Study on Social and Health Services of General Interest in the European Union

Final Synthesis Report

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Foreword

Social services are undergoing important changes in European Member States. They adapt to demographic challenges and the need to improve quality and to become better targeted. The incentives or disincentives that they create for active labour market participation have increasingly come under scrutiny. In response, EU countries have implemented a wide range of reform initiatives in social services, including in social insurance and social security. In many instances, there is a trend towards a more important role for private initiatives and of market-based principles.

As a result of these reform trends, the influence of EU rules on the way social and health services operate in Member States has become more important over recent years and there is an increasing concern among stakeholders and policy makers about legal uncertainties and about lack of knowledge and understanding of the complex legal issues at stake.

The Commission Communication "Implementing the Community Lisbon programme – Social services of general interest in the European Union" of April 2006 has addressed these uncertainties and announced to establish a monitoring and dialogue tool in the form of biennial reports from 2007 onwards in order to improve the knowledge of both service providers and stakeholders on the one hand and of the Commission on the other, of the situation of social and health services of general interest in the EU and the application and impact of EU rules on the development of these services.

This document presents the final synthesis report of a major study that the European Commission, DG Employment, Social Affairs and Equal Opportunities, has commissioned to a consortium led by the European Centre for Social Welfare Policy and Research, Vienna, with the goal to obtain essential input in the form of a fact-finding exercise to this monitoring and dialogue tool.

The consortium partners of the European Centre for Social Welfare Policy and Research in this project are the International Centre of Research and Information on the Public, Social and Cooperative Economy, Liège (CIRIEC) and the Institute for Social Work and Social Education (ISS), Frankfurt/Main.

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The authors have, however, the sole responsibility for the selection of the contents and the presentation in this paper and for anyremaining errors. Moreover, this report does not necessarily represent the view of the Commission or of the Directorate General for Employment, Social Affairs and Equal Opportunity.

Overview on Contents

Executive summary

The Commission Communication "Implementing the Community Lisbon programme – Social services of general interest in the European Union" of April 2006 has announced to establish a monitoring and dialogue tool in the form of biennial reports from 2007 onwards in order to improve the knowledge of both service providers and stakeholders on the one hand and of the Commission on the other, of the situation of social and health services of general interest in the EU and the application and impact of Community rules on the development of these services.

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Social services have been expanding in the past two decades, driven by shifting demographic structures, the changing role of families and informal networks, and growing concern about new threats to social cohesion. As a consequence, growth in employment was to a large extent based on the creation of jobs in the area of social services that have to be financed by growing shares of public budgets and increasingly by private households.

The expansion of social services was accompanied by the introduction of new steering mechanisms, targeting and decentralisation processes as well as by shifting shares in the mixed economy of welfare that may best be illustrated by the emergence of new stakeholders in quasi-markets such as, for instance, private for-profit providers or new kinds of third sector organisations. Provider and other stakeholder organisations, including public authorities, in this area are increasingly perceived as hybrid organisations guided by a mix of competition, concepts of solidarity, and public interest. Furthermore, networking, co-ordination and integration between hitherto divided areas and actors has contributed to the growing complexity of social service systems.

These developments, however, started from very different levels in individual countries, depending on political, historical and cultural context. But the evidence base for modernising social services in an international perspective and for evaluating reform is underdeveloped, which is in contrast to their growing importance. Internationally comparable indicators, for example, are largely lacking.

In the context of growing interference between EU law and national, regional and local competences and responsibilities to define, organise, provide and finance social services, the EU conceptual construct of 'social (and health) services of general (economic) interest' usually does not have a close correspondence in national laws and regulations in Member States but it is perceived in different ways according to

institutional structures, welfare traditions or stakeholders' awareness. This leads to uncertainties, misunderstandings or even misinterpretations of the body of Community law when it comes to its application in the area of social services. Additional difficulties arise if social services are not explicitly defined as 'services of general interest' by public authorities.

