Combining Choice, Quality and Equity in Social Services Provision
Discussion Paper

Caroline Glendinning
Social Policy Research Unit
University of York

A Brief description of the host country policy

A 1. Background

A 1.1. Demography and public spending on health and social care

Currently 14.8 per cent of the population of Denmark is aged 65-plus and four per cent is aged 80-plus. Between 2007 and 2040, the number of Danish citizens aged 80-plus is expected to double, from 224,000 to 450,000. The old age dependency ratio (the number of older people divided by the working age population) is currently 22 per cent, but is expected to increase to 42 per cent in the future (OECD, 2006). Unusually, expenditure on health care decreased between 1980 and 2002, from eight per cent to 7.3 per cent of GDP. Public spending on long-term care is currently around 1.8 per cent of GDP; private expenditure on home care is very low, at about only 0.1 per cent (OECD, 2005). Details of the coverage of long-term care services are given in Section 1.4 below.

A 1.2 Government responsibilities for services for older people

The national legislative framework entitles every Danish citizen to services free of charge if they are in need, regardless of their income.

The five county (regional) authorities are responsible for the funding, planning and operation of secondary medical services and hospitals; primary care (except home nursing); pharmaceuticals; and health promotion. Health services are mainly funded from taxation, so individuals' financial or labour market situation plays no role in determining access to health care. The main role of the counties in long-term care for older people is in the provision of primary care (general practitioners, dental care, etc.), hospital and psycho-geriatric services (Ministry of Social Affairs 2006).

The 98 municipalities are responsible for home nursing services, supported housing, nursing homes and all domiciliary personal and domestic help services for older people, including round-the-clock support for people living in their own homes or in specialist housing. Funding for these services comes from local (municipal level) income taxes, with additional funding from central government block grants. Municipalities have responsibility for determining and prioritising levels of services within their area; and for setting targets, quality and performance frameworks for local service providers. Municipalities have discretion in deciding how to allocate their resources between different services, within budgetary guidelines set by central government (including upper limits for local taxation); and for allocating help based on individual assessments of need. There are no formal minimum standards and the legislative requirement to provide domiciliary

care according to an individual's needs is open to local interpretation (Doyle and Timonen, 2007). There is a widely accepted principle that everyone living in the same municipality should be treated equally and have equal access to services. The Scandinavian tradition of municipal autonomy means that levels and patterns of services between municipalities may vary. However, as services are allocated in response to individual need, it is not always easy to compare equity in service provision between individuals, either within or between municipalities (Rostgaard, private communication).

The 1972 Social Services Act set a legal framework for municipal services. All municipalities are required to offer domiciliary services to anyone unable to perform regular activities of daily living. These services include:

- Domiciliary domestic (home help) and personal care and home nursing
- Meals-on wheels
- Home adaptations and equipment loan
- Transport
- Day care facilities
- Preventive home visits
- Opportunities to participate in activities that have a preventive function and/or help promote independence
- Supported housing, specially adapted dwellings, and nursing homes.

Almost all these services are free of charge to the user. A standard charge is made for meals-on-wheels; in nursing homes income-related charges are made for hotel costs and for additional services such as hairdressing and chiropody. Income-related charges are made for temporary help, but long-term care is free of charge.

A 1.3 History of policies for older people

Denmark was one of the first European countries to adopt an explicit policy of supporting and maintaining older people in the community rather than in institutional care. The 1987 Act on Housing for Older and Disabled Persons prohibited the building of any more nursing homes and promoted instead the construction of a range of special and supported housing for older people. This prompted an extensive building programme of sheltered and adapted housing. As a result, over the next 20 years the availability of nursing home places halved and there was a marked shift in spending, from institutional to home- and community-based services. By 2002, only three per cent of people aged 65-plus and ten per cent of those aged 80-plus lived in a nursing home. Only the most dependent older people, often those with dementia, are now admitted to nursing homes; it is estimated that between 50 and 80 per cent of residents in nursing homes suffer from dementia. The shift from residential to community-based care led to a reduction in expenditure on long-term care between 1985 and 1995 from 2.4 to 2.2 per cent of GDP (Stuart and Weinrich, 2001a).

A 1.4 Local domiciliary and community-based services for older people

The actual range and level of services, the eligibility criteria used and the levels and types of help that are allocated vary according to each municipality's budget and political priorities. Up to 1998, municipalities were generous in their provision of domiciliary services, with around 60 per cent of over-80s receiving these; about a third of over-80s received only practical domestic (home) help. Since 1998, municipalities have increasingly restricted the provision of practical domestic help to people who also need help with personal care. Nevertheless, of all European countries, Denmark still has the highest level of home care provision for the over-65s (Doyle and Timonen, 2007). Around 25 per cent of all over-65s receive some kind of domiciliary care service, compared with 15 per cent of over-65s in Norway, just over five per cent in the UK and around two per cent in Germany (Rostgaard, 2007a). As in other countries, however, these services appear to be increasingly targeted on those people with higher levels of need. Thus between 1982 and 2001 the percentage of people aged 67 to 79 receiving home care services remained stable at around 13 per cent. However, the percentage of people aged 80-plus receiving home care increased from about 36 to 50 per cent – although in some cases these figures included the home help and personal care services provided to people in nursing homes and very sheltered housing (Lewinter, 2004). Recent changes in methods of compiling activity data make it impossible to discern long-term trends; however, in 2005, 203,261 people received home help services on a permanent basis. Of these 109,454 were aged 80-plus - about half of all over-80s. In addition, 60,966 people received meals services and 44,740 people lived in sheltered housing with 24-hour help on call or in care homes (Ministry of Social Affairs 2006).

Since 1998 legislation has required that everyone aged 75-plus who is not receiving other services should be offered two 'preventive' visits a year from a municipally-employed care manager. The aims of these visits are to assess the older person's current needs; anticipate potential future needs; and encourage participation in health promotion activities. People who do need help and support are entitled to an individual assessment of need; this assessment is conducted by a home care assessor employed by the municipality. No standardised, universal assessment tool is used; rather, each assessment considers the functional capacity of the individual in the context of her/his wider needs and circumstances. The assessment takes into account the capacity of a partner to provide domestic (household) help, but not the availability of adult children or other family members outside the household who might, in theory, provide care. Rather, the provision of personal care, and domestic help to people living alone, is regarded as a welfare state responsibility. Older people receiving services are regularly and automatically reassessed – every six months if personal care is involved. Older people who are unhappy with their assessment have a right of appeal. Admission to a nursing home is decided by a multi-disciplinary municipal admissions board, after considering whether any alternative or additional domiciliary support could avoid admission. Admission to a nursing home cannot be enforced, even when it would be cheaper than providing domiciliary services.

