Health Care Funding 'Legislation' History

Introduction

This article summarises the interface between the NHS's responsibilities for social care support and the responsibilities of social services authorities under the community care legislation. At some point individuals, because they have become so unwell, may move across the interface - from the means tested social services system to the 'free at the point of need' NHS system. In crossing the interface one moves from a detailed community care statutory regime into a system regulated by largely aspirational legislation and guidance of questionable quality. In many respects such people are crossing from a system steeped in the principles of the Poor Law to a regime steeped with the idealistic principles of the Attlee government - principles that come at a cost that no government has been able or willing to fund fully. However, governments are not the only bodies who balk at the cost implications of the health/social service divide. For many individuals, entitlement to fully funded NHS health care is of great significance, particularly if living in a care home. NHS Continuing Care is controversial territory, largely because of its financial implications - both for private individuals and for the social services/PCT officers who police it.

This section considers the position applicable during my mother's residential care and the period relevant to my CHC funding application including the 'Decision Support Tool' introduced in 2007 to enable PCT's to supposedly make a more consistent, reliable and uniform eligibility decision. However, in 2011 for instance, Suffolk Primary Care trust had a remarkably low rate of approval of CHC for people with dementia, just 17% of all applicants (1), so the odds were never in my mother's favour, whatever assessment tool was used.

Historical and legal context of the health and social care divide

The debate over continuing health care responsibilities is not new. Organisational tensions that have existed over the health/social care divide since the formation of the NHS are characterised by a general failure of the NHS to invest in community health services or to transfer significant resources to social services. The conflict has generally been expressed in debates over what is health care and what is social care. Pivotal to an understanding of the health/social services divide is the interaction between NHS Act (NHSA) 1946 and the National Assistance Act (NAA) 1948. The boundary that defines the responsibilities of the NHS / social services has been contested since the formation of the Welfare State. NAA 1948 places a duty on social services authorities to provide residential accommodation for (amongst others) elderly ill and disabled people but unlawful for social services to provide a service that could be provided by the NHS. Although these Acts have been much amended over the last 60 years their material responsibilities remain unchanged. The full implications of this provision however had to wait until 1999 when the Court of Appeal delivered its judgment on *Coughlan* (2).

The 1957 Boucher report (3) is an early example of the government's continuing attempts to identify the line between the two statutory regimes. The impetus for the report stemmed from local authority concerns that their residential homes cared for many people who ought to be cared for in hospital. The report resulted in circular guidance outlining the respective responsibilities of the welfare and hospital authorities and in particular hospital authorities were to take responsibility for care of the senile confused or disturbed patients who were, owing to their mental condition, unfit to live a normal community life in a welfare home (4). Although the demarcation of the health/social care boundary described in the Boucher report is a long way from the situation today, legally there has been no reduction in the scope of the NHS's continuing health care responsibilities since that time. There has been no amendment to the primary statutory obligation, no ministerial statement, no direction by the secretary of state or any other kind of announcement to the effect that the entitlement to continuing health care has been curtailed. Indeed in 2007 the Care Minister was reported as having accepted that PCTs had 'reneged on their responsibilities for funding continuing care and shunted costs on to councils' (5).

The material changes have mostly been in terms of policy and funding arrangements. The most significant change concerned the availability in 1979 of supplementary benefit payments (later income support) to cover the cost of private nursing home accommodation. This situation led to the closure of many NHS continuing care wards, with the patients being transferred to privately run nursing homes funded by the social security budget. The 1980 and 90s were then characterised by a rapid closure of long term beds which led to a general, **but incorrect**, assumption that the NHS no longer had the same responsibility for funding long term care. (Between 1988 and 2001, the NHS removed 50,600 long term care and geriatric beds.) The fact that social services authorities were (for the first time) empowered to make payments towards the cost of independent nursing home placements also encouraged the view that the NHS was no longer an agency responsible for making similar payments. So by the early 1990s many individuals found that when they became chronically ill and needed care outside their own home, they had to pay for this in a nursing home - whereas previously such people had received it free in a long stay continuing care ward. They (and their carers) accordingly paid substantial sums to private nursing homes (frequently having to sell their own home) in situations where previously the care would have been provided without charge by the NHS.

