



Peer Review in Social Protection and Social Inclusion and Assessment in Social Inclusion

Denmark 2009

Peer Review: Combining choice, quality and equity in social services

Minutes



On behalf of the
European Commission
DG Employment, Social Affairs and Equal Opportunities



Peer Review: Combining choice, quality and equity in social services Copenhagen, 1 April 2009

The Peer Review was hosted by the Ministry of Social Welfare, Denmark.

Welcome and introductory remarks

Welcoming the participants, **Jesper Brask Fischer** (Ministry of Social Welfare, Denmark) said that Peer Reviews are at the core of European cooperation in the area of social policy. Member States with very different backgrounds can learn much from each other. As social services in general are such a broad topic, it had been decided that the Peer Review should focus more particularly on care for the elderly. This is probably the most important social policy area for Denmark, and it is suited to Peer Review both because Denmark has conducted a lot of experiments in this field and because it presents many challenges in all European countries. These include the demographic issue and the question of finance, as well as the legal problems created by the mixture of public and private providers. Another difficult question is the assignment of responsibility for elderly care. What should be expected of the elderly themselves, of their families, of the State and the public? Care for the elderly is a cross-border sector, with increasing cooperation between ministries in different countries. It is also a topic that attracts considerable media attention. He looked forward to the discussions.

Concetta Cultrera (European Commission, DG Employment, Social Affairs and Equal Opportunities) is Head of Sector of social services of general interest (SSGI) at the Commission. She said the Commission's annual report on social services shows that Denmark is one of the countries with the highest percentage of GDP spent on social sector benefits, particularly long-term care, childcare, social inclusion services and social housing. It is also the EU Member State with the largest share of workers in the health and social services sector. That share actually increased between 1995 and 2007, which is quite an exception compared to other Member States with a similar starting point. So Denmark is definitely a model for the delivery of social service provision, and thus the ideal host country for this Peer Review. The complex issues to be discussed are at the heart of the reforms on which Member States have embarked. User involvement and better choice are key features of that reform process. The Commission Report on SSGI of July 2008 showed a shift towards what it called "market-based regulation". There has also, in some cases, been a move from financing service providers to financing service users. Instruments such as personal budgets or vouchers are being increasingly used in Member States. This lends a new dimension to the task of combining choice, quality and equity in social services. So this Review would be tackling some difficult questions: Where should the balance be struck between the impetus towards a more rational use of resources, often dictated by budgetary constraints, and the maintenance of a high quality level? Does more choice necessarily mean better quality? What are the implications, in terms of administrative costs, of the increased use of instruments such as vouchers and personal budgets? In the interests of quality, what balance should be struck between financing services via the providers and via the users? How can we ensure that instruments such as vouchers do not become an obstacle to access? How can we support the capacity of the most vulnerable to make an informed choice?

Moreover, Concetta Cultera described the Commission strategy to support the quality of social services announced in the 2007 Communication. This strategy is gradually being put into place. A discussion on a new quality framework will begin in the coming months within the Social Policy Committee. This will be a voluntary framework and will definitely not set European standards. But it will concern the development of tools for the measurement and definition of quality. Moreover, eight transnational projects have been launched within the PROGRESS programme for the development of quality tools. These projects, which began in December 2008, will feed into the debate in the Social Protection Committee. Another PROGRESS-financed project is the establishment of a network of local observatories. Finally, the Commission will try to launch a training initiative for public authorities on the application of EU rules to social services. There is often a mistaken impression that the application of EU rules would lead to cheap, bad-quality services. EU law is absolutely neutral on the question of whether authorities should "make or buy" social services. Moreover, public authorities can set quality requirements when they decide to "buy" social services and have to apply public procurement procedures. The Commission wants to make this clear to local authorities and also to explain what their options are for the financing of social services.

Introduction to the Danish policy context

Kirsten Munk (Ministry of Social Welfare, Denmark) explained that the Danish care service system, which covers both elderly people and those with disabilities, is decentralised. The local authorities pay for the services, set the standards for assistance and decide how much help a person is entitled to, on the basis of need. Public services are at the heart of the Danish policy and the system is universal. Social services, benefits and pensions are tax-financed and are free to the user, regardless of income. Danes pay one of the world's highest income tax rates and expect public services to match. A structural reform of the framework for public services came into effect in January 2007. The State establishes the general framework, but the local authorities have the overall responsibility for social services. There is no prescribed minimum level of service. The municipalities cover tasks that imply direct involvement with citizens, and have therefore become the main access point to the public sector for citizens and companies. Five new regions are responsible for health care and regional development.

Anne Bækgaard (Ministry of Social Welfare, Denmark) looked at the principles underlying Denmark's care services for older people. They have different needs and resources, so the public service offer to them must be flexible. The Danish policy is that older people should receive help when they need it. Assessment also encompasses the needs of the person's family. The Consolidation Act on Social Service emphasises help for self-help, but the reality is that many people need considerably more assistance. Local authorities are also mandated to provide activities aimed at activating certain groups of people or preventing disease or disability, the idea being that elderly people should be looked upon as a resource.

The aims of home help are to enable people to stay in their own homes and to prevent a further deterioration in their physical and mental health. Local councils are required to set and publish the quality and price requirements for all providers of personal and practical assistance. The quality standards must also ensure that citizens know their rights in relation to the local authority. Local councils must set and monitor quality standards at least once a year. Local authorities used to be the only providers of home care for the elderly, but a law on "greater choice of provider" came into effect in January 2003. It lays down that, in the first instance, a choice must be

available between at least two providers. In reality, this meant that most municipalities decided to continue with public provision and bring private providers in at the same price. In this model every provider who can deliver at the same price as the public provider can be approved. The approval does not necessarily mean that they get any clients since it is the clients who choose which provider they want.

Surveys show that 85% of users are happy with the current service provision, whether public or private. The introduction of private providers has helped to develop a new focus on cost-effectiveness.

Kirsten Munk said that, under the reform, local authorities must allow qualified private companies into the care market. Older people have the right to change providers and to move to another municipality. The aim is to put the individual before the system. The “free choice” reform has led to greater transparency and a clear separation between authorities and providers. The Danish government has submitted a proposal for a quality reform in the old age care sector. This calls for even greater flexibility and an even stronger focus on individual needs. There will also be more emphasis on exchanges of experience and best practice between local authorities. A system enabling staff, users and relatives to report errors and unintended incidents in the care service will create better learning possibilities. Efforts are being made to build an accreditation model and quality indicators. One challenge is to safeguard citizens’ rights without diverting resources away from frontline personal care (“warm hands”) into bureaucracy (“cold hands”). Under the quality reform, recipients of home help services will be entitled to one permanent contact person. A quality fund has been established to improve the physical infrastructure and introduce new technology. Better use of technology (such as robot vacuum cleaners) will free up more “warm hands”. From 2010, quality contracts will replace the present local authority service strategies. Quality contracts are the local council’s contract with the citizen and must include clear and measurable objectives for each of the local authority service areas.

