

Welfare state – health care provisions essay sample



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This essay will explore the changing attitudes of society, within a healthcare context, towards the poor and people with disabilities. It will examine the impact of progressive legislation and how welfare provision has changed from 1971 to the present date. The effect of these changes on how the poor and disabled are viewed and treated will also be analysed.

Healthcare is defined as “ The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.” (medical-dictionary, 2008). This essay will closely examine the key changes, through both social advancement and legislative modifications, from the specific perspective of the impact on those with low incomes or disabilities.

Before looking at these key changes from 1971, it will be appropriate to provide context in the form of a brief overview of how the healthcare arena looked in earlier years and how the poor and disabled were treated. Prior to the creation of the National Health Service in 1948, low-paid working men had to pay each week for a ‘ panel’ doctor and this deal did not provide hospital care, with hospitals charging all users for access to services. Women and children had to pay to see a doctor, usually laying the money on the desk as they walked in (dh, 2008).

The National Health Service signalled a revolution in healthcare provision. People were able to access medical assistance as a basic right rather than by the previous criteria of affordability. The establishment of antibiotics, the development of anaesthetics and increased surgical expertise all contributed to much more effective treatment of previously serious conditions.

Those in poverty in the mid to late nineteenth century were regarded as being the architects of their own misfortune. They were considered lacking in morals and possessing a lack of Christian discipline, leading to drinking, gambling and promiscuity (Horner, 2007). Furthermore, Charity Organisation leaders believed that deterrent Poor Laws were the answer and that financial provision by the state should be resisted. For the first half of the twentieth century, older people had very limited options for financial stability and working class elders usually lived in extreme poverty. They were often placed in workhouses and, if too infirm to work, were left unoccupied day after day in bleak conditions.

Disabled people around the time of the Industrial Revolution, in the early nineteenth century, were regarded as a social and educational problem. They were increasingly segregated in institutions such as asylums, workhouses and special schools (Oliver, 1990). Legislation such as the 1808 Lunacy Act and the 1845 Lunatics Act increased the focus on institutionalisation (Horner, 2007) and the language of the time, with the common use of terms such as 'idiot', 'feeble-minded' and 'unproductive', is highly indicative of the attitudes that prevailed.

Against this historical backdrop, an analysis can be made of how welfare provision has changed. Particular focus will be given to the period from 1971 until the present time and relevant milestone legislation will be covered. Social practices and attitudes also change as a result of factors outside of legislation and this too will be examined.

Healthcare provision in the 1970s was subject to many positive developments. General Practitioners began to move to group practices that included nurses and support staff (dh, 2008). This improved access to health services in the community, particularly benefiting those who struggled with travel costs associated with visiting hospitals that were often some distance away. It also provided more local provision for those with disabilities, with home visits becoming more readily available.

Family planning services were introduced and the contraceptive pill became widely available, regardless of marital status. This gave more options, and professional advice, to women who were struggling with large families and poverty. The decade also saw great advances in terms of successful organ transplants and the use of heart pacemakers. It is important to realise that conditions such as organ failure or under-performance would previously have consigned the sufferer to a life of effective disablement.

On the legislative front, the Employment Medical Advisory Service Act 1972 recognised the often poor working conditions present within factories and set out to appoint advisors to replace the previous 'factory doctor' arrangement. This offered increased protection and health advice to a workforce that was often made up of low-paid men and those less than eighteen years of age (opsi, 2008).

The National Health Service Act 1977 made the government legally responsible for providing, free of charge, a comprehensive health service designed to improve the physical and mental health of the population. The Act specified that hospital accommodation, medical, nursing, dental and

ambulance services should be provided where required. This also extended to diagnostic services to assist prevention and early treatment and specialist services for nursing mothers and young children (dh, 2004).

In 1979 the Report of the Committee of Enquiry into Mental Handicap Nursing and Care, most commonly known as the Jay Report, after the Chair of the Committee Peggy Jay, recommended that long-stay hospitals should be closed and that people with disabilities should live in the community with support from social services. The changes implemented as a result of the Jay Report brought many positive changes to the lives of adults with disabilities. They were given more freedom and responsibility and increasingly became active members of society and held personal bank accounts and rented or owned their own homes (saifscotland, 2007).

The 1980s saw further advancements in healthcare, with Polio and Whooping Cough virtually wiped out (dh, 2008). The treatment for cancer and heart disease sufferers became more effective, freeing many from disablement. The invention of keyhole surgery provided a less invasive and risky surgical method and clot-busting drugs helped heart attack patients. This decade also saw the opening of the first In Vitro Fertilisation clinic, offering great hope to infertile couples. Whilst the availability of this pioneering treatment was very welcome, it should be noted that those in poverty were much less likely to be able to access such services due to prohibitive costs.