The UK's move away from caring for patients with long term conditions in 'hospital' settings is not unique in the developed world. The particular difficulty that arises in the UK is the divergence that has arisen between institutional and individual expectations of the NHS's role. Individuals have expected the NHS to respond on the basis of a person's need for health care, whereas institutionally the NHS has sought to limit its responsibility for providing 'free' NHS care, to care in a hospital setting - and to argue that other forms of care (for example care provided in community and home settings) is the responsibility of the social services means tested system. Accordingly, as it has become acceptable and feasible to care for all but the most acutely ill in non-hospital settings, the NHS has admitted responsibility for fewer and fewer patients, even though the 'disenfranchised' are objectively in need of 'health care'. The NHS has therefore redefined its role: its *raison d'etre* is not to care for ill people but rather, to care for certain limited categories of ill people: most particularly, *acutely ill* people. Such a re-branding has had the effect of 'shunting costs' to social services: ie the funding responsibility for patients who in former times would have been its responsibility.

It is this aspect that came prominently to the fore with the publication by the Health Service Commissioner of a highly critical report into a premature hospital discharge by the Leeds Health Authority in 1994 (6). In spite of considerable health needs the patient was discharged to a nursing home where he had to pay for his care. The ombudsman was so concerned about the situation disclosed by the Leeds complaint that the government undertook to issue guidance, indicating that if in the light of the guidance, some health authorities are found to have reduced their capacity to secure continuing care too far then they needed to take action to close the gap (7).

<u>1995 guidance, case-law and complaints</u>

In February 1995, as a consequence of the Health Service Ombudsman's 'Leeds report' (6), continuing care guidance was published in England and Wales as a first step towards defining with greater precision the boundaries between the responsibilities of the NHS and social services authorities for continuing care (8). The guidance required every health authority to prepare and publish local 'continuing health care statements' which spelt out which patients would be entitled to free continuing health care funded by the NHS. Although in 1996 the Department of Health issued follow up guidance to improve the quality of continuing health care statements (9,10), the evidence suggests that the 1995 guidance (which was superseded in England by 2001 guidance and now by framework guidance) was misapplied by health authorities and that the Department of Health was inactive in policing individual health authority continuing care statements (11). In reality, many PCT's used this state of affairs to 'do nothing'.

<u>The Coughlan judgment</u>

In 1999 the Court of Appeal (2) reinforced the finding of the Health Service Commissioner in the Leeds health authority complaint, that entitlement to NHS continuing care support arose, not merely when a patient's health care needs were complex, but also when they were substantial - the so called 'quality/quantity' criteria.
The Court of Appeal held that social services could only lawfully fund low level nursing care - low in terms of its quality and quantity. The court expressed this as follows:

a) There can be no precise legal line drawn between those nursing/services which are and those which are not capable of being treated as included in such a package of care services.
b) The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are:
    - merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide
    - of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide

It will be appreciated that the first part of the test is focusing on the overall quantity of the services and the second part on the quality of the services provided. Additionally the court emphasised that the setting of a person's care was not determinative of eligibility for continuing health care funding. In its view, 'where the primary need is a health need, then the responsibility is that of the NHS, even when the individual has been placed in a home by a local authority' and 'the fact that a case does not qualify for in-patient treatment in a hospital does not mean that the person concerned should not be a NHS responsibility'. A 1999 Royal College of Nursing Report (12) suggested that the continuing care policies of over 90 per cent of health authorities were deficient in health care funding.