John England (Eurocities) asked if there is no consideration of cost in the Danish system. Basically not, **Anne Bækgaard** replied. And no personal contributions? Not for care, but rent is payable for residential accommodation. **Pedro Andrade Saraiva** (University of Coimbra, Portugal) asked about the size of the private providers. **Anne Bækgaard** said that, at present, they are mainly small (cleaning) companies, although a few large providers do exist. **Concetta Cultrera** wanted to know if the private providers are both for-profit and non-profit. Mainly for-profit, **Anne Bækgaard** replied, but alongside the existing public providers – so the private providers have to be cost-effective. **Andrea Tardiola** (Ministry of Labour, Italy) wondered who ultimately sets the standards. This is a political decision, **Anne Bækgaard** said. **Kirsten Munk** added that the local authority first sets the standards, then communicates them to the providers and monitors compliance. **Manuel Montero Rey** (Ministry of Education, Social Policy and Sport, Spain) asked about the cost of the reforms. **Anne Bækgaard** answered that the clear distinction between authority and provider has led to greater cost-consciousness. This helps to ensure that equal help is given for equal needs. **Luca del Vecchio** (Confindustria, Italy) asked how the services are financed. By block grants, **Anne Bækgaard** replied. **Laila Onu** (Foundation “Pentru Voi”, Romania) wondered if there are any abuses of the system. Needs are first assessed by visiting nurses, **Kirsten Munk** pointed out, so it is difficult to cheat. **John Halloran** (European Social Network) asked if local authorities provide services to each other. No, **Anne Bækgaard** said, they are not allowed to do so. **Nigel Meager** (Facilitator) asked how it can be ensured that there is enough of a market to provide real choice. The Danish experience, **Anne Bækgaard** replied, is that enough private providers have come forward in the cleaning sector. There is also a market in personal care, although this is taking longer to develop. **Jesper Brask Fischer** added

that the Danish discussion about stimulating the market has centred more on how the prices are set. **Eglė Radišauskienė** (Ministry of Social Security and Labour, Lithuania) asked if the budgets are earmarked. No, answered **Anne Bækgaard**. But most municipalities divide up their spending in roughly the same way.

Presentation of the discussion paper

Caroline Glendinning (Thematic Expert, University of York) first summarised an evaluation¹ of the individual budget (IB) pilot projects in England. The principle behind “direct payment” is that purchasing power is devolved from the local authority to the user, thus increasing transparency and making the user more sensitive to cost-effectiveness. This idea underlies the IB scheme piloted by 13 English local authorities in 2006-7. An IB can be used in any legal way to support the individual. It can take the form of a direct cash payment. Alternatively, a care manager can purchase services on the user’s behalf, or a provider account can be set up, or various other third party and trust arrangements can be used. Personal budgets are being extended to all English adult social care in 2008-11.

The evaluation found some evidence of cost-effectiveness with respect to social care outcomes, but less in relation to psychological well-being. There were significant variations among user groups. IBs were seen to be cost-effective for younger people and for those with physical or mental disabilities, but less so for older people. The IBs were used mainly for personal care from care agencies or personal assistants. Other uses included gardening, cleaning and decorating; daytime activities (culture, IT, gymnasium membership); and health-related services (massages and alternative therapies). Most IBs were taken as a direct cash payment (67%) or managed by a local authority care manager (20%). It was found that users became more discerning as a result of IBs. However, the scheme also created a number of workforce and financial issues for the providers. They faced demands for more flexibility, leading to more complex staff rotas. The loss of staff into private employment as personal assistants was another issue for the providers, as was the management of “risk” and difficult clients. Demand for new types of help could lead to a two-tier workforce, with some deskilling (for instance, some people used IB to pay for dog-walkers). Loss of bulk contracts and economies of scale was a further concern for the providers, together with higher administration costs and higher financial insecurity.

Turning to the current Peer Review, she suggested a number of **points for discussion**, based on the participants’ written reports:

- **Demographic challenges.**
 - Increasing efficiency.
 - Reducing need and/or demand.
 - Promoting independence and well-being (with choice as an important factor).
- **What kinds of choice are most important?**
 - Choice of provider?
 - Type of service?
 - Timing and content of service?

¹ C. Glendinning et al. (2008), *Evaluation of the Individual Budgets Pilot Programme: Final Report*. www.york.ac.uk/spru/pubs/1119.

- **Is choice a luxury? Is access more important? And what about “wrong” choices?**
- **Who is the purchaser?**
 - The State?
 - The local authority?
 - The individual?
- **Do markets really lower costs?**
 - Impact on the workforce.
 - Risks of market failure.
 - Role of the State in managing market risks.
- **Do markets increase inequity?**
 - Social capital.
 - Personal wealth.
 - Rural vs. urban inequalities.
- **How can both buyers and sellers access the information they need to make markets work properly?**
- **How can we prevent care markets from threatening integrated long-term care systems?**
- **Should there be a free choice of provider or should it be restricted to accredited providers?**
- **To safeguard quality, should we rely on the market or on State regulation/accreditation?**
- **As service quality depends on good care workers, what will be the impact of choice and markets on worker recruitment, retention and training?**
- **How should quality be measured?**
 - “User satisfaction”?
 - Quality standards built into contracts?

Pedro Andrade Saraiva asked how IBs are approved. **Caroline Glendinning** explained that the user first agrees a plan with the local authority care manager. This plan has to be approved, and is then periodically reviewed. The problem is that all kinds of changes can take place between reviews. But the monitoring is intended to be light. **Concetta Cultrera** wondered how, if people are spending their budgets on things like gardening, would then been met the care needs for which the individual budget had been allocated. In reply, **Caroline Glendinning** emphasised that people are free to make trade-offs between personal care and other services according to what is important to them. **John England** wondered about the role of local authorities in maintaining standards. **Caroline Glendinning** agreed that personal budgets do imply a change in that role. This is an issue that has not yet been fully worked through. **Gellért Ghyczy** (Ministry of Social Affairs and Labour, Hungary) suggested that separating direct costs from system operational costs, as in the USA, could be a useful exercise. He also wondered if there is not a lack of

symmetry between the bargaining positions of the educated carers and the sometimes low-educated users. **Caroline Glendinning** emphasised that the role of advocates is often not sufficiently discussed. People who have cognitive disabilities can indeed be put at a disadvantage. She accepted that, in a cash-based system, the risks of financial abuse are greater. **Sarah Mitchell** (County Hall, Isle of Wight, UK) pointed out that cases of abuse are by no means limited to the IB system. However, safeguarding procedures do exist, as do ways of ensuring that, for example, there is at least minimal cleaning of users' houses. **John Halloran** felt that cash payments also raise problems of accountability. Has England experimented with vouchers? Not really, **Caroline Glendinning** replied, except in the county of Kent, which introduced a card similar to a charge card. **Laimutė Žalimienė** (Vilnius University and Institute of Social Research, Lithuania) wondered how such a market could develop in countries where private providers do not exist. **Caroline Glendinning** set out the classic argument that, if people are given money, the market will respond. But the role of the local authorities in ensuring stability of provision is crucial. Asked by **Pedro Andrade Saraiva** why older people had benefited less from the IB pilots, **Caroline Glendinning** said they had been more likely to ask the local authority to manage their budgets for them. It might be that older people felt more threatened by the changes. **Sarah Mitchell** thought that staffing issues may also be involved here. Older people are less likely to want to become the employers of their assistants.

