HUMAN RIGHTS IN THE CONTEXT OF COMMUNITY CARE: MOVING BEYOND PATCHWORK REFORM

Introduction

Due to the House of Lords’ overly restrictive interpretation of “hybrid” or “functional” public authorities in *YL v Birmingham City Council*,¹ many vulnerable people risked being denied the protection of the Human Rights Act 1998. The controversial case has spawned voluminous commentary and debate, culminating in the enactment of section 145 of the Health and Social Care Act 2008 (HSCA) which reversed the effect of the ruling. As a result, private bodies providing residential care services under local authority arrangements pursuant to the National Assistance Act 1948 (NAA) are now deemed for the purposes of the HRA, s.6(3)(b) to be exercising a function of a public nature. The legislative intervention is welcome, but only a limited change has been brought by s.145 HSCA, given that certain mentally ill patients who are placed within the independent sector at public expense still cannot invoke human rights claims against their service provider. This article therefore argues that the scope of s.145 should extend beyond arrangements made under the NAA 1948 and be amended to include all publicly arranged or authorised care.

Background issues

The HRA makes it unlawful for a public authority to act incompatibly with a Convention right.² Under s.6(3)(b) public authority includes “any person certain of whose functions are functions of a public nature”, except if “the nature of the act is private” as provided under s.6(5). In effect, there are two categories of persons: “pure” public authorities such as local councils must comply with human rights standards in all their actions; whereas “hybrid” public authorities are so

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¹ [2008] 1 AC 95 (hereafter *YL*).
² HRA 1998, s.6(1).
required only when carrying out public functions. The then Home Secretary and the Lord Chancellor explicitly stated during parliamentary debates that the HRA would apply to persons delivering privatised services.\(^3\)

However, the courts in a series of cases\(^4\) have construed s.6(3)(b) narrowly by focusing on institutional – the type of bodies and source of power – rather than functional aspects to determine whether any contracted-out governmental responsibilities were of a public nature.\(^5\) Such restrictive approach led to a regrettable situation where the frontiers of human rights protection shrunk due to the successive governments’ privatisation moves since 1980s, leaving many users of erstwhile public services stranded without public law redress.\(^6\)

Amid widespread disquiet that private bodies which have contracted to provide publicly funded services for some of the most vulnerable groups in society would not be subject to the HRA,\(^7\) the case of YL came before the House of Lords. At issue was whether a private care home, SC, would be in breach of the European Convention on Human Rights (ECHR) if it terminated its care services to YL, a woman with Alzheimer’s disease whose residence was funded and arranged by Birmingham City Council pursuant to ss.21 and 26 of the NAA 1948. This turned on whether the care home was performing “functions of a public nature” within the meaning of s.6(3)(b) HRA. By a 3-2 majority, the House of Lords drew a distinction between local authorities


\(^6\) First MPA Report (n 5) para 84.

arranging the care and the actual provision of services by private care homes, holding that the latter did not constitute a public function.8

The Health and Social Care Act 2008: a step too small

The YL decision was disappointing, as the House of Lords had ignored the concerns voiced in many quarters over the “gap” in human rights protection especially for frail elderly people who were placed within the private sector. In response, Parliament addressed this problem by enacting s.145 of the HSCA 2008 which states:

“A person (P) who provides accommodation, together with nursing or personal care, in a care home for an individual under arrangements made with P under ... [ss.21(1)(a) and 26 of the NAA 1948] is to be taken for the purposes of [s.6(3)(b) HRA 1998] ... to be exercising a function of a public nature in doing so.”

It follows that publicly funded residents in private care homes now have the same directly enforceable Convention rights against the service provider as those residing in local authority homes.9 Parliament deserves credit for taking swift action to counter the restrictive judicial interpretation of “public function”, yet there is no room for complacency with the current state of the law because s.145 HSCA only applies to the care home context, besides self-funding residents cannot benefit from it.

Remaining gaps

The above provision falls short of bringing all types of publicly arranged care within the protection of the HRA. Indeed, the Equality and Human Rights Commission has pointed out several lacunas left open by s.145 HSCA which made sole reference10 to the NAA 1948 but

8 YL (n 1) paras 115, 147.
9 L Clements and P Thompson, Community Care and the Law (5th edn, Legal Action Group, 2011) 925.
10 HSCA 2008, s.145(2)(a) in relation to England and Wales.
omitted other relevant framework of community care. For instance, local health and social
departments have a duty to provide aftercare services\textsuperscript{11} to certain patients who have been
detained under the Mental Health Act 1983 (MHA). Part of the aftercare package may include
residential accommodation, sometimes provided by non-governmental sector.\textsuperscript{12} Secondly,
under ss.4A and 4B of the Mental Capacity Act 2005 (MCA) the deprivation of liberty of persons
lacking mental capacity without their consent will be lawful only if formally authorised. Despite
not being subject to compulsory detention, a considerable number of residents in private care
homes are effectively deprived of their liberty but they cannot complain under the HRA.\textsuperscript{13}