Each municipality is required to publish the prices and quality standards for all personal and practical domiciliary services. These quality standards are reviewed annually.

A 1.5 The 'free choice' reform

From the early 1990s, there have been debates about introducing more choice into the provision of health and social care services; at the time counties and municipalities were the only providers of services. In 2002 the Liberal-Conservative Government introduced legislation requiring counties and municipalities to offer a 'free choice' of providers of day care services for children, hospital services and home care services for older people. Municipalities are now required to inform their residents about their rights to choice and to consider at least once within any term of office how existing opportunities for choice could be expanded or new opportunities for choice introduced into other services. These changes were intended to improve efficiency; introduce greater financial objectivity and accountability; and contain costs. Many municipalities were reported to favour the changes, perceiving existing services to be poorly led and excessively bureaucratic (Doyle and Timonen, 2007). The costs of implementing these changes have been met by an annual Government grant of DKK500m to the municipalities. From 2006 a further DKK500m annually has been granted to municipalities to ensure better and more flexible home help services; and from 2007 municipalities have been granted a further DKK300m annually to meet the additional pressures of a growing older population (Ministry of Social Affairs, 2006).

A 1.5.1 Practical/domestic help vs personal care

Free choice in the provision of practical and domestic home help services was introduced in 2002. Assessments are still carried out by the municipality, but purchasing has been split from provision and public (municipal) providers compete on equal terms with news service providers.

Thus from 2002, older people have been able to choose between a private or public service to undertake tasks such as cleaning, shopping and laundry, while still being paid for from the public purse. The initial restriction of choice to the provision of practical and domestic help reflected concerns about whether it was appropriate to introduce marketisation into intimate services such as personal care. However, in 2003 personal care became included in the free choice arrangements. Free choice is to be extended in future to the choice of equipment and the design of disability-friendly dwellings, but is unlikely to be extended to the provision of home nursing.

Municipalities must now ensure that a number of alternative home help providers are available, along with the public home help provider; ideally all should be able to provide both practical/domestic help and personal care. In reality, many private firms provide only practical assistance, because of the smaller numbers of recipients requiring personal care and the organisational problems of providing around-the-clock services. All practical/domestic help and personal care remains free of charge.

A 1.5.2 Choosing a provider

During assessments users are presented with information about the available service providers and are asked to make a choice based on how the companies present themselves and their company profiles. The assessor must not assist in the choice of provider; however, there is no evidence on what happens when an older person is unable to make a choice, even though this happens often (Rostgaard, 2007b). There are no incentives to use either public or private providers, just the obligation to make a choice. However, private providers often argue in their

promotional literature that they are more likely to guarantee continuity of service, with only one or a very limited number of people visiting. Private providers can also offer additional services, such as window cleaning, on a fully commercial basis. Municipal providers cannot offer additional services outside those funded by the municipality and consider this constitutes unequal competition.

Attitudes towards the free choice policy appear to have shifted markedly. In 2003 over half the users interviewed in 15 municipalities said that free choice of provider was not important or that they did not know about the policy; 76 per cent did not wish to change their current provider (Rostgaard, 2007a). However by 2007, 63 per cent of people using private home care providers considered choice was important or very important, as did 45 per cent of people using municipal home care services. Users of privately provided home care services were significantly more likely than people using municipal services to be satisfied with the number of workers visiting them and also more likely to be satisfied with the reliability of their private home help service (SFI, 2007). Older people now rate free choice very high, compared to other service attributes (Rostgaard and Thorgaard, 2007). However, these differences in satisfaction may partly reflect differences in the caseloads of private and public providers. People needing personal care are more likely to choose municipal provision and their higher levels of functional impairment will also necessitate several visits a day. They are therefore more likely to experience multiple care workers and be less able to cope if visits are cancelled or delayed. The financial agreements negotiated between municipalities and central government in 2009 committed local authorities to reduce the number of different workers visiting each person; recent legislation also requires that all home help recipients must have one key contact person.

A 1.5.3 Take-up of the free choice policy

The supply of private and publicly provided home help has been evaluated in 2004, 2005 and 2007. In the 2007 evaluation, 88 per cent of municipalities took part, covering approximately 92 per cent of all citizens aged 67-plus (Ankestyrelsen, 2007). The evaluation showed that 76 per cent of municipalities were able to offer a free choice of provider in at least one main area of domiciliary services – either personal care, practical help or meals-on-wheels. This was the same as in 2005, indicating no recent expansion of free choice. In 2006, 74 per cent of the responding municipalities offered choice of providers of practical assistance and four per cent offered free choice in all three areas of services.

The 2007 evaluation does not state how many older people had chosen private providers. However, data from Statistics Denmark show that between 2004 and 2005 there was a 44 per cent increase (7,500 older people) in the numbers of people using private providers for practical/domestic home help services. By 2005, a total of 24,631 people (all ages) were using private providers of practical/domestic help services; this constituted 15.3 per cent of those who had an opportunity for choice, a proportion which did not vary noticeably between different age groups. By 2005, private providers were estimated to have a 10.5 per cent share of the domestic/practical home help market.

However, private provision was much less popular among recipients of personal care. In 2005, 2,800 people chose a private provider of personal care - an increase from 1,900 the previous year, but still only 2.8 per cent of all recipients of personal care who had an opportunity for

choice. Again the percentage did not vary noticeably between younger and older personal care recipients. In 2005 the private provider market share of personal care was only three per cent.

Table A.1 Use of private providers for personal care (getting out of bed, bathing getting dressed etc) 2005

	Recipients of private personal home care	*With possibility to choose*	*%*
In all	2,805	99,116	2.8
Under 65 years	462	12,882	3.6
65-66 years	56	2,001	2.8
67-79 years	836	27,868	3.0
80+	1,451	56,365	2.6

Source: Statistics Denmark, 2005.

