policy paper

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ACCESS TO QUALITY SOCIAL SERVICES

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Access to Quality Social Services

This paper is motivated to capture the added value and 'lessons learnt' from the peer reviews (2004 and 2005) cross cut with a contemporary understanding of access to quality social services and its relation to social exclusion.

The pivotal role of social services in the fight against social exclusion, by its very nature, requires provision that is accessible to those who need it and of high quality. The terms accessibility and quality are widely used in relation to service provision and it is generally agreed that the lack of them presents a stumbling block for combating poverty and the inclusion of people who may need a range of assistance to participate fully in society.

Whilst appearing to be a straightforward process, however, it does on closer inspection reveal a spectrum of meaning including, informing people of what is available, providing physical access to buildings (for disabled people), removing ethnic or ageist discriminatory, barriers' but beyond that, 'access' is increasingly viewed as about moving from a traditional and sometimes paternalist 'service definition of need' (professionals decide what you need) to one based on individual needs and preferences; a 'partnership' in the design, assessment, delivery and evaluation of services.

Seeing access as empowering citizens in this way then presents new challenges for policy makers and professionals, such as between offering a choice between service providers (and levels/cost of services) v guaranteeing equity, on the one hand and between targeting resources on those, deemed, most in need v ensuring universal (minimum ?) service provision. For services to be accountable in terms of access and quality, these elements should also be quantifiable i.e. 'performance – led' with their own developed indicators.

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EU Policy

The importance of accessible and quality social services in the fight against social exclusion is confirmed and underlined in the EU social inclusion policy. The **National Action Plans** and the **Joint Report on Social Inclusion**, the **Peer Review in the Field of Social Inclusion Policies** and most importantly, the **Common Objectives**[1] formulated at the Lisbon Council in 2000 are particularly relevant in this context.

Their importance is further underlined in the Joint Report on Social Inclusion (2005) which has identified several core challenges, among them *guaranteeing equal access to quality services*, including social and care services and the *regeneration of areas of multiple deprivation*.

In the New Member States, the Report identified a serious deficit in terms of key social services at a community level, linking this to a low expenditure on social protection. The urban-rural divide in the geographical distribution of poverty is considered particularly worrying. Significantly however, the range of social services has broadened and care outside residential settings is starting to take roots in the EU10. In the National Action Plans, particular emphasis is given to improving the availability and quality of services, promoting individual approaches and community care, and training for professionals working in social services. Another relevant aspect of the EU policy in this field refers to social care, especially with regard to care for the elderly, one of the most vulnerable population group towards whom a significant and growing proportion of services is directed[2].

1 *All four of the Common Objectives - to facilitate participation in employment and access by all to resources, rights, goods and services, to prevent the risks of exclusion, to help the most vulnerable and to mobilise all relevant bodies - call for the active involvement of social services.*

2 *The most important initiatives are the 'Green Paper on European Social Policy' (1993), the EU communication on 'The future of health care and care for the elderly; guaranteeing accessibility, quality and financial viability' (2001) and the 2004 Communication on 'Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies', which recognises inequalities in the distribution of services and emphasises that access must be ensured for disadvantaged groups.*

'Access', and the Peer reviews 2004 - 2005

Most of the peer reviews from 2004 and to date in 2005, have in various ways, though not always explicitly, addressed the issues of access to services and to a lesser extent quality across a range of different social policies.

The Swedish review places emphasis on the participatory mechanism afforded by the Local Development Agreements (LDAs) which effectively encourage marginalised individuals and communities to overcome barriers of spatial segregation[3] by a programme of empowering and enabling. The UK's approach to street homelessness was to set a rigorous top down service delivery capacity target regarding access to sheltered accommodation for all street homeless in London[4]. The Austrian school leaver 'clearing system' provided a programme/route map of access for young people with learning difficulties to prepare for employment. According to the peer review document, clearing is based on the principles of voluntary action, inclusion and individual support[5].

Both single issue peer reviews, the UK Rough Sleeping Strategy and the Austrian Assistance for young people with special needs also emphasise coordinated and integrated partnership approaches between different public agencies, including social services, and the voluntary sector. Here it is important to mention that the Austrian strategy, an approach with an extremely wide array of service providers from the State, federal and NGO sectors, has led to a certain amount of policy and service fragmentation which not only confused the users but also policy makers. This of course does not invalidate the multi-actor and partnership approach; it simply highlights the need for close cooperation and the coordination of services, such as the One Stop Shop in the UK, a central access point for a range of services and providers which offers information for users.

