵² Joan B Walker, 'The problem of the elderly diabetic', *Medical Officer*, 1954, 91: 129–30; *idem*, *Chronicle of a diabetic service*, op. cit., note 51 above, p. 37; interview between Joan Walker and the author.

⁵³ R E Tunbridge, 'Sociomedical aspects of

Diabetes Mellitus', *Lancet*, 1953, ii: 893–9; J E Cates, 'A survey of diabetics visited by district nurses in Bristol', *Medical Officer*, 1956, 95: 107–8.

⁵⁴ LRO: Leicester Health Committee, *Report of the MOH, 1948*, Leicester, 1949, p. 23.

⁵⁵ LRO: Leicester Health Committee, *Report of the MOH, 1952*, Leicester, 1953, p. 81; *idem*, *Report of the MOH, 1958*, Leicester, 1959, pp. 44–52.

⁵⁶ Institute of Municipal Treasurers (hereafter IMT), *Local health services statistics, 1956–57*, London, IMT, 1958, p. 12.

⁵⁷ LRO: Leicester Health Committee, *Report of the MOH, 1952*, Leicester, p. 100.

relative' and this aptly describes her place in the home life of this city", and the MOH pointed out that fewer old people were now removed from their homes under Section 27 of the 1948 National Assistance Act.⁵⁸ The Home Help Organizer suggested that there were three distinct groups of old people in the city; those who were living alone in a state of mental and physical "degeneration"; nearly 500 bedridden cases suffering from illnesses such as rheumatism; and a larger number who needed occasional help and who could be grouped together for shorter visits.⁵⁹ Home helps offered advice on welfare benefits and services such as spectacles, dentures, and meals on wheels, and four who were mounted on bicycles attended to the hair, hands and feet of old people and invalids. In 1955, the preparation course for home helps was extended to six weeks, and it interspersed sessions on budgeting, home safety, home nursing, other social services, and human relationships with days of work-experience.⁶⁰ The amount of help could vary; home helps could call weekly to collect pensions or shopping, they could make daily calls to prepare meals, clean and give personal attention, or they might make several calls in one day. In some cases they would supervise the entire household budget, collect pensions, buy food or equipment for the home, and pay bills for fuel and lighting. In 1956–57, Leicester spent £270 15s on domestic help per 1,000 population, against the County Borough average of £116 5s, and the service attracted numerous visitors.⁶¹ A better qualified Assistant Home Help Organizer was appointed in September 1956, and at the end of the decade, a new experimental training course offered three weeks intensive preparation for work with the elderly.⁶²

Leicester's MOH was particularly interested in health education, and by the late 1950s this extended to the elderly; exhibitions during Old People's Week in 1959 included one on the Health Committee's services, and another on "home safety for the aged".⁶³ Yet, in general, voluntary organizations continued to shoulder much of the responsibility for services, and were often more imaginative in initiating new ones. From September 1958, the local branches of the Old People's Welfare Association and the WVS organized a laundry service based at Hillcrest which received a grant through the General Welfare sub-committee but was essentially self-supporting.⁶⁴ Local branches of the Red Cross and Charity Organization Society, and the Leicester Aid-in-Sickness Fund, together funded a scheme to supply nursing equipment and other services, and the local branch of the WVS served over 7,000 meals in 1959.⁶⁵ In the same year, the District Nurses Superintendent admitted that an adequate service was provided only through co-operation between statutory and voluntary organizations, and the Health Committee accepted that voluntary organizations played an important role.⁶⁶

⁵⁸ *Ibid.*; LRO: Leicester Health Committee, *Report of the MOH, 1954*, Leicester, 1955, pp. 59–60.

⁵⁹ *Ibid.*, p. 120.

⁶⁰ LRO: Leicester Health Committee, *Report of the MOH, 1955*, Leicester, 1956, pp. 110–12, 114.

⁶¹ LRO: Leicester Health Committee, *Report of the MOH, 1959*, Leicester, 1960, p. 63; IMT, *Local health services statistics, 1956–57*, op. cit., note 56 above, p. 13.

⁶² LRO DE 3277/121: General Welfare sub-committee minutes, 14/10/59, p. 56.

⁶³ LRO: Leicester Health Committee, *Report of the MOH, 1959*, Leicester, 1960, p. 50.

⁶⁴ LRO DE 3277/123: General Welfare sub-committee minutes, 11/10/61, p. 76.

⁶⁵ WRVS archive, 11 Millstone Lane, Leicester: 'Meals-on-wheels 1 returns', file, Barbara Potter to Mrs Goddard, 23/2/60.

⁶⁶ LRO: Leicester Health Committee, *Report of the MOH, 1959*, Leicester, 1960, p. 48.

