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P 03411

PRIME MINISTER

COMMUNITY CARE

[Mr Clarke's minute of 8 April]

DECISIONS

1. Mr Clarke's concern is whether the Ministerial Group is going to be able to agree a Government response to the Griffiths Report fairly quickly, so that he can make an announcement before the Summer Recess; or whether this is going to turn into a lengthy exercise like the NHS Review. His own strong preference is to find a quick solution. You may wish to use this meeting as an opportunity to assess the prospects.

2. Three basic options seem to be emerging. You may wish to go through them with Mr Clarke:

   i. Local authorities. One option would be to implement the Griffiths report, making local authorities responsible for assessing all the non-health needs of individuals in their area. At the last meeting Mr Ridley argued for a variant of Griffiths in which local authorities would not be directly involved in provision of community care except as a last resort. Mr Clarke and Mr Major were opposed to the Griffiths report, not least because they doubted the ability of local authorities to do the job well. You may wish to run over the arguments in the light of your talk with Sir Roy Griffiths.

   ii. NHS. Mr Clarke's preferred alternative is to give District Health Authorities responsibility for a new

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care test for residential care, and for purchasing home care services for those able to live at home. Perhaps the main question which this raises is whether District Health Authorities would be able to cope with this, on top of the NHS reforms (years)? You may wish to explore this.

iii. An immediate package. Changing the present arrangements just for the sake of it might simply make matters worse, and solve nothing. On the other hand, the Griffiths report has raised expectations, and there are some practical problems which need to be put right (eg on the mentally ill, the introduction of a care test for residential care and the need to encourage people to live at home). You might find it useful to ask Mr Clarke, putting the Griffiths report aside, what are the practical problems that actually need to be tackled now. One approach might simply be to put together a package which concentrated on them.

3. In practice, the Government will probably have to make a basic choice between local authorities and health authorities, if only because someone will have to be responsible for administering a new care test for residential care. If you prefer the health authority route, you may wish to test out the possibility of a phased approach which only built up the role of Health Authorities in community care gradually as the NHS reforms were implemented. This might begin with a minimum package directed at immediate problems and those parts of the Griffiths report which were acceptable. It could then take in the outcome of the review of disability benefits, expected next year, which the Department of Social Security are carrying out. And it could in due course lead to more substantial budgetary responsibilities for District Health Authorities in, say, five years' time, when

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their viability may anyway need to be reviewed following the NHS reforms. Preliminary soundings suggest that the Treasury and the Chief Secretary might support this approach.

4. In conclusion you may wish to invite Mr Clarke to put forward papers which reflect the discussion for the next meeting of the Ministerial group, which has been arranged for next Wednesday, 19 April, at 10.00 am.

MAIN ISSUES

Griffiths Report

5. On paper the Griffiths proposals have a tidy logic and coherence. But in practice there are some major concerns about:

i. philosophy. Some passages in the report have a strong flavour of the State taking over responsibility for elderly people: for instance -

> "Those arranging public services must..., taking account of the views and wishes of the person to be cared for, and of any informal carers, decide what packages of care would be best suited to the individual's needs." [paragraphs 3 and 8];

ii. competence. Both Mr Clarke and Mr Major have raised doubts about the competence of some local authorities to carry out the role envisaged for them by Griffiths. There must be a risk that in some areas it would lead to more bureaucracy and greater politicisation of community care, rather than to better services for those in need;

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iii. pressure for more money. There must also be a risk that local authorities would become a lobbying point for extra public expenditure.

You may wish to go over the ground with Mr Clarke, in the light of your discussion with Sir Roy Griffiths, of which he is aware.

District Health Authorities

6. In his minute Mr Clarke says that the best option is for health authorities to take on a new role in relation to community care, with two functions:

i. the assessment of need for residential or domiciliary care, either doing the assessment themselves or arranging for other bodies to carry it out;

and ii. purchasing home care services for those judged able to stay at home or in sheltered accommodation. They would be able to go to any source of supply including voluntary agencies and the private sector as well as local authorities.

7. This approach would have a number of advantages:

i. it would bring in health as well as non-health care. The more types of care that are covered, the better the chance that the authority will establish the best solution for each individual. In practice those who need community care may often also need medical care, and GPs can be a good listening-post for identifying those in real need (GP contracts already recognise this by giving GPs responsibility for "advice to enable patients to take advantage of the local authority social services").