It is unsatisfactory that these arrangements have not been referred to in s.145 HSCA, with a
consequence that the uncertainty surrounding the question of whether a particular private
provider of care is or is not a “functional” public authority will continue to plague the parties
concerned. In the Government consultation following the Strasbourg Court ruling in the
\textit{Bournewood} case,\textsuperscript{14} the Department of Health estimated that 50,000 care home admissions per
year involved a deprivation of the resident’s liberty without access to an independent review of
their detention, contrary to Art.5(4) ECHR.\textsuperscript{15} Although ss.4A and 4B of the MCA 2005\textsuperscript{16} have
now mandated an authorisation by the local authority, this safeguard can only be triggered by
private care home managers. According to Help the Aged, it defies logic to require care homes
to identify any potential deprivation of liberty and make an application for authorisation, but not
regard this as a public function.\textsuperscript{17}

\textsuperscript{11} MHA 1983, s.117.
\textsuperscript{12} Memorandum to the JCHR, \textit{Any of our business? Human rights and the UK private sector} (2009-10, HL 5-I, HC 64-I) Ev 337.
\textsuperscript{13} Ibid.
\textsuperscript{14} \textit{HL v United Kingdom} (2004) 40 EHRR 761.
\textsuperscript{15} Department of Health, \textit{Bournewood Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the “Bournewood” case} (TSO, 2005) para 3.4.
\textsuperscript{16} As inserted by the Mental Health Act 2007.
\textsuperscript{17} JCHR, \textit{The Meaning of “Public Authority” under the Human Rights Act} (2006-07, HL 77, HC 410) Ev 21 (hereafter Second MPA Report).
Reasons for further reform

(i) Desirable

Given the growing involvement of non-governmental sector in public service delivery especially in the social welfare field, it is imperative for Parliament to clarify the extent of their human rights obligations. Admittedly, every care home operator (public or otherwise) is already governed by the Care Standards Act 2000 and the HSCA 2008 also established a Care Quality Commission with monitoring responsibilities over all such homes, but extending the scope of s.6(3)(b) HRA to all contracted-out care services is still crucial. As the Joint Committee on Human Rights explained, there is a key distinction between a “duty to provide” and a “right to receive” decent care. While compliance with the former can be ensured through external regulation, the latter is more about empowering service users themselves who are often in vulnerable circumstances and who would otherwise be helpless in the face of inherently unresponsive systems.18

Condescending or, at best, paternalistic attitudes are prone to develop in a setting where personal care is being provided daily to those with problems of physical functioning or mental confusion. This is why health and social workers in the private sector must be made aware that each patient or care home resident has a right to be treated with dignity.19 The power imbalance between service providers and service users is particularly marked in regard to persons with mental impairment. As Baroness Hale noted in YL, “their capacity for self-determination is diminished and their vulnerability to human rights abuses increased even before any compulsory powers [of detention under the MHA 1983] are invoked”.20 Few would dispute that

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18 Ibid, para 82.
19 Ibid, para 77.
20 YL (n 1) para 69.
the right to liberty, respect for private and family life, or even freedom from inhuman and degrading treatment might be violated if such persons are not appropriately looked after.

It is no answer to say that where care duties are contracted out, the commissioning local authority remains accountable for any breach of Convention rights that results. In reality, “notwithstanding the requirement for local authorities to keep care plans under review, one of the impacts of resource and staffing pressures is that [publicly funded] residents have minimal contact with social work professionals once they are accommodated”. Thus, the authority can scarcely be counted on to reduce the incidence of rights abuse, let alone preventing it.

By widening the reach of s.6(3)(b) HRA to all publicly arranged care, an individual will be able to use human rights arguments to challenge poor treatment at its source. Furthermore, the staff and managers who run private care homes should be taking direct responsibility toward their residents because arguably the ultimate aim of applying s.6(3)(b) HRA is not to lay blame on a distant authority when something goes wrong, but rather to bring about tangible improvements in service quality for the benefit of all those affected. Viewed from this perspective, the difference between the legal position of publicly funded residents and self-funders is essentially theoretical, and should not be employed as an excuse for not bringing more people within the HRA’s protection.

(ii) Practical and useful

Some commentators have argued against imposing the status of “functional” public authority upon business entities and charities, in preference for governance using private law

21 Art.5 ECHR.
22 Art.8 ECHR.
23 Art.3 ECHR.
24 First MPA Report (n 5) para 78.
26 Second MPA Report (n 17) Ev 45.
mechanisms such as tort and contract. This approach is misguided insofar as it perceives the 
meeting of human rights standards as a burden instead of a norm of good practice. 28 Meanwhile, a finding of breach of contract also fails to reflect the seriousness of a wrong on the 
private provider’s part, unlike a violation found under the HRA which tends to give the aggrieved 
applicant a sense that their rights are vindicated. Protection of Convention rights through 
contracts between a public body and a private service provider is possible but weak, for the 
terms may not always be enforceable at the suit of users if they themselves are not parties to 
the contract. 29

