

Achieving excellence in social service provision

Discussion Paper

Flip Maas / Ricardo Rodrigues¹

European Centre for Social Welfare Policy and Research

Introduction

This paper serves as an input to the debate on the improvement of quality of Social Services of General Interest (SSGI) in the European Union. It is primarily the responsibility of individual Member States to define the scope of social services and to regulate their quality, in compliance with applicable EU rules. Nevertheless, both the debate over SSGI and the Open Method of Coordination (OMC) allow for the coordination of national policies and for the definition, at EU level, of principles that should apply to social services, for example: access, quality and sustainability. In this context, the Commission expressed in 2007 its intention to promote the development of an EU quality framework within the Social Protection Committee (see Communication from the Commission. "Services of general interest, including social services of general interest: a new European commitment, COM (2007) 725 final, 11.2007) and today the Social Protection Committee is well engaged in this exercise. Romania has initiated a process of continuous improvement of the quality of SSGI since 2003 with several legislative measures (Governmental Ordinance no. 68/2003 and 86/2004; Governmental Decision no. 1024/2004; Ministerial Order 383/2005). The Peer Review that will take place on 29-30 June 2010 in Bucharest has the goal to review the progress the country has made in this respect and to consider elements for transferability to other contexts.

A. The policy debate at European Level

A.1 Policy framework at European level

Regarding the debate on SSGI, while these services belong to the larger category of general "services of (economic) general interest" (SGI - SGEI), they have specific characteristics, objectives and principles of organisation. The Commission made an important step in identifying the specificities of SSGI in its Communication dealing specifically with SSGI (Communication from the European Commission "Implementing the Community Lisbon Programme: Social Services of General Interest in the European Union" COM(2006)177 final, 26.04.2006). This exercise culminated in a subsequent Communication (Communication from the Commission. "Services of general interest, including social services of general interest: a new European commitment, COM (2007) 725 final, 11.2007) which emphasized the importance of social services for the fulfilment of EU objectives, specified the objectives that social services are often meant to achieve and explained how these objectives are reflected in the ways that SSGI are organised, delivered and financed.

According to the text of the 2006 Communication, social services can be broadly divided into two groups (cf. p. 4): i) statutory and complementary social security schemes covering the main risks of life (e.g., linked with health, ageing, etc.); and ii) other essential services provided directly to

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the person which play a preventive and social cohesion role consisting of customised assistance to facilitate social inclusion and safeguard fundamental rights (e.g., rehabilitation, occupational training, social housing, etc.)². Still according to the Communication (cf. pp. 4-5), SSGI present one or more of the following organisational characteristics in the performance of their social interest function:

- They operate on the basis of the solidarity principle, which is required in particular by the non-selection of risks or the absence, on an individual basis, of equivalence between contributions and benefits;
- They are comprehensive and personalised, integrating the response to differing needs in order to guarantee fundamental human rights and protect the most vulnerable;
- They are non-profit and in particular address the most difficult situations and are often part of a historical legacy;
- They include the participation of voluntary workers, as an expression of citizenship capacity;
- They are strongly rooted in (local) cultural traditions. This often finds its expression in the proximity between the provider of the service and the beneficiary, enabling the consideration of the specific needs of the latter;
- An asymmetric relationship between providers and beneficiaries that cannot be assimilated with a 'normal' supplier/consumer relationship and requires the participation of a financing third party.

Crystallising the results of a large consultation process on the characteristics identified in the 2006 Communication, the Commission identified in its 2007 Communication a set of objectives and principles of organisation concerning social services (see box below).

Objectives and principles of organisation of social services

Social services are often meant to achieve a number of specific aims:

- they are person-oriented services, designed to respond to vital human needs, in particular the needs of users in vulnerable position;
- they provide protection from general as well as specific risks of life and assist in personal challenges or crises;
- they are also provided to families in a context of changing family patterns, support their role in caring for both young and old family members, as well as for people with disabilities, and compensate possible failings within the families;
- they are key instruments for the safeguard of fundamental human rights and human dignity;
- they play a preventive and socially cohesive role, which is addressed to the whole population, independently of wealth or income;
- they contribute to non-discrimination, to gender equality, to human health protection, to improving living standards and quality of life and to ensuring the creation of equal opportunities for all, therefore enhancing the capacity of individuals to fully participate in the society.

² Health services were not included as they are outside the scope of the Communication.