A 1.5.4 Unequal access to choice in personal care

The municipalities estimate that in 2005 on average five per cent of those assessed as needing personal care choose a private provider. However, only 43 per cent of municipalities in fact offered a free choice of personal care during the day; in these municipalities ten per cent choose a private provider, suggesting that if free choice of personal care was available nationally, actual take-up would be higher than five per cent (Ankestyrelsen, 2007). Indeed, opportunities for choice of personal care provider are very unevenly distributed. It is typically in Copenhagen and urban areas that there are private providers offering personal care. By 2006, 459 private providers offered personal care services[1]. In Copenhagen and other urban municipalities there are on average three providers of personal care, but only 1.3 on average in rural municipalities.

Seventeen per cent of municipalities have reported reasons given by private providers for not offering personal care. These include a limited market for personal care services; big geographical distances; the obligation to provide personal care round-the-clock; the educational qualifications needed by staff providing personal care; the level of responsibility; and continuing user preferences for publicly provided personal care. Three out of four municipalities require that private providers must offer services round-the-clock. Sixty per cent also require staff to have obtained a basic care qualification (*social- og sundhedshjælper*) and 17 per cent require further qualifications for staff working with people with particular conditions such as dementia or visual impairment. A further obstacle, reported in 27 per cent of municipalities in 2006, is that private providers are required to use the municipal IT systems. Some private providers have also reported difficulties liaising with the municipal home nursing service, but these are not widespread and may reflect a lack of experience on the part of new provider organisations.

[1] Some offer services in more than one municipality and so may be counted twice.

A 1.5.5 The impact on care workers

Compared with many other countries, the Danish home care workforce is relatively skilled. Most care workers are employed part-time. Anecdotal reports indicate that many combine work for both public and private service providers, with private providers offering slightly higher salaries (Doyle and Timonen, 2007). Home care staff employed by private providers also report greater flexibility and higher levels of autonomy over the organisation of their work; this gain may be offset to some extent by higher levels of responsibility and reduced opportunities for teamwork with colleagues (Rostgaard, 2007). Nevertheless, given the current age structure of the home care workforce, an estimated 6,500 new domiciliary care workers will need to be recruited over the next decade to compensate for employee turnover and meet increasing demand for services (Doyle and Timonen, 2007).

A 1.5.6 The impact on the quality of care

For the past decade, municipalities have been required to draw up formal service agreements and quality standards, covering access to services, forms of service provision, staff working conditions, occupational health and sickness cover. However, more recently municipalities have been preoccupied with developing the new 'mixed economy' of home care; quality is only recently emerging as a priority on the domiciliary care agenda. Contracting out service provision takes place within a tightly controlled framework, with municipalities setting standards and controlling prices. Service-level agreements with providers should be reviewed and updated annually by local councillors, but this does not always take place.

The free choice development has had some impact on the way that care is allocated, with greater specification of the tasks to be undertaken and less time available for these to be completed. Previous allocations of, say, an hour in which a range of tasks could be undertaken have been replaced by visits of 15, 25 or 45 minutes, with a specified number of minutes allocated for each task. This has been criticised as inflexible and user unfriendly (Doyle and Timonen, 2007).

Other recent measures agreed between the Government and muncipalities have also aimed to improve the quality of care. These measures include:

- Improving the attractiveness of jobs in order to enhance staff recruitment and retention
- Reducing the numbers of care workers visiting individual older people to improve continuity
- Improving buildings and updating technology in social care
- Encouraging learning from errors and unintended incidents
- Accreditation and quality development in care homes and supported housing/assisted living
- Extending free choice to equipment and the layout of special housing (Ministry of Social Welfare, 2008).

A 1.5.7 Personal budget experiment

In 2003 a pilot project was conducted in a number of municipalities in which people were given a cash payment to purchase for themselves the services they were assessed as needing. The provider had to be approved by the municipality, which also oversaw the quality of the services received. By 2006, seven municipalities were taking part, involving 58 people. There are no plans to make the scheme permanent.

An evaluation was conducted with 32 out of the 58 personal budget users (Socialministeriet, 2006). None had any cognitive impairment and all were able to make decisions for themselves. Users appreciated being able to plan their care and felt that they had received appropriate services. The municipalities were also generally satisfied with the trial, which had enabled previously difficult support needs to be met.

However, not all users could handle the responsibility of acting as an employer. Moreover, providers of care were not obliged to cooperate with the municipality and report back on changes in care needs. Additional concerns were the suitability of the scheme for people with cognitive impairments; whether resources were used in the most cost-effective way; the appropriate hourly pay rate for care workers; and the difficulties of monitoring changes in needs and how money was being spent if the recipient chose to use it outside the country.

B Policies at European level with a special emphasis on services for older people

B 1. The Policy Framework at European level – contexts

B 1.1 Demography

The population in developed countries is ageing rapidly. As a result of increased life expectancy and the ageing of the post-war baby-boom generation, both the proportion of the population and absolute numbers of older people are expected to increase dramatically over the next fifty years. Between 2004 and 2050 the number of older people (65-plus) is expected to increase by 77 per cent in the EU25; the number of very elderly people (80-plus) is expected to increase by a massive 174 per cent over the same period (EC, 2008). Although ageing does not in itself cause disability and needs for support, the risks of needing help with activities of daily living and with personal care increase with age. Moreover, the incidence of age-related conditions such as dementia that require high levels of support will increase in line with general population ageing.

Overall, 12.6 million people - 17 per cent of those aged 65-plus - were estimated in 2004 to need age-related care and support (Tsolova and Mortensen, 2006). Rates of disability in old age vary between countries, but women are more likely to experience disability in older age than men. Debates continue as to whether future cohorts of older people will have similar experiences of disability (and therefore needs for long-term care); or whether better population health and preventive interventions will lead to longer periods of older age being spent in good health, with any needs for support compressed into a short period at the end of life. Assuming that disability-free life expectancy increases in line with overall increases in life expectancy, it is estimated that there will be an increase of 31 per cent in the number of dependent people in the EU25 by 2050 (EC, 2008).

Of course for many older people, family members (particularly spouses and adult children) provide a very substantial amount of care. However the future supply of this care is not guaranteed. Increasing labour market participation by women, family breakdown and reconstitution, and the geographical mobility created by regional and global labour markets will all affect the capacity of younger generations to provide day-to-day support for older relatives.

