PRIME MINISTER

COMMUNITY CARE

You have already seen Mr Clarke's paper for the meeting (Flag A). At Flag B is the Cabinet Office brief (which I discussed earlier with Cabinet Office); and at Flag C is a note from Policy Unit. At Flag D is my earlier note of 30 April.

Mr Clarke's paper is unsatisfactory: his case is poorly argued; the numbers are positively misleading. The focus of the discussion, as noted earlier, should be on three issues.

i. What are the public expenditure implications of going ahead on 1 April 1991, as against delaying until April 1992 - or perhaps to April 1993 or 1994?

ii. What are the community charge implications for next year if implementation goes ahead in April 1991?

iii. Are local authorities sufficiently well prepared to take on their new responsibilities for community care?

Public Spending

The numbers in Mr Clarke's paper are incomplete. To help identify the total public expenditure effects I asked Department of Health to provide an additional table showing total public spending over the next three years, if the transfer goes ahead on 1 April 1991 and on 1 April 1992 respectively, incurred by: (a) local authorities, (b) the Department of Social Security and (c) the Department of Health.

I attach the material provided by DoH. The key points are as follows:-

- public expenditure would be lower by around £100 million if the transfer is delayed till April 1992;

- local authority expenditure would be £500 million lower next year, if the transfer does not begin till April 1992;

- but total public spending would be higher over the three year survey period - because the perverse incentive to move to residential care would remain in place longer.

These figures have not been cleared with the Treasury: the assumptions underlying them are unclear. Before any decision is taken, further work on the likely range of public spending effects for given assumptions must be worthwhile. The DoH numbers could well overstate the net short-term savings over the Survey period from implementing the reforms.

Community Charges

There are two main reasons why the transfer might lead to higher community charges in 1991.

- First, local authorities may spend more on community care than allowed for in the local authority settlement. Many ambitious local authorities are almost bound to increase their spending above what the Government has allowed.

- Second, local authorities may well spend up on other services (and not just social services) and attribute the higher expenditure to their new community care responsibilities i.e. the transfer becomes a good excuse for higher community charges next year.

As the Cabinet Office brief brings out, there is great uncertainty about the outcome on community charges. But, by assumption, the first source of pressure on the community charge identified above might add £9-15 on community charges. To this however should be added the risk of higher charges "attributed" to the introduction of community care responsibilities.

I agree with Cabinet Office that, only if a satisfactory method of comprehensive capping can be devised, can the risk of higher community charges as a result of the transfer of community care be satisfactorily mitigated.

Preparedness

The Cabinet Office brief does not add much. It is disappointing that Mr Clarke's paper is so bland on this. But the Policy Unit note seems to indicate that even efficient local authorities are not as well prepared as they should be. And the inefficient have not even started to make preparations.

There are risks of both excessive and inefficient expenditure on the one hand, and inadequate services on the other. This would discredit the policy from the outset.

Conclusion

The rationale for the reform is the need to end the perverse incentives for the elderly to move to residential care in private homes (with the income support and care bill paid by DSS), rather than to stay at home. The public expenditure savings arise in two ways:

(i) lower rental costs (and thus DSS housing benefit payments) in private residential care accommodation once the care element moves to LAs

(ii) lower per case costs, as more individuals are dealt with by LAs in their own homes.

How quickly LAs would stop putting people into private care homes is critical to the assessment of costs and community charge implications. There must be a danger it will take two or three years to change existing practices.

From the evidence in Mr Clarke's paper plus the additional table, there would therefore appear to be risks of higher public spending in the short term; higher community charges; and

unsatisfactory service levels if the transfer goes ahead on schedule on 1 April 1991. Further analysis of the risks is essential before a decision is made.

Mr Clarke is unlikely to be willing to delay the whole transfer - not least if a slower implementation of the NHS reforms is also planned. Both Cabinet Office and Policy Unit suggest that it might be possible to go ahead with the mental illness initiative in the meantime, while postponing the main changes - in particular the switch of responsibility for residential care.

The next step might be to ask Mr Clarke to produce a paper looking at that and possibly other models for phasing in the transfer of community care plus full analysis of the total public spending costs and community charge effects of the different options.

BHP

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c: community (MJ)

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TABLE 1: LOCAL AUTHORITY EXPENDITURE ONLY

England (1991/92 Prices)	91/92 £m	92/93 £m	93/94 £m	94/95 £m
Implementation April 1991	232	278	279	208
Implementation April 1992	30	242	293	294

TABLE 2: TOTAL PUBLIC EXPENDITURE

England (1991/92 Prices)	91/92 £m	92/93 £m	93/94 £m	94/95 £m
Implementation April 1991				
Local Authorities	535	948	1217	1446
HCHS	53	50	58	64
Social Security	1368	1186	1077	956
TOTAL	1956	2184	2352	2466
Implementation April 1992				
Local Authorities	30	572	1021	1305
HCHS		57	54	61
Social Security	1825	1675	1437	1333
TOTAL	1855	2304	2512	2699

Note: The automatic transfer from DSS to LAS and the HCHS is included in their lines and subtracted from the Social Security costs.

NB: Figures not cleared in detail with DSS.