Long term nursing: social care or health care?

Judgment clarified the law but did not remedy its unfairness

The Court of Appeal last year lent support to the Royal Commission on Long Term Care in a case that marked a watershed in the politics of long term care in Britain. The Department of Heath guidance that followed the judgment is a partial retreat from three decades of policy which has seen responsibility for funding long term care shift from the NHS to individuals and local authorities.

The landmark case was brought by Pamela Coughlan, who sought judicial review of a health authority's decision to close the NHS home, Mardon House, where she had been promised "a home for life." Ms Coughlan, rendered quadriplegic in a road accident in 1971, won at both the High Court and the Court of Appeal. The health authority was forced to make good its promise, and the court upheld Ms Coughlan's right under article 8 of the European Convention of Human Rights to respect for her home.[1] In the High Court the judge went further and declared that nursing is "health care" and can never be "social care."[2] The effect of that judgment would have been to make the NHS responsible once more for long term nursing care and the extra costs of some 200 000 residents whose nursing home places are funded by the local authority, the Department of Social Security, or private payers.

The critical issue for the Court of Appeal was whether nursing care may be provided by a local authority as a social service (in which case the patient pays according to means) or whether it has to be provided free as part of the NHS. The issue of nursing care transformed the case of an individual into a test case.

The secretary of state and the Royal College of Nursing joined the litigation on appeal. The secretary of state was treated as a party to the litigation because of his interest in upholding the statutory scheme by which responsibility for long term care is divided between health and social services.[3] The Royal College of Nursing intervened on a more limited basis on the question of whether nursing care should in all circumstances be free at the point of delivery and to challenge as unlawful the distinction between "general" and "specialist" nursing in the health authority's eligibility criteria.

The court's answers were such that both sides could claim victory. Under the headline "Woman's nursing home victory saves NHS millions" the secretary of state claimed that the judgment confirmed "the … current legal position and safeguards the funding for tens of thousands of elderly and vulnerable people in nursing homes."[4] Meanwhile the Royal College of Nursing presented the ruling as bringing an end to means testing for tens of thousands of people in nursing homes whose "primary need . . . is a health one."[5] The court overturned the lower court's ruling that all health care is the responsibility of the NHS (so pleasing the secretary of state). But it held that the health authority's criteria for determining who should receive NHS nursing services were unlawful (so pleasing the royal college). Ms Coughlan had argued that the health authority had reduced demand for Mardon House by applying rigorous limits on entitlement to NHS care. The court agreed that the health authority held a wrong view of its obligations to provide care and this called into question its decision to close Mardon House.

The judgment has refined the lawful distinction between nursing care that must be provided free by the NHS and that which can, under present legislation, be provided on a means tested basis by local authorities. Whether local authority social services departments can be expected to provide nursing services depends on the quantity and quality of these services. Such services are limited to those which can be said to be "incidental and ancillary" to the provision of accommodation under section 21 of the National Assistance Act 1948, as amended (the quantitative test), and which are such that "an authority whose primary responsibility is to provide social services can be expected to provide" (the qualitative test). The court was firm that where it was difficult for reasons of bureaucracy to distinguish between NHS and local authority responsibilities the NHS must presumptively provide health care.

This judgment sent three messages. Firstly, health authorities may not use their eligibility criteria to absolve them from their responsibilities for funding and providing continuing care. When a patient's need is primarily for health care such placements must be funded by the health authority. The court recognised the increased emphasis being placed on care in the community (and the trend to closing NHS facilities), stating that "simply because individuals no longer qualified for treatment as inpatients in hospital this no longer automatically disqualified them from receiving care on the NHS." Eligibility criteria must identify at least two categories of people, who, although receiving nursing care in a nursing home, are still entitled to receive care at NHS expense. These are people who, because of the scale of their healthcare needs, should be regarded as wholly the responsibility of a health authority, and those whose nursing services can be regarded as being the responsibility of the local authority but whose additional requirements are the responsibility of the NHS. The Department of Health has now incorporated this into interim guidance to all health and local authorities, and new guidance is due shortly.[6]

Secondly, the refinement of the eligibility criteria by the courts will not remedy the fundamental unfairness of the law as it stands, where nursing is provided free for individuals receiving care in hospitals or at home but not when it is provided in nursing and residential care homes and funded by local authorities or individuals. The court was powerless to undo what parliament had legislated for.

Thirdly, further litigation is likely. Ms Coughlan was described in the judgment as having disabilities of a scale beyond the scope of local authority services. Many people have levels of disability and healthcare needs that match those of Ms Coughlan but because they are not receiving their care in an NHS setting find their personal care subject to means testing by local authorities. The court was told that the division between health care and personal care can be difficult

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if not impossible to draw. It concluded, "Either a proper division needs to be drawn … or the health service has to take the whole responsibility." In the light of this judgment some client groups may seek to assert that since their primary need is a health need the NHS is wholly responsible for their care. When disputes arise the courts will be forced to revisit the issue of the boundary between personal and health care.

The Court of Appeal drew attention to the recommendation of the Royal Commission on Long Term Care that the unfairness in the statutory scheme should be remedied.[7] Parliament should now either act on the recommendations of the royal commission or foot the bill for further litigation against the NHS.

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1 The Court of Appeal. Judgment QB COF 99/0110/CMS4. http://tap.ccta.gov.uk/courtser/judgments. . .2da1f63048cc802567b0003352a21.
2 Regina *v* North and East Devon Health Authority, ex parte Coughlan. *Times* 1998;29 Dec.
3 Justice. A *matter of public interest: reforming the law and practice on interventions in public interest cases*. London: Justice, 1996.
4 Dyer C. Woman's nursing home victory saves NHS millions. *Guardian* 1999;17 Jul:1-2.
5 Hancock C. Hope for the elderly. *Express* 1999;21 Jul:32.
6 Department of Health. *Ex Parte Coughlan: follow up action*. London: DoH (HSC 1999/180:LAC(99)30).
7 Royal Commission on Long Term Care. *With respect to old age: long term care—rights and responsibilities*. London: Stationery Office, 1999 (Cm 4192-I).

Giving something back to authors

Some changes to our copyright agreements

For centuries scientific publishing has worked on a bizarre economic model: the real producers of the raw material, the researchers, have received no direct payment for their work. In return for publication they have received exposure, "findability" for their work (thanks to bibliographical databases provided by others), and the "imprimatur" of peer review. Since peer review is an imperfect process,[1] exposure and findability are probably the more important benefits. For their part publishers have largely borne the costs of funding peer review systems and of providing the exposure and in return have controlled all the rights to their authors' work and taken all the cash. That has been as true of professional association publishers as it has been of commercial ones: the professional associations can argue that their surpluses have helped to support the work of the associations and their members, but individual researchers have not received any direct monetary reward for their labours. The *BMJ* is now proposing to share some of the cash from commercial reprint sales with its authors. We also hope that we can use the part that we don't share with them to increase something that may matter more to them—exposure.

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Jane Smith *deputy editor, BMJ*

1 Rennie D. Editorial peer review: its development and rationale. In: Godlee F, Jefferson T, eds. *Peer review in health sciences*. London: BMJ Books, 1999.

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