Leicester also illustrated how the Ministry of Health's delay in introducing chiropody schemes affected services at the local level. In November 1949, inspired by a visit to Finsbury's foot clinic, Dr Macdonald had proposed a chiropody scheme, but local GPs were reluctant and the Ministry refused to sanction all local authority proposals for chiropody under Section 28 of the NHS Act.⁶⁷ Dr Joan Walker had observed on her visit to the Mayo Clinic that a specialist foot clinic, weekly visits by a surgeon, and foot baths reduced amputations, gangrene and bad foot infections, and from the mid-1950s, her clinic employed a local chiropodist for the city's diabetics.⁶⁸ Some treatment was provided by a chiropodist in the south of the city, and through the home helps and the Red Cross chiropody clinic, but a survey by district nurses in July 1956 indicated that the need for a domiciliary service remained. Yet although Leicester's MOH suggested in March 1957 that the Health Committee could employ a chiropodist or contribute to voluntary organizations, the Ministry remained opposed.⁶⁹ Finally in November 1959 the Ministry changed its stance, and although wrangling with chiropodists over fees delayed matters further, a local scheme was introduced in September 1960; by the end of 1964, 946 cases were receiving treatment.⁷⁰

In the 1950s, Dr Joan Walker had established the clinic and health visitor service for Leicester's diabetics, and in 1961 she published an important study of the incidence of diabetes. In 1955, the British Diabetic Association had begun to try to evaluate the problem of diabetes in Britain, and its survey was based on Ibstock, a village of 5,406 inhabitants situated fifteen miles north-west of Leicester. The survey, conducted between May 1957 and July 1958, aimed to establish the number of diabetics and undiagnosed cases, and the results revealed that there were thirteen diabetics per 1,000 population and that half of these were asymptomatic.⁷¹ Walker acknowledged that her methods, using urine testing as a rough screen rather than glucose tolerance, were constrained by limited laboratory resources and the distance of Leicester from any centre with specialist knowledge, so that later advances made them appear "archaic".⁷² Moreover the impact of the survey was greater in Scandinavia than in Britain, and in Leicester Walker's successes appeared to antagonize her colleagues at the Royal Infirmary. Although she was increasingly influential through the British Diabetic Association and gave the prestigious Banting Lecture, she remained a Senior Hospital MO for twenty years and became a consultant in February 1965, only three years before her retirement. Walker later claimed that "I had a raw deal from the physicians. They didn't want anyone messing with their patients. They were really very awkward".⁷³ Overall, her unusual career, in which she gained an international reputation for research carried out within the context of local

⁶⁷ LRO DE 3277/117: General Welfare sub-committee minutes, 13/7/49, 9/11/49 and 14/12/49, pp. 23, 79, 96.

⁶⁸ Interview between Joan Walker and the author.

⁶⁹ LRO DE 3277/120: General Welfare sub-committee minutes, 14/11/57 and 13/3/57, pp. 259, 320; LRO: Leicester Health Committee, *Report of the MOH, 1959*, Leicester, 1960, p. 64.

⁷⁰ LRO DE 3277/120: Health Committee minutes, 20/11/59, p. 80; *ibid.*, Health Committee minutes, 18/3/60, p. 138; *ibid.*, General Welfare sub-committee minutes, 9/11/60, p. 254; LRO: Leicester

Health Committee, *Report of the MOH, 1964*, Leicester, 1965, pp. 62–3.

⁷¹ Joan B Walker and David Kerridge, *Diabetes in an English community. A study of its incidence and natural history*, Leicester University Press, 1961, pp. 4–5, 7–9, 12–13. See also Armstrong, *op. cit.*, note 9 above, pp. 93–4.

⁷² Walker, 'Chronicle of a diabetic service', *op. cit.*, note 49 above, p. 1.

⁷³ *Ibid.*, p. 20; interview between Joan Walker and the author.

authority services, was indicative of the low status of public health within the medical profession.

In the 1960s, the Ministry of Health tried to tackle local authority services for the elderly, and at the local level the new decade also coincided with the retirement of Dr Macdonald and the appointment of Dr John Moss as Leicester's MOH. District nurses were now more involved with the elderly than health visitors, but staff shortages and poor housing continued to hamper their work. In winter, when older patients suffering from respiratory illnesses required more nursing, the weekly bed bathing of patients had to be postponed.⁷⁴ District nurses found that many of their older patients lived in houses without a hot water supply or a bathroom, and they claimed that some old people were unable to cook good meals regularly. A mobile meals service was introduced in February 1962, but the emphasis of Leicester's initial plans for *Health and welfare* was very much on residential accommodation and the replacement of Hillcrest and The Towers, the Victorian mental hospital.⁷⁵ After the MOH had lobbied for additional domiciliary services, the published plans in *Health and welfare* revealed that by 1972 Leicester intended to increase the number of health visitors from 26 to 70, and fund a smaller expansion of district nurses.⁷⁶ A local enquiry in September 1964 revealed that district nurses attended to only one in ten of the old people living there, and this was followed by a period of limited expansion; in 1965, the number of district nurses was increased from 61 to 76, and night visits doubled.⁷⁷ Moreover Leicester continued to spend more on these services than other cities; in 1965–66, for example, £224 18s on health visiting and £305 18s on district nursing per 1,000 population against the County Borough averages of £155 14s and £236 2s respectively.⁷⁸