In the Dutch work activation programme and French migrant platform, access has a contractual element requiring co-responsibility. In the Netherlands between 1996 an 2001, the government created flexibility in the national Social Assistance Act to stimulate people with little prospect of securing employment to become more active. Access to the labour market through voluntary work and training has improved considerably through the social activation programme[6]. According to research, social activation as the first step on the ladder to social re-integration has a satisfaction rate of 87% among clients[7] who also reported higher self-esteem and wider social contacts.

The Czech approach to promote the social inclusion of Roma sought to improve their access to services which **I)** may be denied for racial/ethnic discriminatory reasons or **II)** may be difficult to bring about because Roma

3 *According to the peer review document, spatial segregation is a major issue in the development of social inclusion policies. People who are economically well off, leave an area while disadvantaged individuals move in. Spatial segregation is a downward spiral because it is also the area itself that generates social exclusion by offering low-quality educational facilities, health and social services and a stagnant labour market. (Lukkarinen, 2004, p. 6)*

4 *Although the strategy led to the desired result over a very short period of time (the number of homeless people sleeping rough in England was reduced from 1.850 in 1998 to 504 by 2001), the peer review document points out that an exclusive focus on a quantitative target might lead to a one-sided strategy. More diverse and longer-term targets and appropriate result indicators would be needed to maintain high quality services. (Vranken, 2004, p. 3)*

5 *The service is easily accessible to disabled young people from 13 – 23 years and promoted through visits to schools, particularly the special schools, during which pupils and parents are able to make an appointment. One of the most important aspects of the Austrian system is the provision of individual support packages which then also serve to indicate gaps in the existing system of support. (von Bothmer, 2004, p. 3)*

6 *People could, for example, be exempted from their job search obligation and were allowed to obtain premiums for training and voluntary work. (Nicaise, 2004, p. 3)*

7 *The programme was aimed at the most vulnerable, including alcoholics and drug addicts, people with health or psychological problems, single mothers with little support, immigrants with poor language skills, and those who are unqualified or illiterate. (ibid, p. 4)*

communities often live in localities that are deprived of quality education and housing, vibrant labour markets and road infrastructure. *People in Need*, the non-governmental organisation attempting to redress this situation, has adopted an individual approach, offering a range of services, negotiating with the client on the basis of his or her wishes and needs, and agreeing in partnership on a plan of action which is constantly re-assessed and revised. Programme participation is dependent not only on the ethnicity of the clients, but also on their social and economic situation and that of the locality in which they live.

The Danish approach to drug or alcohol related anti-social housing behaviour focuses on accessible housing adapted to the people who use it. Previous housing projects failed because people had difficulties living in a traditional shelter or had been living for too long in a shelter. This new and innovative approach, also called 'Freak houses for freak existences, is aimed at people who have not responded to conventional forms of support offered along with ordinary housing. Also of great importance is social work skill and approach. Social workers, or the 'social caretaker', is crucial for the success of the programme, taking on advocacy work, the role of community worker and facilitator.

The peer review document on basic social services in rural settlements in Hungary identified out migration as an additional challenge in these areas. In many countries, this is accompanied by a decline in access to social services and infrastructure which adversely affects the most vulnerable and can set in motion a downward spiral. Access to child welfare and family support services, for example, are almost non-existent in rural areas and schools are increasingly at risk of closure[8]. Other services, such as home care and the provision of warm meals is also scarce. In response to this service gap, more than ten years ago Hungary started developing a local service model centred around the employment of a village-based 'Gondnok' or 'caretaker' in 828 villages and settlements[9].

The above mentioned peer review on rural social services includes the example of Finland, which is currently undergoing a major reform in the public service sector. Universal public service provision has at times failed to reach people in need and is also growing more and more expensive as remote rural areas experience out migration. There, small NGOs and private companies of only one or two local people who are also partly supported by the State, have started to provide services such as meals on wheels, gardening, cleaning, hygiene and escort services to people in need for a small fee. This has the desired effect of achieving cost efficiency and reaching vulnerable people, while at the same time initiating a genuine bottom-up approach to service provision.