<u>Continuing care guidance following the Coughlan judgment</u>

The *Coughlan* judgment was followed in England by 'interim guidance' (13), that did little more than ask health and local authorities to 'satisfy themselves that their continuing' care policies were in line with the judgment'. Unfortunately it also gave a clear indication that further guidance would be issued 'later that year' and

this expectation of this further guidance led to many health authorities taking no decisive action in the wake of the *Coughlan* judgment (11). The Department of Health took two years to issue further guidance (14). This guidance has been the subject of significant criticism by the High Court (15) and the Health Service Commissioner, most particularly in her special report on continuing NHS healthcare (11). The need for a special report stemmed from the large number of complaints that the Commissioner had received on this issue. She was forthright in her criticism of the Department of Health's failure to provide clear guidance in conformity with the Court of Appeal's judgment in *Coughlan;* commenting:

> *I do not underestimate the difficulty of setting fair, comprehensive and easily comprehensible criteria ... But that is all the more reason for the ' Department to take a strong lead in the matter: developing a very clear, well-defined national framework. One might have hoped that the comments made in the Coughlan case would have prompted the Department to tackle this issue .. . [however] Authorities were left to take their own legal advice about their obligations to provide continuing NHS health care .. . The long awaited further guidance in June 2001. .. gives no clearer definition than previously of when continuing NHS health care should be provided: if anything it is weaker, since it simply lists factors authorities should 'bear in mind' and details to which they should 'pay attention' without saying how they should be taken into account. . . I fear I would find it even harder now to judge whether criteria were out of line with current guidance. Such an opaque system cannot be fair.*

The Ombudsman has since 2003 issued further reports expressing concern about the processes PCTs and strategic health authorities (SHAs) were adopting to remedy their past failures (16) and relating to restitution and the level of interest that should be paid. In addition she has given written and oral evidence to the Health Select Committee.

Pointon and the Health Service Ombudsman's report

A further individual report of note relates to the home care provided to a man suffering from Alzheimer's disease by his wife and care assistants, known as the Pointon case. The Health Service Ombudsman held that the fact that Mr Pointon was receiving (what was in effect) nursing care from his wife, did not mean he could not qualify for continuing health care; that the health bodies had failed to take into account his severe psychological problems and the special skills it takes to nurse someone with dementia; that the assessment tools used by the NHS were skewed in favour of physical and acute care; and the fact that Mr Pointon needed care at home - rather than in a nursing care home - was not material to the question of continuing health care responsibility (17)

The Pointon report is of considerable importance, being a clear example of entitlement to continuing health care funding where (a) the nature of the health care need was not for acute medical support but for nursing of a quality that could manage his psychologically challenging behaviour and (b) the need arose from someone living in the community and not a residential care setting. Mr Pointon was also receiving care from untrained assistants and his wife, and this too is sometimes used as a reason for refusing entitlement to continuing health care. This is an irrelevant factor. What is of key importance is what a person needs - not what he or she is receiving.

The Entitlement Gap

A central dilemma of continuing health care is the different entitlements provided by the social care statutes and the NHS Acts. The former creates specifically enforceable duties and the latter mere 'target duties'. In principle there may be an ‘entitlement gap’ – essentially that a person could cease to be eligible for social care support because his or her need fell above the limits of what social care could provide but have needs below that which the Department of Health/Assembly had specified as necessary to qualify for NHS continuing care support, ie the 'primary health need' requirement. The question of a 'gap' in entitlement was addressed directly in The Grogan case (5). In essence the judgement held that the 'limits of social care' test was the crucial determinant. The reason for this conclusion was straightforward. The 'limits of social care' test is statutory in origin and had been authoritatively interpreted by the Court of Appeal in *Coughlan.* On the other hand the 'primary health need' test is a policy construction developed by the secretary of state. While it is the secretary of state's entitlement under the NHS Acts to propound such a policy, she could not (by guidance) undermine the statutory regime. Since the secretary of state had made unequivocal statements that there must be no gap in entitlement, then the only way of resolving this dilemma (short of statutory amendment) was for the NHS to drop the policy 'bar' to the height set by the Court of Appeal in *Coughlan* when defining the limits of social care support.

Directions and Guidance

Since 1995 the debate concerning continuing health care responsibilities has been dominated by criticism of the relevant Department of Health guidance. The 1995 guidance was shown to be inadequate in *Coughlan* and the

replacement 2001 guidance was rejected as wholly unfit for purpose by the Health Service Ombudsman, the High Court, the Health Select Committee and many other commentators. For the Department of Health to have been so consistently criticised for the quality of its guidance is unusual - possibly unique. The problem is almost certainly a political one. The NHS has for many years been driven by government targets that focus on the government's priorities which are almost exclusively short term acute health care - primarily the cutting of waiting lists. Diverting resources to fund the long term needs of ill people does not advance the agenda.

