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PRIME MINISTER 17 March 1989

COMMUNITY CARE

Meeting on 21 March

Community care is a complex issue. There is no unique solution for tackling the diverse needs of the infirm elderly, mentally ill, mentally handicapped and physically disabled. Kenneth Clarke is right to consider the mentally ill as a separate issue.

Responsibility spans four departments. Nicholas Ridley supports the Griffiths' proposal. John Major would prefer to tighten up income support payments for residential homes. John Moore is undecided.

Kenneth Clarke's approach seems very reasonable. Fundamental questions should be addressed before we attempt to select an option. In particular, the need to provide 'a better range of choice and provision for more vulnerable people' is crucial.

THE NEED FOR CHANGE

There are three main reasons for reforming the provision of resources for the priority care groups:

1. Perverse financial incentives

Often, a small increase in support can make all the difference to a family caring for an elderly relative at home. A home help for a few days a week can ease the pressure. Alternatively, temporary residential care for an elderly parent once or twice a year can regenerate home life, enabling the family to take a holiday break.

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But the current system mitigates against home care in the community. Payments of up to £10,000 a year are available for an elderly person in a private nursing home. Payments for those living at home - such as the state pension, attendance allowance and mobility allowance - are much smaller. In practice, these payments are often insufficient. An elderly parent will then be moved into a residential or nursing home prematurely, and probably permanently. The family support structure will than have broken down irretrievably.

Health Authorities are also encouraging this trend. A bed in a long-stay geriatric hospital can cost as much as £500 a week. Increasingly, hospitals are identifying long-stay elderly patients suitable for private nursing homes. In many cases, income support is insufficient to match the nursing home fee. The health authority will then sign a contract with a nursing home to 'top-up' the weekly income support payment by as much as £50 a week. This represents a very substantial saving for the hospital. But is this appropriate for the individual and their family?

Closure of asylums

In the context of the mentally ill and the mentally handicapped, care in the community has been a Government policy for many years. The number of institutional beds has fallen by over a half since the early sixties. But the provision in the community has not matched the increased need. Sometimes, unbearable pressures have been faced by families. And where there is no family or hostel support, discharged patients can find themselves on the streets caught up in a cycle of crime and deprivation.

Health authorities and local authorities have attempted to tackle the problem by 'joint planning'. But successes are patchy. There are three main problems:

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First, resources cannot be released instantaneously. Asylums are run down over time. Capital assets and fixed running costs cannot be released until the last person has been discharged.

Second, many community projects are too ambitious. When Darenth Park was closed down, Lewisham Health Authority moved the residents into converted homes in the community mainly financed by the Housing Corporation. In one home I visited, three mentally disabled men were supervised by eight workers on a shift system. The three men still work during the day! Perhaps a smaller residential home or sheltered accommodation may have been appropriate and more cost effective.

Third, joint planning is often ineffective. Real co-operation between health authorities and social services is difficult to achieve in practice.

Demographics

By the turn of the century, people aged 85 and over will increase by more than 250,000. Existing services will be put under a significant strain. Families will have little choice but to place their elderly parents in residential care.

Change is essential. The announcement of the NHS reforms and the earlier publication of the Griffiths Report has heightened public expectations for a new policy for the 'priority care' groups.

MINIMUM CRITERIA FOR FUTURE PROVISION

Those in need of care should come first - 'Almanas' set an extemely high standard of care when they were introduced in St Thomas's hospital in 1938. They were disciplined and knowledgeable. In many hospitals and communities this sense of responsibility has been lost. Personal commitment to support an individual has been replaced by a more dictatorial manner. We need to turn the clock back.

Family Choice Those in need of assistance (and their families) should be able to exercise a positive choice over the accommodation and services which they need.

Diversity of supply - Competition between private residential homes has improved quality markedly. But practical support in the family home is provided mainly by local authorities (eg home helps). A competitive market should be encouraged between LAs, DHAs, the private sector and voluntary organisations.

Value for money - Money should follow the person in need of care, as far as possible.

Minimal upheaval - The legislative calender is heavy in the next session. There will be little room for major legislation. Also, we should keep major structural changes to a minimum during a time when we will be driving the health service reforms forward.