European NGO statements

John Halloran (European Social Network) said that some of the topics raised at this Peer Review would be picked up at the ESN annual conference which would, during the Czech EU presidency, focus on quality and performance in social services. This Peer Review was about a change of values in how people who need or use services are regarded. There is a move away from a standardised, institutionalised view of service provision towards something more personalised, more localised and more human in scale. People should make their own choices about their needs, but they must be informed choices. For example, new residential homes for old people in Belgium have around 250-260 beds. Assessment for entrance to those homes is done by social workers based in the homes themselves. In such circumstances, how informed can people's choice be? How does one choose between one 250-bedded home and another?

There is a need for individual packages of care. These might, for instance, include an element of home care and an element of residential care, together with some form of activity – cultural, sporting or whatever, which enables people to maximise their independence and potential. Even within one service setting, there can be choices – for instance, the choice of which professional will provide your support. Choice can be multi-layered. It is about more than simply choosing between provider A, B or C. If local authorities have a policy on service priorities, it must be communicated. People must understand, for example, that a local authority has opted to put resources into home care rather than providing open-ended choice, which is often uninformed choice. In Germany, local social service directors are constantly being telephoned by nursing home companies wishing to open more homes, because they say that is what people want. But the directors then find it difficult to point out that many people may not actually need residential care at that stage in their lives. So who is going to ensure that choice is real and informed? Who is going to develop new alternatives in the marketplace? And, in a market-based system, who is actually responsible for the quality of the service? Accreditation, he felt, is just the first step. There need to be other ways in which people are consulted and quality is monitored.

Personal budgets are a concept initially promoted by those directly concerned. People with disabilities in the Nordic countries, the Netherlands and the UK led this movement, which has shown real success in terms of empowerment. That is to be applauded and built upon. It may not work in every situation. People's needs vary. But it can stimulate innovation. He noted that, in the USA, many of the companies providing services to people with disabilities were set up by those people themselves. Standards can be levered up, but this requires a whole-systems approach, with monitoring of quality. Otherwise, just giving people money to purchase care can lead to problems, particularly where the market is not yet mature. There is a lot of unofficial, black market care in Europe, often involving an East-West trade. The Peer Review should also look at this issue, he suggested. If we are going to offer choice, we do need to ensure a certain level of liability protection. For example, schemes exist in some countries to provide training to unofficial carers and bring them into the official system.

Democratic accountability for the use of public funds is important. Inclusiveness must be built into the structure of local communities. The changes, however they are tackled by different countries, will require new skills. These will go beyond administrative skills. They will involve leadership, risk management and financial accounting, and they will be needed by administrators and providers but also by the users themselves. How can overall social policy and financial sustainability be reconciled with the need to equip users with the negotiating skills required to secure the individual care packages that they need?

For the future, we need to bring together our duty to promote choice and ensure the highest standards within a strategic commissioning and contracting framework led by local government but which brings together all stakeholders to ensure we have effective, affordable and sustainable social policy.

John England (Eurocities) recalled that, in dialogue with various Directorates-General in the European Commission, Eurocities has been involved in the issue of public services of general interest. Demographic change has been an important policy debate over the past five to six years, but the issue of ageing needs to be given a higher profile within that discussion. There is strong evidence that personalised approaches to social care are already well-established. More could be done to share experiences and good practices, and the Open Method of Coordination could contribute to this. However, the conditions and starting points for social service development differ considerably across Europe, so the conclusions of this Peer Review should not overemphasise the more mature service development that has taken place in Western Europe. A lot can be learned, for instance, from Romania's emphasis on NGOs and the voluntary and community sector. Without strengthening those sectors, the prospects for meeting long-term care needs in future are fairly bleak. In the UK and elsewhere, the policy emphasis is moving more and more towards encouraging local authorities to support and develop the third sector.

A whole range of services that local authorities provide, alongside their long-term care provision, will all ultimately contribute to meeting long-term care needs. Housing is one, as are the regeneration of communities and the health and well-being agenda. The role of local authorities, he suggested, is to bring these different strands together. Among Eurocities' member cities, there is interest in developing a broad consensus across Europe around the quality standards that should apply within long-term care. The network of observatories in five European cities will focus in part on developing quality standards and the exchange of good practice. Equality and diversity should be at the heart of our thinking on standards for long-term care. Most European cities have increasingly diverse communities, so we need to develop care sector providers who are able to meet the needs of those communities. Eurocities is involved in developing quality standards and

benchmarks around equality and diversity.

Peer country contributions

Estonia

Sirlis Somer-Kull (Ministry of Social Affairs, Estonia) said the responsibility for the provision of long-term care in Estonia has been divided between the healthcare and welfare systems. The healthcare system provides nursing care, assessment services and home nursing, while the social care system provides long-term institutional care, day centres, home care and housing services, other social services and care support benefit. Care services are organised and financed by local government. Co-payments are mainly applied within funded local care services, and are rare in the case of community services. But for home care or round-the-clock care, the recipients or their families can face quite high charges, amounting to 60% of the cost. On the other hand, nursing at home or in an institution is almost 100% covered by the health insurance fund. One current aim is to integrate these two very different structures. Care support benefit, received by about 33,000 people, provides some financial support for practical everyday needs ranging from transport to home help. It also helps to support informal carers, such as neighbours or relatives, who play an important role. However, the low level of the benefit means that it is really only symbolic. Responsiveness to clients' needs is being pursued at the local government level through assessments. Service providers may be a non-profit organisation, a business or a local community. More and more non-profit organisations are becoming involved. Business uptake is slower, due to low profitability. 75% of the care is still provided by local authorities. But some groups, such as those with learning difficulties and with special mental needs, are now mainly in private sector care.

In principle, people can choose a provider. In practice, however, they have little choice, due to cost considerations and the shortage of places. Use of home care services is still low in Estonia – proportionately ten times less than in Denmark. The caring responsibilities are still mainly taken on by family members. This affects their ability to be active on the labour market. One way of tackling this problem would be to reduce or abolish the co-payments for care. Various possibilities are being examined, including care insurance, but no decision has been taken yet. The promotion of home care, better use of technology and the reduction of bureaucracy are other priority aims.

Meelis Joost (Estonian Chamber of Disabled People) said the disability movement has been emphasising that there are currently too many municipalities in Estonia. There are 227 of them, and the smallest has just 94 inhabitants. This obviously affects their ability to provide quality services. Up to now, Estonians have tended not to anticipate their future care needs what concerns suitable housing and place of residence. This is likely to change in future. He explained that currently two-thirds of care costs are covered by local government, with the rest coming from other sources such as the NGO-s and Foundations working with care provision. For example, his organisation is involved in the provision of respite care for disabled children. Estonia is moving in the right direction on care provision, he thought, but the situation is still far from ideal.

Nigel Meager asked if there are any plans to reform Estonian local government. **Sirlis Somer-Kull** replied that the need to reduce the number of municipalities has been a hot topic ever since the 1990s. But there are political issues and nothing has been decided so far. **Jørgen Witsø-Lund** (Ministry for Social Welfare, Denmark) recalled that, until 1970, Denmark had 1,000 municipalities. After that, there were 275, and now there are 98.

