

## Combining choice, quality and equity in social services

Balázs Krémer  
University of Debrecen

*“The purpose of the Peer Review is to discuss the challenge of combining choice, quality and equity in the provision of social services taking into account new policy options, such as free choice between private and public providers of personal or practical care, and new trends concerning the financing of service provision via innovative instruments involving users, such as vouchers or personal budget. These instruments allow for the greater involvement of the user and are clearly related to the issue of users’ empowerment. At the same time, they might raise questions in terms of access and equity.”*

The Danish Host Country Paper has described the most important challenges within the field of social services for Elderly, and some of the ways in which the Danish government and municipalities try to resolve these challenges for example by offering more choice to the service users.

The Discussion Paper has focused on services for the elderly and has presented the policy debate on choice.

In preparation of the Peer Review, the peer countries might take the following questions into consideration:

- *What are the most important challenges your country faces within the field of social services, and notably services for the elderly? What initiatives have you taken – or are you planning to take – to counter these challenges? How is your country preparing the social services for the elderly for the changing demographics?*

### 1. Key Policy Problem Areas

Structure of social services in Hungary: The system of social services embraces basically the various forms of personal care.

According to the Social Act social services are provided by the state and municipalities. All municipalities are due to provide basic social services: home care and meals provision, while residential social care must be provided by bigger towns and counties, but churches, as well as non-profit organisations and profit-oriented enterprises are also entitled to operating a given service. To finance their tasks the service providers are entitled to get normative support from the state. They also can get financial resources from its maintainer and furthermore they can use their own revenues. The state determines the amount of the normatives in the annual budget. (So from the state’s side, the social services are financed from the budget.)

Rural disadvantages: Elder population concentrates in rural areas, the ratio of frail elderly is higher in small villages than their overall rate – but, the service capacities are poorer, not so well organised in these municipalities. In 2007 there were 866 settlements (mostly small villages) from almost 3200, where home care service was not available (KSH 2007.). Disadvantages might be

higher than by statistical figures show up: the existent institutional service-models are too differentiated, in elements of them, it is more fit to urban than rural circumstances: better educated management and service-provider staff, larger sizes, higher number of costumers/service units, etc.

Inherited dominancy of residential care: as a legacy of the past, the dominant care sub-sector is residential care (in 2007. 47.700 elderly people lived in long term residential institution, and the number of home care recipients was nearly 49.000 (KSH 2007)). The running costs of large and old buildings is high, it is very tough to reduce the number of applicants (people are familiar with that form, and they do not claim new, innovative forms), and the number of inhabitants (to maintain the same business in same buildings with lower number of users would raise extremely the per capita costs, and would push down efficiency). This means also a slow and painful shift in composition of users: to replace "younger" and healthier inhabitants with frail, care-dependent costumers. These shifts may decline general living-standards in residential homes: instead of individually managed lives in homes more and more consumers are unable to arrange their lives on their own; the character is smoothly shifting toward "nursing home" chronic bed dominant hospital character.

Lack of harmonisation among branches, especially between health and social branches: Health care and social care are two independent branches in Hungary with independent management, institutional and financial frameworks. It is generally not an easy job to draw borderline between nursing and social care, but, it is even tougher job to design co-operation among health and social care-givers, care-giving organizations and institutions. During the past years reforms the relatively high number of active hospital beds had been reduced by changing the profile to chronic treatments - and the harmonization of activities and tasks of health and social residential institutions (in terms of regulations, service profiles, standards, etc.) started in 2008 but has not finished yet.

Serving poor people: it is also a tough problem, affecting both, targeting and service standardisation strategies, what about there are no clear policies. Maybe, that on the surface it is similar duty to insure basic needs for old and poor people, and for old and frail people – but below the surface any explicit decision would imply major shifts in every service-aspects. Social services, including long term care for elderly have still some sort of poverty-relief commitments that is still relevant from the side of needs, but still disturbing to govern services.

## 2. Major Attempts Reforming Care Sector

Hospital reforms: During the recent years reshaping of hospital structure took place by decreasing capacities of active nursing and increasing chronic medical care units .

Home-care and home-nursing developments: Government and EU funds support the development of outpatient forms of care, including not only the classical care, but also long-distance alarming systems and other technical equipments improving the security and protection of old persons, especially those are living alone.

Service specification and standardization: Ongoing legal and administrative system is still dominantly geared from input side: prescribe the eligibility criteria for users, the needed licence and permit criteria for providers, and registers the normative fees paid by government to licensed

public and NGO providers, by the number and composition of eligible costumers. Ongoing development programs aim at focusing to output and to outcome criteria – partly as a preparation of mixed service regimes. More intensive involvement of for-profit public sector would suppose adequate public authorities providing costumers protection and other forms of market-regulations and –controls – instead of the ongoing, purely public sector oriented regulative and controlling regime.