The effect of the *Coughlan* judgment was that entitlement to continuing health care support was more substantial than the government would have liked it to have been. The difficulty could have been resolved by amending the NHS and community care legislation, but this was presumably deemed political suicide. The response in 2001 could be viewed as an attempt to blunt the impact of the *Coughlan* judgment - to use guidance in effect to frustrate the law (18). With the judicial rejection of the 2001 guidance, new guidance was issued and a commitment made to divert limited resources into this domain. Whether the 2007 guidance was an adequate response to the *Coughlan* judgment has been shown to be somewhat wanting.

The NHS Ombudsman decisions and the Court judgments have, in general, placed the bar for qualifying for NHS CC support at a relatively low level, whereas the guidance issued by the Department of Health has put it much higher, suggesting in effect, that eligibility for NHS funding is limited to a very few patients with unusual conditions. This divergence has caused significant inter-authority tensions, with PCT's following the restrictive guidance and social services (and patients) seeking to rely on the case law and Ombudsman's findings.

The 2007 National Framework and Continuing Care

A primary objective of the 2007 framework was that instead of each of the 28 SHAs in England having its own rules, tools and processes for determining eligibility for NHS continuing healthcare, there should be one single national approach for the NHS in England, with a common process and national tools to support decision making.

The framework guidance states that 'Continuing Care' means care provided over an extended period of time to a person to meet physical **or** mental health needs which have arisen as the result of disability, accident or illness' and adds that "NHS Continuing Healthcare" means a package of continuing care arranged and funded solely by the NHS. The framework guidance states that the secretary of state has developed the concept of 'primary health need' to assist in deciding what treatment and health services it is appropriate for the NHS to provide 'and to distinguish between those and the services local authorities may provide'. This concept of primary health need has been incorporated into the 2007 Responsibilities Directions. The primary health need test is **not** that adopted by the Court of Appeal in *Coughlan.* The framework guidance resolves the differences between these two approaches by stating that a 'primary health need' arises where a person has exceeded the limits of the social care responsibility. This acceptance is important, the Framework states there should be no gap in the provision of care, such that people might be in a situation where neither the NHS nor (subject to the person meeting the relevant means test) the relevant Local Authority, separately or together, will fund care. Therefore, the 'primary health need' test should be applied so that a decision of ineligibility for NHS Continuing Healthcare is possible only where, taken as a whole, the nursing or other health services required by the individual:

i. are no more than incidental or ancillary to the provision of accommodation which LA Social Services are under a duty to provide; and
ii. are not of a nature beyond which a LA whose primary responsibility is to provide Social Services could be expected to provide.

The framework guidance retains reference to the terms nature, intensity, complexity and unpredictability which first appeared in the 1995 guidance. These have been criticised as unnecessarily complicating the assessment process (19). The framework guidance attempts to link these four indicators with the quantity/quality test preferred by the Court of Appeal in *Coughlan* and provides a more detailed explanation of each of these characteristics than that in the 2001 guidance. Crucial to the correct application of the decision support tool is the way in which its 'user notes' are interpreted. If there are a number of domains with **high** and/or **moderate** needs, **this can also indicate a primary health need.** In this case, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments, should be taken into account in deciding whether a recommendation of eligibility to NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, for example 'two moderates equals one high'. If need in all domains are recorded as **'low'** or **'no need',** this would indicate ineligibility. This does not, however, mean that these domains should be disregarded, as low needs can add to the overall picture and alter the impact that other needs have on the individual.

The details of Ms Coughlan's condition are well documented and were analysed in detail by the Court of Appeal. It concluded that her needs were well outside what social services could provide - of a 'wholly different category' (10). It is of concern therefore that the decision support tool does not clearly establish that she would

qualify for NHS continuing care funding - indeed unless substantial weight is given to the above advice, it would appear likely that Ms Coughlan would not meet the requirements of the tool. In practice therefore, the decision support tool may prove to be inadequate in addressing what has been described as a culture of 'ineligibility (20) within certain health bodies. It is this particular aspect of the case that is most intriguing, since Ms Coughlan's health care needs were objectively modest. Although she was tetraplegic; had recurrent headaches caused by an associated neurological condition; was doubly incontinent; required regular catheterisation and was partially paralysed in the respiratory tract - in many respects she lived an autonomous life, being intellectually active and because her condition was stable; had little need for NHS 'specialists' and could have lived in many semi-independent settings. If, as the Court held, her care needs put her well outside that which could be funded by a social services authority, then the bar to accessing NHS CC would appear to be set at a low level.