Knowledge of stakeholders and policy makers in EU Member States about the notion of "SHSGI" and of the EU-level legal regulations and ECJ case law that it stands for is currently very limited. Those stakeholders who are actively involved in the debate confirmed that there is uncertainty coupled with great concern about the possible directions any regulatory steps the Commission may undertake. The debates on the EU level on SSGI are perceived as an additional factor, which interferes with an increasingly complex situation in Member States as consequences of modernisation trends, multi-level governance, fast evolving legal systems and quality developments.

The different institutional settings in Member States and on sub-national levels within which social services are generally operating meet, at Community level, with a dominant mainstream concept of competition, economic activity and undertaking within the single market, usually reflected by Community Law and ECJ rulings. The current challenge is to regulate difficulties that stem from this interaction between concepts of solidarity and universal coverage on the one hand, and competition in social service provision, on the other hand. Public regulators (states, regions, municipalities) as well as public, private non-profit and commercial providers are concerned by this interaction in different ways, depending on their size, the extent of their operations, the range of services provided and their internationalisation.

Documentation, monitoring and analysing the consequences of modernisation trends, new governance regimes and EU level intervention has to be seen in the context of different modes of organisation, institutional arrangements, regulation, provision and sustainable financing of social services, reflecting different concepts and developmental states of social policy and welfare cultures in Member States.

The existing variety of quality assurance policies and quality development mechanisms in Member States can be used to learn from each other. It is indispensable, however, to further invest in methods, institution building and training of staff to realise improvements in accountability and user-friendliness of social services.

In order to enter into a dialogue between EU institutions, Member States and stakeholders in the framework of multi-actor and multi-level governance of Social Services of General Interest, it is necessary to increase the accountability and transparency of institutional frameworks, the data base of the sector and its individual areas, and the description of quality indicators to support the role of the citizens as customers, beneficiaries and users in the definition, planning, assessment and monitoring of service quality. EU institutions can help with advancing monitoring and documentation of good practice as well as learning between Member States, such as in the context of the OMC.

Summary

Introduction

What is the background of the study?

Following the Communication on social services of general interest (SSGI) (COM(2006)177), a *Study on the Situation of Social and Health Services in the European Union* (SHSGI) has been entrusted to a consortium led by the European Centre for Social Welfare Policy and Research, Vienna. The project partners are the International Centre of Research and Information on the Public, Social and Cooperative Economy (CIRIEC), Liège and the Institute for Social Work and Social Education (ISS), Frankfurt/Main.

What does the study cover?

This study has collected facts and illustrations to improve the knowledge of both service providers and the European Commission on questions concerning the application of the EU rules to the development of social services. The study covers a broad range of topics relevant for all SHSGI but also studied five sectors more in detail (see below) for the situation in eight countries: the Czech Republic, France, Germany, Italy, the Netherlands, Poland, Sweden, and the United Kingdom.

The role of social services as a core element of social policy

How do SHSGI contribute to core values and objectives of Member States and of the EU...

Social services are an essential element of national social protection schemes. They contribute to core values and objectives of the EU Member States and of the EC, such as achieving a high level of employment, social protection, health protection, equality between men and women, and economic, social and territorial cohesion.

…and to social protection over the life-course?

Social services aim at both improving the quality of life of citizens and at providing social protection. Childcare, health and medical care, and social insurance (for example against unemployment) support everybody at some point in life. Social services also assist vulnerable individuals and persons who have a range of special needs and risks, such as needing long-term care, having a disability, living in poverty or being at risk of social exclusion. They are embedded into a broader institutional and regulative framework. The study focuses on personal social services.

How are SHSGI organised within different historical, cultural and socio-economic contexts?

Outside the family (in its role of providing support and care), social services can be provided either by public authorities, by the non-profit/social economy sector or by the private commercial sector. This entails a variety of modalities of organisation, types of providers, regulatory frameworks and contract-based relationships. The relative role and mix of provider types depends very much on the historical, cultural, and socio-economic context and may differ according to the services provided.

