CONFIDENTIAL

P 03394

PRIME MINISTER

COMMUNITY CARE

Paper by the Secretary of State for Health,
17 March 1989

DECISIONS

1. Mr Clarke seeks agreement on the "broad lines of a response" to the issues which have been raised on community care. The Griffiths report was published in March 1988 and the Government then promised to consider it and bring forward its own proposals 'in due course'. Mr Clarke says that the Griffiths Report has aroused widespread expectations and that it would be untenable to do nothing.

2. You may wish to begin by making it clear that the purpose of this meeting is to have a Second Reading debate, not to take firm decisions on a subject which is complex, confused and politically highly charged. Despite reports from the Audit Commission, Sir Roy Griffiths and an interdepartmental group, it is not easy to see the outlines of a solution in the papers, and there does not appear to be much unanimity between departments.

3. Perhaps the central issue at this stage is how far you want the Government to embark on a radical overhaul of policy in this field. If you do, the best course may be to set up a small Ministerial Group - as for the reviews of social security and the NHS - to carry out the exercise. If not, you may wish to concentrate on identifying specific, practical problems which can be tackled within the present legal framework, leaving a more radical overhaul until later (when perhaps it may be possible to build on some of the achievements of the NHS Review). It is not clear how far the options outlined in Mr Clarke's paper would require legislation: but given the pressures on the legislative programme next Session there may be no alternative but to adopt a staged approach.

CONFIDENTIAL

CONFIDENTIAL

4. On handling, you might find it helpful to ask each Minister in turn to say which problems in the field of community care particularly concern him and what solutions he prefers. One of the difficulties in this field is that there are many different groups and problems mixed up together which need to be disentangled. Mr Clarke's papers indicate the range. In discussion you may wish to pick out the following:

a. residential care. Perhaps the most urgent aspect of present arrangements is the open-ended social security support for residential care. Income support is paid without a test of need for the care. This creates a perverse incentive in favour of such care, and expenditure has rocketed from £10m. in 1979 to £878m. in 1988 and possibly to between £1.85 billion and £2.9 billion in 1992, according to different projections. The Treasury wish to concentrate on putting this right (option D); Mr Clarke believes that the Government's response 'must embrace much more'. You may wish to explore what the implications would be if the Government decided to tackle only this problem.

b. domiciliary care and day care. Community care over the last 10 to 20 years has been based on a policy of moving vulnerable people out of institutions to lead independent lives in the commuunity. But, as Mr Clarke indicates, the ability of local services to cope with the long-term care of people in the community is patchy. He therefore wants not only to have a 'care test' for income support for residential care but also to build up domiciliary services as a serious alternative to residential care, and to give responsibility for their administration to a local agency which could be a district health authority or family practitioner committee (option E). You may wish to ask how this would fit in with the NHS reforms and what it would cost; and perhaps ask for a paper setting out the option more fully.

c. financial and managerial issues. The Griffiths report was focused on ensuring that the machinery and resources were available for implementing community care policy, rather than on what that policy should be, and was not therefore directed to the problems above. It favoured integrated budgets under the control of local authorities. Mr Clarke says that the Griffiths proposals

CONFIDENTIAL

CONFIDENTIAL

have achieved widespread public support but that he has strong doubts about the capacity of local authorities to do what would be expected of them. Mr Ridley on the other hand may argue for this approach. You may wish to discuss whether the Griffiths report should be pursued any further.

d. mentally ill. Discussion about community care tends to lump together those who are mentally ill or mentally handicapped with those who are elderly, even though very different considerations - for instance about consumer choice - may apply to them. You may wish to endorse Mr Clarke's proposal that the mentally ill should be treated as a separate subject and ask him to discuss the cost implications of his proposals with the Treasury.

e. social security. Mr Clarke's paper says only that the Government's review of disability benefits needs to be kept in mind but that it is not directly relevant. You may wish to probe this and ask Mr Moore for his views. On the face of it, the substantial sums of taxpayers' money going into disability benefits and attendance allowance should have some overlap with the ability of individuals to cope in the community rather than in residential care.

See John Moore's separate note at Flag G.

5. In conducting the discussion you may wish to ask Mr Clarke and other Ministers to bring forward papers commissioned during the discussion for another meeting in, say a month's time. It would be helpful if you could stress that the financial implications must be cleared beforehand with the Treasury. You may also want Mr Clarke to make clear how his proposals tie in with the NHS reforms and what timetable he has in mind for implementation, given the legislative constraints.

BACKGROUND

6. The term "community care" describes the whole range of services provided for vulnerable groups in the community, whether or not they would have been clients for institutional care:

CONFIDENTIAL

CONFIDENTIAL

i. the main clients are the elderly, the mentally handicapped, the mentally ill and the physically disabled;

ii. the main services are residential care, day services (eg day care centres, adult training centres), domiciliary services (eg home helps, meals on wheels), housing services (particularly sheltered and warden-assisted housing), and primary health care;

iii. the main providers are local authorities, the voluntary sector, the private sector and health authorities;

iv. the main sources of funding are direct payments by individuals, public expenditure by local and health authorities and social security payments from income support and the Social Fund.