The 2009 Revision

The revised Framework issued by the Department of Health in July 2009 (21) commenced with a brief review of the tensions that existed between the guidance and the law (in the form of Court judgments). However, even with the minor amendments, the Framework and the associated Decision Support Tool remain problematical. In general the changes were minor in nature, and primarily directed at recasting some of the descriptors in the DST to accentuate the distinguishing features between the various bands. The new Framework emphasised that it was a clean break with what had gone before and the local authorities and PCTs would need to 'think and act differently' and that the expectation was that the new policy would result in 'more people [being] eligible for full funding'.

A troubling aspect of the revised Framework guidance was its continued reliance on a number of concepts that were not thought to be of major value by the Court in *Coughlan:* concepts such as a 'primary health need' and the 'nature, intensity, complexity and unpredictability' of a health need. These have been criticised as unnecessarily complicating the assessment process (19) and as the Framework acknowledges (§15) do not appear in the legislation. Ultimately however the guidance accepts (§26 and §28) that these concepts can (and should) be equated with the Court's 'quality/quantity' test as the defining issue in identifying the eligibility boundary. Notwithstanding its failings, the Framework contains much valuable advice (such as stressing the importance of involving the disabled person, their representative and carers) and a number of vitally important requirements, including *'that the reasons for a decision on eligibility should not be based on: the person's diagnosis; the setting of care; the ability of the care provider to manage care; the use (or not) of NHS-employed staff to provide care; the need for/presence of 'specialist staff' in care delivery; the fact that a need is well managed; the existence of other NHS-funded care; or any other input-related (rather than needs-related) rationale'.*

The revised DST (22) is a standardised document used by the relevant health and social care multidisciplinary team when collecting information about a patient's health care needs. It contains guidance notes and 31 pages of forms that are designed to capture, and categorise a patient's needs in relation to 12 care domains. Use of this document is illustrated in my mother's IRP appeal. The Department of Health has stressed that the DST is not 'a decision making tool', nor is it 'suitable for every individual's situation' nor is it a 'substitute for professional judgement' (23). Problematically, however, the advice within the DST then states that a person would be expected to qualify for NHS CC if his or her DST record contains a priority need in any one of the four domains that carry this level or a total of two or more incidences in the severe category. In addition it advises that eligibility for NHS CC may arise where there is one domain recorded as severe, together with needs in a number of other domains, or a number of domains with high and/or moderate needs.

Whilst a standardised process for assessing eligibility for NHS CC can be welcome, albeit humiliating and restricting, degrading a health need to a numbers game is dehumanising to anyone being processed. Further to this, the descriptors inevitably are capable of being misunderstood, especially to those steeped in the previous regime where the bar to qualification was at an unrealistically high level. The NHS Ombudsman has criticised criteria which were 'skewed in favour of physical and acute care' and failed to take into account the patient's significant psychological problems (17). The descriptors are largely inappropriate for that, and arguably this is the case with the revised DST. Perhaps the most obvious example of this incongruity, concerns the care needs of Pamela Coughlan, which were described in some detail by the Court of Appeal. Even on the basis of the revised DST it is unlikely that any of her care needs would be categorized as anything greater than 'high' and most would be below this level. Whilst the guidance envisages that a person with 'a number of domains with high and/or moderate needs' might qualify for NHS CC, it is by no means certain that PCT's would support this statement in practice. However, since the Court of Appeal held that her care needs were of a 'wholly different category' - ie well into the territory of NHS CC, it follows that this view must prevail in such cases.