Policies to support informal care-giving are now high on the agenda of the EU; during their spring 2007 meeting, European Ministers of Employment and Social Affairs endorsed support for informal carers as a top priority of the EU in their headline messages to the European Council (EPSCO, 2007). Nevertheless, despite this important initiative, there will be increasing demand for collectively funded and formally organised services to support older people across Europe. At the same time, however, dependency ratios are also expected to alter significantly as the proportion of working age (and economically productive) people decreases relative to the growing older population.

B 1.2 Public expenditure implications

Increasing demand for services has major implications for public expenditure. Currently levels of public spending vary very considerably between member states; for example, the levels of expenditure on long-term care services for older people in many of the Nordic countries are several times higher than in some southern and eastern European member states. One factor affecting levels of expenditure within and between countries is the balance between more expensive institutional provision and community-based care (Huber *et al*., 2008). Partly because of this, spending on long-term care varies much more across European countries than does spending on acute health care (Huber, 2008).

Estimates of future spending on long-term care indicate that substantial additional investment will be required to meet the needs of an ageing population. 'By 2050, spending (relative to overall growth of the economy) in EU-15 may almost double from currently around one per cent of GDP to almost two according to recent OECD projections' (Huber *et al*., 2008: 102). It is significant that this projection excludes newer EU member states which have considerably lower historical levels of expenditure and service provision, where the future increase in spending is likely to be considerably greater in order to 'catch up' with demographic trends. It is widely accepted that any future productivity gains in labour-intensive care services are likely to be much lower than in manufacturing and other economic sectors.

In all European countries, private households make major contributions towards the overall costs of long-term care, both financially and by contributing a majority of the total hours of care needed. Private financial contributions include both co-payments and private purchase of services. Compared with Norway, Austria, Spain, Germany and Switzerland, Denmark has the lowest proportion of private spending as a proportion of total spending on long-term care (Huber, 2008).

B 2. Relevant EU Policies

B 2.1 Overarching EU policy commitments and the Open Method of Coordination

Member states are committed to accessible, high quality and sustainable health and long-term care by ensuring:

- Access to adequate care for all, including tackling inequalities in access.
- That needs for care do not lead to poverty and financial dependency.
- Quality care provision, including preventive services and services that are appropriate for the changing expectations of older people and their families.
- Adequate, high quality and economically sustainable services, including:
  - appropriate incentives for providers and users
  - good governance and co-ordination
  - responsibility on the part of professionals and service users.

The Open Method of Coordination (OMC) provides a framework of political coordination among the EU Member States. It covers activities such as employment policy, social protection and social inclusion, and notably issues related to pensions, health and long-term care. The Lisbon strategy commits the EU to foster the implementation of a common market by improving the labour supply in Member States. This commitment covers the responsibilities of current working age populations to finance social protection schemes; thus improving social protection can assist economic performance (Rothgang and Engelke, 2009).

However, variations in definitions of long-term care (EC, 2008) and informal care (Morée *et al*., forthcoming), combined with inter and intra-country differences in the structure and organisation of services, combine to hamper efforts at policy co-ordination. Moreover, the supply of long-term care is considered inadequate for current, let alone projected future, needs. Barriers to access also persist and these are very unequally distributed within and between countries (EC, 2008).

B 2.2 The developing focus on 'social services of general interest'

Since the mid-1990s there has been a growing interest within the EU on 'services of general (economic) interest'.. 'Services of general interest' contribute to economic, territorial and social cohesion within and between EU member states, but remain the responsibility of the public authorities within each member state. The scope of this policy interest now extends beyond physical infrastructure services to encompass health and social services as well.

A 2004 White Paper recommended a systematic approach towards 'social services of general interest' (SSGI), in order to identify and recognise their specific characteristics and to clarify the framework in which they operate and can be modernised. As a first step towards this systematic approach, the Commission adopted in April 2006 a Communication on SSGI in the European Union. The Communication provided a first indication of the specific characteristics of this sector; offered guidance on the application of Community rules; and announced a new consultation of Member States and stakeholders to prepare the next steps in this process. The subsequent Communication on services of general interest, including SSGI, adopted in November 2007, set

out the results of the consultation. The Communication emphasized the importance of social services for the fulfilment of EU objectives; listed a number of specific aims that social services are often meant to achieve; and explained how these aims are reflected in the ways that SSGI are organised, delivered and financed. The Communication was therefore an important step forward in recognising the specific features of SSGIs. The Communication also confirmed the Commission's commitment to clarifying the legal framework applicable to these services. Two "Frequently Asked Questions" (FAQ) documents, which clarify issues relating to the application of State aid and public procurement, and the interactive information service (IIS) that answers questions from citizens, public authorities and service providers, are the expression of this commitment. The Communication has also proposed a strategy aimed at promoting the quality of social services.

In its 2006 Communication, the Commission also made a commitment to produce biennial reports to improve the knowledge of service providers, other stakeholders and the Commission alike on the situation of SSGI in the EU and on the application and impact of Community rules on the development of these services. The Commission subsequently commissioned a major study on the development of social services (CEC, 2006; Huber *et al*., 2008). The First Biennial Report, published on 2 July 2008, provides an overall picture of SSGI in the EU. It describes their socio-economic situation and the major economic and societal changes to which they have to adapt. It looks at the ways in which they adjust to developing needs and constraints and how these changes affect the organisation, financing and provision of social services of general interest in terms of relevant EU rules.

B 2.3 Care, services and employment objectives

Formal care services, whether provided in institutions or community or domiciliary settings, are highly labour intensive. Indeed, the quality of services depends substantially on the characteristics of care workers and the relationships they are able to develop and maintain with people receiving care. Within an increasingly service-focused EU economy, social and long-term care services have considerable potential for creating new employment and, therefore, for contributing to the Lisbon policy strategy. These sectors have performed well since 1995 in creating new employment opportunities (Huber *et al*., 2008). Between 2000 and 2007 the share of employment in health and social care, calculated from the numbers of people employed in this sector relative to the total working age population, rose from 2.4 per cent to 2.7 per cent for men and 8.4 per cent to 9.8 per cent for women. This gender gap is even more marked in the EU15 countries, where the employment share in health and social care in 2007 was 3.1 per cent of men and 11.1 per cent of women. The proportion of working age women employed in the sector is especially high in Scandinavian countries and the Netherlands; indeed, the gender gap is highest in those countries where female employment is also highest. Between 1995 and 2007, the numbers of older (55-64 years) workers employed in health and social services also increased markedly. The EU is committed to encouraging the adequate recruitment, training, and retraining of the long-term care workforce (CEU, 2008).