### 3. Political Concerns in the Context of Demographic Shifts

In shorter term there is no dramatic shortage of capacities: Since the ongoing caring regime mismatched the poverty-relief and the classical caring functions – on short term to clean and brush-up the existent capacities, easing them from poverty oriented functions, and strengthen their caring-nursing character and the co-operation among existent care-givers might reflect properly to social and demographic shifts.

Improving management and administration: According to the ongoing system the responsibility of organising social services belongs to almost 3200 independent municipalities. With special regards to rural, small villages, it is necessary to concentrate the resources onto micro-regional levels, where human and fiscal resources could be managed more efficiently. This means also to improve logistics (fewer time of care-givers spent on the road from each user to other), more efficient involvement of low-skilled, informal helpers (especially in domestic, household managing helps), and more efficient replacement of manpower by specially designed household equipments and even high-tech solutions (especially in the sphere of information-communication and long distance emergency alarms).

Public finance reforms: Currently all social services are financed by the state budget, completed by own resources of the institution as well as users fees. Pre-tests and micro-simulation of caring insurance systems provided doubtful results – therefore financial reforms have not been taken place until now. Public finance reforms plan different “fine-tunings”, partly trying to implement more production-incentive effects to state-financed service-providers, partly to involve more co-payments on the basis of private choices.

- *Which experiences does your country have in giving private providers opportunity to enter the market of care services for elderly, such as cleaning services and personal care? Can policy options such as free choice between public and private provider in the care sector create a more flexible and more efficient system?*

Private actors in care: mostly NGOs, and especially in central state financed sectors, like residential care. The formulised care-market – based on consumers’ choices and market demands - does not exist at the moment. Private market actors play some role in such publicly financed and purchased business, like “meals on wheels”, providing hot meals for people in need.

Private/public choice: The dominance of municipalities does not favour for the public/private choice. In most of small villages, and rural areas only one provider is available, which usually belongs to the local government. In larger cities choice can be possible, but the dominance of local governmental providers is prevent public choice. In this situation usually no room for public, or private-public competition that suppose some oversupply of capacities – in contrast of the existing shortages. Openly competitive regimes would lead towards a definitely unjust “creaming” effect in shortage situation: service providers would select the better off, healthier persons demanding services – and the “remedy” would not be served at all, or, exclusively by public organizations. That would not result a sector-neutral, normative competition. Meanwhile, it is true, that there is no realistic way to establish and maintaining enough public caring capacities – it would be necessary to open market based care business, as well. Doing so, it would be necessary to reshape the profile of public authorities: nowadays they govern a public (partially NGO) service-provider sector – but in a privatised system they would have only less and indirect influence to the locally-privately managed service organizations, they should focus on market-like forms of regulation and control, like: licensing, quality control, consumer-protection, direct and indirect subsidies (instead of public finance of services), etc.

- *What experiences – or future plans – does your country have with regard to innovative instruments encompassing the financing (total or partial) of the service provision via the users, e.g. vouchers or personal budgets?*

Payment of consumers for services: in the ongoing regime the typical form of individual contributions are mandatory co-payment tariffs, based on the amount of consumed services and the personal incomes. That means also the lack of patients' choice and power in the sense that they can get what they are legally entitled, and they must pay, what amounts are they legally committed for. Methods for limiting the public responsibilities by “individual earmarked budgets” (e.g. personal cash or vouchering, or virtual budgets), and allowing people needing more care to by more care – are not in operation. Principally, the information asymmetry might cause huge problems: frail, mentally disabled users are not fairly informed about supply and choices, meaning also, they are not in equal bargain position with providers – that might cause problems not only in the use of private money, but also in the accountability of public money earmarked for individuals in care-need. As a consequence, such methods seemed to be applicable partly in those caring sub-sectors where there might be established fair competition on the basis of market over-supply, partly in those, where the consumers might fully control the amount and the quality of services are provided, e. g. meals on wheels, etc. In these service-areas introduction of the use of vouchers, as individually calibrated, targeted forms of subsidies are planned in near future.

- *Does your country have any experiences with regard to better ensuring the quality of the services provided, and how to develop innovative methods? Where does the balance lie between future challenges in demographic and the maintenance of a high level of quality in the provision of social services, and notably of services for the elderly? Is the right to free choice for the user a way to improve quality in the provision of social services?*

No policies to use private choice and market as a form of quality control: “caring market” is seen in Hungary generally as a possibility to extend resources and capacities in caring sector characterised by shortages. This means also not to have conceptual strategies to change the basic machinery of the system by hosting market principles into the system of care – including not having market- and patient's choice-based policies to improve quality of care.