The DST is not, as the Department of Health emphasise, a decision making tool: it is merely a Decision Support Tool. In disputed cases, therefore, the 'quality/quantity' approach of the Court of Appeal should decide the decision making process and NHS CC eligibility should only be denied to those whose health care needs are marginal

(or in the Court's terms 'merely incidental or ancillary' to the provision of the social care) and quantitatively of a low level. On the basis of the above comments, it is arguable, that the revised guidance - especially the DST - continues to place the bar to qualifying for NHS CC considerably higher than that suggested by the Courts and Ombudsman. Whatever the merits and de-merits of the revised guidance, it is inevitable that eligibility for NHS CC will remain contested territory, and that this will continue until such time as a wider settlement is reached on the funding of long term care. At present, there are simply insufficient funds within the NHS and social services to meet all the legal obligations created by the welfare settlement 80 years ago.

The 2012 Revision

This is a far more bulky document than the 2009 version and in line with the DoH inate ability for excessive paperwork production. Several additional ancillary areas are covered but for the first time there are particular explanations of 'health care vs social care' and the 'primary health need' but in reality nothing new. These are as follows:-

The difference between a healthcare need and a social care need

- Whilst there is **not a legal definition of a healthcare need** (in the context of NHS continuing healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).
- In general terms (**not a legal definition**) it can be said that a **social care** need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation.
- Social care needs are directly related to the type of welfare services that LAs have a duty or power to provide. These include, but are not limited to: social work services; advice; support; practical assistance in the home; assistance with equipment and home adaptations; visiting and sitting services; provision of meals; facilities for occupational, social, cultural and recreational activities outside the home; assistance to take advantage of educational facilities; and assistance in finding accommodation etc.

What exactly is a primary health need?

- 'Primary health need' **is a concept** developed by the Secretary of State to assist in deciding when the NHS is responsible for meeting an individual's assessed health and social care needs as part of his overall duties under the NHS Act 2006 to provide 'services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness'.
- The Framework states that 'Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's assessed needs – including accommodation, if that is part of the overall need.'
- The term 'primary health need' **does not appear, nor is defined, in primary legislation**, although it is referred to in the Standing Rules (24) where it sets out that a person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are: '(a) where that person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or (b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide '
- The Local Authority can only meet nursing/healthcare needs when, taken as a whole, the nursing or other health services required by the individual are below this level. If the individual's nursing/healthcare needs, when taken in their totality, are beyond the lawful power of the LA to meet, then they have a 'primary health need'.
- Whilst there is **not a legal definition**, in simple terms an individual has a primary health need if, having taken account of all their needs, it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs.
- Primary health need is not about the reason why someone requires care or support, nor is it based on their diagnosis; it is about their overall actual day-to-day care needs taken in their totality. Indeed it could be argued that most adults who require a package of health and social care support do so for a health-related reason (e.g. because they have had an accident or have an illness or disability). It is the level and type of needs themselves that have to be considered when determining eligibility for NHS continuing healthcare.

In a question to the Ombudsman (25) regarding the eligibility assessment process, she replied that the distinction between a primary need for healthcare or social care is **not a clear one**. There is a continuum of care needs and the threshold for achieving eligibility for NHS funding is not derived from hard fact, but from the range of **subjective** personal and clinical opinions of people involved with each patient. The assessment process, properly carried out, is capable of being thorough, balanced and representative of the views of all those who should be involved in the decision. Where we encounter problems, it is usually because the process has not been followed thoroughly: the problems we see are not with the process itself but with the way in which it might be carried out in individual cases. So as I found by experience, the Ombudsman will not look into whether or not the process is legal or not or whether it is Couglan compliant or not.

Summary

So that is where we are today. The eligibility decision making process is still confusing and successive governments have totally failed to ensure the DoH assessment methods are truly Coughlan compliant. I have tried the Continuing Healthcare procedure process quoting Coughlan equivalence at every opportunity, the Appeals process and the Ombudsman, but it clearly doesn't work. Because the eligibility system is policed by the NHS there is an obvious bias towards a 'not guilty' verdict, and getting it overturned would be tough. Basically healthcare has been redefined over the years as social care without any primary legislation or debate with the effect that the 'state' in effect seeks payment for chronic and long term health services, ie you pay.

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