Employment in health and social services as a proportion of total employment varies widely throughout the EU. Three groups of countries can be identified. In Baltic, southern and eastern European countries, only four to eight per cent of all employment is in health and social care. In the second group, which includes Austria, Luxembourg, Ireland, Germany and the United Kingdom, employment shares range from eight per cent to 13 per cent. The third group, which

includes most Scandinavian countries and the Netherlands, has the highest share of employment in health and social services. Denmark has the highest employment share in health and social services of all EU member states, at 18 per cent (Huber *et al*., 2008).

The expansion of the health and social services sector will continue to be crucially important in achieving EU employment goals. This expansion appears particularly important in relation to the employment opportunities this sector offers women and older workers, who are prioritised by the Lisbon agenda to enter the labour market. However, employment in this sector is more likely to be characterised by part-time contracts, non-standard work patterns, temporary contracts and lower wage rates (the latter reflecting the predominance of women employed within the sector). On the other hand, as much employment in this sector is financed, directly or indirectly, from public expenditure, it is more stable and less vulnerable to short-term economic cyclical effects. Indeed, the sector has performed remarkably well in terms of employment creation at times when other sectors were shrinking; the growth in social services employment has continued steadily during periods of both faster and slower economic growth (Huber *et al*., 2008).

Ensuring an adequate, appropriately qualified supply of labour for home care, residential and day care services is a major preoccupation for member states (EC, 2008). The employment of recent non-EU migrant workers has increased more rapidly in the health and social care sectors than across the EU as a whole, but is still relatively limited.

B 2.4 The development of markets within social and long-term care services

Markets are widely advocated on the grounds that they improve efficiency, choice and transparency. There is now considerable competition between different types of suppliers of long-term care services in many EU countries.

Public providers of long-term care services still dominate in the Czech Republic and Sweden (with market shares of 80 per cent and 70 per cent respectively). At the other end of the spectrum, public providers account for only ten per cent of the long-term care service market in the UK and five per cent in Germany. Among private providers, there are also substantial variations between countries in the market shares of non-profit and for-profit providers. In the Netherlands, non-profit providers account for 80 per cent of total supply, but in the UK it is for-profit providers who enjoy a similar market share. Elsewhere in Europe (with the exception of Germany), the share of for-profit providers is very low (CEC, 2008).

Following this market development, there has been a shift from 'public programme' regulation, including budgetary planning, certification and control mechanisms, to regulation based primarily on market mechanisms. The latter can include competition for the market (for example, for large scale contracts from public sector purchasers); and competition within the market (for example, for the business of individual customers). In many instances the user becomes a direct customer, using public funding to purchase privately-provided services. Cash allowances, vouchers and individual budgets are among the mechanisms used to create competition within the market. However, 'pure' market regulation mechanisms are invariably modified: public sector organisations are major purchasers; information asymmetry is widespread; and other regulatory mechanisms such as price control or quality-based licensing are also common (CEC, 2008). Moreover, value-driven competition – linked to the quality of services – is considered to be still underdeveloped (Huber *et al*., 2008).

B 3. European and international comparative aspects

Market developments have been integral to recent reforms in the funding and organisation of services in many countries, outside as well as within Europe. Market developments in long-term care have two overarching aims:

- To introduce competition into the supply of services, in the expectation that this will reduce costs, improve efficiency and increase quality.
- To allow service users greater choice and opportunities to behave as consumers.

However, within this broad trend, a number of different models and country-specific rationales can be identified; all are compatible with continuing public funding of long-term care services. Differences in market-related developments include:

- The form in which resources are allocated to users – as a set level of service entitlements, as vouchers or through cash payments. For example, German long-term care insurance offers a choice of in-kind service entitlements or cash payments to beneficiaries; the new personal budget arrangements in England offer choices between receiving local authority-commissioned services up to a given level or the same level of resources in the form of a cash direct payment. Combinations of the two may also be possible.
- Whether a proxy, such as a care manager, co-ordinates and purchases services from a range of different providers, on behalf of a disabled or older person (as in England until recently); or whether individual service users themselves have complete control over the public resources allocated to them and negotiate directly with care providers (as with Dutch personal budgets or German long-term care insurance beneficiaries choosing the 'in kind' service benefit entitlement).
- Whether care can be purchased or procured only from accredited provider organisations with whom the funding body (local authority or insurance fund) has a formal contract; or through less formal arrangements (including from relatives and friends). For example, in Germany care secured through the in-kind service entitlement must be procured from providers who are approved by the insurance funds; in Austria, long-term care allowances can be used to purchase services, pay relatives or employ 'grey' care labour. The employment of close relatives to provide care raises critical debates about the commodification of kinship obligations and responsibilities and about the potential exploitation of female relatives in particular (Ungerson and Yeandle, 2007).
- Whether minimum labour laws (contracts, minimum wages, explicit terms and conditions of employment) apply to people providing care labour. In the Netherlands, carers paid through a Personal Budget (even if they are close co-resident relatives) must have minimum labour contracts; the recent German care management trial also required that non-standard care providers had formal terms and conditions of employment consistent with part-time employment (so-called 'mini-jobs'). In England, Austria and Italy there is no requirement for minimum social protection for carers who are employed using care allowances or direct payments.
- The level of scrutiny and supervision exercised over how public funds are used by individuals who need care. In Austria there is no regulation or scrutiny of how long-term care allowances

are used. In contrast, in England, direct payment users must account for how the money has been spent and also have regular reviews undertaken by local authority care managers to see that direct payments have been used appropriately for individual needs and outcomes.

Interestingly, formal restrictions on the use of additional private resources to complement or 'top up' publicly-funded vouchers, cash payments or service entitlements appear rare and there is little evidence on how extensively these might actually be used in different countries. In England, it is estimated that about half of total spending on social care services comes from private sources: the means- and assets-tested co-payments required by local authorities from users of residential and domiciliary services and the payments made by people who purchase their care services privately. Private expenditure on adult social care was estimated to be £5.9 billion in 2005-06 (CSCI, 2008). However this exceptional level of private spending undoubtedly reflects the high needs eligibility criteria that restrict access to publicly funded social care and the assets test that restricts access to residential care for all but the very poorest; it is far from clear that many people use additional private resources to 'top up' publicly funded service provision.