Social services of general interest are an emerging EU policy topic

How did SHSGI emerge as EU policy topic...

Services of general interest (SGI) are distinguishable from other services by specific missions of general interest as defined by public authorities and public service obligations that providers have to fulfil. SHSGI are a relatively new concept in the EU policy debate, which considerably accelerated and deepened since 2003, in which year the Green Paper on services of general interest was published, followed by the White Paper on the issue (2004).

A further stage of the discussion was achieved with the publication of the Communication on SSGI of 26 April 2006, followed by a second enquiry of the Social Protection Committee (SPC) on SSGI in late 2006 and early 2007. One of the next steps foreseen is to implement the monitoring and dialogue tool for SSGI at EU level, to which this study contributes.

…and how are they characterised?

Replies to a SPC enquiry undertaken in 2004 consistently recognised that SHSGI are different from other SGI. They are, among others distinguishable by: additional objectives (mainly of social policy) or functions (for societal and labour market integration), particular aspects of governance and elements of service quality, and specific characteristics of their users.

Being part of the overall social protection system, a common cross-country feature is that they guarantee access to entitlements reflecting individual social rights. The solidarity dimension with regard to their organisation, regulation and financing is probably the most distinguishing factor from other services.

How are general interest concerns reflected in national social protection schemes and regulations?

The country reports under this study identify three aspects of how general interest concerns are reflected in national social protection regulations:

(1) They are either equated with social policy objectives; or
(2) Constitute social rights; or
(3) An (implicit) assumption is made that certain (sub-) sectors or benefits are a priori of general interest.

There are important differences in the notion of social services…

National experts in charge of the country studies as well as stakeholders have highlighted the great variety of social services and the numerous differences in their understanding and the varying delimitation of the field of SHSGI within each country.

…,which are often closely interlinked with health care and other fields of policy.

Moreover, social services are often closely interlinked with health services as this has become obvious in the fields of long-term care, rehabilitation, care for persons with disabilities, services for drug addicts and services for homeless persons. The experts of this study consider that there is a need for a chain of actors and providers to take care of individual needs and to provide solutions in an integrated and coordinated manner.

Discussions continue on what to understand by general interest,…

Under Community law, social services do not constitute a category, legally distinct from other services. This study has confirmed that legal stipulations or administrative regulations are the tools used to specify - in an often rather general manner or by setting objectives - the way in which general interest should be defined in case of the delivery of a particular (personal) social service.

… and on the public authorities that should be in charge of defining general interest missions and public service obligations.

Legal or official acts, etc. laying down public service obligations in a precise manner for a specific social service in a written and transparent way, and thereby also opposable to third parties, are currently the exception rather than the rule in many Member States.

Ongoing discussions about the concept of ‘general interest’ concern: the meaning and understanding of the term and its elements, what authority/institutions are competent to define missions of general interest and public service obligations, and the form in which these need to be explicitly and transparently defined. As far as the application of certain EU rules (competition rules and internal market rules) is concerned, concepts like ‘economic activity’ or ‘undertaking’ have become crucial.

Employment and expenditure trends in social services

How do SHSGI contribute to job growth and structural changes?

The study confirms the importance of health and social services in the EU for job creation and structural change on the labour market. They contribute to the increase of female employment and the participation of higher age groups. Even in times when other sectors were shrinking, the sector continued to grow and this is likely to continue in the future. This has consequently helped to raise the labour market participation of groups that did not gain from past periods of employment growth.

What are the challenges to make these trends sustainable?

But there are a number of challenges for job growth in health and social services. As the sector provides services to individuals, non-standard working hours are more frequent. Moreover, the above-average educational levels and the higher share of non-standard working hours contrast with gross hourly earnings that are below average in those countries for which data are available.

