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COMMUNITY CARE

Note from John Redwood

In his helpful note, John Redwood compares three main models and then opts for a social security solution. He does so because he has a real concern that the local authority model and health model would create a vast bureaucracy which would restrict personal choice. He believes the other models will exacerbate the problem.

His proposal is similar to Lady Wagner's proposal for "community care allowances" mentioned in my previous note. It would build upon some existing responsibilities of social security officers who allocate benefits on the advice of doctors. The attendance allowance is one example.

There is one significant risk. If benefits are awarded automatically (subject to a means-test and a care-test), demands for benefits could rise dramatically. Reliance on informal carers may then diminish. And there would be a substantial dead-weight cost which is difficult to estimate. Perhaps this risk could be minimised by awarding discretionary benefits within a cash limited budget.

While the social security model is not perfect, I believe it has sufficient merit to justify further examination. You may want to discuss this option with Ministers.

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COMMUNITY CARE

The current arguments over the future of community care are reminiscent of the worst days of departmental imperialism. Each department seems to be seeking more control over bigger budgets to handle the problem. The government should beware of trusting either local government or the health service with the overall direction of the large budgets required for community care, especially if the interests of the service user have been neglected. No change in the current regime would be better than establishing a new care authority outside central government control, which would politicise the problem and increase costs.

The local government model

Under this model the caring agency capable of allocating resources and co-ordinating social security, health, housing and other interests would be a local government authority. It could either be the district as housing authority or the county as social service authority. Whichever was chosen there would need to be representation and co ordination from the other councils, as well as from the family practitioner committees, the district and regional health authority, the departments of health, housing and social security and the minister for community care as recommended under the Griffiths Report.

The two main advantages of local government leadership are:

1. It provides a caring agency which might be able to co ordinate all the other interests.

2. This agency would have some flexibility to respond to local conditions.

The disadvantages are more numerous and more substantial.

1. Granting these large powers to local government runs contrary to the government's policy of trying to limit the size and budget growth of local government.

2. Local government would find it difficult to co-ordinate the regional and district health authorities, the family practitioner committees, the private sector and the national departments of state, placed as they are somewhat lower down the normal chain of command.

3. Local government would nearly always demand more money when any problem arose in the system.

4. Local government would bureaucratise the system, adding to the substantial administrative overhead.

5. In some parts of the country left wing local authorities would politicise community care, both seeking to experiment with it as part of a policy of social engineering and trying to use it as a means of embarrassing the government on issues of funding and style of provision.

6. It would be difficult to build in a substantial role for individual choice.

Department of Health model

This model would require the formation of a new body arising from the regional and district health authorities and the family practitioner committees which would be called a community care authority. It would have representatives from local government, from the regional and district health authorities and would have to interpret general government guidelines laid down by the Department of Health, Social Security and Housing. It would need to co-ordinate with housing authorities.

The advantages of such a scheme are

1. Regional and district health authorities should understand local conditions and display some flexibility in decision making.

2. Because there is a medical judgment involved in deciding the level of care appropriate for each individual this could be given a central position.

The disadvantages are more numerous and substantial.

1. The powers of unelected bodies would be extended substantially by such a creation, and there would need to be careful control over the choice of people to sit on them given the big budgets they would be dispersing.

2. There is already confusion between the powers and remits of the regions and the district within the health system. The creation of another body responsible for community care could serve to highlight these difficulties.

3. It would entail the creation of further bureaucracy to co-ordinate all the relevant activities and interest groups.

4. Although it would not politicise the process as much as local government involvement, there would be a temptation to play up the difficulties and demand more money as the sole purpose of these bodies would be to build bigger budgets and dispense more care.

5. It would upset social service departments unless they retained their current heavy involvement.

The DSS model

Under this scheme Department of Social Security offices would continue to be the financiers of the system of community care. Just as at the moment DSS staff decide on the allocation of benefits to elderly people entering residential care on the advice of social service departments and with the benefit of medical in-put, so under this scheme DSS offices would have an expanded role to adjudicate between applications for all kinds of support payments and benefits under a wider community care programme. Individuals would be able to explain their wishes and needs and make the relevant applications either themselves or with the help of their families and advisers, giving a greater role for the individual to choose. The whole

system would be based upon different types of "voucher" which might need to be varied in value geographically as well as by style of care. Any use of a "voucher" would be dependent on capital and income tests as well as on demonstrating need based on disability or medical condition. They might cover the costs of home helps, preparing meals and the like. Local government could continue to approve and register homes.

The advantages of this scheme are

1. The financier gatekeeper to the system builds upon a system already in operation to control the flow of benefits to the elderly going into residential care.

2. There would be no favouritism as between the public or private sectors in the provision of this community care, as the DSS offices would not be tempted to become providers themselves. Community care agencies under local government or the Health Department might wish to build up their own provision.

3. It enables the government to keep overall central government control and national standards, subject to any regional cash variations that might be appropriate in the light of different costs.

4. The system would not be as heavily politicised or as bureaucratised as the establishment of new community care agencies.

5. The system would be more flexible and responsive to individual needs and requests.

6. It can be controlled financially by controlling the extent to which people's eligibility for new community care grants is expanded.

The main disadvantages of this scheme are

1. It is still going to be difficult co-ordinating housing, health and social service inputs, and will require some expansion of staff and training within DSS offices. DSS ministers say their staff could not take this on, claiming that they can only adjudicate claims in relation to income and capital rules. Yet they already distribute benefits to the disabled, which require medical reports to assist in establishing eligibility.

2. If the government offers too big a range of new grants for community care there will be a substantial deadweight cost.

There is no perfect model for expanding and developing community care. the objectives of the scheme must be

1. To provide some control over costs. It is much cheaper for elderly people to be in properly developed residential accommodation than to keep them in NHS hospitals when they are no longer requiring surgery. It is cheaper to support an elderly person in their own home than in residential care. The aim of the policy should be to encourage reasonable economy.

2. Individual choice is also important and there is a danger in some of the grander schemes that too much attention and too many changes will be forced upon the elderly people. A good system will respond to the wishes of the elderly or the disabled people and their families in a sensitive way.

3. A good providing agency will not feel that it has to own and run all or most of the facilities required to produce a sensible care in the community policy. A good policy will be based upon empowering families and individuals to choose what they require whilst encouraging the maximum choice and competition amongst providers.

In order to fulfil these aims I conclude that the best model is to build upon the present social ~~service~~ security offices who have to make the allocations of benefit drawing on the advice of the other interested parties. Local housing departments would still be involved when the issue is the provision of semi sheltered or sheltered accommodation. The role of the social service department would be to direct the person to the right housing department or to take care of the provision through residential care benefit awarded by the DSS.

The establishment of brand new large care agencies, whether with a local government or a health flavour, is more likely to cause problems. The first consequence of this decision would be for the care agencies to argue over funding and to survey need to establish a large unrequited need as a basis for additional money.

If there can be no agreement on any new or evolving delivery mechanism it would be far better to do nothing. This would also be the course most likely to control the growth in spending. There would be a few days of bad press and parliamentary comment and then the issue would die down. The political fallout from the large changes required for a health or local government based system would last much longer, with many vested interests complaining about lack of cash and upset by changes that had reduced their power or status.