Peer Review
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Denmark, 1.4.2009

Synthesis Report

On behalf of the
European Commission
Employment, Social Affairs
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A. Relevant European policy context

A.1 Demography

The population of the EU is ageing rapidly. Because 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 and the number of very elderly people (80-plus) by a massive 174 per cent over the same period in the EU25 (EC, 2008). Although ageing does not in itself lead to a need for care, the risk of developing disabling conditions that lead to a need for help with activities of daily living and/or personal care increase with age. Moreover, the incidence of age-related conditions such as dementia that require high levels of support also increases in line with 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). In general, 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 levels of disability (and therefore needs for care); or whether better population health and preventive interventions will lead to longer periods of older age being spent in good health, with any need for support compressed into a short period at the end of life. However, assuming that disability-free life expectancy increases in line with overall increases in life expectancy, it is estimated that there will be a 31 per cent increase in the number of dependent people in the EU25 by 2050 (EC, 2008).

Family members (particularly spouses and adult children) provide very substantial amounts of care for older people and vastly outnumber professional carers such as social workers and nurses. However the future supply of this care is not guaranteed. Increasing labour market participation by women, family breakdown and reconstitution, and the geographical mobility resulting from 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, there will remain increasing demand for collectively funded and formally organised services to support older people; pressures will be particularly acute in southern and eastern European Member States, where formal long-term care services are relatively under-developed.

A.2 Public expenditure implications

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

Future estimates show that substantial additional investment in long-term care services 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). Significantly, this projection excludes newer EU Member States which have considerably lower historical levels of expenditure and service provision, where future increases in spending are likely to be considerably greater in order to 'catch up' with demographic trends. It is also widely accepted that labour-intensive care services have far lower potential for productivity gains than 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 the majority of the total hours of care needed. Private financial

contributions can 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 share of total spending on long-term care (Huber, 2008).

A.3 Overarching EU policy commitments and the Open Method of Coordination

Member States are committed to providing 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 services, 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 issues related to pensions, health and long-term care. The Lisbon strategy commits the EU to support the development of a common market by improving the labour supply in Member States. This commitment includes safeguarding the responsibilities of working age populations to financing social protection

schemes, because of the relationships between social protection and economic performance (Rothgang and Engelke, 2009).

However, variations in definitions of long-term care (EC, 2008), combined with inter- and intra-country differences in the structure and organisation of long-term care services, together 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 accessing services also persist and these are very unequally distributed within and between countries (EC, 2008).

A.4 The developing EU focus on 'social services of general interest'

Since the mid-1990s there has been growing focus on 'services of general (economic) interest'. This cluster of services remain the responsibility of public authorities within each Member State, but are important because of their contribution to economic, territorial and social cohesion within and between EU Member States. The scope of this policy interest now extends to health and social services as well as physical infrastructure.

A 2004 White Paper recommended a systematic approach towards 'social services of general interest' (SSGI), in order to clarify the framework in which they operate and can be modernised. The first Communication on SSGI was adopted in April 2006. The Communication started to define the specific characteristics of this sector; offered guidance on the application of Community rules; and announced a new consultation of Member States and stakeholders. The subsequent Communication on services of general interest, including SSGI, adopted in November 2007, set out the results of the consultation. It emphasised the importance of social services for the fulfilment of EU objectives; listed the specific aims of social services; and explained how these aims are reflected in the ways that SSGI are organised, delivered and financed. The Communication was therefore an important step towards recognising the specific features of SSGI. The Communication also confirmed the Commission's commitment to clarifying the legal framework applicable to SSGI. Two 'Frequently Asked Questions'

(FAQ) documents, clarifying 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 an expression of this commitment. The Communication also proposed a strategy aimed at promoting the quality of social services.

In its 2006 Communication, the Commission also made a commitment to producing biennial reports to improve the knowledge of service providers, other stakeholders and the Commission alike on the situation of SSGI in the EU and 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 (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 will need 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 in terms of relevant EU rules (CEC, 2008).

A.5 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, as experienced by end users, depends substantially on the characteristics of care workers and the relationships they are able to develop and maintain with care recipients. 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 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 differential 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 (CEC, 2008).

However, 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 (including Austria, Luxembourg, Ireland, Germany and the United Kingdom), employment shares range from eight per cent to 13 per cent. The third group, including 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 Member States, at 18 per cent (Huber *et al.*, 2008).

The expansion of the health and social care sector will continue to be crucially important in achieving EU employment goals. This expansion is particularly important in relation to the employment opportunities the sector offers women and older workers, who according to the Lisbon agenda are priority groups to encourage into the labour market. However, employment in this sector is more than usually likely to be characterised by part-time contracts, non-standard work patterns, temporary contracts and lower wage rates (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 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 have shrunk; 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.

A.6 The development of markets within social and long-term care services

Market-based approaches to the delivery of long-term care services are widely advocated on the grounds that they improve efficiency, choice and transparency. There is now considerable competition between different suppliers of long-term care services in many EU countries; these suppliers increasingly compete for publicly-funded service provision, as well as for private purchasers in those countries with more residual public long-term care systems.

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 constitute 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 for-profit providers 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 these market developments, there has been a shift in emphasis from 'public programme' regulation using mechanisms such as budgetary planning, certification and control, to regulation utilising market mechanisms. The latter can include competition for markets (for example, for large scale contracts from public sector purchasers); and competition within markets (for example, for the business of individual customers). In some schemes the user becomes the direct purchaser, using individually-allocated public funding to purchase privately-provided services. Cash allowances, vouchers and individual budgets are among the mechanisms used to create competition within long-term care markets. However, 'pure' market regulation mechanisms are invariably modified: public sector organisations

are often major (monopsony) purchasers; information asymmetry is widespread; and non-market, managerial regulatory mechanisms such as inspection and quality-based licensing are also common (CEC, 2008). Value-driven competition — competition in which the quality of services is a major factor — is considered to be underdeveloped (Huber *et al.*, 2008).