Findings from the in-depth country studies also indicate that the priority on sustainable public funding continues to put pressure on the already relatively low wage levels in the sector. As a result, staff shortages are already a major concern for a number of services, such as for long-term care.

Long-term care for older people

Availability of services varies greatly…

… as well as their quality.

This study has confirmed that the availability of services for older people who experience functional limitations in their everyday life and with basic tasks of self-care varies greatly between, and sometimes also within countries. There is evidence that the quality of services is frequently not up to the expectation of users or of their families.

How can services be better integrated?

Moreover, there remain many challenges of better integrating care for older persons between health and social services. Frail older persons have complex service needs that often combine acute health care (in particular for chronic conditions), rehabilitation, nursing care and other social services. Provision across this range of services is typically fragmented. Services of prevention and rehabilitation that could contribute to preventing or postponing dependency and functional limitations that lead to the need for long-term care are still underdeveloped.

Home care,…

… care for people with dementia...

Home-care services are in many cases less developed than care provided in institutions such as nursing homes. Moreover, dementia patients face in many cases more severe problems of access to care than people with care needs that are of a somatic nature.

…as well as part-time inpatient and short-term care facilities show important deficits.

Part-time inpatient and short-term care facilities (e.g. respite care to relieve caregivers during holidays or illness) are also underdeveloped in many countries. They may be almost non-existent in other cases, namely in new Member States, and in Southern European countries.

What are the drivers of change?

Demographic trends and the need to improve the supply of better quality services that are affordable to users and their families are currently more important drivers of modernisation than the EU legal framework. But this may change fast with the ongoing modernisation and a changing public-private mix of providers in this sector.

Social integration and re-integration

How do EU rules impact on this broad and complex range of services?

The complex and scattered range of services to promote social integration and reintegration into the society does not seem to be strongly affected by either of the core issues of EU rules and European Court of Justice (ECJ) ruling on competition or internal market rules. In some countries a legal issue currently relevant is the question under which conditions (national and/or EU) public procurement rules do apply.

Limited awareness of relevance of EU rules

An interesting finding from the stakeholder enquiry is the fact that many organisations on the national level are not aware of 'European influences' or at least do not consider them as being of immediate relevance as far as competition law, financial conditions etc. are concerned. However, on the other hand, it was frequently mentioned that a positive influence comes from European policies such as, for instance, regarding equal opportunities and anti-discrimination policies.

Services for migrants cooperate across policy fields and for different types of providers.

The country reports underline the important role that non-profit providers play in the field of the social integration of migrants. Organising and providing these services for users with often multiple social needs and risks calls for person-centred service provision. The role of social services for migrants in different Member States and their dominant forms depend on a range of factors independent from social policy. In several countries an increasing importance is being attributed to comprehensive approaches in the framework of urban regeneration policies to counter ethnic

and social problems, spatial segregation and ghetto formation, and to promote social integration in metropolitan areas.

Services for drug addicts…

The analysis of the situation of services for drug addicts in six European cities shows how closely they integrate health, social and penal aims.

…have expanded strongly but still differ widely.

Special addiction and drug services have been strongly expanding during the last three decades due to increasingly undesirable consequences of the consumption of psychoactive substances, but also due to the changing socio-political and professional understanding of the problem: addictions are more and more considered to be a chronic illness and other consequences than addiction itself are considered to be more important. But the availability of services still differs widely across countries.

More emphasis on prevention and social integration

According to the new understanding of the problem, the services have often been diversified and they almost everywhere in Europe now include besides care and cure, primary prevention for the whole population, low-threshold services for socially disintegrated consumers that aim at harm reduction for themselves as well as for their environment and social re-integration services including social housing and vocational training programmes.

Labour market services for disadvantaged persons

How are these services organised and implemented?

