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10 DOWNING STREET

LONDON SW1A 2AA

20 April 1989

From the Private Secretary

Dear Andy,

COMMUNITY CARE

The Prime Minister held a further meeting on Wednesday 19 April to discuss policy on community care. Those present were the Secretaries of State for Wales, the Environment, Scotland, Health and Social Security, the Chief Secretary, Treasury, the Minister for Health, Richard Wilson, George Monger and Andrew Wells (Cabinet Office) and Ian Whitehead (Policy Unit). The meeting considered papers by your Secretary of State, attached to your letters of 14 and 17 April, and minutes from the Secretary of State for Wales dated 7 April, the Secretary of State for Social Services dated 17 April, and the Chief Secretary, Treasury dated 18 April.

I should be grateful if you and other recipients of this letter would ensure that it is copied only to those with a clear need to know.

Your Secretary of State said that his paper of 17 April fulfilled the remit from the last meeting of the Group to consider options for providing further help towards care of the elderly at home, without introducing new entitlements; to examine the best way of introducing an assessment of the need for residential care before income support was paid; and to discuss how to ensure better co-ordination between the existing agencies active in community care. His conclusions shared many common features with the approach taken by Sir Roy Griffiths. In particular he accepted the case for a "care test" to establish a claimant's need for residential care; the importance of striking a proper balance between residential care and care in the home; and the value of an agency with an enabling and stimulating role to ensure that the right services were provided locally. But in his view it would not be right to give these new functions to the local authorities. A better approach would be to provide for district health authorities both to carry out a care test for income support purposes, and to act as an enabling authority, putting together packages of domiciliary care for those who could continue to live in their own homes. He invited colleagues to endorse these proposals as the basis for further work.

In discussion the following main points were made -

a. The crucial problem which needed to be addressed was the current perverse incentive in favour of residential care, which was funded through income support, and against cheaper domiciliary care options, which had to be funded locally. Given demographic trends and rising expectations it was inevitable that overall spending on community care would rise. But if the present system were retained there would be a wholly unacceptable escalation in income support spending, and the provision of residential care at the expense of the State would come to be seen as an entitlement. What was needed was an alternative system which would ensure that the resources which could be afforded were adequately controlled and spent to the best effect.

b. One option would be to make the minimum of necessary changes to the present system. A care test would be introduced, conducted by the district health authorities, to identify those with a real medical need for residential care. The health authorities would also have a responsibility to direct other claimants to the agencies who already provided domiciliary services: the local authorities, voluntary bodies and so on. It might be necessary to increase the resources provided to these agencies, through Exchequer grants. But the health authorities would have no budgets to finance care (as opposed to the care test), and the danger of escalating expenditure would be reduced.

c. On the other hand, it seemed unlikely that such a system would achieve the Government's aims. Any care test was bound to be subjective. Those carrying it out, most probably General Practitioners (GPs), would in most cases simply comply with the wishes of the claimant or the claimant's family. Indeed, the very existence of a care test could be expected to encourage applications from families who would not otherwise have considered residential care, with entirely perverse results.

d. To solve the problems it would be essential to bring together in the hands of some local body the responsibility for deciding what services should be provided to individual clients and the budgetary responsibility for the expenditure implications of those decisions. That would ensure the best use of the limited resources which could be made available at public expense. Residential care would be made available to those in the greatest need, and others would receive domiciliary services so that they could continue to live in their own homes. Families would of course be able to top-up the assistance made available by the public sector.

e. One option would be to require the district health authorities to fulfil this role. They were not as likely to be biased against the private sector as some local authorities. On the other hand they already faced the major task of implementing the Government's reforms in the National Health Service. But more important, they were not subject to local democratic pressures to restrict expenditure. If they were given a new role in community care they could be expected to become a lobby in favour of increased expenditure and excessive provision by the State.

f. The main alternative was to give full responsibility for community care to local authorities, which was what Sir Roy Griffiths had recommended. There were substantial problems with this approach, particularly with regard to the minority of authorities who could be expected to take a doctrinaire attitude in favour of an ever-increasing level of State provision. On the other hand it had to be recognised that the local authorities had the skills, expertise and facilities to carry out the task. They were also subject to the pressures of local accountability for their expenditure decisions: this would be particularly true from 1 April 1990 when the community charge and the new system of capital expenditure controls would both be introduced.

g. There was a danger that some local authorities would use a new role in relation to community care to expand their own provision, e.g. of residential care homes. The best way to tackle that would be to insist that they acted as enablers rather than providers. They could be required to seek tenders for residential care places, with their own homes competing against those in the private and voluntary sectors. In the longer term it might even be right to require divestment of local authorities' own homes.

h. Attendance allowances were another example within the social security system where there was a massive and increasing level of expenditure resulting from an inadequate system for deciding eligibility. This was being considered separately in the disability review.

The Prime Minister, summing up the discussion, said that the crucial need was to develop a new system for providing and funding community care which made the best use of the resources which could be afforded at public expense. The introduction of a care test for income support for residential care would not achieve that. Any such test was bound to be subjective, and those carrying it out might well in practice accept the wishes of the claimant or his family in the great majority of cases. The very existence of a formal test would create a new entitlement, and might well encourage more people to apply for residential care. What was needed was a system which brought together in the hands of a single local body both the responsibility for deciding what care should be provided to claimants and the

responsibility within a budget for the expenditure implications of those decisions. The district health authorities were not the bodies to take on this new role. They were not locally accountable for the results of their expenditure decisions, and could be expected to become lobbies for additional expenditure. The main alternative was to give the expended role to the local authorities. There were disadvantages to this approach, particularly in relation to the minority of authorities who would strike a political stance in favour of ever-increasing provision by the State. Nevertheless it seemed the least bad of the alternatives. Some of the problems could be tackled if sensible systems of financial control were put into place, and if authorities were required to act as enablers rather than providers. The Secretary of State for the Environment, in consultation with the Secretaries of State for Social Security and Health and the Chief Secretary, Treasury, should bring forward a new paper setting out the details of this approach and the ways in which the problems might be overcome. The Secretary of State for Health should also prepare a new paper with proposals on which of the remaining recommendations in the Griffiths Report the Government should accept. In general it would be right to accept as many as possible of the recommendations, but it would not be right to create a new Ministerial responsibility for community care, or to establish a new profession for carers. These papers should be circulated to the Group by close of play on Friday 28 April, for a further meeting as early as possible in May. Sir Roy Griffiths should be invited to attend that meeting.

The Group had not had time to consider the Secretary of State for Health's separate paper on the mentally ill. He should now discuss the financial implications of his proposals with the Chief Secretary, Treasury, and bring forward a further paper setting out the outcome of those discussions for the next meeting.

I am copying this letter to the private secretaries to the other Ministers present, to the others who attended, and to Trevor Woolley (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.