Similar approaches can be observed in the UK where coordinated partnerships between public services and NGOs complement each other and also offer users a choice between different providers. Ireland also emphasizes interagency cooperation and information to broaden and improve access to its Money Advice and Budgeting Service[10]. The Finnish peer review on the citizen's social support network model provides another

8 *This is also the case in Finland, one of the peer review countries. Over the last 10 years, approximately a thousand rural schools were closed. (Calderon Vera and Halloran, 2005, p. 12)*

9 *Although the service is unevenly distributed within Hungary, the caretaker policy has succeeded in addressing very specific, local needs:*
- providing social basic provisions;
- access to health care; (for sick and needy);
- transport of children of kindergarten-and school age (aged 3 – 18yrs);
- purchasing goods (institutions of the local authorities); and
- managing public utility workers; (long-term unemployed, receiving social assistance who undertake paid work typically in public areas (e.g. parks) of a community).
(Calderon Vera and Halloran, 2005, p. 5-6)

10 *The Synthesis report states that financial inclusion - access to financial services such as bank accounts and credit cards – is a crucial precondition to social inclusion. (Korczak, 2004, p. 7)*

example of raising quality and increasing the accessibility of social services. The network is a model for building local multi-actor partnerships in the context of universal welfare provision, based on the concepts of horizontal co-operation and shared responsibility between the public authority and the third sector at a local and regional level. Shared training of all actors and an emphasis on research, user involvement and bringing local actors together has made this model a success in the regions where it is being piloted. In the process of improving quality and access, this model has achieved a marked reduction in public expenditure.

Quality and Accessibility of Social Services

The importance of accessibility and quality in service provision makes it necessary to clarify the terms and to identify the challenges social services face in the process of improving their provision. The following points, although not exhaustive, give an overview of/about the elements that are considered vital for introducing and raising the quality of service provision:

Quality of services

- *User involvement, participation, influence and management* can significantly improve the quality of services[11]. This includes consultation and participation mechanisms on policy design between services, providers and users and the creation of networks of local stakeholders; and the formulation of local action plans.
- *Monitoring, performance evaluation and sharing of best practice*. It is difficult to underestimate the importance of these issues because they provide the foundation for the future development of services. It is necessary to have a regular data transfer linked to service planning, cost and evaluation. Here too, local action plans can play a role. Setting minimum standards will provide quality assurance for both social services and their users on which can be built further. Audits are also valuable assessment mechanisms.
- *Creating a learning environment*. Training for professionals and volunteers is an investment that ensures low staff turnover and a quality service provision. Service users should also be consulted in the design and content of training; it furthers social inclusion through user empowerment and will lead to well-tailored and individual service provision.
- *Equality framework for employment*. A diversity framework in which recruitment policies and the monitoring and evaluation of services are integrated will root social services firmly in the community they serve. A diversity mentoring scheme would also be a useful step to ensure minority staff retention[12].
- *Coordinated and integrated services* require an effective communication system and mechanisms for cooperation between different branches of social service provision. Substance misusers, for example, may also face housing difficulties or over indebtedness, making it necessary to formulate a strategy that involves the respective departments.

Accessibility of services

Any concept of access should consider its changing nature and distinguish between the different dimensions that emerge together with new patterns of service delivery. A distinction can be made between physical and intellectual access concerning on the one hand people with disabilities and those living in remoter areas (or sometimes in poorer districts in urban settings) and on the other hand people from minority ethnic groups who may have difficulties accessing services because of language and cultural barriers. There is also the question of financial accessibility because cost sharing models and user fees are becoming more and more

11 *For a more detailed discussion on user involvement within different social service traditions, see Council of Europe documents listed in bibliography.*

12 *Equality frameworks and mentoring schemes were part of an ESN project, Managing Diversity. The website contains a useful resource pack: http://www.socialeurope.com/mandiv/en/resourceintro.html*

relevant as the cost of services rises and the outsourcing of services proves to be an increasingly popular option to contain costs. Multi- and interagency access through outsourcing and more integrated and coordinated services is now also a reality. Finally, there is the phenomenon of internet technology and 'telemedicine' which also adds a new dimension to accessibility.