In the EU, a broad range of curative, rehabilitative and caring forms of labour market services are provided to persons who are disadvantaged in having equal access to employment opportunities or in their ability to retain employment while working. The Member States also have a varying nature of partnership models in their modes of service provision, involving participation of public, private and semi-private agencies and other social partners. The resources available to spend on provision of these services as well as the availability of local service providers and professional expertise also vary markedly across countries.

Commonalities

One of the commonalities is that, in the majority of the Member States, the framework programmes, their priority groups and targets are set by national public employment service authorities and these programmes are implemented by regional and local agencies.

How to move towards more active labour market measures?

Also, in the majority of countries, a large part of the spending on these services is made in the form of passive measures of income support policies. Many national and European employment initiatives have called for a higher share of labour market expenditures to be spent on active labour market policies, since active measures target more effectively the labour market integration of disadvantaged persons. Many EU countries have expressed their intention to shift resources from passive to active measures.

Mainstreaming of disability issues

A move towards active measures will imply a shift from welfare provision to self-reliance. Another initiative that is currently pursued in many countries is the mainstreaming of disability issues, which will involve all relevant Ministries and other levels of Government to protect the rights of people with disabilities.

Further research is needed.

In many countries, the cost-cutting initiatives and larger contracts are driving away local small-scale needs-driven service providers. Also, national targeting of priority groups is sometimes less relevant at the local level. Such and other nation-specific policy design and implementation issues will need to be researched in-depth so as to provide more effective labour market services to people with disadvantages. More data need to be collected and research undertaken so as to better understand these issues and public policy responses required.

Childcare

Childcare services have been expanding…

…but there are still important gaps in quantity,…

Due to an increasing labour market participation of women and changing family structures as well as a new emphasis on the early socialisation of children, childcare services have in recent years been rapidly growing. However, most countries are still far from reaching the EU-Barcelona targets for a number of services, in particular for children up to three years. There are also shortages of supply for afternoon care of school-aged children.

…quality…

Quality of services has increasingly been addressed but there remain problems with opening hours that do not sufficiently cover the working hours of parents.

…and affordability.

Sustained public funding is key.

Moreover, childcare services are not always affordable for families, especially on the private market. Sustained public funding and investment in policy, services and management, are key for affordable and high-quality services in the future.

The trend towards more private provision has made regulation and quality assurance more complex.

Modernisation and diversification of childcare services affected regulations, the types of providers and the ways of financing. Services are increasingly delegated to the private sector, stimulated for example by the introduction of demand-side subsidies.

This diversification of childcare services has increased the supply and eased the pressure on public costs but can lead to fragmentation of responsibilities and lack of coherence in childcare policies and may render quality control more difficult. Moreover, childminders or family crèches often lack any quality regulation.

Overall, the influence of the European Union ruling on childcare is currently reported as relatively low.

Social housing

How do social housing policies differ?

Social housing in the European Union is characterised by a wide diversity of national housing situations, approaches, welfare traditions and policies across Member States. Depending on the country, social housing policies can be aimed very generally, open to all, or on the contrary be targeted to households experiencing the biggest barriers of access to decent and affordable housing on the regular market.

How do they contribute to other social goals?

It is increasingly recognised that social housing is closely interrelated with other social polices. The provision of good quality, affordable housing directly impacts not only on social inclusion but also on environment, cohesion, and sustainable community development. Social housing as part of mixed urban renewal schemes contributes to social diversity and helps prevent 'stigmatisation' and 'social ghettos'.

What are the main challenges?

But social housing in the EU currently faces a number of other challenges, such as waiting lists, lack of financial resources, increased social segregation, older and unhealthy dwellings, and the need for urban regeneration more generally. Challenges also arise from the need to respond to the changing demographic profile of social housing tenants, i.e. increasingly so-called 'patchwork' families, lone parents, older persons with care needs and large or extended families of immigrants and ethnic minorities.

How to secure adequate funding?