The publication of the Black Report in 1980 which is titled 'Inequalities in Health', against the backdrop of a newly elected Conservative government who had pledged to dramatically cut public expenditure, highlighted how

social class and poverty greatly impacted health and how investment in health services and a health and social development programme were urgently required to address the problem (sochealth, 2005).

The Report produced evidence that unskilled or manual labourers were significantly more likely to die before retirement age and were also much more prone to suffer the death of one of their children. It also said that the health of the lower working classes was actually deteriorating and that provision of health services was unacceptable in working class areas.

Difficulties faced by those with disabilities were also highlighted in the report and a plea was made for greater mobility via the extension of home-help responsibilities and free transport to day centres.

The legal protection of adults with disabilities who were resident in care homes was strengthened by the Registered Homes Act 1984. The Act made provision for the registration and inspection of all care homes by local authorities (opsi, 2007a). It also placed an obligation upon named officers within the care homes to regularly monitor standards. The rights of people with disabilities were further strengthened by the Disabled Persons' Act 1986.

This Act obligated local authorities to assess a person with disabilities' needs when asked to do so. Local authorities were also required to provide as much relevant information as possible on available services and to take the abilities and limitations of carers into account when making assessments (enabletogether, 2006). These measures began to provide people with disabilities with more involvement in decision making.

Technological advances allowed healthcare to progress further in the 1990s, with the introduction of Positron Emission Tomography scans and the ability to perform laser surgery on babies in the womb (dh, 2008). An organ donor register was established and the UK moved to the forefront of world meningitis treatment with vaccines introduced for all three strains of the disease.

This decade saw much more focus on prevention and low-income families, once disregarded by healthcare and society, were now given increased assistance and advice around how to improve their health through positive lifestyle choices. A further source of health advice, in the shape of NHS Direct, was launched, allowing immediate professional medical advice to be available by telephone. This greatly increased options for those who found it difficult to access services locally, including those in low-income areas and those housebound by disabilities.

In 1992 the Department of Health published a White Paper titled The Health of the Nation. This was the first ever national target-based strategy for health in England and was a significant step forward in making health a central concern (Postle-Hacon, 1998). It promoted the creation of 'healthy alliances' between clients, health professionals and other agencies and further signalled the move toward individuals being given more choices and being able to make informed decisions about their health and treatment plans.

The Disability Discrimination Act was introduced in 1995 and made it unlawful to discriminate against disabled persons in relation to various areas

(opsi, 2007b). Included was the provision of facilities and services, thus having an impact upon the accessibility of healthcare services. The Direct Payments Act 1996 was another step toward independence and social inclusion for people with disabilities. The Act instructed local authorities to pass day-to-day control of funds to service users in order that customised care packages could be designed to meet individual needs (dh, 2000). Placing such trust in people with disabilities, and including them in a genuine and active partnership, would have been unimaginable just 20 years earlier.

The introduction of the Health Act in 1999 saw the government instructing the health and social care professions to work together for the good of the client. Those who regularly accessed health and social care functions, such as the elderly poor and people with disabilities, were promised more co-ordinated services and pooled budgets to remove competing professional interests. Joint funding meant that a more holistic approach could be taken to meeting needs (Brown, 2000).

In the years since 2000, patients have continued to be given more choice over which services to access and are able to play an active role in agreeing treatment. The introduction of hospital league tables has allowed patients to make informed choices around where they wish to be treated. There has also been more flexibility available in service provision. In-home support is now available in relation to many chronic illnesses and the launch of NHS Walk-In Centres has also helped. With radiotherapy and chemotherapy now readily available and with gene therapy continuing to demonstrate successes, conditions that may previously have left sufferers practically disabled are

now tackled with real hope of more positive outcomes and a resumption of an active and healthy life (dh, 2008).

A key aspect of contemporary practice in relation to those with disabilities is to address the issues of power, control, participation and engagement to allow self-advocacy and empowerment (Horner, 2007). The 2003 Community Care Direct Payments Regulations provided further progression in these areas by allowing disabled people to employ close relatives and spouses as personal assistants. It also legally obliged local authorities to offer direct payments as an alternative to existing services.

The present welfare system provides practical and financial benefits to both groups discussed in this essay. Those under 65 with disabilities are entitled to apply for Incapacity Benefit if they are unable to work due to their condition (directgov, 2008a) and may also be eligible for Disability Living Allowance. For people with a disability who are over 65, Attendance Allowance payments may be available. People who are on low incomes can benefit from free access to health services and equipment that normally incur a fee (directgov, 2008b). Included in this list are waived prescription charges, free eye-tests and reduced charge, or free, spectacles and hearing aids.

The fact that all citizens can now access health services, regardless of personal wealth, and that society deems this to be a basic right, demonstrates how much attitudes have changed over the years. It would seem that the days of the poor and disabled being institutionalised, marginalised and devalued have indeed ended.