Hungary

Hungary has some 3,000 municipalities, **Balázs Krémer** pointed out. This is to some extent a reaction to over-centralisation under the previous regime. However, there is a growing realisation that the municipalities are not big enough to provide efficient, professional public services. He suggested that there is a tendency, at European and international events of this kind, to avoid talking about problems. This Peer Review, for example, had been looking at such questions as personal budgets. But these are gadgets or tactics. They are not the core issues of social service policy. There are two fundamental problems. One is that current social care systems provide a rather inadequate set of services. The other is that, if needs and the proportion of older people grow as projected, it will be impossible to keep care budgets under control. The real issue is how to help people to live an autonomous life, rather than a “normal” one. Choice is not so much market-oriented as empowerment-oriented. We need to analyse the conflicts among the various shareholders within the social services. The private and the public providers, the local and central administrators, the people who are eligible to receive the services, and the people who are in difficulty but are not eligible – all of these groups have different interests. Social policy is often formulated to satisfy interest groups and this makes it very difficult to follow, even for professionals. Policy often focuses on financial techniques. Such techniques may have positive results for some stakeholders but not for others. So analysis of the outcomes of financial techniques would be very useful, including at the European level.

How can social inequalities be reflected in care systems? Informal care and social deprivation are closely related issues. Services tend to be accessed by middle-class, urban people and to reflect their values. In rural areas, service provision may be more a matter of personal trust. Over-professionalisation of care services may in fact perpetuate social inequalities, as only those with sufficient education and bargaining skills will be able to cope with the complexities of the system.

We should focus more on the opportunities presented by new technology. For instance, Hungary has introduced a long-distance alarm system, especially in rural areas. People can wear a bracelet or necklace with a button that they can push to summon help if needed. In the long term, this can reduce the need for care, simply by providing reassurance to people who might otherwise be afraid to live alone. It enables people to remain independent and live their own lives. The system costs around €100 per user.

Nigel Meager pointed out that the Peer Reviews are, quite explicitly, forums for open discussion of what doesn't work as well as what does. They are not about good practice alone.

Italy

Andrea Tardiola (Ministry of Labour, Italy) said Italy has 21 regions and more than 8,000 municipalities. These numbers help to explain the difficulty of building a new model of governance, even though that is a current legislative aim. Care services are provided mainly at the local and regional levels. While this is an over-simplification, he would, for the purposes of his presentation, divide Italy into two parts. One is the North and Centre, where social services are characterised by high staffing levels in the public sector, high quality standards, and assessment of user satisfaction. In this part of the country, choice is not a luxury but is at the heart of the governance of the regional systems. But in the other part of Italy, choice is indeed a luxury, because basic access to services is not guaranteed for older people. Instead, there is a wider informal care system provided by families, or by care-givers who are usually immigrant women.

A major aim of Italy's current federal reforms is to guarantee basic service access where it is currently lacking. To that end, a national fund is being used to co-finance regional and municipal service provision. The intention is to ensure, in each region and municipality, a unique point of access to services, while promoting multidimensional assessment of people's needs. This is on the basis of the international classification adopted by the World Health Organisation. Another aim is to completely devolve health, social and transportation services, while setting national standards for needs and costs. The financing of the new system will be based on local taxes, national grants and a special fund to assist areas that have major gaps in their infrastructure.

Nigel Meager asked how far the private sector is involved in care provision in Italy. **Andrea Tardiola** replied that it is an important sector – but it shows the same geographical variations as the public services. In the North, transactions between the private and public sectors are based on high quality standards, while elsewhere the main criterion is the cheapest offer. So the aim of setting national standards is also to raise quality in the private sector. **Concetta Cultrera** asked about the role of non-profit providers. **Andrea Tardiola** explained that they are strongest in the care sector, while profit-making providers predominate in the health system. Italy has a long tradition of volunteer social care. **Concetta Cultrera** asked if the legislation limits any areas of care to non-profit providers. There are no legislative provisions on this, **Andrea Tardiola** replied. **John England** enquired about Italy's experience with multidimensional assessment tools to measure quality and access. **Andrea Tardiola** said the idea is that the national standards will be the main tool for guaranteeing equality of access. The problem is how to combine the devolution of power to the local level with a commitment to levelling standards up. The experience of this already gained in the health services is now being applied to the social field. **Gellért Ghyczy** suggested that a system based on local taxation can in fact lead to wider variation in standards. Federal grants can compensate for this to some extent, but they tend to be tied to standards, rather than to people's needs. Block grants are also sometimes earmarked for the most expensive services. In Hungary, block grants are used to give support to the residential institutions, as they are very expensive, but this helps to maintain the dominance of those institutions, as they have access to safe money. So a comparison of how different countries go about matching the various sources of finance could be a useful exercise.

Laila Onu said that, in Romania, only non-profit NGOs can be accredited as private service providers. If for-profit providers are allowed into a system, she wondered if they should be allowed to fundraise in the same way as NGOs do. **Concetta Cultrera** felt that the decision about whether to let for-profit actors into the provision of social services is a political one that each society must make for itself. **Sarah Mitchell** commented that England does have a mixed system. This poses a challenge, because the relationships are different. A local negotiator has to strike the right balance between the charge to the individual and the profit margin for local service providers. It is the role of local and national government to ensure that people are not exploited. **Caroline Glendinning** asked how effective the Italian market mechanisms, such as vouchers, have been in stimulating service provision. **Andrea Tardiola** replied that the main experiences with this have been in Lombardy, which is one of Italy's richest regions. The Lombard government has set certain standards for public or private provision, but otherwise anybody can come in as a provider. The vouchers are accepted by multidimensional staff who can formulate a personalised programme for the person concerned. The person can then choose a suitable provider.

Lithuania

Eglė Radišauskienė recalled that in 2006, Lithuania brought in a revised Law on Social Services which clearly distributed the responsibilities between the ministry, the counties and the municipalities. The 60 municipalities are mainly responsible for organising services. Among the counties' responsibilities are caring for those with mental disabilities and for children deprived of parental care. The ministry is responsible for the formulation of social service policy and enacting legislation. Changes in the Lithuanian social service system began in 2002, but the new financing model was not implemented until 2007. It is based on three sources: special state subsidies, municipal budgets and payments by users. Personal payments are levied according to income and also, in the case of long-term care, according to assets. The social workers evaluate the needs of each user and of the user's family, everything depends on the kind of services and on the social services; receiver. Both private and public providers are permitted. However, the public sector predominates. Only legal entities can provide services. Individuals are not accepted as providers. Quality standards exist for social care, but not for other services. Services of general interest and social attendance are controlled by the municipalities. Social care is controlled by the Social Service Monitoring Department. In Lithuania, choice means a choice of provider. The care is provided according to the established social care provision plan, over which practically the user has no influence though it is established according to the needs of the user. Residential care is usually the first preference in Lithuania.

Laimutė Žalimienė added that it is not yet clear how the new system will develop in future. A strongly formalised quality assurance system is likely to have both positive and negative implications for service providers. On the plus side, the standards will increase trust among the actors in the services market. On the other hand, quality assurance entails additional administrative costs which will ultimately be passed on to the client. Another drawback is the potentially negative impact on small service providers, notably the NGOs. Unless they receive external support from the State or the municipalities, they will not have the capacity to implement quality assurance. So Lithuania is now faced with a choice between a more formalised standards system, as in the UK, or a freer system, as in Denmark.

