PRIME MINISTER 12 April 1989

COMMUNITY CARE
Meeting with Kenneth Clarke

Kenneth Clarke is right to aim for an early resolution to the Ministerial discussions on community care, possibly before the Summer Recess. Public expectations are high. A prolonged NHS-style review will be inappropriate if our reforms emerge as modest changes.

I believe that his proposed new role for health authorities is a reasonable one. But a number of basic questions will need to be addressed.

A new role for DHAs

In his note, Kenneth Clarke suggests that health authorities should take on a new gatekeeping role for residential care social security payments. The DHAs would also help to arrange packages of care from existing sources, building upon the central role of the informal carer (family member or neighbour). Contributions of cash or services-in-kind would be discretionary, to be paid out of a ring-fenced budget.

The proposal has a number of merits:

- The health service has a proven track record of looking after people in their own homes, through community health visiting.

- DHA management has been strengthened in recent years. District General Managers are more innovative and versatile than ever before.

- This reform would be introduced during a period when DHAs will lose direct responsibility for managing hospitals. This void could be filled by giving DHAs an additional role.

But the model has its limitations:

- Public support for domiciliary and residential care will remain fragmented. We will be criticised heavily for duplicating the work of social services departments. Some people will argue 'the elderly will not know which way to turn - social security, health authority, social services or perhaps all three'.

- There is a danger that the lion's share of any new budget would be spent on a new 'assessment' bureaucracy.

We will need to minimise these limitations as far as possible.

KEY POINTS TO RAISE

Kenneth Clarke should be asked to address three key questions in the Ministerial papers.

First, how will we introduce an even-handed system of care? If DHAs are chosen to be the care assessment agent there will be a financial incentive to discharge long-stay geriatric patients from hospitals and then place them in nursing homes. This process already happens in practice. Perhaps even-handedness could be achieved by requiring DHAs to contribute towards the cost of institutional care.

Second, what level of financial commitment is envisaged by Kenneth Clarke? Will new cash be injected or will funds be generated by restricting existing social security benefits.

For example, income support for residential care will cost £1 billion this year (means-tested but not care-tested) and attendance allowances for domiciliary care will cost £1 billion for 760,000 people (care-tested but not means-tested).

Third, when will the new system be introduced? It may be better to phase the changes over a period of time.

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