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D CCB/UP

PRIME MINISTER 17 April 1989

COMMUNITY CARE

Ministerial Meeting on 19 April

Kenneth Clarke's Proposal

1. A two year pilot scheme would operate. A group of district health authorities would be invited to volunteer to carry out 'care assessment' tests on individuals applying for social security payments for residential care.

   Local applicants for income support would then be asked to volunteer to undergo the care assessment test. This will need to be voluntary because social security benefits cannot be restricted for one section of the population.

   The test would focus on each individual's personal care needs, the circumstances in their own home and the availability of services from other sources, namely local authorities and voluntary organisations. No extra budget would be transferred to the DHA to 'oil the wheels' of care provision in the home.

2. Enabling legislative framework would be included in next year's NHS Reform Bill.

3. A care assessment test would be introduced across-the-board by health authorities during 1991. No extra budget would be transferred.

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4. Consideration would be given at some point to transfer budgetary responsibility for all or part of the income support payments for residential care.

Kenneth Clarke is right to press for a health authority solution. Many local authorities would not have the capacity or willingness to take on this crucial role. The health service will often be better placed to decide whether a person is capable of being supported in their own home or not. After all, the NHS has a proven track record of helping people in their homes, through community nursing and supervision by GPS.

But I believe there are significant problems with Kenneth Clarke's note on the care of the elderly. The note is patchy and unclear. And the impact could be ineffectual.

In our search for a detailed solution, Kenneth Clarke seems to have lost sight of our main objectives:

(1) To give individuals and their families real choice and a better quality of life.

(2) To stimulate a diversity of supply of home care services.

(3) To achieve the best value for money possible.

and not to simply a govt. prime duty.

SIGNIFICANT PROBLEMS

First, the pilot scheme will have little impact.

1. The individual applicants for income support will see no benefit in applying for a care test. Volunteers will not be forthcoming.

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2. Public expenditure will continue to rise as more people apply for residential homes.

3. Families will not be given any real choice.

4. Residential care will continue to be the preferred option for many.

5. The pilot schemes will not help us to develop an effective model for the future.

Second, there will be little or no change in the pattern of provision for many years.

In paragraph 10 of Kenneth Clarke's covering note, he indicates that a budget should not be transferred to the health authority until the new assessment test is working smoothly. This could take many years.

Assessment without budgetary responsibility will have little impact.

Surely, if we hope to have any impact on changing the imbalance between residential care and home care, we must transfer a budget to the DHA at the same time as introducing an assessment test. The health authority would then be responsible for buying all or part of the cost of residential care or alternatively help to support people in their own homes. If no budget is transferred, DHAs will have little incentive to give help to informal carers.

During my recent trips around the country, I have noticed an increasing practice among health authorities. A DHA may sign a contract with a local private nursing home to

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fill 40 beds for a 5 year period. The DHA agrees to pay an extra fee currently in the range of £25 to £50 a person on top of the individual's £195 a week income support payment. The latter is a standard payment made by social security depending on financial means not care needs.

In theory, the top-up fee should be deducted from the individual's income support benefit, as with other sources of income. But the DHA avoids this requirement by signing a top-up contract directly with the nursing home.

On the surface, this trend may seem beneficial. The DHA will have discharged a hospital patient costing £400-£500 a week. The bed can then be used by another patient. And the individual will be transferred to a more amenable non-clinical environment in a nursing home. But in the meantime, total public expenditure rises. And the elderly patient will be trapped in an institutional home for the rest of their life.

A budgetless DHA would encourage this trend.

Third, families may still be left out of the decision making process.

In the absence of real consumer choice, the link between competition and efficiency is weakened.

Absolute freedom and limited budgets are incompatible. But their is no reason why a health authority should not award discretionary community care allowances to individuals in place of residential care to be used by the individual and their informal carers.

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These allowances would be used to buy a wide range of home care services from the voluntary sector, private sector or local authority. The outcome is likely to be more satisfying to users and possibly more economical.