John Halloran wondered about the preference for residential care. Are there waiting lists for residential care, and what alternatives are presented to people? **Eglė Radišauskienė** was not sure about the reasons for this preference. Home care, short-term care and social care are available. Some older people are looked after by their families. But those who are on their own generally do not own property, and so they want to go into institutions. **Gellért Ghyczy** felt that people tend to opt for what they know. In Hungary, people are aware that residential care is far from perfect, but it is seen as a way around everyday problems. He wondered whether it might be possible to evaluate quality in terms of outcomes rather than inputs. That would no doubt be more difficult and more expensive, but also much more relevant. **Eglė Radišauskienė** replied that Lithuania's standards do measure outcomes. But these standards are new, and their practicability remains to be seen.

The Netherlands

Dirk Beekman (Ministry of Social Affairs and Employment, Netherlands) said his country has created a very large market for social services, both in the care sector and in social security. This has been a process of trial and error, from which we can draw a number of important lessons. The first lesson to be drawn from the Dutch experience with combining choice, quality and equity

in social services is that they should be affordable, but of a quality that is acceptable to the majority of people. This means having a clear idea of what one wants to pay for. The purpose of social services may be to improve social well-being or to meet certain people's needs. But it may also be seen as compensation for the loss of skills or health. Any country wanting to revise its system needs to keep those elements in mind. Choice means markets, but sometimes markets work and sometimes they don't. That will depend on cultural factors, the way a country is organised and the finance available. Choices can be created only if there is a plurality of suppliers, be they public or private. There must also be a choice available between services and goods, such as technical aids. Technological developments will open up many new possibilities in the coming years. The market can help here, because it is very good at developing products. For example: in the past there were only a few types of wheelchairs available and many more types of bicycles. Give people more choice and you see a whole range of customized wheelchairs being developed.

In the Dutch experience, quite a few social services can be performed in a market-oriented, profitable way. For instance, a centre for the treatment of back complaints may be of interest to the elderly, but also to the health insurance and to the employer who has a sick employee. This is an example of how a normal market-based organisation can function well within the social service system. A country that wishes to open up its social services to the private sector should first analyse what goods and services the social system is providing. Then, a sketch can be made of the things that the market might possibly do well. Some services should then be selected, the necessary legislation should be put through, and the whole thing should be given time to work. The Dutch experience learns us that it make take several years before a system starts to work properly, so resist the urge to changes your system when things do not seem to work right away. The market should be given a chance to find its own solutions to the problems that will inevitably arise. It should also be remembered that the market may work for 80% of people but not the other 20%. The objective is equity, not equality. The system should make special provision for people who are unable to look after themselves. On that basis, he thought that it is possible to build a system that combines choice, quality and equity.

Regarding the Danish policy under review, he praised the idea of centralising most of the activities within the municipalities. This means that people know where to go in case of need. It also assigns clear political responsibility for social services. But he felt that market forces are not really up to strength in the Danish system. It lacks a level playing field, as the very powerful municipalities prefer to do things themselves. They may regard the market as an intruder. This attitude needs to change. Otherwise, the market will not be given the chances that it needs. The Danish municipalities appear to be predominantly supply-side, he contended. They have a multiplicity of services which they go out and offer to people. In the long run, this will make the Danish system unaffordable. There needs to be more choice and more personal contributions.

Anne Bækgaard (Ministry for Social Welfare, Denmark) agreed that Danes pay a lot of taxes. That is why the opening of the market to private providers has been quite controversial. There has been a history of the municipalities providing the services. The Danish system is not a traditional market, because it is not based on the cheapest offer. The municipalities can use two models to secure free choice – either after a tender procedure to enter into contracts or via governing approval of any qualified supplier. The aim is to provide people with a choice between high-quality services. Regarding technology, she pointed out that it can be used not only to help people who already need it, but also to postpone the time when people will need help. **Maj Vingum Jensen** (Dane Age Association) said the Danish system is indeed supply-side oriented, but this does not necessarily mean that the consumer is empowered. Rational choice implies full

access to information. But precisely those people who need care may have particular difficulty in making the right choices. **Dirk Beekman** fully agreed that account must be taken of different people's position of strength or weakness on the market. Nonetheless, he felt that the Danish system is quite encompassing and is tending to grow. This is something that may be hard to afford at a time when the number of elderly people using the system is rising. **Maj Vingum Jensen** accepted that this is a huge challenge. But in the freest market for social services, the US, service costs as a proportion of GDP are rising faster than in any other country. This, she felt, is due to the information gap and the complexity of the market. US costs for administration, marketing and PR have exploded. So we should not assume that more market means cheaper care. **Dirk Beekman** agreed that markets do not solve all problems. However, a market does at least mean that costs can be compared. If all care is in the public sector, there is no benchmark.

John Halloran asked how the Dutch social market will look in ten years' time. Will there be increased use of home care? Or is it anticipated that the incentives in the system will work to maintain cost control? **Dirk Beekman** replied that the costs are rising but are not out of control. This is different from the way things were in the past, so the government is quite content. The social services have not been evolving in one single direction, and not all of the market developments have been positive. For instance, a number of home care providers have grouped together into big market-like organisations, which also suffer from the risks market oriented organisations run: losses on real estate or other risky investments. So there is now a move back away from the pure market thinking of five or six years ago. At first, the municipalities and social insurers were required to use market partners. Now, they are once again allowed to "make it themselves" if they so wish. Efforts now are directed towards finding a middle way between the market and public services. That would be the best result of the policies undertaken in recent years. The important thing is to keep the options open. **Theo Veerman** (AStri Research and Consultancy Group, Netherlands) pointed out that, when the Dutch talk of the privatisation of social services, they mean more than services for the elderly. The occupational health service, the administration of the sickness benefit system, part of the disability pension scheme and reintegration into work have all been privatised. But he agreed that, in recent years, Dutch authorities have to some extent gone back from "buying" to "making".

Nigel Meager recalled that, when the integration of social assistance recipients into the labour market was decentralised to the Dutch municipalities, a strong financial incentive to the municipalities was built into the system. They were given a budget but, if they managed to do the job more cheaply, they were allowed to use that money for other purposes. Does this incentivisation also apply to social care for the elderly? **Dirk Beekman** said it was difficult to answer this question, as there are multiple streams of funding coming into the municipalities. But in any case, the effect is the same. Long-term care is gradually being moved from an insurance-like organisation to the municipalities. As a result, the municipalities are tending to contract various services out to smaller private organisations. Some of these are quite successful in the care sector. Neighbourhood-based organisations have been started up by former home workers. This is a new development, and its longer-term prospects cannot yet be assessed, but it is an alternative to the big private care organisations that have also emerged. **Nigel Meager** asked if the Dutch have also found that care schemes tend to work better in the big, urban municipalities than in the smaller rural ones. **Dirk Beekman** replied that the smaller municipalities join together for the provision of such services. But in any case, Dutch municipalities are no longer very small. And the smaller communities can often operate more efficiently, especially if they pool their resources and join together when buying in services.