B. Policy and situation in the host country — Denmark

B.1 Background

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

Currently 14.8 per cent of the Danish population are aged 65-plus and four per cent are 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). The coverage of long-term care services is detailed further below.

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 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, 2001).

B.1.2. Government responsibilities for services for older people

Public services are at the heart of Danish policies and the system is universal. Services are tax-financed and free to the user, regardless of income.

Local, regional (county) and national governments each have their own responsibilities. The structural framework for public services was revised in 2007; this confirmed that central government sets the general legislative framework, while municipalities have overall responsibility for social services and provide the first point of access to services for citizens.

The five county (regional) authorities are responsible for the funding, planning and operation of specialist medical services, 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 counties contribute primary care services (general practitioners, dental care, and so on), hospital and psycho-geriatric services to the long-term care of older people (Ministry of Social Affairs, 2006).

The principles underpinning services for older people include flexibility and responsiveness to meet individual needs; consideration of any needs on the part of the older person's family; and an emphasis on self-help and prevention.

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 specialist housing. Funding for these services comes from municipal level income taxes, with additional funding from central government block grants. Municipalities have responsibility for determining 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 ceilings for local taxation); and for allocating help according to individual assessments of need. There is no formal eligibility threshold

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 long-term care services. All municipalities are required to offer domiciliary services to anyone unable to perform regular activities of daily living, with the aims of enabling them to stay in their own home for as long as possible and preventing further deterioration in physical and mental health. These services include:

- domestic (home help), 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.

B.1.3 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, these services appear increasingly targeted on people with higher levels of need. Recent changes in methods of compiling activity data make it difficult to discern long-term trends; however, between 1982 and 2001 the percentage of people aged 67 to 79 receiving home care services remained stable at around 13 per cent, whereas the proportion of people aged 80-plus (that is, those likely to have higher care needs) who received home care increased from about 36 to 50 per cent. 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 at least two 'preventive' visits a year from a municipally-employed care manager. These visits aim to assess the older person's current needs; anticipate potential future needs; and encourage participation in health promotion activities. Although the offer of a preventive visit can be refused, the number of such visits is increasing. People who do need help and support are entitled to an individual assessment

of need, which 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 circumstances. The assessment takes into account the capacity of a partner to provide practical 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. From January 2009, elderly people eligible for nursing home care are guaranteed a wait of no more than two months.

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

B.2 Recent reforms

B.2.1 The 'free choice' reform

From the early 1990s there have been debates about introducing more choice into the provision of long-term care services; at that time 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 consider at least once within any term of office how existing opportunities for choice could be expanded or new opportunities for choice introduced. These changes aimed 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 the 'free choice' reform have been met by an annual Government grant of DKK 500 million to municipalities. From 2006 a further DKK 500 million annually has been granted to municipalities to ensure better and more flexible home help services; and from 2007 municipalities have been granted a further DKK 300 million annually to meet the additional pressures of a growing older population (Ministry of Social Affairs, 2006).

B.2.1.1 Extension from practical/domestic help to 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 new 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; this help is still 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 more intimate services such as personal care. However, in 2003 personal care became included in the free choice arrangements; choice has also been introduced to residential accommodation, including the option of accommodation in another municipality. 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 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.

B.2.1.2 Choosing a provider

During assessments older people are given information about the available local service providers and are asked to choose, based on how providers 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 often occurs (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 private purchase basis. Municipal providers cannot offer additional services outside those funded by the municipality and consider this constitutes unequal competition.

Attitudes towards 'free choice' 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). Differences in satisfaction may reflect the different case-mix 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.

B.2.1.3 Take-up of the free choice policy and market shares

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); this found that 76 per cent of municipalities were able to offer a choice of provider in at least one main area of domiciliary services — personal care, practical help or meals-on-wheels. This was the same as in 2005, indicating no recent expansion. 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.

Private provision is much less popular among recipients of intimate personal care. In 2005, 2,800 people chose a private provider of personal

Table B.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.

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.

B.2.1.4 Unequal access to choice in personal care

The municipalities estimate that in 2005 five per cent of all those assessed as needing personal care chose a private provider. However, only 43 per cent of municipalities in fact offered a free choice of personal care provider during the day; in these municipalities ten per cent choose a private provider. This suggests 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, with private providers of personal care being largely restricted to Copenhagen and other urban areas. 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 personal care 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 specific 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 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.

B.2.1.5 The impact on care workers

Compared with many countries, the Danish home care workforce is relatively skilled with most care workers working 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; these gains may be offset to some extent by higher levels of responsibility and reduced opportunities for teamwork with colleagues (Rostgaard, 2007b). 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).

B.2.2 Quality reforms

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).

However, as part of a framework for strengthening local self-government, the Government and municipalities have recently agreed a number of principles of good devolved management. These principles emphasise the rights and duties of municipalities to determine appropriate service levels and provide clear frameworks and targets for local authority services and contracted suppliers. Thus in relation to services for older people, municipalities must publish quality standards for all suppliers of domestic and personal care. These standards must cover access to services, forms of service provision, staff working conditions, occupational health and sickness cover and citizens' rights in relation to the local authority. Recently municipalities have been preoccupied with the new 'free choice' reforms and quality is only now re-emerging as a priority for domiciliary care. 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.

Specific measures agreed between the Government and municipalities aimed at improving the quality of care include:

- Improving the attractiveness of jobs in order to enhance staff recruitment and retention and develop worker competencies through new qualifications developments.
- Developing tools to measure quality in services for older people and user satisfaction.
- Improvements in the responsiveness of services to meet the wishes of individual service recipients.
- 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.
- Improving buildings and updating labour-saving technology in social care.
- Developing and testing systems where care staff, residents and relatives can report errors and unintended incidents, in order to promote learning.
- 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 shift in priorities from service management to front-line care; and increased local autonomy to facilitate innovation.