7. Sir Roy Griffiths' report recommended a complete reorganisation, with local authorities given the responsibility for assessing all the non-health community care needs of people in their area, and given the funds to arrange for them to be met. His report was published in March 1988. Mr Moore said that the Government would consider it and bring forward its own proposals 'in due course'.

MAIN ISSUES

Shortcomings in the present arrangements

8. The most urgent issue is the open-ended nature of income support for residential care in the private and voluntary sectors. Unit costs have now been controlled through limits on the fees which will be met. But the payments are made without any test of whether residential care really is needed. This creates a number of problems:

i. expenditure has rocketed from £10m in 1979 to £900m in 1988. It might reach £2.9bn in 1992 according to the Department of Health;

ii. there is a perverse incentive in favour of residential care (because the cost is met by income support) and against care in people's own homes (because the costs would then have been met personally or from local or health authority budgets);

CONFIDENTIAL

CONFIDENTIAL

iii. inappropriate care. Many people getting residential care might be better served by, and prefer, cheaper domiciliary and day services.

Way forward: the options

9. You will probably not want to take final decisions at this meeting. You might instead seek to narrow down the options and commission further detailed work for a second meeting. A key question is whether you favour radical change, to deal with all the shortcomings noted above; or minimum change mainly to control the increase in income support.

10. Major change would involve bringing at least all the non-health services, including the funding of residential care, together under the control of a single local body. Income support for the costs of care would cease. The main candidates for the new responsibilities are:

i. the local authorities responsible for social services (the county councils in shire areas and the borough councils elsewhere). This is option B in Mr Clarke's paper, and what Sir Roy Griffiths recommended. Option C, developed by the Inter-Departmental Group, is essentially the same, with measures to ensure that a mixed economy of provision develops. You may however have doubts about expanding the role of local authorities in this way. A decision the group may be able to take at this meeting is whether the local authority option is a runner at all;

ii. the district health authorities. They would have the advantage of covering health as well as non-health care. However you might not want to give them more work until the NHS reforms have been implemented successfully;

iii. new community care authorities, responsible only for non-health services. This option would however involve the expense and disruption of setting up new local bodies throughout the country;

CONFIDENTIAL

iv. new primary care authorities, responsible for non-health and health services, subsuming the existing Family Practitioner Committees (FPCs). This is similar to the previous option, but with a broader scope.

11. Minimum change options would be aimed mainly at controlling the growth in income support. The two options in Mr Clarke's paper are:

v. a simple "care test" (option D) for claimants seeking residential care to ensure that they really needed it. There are doubts about its effectiveness: the perverse incentive to favour residential care would remain, and there would be constant pressure for positive care test results. It would do nothing to address the other shortcomings of the existing system. If however you are interested in this option you could ask for it to be worked up in detail, with a view to making it as effective as possible in controlling costs.

vi. a "care test" and a new "enabling" agency (which might be the health authority) to facilitate the provision of non-residential care (option E). This option would address some of the wider problems. But the scope of the new agency is unclear. At one extreme it could simply add to local bureaucracy, making responsibilities even less clear. At the other extreme it would take over responsibilities from other bodies, and merge into one of the options for major change. If this option is to be pursued, you may want to ask Mr Clarke for a much fuller explanation of it, including its links with the NHS reforms.

If there were to be a minimum package it could be bolstered by accepting some of the other Griffiths recommendations, such as appointment of a special Minister of State, who could review local authority and health authority plans, and introduction of new specific grants to local authorities.

12. You might seek to agree two or three options from this list which could be subject to further work. One possibility would be to move to the favoured option over a period of time. For example, it would be possible to opt for minimum change now but to make health authorities responsible once the NHS reforms have been successfully implemented.

CONFIDENTIAL

Expenditure implications

13. Mr Clarke gives no detailed analysis of the cost of the various options. The Treasury have complained about this. The projection of income support costs suggests a very sharp increase from £900m to £2.9 billion by 1992. The discussion of option D and E quotes savings of up to £30m by 1992, but these are very small compared with the projected increase. You might ask Mr Clarke to produce for the next meeting detailed figures for each option you decide to pursue and to discuss them with the Treasury.

The Chronically Mentally Ill

14. Mr Clarke's separate paper explains how the community care policy has been applied to the chronically mentally ill. He reports that until very recently, there have been serious shortcomings in implementation. But he says that he is working on a number of initiatives to improve matters. You might ask him to bring forward a paper on these initiatives for your next meeting, consulting the Chief Secretary. One particular concern about the policy is whether it has been applied indiscriminately, eg. whether seriously ill patients have been forced out into the community even where they have a real need for institutional care. You might wish to ask Mr Clarke to cover these concerns in his further report.

VIEWS OF OTHER MINISTERS

15. The views of Departmental officials are at present as follows:

- The Treasury favour Option D, the simple care test, and perhaps moving to the health authority solution in the long-term.

- The Department of Health favour Option E, the care test with a new enabling agency.

- The Department of the Environment favour Option C, the local authority solution, with safeguards on competition, etc.

- The Department of Social Security favour major change. They would like income support for residential care to cease. They think introduction of a care test would be insufficient. They

CONFIDENTIAL

CONFIDENTIAL

may not be so concerned as to which agency takes on the responsibility, although Mr Moore may see political difficulties in the local authority solution.

RTJW

R T J WILSON
Cabinet Office
20 March 1989

CONFIDENTIAL