Where community-based services are in short supply, care allowances may aim to stimulate the development of a diverse range of formal services in response to the demands of individual purchasers. Care allowances, vouchers and similar hypothecated cash payments enable new resources to be targeted at provider organisations who, according to market logics, are incentivised to expand their capacity and compete with each other for customers on the basis of a combination of quality and cost, thereby both enhancing the range and efficiency of services. This was one rationale behind the introduction of the 'in kind' service entitlement option within German long-term care insurance; it aimed to break down the former 'virtual cartel' of traditional provider organisations (Schunk, 1998). In Finland, home care service vouchers are also intended to increase the numbers of private home care provider agencies (Timonen *et al.*, 2007). In the Spanish region of Valencia, the introduction of vouchers for nursing home care aimed, amongst other things, to increase the supply of publicly-funded rooms and hence improve equality of access (Tortosa and Granell, 2002). Indeed, vouchers that can only be spent within a precisely-defined service sector may be targeted quite effectively, as the Valencia experience showed.

However, there is only limited evidence that newly empowered individual purchasers can, on their own, stimulate the supply of a range of flexible, good quality services. For example, in Germany a traditional preference for family care and the consequent continuing popularity of the long-term insurance cash benefit option has restricted consumer pressure for a wider range of flexible formal services. Consequently it is still the case that only a small minority of the 12,300 registered providers of community-based services offer basic support to people with dementia, even though additional resources have been targeted through long-term care insurance at people with severe cognitive impairments. Moreover, although long-term care insurance has been credited with the creation of over 200,000 jobs in social services, increases in the numbers of qualified homemakers and housekeepers (who provide mainly domestic help) are very small (Schneider and Reyes, 2006). Indeed, the proportion of 'care dependent' insurance beneficiaries receiving institutional care increased between 1995 and 2003, while the number of beneficiaries receiving formal domiciliary services remained more or less stable (Glendinning and Igl, 2009). All this suggests that the impact of the long-term care insurance 'in-kind' service entitlement option in stimulating a wide range of new, flexible and acceptable community-based services may so far have been limited.

Similarly the individual budget pilot projects in England found only limited responsiveness among service providers once individuals were given command over the resources for their care, at least in the short term. Providers were often protected by large, long-term contracts with local authority purchasers from the full impact of a new 'mixed economy' of purchasing. They were also deterred from making changes in the range of services they provided by uncertainties about future market conditions and by constraints on the supply of care workers. Moreover, they anticipated being exposed to new risks and uncertainties once these contracts expired; small providers in particular were thought to be vulnerable. Many providers anticipated increased unit costs as economies of scale were removed and individualised accounting and billing replaced existing block payments (Glendinning *et al*.; 2008; Baxter *et al*., 2008). Similarly, the introduction of care allowances in Austria, in principle a measure aimed at increasing choice on the part of older and disabled people and stimulating competition between providers, actually led to an increase in the costs of services provided by welfare agencies and care providers (Kreimer, 2006).

Policy objectives of increasing the volume, flexibility and responsiveness of services may be particularly difficult to achieve when the use of care allowances or direct payments is not restricted to the purchase of formal services from established, registered or accredited service providers. Thus care allowances may also stimulate increases in 'grey' care-giving labour, particularly from migrants who are employed by families at less than market rates to live in the households of older people and provide round-the-clock care; these developments are particularly marked in Italy (Bettio *et al*., 2006) and Austria (Ősterle and Hammer, 2007), as families find alternative ways of coping with serious shortages of formal services. In contrast, carers – including spouses – employed by both Dutch and Flemish personal budget holders must be employed according to minimum labour market regulations (Breda *et al*., 2006). The recent German Personal Budget experiment also required non-traditional care providers to be employed according to standard labour market conditions for part-time workers (Arntz and Thomsen, 2008). Concerns have also been expressed about the impact of care allowances in encouraging very low paid care work by female relatives (Kreimer, 2006); and about the difficulty of regulating the quality of care provided under such arrangements.

C Policy Debate

Older EU member states (for example, France, Germany, Italy, Netherlands, Sweden, UK) are increasingly reforming their long-term care systems to introduce or extend social care markets based on competition between care providers (Pavolini and Ranci, 2008); newer member states are developing for the first time long-term care systems based on similar approaches. Such models assume that choice delivers benefits for service users and also for the wider society as competition can generate lower cost and/or higher quality services.

This section sets out some of the issues that need to be addressed if these potential benefits for users and the wider society can be realised.

C 1. The importance of choice for users of long-term care

Choice is undoubtedly crucially important to disabled and older people. It has been argued (Morris, 2006) that the ability to exercise choice and control over daily life is fundamental to citizenship, social inclusion and human rights. Choice and control (rather than physical self-

reliance) are also central to concepts of independence, particularly for older people (Parry *et al.*, 2004). Being able to exercise choice helps to redress the power imbalance and vulnerability that pertains between the givers and receivers of personal care (Morris, 2006). Finally, choice and control over daily life is often considered by disabled and older people to be a desirable *outcome* of long-term care – services should, ideally, enable their recipients to enable users to fulfil a wide range of everyday activities and fulfil broader roles, obligations and lifestyle choices.

However, many users of social and long-term care services are disadvantaged in exercising choice. Frequent changes in symptoms and capacity or major life transitions requiring multiple choices or repeated revisions of choices may be experienced as a burden. Earlier choices (for example, to follow a particular treatment pathway) may inadvertently close off new options. Information about choice options and their consequences may not be easily accessible in appropriate formats, particularly for people with sensory or cognitive impairments (see Glendinning 2008 for a longer discussion).

C 2. Preconditions for effective choice

As indicated above, choice has both structural and cultural elements (Greener, 2008). At a structural level, there must be a minimum number of potential providers available within a relevant geographical area – so far as long-term care services are concerned, that local area is likely to be very constrained (in contrast, say, to specialist medical services). Yet people with relatively specialised conditions may have little or no choice of appropriate provider – there may well be only one available locally that is able to provide appropriate care. Moreover, when the supply of services is limited, opportunities arise for providers rather than consumers to exercise choice, by selecting the least costly or least difficult clients.