The quality reform initiatives are supported with funding of DKK 10 billion (€1.3 billion) between 2008 and 2011, and a further DKK 50 billion (€6.67 billion) from 2009 to 2018.

From 2010 quality contracts will replace the current local authority service strategies. Quality contracts represent the municipality's agreement with its citizens and must include clear and measurable objectives for each municipal service so that citizens are clear about what they can expect to receive in each local authority area.

B.2.3 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.

C. Policy and the situation in the peer countries

This section is compiled from the background Statements and Comments contributed by the Peer Review countries before the meeting in Copenhagen on 1 April 2009; and from the detailed minutes of that meeting.

C.1 Estonia

C.1.1 Background

Municipalities are responsible for long-term care services for older and disabled people. Many municipalities are very small so reforms are proposed to merge some municipalities and create a viable base for service provision. Many older people live in unsuitable housing and there is extensive reliance on family and neighbours, particularly in rural areas. There are problems at the interfaces between health and social care, because data protection restricts the sharing of information about people needing support. However, EU funding 2007–2013 is earmarked for public service development, including services for older and disabled people.

C.1.2 Range of services and service mix

Medical, nursing and care services are provided on the basis of need, not according to ability to pay. There are 120 care homes (public, for-profit and non-profit); their quality varies widely. Residents are expected to contribute all but 15 per cent of their pensions to fund residential placements, often with additional contributions from relatives. In small municipalities, domiciliary services are likely to be provided by in-house staff; in bigger municipalities these services may be delegated to non-municipal providers, particularly non-profit or community organisations. Charges can be made for community services. Until recently about a third of municipalities had no home care services, but since 2007 municipalities have been responsible for assessing needs and providing appropriate funding for services. Ensuring basic levels of services, improving co-operation between municipalities and improving integration between health and social care are current policy priorities.

C.1.3 Policies on choice and quality

Experiences with rehabilitation services for disabled people have shown that choice of provider is important for service users. However, the entry of new long-term care service providers to increase opportunities for choice is slow because of low profit margins, so in many places choice is not possible because of a widespread shortage of services. Moreover, extending choice to long-term care services has much lower priority than achieving full coverage of good quality services across the country. In addition, it is believed that introducing mechanisms like personal budgets or vouchers would create additional administrative burdens and monitoring problems.

C.2 Hungary

C.2.1 Background

Two historical legacies shape long-term care services in Hungary: a traditional reliance on residential care as the most common form of service provision; and the targeting of services on poorer older people. Both demand and supply factors make it difficult to reduce the overall number of residents in care homes, although the resident population is slowly changing towards more dependent older people who need nursing care. There is no consensus about the balance between universal and targeted services. Health and social care services have separate institutional and financial frameworks and co-operation between the sectors is poor.

Municipalities are responsible for providing home care and meals services. There are challenges in delivering these in rural areas, where the elderly population is disproportionately located; in 2007, about a quarter of all villages had no home care services. Residential care is available in larger towns and counties. Churches, for-profit and non-profit organisations all provide services; these are funded from state grants, their own resources and user contributions. Users pay charges for services based on the volume of service used and their income levels, but these payments do not confer any consumer-related opportunities for choice. Even private 'top up' purchase of

services in addition to publicly-funded services is not favoured because of the risks of increasing social inequality.

C.2.2 Range of services and service mix

Service providers are mainly NGOs and public organisations. Private for-profit providers are involved in delivering some publicly-funded services like meals on wheels. The Government issues licenses to service providers and regulates payments to public and non-profit independent service providers. Current priorities are to develop output and outcome-focused regulatory criteria, partly in preparation for further development of a mixed economy of provision.

In order to improve coverage of services in rural villages, resources are allocated at micro-regional levels, to facilitate efficient management of human and fiscal resources. Government and EU resources are helping to develop assistive technology such as alarms, particularly for use in remote rural areas.

C.2.3 Policies on choice and quality

Municipalities are the main service providers and in rural areas and small villages they are likely to be the only provider. Even in cities, the dominance of public sector provision restricts choice. There are anxieties about promoting choice because of: the risks of 'creaming off' better off, healthier older clients in situations of scarcity; the problems of information asymmetry; the increased transaction costs likely to accompany the use of vouchers or personal budgets; and the potential increase in social inequalities. Nevertheless, encouraging private providers may be the only way of increasing service capacity; this would require a transformation in the role of public authorities. Only in services where there is ample supply and where users can exercise full 'consumer' control such as meals on wheels, are there plans to introduced individual vouchers. Otherwise, market developments are considered inappropriate in a system characterised by shortages. Regulating quality is a public sector responsibility; consumer feedback will be sought through satisfaction surveys, rather than using market mechanisms to improve service quality.

C.3 Italy

C.3.1 Background

Italy has 21 regions and over 8,000 municipalities. Since 2001, policies have aimed to clarify the responsibilities of different levels of government; regional and local governments have lead responsibilities for planning and implementing welfare policy. The policy priorities of the Ministry of Labour, Health and Social Policies are to reduce fragmentation; extend access to basic services across the whole country; increase integration between health, social care and welfare policies and services; and improve consistency between regions through national guidelines and an internal open method of co-ordination.

C.3.2. Range of services and service mix

GPs supervise Integrated Home Care for people needing continuous health and social care services at home from a team of qualified professionals. Home care services include less intensive nursing and/or rehabilitation services. There are also home hospitalisation services for people requiring short-term, intensive specialist medical care. There has been an increase in residential care homes over the past 20 years, although there are wide regional variations in their remit and practices; current policies aim to standardise classifications of residential care facilities in order to reduce inappropriate admissions. Multi-disciplinary assessments are important in identifying needs that can be addressed in individual care plans; however, there are regional variations in the assessment tools used. Family care is supported through benefits for health and social care.