The number of home helps employed by the local authority had grown quickly in the 1950s, but the Organizer maintained that families could do more for their elderly relatives, and in this her analysis carried echoes of her punitive approach to the city's "problem families". She also appeared to be uncertain whether the purpose of home helps was to help old people to move from the slum areas to the Housing Department's new modern bungalows, or to enable the elderly to remain in their own homes.⁷⁹ By 1965, when there were 222 home helps, most of their visits were to people over 65. Yet the early release from hospital of elderly patients placed a growing strain on the service as many lived in homes with no hot water and outside lavatories, and in which old-fashioned coal fires and dangerous cookers created a constant risk. In 1966 the MOH proposed a small pilot scheme to provide modern gas fires to elderly people, and he pointed out that home helps

⁷⁴ LRO DE 3277/122: A Ratcliffe, 'Home Nursing Service', 24/2/61, p. 3; LRO: Leicester Health Committee, *Report of the MOH, 1961*, Leicester, 1962, p. 49.

⁷⁵ LRO: Leicester Health Committee, *Report of the MOH, 1962*, Leicester, 1963, p. 65.

⁷⁶ LRO DE 3277/123: 'Development of local authority health and welfare services. Summary of the ten year plan', 22/8/62, pp. 4–8; LRO DE 3277/16: Council minutes, 30/10/62, pp. 241–63; LRO DE 3277/124: B J L Moss, 'Reorganisation of medical staff', 18/6/63; *Health and welfare*, op cit., note 31 above, pp. 122–3.

⁷⁷ LRO DE 3277/124: Health Committee minutes, 25/9/64, p. 240; *ibid.*, B J L Moss, 'Home Nursing Service—staff establishment', 19/10/64; LRO: Leicester Health Committee, *Report of the MOH, 1965*, Leicester, 1966, p. 50.

⁷⁸ IMT, *Local health services statistics, 1966–67*, London, IMT, 1968, p. 10.

⁷⁹ LRO: Leicester Health Committee, *Report of the MOH, 1960*, Leicester, 1961, pp. 68–9; *idem*, *Report of the MOH, 1961*, Leicester, 1962, pp. 68–9.

could spend only short periods in patients' homes, so that for the rest of the time the well-being of these old people was a source of concern.⁸⁰ The *Health and welfare* plans revealed that Leicester's home help scheme was one of the most developed, and the city continued to spend more on this service than many other cities; in 1966–67, Leicester spent £399 18s on domestic help per 1,000 population against the County Borough average of £324 5s.⁸¹ In the Good Neighbour Scheme set up in 1966, auxiliary home helps made evening and weekend visits to old people unable to leave their beds or houses, and the MOH claimed that this scheme had been effective for those elderly people whose needs were difficult to cover adequately.⁸² However there were only four auxiliaries by December 1966, and the state of the city's housing continued to hamper both their work and that of the full-time home helps.⁸³

Some of the Ministry's emphasis on the potential of voluntary organizations was taken up by local authorities such as Leicester. In 1963, the District Nursing Service and Red Cross schemes for lending medical equipment were amalgamated, with the Red Cross administering the new service, and in 1966, a helpers club for stroke patients was formed on the New Parks estate.⁸⁴ The Leicester branch of the WRVS remained energetic, so that by 1972 it delivered 66,907 meals, and served 15,895 meals in its six luncheon clubs. This marked a move away from the mobile meals service to the luncheon clubs, and in 1971, 229 people remained on the waiting list for mobile meals and luncheon club services including 49 living in areas served by WRVS vans. In general the WRVS remained fiercely proud of its meals-on-wheels service and its local Organizer, Mrs Helena Cooper, admitted that she was disappointed when the local authority set up its own scheme.⁸⁵ Although the Health Committee took over the laundry service in June 1971, Leicester Old People's Welfare Association remained active, and it was renamed Age Concern in October 1972.⁸⁶

The years leading up to the 1974 reorganization illustrated both new innovations and the persistence of existing problems. In 1965, Leicester had appointed an Area Consultant Geriatrician, and the British Medical Association and Royal College of Physicians reports had focused attention on hypothermia.⁸⁷ Yet surveys continued to show that Leicester's elderly population were in poor medical condition; one in 1965, for example, claimed that 20 per cent of the elderly were isolated, depressed, apathetic, and immobile, and that nutritional anaemia and hypothermia were becoming more common.⁸⁸ In 1966, Dr Moss pointed out that many old people were trapped in poor housing, and he concluded that "these old people increasing in number year by year are a group who do not fit into the materialistic plan of the present affluent society. . . . They wait and hope that perhaps before they die

⁸⁰ LRO: Leicester Health Committee, *Report of the MOH, 1965*, Leicester, 1966, p. 55; *idem, Report of the MOH, 1966*, Leicester, 1967, p. 56.