Portugal

Pedro Andrade said non-profit private organisations have always played the major role in Portuguese social service provision. They receive public funding based on the number of people to whom they provide the services. There are also a number of for-profit private organisations, but these have not so far been eligible for public funding. The non-profit organisations account for some 80% of the provision. They are locally based initiatives. This may explain why in Portugal, unlike other countries, the local authorities have no significant role in the management of the system. There is the Institute for Social Security, which has 18 branches in the main conurbations. So the size of the municipalities (of which there are 308 – a huge number per capita) is not a significant issue for the Portuguese care system. A possibility of choice of service providers is generally available in the cities, but not in the rural areas. The aim is a type of constrained market in which choice is available, but only among suppliers that meet certain criteria. An inspectorate ensures that those requirements are met. At present, the funding goes directly to the provider. The possibility is now being examined of channelling at least part of the money to the user, but only for payments to an accredited provider. **Maria da Luz Claro** (Institute for Social Security, Portugal) added that the user funding could be organised in an indirect way, via those commissioning the care. **Pedro Andrade Saraiva** said there will also be regulation of marketing and promotion.

He welcomed the moves by the European Commission to build a generic quality framework for care. That has been precisely the Portuguese approach in recent years. It now has an integrated quality model for the most of social services. This was developed by the Portuguese Institute for Social Security, with the involvement of many experts and providers. There are now eight versions of the model, according to the service concerned. Alongside the quality model, there is a key processes management handbook which describes in simple terms the steps needed to reach a certain quality level. A third component is the stakeholder satisfaction survey template. This can be used to measure user satisfaction in a standardised way, regardless of whether the provider is for-profit or non-profit. The template was inspired both by the ISO 9001 standard and the EFQM Excellence Model. The Portuguese instruments deal with leadership strategy and planning, human resource management, partnerships and resources, management of key processes. There are also four output-related criteria: customer results, people results, society results and key performance results. Use of the quality model will be on top of the regulatory requirements which have to be met in order to operate at all. Quality evaluation will be on a three-level scale (A,B and C in descending order). Level C represents the minimum acceptable performance for the receipt of public funding. A and B indicate above-standard quality. For instance, in care for the elderly, achieving level C entails fulfilling a 270-point checklist. B requires an additional 83 activities, and an A grading involves a further 33 requisites. Some 8,000 organisations currently provide social services in Portugal. Whether private or public, they have all been invited to apply these quality management models. They will then be audited by accredited private certification bodies. The first certifications under the new framework are expected to be awarded after June 2010. While it is obviously too early to judge the scheme, expectations are high that it will enable Portugal to combine choice, quality and equity in its social services. **Maria da Luz Claro** explained that, under the quality model, there will be a follow-up audit every year. While the development of the model is important, equal attention has been paid to helping people to implement it. The process manual explains how to conduct the activities. It sets out processes such as mission implementation, individual development, planning and monitoring, social and cultural activities, personal and health care, nutrition, instrumental support and psychosocial support.

Caroline Glendinning asked what impact the quality model is expected to have on providers. Will public funding be available where necessary to help providers meet the standards? Will some go out of business because they cannot afford to meet them? **Pedro Andrade Saraiva** replied that it is too soon to know, but the level C standards are not too difficult to meet. Anyone who cannot achieve them really does not deserve public funding. Providers can take their time to reach levels B or A, although they may be keener to do so in areas where competition is stronger. **Gellért Ghyczy** wondered if this process might not lead to providers' spending large amounts of time on paperwork, and therefore less time on care. But **Pedro Andrade Saraiva** felt that the process really will not take up much time. Particularly at level C, it consists mainly of things that ought to be done in any case. This is self-assessment. It will simply be audited, and the results will be collated in a database. **Maria da Luz Claro** said the providers did at first suspect that this would mean more bureaucracy, but having tried out the scheme, they now see it as a useful, practical tool, especially as the processes have been well defined and the forms are questionnaires. **Pedro Andrade Saraiva** pointed out that the templates can actually save the providers' time, as they do not need to devise user satisfaction surveys of their own. **Sarah Mitchell** said that England regulates and inspects regularly. Providers are expected to keep up to standard. Recent events in England have shown even where all the boxes have been ticked, abuse can happen. Quality indicators are important, but it does not mean that nothing can go wrong tomorrow. This is a major challenge.

Romania

The key word in Romanian social care today is "struggling", **Laila Onu** said. The country is struggling to build up a system from nothing. Twenty years ago, there were no social services and no professionals were graduating because, in the late 1970s, universities teaching social work and psychology were closed down all over the country. Residential care was the only possibility offered to people by the State under the previous system. She would not comment on the quality of that care, as it had already received substantial media coverage. Romania is an impoverished country with few resources, so the aim now is to provide people with social services by any means possible, including the market. Since the year 2000, there has been a legislative framework for this. There is a system of accreditation. Only NGOs and local authorities can be care providers in Romania – not for-profit organisations. Accreditation entails meeting certain requirements. In addition, there is a system of quality standards. Specific standards are approved by different ministries for different types of services. For instance, in care for people with disabilities, there are four sets of standards – for daycare, protected housing, home care and respite care. For elderly people, there are two sets – for home care and residential care. The recently created Social Inspectorate has the task of ensuring that accredited providers respect the quality standards. This system has been operating for two years now, and one complaint already emerging is that the Social Inspectorate looks only at papers and not at people. The inspectors check off how many bathrooms there are, but they do not ask the users if they are happy with the services. The Romanian legislation on social care is beautiful, partly thanks to pressure from the EU during the accession phase. But the reality is rather less pretty. The legislation does allow for competition between the private and public sectors, and it provides various mechanisms for public financing of service provision by NGOs. But in reality, most services are provided by local authorities. Sometimes, the NGOs tap into other sources of finance – either EU grants or money from international donors. But now that the donors have become less interested in Romania, there is more pressure on local authorities to finance the NGOs' work.

Meelis Joost asked if the gap between the accreditation standards and realities on the ground

could actually make it impossible to provide services in Romania. **Laila Onu** agreed that the standards are very high, and this does pose challenges. Some of the old residential care for elderly people is continuing to operate even though it does not meet the standards, because otherwise people would have nowhere to go. **Gellért Ghyczy** felt this was a problem for all of the newer EU Member States. Regulation that is unrealistic simply brings the law into disrepute, as well as putting prices up. Deregulation might be a way of dynamising services in these countries, but there are also risks in this – notably as regards labour standards. But over-regulation puts services beyond the reach of all but the well-off. **John England** disagreed. In the UK, there is strong evidence that regulation has improved services for everyone, not just those who can afford to pay. The recent introduction of regulation in home care, for example, has managed to rid the system of those providers who were only in it for profit and were not really interested in the quality of care. The UK is waking up to the fact that vulnerable people are at risk of being financially or physically abused, either in care or in other settings, and that great vigilance is required. So the case for purposeful regulation is well made. **Gellért Ghyczy** accepted that some regulation is necessary. But in Hungarian villages, there are often no professionals available. There are people who can and do provide some care, but over-regulation means that they have to cheat in order to do so, and this also opens the door to overcharging.