Quality assurance, quality management – as new orientation of welfare administration: quality related issues are regarded as challenges of public administration that must be managed basically by administrative and regulative reforms within public sector. Hungarian government policies emphasise developing standardization and quality management to improve the quality and efficiency of services. This implies certain innovative methods of public management, (like case- or care-management implemented by civil servants), but have no consequences to involve the control of users, especially, the control of users implemented by free choice. The controlling role of consumers is planned to be strengthened via satisfaction opinion-polls and other evaluating feed backs of users, applied by public authorities and service providers themselves.

- *Would moving from directly providing the services/financing the service providers to financing the service provision (totally or partially) via the financing of the users raise problems related to the service supply? In other terms, how it is ensured that the services will continue to be offered – at the same level of quality - when public authorities opt for instruments such as vouchers/personal budgets?*

Informal care in the focus: The experiences of other countries as well as projections based on Hungarian experiences make evident that there is no realistic opportunity for replacing free and volunteer caring contribution of family members, relatives or neighbourhood by paid care-work, because of the lack of resources. From this view-point the dominant question is how to integrate the non-paid informal care into the caring structure. Vouchers – as new positive method of allocation: Vouchers/personal budgets and care managements are basically tools for allocating the existing amount and quality of services. Even if personal choices might have minor roles to avoid wasted, not necessarily needed service inputs – this have no major influence on improving capacities of really needed services and clients most in need. The vouchers' implication to the distribution of services is still ambivalent: as a positive factor it rise and strengthen the patients' choices; might be shared and allocated on a better calibration, than the distribution of in-kind services, and might involve new, private resources if the individual market demands for services are higher than the value of legal entitlement-based amount of distributed vouchers. In contrast of that, the administration of vouchers is expensive (special printing, distribution, controlled use preventing secondary markets, cashing back the vouchers to licensed and contracted providers, etc.), and individual choices and competition might increase the social inequalities, since better educated and informed, better positioned users are in better bargaining position to exchange vouchers for more and better quality services. Summing up: vouchers might be very efficient converting tools to achieve better distributions of existing caring resources – especially, if the large number of disturbing and damaging effects can be protected and prevented by innovative, tricky and new administrative techniques.

- *In case vouchers/personal budgets do not cover the entirety of the costs for the service provision, how to ensure that the direct costs to be born by the user (i.e. not covered by the vouchers/personal budget) do not create an obstacle to service access? How to support the capacity of the most vulnerable to make informed choice?*

Obstacles of matching public and private money: Most of the people, including social professionals do not understand the principal difference between the two major forms of matching private and public money. In case of mandatory co-payment regimes (in Hungary this exists at the most of social services, the sum of co-payment depends on the client's income) public authorities own power to define the type and amount of services, as well as to define quality criteria of services purchased by them. In these regimes co-payments are mandatory

complementary measures – offering no power for choosing. In case of vouchers the real purchasing power is in the hand of consumer, who can apply vouchers on his/her own to buy services he/she wants to consume from the given supply of the set of services convertible to vouchers. This regime allows the consumers to buy extras of services, if the amount of vouchers is not satisfactory to buy the needed amount and quality of services. This open ended scheme seems to be very attractive by institutionalizing the limited scope and amount of public responsibilities in care, and the free choice of consumers; but, the inequality and exclusion risks can be higher than in case of “old regimes”. Of course, classical market-controls and consumer protective administrative supervision is unavoidably needed (even if such options do not exist at this moment), but their realistic perspective is not much better by easing exclusion and inequalities – than in other segments of markets.

Other hopes: personal budgets and case managers: If personal budgets are operated by highly educated and respected case/care managers by putting together “service-packages” from individual service pieces, and the role of managers is not exclusively to control the public budgets, but also to be an agent of persons in need to make fit the package to their needs – it could be an answer to avoid unintended inequalities. The only problem is that the elements of this “service-package” comes into existence from the choice of case-manager, not from the choice of the service recipients. This problem can pull back the advantages earned in “currency” of private and free choice and smooth matching of private-public money by implementing vouchering regimes.

- *What experiences does your country have with regard to the shared responsibility between the state and the local level?*

Problem of de-centralized service provision and centralized purchasing power: There is a conflict between local authorities responsible for providing good services and central states responsible for controlling budgets. The system is unfortunately characterised by a lack of resources as the central normative support only partly covers (about 60-70 per cent) the costs of the services. Thus local authorities have to use their own revenues, too. On the other hand local authorities don't have enough flexibility to find the optimal way of organising services because it is strongly determined by the law. With almost 3200 independent local authorities the fundamental reform of the social system is hardly manageable, as it is the subject of political power balance between central and local levels. From this view-point, designing new forms of distributions, new financial regimes are not simply professional innovations, but also new courts for political struggles. In the current Hungarian political and economic situation reforming the ongoing social service regime comes up against major difficulties. At the moment there is no chance for fundamental reforms, only for minor steps, that might help for smooth developments.