The Reality of Healthcare Funding

According to the Coughlan judgment, the boundary between health and social care is not one of policy, but of law. Legally, there has been no material change in the scope of the NHS continuing healthcare responsibilities since inception and no amendment to the primary statutory obligation (1). However over the past decades, changes in the provision of long term chronic health care services following the development of community care has created confusion in relation to funding responsibilities and blurred the practical boundary between health and social care. However, the reality that we experienced can be summarised by the general points as follows:

- If you have health needs equivalent to Ms Coughlan you will not get NHS Continuing care funding under the present assessment criteria.
- SHA compliant criteria prior to the National Framework were miles removed from Coughlan compliance and totally illegal.
- It matters not that SHA criteria used following the DoH guidance in 2001 were not Coughlan compliant as long as the SHA's convinced themselves that they were (ie do the bare minimum).....a highly illogical situation since the position would not have been upheld in the Courts.
- Any denial of Continuing Health Care Funding based on the illegal SHA criteria could only be contested if the assessment 'procedure' was not applied correctly, not the fact that the criteria were not related to the Coughlan judgement.
- The entrenched view of many NHS and social services staff in 2001 was that eligibility for continuing care funding required very severe ill health allied to an unstable condition (2)
- The current National Framework seeks to patch-up a system that has been condemned as not Coughlan compliant with evaluation criteria that are opaque, unfair, highly subjective, ambiguous and incomprehensible.
- Whether SHA criteria or the National Framework, the eligibility bar for funding has and is set at an unlawfully high level.
- There is an entrenched mentality of ineligibility prevalent amongst NHS and social services staff.

In a report by Clements (3), he has applied the decision support tool to 4 cases that the Courts had upheld their funding claims. These were the Leeds case (4), the Coughlan case (5), the Wigan case (6) and the Pointon case (7). In referring to the DST, none of these cases scored a 'priority' rating, two cases had 2 severe levels and may possibly have received entitlement but Couglan did not. Thus something is seriously wrong. Some might argue that there is nothing wrong with the descriptors of the various levels within the Care Domains in the Decision Support Tool but the main problem is with the NHS assessing itself, especially practitioners inured in the previous regime where the bar to qualification was placed at an equally unrealistic level.

However, where a person has been assessed to have a 'primary health need', they are eligible for NHS continuing healthcare. So what is a 'primary health need' and how is it decided? This is a fundamental proposition in the National Framework and it is **not** one adopted by the Court of Appeal in Coughlan (5). Whilst there is not a legal definition (8), in simple terms an individual has a primary health need if, having taken account of all their needs (following completion of the DST), 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(8).

Four characteristics of need, namely 'nature', 'intensity', 'complexity' and 'unpredictability' '**may** help determine whether the 'quality' **or** 'quantity' of care required is beyond the limit of an Local Authority's responsibilities, as outlined in the Coughlan case (8), ie if the 'quality' **or** 'quantity' thresholds have been crossed. The characteristics of need, namely 'nature', 'intensity', 'complexity' and 'unpredictability' are ambiguous, highly subjective, frequently conflicting and of questionable legality, creating an intermediate hurdle. The Court of Appeal in Coughlan considered the key criteria were simply the 'quality and quantity' of the care provided and to decide if these quantities crossed a threshold the court provided ' the merely incidental or ancillary' test for quantity. Care domains in the DST basically refer to the quality of care but should be simpler. However, in the DST and PCT documentation, the term 'specialist' crops up many times in reference to the care domain grading. The requirement for an input from a 'specialist' or 'professional' suggests it is not the existence of need but a formal acceptance by a 'specialist' or 'professional' that is a necessary eligibility requirement. However, the 2012 Framework does make it clear (§ 38.4) that "the reasons given for a decision on eligibility should not be based on....the use or not of NHS employed staff to provide care; the need for/presence of "specialist staff" in care delivery or any other input related (rather than needs-related) rationale."

The volume of complaints concerning the failure of health bodies to accept responsibility for NHS Continuing Care funding and the success of many of these complaints is strong evidence that the system has failed large numbers of people. Many of these have come into contact with health and social care professionals who have either ignored or inappropriately rejected their entitlement. The creation of a single set of criteria for all health bodies in England is welcome but unfortunately, local variations in entitlement (see table) and lack of central scrutiny means that at present very imperfect local criteria can still exist. Given the failure of the Department of Health to adequately scrutinise the Continuing Care Statements issued by the Strategic Health Authorities and the failure of these authorities to properly police the day to day decision making by their local health bodies it is unlikely the Continuing Care system will improve. It contains no truly independent stage, is slow in its processes and has a strong tendency to uphold the NHS decision. It is generally perceived that the Ombudsman can provide a reversal to patently unfair Health Service eligibility decisions judging by the reports of past cases. This does no longer seems to be the situation, comparisons with equivalent past cases doesn't work. As to what the Ombudsman decides as to what can and cannot be done, in a 2004 report (9), the Ombudsman stated that:-

a) We cannot make a definitive judgment about whether an individual authority's (new) criteria are lawful or otherwise; that is for the courts. We can only investigate if maladministration has been alleged, either in individual cases or because of systemic faults.
b) Our recommendations do not extend, as some commentators have maintained, to providing continuing care funding to all those who suffer from dementia. It is the healthcare needs, not the diagnosis, that determines whether the criteria for funding are met.

In a recent question to the Ombudsman (10) regarding NHS continuing care being able to meet people's care needs, she said that "only a minority of people are successful in claiming NHS funding for their continuing care needs. As long as there is a distinction between social and healthcare, with only the latter being fully funded by the public purse, it is clear that most people's care needs are not being met by NHS continuing care funding. It is not possible for us to say whether all those who should be receiving NHS continuing care funding are actually receiving it. However, what is clear is that there are many people who feel that they should be funded by the NHS for their care who are not assessed as eligible. There is no question, from looking at the circumstances of the people whose complaints we see, that some of the people who are turned down are in extreme need and that the threshold for achieving NHS funding **is a high one"**.

References

1) National Health Service Act; 1977
2) Norfolk, Suffolk and Cambridgeshire Strategic Health Authority JOINT POLICY AND ELIGIBILITY CRITERIA For NHS FUNDED CONTINUING HEALTH CARE., April 2003
3)Clements L., Briefing document for NHS continuing healthcare national framework proposal., 19th.June 2006
4) Health Service Ombudsman., Session 1993/4., 2nd.Report; case no. E62/93-94
5) England and Wales Court of Appeal (Civil Division); R v North & East Devon Health Authority [1999] EWCA Civ. 1871 (16 July 1999)
6)Wigan and Bolton health Authority and Bolton Hospitals NHS trust case No. E.420/00-01
7) Cambridge health Authority PCT complaint., Case No.E22/02/02-03)
8)Department of Health., National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)
9) NHS funding for long term care: follow up report., health Service Ombudsman 1st Report – Session 2004-5., December 2004., HC 144
10) PHSO submission to the Parkinson's APPG enquiry into NHS Continuing Healthcare., 10th.June 2013
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