These aims are reflected in the ways in which these services are organised, delivered and financed:

- in order to address the multiple needs of people as individuals, social services must be comprehensive and personalised, conceived and delivered in an integrated manner;
- they often involve a personal relationship between the recipient and the service provider;
- the definition and delivery of a service must take into account the diversity of users;
- when responding to the needs of vulnerable users, social services are often characterised by an asymmetric relationship between providers and beneficiaries which is different from a commercial supplier / consumer relationship;
- as these services are often rooted in (local) cultural traditions, tailor-made solutions taking into account the particularities of the local situation are chosen, guaranteeing proximity between the service provider and the user while ensuring equal access to services across the territory;
- service providers often need a large autonomy to address the variety and the evolving nature of social needs;
- these services are generally driven by the principle of solidarity and are highly dependent on public financing, so as to ensure equality of access, independent of wealth or income;
- non-profit providers as well as voluntary workers often play an important role in the delivery of social services, thereby expressing citizenship capacity and contributing to social inclusion, the social cohesion of local communities and to intergenerational solidarity.

The 2006 Communication had also delineated the terms for a biennial monitoring and dialogue tool that should improve the “reciprocal knowledge of operators and the European Commission of questions concerning the application of the Community rules to the development of social services and (...) deepen the exchange of information between operators and the European institutions” (p. 10). The first of these biennial reports has already been published in July 2008 (Commission Staff Working document “Biennial Report on social services of general interest” COM(2008)418 final, 02.07.2008). The next is expected by the end of 2010 and will focus on Quality of social services.

Finally, the Commission has also vowed to support the development of a voluntary EU quality framework providing guidelines on how to set, monitor and evaluate quality standards. The consultation on social services has highlighted the need to support the promotion of the quality of social services in a more systematic manner. The European Social Fund and the ERDF already provide direct financial support to a number of services. The Open Method of Coordination for social protection and social inclusion sets a policy framework for the pursuit of reforms and the exchange of good practices. Based on this experience, the Commission supports the development, within the Social Protection Committee, of a voluntary EU quality framework providing guidelines on the methodology to set, monitor and evaluate quality standards. Moreover, via the PROGRESS programme, the Commission supports cross-European bottom-up initiatives aimed at developing voluntary quality standards and exchange of experiences. It will also promote the training of public authorities in the field of public procurement (European Commission, 2007: 13). A first series of projects have been supported in the PROGRESS Programme 2008-2010 (<http://ec.europa.eu/social/main.jsp?catId=327&langId=en>).

A.2 Summary of the policy debate at EU level

The present discussion on achieving high quality in the provision of social services is “inextricably linked with the modernisation processes” of social services that is taking place in Europe (Huber et al., 2008: 292). In particular, what the Study on Social and Health Services of General Interest in the EU identified as the quest for improved efficiency and effectiveness in the provision of social services, the changing forms of regulation and governance and the strengthening of user orientation and consumer protection (Huber et al., 2008: 209 and subsequent pages).

As public authorities are faced with concerns over the fiscal sustainability of social protection systems, efficiency and effectiveness gained a prominent role in the policy debate and subsequent reforms that countries introduced in personal social services. Influenced by the New Public Management rationale, a greater emphasis was placed on the measurement, evaluation and comparison of performance. In this context, quality management mechanisms (many times borrowed from the manufacturing sector) became a tool to improve productivity in social services (Huber et al., 2008). The increased reliance on processes of contracting, tendering and the development of the purchaser-provider split also called for a more detailed regulation, specifying the terms under which services were being purchased/provided. Quality standards thus became part of the yardstick on which proposals were evaluated and chosen, on the basis of the "best value for money".

The strengthening of user orientation placed a greater focus on the issue of quality of services provided. As countries have experimented with mechanisms that allow for user choice, such as cash benefits or social vouchers (Glendinning, 2009), this translated into a demand for greater transparency and the disclosure of information on the quality of the service that users are choosing. On the supply side, quality was seen as a differentiating factor for providers and as a potential competitive advantage in attracting consumers. Concomitantly, users and their representatives now express their wish for a clear definition of access to social services of adequate quality as a social right. Here the argument is one of protection of users against abuses and malpractices found in the past.