THE GRIFFITHS REPORT (AND DERIVATIVES)

The local authority model has gained support from many quarters. On the surface, it may look attractive to some. The localised nature of the services seems conducive to local authority control. Difficult questions are asked in the local council, not in the House of Commons. And some have argued that a unified budget will provide better value for money.

Surely, significant problems would emerge:

- A competitive market is incompatible with bureaucratic control. Many social services departments would frustrate the development of a competitive market both in residential accommodation and home support services.

- The formal process of assessment of care needs by social services would restrict the choice of the individual and their families.

- The size and influence of social services departments would rise dramatically. Social workers would probably demand 4 years of basic training rather than 2 years.

- One authority will be unable to manage the broad spectrum of need for all the priority care groups. In particular, the mentally ill may require close supervision and intensive drug therapy.

- Assessment and budgetary control under the same roof has some superficial attractions. In theory, the assessor will think twice before spending the money. But this ideal has failed in the past. In many local authorities, spending has risen dramatically at a time when the quality of service has fallen.

OPTION D Para 40 ("THE TREASURY PROPOSAL")

The Treasury's proposal is half-right. A care test would be introduced to restrain the entry into residential homes and nursing homes. But they go on to propose that part of the saving would be used to strengthen domiciliary care - presumably for improved community nursing in the local health authorities and more home helps in the local authority. This is the central weakness of the proposal.

Questions:

How will the saving be determined?

Will it be based on every failed applicant?

And most importantly, for those who have passed the 'care needs' test, why is there no incentive for them to remain at home if they so desire?

OPTION E

This is a variant of Option D. A local agency (DHA or FPC) would be appointed to administer the 'care tests'. A more serious attempt would be made to introduce more domiciliary services for failed applicants and long-stay patients in hospitals.

And this proposal still suffers from the same weaknesses as Option D. DHAs and FPCs will be far too busy responding to the NHS reforms.

AN ALTERNATIVE PROPOSAL - "COMMUNITY CARE ALLOWANCE"

Lady Wagner's independant review of Residential Care - commissioned in December 1985 by Norman Fowler - was published last year in a book 'Residential Care: A Positive Choice'. In Chapter 3, she makes an interesting proposal:

> **'We considered ways in which users of any community services might exercise a stronger influence over the allocation of resources. We have been much attracted by the idea of issuing Community Care Allowances to people with special needs, to be used by them to procure care services of their choice.'**

There are obvious benefits. Consumer choice would be encouraged. The outcome is likely to be more satisfying to users, and possibly more economical, where community care options are viable. They would encourage flexible provision of community care. And it would remove the perverse financial incentive of simply relying on the residential care allowance.

The Treasury will argue that existing allowances are already sufficient. But if this was so, income support for residential care would not have risen at such a fast pace.

They will also claim that expenditure will grow. But surely, this allowance is only an alternative to residential care. The care test will be the rationing mechanism.

A possible mechanism for operating a new allowance is outlined in the Appendix.

RECOMMENDATIONS

1. The fundamental issues should be discussed first, as outlined in Kenneth Clarke's covering note.

2. Kenneth Clarke should be asked to examine each priority care group separately, not just the mentally ill. The mentally handicapped are more stable. Their needs are substantially different.

3. It is crucial that an alternative option be considered. If a 'care needs' test is passed, an individual (and their relatives) could be given the choice of buying a variety of care - residential or community based.

Ian Whitehead

IAN WHITEHEAD

APPENDIX

COMMUNITY CARE ALLOWANCE

This option could operate as follows for the infirm elderly on income support:

- A 'care test' would be introduced. (as in OPTION D)

- Those passing the care test could choose to enter a residential home.

- A 'stricter' regime for income support payments would be enforced.

- If the claimant decides to remain at home, a community care allowance would be paid under the income support rules ie means-tested.

- This means-tested benefit would be higher than the current level available through the attendance allowance and mobility allowance, but probably lower than the residential or nursing home allowance.

- The payment could be made in cash or as a credit that could be 'banked' with a 'broker' in the private sector, voluntary sector or local authority.

- Those failing the 'care test' would continue to rely on existing services. Existing services would focus on the less needy.