Spain

Manuel Montero Rey (Ministry of Education, Social Policy and Sport, Spain) pointed out that, at 20.9% in 2006, Spain's social expenditure as a percentage of GDP was significantly below the EU average of 26.9%. Old age and survivor benefits in Spain accounted for 8.4% of GDP. Reforms of the public pension system must continue. Public finances will be under great pressure, as spending is expected to increase from 8.6% of GDP in 2004 to 15.7% in 2050. The mandatory pension system is financed by social contributions from workers and employers. There are also voluntary private pension plans covering nearly 9.8 million people. The social security system has recently been reformed through several legislative initiatives, including longer minimum periods of contribution, tougher requirements for early retirement, controls to avoid fraud in incapacity protection, changes to death and survival benefits and new incentives to extend working lives. Minimum contributory pensions represent 27% of the total. Non-contributory pensions cover 11.4% of pensioners. The National Health System is a mix of central government and regional government services. The Ministry of Health monitors and ensures the equity of the system all over Spain. It is a tax-funded system, free at the point of access. Private voluntary supplementary medical insurance covers 4.7% of the population.

Traditionally, the family was involved in the provision of long-term care, but socio-demographic changes are making this an ever more pressing concern for the authorities. So various laws have extended the range of services in this area. They now include primary health care at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers. A new law approved December 2006 represents a revolution in the Spanish social system, as it enshrines a new citizens' right to the promotion of personal autonomy and care for dependent persons. The dependency care benefits may be in the form of services (prevention of situations of dependency, personal alert systems, home help, day and night centres or residential care) or they may be financial (to pay for services, care in the family or personal assistance). The law recognises three degrees of dependency: moderate, severe and major. The Autonomy and Dependency Care System (SAAD) guarantees, all over Spain, the basic conditions and common content to which the law refers. The levels of protection in the system are: the minimum level established by the Central State Administration; the level agreed

between the Central State and each Autonomous Community (agreements on this were signed with most Autonomous Communities in 2008); and any additional level established by each Autonomous Community. Local authorities are to participate in the management of care services for dependent persons in accordance with the regulations of their respective Autonomous Communities. The division of responsibilities between the local authorities and the Autonomous Communities is not well defined, and this gives rise to conflicts. It remains to be seen how this structure will evolve. Informal care is provided mainly by families or by undocumented immigrant women. There is potential for regular employment creation here, as the informal care market is a very large one in Spain.

Pedro Andrade Saraiva asked if social services differ significantly across Spain, in line with the priorities set by each Autonomous Community. **Manuel Montero Rey** replied that only a minimum level of care is defined centrally. Anything above that level is a matter for the Autonomous Communities. So there are big regional differences. **Caroline Glendinning** wondered if the new law has led to the creation of new services in Spain. Or is the funding being used more to support informal care by families and immigrants? **Manuel Montero Rey** said the new law aims to establish a system under which informal carers, by agreement with the social security authorities, would be brought into the formal labour market. It also sets professional criteria for these carers and provides for training and support. **Jørgen Witsø-Lund** asked if Spain has any appeals board that can ensure convergence between the regional or local authorities. **Manuel Montero Rey** confirmed that it does.

United Kingdom

The UK speakers concentrated on the situation in England. Separate care systems exist in Scotland, Wales and Northern Ireland. **Anne McDonald** (Local Government Association, UK) recalled that British social services originated in the poverty relief provisions of the nineteenth century. So they are a safety net which has had other things added to it over the years. When the British welfare state was established in 1948, social services were not part of it. This means that the personal budgets are available only to those who are needy or poor enough to come within the public funding system. A large number of older people, and some people with disabilities, fall outside the publicly funded system. This creates some very strange incentives. The priorities are different in each local authority, of which there are 150 in England. Local delivery also varies, according to whether the area is rural or urban. And the funding system means that different authorities have different amounts of money to spend on social services. As well as personal, individual services, they have developed more community-based services concerning technology, home adaptations and equipment, active lifestyles, independent living, and the avoidance of falls and hospital admissions. Both users and carers are involved in developing improved services and acting as advocates.

In terms of equity, one of the ideas behind personal budgets was that they would give people within the publicly funded system the same responsibility and control over their own care as those who were paying with their own money. But in fact, inspections have shown that people using the public service have often been receiving much higher quality than those buying services with their own money. So improving the system entails helping everybody with information, advocacy and advice. Greater transparency about how money is spent and care is delivered has helped to increase equity. The availability of a personal budget that can be spent on a care package designed by the user has encouraged people from ethnic minorities to use the public services. The only way to make the system equitable is to develop advocacy and support for those who are least able to make their own decisions. Local authorities see themselves as having a role in

ensuring quality and safeguarding the whole population, not only those whose care is publicly funded. England is looking to reform its funding system for social care and support over the next five years, as the present system is regarded as unfair and unsustainable. The treatment of family carers is currently very inconsistent and she felt that not enough thought has been given to their role in a future reformed system.

Sarah Mitchell said that, like the Netherlands, England Has had many cycles of reform. Under the current system, England spends a huge amount on a relatively small proportion of the population. The politics of care can vary considerably from one local authority to another. On the Isle of Wight, there had been a wish to do something for older people who were asset-rich but cash-poor. A lot of older people on the island had been going into expensive residential care. Nobody, she believed, really wants to go into residential care. They do so because they or their families feel unable to manage the risk. If there were sufficient community care services, people would be safer and happier. So the Isle of Wight introduced a scheme under which everybody aged over 80 would get free home care. This raised a few eyebrows, as other local authorities were saying that they did not have enough money to fund free care. But the Isle of Wight scheme offered advice at the initial point of contact, so that the local home care service was also turned into a rehabilitation service. The result was a 44% reduction in residential care placement by the local authority within one year. This was achieved both by reducing new admissions and by offering people the option of coming back out of residential care. In England many people have to sell their houses to pay for their residential care. When the free home care service was launched, many older people wrote in to say "I can afford to pay, but thank you for the offer, which makes me feel much better about being an older person in the community."

Social care in England has become very bureaucratised, she said. The risk is that personal budgets will become similarly bureaucratic. Avoiding that is a real challenge.

Dirk Beekman asked how the Isle of Wight pays for free care. Is it an exceptionally rich island? **Sarah Mitchell** denied this. The average income on the Isle of Wight is £18,000 a year (about €20,000 in April 2009), which is lower than in other parts of Southern England. Cost avoidance, through the reduction of residential care placements, was an important element in the financing of the scheme. The first year's reduction of 44% was followed by a further 20% cut in placements the next year. Efforts to improve health and fitness among older people on the island have also contributed. As the Isle of Wight does not have land borders with other counties, there was no movement of older people into the island to take advantage of the scheme. At the age of eighty, people do not get on a ferry to move house. So not all elements of the Isle of Wight experience might be transferable, but the substance probably would be. **John England** said the English city of Leeds had implemented a rehabilitation service and had experienced a similar reduction in people going into residential care. **Meelis Joost** wondered about the impact on the residential care providers. Did they just close down? Some of them did, **Sarah Mitchell** replied. But the Isle of Wight still needs good-quality residential care for people with dementia, as well as respite and intermediate accommodation for people who otherwise live in their own homes. The good providers have responded well to this, developing new services. That is a positive result. **John England** pointed out that the system in Scotland which provides free home care services has led to rationing of care in some areas.