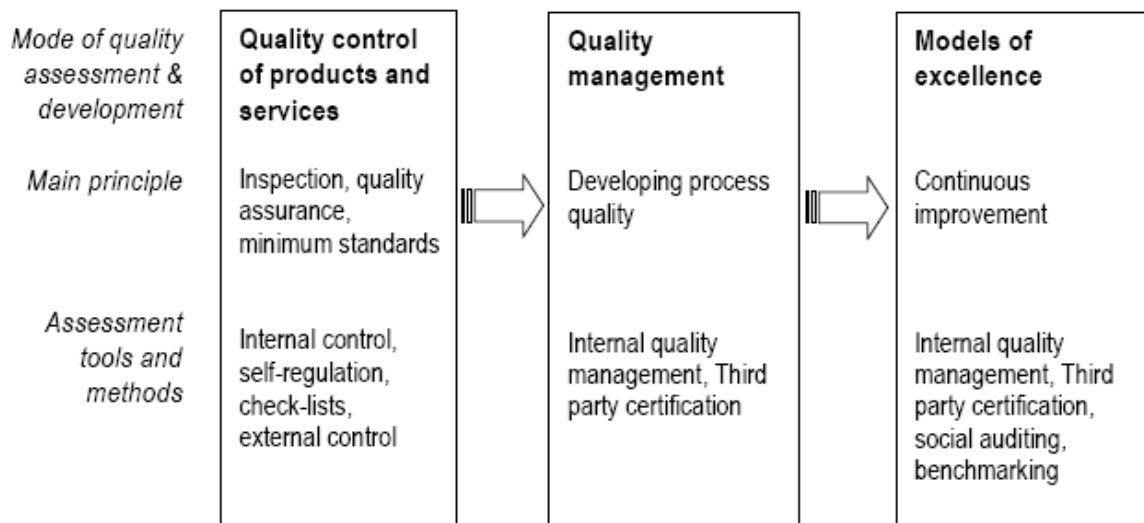
As part of the enhanced focus placed on efficiency and effectiveness in the delivery of social services, there has been an increasing reliance on market-based mechanisms for the provision of social services. The creation of "quasi-markets" for social services has caused profound changes in the governance of social services, for example, forcing the functions of purchaser and provider to be separated in public bodies. But it has also created new tensions by replacing public programming carried out by public authorities and relations with providers based on trust with market-based regulation and contractual relationships.

Social services have been a particularly dynamic sector in terms of job creation within the EU (Huber et al., 2008) and its potential as a job machine cannot be overlooked, especially for some groups that may find themselves under-represented in the labour market, such as older workers, women or low-skilled workers. According to figures from Eurostat Labour Force Survey, social and health services accounted for 9.8% of total employment in the EU-25 (Huber et al., 2008). Still, there are already concerns about the high turnover of those working in certain social service sectors, e.g. in long-term care, and about possible labour shortages in the future (see Fujisawa and Colombo, 2008). On the other hand, possible solutions for these foreseen labour shortages will be constrained by concerns over the financial sustainability of social protection systems. Whichever policy options are made regarding the workforce of social services, they are likely to impact on the quality of services, given that the interaction between the person(s) supplying the service and the one benefiting or using it is intrinsic to social services.

A.3 European and international comparative aspects

The situation of social services in the EU Member States is greatly influenced by the national context: the welfare state model, economic status, traditions and historical determinants, society values (e.g. on the role of the family and women), among others (Huber et al., 2008: 292). While social services are in some cases relatively well-established, as with childcare, in other cases they may just be emerging as an independent field of social policy, as is the case with long-term care in several European countries (Marin, et al., 2009). A great diversity in the values, legal framework, provision and financing arrangements of social services is therefore to be expected across countries. Still, with regards to quality development in social services, it is nevertheless possible to identify some common trends and transversal issues.

Figure 1 Outline of modes and methods of quality assessment and development



Source: Huber et al., 2008: 293.

Regarding quality development in social services, Huber et al (2008: 292ff) outlined three main modes: *quality control*, *quality management* and *models of excellence*, represented in figure 1. The first, quality control (or assurance) aims to guarantee the fulfilment of minimum basic quality standards by providers. Quality management ensures that minimum quality standards are met, but goes beyond that by aiming to improve the structures, processes or outcomes (to use? Donabedian, 1980, dimensions of quality of care). This is done through a management cycle of setting up objectives, planning and organising the processes to achieve them, evaluating results and correcting them if necessary. Ultimately, achieving excellence means the establishment of a continuous improvement process involving all stakeholders.

A.3.1 From quality assurance and control to quality improvement and self-regulation

Quality assurance has been the most common approach in social care, whereby public authorities establish *minimum standards* that providers must comply with (OECD, 2005, MISSOC, 2009). These minimum standards are usually defined in terms of *structures*, such as infrastructures (e.g., number of square meters per child), safety measures (e.g., evacuation plans

in case of fire), or staff-ratios (e.g. number and qualification of staff per user). Effective as these minimum criteria may be in keeping “inadequate organisations” out of the pool of available providers, they are usually insufficient in triggering processes of continued improvement, as the focus of quality assurance is rather on the detection of errors and enforcement, namely through bureaucratic procedures (e.g. inspections). Although minimum structural standards may be seen as the very basic tools of quality development, that is in itself no assurance that all social services within a country will adhere and comply to it – see Huber et al., 2008: 295-296 for some examples on this.

Fulfilment of minimum quality standards is usually imposed by legislation enacted on a national, regional, or even local level, depending on the political structure of the countries. In the case of long-term care, an emerging field at the boundaries of health and social care, the examples of legislation on quality specifically designed for long-term care services remain scarce (Nies et al., 2010).