Moreover, the entering into of a contractual arrangement between the care home and the 
resident does not necessarily remove public flavour from the character of an act. 30 Where the 
local council in one area does not directly provide certain services, e.g. aftercare for mental 
health patients, these people will have no practical alternative but to accept the accommodation 
offered by independent sectors. Given that over 90% of supported residents live in privately run 
care homes, 31 it is undesirable to have the parties dealing with potential legal issues by way of 
contract since the freedom of choice element which lies at the heart of a contractual ideology is 
often absent. 32

As more and more social welfare functions get privatised, it is in the public interest to ensure 
that vulnerable service users will not be denied an effective remedy simply because their care 
arangements happen not to be made by local authorities pursuant to the NAA 1948. As the law 
currently stands, private hospitals accommodating patients who are detained under the MHA

28 S Palmer (n 5) 571.
29 First MPA Report (n 5) para 115. The JCHR has pointed out that while the Contracts (Rights of Third Parties) Act 1999 relaxes the common law rules of privity, the ability of third parties to enforce contracts under the Act is conditional and not straightforward.
30 See Davis v West Sussex County Council [2012] EWHC 2152, paras 78-82.
1983 are classified as functional public authorities,\(^{33}\) while a private provider of mental healthcare may not always be subject to the HRA. It is submitted that discounting the absence of compulsion, the position of incapacitated persons residing in private care homes is not qualitatively different from mental health patients held in hospitals.\(^{34}\) Hence, fairness requires that both groups be given equal protection of their rights.

At present, whenever disputes arise in the independent sector in relation to the acts or omissions which are allegedly incompatible with Convention rights, service users will either have to put up with the problem, or incur significant time, expense and effort to lodge a complaint against the private provider.\(^{35}\) Even after the passing of s.145 HSCA, many government-funded individuals still face difficulty in establishing the accountability of a private body for human rights breaches. Since court litigation is hardly a realistic option for those who lack mental capacity and/or financial means to pursue their case, the onus falls on Parliament to create a clear, comprehensive solution to close the existing gaps in human rights protection.

Indeed, the Law Society has suggested one plausible legislative amendment stating that “where a public body delegates functions that would otherwise be the responsibility of that body, those functions and the private body delivering them are considered public.”\(^{36}\)

Of course there is understandable concern about defining “function of a public nature” so broadly that too many private organisations might end up being categorised as functional public authorities, thereby driving service providers away from the market for social care.\(^{37}\) But such fears are without solid basis, after all s.6(5) HRA reduces the scope of s.6(3)(b) by exempting a body “if the nature of the act is private”.\(^{38}\) The breadth of the sphere of public responsibility can

\(^{33}\) Following the decision in *R (A) v Partnerships in Care Ltd* [2002] 1 WLR 2610.

\(^{34}\) Memorandum from Help the Aged, Second MPA Report (n 17) Ev 21.

\(^{35}\) Second MPA Report (n 17) para 76.

\(^{36}\) First MPA Report (n 5) Ev 50 [paraphrased].

\(^{37}\) Second MPA Report (n 17) para 84.

\(^{38}\) S Palmer (n 5) 571.
thus be moderated by not conflating the performance of “functions” with “acts”. Even when the HRA does apply, private organisations will not be liable, provided they can show that due regard has been paid to whichever Convention right at issue. Accordingly, there seems little reason why the legislature should hesitate to render the provision of all publicly arranged or authorised care a public function.

Conclusion

Section 145 of the HSCA 2008 is a step in the right direction, yet it does not go far enough to close the loophole in human rights protection as it only covers private care homes that provide accommodation and/or nursing services funded by local authorities acting under the NAA 1948. Care arrangements made under other statutory provisions, e.g. the MHA 1983 and the MCA 2005, are omitted despite these being likewise funded at public expense. In view of the frequent failures of care standards regulatory schemes to safeguard vulnerable people from neglect and abuse,39 this article calls for a widening of the scope of s.145 HSCA so that whenever state powers or duties to meet care needs are delegated to private organisations, the latter will be automatically deemed as discharging a public function for HRA purposes.

In terms of the effectiveness in securing human rights, neither the contractual mechanism nor scrutiny by the commissioning local authority can match the imposition upon frontline providers of the s.6 duty to act in Convention-compatible ways. The ability to hold private bodies directly accountable under the HRA would provide those affected by mental illness or other disabilities with a powerful leverage in their struggle for respect and understanding. Given the extent and range of human rights concerns that exist in the community, dignified care is best achieved

through the empowerment of the individual service user.\textsuperscript{40} It is also hoped that a broader legislative designation of “public functions” would eventually embed a human rights culture and facilitate the development of a proactive approach to the mainstreaming of rights considerations into social care policy across the board.\textsuperscript{41}

\textsuperscript{40} H Carr and C Hunter, ‘Are Judicial Approaches to Adult Social Care at a Dead End?’ (2012) 21 Social & Legal Studies 73, 78.

\textsuperscript{41} Second MPA Report (n 17) para 69.