Fourth, the development of a mixed economy of provision in home care services would not occur.

Local authorities would continue to hold the purse strings for the bulk of domiciliary care (home helps, meals on wheels).

Fifth, public expenditure will continue to rise as fast as ever.

DHAs would have no financial incentive to help support people in their own homes. Surely we are overly optimistic to believe that DHAs 'would where necessary arrange the provision of individual packages of care by another agency' (para 7) without any financial support.

In practice, DHAs will refer increasing numbers to residential homes, placing greater pressure on public expenditure.

Sixth, the political problems are immense

Kenneth Clarke's intention is to introduce a DHA assessment test based on (i) the care needs of the individual and (ii) on the existing home care services available from other sources. This is a reasonable objective but perhaps it is too ideal to work in practice.

For decades, we have closed asylums in the belief that alternative services are available in the community. But that strategy has fallen short. Health authorities manipulated that policy decision - originally proposed by Enoch Powell - to release substantial capital resources for use by the acute services, rather than redirecting resources towards mental health care in the community.

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Most people will see the assessment test as a cut-back in services, if no alternative support is forthcoming. And the proposal for £30 million of new expenditure (Para 14) to pay for 900 new assessment staff will be seen as a bureaucratic exercise. Not one penny of the budget would be spent on home care support.

HOW CAN WE ADDRESS THE PROBLEMS?

1. Transfer budgetary responsibility

As an absolute minimum, no powers of assessment should be given to the district health authorities, unless budgetary responsibility is also transferred at the same time.

The budget could be transferred from four possible sources:

(1) As Kenneth Clarke suggests in paragraph 10, a budget for the care element of income support could be transferred to health authorities. This money could either be used to support individuals in their own home or to top-up the income support payment for residential accommodation.

(2) The £60 million community care grant portion of the Social Fund could be transferred to the health authority. These are one-off payments by social security offices to help people return to the community.

(3) The £5 million independent living fund budget administered by DSS - could be transferred from DSS to DHAs. These are regular payments to help individuals remain in their own home.

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(4) A reform of 'attendance allowances' should be considered. Income support for residential homes is not the only fast growing social security expenditure. In 1989/90, attendance allowances will be claimed by over 700,000 people amounting to a total expenditure of £1 billion. Expenditure will increase by over £200 million a year.

The attendance allowance is a social security benefit paid to a person who needs close supervision. There are two levels of payment:

- £22 a week if frequent attention is required during the day;

- £33 a week for day and night attention.

The amounts are too small to make a significant impact on support in the home. And it is spread far too widely. A care test is required by a GP. But the benefit is not means tested.

As a minimum, we should consider reforming 'attendance allowance' by directing larger payments to those most in need financially. And we could consider passing the responsibility for the 'care test and budget' to the health authorities.

A budgetary transfer will produce a real change in the balance of provision between residential care and home care. The rise in public expenditure would be contained. And the political risk is more manageable.

2. Give families real choice

DHAs should allocate community care allowances on a discretionary basis from a cash limited budget.

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Those in need of assistance will be able to exercise a positive choice over the accommodation and services which they need. And the development of a mixed economy of provision in home care services would then be a reality.

3. Change the programme of implementation

Kenneth Clarke proposes a phased programme (Paras 11 and 12). This strategy is reasonable in principle but it looks weak on implementation.

Kenneth Clarke should be asked to make the following changes to his programme:

- The pilot programme should be reduced from 2 years to 1 year. 1991 is too close to the next election. Also, DHAs should be given a budget.

- The budget would be used to award discretionary community care allowances to individuals and their informal carers to be spent on a range of home care services provided by the voluntary sector, private sector or local authority.

- Legislate in the next session for a transfer of all (or part) of the income support payment for residential care to the DHA to be distributed out of a ring fenced budget. The community care grant element of the social fund and the independent living fund could also be transferred to DHA control.

- After the pilot programme has been completed, transfer the budgets to the DHAs and give them responsibility both for assessing need and issuing discretionary community care allowances.

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