- *Physical accessibility* removes barriers for people with disabilities, one of the most excluded groups in society. Flexible administrative opening times also help to make social services more accessible, particularly for people with inflexible working hours or for those who live far away. Another aspect of physical access is outreach work. Although expensive, it ensures the presence of social services in physically inaccessible areas and has the potential to reach people who are unable or reluctant to seek help directly.
- *Spatial accessibility* concerns those living in deprived (often urban but not exclusively so) areas which provide less availability to mainstream services than those more economically successful inducing a downward spiral of exclusion.
- Improving *intellectual access* can be achieved by removing language and cultural barriers. It includes the provision of information in a variety of formats and languages, and within a larger diversity framework of the organisation, customer service training for front line staff will also address potential cultural barriers[13].
- Meeting *Individual need* is vital for the social inclusion process. As new treatments and living aids become more expensive, the universal service delivery model is increasingly unable to carry the cost and therefore introduces cost-sharing schemes between the user and the service provider. This of course raises the question of (equality) of access with particularly severe implications for poorer people who may not be able to afford the latest medicine or technology.
- *Multi- and interagency access* – outsourcing of services to NGOs or private companies, partnerships between public services and non-governmental organisation and a more integrated and coordinated service delivery alleviate financial and human resources pressures in public services and also ensure a choice of service providers and can potentially help to build social capital with the community[14].
- *Access to self-management of care* in the form of direct payments, for example, is another form of user empowerment and a flexible form of providing care. It expands access to services and gives people control over care provision[15].
- *Access to new technologies*, such as self-assessment tools on the websites of service providers and telemedicine, a video conferencing technology to improve access to services, is one of the fastest growing areas in this field. The benefits are particularly felt by people who have little mobility and/or live in isolated and rural communities. As more information and activity is carried electronically, IT will paradoxically then itself become a barrier for those without access to this key technology[16].

13 *ibid*

14 *A 'mixed economy' of services approached can be seen in many EU countries. Munday analyses social service provision in European countries and (Council of Europe paper) distinguishes between the informal, the voluntary non-profit, the state and for-profit sector contributions to services.*

15 *The ESN report 'Towards a People's Europe' lists many examples of successful care provision for older and disabled people in the form of direct payments. Legislation facilitating direct payments exists in most EU countries; examples are Italy's Law on Social Assistance, Belgium's Personal Assistance Budget and the Netherlands's Provisions Act for Disabled and Elderly People.*

16 *Gavira (Council of Europe document) also cautioned that commercial interests and the short shelf-live of IT applications can pose obstacles to IT use among vulnerable people and user involvement.*

Some issues for the future

Much has but also remains to be done to ensure that services are of the highest quality and that they can be accessed by all those who need them. From the peer reviews and from the discussion here, Member States increasingly recognize the importance of improving access to services and ensuring they are of the highest quality. Different marginalized groups may require different approaches to maximize their participation, from the removal of physical barriers to tackling linguistic, attitudinal, cultural and geographic (remote communities) obstacles. This is not just about enabling people to use standard services, important though that is, but as some of the peer reviews have demonstrated, it about adapting services themselves to meet people's changing needs.

Beyond this, service access is increasingly seen as a contractual relationship involving rights and responsibilities. This approach requires new skills and changing attitudes on behalf of all parties and in particular will provide a challenge with regard to the assessment and management of risk, where, for example, clients disagree with a professional assessment with regard to their health or safety and may choose to place themselves at some risk as a consequence (refusal to accept medication or seek residential/hospital care etc).

The issue of 'mainstreaming' access to a whole range of services (e.g. drop in clinics for drug users in the high street, small group homes for learning disabled in residential communities etc) also raises issues about the individual versus the wider community, not just in terms of access to financial and service resources but about inclusion. The Danish 'freak house' is an interesting response to this question.

The question of access can be a developmental one where new needs cannot be satisfied simply because there was little knowledge that a particular need existed. In such circumstances, those wanting to access a service may have to also become the provider. There is an increasing number of examples of social entrepreneurial self-help groups that have been established to that end[17].

Whilst the development of service quality indicators/standards is quite well advanced, there has been less attention paid to access. Some countries do measure the 'take up' of services/benefits according to 'risk groups' including those with a disability, those from certain ethnic groups etc but this is sadly by no means widespread. Lack of accurate data renders evaluation of innovation in this field problematic. More developed areas are those based on legal regulations e.g. requiring accessibility for the use of buildings for people with a physical disability and particularly health service waiting times for treatment/emergency response.

Of recent interest has been the employment, by some local authorities, of disabled, older people, ethnic minorities etc. as consultants to monitor the accessibility and quality of services themselves[18]. This may be a fruitful route worth further exploration.

Opportunities for EU policy development in this field might include a discussion as to the advisability of extending the Equality Directive to include access to services.

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17 *The Hungarian Synthesis paper on basic social services in rural settlements mentions for example Finnish entrepreneurs setting up their own home care business to satisfy demand in the area. (Calderon Vera and Halloran, 2005, p. 11)*

18 *Dr. Jane Pillinger collected several such examples on race/ethnicity and disability for the ESN project Managing Diversity. Her reports can be accessed at http://www.esn-eu.org/mandiv/en/thematic_reports.html*

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