To secure additional financial means, social housing organisations in some countries such as in Italy or the Netherlands are increasingly diversifying their portfolios and undertake so-called non-landlord activities as a means

to cross-subsidise their social dwellings via the development of profitable activities (e.g. by building commercial properties, and by selling or renting dwellings to the middle classes).

Modernisation in social services: evolving forms of organisation and management

What are the elements of modernisation?

The expansion of social services was accompanied by the introduction of new steering mechanisms (particularly in quasi markets), targeting and decentralisation processes as well as by shifting shares in the mixed welfare economy. Provider and other stakeholder organisations, including public authorities, in this area are increasingly perceived as hybrid organisations guided by a mix of competition, concepts of solidarity, and public interest.

Modernisation processes start from different levels and follow various motives within different political, economic and cultural contexts.

The modernisation of modalities of organisation and management of social services, however, started from different levels of government in individual countries, depending on the political, historical and cultural context, following different drivers of reforms. Moreover, moves for modernisation may be steered by the providers themselves, by public authorities and following users' expectations assertions. The overall globalisation of the economy and technological developments have certainly also had their influence.

More evaluations are needed, also for comparisons in the EU.

The evidence base for modernising social services in an international perspective and for evaluating reform is still underdeveloped, which is in contrast to their growing importance. Mid- and long-term assessments are lacking; the results of evaluations in turn depend on the set of criteria used, the objectives stated, and the range of actors involved. Moreover, internationally comparable indicators are largely lacking.

How has modernisation affected the way social services are organised, financed and provided?

What are the elements structuring the institutional framework for modernisation processes/structural changes and how do these elements vary across countries?

Social services are currently undergoing many changes in the quest for improving social and economic outcomes. The modernisation of SHSGI takes place in an institutional context structured by at least three elements:

- The division of competencies and responsibilities between the different levels of governments and governance;
- The type of entitlement associated to the services;
- The mode of organisation of the provision of services;

The variety of the national institutional frameworks in which the provision of SHSGI is embedded constitutes an important explanatory factor for the variety of modernisation processes that are often path-dependent.

What were the drivers of modernisation?

Amongst the most important drivers of modernisation are the search for (1) efficient and effective provision mechanisms and cost containment, (2) quality improvement and (3) new solutions in order to meet new or changing needs. Other important impulses stem from (4) the quest for a stronger user-orientation in the provision of social services, a strengthening of self-help potentials and more choice for users. Not least (5) the promotion of access to social rights and (6) the quest for improving the outcomes of social services delivery play a role.

New regulatory and steering mechanisms

This takes place at different levels of the delivery system, such as the levels of organisational design and management, of regulatory mechanisms and of governance forms. New market-oriented regulatory and budgeting mechanisms, as well as new forms of partnership and co-operation are appearing.

From "provider state" to "guarantor and enabling state"...

There are two main regulatory mechanisms in the area of social services: public planning and budgeting, and market-based regulation, the latter seemingly supplanting the former in most of the European countries. This is linked to the general trend from a 'provider state' to a 'guarantor and enabling state'. Consequently, the role of public authorities in providing SHSGI has in many cases shifted from direct public provision toward more delegation of delivery, with regulatory, supervisory and (co-)financing obligations.

...from public provision to regulation of quasi markets

The delegation of tasks to private not-for-profit or commercial providers of SHSGI often demands rather comprehensive framework regulations that can range from technical specifications to quality standards and to how financing of operating expenses as well as infrastructure and investment costs is shared between public authorities, providers (and also users).

What orientations have modernisation strategies?

Modernisation strategies within the field of SHSGI are part of a broader trend of modernisation of the public sector during the past 20 years. Basically four orientations, each of them aiming at increasing efficiency and effectiveness of service provision, characterise the organisational and managerial reforms of social services in the countries under review: performance management, user orientation, integration of services, and rescaling of governance levels.

How to adapt new management tools to the specific characteristics of the SHSGI sector?