Where options are available, service users must want, and be able, to navigate through these – they must know how to choose. Moreover, there is an implicit assumption that choices must be made on relevant criteria. However, in the Czech Republic, for example, older people appear reluctant to exercise choice over the use of their newly-introduced care allowances, preferring standardised state provision as in the past. There is also little evidence from any EU country about the criteria on which people actually do make choices between alternative long-term care service providers; about the extent to which these reflect judgements about quality; or about the effects of these choices in driving up the overall quality of services.

Given these prerequisites for effective choice, there is an important role for public authorities in regulating the operation of markets in social and long-term care, particularly in relation to the selection of clients, the provision of information and other support to enable people to make informed choices; and the quality and appropriateness of available local services.

C 3. The risks of choice

Policies to increase choice also have risks. First (and of particular importance for this Peer Review) is that choice can create or increase inequalities. Although, as noted above, there is relatively little evidence from EU member states about the levels and patterns of use of additional private resources to supplement welfare state service allocations, nevertheless 'more money both expands the field of choice – and increases the capacity to make choices come true' (Clarke *et*

al., 2006: 330). Other relevant resources affecting equity of outcome include access to relevant information, for example through the internet or from knowledgeable friends; personal experiences of dealing with professionals; and articulate relatives who can act as advisors or advocates (Lend and Arendt, 2004).

Secondly policies based on individual choice can expose providers – and hence service users – to new market risks. Recent English research on the potential impact of direct payments and personal budgets on home and day care providers (Baxter *et al.*, 2008; Glendinning *et al.*, 2008) suggested that large, block contracts with local authorities gave service providers considerable market stability; facilitated investment in training that in turn helped to recruit and retain staff; and protected providers against potential bad debts from individuals who did not pay bills on time. Moreover, the choices made by some personal budget holders – for example, to 'save up' service allocations for a special event, or request services at short notice – could be difficult to meet, given staffing constraints. Where some existing service users chose to opt out of, say, attendance at a day centre and purchase alternative daytime activities instead, this risked destabilising the service for the remaining users. Above all, there were no mechanisms in place whereby the (actual and potential) choices of individual purchasers could be aggregated and communicated to providers, so that they could plan and invest in appropriate future service developments.

Although choice is assumed to lead to more efficient, better value services, the evidence is again weak. It is certainly true that when choice includes opportunities to pay friends and relatives, the same volume care can be provided at lower cost – this is true of the German care insurance cash benefit and the Dutch and Flanders personal budgets, for example. However, the evidence that choice reduces the costs of formally organised services is less compelling. Thus recent English research (Baxter *et al.*, 2008; Glendinning *et al.*, 2008) showed that the transition from large scale contracts to individualised service purchasing could introduce substantial new transaction costs, as individual bills for non-standard patterns of services replaced one or two large invoices to municipal purchasers; these in turn required new investments in providers' accounting and computer systems. Individual purchasers also have much weaker market leverage than large municipal purchasers and may be unable to secure the same economies of scale.

It is therefore possible that unit costs of formal service provision will increase and that providers will pass these costs on to their customers. Additional new costs may also arise from the creation of new care management and brokerage systems to address the informational asymmetry of social care markets and help individuals realise their preferred choice options. Care and assistance planning are features of choice-focused regimes in the Netherlands, England and France and have been the focus of recent experiments in Germany. Moreover, the creation or restructuring of long-term care markets to increase choice has frequently required the creation of new regulatory regimes covering, variously, price (for example, Germany) and quality (for example, England), risking further increases in cost.

Finally, choice raises some difficult questions over the legitimate boundaries of welfare state activity. Choice delegates risk as well as benefits to individual disabled and older people, who may find themselves undertaking more of the prioritisation and management of scarce resources that have hitherto been the responsibility of managers (Clarke *et al.*, 2006). Individuals may also choose types or patterns of services that deliver suboptimal outcomes or that conflict with professionals' views of appropriate service use – for example, opting to use allocated resources for help with social activities instead of a daily bath, or asking an untrained personal assistant to help with daily nursing routines instead of waiting for the nursing service to visit (Glendinning *et*

al., 2000). By opening up such options, choice policies also raise new questions about the boundaries of welfare states.

References

Ankestyrelsen (2007) *Frit valg i ældreplejen – det frie leverandørvalg til personlig pleje*, Ankestyrelsen, København.

Arntz, M. and Thomsen, S. (2008) *Reforming Home Care Provision in Germany. Evidence from a Social Experiment*, ZEW Discussion Paper 08-114, ZEW, Mannheim, downloaded from www.zew.de/pub/zew-docs/dp/dp08114.pdf.

Baxter, K., Glendinning, C., Clarke, S. and Greener, I. (2008) *Domiciliary Care Agency Responses to Increased User Choice: Perceived threats, barriers and opportunities from a changing market*, Social Policy Research Unit, University of York, York.

Bettio, F., Simonazzi, A. and Villa, P. (2006) 'Change in care regimes and female migration; the 'care drain' in the Mediterranean', *Journal of European Social Policy*, 16, 3, 271--285.

CEC (2004) *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. White Paper on Services of General Interest,* Brussels COM (2004)374 final.

CEC (2006) *Communication from the Commission. Implementing the Community Lisbon programme; Social services of general interest in the European Union,* Brussels, COM (2006) 177 final.

CEC (2007) *Communication from the Commission. "Services of general interest, including social services of general interest: a new European commitment,* Brussels, COM (2007) 725 final.

CEC (2008) *Biennnial Report on Social Services of General Interest,* Brussels, Commission Staff Working Document, SEC(2008) 21/79/2

CEU (2008) *Joint Report on Social Protection and Social Inclusion 2008* Brussels, 7274/08.

Clarke, J., Smith, N. and Vidler, E. (2006) The indeterminacy of choice; political, policy and organisational implications, *Social Policy and Society*, 5, 3, 327-336.

CSCI (2008) *The State of Social Care 2007*, Commission for Social Care Inspection, London.

Doyle, M. and Timonen, V. (2007) *Home Care for Ageing Populations*, Edward Elgar, Cheltenham.

EC (2008) *Long-Term Care in the European Union,* European Commission DG Employment, Social Affairs and Equal Opportunities.

EPSCO (2007) *Key Messages from the EPSCO Council to the Spring European Council*, 23 February, 6705/07, no 14, Brussels.