Mirroring the de-centralised approach followed in the organisation and provision of social services, some countries such as Romania have transferred responsibilities in quality regulation to regional and local authorities. A more de-centralised approach may be able to accommodate for strong regional differences (e.g. in Austria), but it also raises a number of questions. It may create further challenges of coordination between different levels of government, pose questions of social cohesion as differences in quality standards may arise between regions, and hamper benchmarking efforts. As an example, in Austria nine (quite) different regional standards for staffing ratios in care homes exist, which depend on the care needs of residents: ranging from 1:1 of which at least 40% have to be registered nurses, to 1:20 with a requirement that only 20% are registered nurses (Nies et al., 2010).

In order to ensure a certain minimum level of quality requirements on their national territory or to frame the regional or local development of services, some countries have established national standards or guidelines. One such example is that of the National Framework for High Quality Services for Older People in Finland, which provides guidelines for managers and decision makers on a local level on how to develop and evaluate their services for older people. In Austria, the development of a nation-wide regulation on qualifications and education standards for social care workers was hailed as an important improvement in comparison to the previous regional regulations that had resulted in enormous differences (Nies et al., 2010). Nevertheless, in establishing these national standards, very few countries have committed themselves to achieving quality targets. Those that did have only set targets for staffing levels (e.g. Finland and Spain, regarding social services for older people) or structures (e.g., the Netherlands for shared rooms in care homes, Van Campen, 2008).

Compliance with minimum quality standards is usually guaranteed through *inspections*. These can be carried out by a national responsible body, such as the Care Quality Commission (CQC) in England - a result from the merging of three different commissions - which is responsible for health care, social care and mental health. In other systems, inspection is the responsibility of regional administration bodies, such as in Austria (the *Länder*), or France (the *Départments*).

As the provision of social services now involves private (non-profit as well as for-profit) providers, many countries have imposed *accreditation procedures* for service providers, where ex-ante quality assurance is performed by an authority independent from both provider and purchaser. Although accreditation (other than authorisation) can be voluntary, it is many times a condition to

access public funds, either subsidies or reimbursements. Besides organisations (providers), professionals may also be required to be accredited in order to be allowed to perform their tasks and many quality regulations (e.g. on care) impose education or/and training requirements, or compliance with binding professional codes of conduct.

While inspections supplemented by a scale of sanctions in case of non-compliance continue to be part of the quality control procedures of public authorities, Nies et al., 2010, identify a trend towards *self-regulation and self-assessment*. This comes as part of “the push from structural quality indicators to outcome oriented indicators and to quality management methods” (p. 47). For example, in France, nursing homes use a self-assessment instrument, denominated “Angelique”, which aims to implement a process of continuous improvement and supplements the more traditional inspections that are carried out.

In some cases self-regulation is associated with the take-up of responsibilities by other stakeholders such as umbrella organisations of providers or health insurance companies. In the area of social care, the Medical Service of the Health Insurance Funds in Germany has developed quality criteria in cooperation with other stakeholders, such as the national Association of Municipalities and the Association of Care Service Providers (Nies et al., 2010). In the Czech Republic, the Information Centre for Non-profit Organisations (ICN)³ supports non-profit organisations in their efforts to introduce quality management or to apply for certification.

This trend towards self-assessment and self-regulation can also signal the increased awareness and importance that is attached to quality development by providers. Quality development may be seen as a tool to improve performance within the organisation, but also as a marketing device to gain a competitive advantage in the context of quasi-markets (Huber et al., 2008).

In the context of self-regulation, some providers have sought to obtain quality certification of their services. Certification is a voluntary process by which conformity with a specific quality management system is regularly checked by an independent accredited private certification agency. Certification has been based on existing “classical” international systems, such as ISO 9000 or the model of the European Foundation for Quality Management (EFQM), which had been initially developed for the manufacturing sector and thus had to be adapted to the specific characteristics of social services. But this has been supplemented by other quality managements systems developed by stakeholders (public authorities, provider umbrella organisations, researchers) to better fit the particularities of quality development or measurement in social services. An example of this is the E-Qalin[®] Quality Management System⁴ applied in care homes in Austria, Germany, Luxembourg, Italy and Slovenia, which aims to involve representatives of all stakeholders in assessing and improving a series of enabling criteria (structures and processes) and key-performance indicators (results). However, from the plethora of quality management models in existence no particular model seems to have become predominant (Nies et al., 2010).

As mentioned before, some countries have begun to move beyond quality assurance based on (structural) minimum standards, for example, by extending it to *processes* and *outcomes* - (Donabedian, 1980), or by including new kinds of standards based on *excellence* and *benchmarking*. Health outcomes such as falls, the prevalence of pressure ulcers and depression are measured and monitored in the context of quality of care in social services for older people in Austria, Finland, France, Spain and the Netherlands. In Finland, one third of residential facilities

³ See <http://neziskovsky.cz/cz/icn>.