C.3.3 Policies on choice and quality

Health and social care vouchers are available for purchasing care from accredited public and private sector providers, but only in the richest regions such as Lombardy. Choice is possible in northern and central Italy, where social services are characterised by high staffing levels in public and private sector services, good quality services and high levels of user satisfaction. In southern Italy, choice is regarded as a luxury because even basic access to

services cannot be guaranteed; here there is extensive reliance on informal family care, supplemented by the employment of immigrant labour. Current policies aim to introduce national standards for services which will help to guarantee equality of access; the challenge is to 'level up' service standards while maintaining devolved power at local levels.

C.4 Lithuania

C.4.1 Background

Legislation came into force in July 2006 to clarify the responsibilities of national, county and municipal governments; encourage competition between service providers through reforms to reimbursement; and introduce quality standards in social services. The 60 municipalities are responsible for social services; this means that regional variations in the quality and infrastructure of services are apparent. Entitlement to services depends upon the assessed needs of the older person and family. Services are funded through special state subsidies, municipal budgets and by users (or their families) who also pay charges according to their income (and assets, for residential care). Municipalities guarantee services for those whose incomes are too low to afford user charges.

C.4.2 Range of services and service mix

Services are provided by private and public organisations. Official policies are to encourage a shift from residential care to care at home, including integrated nursing and social services for people with complex needs. However municipalities have poor mechanisms for anticipating future demand, while demand for residential care continues to increase because of older people's preferences for this type of care.

C.4.3 Policies on choice and quality

The 2006 legislation aimed to introduce a bigger role for markets in the organisation and delivery of social services through the introduction of charges/co-payments for all users; quality assurance systems; and licensing of providers. However, some municipalities provide only a limited range of

services and in other areas municipal service provision still dominates. In 2007, a national quality system was introduced; from 2009 compliance with these quality standards will be enforced. There are anxieties about the possible increase in administrative costs arising from compliance with quality standards and who will bear these costs.

Choice between providers is possible in principle and user charges are regarded as an important mechanism for promoting consumer-related expectations of services. However, in practice users' choices are often limited by their inability to afford higher levels of user charges — the prices charged by providers are not regulated. There are no opportunities for choice over the content of the individual's social care plan. Municipalities also have discretion to offer older people and their families a cash payment instead of services, where it is expedient to do so.

C.5 Netherlands

C.5.1 Background

The Netherlands has introduced vouchers or personal budgets to facilitate choice in labour market reintegration services and in personal care. There is now also free choice of health insurer; (limited) choice of insured health package; and choice of private providers.

The Netherlands country report focused on the use of vouchers or personal budgets in labour market re-integration services. Economic pressures during the 1980s prompted the transition from state administration of social security and welfare systems to greater roles for private providers and for consumer choice. Social insurance sickness benefits were replaced by employer sick pay; consequently, employers developed (or purchased) occupational health services to reintegrate sick employees back into the labour market.

C.5.2 Policies on choice and quality

The development of choice and markets has been gradual. In 2000, the public body regulating unemployment and disability benefits and municipalities

were required to buy all re-integration services from private providers through open tender; by 2008 this had stimulated the emergence of some 2000 private providers. However, this development was criticised for not being (cost-) effective and the option of direct provision by public bodies and municipalities was reintroduced.

Individuals can opt for an individual, tailor-made reintegration package in which s/he chooses her/his reintegration provider and designs her/his own programme. These options are increasingly popular; result in higher satisfaction levels than traditional approaches; are more effective in getting clients back to work and have attracted many new small providers to the supply-side of the market. On the other hand, they are more expensive than traditional services and tend to attract better qualified clients who have good employment prospects.

In relation to social care, there has been a partial retreat from policies of privatisation and the reintroduction of opportunities for municipalities and social insurance companies to provide care themselves rather than being required always to use a private provider.

C.6 Portugal

C.6.1 Background

Opportunities for choice are very different for older people in rural areas and cities. Portugal aspires to make care for older people universally available. Unlike other countries, local authorities play little part in managing long-term care services; providers receive public funding based on the numbers of people who receive their services.

C.6.2 Range of services and service mix

Social care is financed from direct and indirect public funding and private funding. There is a mixed economy of providers, with many non-profit providers linked to the Church; non-profit organisations have always played a major role and account for about 80 per cent of provision. Some for-profit providers, funded through private purchase or private insurance, operate

mainly in large cities. Agencies that meet minimum quality standards are funded according to the volume of services they provide and the number of people who use their services. Older people and families can purchase additional complementary or private services.

C.6.3 Policies on choice and quality

Policies aim to create a limited market, with competition between those providers that meet basic criteria. Choices for older people outside large urban areas are limited — here the priority is to ensure that the existing provider can increase capacity so as to meet all needs. On the other hand, local and regional service developments in rural areas have the potential to create new jobs and contribute to social cohesion. Where choice is available, families are best placed to choose between providers that meet the minimum quality standards. There are discussions about possibly channelling part of the funding currently going directly to providers through the service user or a care manager, who would then make payments to the chosen accredited provider.

Policies on quality aim to both establish minimum compulsory baselines, enforced through rigorous inspection regimes; and encourage voluntary improvement above these baselines. These quality assurance mechanisms set the terms on which providers can offer services. The Portuguese Institute for Social Security has developed a quality model, including quality assessment and user satisfaction surveys, that can be adapted for different types of social services. The model was derived from ISO 9001 and the EFQM Model of Excellence and covers: Leadership, Strategy and Planning; People; Partnerships and Resources; Processes; Customer Results; People Results; Society Results and Key Performance Results. Scores can be benchmarked and compared with previous years and with other organisations. It is expected that this model will enable choice, quality and equity to be achieved.

C.7 Romania

C.7.1 Background

Romania is struggling to develop a social care system from scratch, partly as the result of EU pressure during the accession phase. Since 2006, the respective responsibilities of state and local public authorities for social protection, including the development and delivery of social services, have been clarified. As an element of social assistance, social services are the responsibility of local authorities. 'Primary' social services identify, diagnose and assess; provide information; offer preventive services; and refer people on to 'specialised' services where necessary. The latter are responsible for ensuring adequate housing, care, recovery, rehabilitation, social integration and support.