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ii. it would have less risk of politicisation. One of the aims of the NHS reforms is to make District Health Authorities non-political and more businesslike.

iii. it would tie in with the NHS reforms. The emphasis in the Griffiths report on buying community care services fits in well with the responsibilities proposed for the health authorities in the NHS White Paper. Moreover, the White Paper recognises that as more and more hospitals become self-governing, District Health Authorities may need to be merged, with each other or with FPCs. So they will have spare capacity.

8. But there are also some important points against Mr Clarke's proposal which you may wish to explore:

i. timescale. Sir Roy Griffiths rightly made the point that all parts of the NHS had more than enough on their plate at present in implementing the NHS reforms. There must be a strong case for not adding further major disruption for the time being.

ii. means-testing. Sir Roy also argued that it would be difficult for means-testing to be operated within the NHS.

iii. accountability to Parliament. Extending the responsibility of District Health Authorities could lead to an expansion of the issues for which Ministers might be accountable in Parliament. It would be important to make sure that the new approach to Ministerial accountability in the White Paper was adhered to, and that questions on individual cases did not become a matter for detailed questioning in the House;

iv. conflict of interest. District Health Authorities bear the cost of elderly people in hospital and nursing homes: is there a risk that they might use their new role to transfer such people into residential care for which they are not financially responsible?

A Phased Approach

9. If you preferred the health authority route to the Griffiths proposals, you might wish to explore whether there could be a phased approach which began with a fairly limited package of measures, designed to deal with immediate problems, and gradually built up the role of District Health Authorities as the NHS reforms took effect. The elements of the immediate package would be for discussion, but possibilities include:

i. mentally ill. Mr Clarke is working up an early announcement on a package of measures to deal with the problems which you discussed at the last meeting, of releasing mentally ill people without adequate support. You may wish to ask about its contents. It might, for instance, include a commitment that no further mental hospitals will be allowed to close unless Ministers are satisfied that adequate alternative services have been put in place.

ii. care test. Expenditure on residential care in the private and voluntary sectors has rocketed from £10m. in 1979 to £900m. in 1988 and may reach £2.9bn. in 1992 on some estimates. One possibility would be to begin by giving District Health Authorities responsibility for arranging for this test to be carried out.

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iii. support for people at home. Introducing a care test needs to be balanced by ensuring that those who do not go into residential care are given adequate support to continue living at home if they are in real need. District Health Authorities might also, initially, have responsibility for alerting voluntary and other bodies to an individual's needs for domiciliary care, without necessarily being required to pay for it within a budget. In other words they would "knock heads together" if there was a failure of co-ordination between the various agencies in the field. To reinforce this, they might also be given modest extra money to help oil the wheels with voluntary and other agencies. This might incorporate the community care grant element of the Social Fund (£60m) and the Independent Living Fund (£5m).

iv. Griffiths report. There are recommendations in the Griffiths report, not to do with local authorities, which the Government might well want to accept. For instance, Sir Roy emphasises that many of the needs of the elderly and disabled living at home are practical matters (eg getting dressed, shopping, cleaning) which do not require elaborate professional skills: he suggests major experiments with school leavers and YTS, to build up a new auxiliary service (paragraph 37). Might this not be explored? And he points out that many of the elderly have higher incomes and savings than in the past, and recommends that more work be done on schemes for encouraging owner occupiers to use their equity to provide income which would pay for services in their retirement (perhaps a subject on which he himself might be asked to do more work). You may wish to ask Mr Clarke for a paper on those parts of the Griffiths report which the Government might consider accepting.

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10. Looking ahead, the Department of Social Security will be coming forward next year with the conclusions of a review on disability benefits. Expenditure is considerable (1987-88 figures):

	EXP (£M)	NO (THOUS)
Attendance Allowance	897	670
Invalid Care Allowance	184	80
Non-contributory Invalidity Pension/Severe Disablement Allowance	295	265
Mobility Allowance	596	490
Total	1972	1505

If a phased approach were adopted, it would be possible to consider whether there was any read-across into policy on community care and the role of District Health Authorities. On the face of it there ought to be: many recipients of disability benefits are the same people as recipients of community care and receive treatment from the NHS.

11. In the longer term, as most hospitals become self-governing and the role of District Health Authorities changed, it would be possible to consider whether they should take on a more formal responsibility for co-ordinating community care, possibly with budgetary responsibility for purchasing community care wherever it could most efficiently be provided. But this would be a major change which would need to wait until the NHS reforms had been implemented.

12. This phased approach would need working up. You may wish to test out with Mr Clarke whether it might offer a possible way through.

RTJW.

R T J WILSON
Cabinet OFFICE
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