⁴ See <http://www.e-qalin.net/>.

and home care services now use the indicators that are derived from the Residential Assessment Instrument (RAI), assessing areas such as nutrition, use of psychotropic medication, rehabilitation care and social interactions (Achterberg et al, 2009; Feng et al, 2009). RAI-based indicators are used at an organisational level to improve the care and wellbeing of clients (Finne-Soveri et al, 2008), and at a system level for purposes of benchmarking between municipalities. Benchmarking is also used in long-term care services for older people in the Netherlands, where it is applied to the areas of service delivery, financial performance, clients' indicators (Responsible Care Standards) and quality of outcomes (Poerstamper et al., 2007).

While quality of care and benchmarking are well established in acute health care, examples such as that of Finland with the use of RAI are still not widespread in social services. This arises, not least of all, given the difficulties in controlling for case mix and historically determined differences (Zimmerman et al., 1995). In the particular context of long-term care, quality of life rather than quality of care may be the most relevant concept, especially from the perspective of the user (Nies et al., 2010). This means that values such as autonomy, user choice, privacy, wellbeing, comfort, access to care, dignity and end-of life care are taken into consideration. The operationalisation of quality of life can be done through user surveys, consumer satisfaction, but also by checking the existing records, process indicators and procedures as to, for example, how user complaints are managed.

User surveys may be mandatory and an integral part of the evaluation process of user satisfaction with social services, but this is only documented to take place in some countries (e.g., for social services for older people in England, Sweden, the Netherlands and Germany, Nies, et al., 2010). In Sweden, survey results are linked to monetary incentives (with good results leading to an increase in funds and fines attached to poor results). In Germany they are part of annual inspections of nursing homes and home care services following which the results are made public on the Internet. Another example of user surveys applied in assessing quality of healthcare services and users' experiences is the Consumer Quality Index (QC-Index) in the Netherlands. This is a standardized system with the aim to help steer users' choice of health insurance, insurers' choice of providers and the performance of individual organisations and the Healthcare Inspectorate (Nies et al., 2010).

A.3.2 The role of quality in the context of market-based regulation

Under the argument for greater efficiency in the delivery of services and increased user choice there is a trend towards increased reliance on competitive markets or market like arrangements (quasi-markets) to provide social services (Huber et al., 2008). Public programming and relationships between purchasers (e.g. public authorities) and providers traditionally based on trust and professional ethics were replaced by competition and contracts. Quasi-markets have called for the establishment of new regulations to define and assure quality ex-ante (Nies et al., 2010: 46; see also Table 1). Still, the new market-based logic of service provision may also be credited with providing some organisations with the incentive to certify the quality of their services. This happened as a response to perceived gaps in the definition of compulsory quality standards by public authorities, but also as part of a signalling process to purchasers and users of the importance attached to quality. For example, this could occur as part of market strategies to enter markets traditionally dominated by monopolies of public providers (the Nordic countries) or large non-profit organisations (Austria, Germany and France).

Table 1 Differences between public programming and market-oriented regulation – and the need for correcting mechanisms

Category	Public programming	Market-oriented regulation	Correcting mechanisms
<i>Regulation of supply</i>	In relation to available resources	In relation to demand (minimum standards to facilitate access)	Time-limited accreditation of providers, regular quality control, monitoring supply
<i>Provider system</i>	Closed	Open (determined by demand and supply)	Case management (Public administration as purchaser of services)
<i>Choice of provider</i>	Public administration as purchaser	Public administration or citizen or user as purchaser (costs are controlled by purchaser)	Accreditation, quality management (quality control ex ante)
<i>Accountability (Warranty)</i>	Public administration controls quality ex ante and monitors services (inspection)	Quality is defined by provider (accreditation); citizen as a purchaser (often co-financed by public resources)	Needs assessment on individual level ; choice between vouchers and benefits in cash; control visits; quality management system requested and in place

Source: Adapted from Bertin/Leichsenring, 2003.

There is mixed evidence regarding the impact of quasi-markets on the quality of social services. Price rather than quality standards has been the main criteria in contracting services (Huber et al., 2008), while public authorities acting as purchasers of services have used their market power to bring prices down, pressuring providers to cut costs at the expense of quality (Kendal et al., 2002). In the case of long-term care, where the user's needs usually comprise a range of services, contracting has mostly been reduced to individual services to the detriment of "chains of services" (Nies et al., 2010), which in itself can also be seen as detrimental to the improvement of quality of care for users.

The greater reliance on market-based mechanisms in the governance of social services, as well as enhanced user orientation, has placed a greater emphasis on the need for transparency and disclosure of information for users to be able to do an informed choice. There have been some experiments with the public disclosure of quality ratings, as mentioned above, and indeed voluntary certification can be seen as a sort of public commitment of organisations towards quality. Public disclosure of information on a local or municipal level (for example in England and Finland regarding social services for older people) means that transparency is extended to include the public authorities and commissioning procedures themselves.