Between 2006 and 2008 a programme to develop formal domiciliary care services for older people supported the training and employment of care workers. Forthcoming priorities are to establish a minimum retirement pension scheme for public employees and a social insurance scheme to provide advice and care services for older people.

C.7.2 Range of services and service mix

There are over 2,000 social services providers; over half are private (non-profit) but many of these are small and have limited capacity. Non-profit providers and volunteers are vital in delivering social services; since 1998 NGOs have received annual subsidies from the state budget according to the type and volume of services they provide. Public providers have larger capacity; the majority are directly managed and financed by public authorities and provide 'specialised' social services, using individual care plans and qualified personnel. If public providers cannot offer all necessary services, they can contract with private providers. In many instances, services are delivered in partnership between public and private providers.

Hostels for older people are provided by public authorities, NGOs and private providers. The number of public hostels for older people has increased from 19 in 2004 to 76 in 2008, funded partly from national resources and

partly from international aid. However waiting lists for hostel and home care services are long.

C.7.3 Policies on choice and quality

Romania has little experience of consumer instruments like personal budgets or vouchers. Although vouchers for nursery care have been available since 2006, there is no information on how these are used.

Since 2000 service providers must comply with minimum quality standards in order to be accredited. Contracts are also established between providers and users — these set out the user's rights and obligations and the activities included in the care plan. Additional quality standards are set for specific services. A new Social Inspectorate has been created to ensure accredited providers comply with quality standards; there have been concerns that the Inspectorate gives insufficient attention to the experiences of users. On the other hand, rigorous enforcement of quality standards would mean some providers would be unable to comply and older people would lose their services.

C.8 Spain

C.8.1 Background

In 2006 Spain's social expenditure as a percentage of GDP was well below the EU average. The 17 semi-autonomous regions run the National Health Service; the Ministry of Health ensures equity and the Inter-territorial Council of the NHS plays a co-ordinating role. Healthcare is funded from taxation and is free at the point of access; voluntary private supplementary medical insurance covers less than five per cent of the population. Traditionally families have provided long-term care but demographic changes are creating pressures for more formal service capacity. Legislation in 2006 created the Autonomy and Care Dependency System (SAAD); this aims to ensure equity of access to support and care by disabled people of all ages — some 1.3 million people — up to 2015. It includes a single definition of dependency,

with standard assessments determining one of three levels — moderate, severe and major.

C.8.2 Range of services and service mix

Recent changes have extended the range of services for older and disabled people, including the provision of primary health care at home, temporary stays in residential home, day centres, residential homes, telecare and financial support to disabled people and carers. The 2006 legislation creating SAAD offers benefits for 'dependent' people in the form of services or cash payments. Services aim to prevent dependency and promote personal autonomy; they include personal alarms, home help services, day and night care centres and residential care. Cash payments are intended for the purchase of services, for family care or for the purchase of personal assistance.

C.8.3 Policies on choice and quality

People eligible for help under the new SAAD arrangements can choose between services or financial support. Informal care is provided by families or by undocumented immigrant labour, raising questions of quality. Professional criteria and opportunities for training and support are available which it is hoped will enable informal carers to be brought into the formal care labour market.

The 2006 legislation prescribes only a minimum level of services; any additional provision is up to the regional Autonomous Communities and this discretion leads to big regional differences. Local governments are responsible for managing services, in line with the regulations set out by their respective Autonomous Communities. However, responsibilities between local authorities and Autonomous Communities are not well delineated and conflicts can occur.

C.9 United Kingdom

C.9.1 Background

Social services are the responsibility of the constituent countries of the UK — England, Wales, Northern Ireland and Scotland. In all four countries, National Health Services are funded and managed separately from social care services, which are the responsibility of local authorities. However there is often close collaboration between the two sectors at local levels, particularly over the commissioning of services for older and disabled people and in the preparation of Joint Strategic Needs Assessments for their shared local populations.

Both NHS and social care services are funded from general taxation; however social care services are heavily means-tested and many people are excluded because of high income/assets levels. Most social care services are purchased by local authorities from independent (non-profit and for-profit) providers.

English social care priorities are to prevent people losing independence (or help them regain independence quickly after illness); exercise choice and control over their lives; and ensure that support is personalised to individual circumstances.

C.9.2 Range of services and service mix

Similar arrangements cover both older people and working age disabled people. Current priorities in England are to improve access to information by disabled and older people; develop preventive interventions such as short term reablement services for new service users; and offer personal budgets (PBs). PBs are being extended to all users of adult social care in England between 2008 and 2011. PBs involve every service user knowing what resources are available to them and being able to choose what support or services they are used to purchase. PBs can be taken as a cash payment, or held by the local authority care manager, or managed by a trust or third party.

Although local authorities also have duties to assess the needs of family carers, levels of support for carers vary considerably between localities.

C.9.3 Policies on choice and quality

Personal budgets are intended to give greater choice to service users. However, whether choices can be realised will depend on the capacity of local provider organisations to respond appropriately to changed market incentives, with individuals rather than local authorities becoming the main purchasers. It is hoped that the emphasis on improving access to information, combined with PBs for publicly-funded social care service users, will improve equity between those whose services are publicly funded and those who pay for their own care.

Care services are regulated by the Care Quality Commission (CQC) Social care providers must register with the CQC, which also carries out regular inspections. Some local authorities use inspection reports to inform their service commissioning; inspection reports are also available on the CQC website for prospective service users.

D. Learning and transferability issues

This section draws on the discussions during the Peer Review meeting about the key issues of choice, quality regulation and equity. It includes evidence from the Danish policy under review and comparisons from the participating Peer Review countries.