Relevance and key learning elements for peer countries

Caroline Glendinning summed up the discussions under four main headings:

- **Choice.** This topic had been central to the discussions. However, it must be remembered that for some Member States, or parts of those states, choice is still a luxury. They face basic issues about ensuring an adequate, or even a minimal, level of provision nationwide. While some countries have a strong municipal tradition, in others NGOs have always played a major role in providing services. So the starting points are different. In some countries, provision has always been a mixed economy. We need to be clear about our goals. Why are we investing in choice? Three reasons might be advanced:
 - *Cutting costs.* But during the discussions, she had heard no conclusive evidence that choice and competition do lead to cost reduction. And indeed, the example from the Isle of Wight had shown that costs can be reduced in other ways – by deliberately shifting expenditure and getting better value out of the service system.
 - *Improving quality.*
 - *Creating greater diversity of provision.* For some countries, this is undoubtedly both an objective and an outcome of choice. But the funding has to be there to enable diverse services to develop. Both the native populations of EU countries and their ethnic minorities are ageing. So in future, provision will need to be made for an increasingly diverse elderly population.
- **Regulation.** The creation and development of regulatory systems has been prompted mainly by the emergence of private provision. However, regulation is also essential for the protection of vulnerable people in state-provided services. There is a balance to be struck, as over-regulation can result in very high costs and in providers' going out of business. That in turn can pose problems of coverage and of access to basic services. The discussion had focussed on top-down regulatory systems, but not much had been said about bottom-up processes. Citizens themselves can contribute to regulation and quality assurance. The Danish complaints system is an example of such a process.
- **The relationships between central and local government.** This is a big challenge for Member States. The discussion had taken for granted that social services are organised and financed by local government. But is this the right level? Reforms of social service provision often entail redefining and clarifying the relations between nation states, regions and municipalities. If we do assume that local government is the correct level for the provision of social services, then we need to ensure that they are appropriately resourced. Equalisation grants from central to local government, such as are found in some EU countries, are essential. They should go in particular to the smallest and poorest municipalities, rather than targeting block grants at the most expensive services.
- **The relationships and boundaries between public and private provision.** Care is a complex issue. Most care takes place in the very private world of families. However, the discussion had also concerned the boundaries between public and private outside provision, and particularly the for-profit sector. Quite a lot had been said about the municipalities' role in gate-keeping access to the for-profit sector. Municipalities can prevent resources from going into private providers purely for profit. In Portugal, for example, public funding cannot go to for-profit providers. So we need to think about the role of local government in directing public resources into private profit. This is a new dimension of the public-private divide. Not much had been said about individual users

purchasing services directly. Only gradually are mechanisms being developed that will fund individuals to buy in the services and support they need, rather than funding the services directly. The use of cash payments to individuals to fund care is a huge issue. It has a gender dimension, because it will be mainly women who are funded through such cash mechanisms. In Japan, for example, a deliberate decision was made not to offer long-term care support in the form of a cash allowance, because it was recognised that this would institutionalise the low-paid, oppressive care that was traditionally expected of daughters-in-law. So Japan took a very clear decision that care benefits would be provided in the form of services.

Anne McDonald felt that the linking of regulation to the issue of private sector provision was a little simplistic. For example, the UK had quite extensive regulation of its National Health Service. **Gellért Ghyczy** had been completely convinced, by the discussions, that having choice is more expensive than having no choice. Direct costs may be reduced by the availability of choice, but it generates many other costs. For example, choice implies over-provision of services, which has to be paid for at some stage. Administrative and regulatory costs are also higher under competitive regimes. The background papers for the Peer Review had assumed that care needs are rising in an ageing society, but none of the participants had actually talked about increased needs. The discussion had not been about how to expand capacity, but about how to reduce it. He suspected that, although people now live longer, older people are also much healthier than they used to be. In terms of care needs, better health more than compensates for demographic ageing. The younger pensioners want to make themselves useful, and are the most active age group in the voluntary sector. Policy should encourage, rather than discourage, such activity. Otherwise, the social costs will be high. It should also be remembered that, in countries with a shortage of preschool provision, the availability of grandparents to look after the children is a precondition for younger women's increased participation in the labour market. The staffing of care services depends on wider labour market developments. Countries that have managed to dynamise the lower end of the labour market are in a better position to employ good-quality carers, whereas those with a large grey economy may have more problems in this respect.

John England said the quality of outcomes had scarcely been discussed at this Peer Review. How do we evaluate the benefits that the services actually bring to individuals? More work is needed to reach consensus on what is meant by good outcomes are for older people in long-term care situations. **Pedro Andrade Saraiva** said Portugal may be an exception to the shifting of care responsibilities from the national to the local level. It had been possible to reach a consensus on national standards because there had previously been few standards at the local level. So the trend in Portuguese care services is towards centralisation. Local authorities have not been much involved so far, and it is not felt that their involvement would be the most effective way of moving forward in future. **Caroline Glendinning** clarified that standard-setting is a national-level matter in many of the peer countries. It is the service provision that, in most but not all cases, has increasingly been decentralised. She agreed that there will be a growing number of older people who are healthy and will not immediately need support. But it should be remembered that the carers will be ageing as well. Within families, care-giving may shift from younger family members to elderly spouses, who will be surviving for longer. She entirely agreed that service outcomes need more attention. The tendency has been to focus much more on service inputs.

Closing remarks

Concetta Cultrera said Caroline Glendinning's comprehensive summary had shown just how rich the debate had been. It had been emphasised that the public authorities are the ones who make the important political choices. They set the scene for the provision of social services. Sometimes they continue to participate in service delivery, but they certainly retain the very important roles of regulation, standard-setting and monitoring. Choice is about multi-layering. It is not just a matter of choosing between service provider A and service provider B. Choice is about the type of service that you want. Choice is about the time at which you want the service to be provided. And so on. Solutions for choice sometimes have to be modulated for different types of service user. True choice also entails equal access. Systems such as the Danish model of providing services free of charge and according to need, without reference to personal income, are undoubtedly the best way of ensuring equal access. She also underlined the importance of the non-profit sector. The outcomes of this Peer Review would feed into the next EU conference on social services, to be held in Prague on 22-23 April 2009. She announced the publication of a call for tenders for a study on social services, covering two important aspects: the legal framework in Member States and quality tools in Member States. She invited participants, in case of problems with the application of Community rules, to use the Commission's online interactive information service.

Jørgen Witsø-Lund thanked everyone for their interesting contributions. He had noted down some of the language used during the discussions, and he wondered what Mrs. Average Jones might make of it all: "Hello, Mrs. Jones. We should give personal autonomy and avoid cold hands. Don't you agree? Not to mention red tape. How about some vouchers or funny money? Do you want some quality control, Mrs. Jones? Did you know there's social inequality in the care systems? Care is absolutely oriented towards the middle class and we have block grants according to social criteria, not to mention market solutions and access to information. What do you think about that, Mrs. Jones?" He wished everyone a safe journey home.