This issue remains contentious though, as it is feared that "public blaming" may have counterproductive effects (incentivising organisations to cover for bad results). Furthermore, quality alone may not be the decisive factor affecting choice by users, as they are faced with financial and mobility constraints. The German website <http://www.heimverzeichnis.de> tried to go around some of these limitations by publishing the results of organisations that fulfil the quality of life criteria in their care homes. Since the participation is voluntary, those mentioned may be perceived as "good" examples while the remaining may have been left out due to failure to score good results or refusal to perform the evaluation. Still, criteria and procedures of this external audit have been criticised by provider organisations for being quite arbitrary.

A.4 Quality of social services in previous Peer Reviews

Reflecting the growing importance attached to the issue of quality of social services, several of the previous Peer Reviews have analysed the matter, namely those on “Freedom of Choice and Dignity for the Elderly” (hosted by Sweden in 2007), on “The Future of Social Services of General Interest” (hosted by Belgium in 2007) and on “Combining Choice, Quality and Equity in Social Services” (hosted by Denmark in 2009).

Besides shedding light on national initiatives and debates on quality of social services, previous Peer Reviews have highlighted some key policy messages regarding quality development in social services, namely:

- The need for a greater emphasis on the user perspective. In his synthesis report, Tesch-Römer (2007) points to the fact that although structural and procedural aspects of quality have thus far received greater attention, outcomes should become the focus of quality development. Aspects such as dignity and respect for human rights should be at the heart of a user-centred approach.
- The need for greater information to be made available to potential users of social services and their families, in order for them to be able to exert choice, particularly in the context where more countries are considering or opting for funding schemes that provide cash directly to users rather than to providers. Better information could also improve the responsiveness of services to the users’ needs.
- Regarding the specific sector of long-term care for older people, the importance of interlinking services (e.g. social and health services, but also bringing informal care into the continuum of care) to ensure that adequate care is provided to users.
- A trained and motivated workforce is essential for good quality of social services and therefore good working conditions should be one of the dimensions of quality.
- Measuring quality is crucial, namely for the benchmarking of organisations, but also for public authorities. While agreeing on common quality indicators on a European level may be difficult, some degree of comparability could nevertheless prove helpful for the dissemination of good practices and experiences (Huber, 2007).
- Whether social care services are provided by municipalities or other public bodies, or by independent non-profit or for-profit organisations, consistent, robust quality assurance mechanisms are essential. Assuring the quality of services is essential for the dignity and quality of life of service users and a right that all citizens should enjoy. There is a need to shift the emphasis of quality assurance processes from focusing on service inputs to a greater emphasis on user experiences and outcomes (Glendinning, 2009).
- There are likely to be variations between Member States in the levels of service quality that can be guaranteed. In countries that are still struggling to provide basic, universal coverage of social care services, quality standards that are too high or rigorous can risk destabilising some providers or prove too costly to implement. This in turn could result in some existing providers going out of business, with consequences for the current users if their services and for lower overall levels of provision. Here it may be important to set lower, but achievable, quality standards in the first instance (Glendinning, 2009).

B. The development of quality of social services in Romania

B.1 Background information on the host country

Romania has undergone significant political and socio-economic transformations in the past two decades, from the toppling of the Communist regime, including the transition from a centralised to market economy, to the accession to the European Union (EU) in 2007.

Its population, estimated at 21537563 inhabitants in 2007 (National Institute of Statistics of Romania), has been decreasing at an average rate of 0.2% a year (which meant a reduction of a staggering 1.1 million inhabitants between 1992 and 2002) (Ministry of Labour Family and Equal Opportunities, 2008). Taking the old-age dependency ratio as a measure, Romania still had a relatively young population in 1992 in comparison with the EU15 (table 2). Since then however, its population has also experienced a relatively rapid ageing process that is expected to continue in the future (Ministry of Labour Family and Equal Opportunities, 2008), bringing it closer to the EU15 average.

Table 2 Old-age dependency ratio

	1992	2000	2006
Romania	16.8	19.5	21.3
EU15	22.3	24.5	26.3

Source: Eurostat.

Despite significant economic growth during the period of 2001-2007 (annual GDP growth above 6% - Ministry of Labour Family and Equal Opportunities, 2008), several socio-economic indicators are still below the EU average, with the GDP per capita at 41% of the EU27 average (after accounting for differences in purchasing parities - Ministry of Labour Family and Equal Opportunities, 2008). These socio-economic indicators also include life expectancy at birth, which for men is still below 70 years (69.2 years in 2006, compared with 76.2 years for women - Eurostat), while for at least half of the EU27 Member States the male life expectancy at birth is above 75 years and above 80 years for women (Eurostat, based on national sources). An estimated 18.5% of Romanians live below the poverty line (compared with 16% on the EU27 - Eurostat), a figure even higher for children and young people and those living in rural areas (Ministry of Labour Family and Equal Opportunities, 2008).