D.1 The development of long-term care markets within EU countries

EU policies are neutral on the question of 'make' or 'buy' — whether it is better for public authorities to provide services themselves or purchase them in a market of independent (non-profit and for-profit) providers. Nevertheless, there is increasing interest in market-based forms of regulation. This interest is consistent with developments within some Member States that involve a shift from practices of providing block funding for service providers (based, for example, on the numbers and/or volume of services they provide) to funding that is more specifically attached to individual service users. The latter mechanisms are assumed to enable service users to exercise choice; to place more direct demands on service providers for the specific configuration of services that suit users best; to stimulate effective competition between providers in terms of responsiveness, quality and value for money.

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); some newer Member States are developing for the first time long-term care systems based on similar approaches. Such approaches assume that choice delivers benefits for both service users and the wider society, on the assumption that competition can generate lower cost and/or higher quality services.

Within this broad trend, different models and country-specific rationales can be identified; all are compatible with continuing public funding most long-term care provision. Differences in market-related developments include:

- the form in which resources are allocated to and used by older and disabled people — for example as a specified level of service entitlements, as vouchers, or through cash payments

- whether a proxy, such as a care manager, co-ordinates and purchases services from different providers on behalf of a disabled or older person; or whether individual service users themselves have control over the public resources allocated to them and can negotiate directly with care providers

- whether care can be purchased or procured only from accredited provider organisations with whom the funding body (local authority or insurance fund) has formal contracts; or whether care can be procured from less formal sources, including 'grey' labour market workers, relatives and friends

- in the case of care being purchased from less formal sources, whether minimum labour laws (legally enforceable contracts, minimum wages, explicit terms and conditions of employment) apply to people providing care labour

- the level of scrutiny and supervision exercised over how public funds are used by the people who receive them.

D.2 Choice and equity

D.2.1 The benefits and drawbacks of choice

Opportunities for service users to exercise choice over who provides their services are generally assumed to lead to competition between provider organisations. In turn competition is assumed to lead to lower costs (because users will opt for the best value services); and greater diversity of services (because, in their search for business, providers will be motivated to provide the kinds of services they think users will want; in turn, users will opt for the services that best meet their needs).

However, countries participating in the Peer Review pointed to the risks attached to opportunities for increased choice. Of particular concern was the risk that choice could lead to greater inequality in user experiences and outcomes:

- Some service users are better equipped with information and other resources to enable them to make choices. People with cognitive impairments such as dementia are likely to find themselves particularly disadvantaged.

- More affluent service users could draw on their own resources, on top of public funding, to purchase services of better quality or in greater volume than poorer people.

- In situations where services are relatively scarce, service providers may exercise choice over the clients that they accept — so-called 'cream-skimming' the most profitable, least costly or otherwise least problematic clients.

For these reasons, the potentially positive benefits of increased choice need to be considered against the potential for increased inequalities, reduced social cohesion and reduced social inclusion.

D.2.2 Choice in different welfare state contexts

D.2.2.1 Choice in Denmark

The unique contexts within which the Danish 'free choice' policy has been introduced need to be recognised. These features may restrict the transferability of the policy.

- Compared with other EU Member States, Denmark has one of the highest per capita levels of public spending on long-term care for older people. This funds an extensive network of high quality local services to older people. Of all European countries, Denmark has the highest level of home help provision for over-65s; between 1982 and 2001, even with growth in overall numbers of older people, the

proportion of people aged 80-plus receiving home help services increased from 36 to 50 per cent.

- Almost all long-term care services, apart from temporary care, meals-on-wheels, hotel costs and optional additional services in nursing homes, are provided free of charge. Apart from these, there are few opportunities for some individuals to purchase extra, or better quality, care services than others. The only sector in which there is substantial private purchase of services is in relation to domestic help; but even this potential for increased inequity may be limited by the relatively generous Danish public pension system.

- Until 2002, all domestic help, personal care and nursing services were both funded and provided by local municipalities. Thus the 'free choice' reforms aimed to create a local market in which new service provider organisations could for the first time compete with municipal providers to supply services to older and disabled people.

These features are very different from the situations in many of the other Member States that participated in the Peer Review.

D.2.2.2 Choice vs. universal coverage

First, a number of countries were experiencing major challenges in achieving a basic coverage of community-based care services across the whole country. These challenges were particularly acute in the Eastern European countries participating in the Peer Review. Particular difficulties were reported where:

- Municipalities, which are responsible for funding and/or providing services, are very small and do not have the capacity to fund or provide a comprehensive range of services.

- Older people live disproportionately in rural areas, which also have lower levels of service provision than urban areas.

- There is a legacy of institutional care as the predominant care service for older people. Here there are challenges in finding the resources

for additional investment in new community and domiciliary options while at the same time maintaining institutional facilities for existing residents and, indeed, improving standards in them. Moreover, older people tend to ask for the types of services they are familiar with. Consequently additional challenges arise in changing the expectations of older people and their families and discouraging new cohorts of elderly people needing care from requesting residential care, at the same time as comprehensive, good quality community alternatives are still being developed.

For Peer Review countries with lower levels of long-term care service provision, the ability to offer older or disabled people a choice of provision was felt to be a luxury. Rather, the more urgent priority was to ensure the basic coverage of services, particularly in rural areas. In some countries, this priority had been helped by EU funding and by requirements placed on national governments during the accession phase. In many countries, 'equalisation grants' and other funding from central government were crucially important in evening out major local and regional discrepancies in resources and levels of services.

D.2.2.3 Municipal vs. 'mixed economy' traditions

A second area of divergence among Peer Review countries was the historical balance between state or municipal service provision and the role of charities, organisations connected to the church and other NGOs in providing long-term care services. Some of the Peer Review countries have long traditions of the 'mixed economy' of care provision that Denmark is now striving to achieve. For example in Portugal, non-profit NGOs provide 80 per cent of the total volume of services. However, in no country did for-profit providers play any significant role and, indeed, were specifically forbidden from providing services in a few countries. In many countries therefore, a rather different trend was apparent — a growing role for central and local government in funding, planning and assuring the coverage and quality of services that have always been provided by non-governmental organisations.