Glendinning, C., Halliwell, S., Jacobs, S., Rummery, K. and Tyrer, J. (2000) *Buying Independence: Using Direct Payments to Integrate Health and Social Care Services*, Policy Press, Bristol.

Glendinning, C., Challis, D., Fernández, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008*) Evaluation of the Individual Budgets Pilot Programme. Final Report*, Social Policy Research Unit, University of York, York.

Glendinning, C. and Igl, G. (2009) Long-term care in Germany and the UK, in A. Walker and G. Naegele (eds), *Social Policy in Ageing Societies. Britain and Germany Compared*, Palgrave Macmillan, Basingstoke.

Greener, I. (2008) Markets in the public sector: when do they work and what do we do when they don't? *Policy and Politics*, 36, 1, 93-108.

Hendriksen, C. and Vass, M. (2003) Preventive home visits to elderly people in Denmark, *Generations Review* 13 ,3, 14-17.

Huber, M. (2008) *Expenditure on long-term care in Europe,* Geneva Association Information Newsletter, 18, April, p8.

Huber. M., Maucher, M. and Sak, B. (2008) *Study on Social and Health Services of General Interest in the European Union, Final Synthesis Report*, DG Employment, Social Affairs and Equal Opportunities, DG EMPL/E/4 VT/2006/0131

Kreimer, M. (2006) Developments in Austrian care arrangements, in C. Glendinning and P.A. Kemp (eds) *Cash and Care. Policy Challenges in the Welfare State*, Policy Press, Bristol.

Kremer, M. (2006) Consumers in charge of care: the Dutch Personal Budget and its impact on the market, professionals and the family, *European Societies* 8 ,3, 385-402.

Lend, A. and Arend, N. (2004) *Making Choices. How Can Choice Improve Local Public Services?*, New Local Government Network, London.

Lewinter, M. (2004) Developments in home help for elderly people in Denmark: the changing concept of home and institution, *International Journal of Social Welfare,* 13 ,1, 89-96.

Ministry of Social Affairs (2006) *National Report on Strategies for Social Protection and Social Inclusion, September*, downloaded from http://eng.social.dk.

Minsitry of Social Welfare (2008) *National National Report on Strategies for Social Protection and Social Inclusion,* September, downloaded from http://eng.social.dk.

Morée, M., Tjadens, F., Glendinning, C., Moran, N., Arksey, H. and Nies, H. (forthcoming) *Care Provision within Families and its Socio-Economic Impact on Care Providers,* Report for DG EMPL, Negotiated Procedure VT/2007/114.

Morris, J., (2006) Independent living; the role of the disability movement in the development of government policy, in C. Glendinning and P.A.Kemp (eds) *Cash and Care: Policy Challenges in the Welfare State*, Policy Press, Bristol, pp 235-48.

OECD (2005) *The OECD Health Project: Long-term Care for Older People*, OECD, Paris.

OECD (2006) *OECD Health Data 2006*, OECD, Paris.

Ősterle, A. and Hammer, E. (2007) 'Care allowances and the formalization of care arrangements; the Austrian Experience', in C. Ungerson and S. Yeandle (eds), *Cash for Care in Developed Welfare States*, Palgrave Macmillan, Basingstoke.

Parry, J., Vegeris, S., Hudson, M., Barnes, H. and Taylor, R. (2004) *Independent Living in Later Life: Research Review carried out on behalf of the Department of Work and Pensions,* Research Report 216, DWP, London

Pavolini, E. and Ranci, C. (2008) Restructuring the welfare state: reforms in long-term care in Western European countries, *Journal of European Social Policy*, 18, 3, 246-259.

Pickard, S., Jacobs, S. and Kirk, S. (2003) Challenging professional roles; lay carers' involvement in health care in the community, *Social Policy and Administration*, 37 ,1, 82-96.

Rostgaard, T. (2006) Constructing the care consumer; free choice of home care for the elderly in Denmark, *European Societies*, 8, 3, 443-463.

Rostgaard, T. (2007a) *Domiciliary care for the elderly – a Danish perspective.* Paper presented at Conference on Home Care for Ageing Populations: International Comparisons of Domiciliary Care Policies for Older People, Social Policy and Aging Research Centre, Trinity College Dublin, 12 March.

Rostgaard, T. (2007b) *Begreber om kvalitet I ældreplejen*, Socialforskningsinstituttet, København.

Rostgaard, T. and Thorgaard, C.H. (2007) *God kvalitet i ældreplejen*, Socialforskningsinstituttet, København.

Rothgang, H. and Engelke, K. (2009) *Long-Term Care. How to organise affordable, sustainable long-term care, given the constraints of collective versus individual arrangements and responsibities,* Discussion paper prepared for OMC Peer Review, The Netherlands, February.

SFI (2007) Brugerundersøgelse om hjemmehjælp til beboere i eget hjemog i plejebolig / plejehjem. Downloaded from http://www.kl.dk/_bin/948af842-e886-48a6-b46e-fadcec925805.pdf.

Schneider, U. and Reyes, C. (2007) Mixed blessings; long-term care benefits in Germany, in C. Ungerson and S. Yeandle (eds) *Cash for Care in Developed Welfare States*, Palgrave Macmillan, Basingstoke.

Schunk, M. (1998) The social insurance model of care for older people in Germany, in C. Glendinning (ed), *Rights and Realities: Comparing New Developments in Long-Term Care for Older People*, Policy Press, Bristol.

Socialministeriet (2006) *Evaluering af personlig budget.* Downloaded from http://www.social.dk/netpublikationer/2006/p5eval2807/html/chapter00.htm.

Stuart, M. and Weinrich, M. (2001a) Home and community-based long-term care; lessons from Denmark, *The Gerontologist,* 41 ,4, 474-480.

Timonen, V., Convery, J. and Cahill, S. (2007) Cash-for-care programmes in four European countries, *Ageing and Society*, 26, 3, 455--474.

Tortosa, M.A. and Granell, R. (2002) Nursing home vouchers in Spain; the Valencia experience, *Ageing and Society*, 22, 6, 669--688.

Tsolova, S. and Mortensen, J (2006) *The cross-Atlantic exchange to advance long-term care*, European Commission and AARP, Brussels.

Wærness, K. (2006) Research on care: what impact on policy and planning? In C. Glendinning and P.A. Kemp (eds) *Cash and Care: Policy Challenges in the Welfare State*, The Policy Press, Bristol.