As stated in its National Strategy for Social Protection and Social Inclusion 2008-2010, social services are seen as an integral part of the strategy to improve the social situation of vulnerable groups (Ministry of Labour Family and Equal Opportunities, 2008: 15). To this effect, the Romanian government has set up several programmes that provide grants and subsidies to the development of social services, including those managed by non-profit organisations. These programmes aimed to increase the still relatively low availability of social services in some areas (table 3), but also to improve its standards, for example, by restructuring institutions for disabled people (Ministry of Labour Family and Equal Opportunities, 2008). Among the areas that were targeted for the development of social services are: services for homeless children, community services for disabled people and long-term care. Besides financial support from the government, social services have also received important funds from international organisations such as the World Bank, the International Bank for Reconstruction and Development, as well as funds from the European Union.

Table 3 Number of beneficiaries in institutional care

	2007
Disabled persons (adults)	16736
Elderly people	6012

Source: Ministry of Labour, Family and Equal Opportunities and National Authority for Disabled Persons

Table 4 Social services for which an accreditation certificate was asked (until 2009)

Social services	Number of services
Children in difficulty	774
Adults with disabilities	553
Children with disabilities	326
Elderly people	301
Home care	155
Youth in difficulty	142
Family violence victims	64
Homeless	58

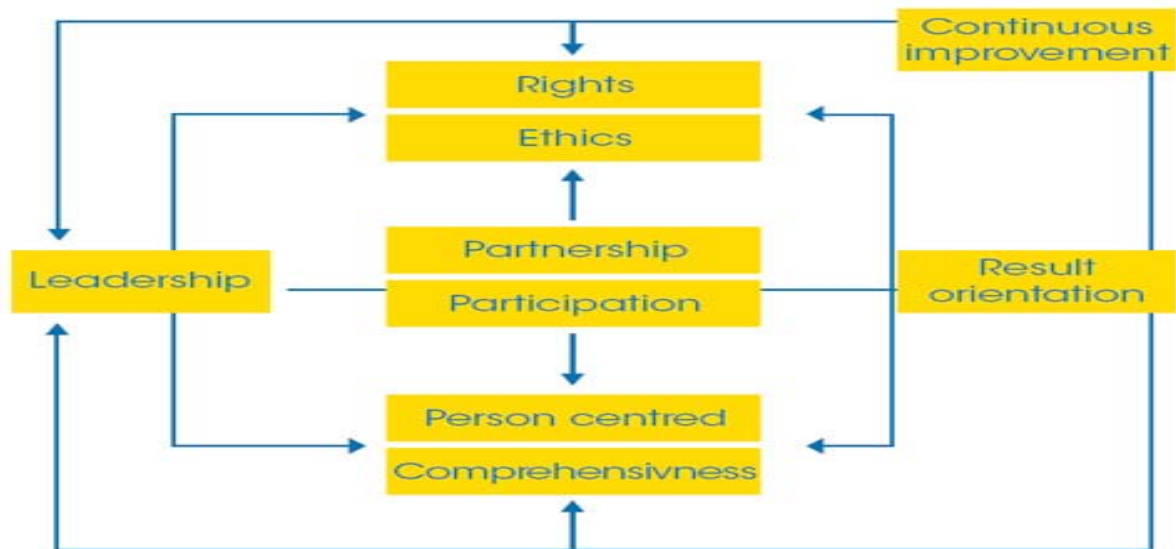
Source: Host country report.

According to the country information, it seems that until 2009, approx. 2.500 public and private providers obtained accreditation from specialised accreditation commissions (see table 4). These are composed at regional levels and include representatives of different stakeholders, such as involved Ministries and county councils as well as providers. However, users as well as their families seem not to be involved in the decision-making process of whether or not an accreditation certificate will be granted (users can be invited to meetings as observers).

B.2 Main elements of the Romanian policy on Social Services of General Interest and their relation to the achievement to quality excellence

Since 2003, Romania has initiated and implemented a variety of measures to better regulate the delivery of social services of general interest. The reform initiatives newly defined these services, acknowledging that they could be delivered by public as well as private providers, in line with the modernisation processes mentioned before in this paper. It also initiated the process of quality assurance, firstly by introducing the need for providers to obtain accreditation on the basis of general quality standards. For this reason, it adapted the so-called European Quality for Social Services (EQUASS) model, developed by the European Platform for Rehabilitation (EPR). The EQUASS-programme in its origins is sector-specific and particularly foreseen for disability-related services. It combines nine principles of excellence in an integrated manner (see figure 2).