D.2.3 Experiences of choice among Peer Review countries

Some of the countries participating in the Peer Review had moved, or were considering moving, from a situation where service providers were allocated block funding, regardless of the volume or quality of services they provided. Instead, more individualised funding arrangements were being introduced or considered that would facilitate choices between providers and greater flexibility over the content of services, with funding reflecting those individual choices.

There was very little experience of vouchers, personal budgets or similar mechanisms that place resources directly in the hands of service users who are then able to exert consumer-type pressure on service providers to deliver the services of their choice. In countries where cash payments or care benefits are available, these tend to be used to support families in providing care. There was also no evidence from the participating Peer Review countries of the use of private resources to 'top up' publicly-funded service entitlements, vouchers or care allowances. In some countries, any such opportunities are in any case limited by the low incomes of older people. Only in England, which has very restrictive eligibility criteria for social care services, was there reported to be extensive private purchase of community-based and residential social care services.

Many countries do however require charges or co-payments towards the costs of basic services from service users and their families. There was some confusion between these charges and the concept of a personal budget. However, there was no evidence that these charges allowed users to exercise choice or purchase higher quality services; again, ensuring access to local, quality services was commonly accorded a much higher priority.

D.2.4 Choice and equity

Given the relatively limited experiences among the Peer Review countries of choice mechanisms in social care services, there was little evidence so far that choice was leading to (increased) inequalities in experiences of services or in outcomes. However several Peer Review countries were concerned about this as a possible consequence. For example, in Hungary, there were

concerns that the promotion of choice and markets in social care could increase existing cultural and material differences between urban middle class people and rural working class people in their respective attitudes towards and use of services. Such developments were considered to risk undermining social solidarity and social inclusion. Only in the Netherlands, which had introduced competition between providers and personal budgets in respect of labour market reintegration services, was there actual evidence of inequality. Here independent providers appeared to have more success in reintegrating unemployed people into the labour market than statutory organisations. However, this may have been because the independent providers had been able to attract clients with higher qualifications and/or more recent work experience, who were therefore easier to assist in finding work. Independent providers were also more expensive. Indeed, the Netherlands was reconsidering policies of marketising services and a move back from 'buy' to 'make' — from outsourcing to direct provision of services by welfare state organisations.

There were considerable concerns expressed about the potential costs of quasi-markets and choice:

- transaction costs were anticipated to increase
- unit costs were also expected to rise, as it is more expensive to provide individually-tailored services than a standard service
- in order to offer choice, there needs to be spare capacity in services, which means that services would need to operate at below-optimum efficiency.

D.3 Regulation and quality

D.3.1 Methods for regulating quality

A transition from municipal or state-provided services to a market-based care system, as in Denmark and England, can prompt the development of new mechanisms to regulate the quality of care. However, this is not the only stimulus for new regulatory mechanisms. Thus in countries like Portugal,

where non-profit NGOs have always played a major role in providing social care services, developing new methods of quality assurance reflects a desire to ensure that all citizens have access to services that meet minimum quality standards. In addition, it is increasingly recognised that elderly people using municipal or state services are entitled to good quality services as much as those using independent providers.

Among the Peer Review countries, regulation took different forms. A common requirement was that as a condition of receiving public funding all organisations and facilities providing care services should obtain initial approval from an accreditation body (either part of government or run on behalf of government) that minimum standards are reached. The inspection or registration body may subsequently also carry out regular inspections.

Experiences in the Peer Review countries suggested a number of other ways in which quality could be assured. These included:

- regular user satisfaction surveys and accessible complaints systems, run by local authorities or otherwise independent of the service provider
- contracts between providers and service users that set out the user's rights and obligations and the activities included in a care plan
- public statements from local authorities of the minimum standards that all service users have the right to expect from each service
- contracts between care providers and local authority funders of services that specify minimum quality standards.

One challenge is to encourage compliance with minimum registration standards, while at the same time encouraging voluntary improvement above these minimum standards. One example of a strategy for achieving both goals is a quality model developed by the Portuguese Institute for Social Security that includes independent assessment and user satisfaction surveys and can be adapted for different types of social services. The model was derived from ISO 9001 and the EFQM Model of Excellence and covers:

Leadership, Strategy and Planning; People; Partnerships and Resources; Processes; Customer Results; People Results; Society Results and Key Performance Results. Scores can be benchmarked and compared with those from previous years and with other organisations.

Peer Review countries and stakeholders pointed to the need for quality assurance mechanisms to focus on the experiences and outcomes for service users, rather than inputs of services.

D.3.2 Improving quality through the workforce

Some Peer Review countries recognised that both the availability and the quality of services depends upon a stable, trained and qualified care workforce. In countries such as Romania, this was a major challenge, given a historic lack of investment in social work training. Romanian policy therefore focused on providing basic training and improving the working conditions, remuneration and benefits received by care staff. At the other end of the spectrum, Denmark has introduced a new framework to improve the recruitment and retention of care staff, ensure good management and encourage the development of staff competencies. This framework is intended to help achieve Danish commitments to improve continuity in services by reducing the numbers of workers visiting an individual; and to provide every older service user with a single point of contact. A further interesting development is in Spain, which has introduced professional criteria and opportunities for training and support for family and informal carers.

D.3.3 Tensions between quality assurance and other goals

Quality assurance mechanisms should be proportionate and not overly bureaucratic. Concerns were expressed by some Peer Review countries that quality assurance mechanisms did not always give sufficient attention to users' own experiences of services. Partly in response to such concerns, Denmark has embarked on a programme of 'de-bureaucratisation' that allows front-line staff to spend more time in direct contact with service users and less time on administration; this is also hoped to improve job satisfaction for staff.