⁸¹ *Health and welfare*, op. cit., note 31 above, pp. 122–3; IMT, op. cit., note 78 above, p. 11.

⁸² LRO: Leicester Health Committee, *Report of the MOH, 1966*, Leicester, 1967, p. 54.

⁸³ LRO: Leicester Health Committee, *Report of the MOH, 1967*, Leicester, 1968, p. 52.

⁸⁴ LRO: Leicester Health Committee, *Report of the MOH, 1963*, Leicester, 1964, p. 66; *idem, Report of the MOH, 1966*, Leicester, 1967, p. 46.

⁸⁵ WRVS Archive: 'Meals-on-wheels 1- returns' file, Harry Thacker to Helena Cooper, 8/10/71; *ibid.*, 'Meals on wheels, summary 1972'; interview between Helena Cooper and the author, Leicester, 3/12/93.

⁸⁶ LRO: Leicester Health Committee, *Report of the MOH, 1971*, Leicester, 1972, p. 42; Age Concern archive, 46 Humberstone Gate, Leicester: 'Leicester Old People's Welfare Association, minutes of the 22nd and 23rd AGMs', 28/10/71 and 2/11/72.

⁸⁷ LRO: Leicester Health Committee, *Report of the MOH, 1965*, Leicester, 1966, p. 62.

⁸⁸ *Ibid.*, p. 3.

conditions may be better”.⁸⁹ He continued to lament the neglect of domiciliary services, and he wrote that the role of loneliness in causing self neglect, malnutrition, hypothermia and suicide in old people was seldom appreciated.⁹⁰ Some services for old people were transferred to the new Social Services Department in 1971, and its new Social Services Committee steadily became more powerful than the old Health Committee. There were some belated improvements such as the appointment in May 1972 of a health visitor as a tuberculosis and geriatrics liaison officer, but the MOH’s final report for 1973 recorded that visits to old people made up a small proportion of the visits by health visitors, and he conceded of chiropody that the total number of patients treated represented only a small proportion of those requiring the service.⁹¹ Moreover despite the earlier comments of the MOH and the Nuffield Provincial Hospital Trust’s surveyors on Hillcrest, the Health Committee anticipated in November 1973 that, with the shortage of geriatric beds, the remaining wards at the former workhouse would be closed only in 1976.⁹² At reorganization, in April 1974, the remaining functions of the Health Committee in respect of old people were transferred to the new Leicestershire Area Health Authority.

Conclusions

What, therefore, does this study of services for elderly people tell us about public health in England and Wales between 1948 and 1974? There was a rediscovery of the issue of old age during the Second World War and in the social surveys of the 1940s and 1950s, and some local authorities, such as Leicester, produced ambitious plans and responded quickly to Ministry circulars. The Health Committee’s use of home helps, its chiropody scheme, its provision for diabetics, and its inclusion of the elderly in health education were all innovative, while it also provided meals, laundry, and other services in collaboration with the local branches of the Red Cross, WRVS and Old People’s Welfare Association. Yet even a progressive County Borough such as Leicester also serves to highlight some of the weaknesses in local authority provision. The Ministry of Health issued circulars and annual reports, but its stance was one of encouragement and guidance rather than coercion, and at the local level, services for old people were split between separate Health and Welfare Committees. In the 1950s, there was little increase in local authority spending, the introduction of new services such as chiropody was delayed and, apart from home helps, the impression is one of stagnation at the local level. Although the *Health and welfare* plans of 1963 indicated a growing determination to come to terms with new challenges to public health, MOHs were increasingly out of touch with developments in social work, and surveys such as those by Townsend and Wedderburn, and the Seeborn Report, revealed that domiciliary services continued to be patchy and haphazard. Domiciliary services were still unimpressive in 1974, at the end of the period, and it remains to be seen whether older people have fared any better under “community medicine”.

⁸⁹ LRO: Leicester Health Committee, *Report of the MOH, 1966*, Leicester, 1967, p. 5.

⁹⁰ LRO: Leicester Health Committee, *Report of the MOH, 1968*, Leicester, 1969, pp. 6, 45.

⁹¹ LRO: Leicester Health Committee, *Report of the*

MOH, 1972, Leicester, 1973, pp. 34–5; *idem, Report of the MOH, 1973*, Leicester, 1974, pp. 29, 39.

⁹² LRO: DE 3277/126: Health Committee minutes, 16/11/73, p. 239.