Figure 2 EQUASS Model of Excellence



Source: <http://www.epr.eu/index.php/equass/certification>

The operationalisation of the model strives to continuously improve the delivery of services through a process of self-assessment and external auditing. This may lead to different labels of certification following an external audit (assurance, excellence, award). Another peculiarity of EQUASS is that through its certification process, it tries to overcome the fact that regulating social services is in the competence of public authorities. Furthermore, it has the potential to be applied in different national contexts and to adjust to different national regulations. In this sense, it is non-prescriptive and criteria to operationalise the nine principles of excellence are non-compulsory. In line with the different modes and methods of quality assessment and development, EQUASS includes in its conception issues like internal quality management through self-assessment, third party certification and (trans-national) benchmarking.

It may therefore be clear that the purpose for which EQUASS has been conceived originally is somewhat different from the goals Romania has had in further developing the model. Romania took the model as the basis for establishing a set of basic quality criteria to satisfy minimum requirements for obtaining an accreditation certificate. Romania further diversified the more sector-specific (disability and rehabilitation-oriented) framework to nearly all services of general interest.

C. Issues for debate

C.1 From accreditation to excellence in quality

The introduction of an accreditation system in Romania is an important step towards the potential improvement of the delivery of social services in general, taking the main principles of accessibility, solidarity, person-centeredness, etc. into account as well as the improvement of the quality of these services. In the above, it has been demonstrated that this as such particularly relates to, what has been called, structural quality improvement. Legally defined minimum standards are not yet quality standards. The improvement of quality standards is often “market-driven”, resulting from increased competition between providers, offering the same types of services and therefore perceiving “quality” as an internal need. This means that all relevant stakeholders have to be involved; it should be jointly agreed what quality should and can be offered to individual persons in need. The issue is, to what extent accredited organisations will further pursue the goal of “continuous improvement”, i.e. go beyond the status of having satisfied minimal requirements (although for a limited duration of three years, which is the maximum length of the obtained accreditation in Romania). It is certainly the case that the adapted EQUASS model, as most other quality management tools, has many elements that may inspire the continuous increase of the quality of services provided, but such a development does not happen automatically. In theory, the more service providers compete for limited available funds, the higher their efforts will be in demonstrating that they are pursuing quality. However, market imperfections, limited budgets, limited availability of trained staff, weak management, etc. might impede this development in practice. Furthermore, it has been experienced that quality management, being a rather new method applied in the context of social services, calls for the development of respective skills at all professional and hierarchical levels, including project management, group facilitation, participative leadership and organisational development. It might thus be necessary to facilitate the development of these skills within provider organisations.

In any case, it would be important to monitor and evaluate the results of accreditations on the levels of individual organisations and within sectors after another 3-year period to identify progress or at least the common developmental trend.

Major questions for debate:

- What could be ways to further develop from accreditation to excellence, i.e. to go beyond structural quality development in the direction of process and outcome quality?
- How can one best organise the inclusion of as many as possible stakeholders, including clients and their relatives in the development of quality of social services?

C.2 National regulations, decentralised implementation and sector-specificity.

Structural quality standards are normally defined at national levels, which means that in principle all providers are treated on equal terms. The accreditation system in Romania is based on nine guiding principles, each containing five indicators with related scores, requiring at minimum a total for each of the principles (12 points out of 25 maximum possible points) as well as for its totality (108 points).

The assessment to find out to which extent these mandatory conditions are accomplished is often carried out however at regional and even local levels. This is also the case in Romania, where accreditation commissions have been established at county level and for Bucharest.

A common issue however in this respect are possible differences in the interpretations of the requirements for accreditation, which might lead also to different assessments of the level of quality. It seems therefore necessary that additional measures need to be in place to assess to equity of assessment. This relates for example to the availability of nationally-based inspections/inspectorates as well as regular communication between and training of accreditation commission members, which can also be the place to discuss the principle of “continuous improvement” and its requirements.

A related question results from the fact that not all services can and should be assessed in the same way: they need to be sector-specific, since the quality requirements and possibilities for child care services, as an example, are different from those for long-term care or for homeless people. The country information from Romania does not give indications that the accreditation commissions are different for each of the sectors. This may contain some obstacles to improve quality and calls for a stronger involvement of all stakeholders at different sector-specific levels and with different perspectives. This would also be in line with the gradual strengthening of the focus on the improvement of quality process management and, further on, to the agreement on outcomes of the service delivery.

Major questions for debate:

- What are the possibilities to overcome regional/local differences in the assessment of quality of services, how to best organise these processes and what contribution can such processes make to the issue of continuous improvement of quality?
- Does the fact that different social sectors need different types of criteria to assess quality mean that different sectoral commissions have to be established?

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