While acknowledging the importance of ensuring service quality, in countries where the supply and overall coverage of services remains poor there was concern that the rigorous enforcement of quality standards could result in some providers being forced to close and existing users losing their services. This risk was in tension with other priorities of improving the overall supply of services. On the other hand, a failure to enforce minimum quality standards and allow substandard provision to continue could lead to new regulatory regimes being discredited by the public and providers alike. Linked to this latter tension was concern about the costs of compliance with new quality standards and who should bear these — public funding bodies or providers? Moreover, compliance with costly quality regulation regimes could further risk provider failure and increase difficulties of access to basic services.

D.4 The roles of different levels of government

Underpinning the Peer Review discussion was the crucial issue of the appropriate roles of central, regional and local government in ensuring choice and quality in long-term care services. EU membership, and the application of EU rules, have consequences for all levels of governance, including regional or local governments, in Member States. In all countries regional or local governments have major responsibilities for funding, commissioning and/or providing long-term care services. Indeed, the Peer Review countries endorsed the primary responsibility of regional and local government for social care. At the same time, however, these devolved responsibilities can lead to wide local and regional variations in levels of services; in many countries these variations were considered unacceptable and incompatible with broader social inclusion and social cohesion objectives.

Thus, in the former Eastern European countries participating in the Peer Review, recent reforms have specifically decentralised responsibilities from central to local governments and have also spelt out the respective responsibilities of each level of government. One consequence of these reforms is that municipalities that have previously not provided long-term care services now have a clear responsibility to do so; in the longer term, major differences in levels of provision may be reduced. However, another consequence of the decentralisation of responsibility is the challenge for

very small municipalities in providing a range of good quality, differentiated, flexible social care services. The resource base of some municipalities is often small and local market conditions are unattractive to potential new service providers. This is a problem even in Denmark, where market conditions are not attractive to potential new providers of nursing care. One solution to this problem was for small municipalities to combine together to pool resources and provide services together, or otherwise improve levels of cross-border co-operation.

Other mechanisms for reducing regional and local inequalities in the Peer Review countries included 'equalisation grants' from central or federal governments aimed at reducing differences in local resource levels. However, these grants need to be appropriately targeted; sometimes they were used to subsidise the most expensive services, rather than increasing the resources available for funding basic services in the poorest municipalities.

Central governments also have clear responsibilities in setting basic standards for services; clarifying the responsibilities of local and regional governments; and, in some countries, ensuring that service provision complies with required standards. In federal countries such as Italy and Spain, where regional governments have substantial devolved responsibilities, mechanisms exist for reducing inter-regional differences in levels and standards of social care services. These include inter-regional councils and inter-regional peer review initiatives.

E. Conclusions and lessons

E.1 Choice and equity

For at least a minority of Member States, major inequity in access to good quality social care services exists because of the very uneven coverage of service provision across the country. Here, the first priority of national governments and other stakeholders is to improve equity by reducing variations between regions, between municipalities and between rural and urban areas in the levels and availability of services. Only once these variations are reduced and older and disabled people are able to access appropriate services regardless of where they live, might it be realistic to consider issues of choice.

Principles of universal access (according to need) to a basic range of good quality services reduce the risks that more affluent individuals will purchase more or better services on a private basis and lead to an increase in inequalities. These principles are compatible with means- or asset-tested user charges or co-payments.

E.2 Choice and markets

The opportunity to exercise choice also depends on alternative service options being available. Member States vary as to whether they have long histories of service provision by voluntary, religious and other organisations, or whether services have traditionally been directly provided by municipalities. In both contexts it is not always easy to encourage new providers to enter local markets. There appear to be particular challenges in encouraging new market entrants in remote or sparsely populated rural areas.

There is no evidence that competition between providers within social care markets is likely to lead to reduced costs. Rather, for a number of reasons it is likely that overall costs will increase.

E.3 Choice and regulation

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. Quality assurance mechanisms should be both 'top down', such as initial registration and on-going inspection by an independent national organisation; and 'bottom up' through regular user satisfaction surveys and accessible complaints procedures. 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.

However, 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 of 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.

E.4 Choice, regulation and responsibilities of central, regional and local governments

Funding, planning and safeguarding provision of appropriate social care services (whether directly provided or purchased from independent organisations) is widely believed to be a local government (local authority or municipality) responsibility. Recent reforms in many Member States have sought to clarify and restate these responsibilities. Some municipalities are very small and unable to provide adequate levels of services. However, mergers and cross-boundary co-operation can increase their resource base and service viability.

Central and regional governments also have important roles to play, in ensuring that adequate resources are available for the provision or purchase of services; in setting and enforcing quality standards for service providers; and in encouraging intra-country policy learning and transfers of best practice.

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Combining choice, quality and equity in social services

Host country: **Denmark**

Peer countries: **Estonia, Hungary, Italy, Lithuania, Portugal, Romania, Spain, The Netherlands, United Kingdom**

Several EU Member States have introduced innovations in the provision of social services in recent years, motivated by a number of reasons, not least in order to provide a wider range of choice to recipients, to help ensure quality and to contain costs, while at the same time maintaining equality of access to the services concerned. Accordingly, they have experimented with giving final consumers more say over the services they receive and the form in which they are delivered, in particular, through 'personal budget' schemes under which users of services can choose how to spend the money allocated to them, or through voucher schemes, which are similar in kind. Both have the effect of introducing market mechanisms into the provision of social services, of linking supply more closely with demand and of introducing competition between providers, so giving them an incentive to maintain quality and to keep costs down.

Although the nature and detail of such schemes varies between countries, they have sufficient features in common that Member States can learn from the experience of their implementation in different places and from the extent to which they have achieved their various objectives without incurring excessive administrative costs or raising problems related to equity and service accessibility or to service supply. In the Peer Review, Denmark, the hosting country, will present details of the scheme which it has implemented and the effects that it has had, with particular focus on choice, quality and equity issues.