Strengthening user orientation and consumer protection as well as introducing procedures to measure and evaluate effects are important modernisation strategies. Furthermore, management tools from the private sector (quality management, controlling, outcome-oriented evaluation and the development of indicator systems for benchmarking) have been introduced and adapted to SHSGI.

This implies defining efficiency and effectiveness for monitoring in a way that goes beyond narrowly defined monitoring of direct economic cost and includes social policy goals, such as how to combat unemployment and poverty traps and other undesirable outcomes that increase the risk of permanent exclusion or increase health costs.

'Modernisation' is viewed differently.

Modernisation is a contested process involving stakeholders that have different conceptions of the reforms to be implemented. It is a multifaceted concept that has been used differently in national and European economic and social policy contexts. As underlined by the stakeholder enquiry under this project, this also entails different assessments of their outcome. Many of the reforms reported on in the study are of recent nature and have not yet been systematically evaluated.

The legal aspects interrelated with the modernisation of social services

What is the legal background?

The European involvement in the field of social services has a legal background in the applicability of EU law as a result of the processes of opening up and diversification initiated by the Member States themselves. As a consequence, a growing proportion of social services until presently managed by the public authorities or by non-profit providers now come under the EU rules on the internal market and competition. This new situation means that there is a growing interaction of social service provision and delivery, on the one hand, and EU rules, on the other.

EU rules increasingly impact on social services

The application of EU rules to social services, particularly with regard to competition and internal market rules increasingly affects social services.

Differences in perceptions what SHSGI are

SHSGI are perceived in different ways in Member States, and among stakeholders, and have a different relevance according to institutional structures and welfare traditions. This may lead to misunderstandings or misinterpretations of EU rules.

National governments, regulative bodies and public authorities enacted structural changes with in-built elements of market-based regulation and with the clear intention to allow for or increase competition amongst providers. However, they did for a long time not consider possible backwash effects stemming from the classification of the provision of SHSGI as "economic activities" leading to the application of Community competition and internal market rules.

To the extent that Member States co-opt private economic operators into their social security systems, or contract out the provision of certain benefits to such operators, or subsidise the activities of a social character of such operators, they must, in principle, observe the Treaty rules on, among others, freedom of establishment and freedom to provide services, public procurement and State aid.

Unintended consequences are becoming more visible

As a result, the unintended consequences for regulating bodies, financing agencies, providers and users of social services have now become more and more visible.

Additional difficulties particularly with mandating providers and the way of delivering public financial support

may arise if social services are not explicitly defined as 'services of general interest' by public authorities.

The present challenge is to reconcile…

The current challenge broadly perceived (among others by stakeholders, providers and the study's expert team) is to overcome fears and mediate tensions that are stemming from the above-mentioned uncertainties and misunderstandings. This may entail the need to adapt modalities of organisation, provision and financing within Member States and at other territorial levels (regions, communities, provinces, municipalities, etc.). It also raises the question whether it would be useful to better define rules of priority between concepts of solidarity and universal coverage and more generally the protection of the general interest and specific organisational characteristics of SHSGI on the one hand, and the application of EU rules, notably competition and state aid rules and public procurement rules, in social service provision, on the other.

…the expectations and objectives of the various stakeholders …

Public authorities are facing new settings (new services, new types of providers, new governance processes) and these may influence and alter their steering capacity. Providers, especially the public and the non-profit ones, might have less freedom in acting as they used to.

…with the modernisation processes under way.

Users might have more choice between new provision modes and new and/or additional services offered. They may also be confronted with modifications in terms of price, quality, accessibility, and territorial coverage, as highlighted in the country reports for selected sectors. These changes can have positive or negative effects. This will depend on the users' financial situation, place of residence as well as their capability to express their needs clearly.

How do European competition rules impact on social services: Financing social services and state aid

EU competition rules do not recognise as such the social dimension of a service.

EU competition rules put all undertakings on the same basis, irrespective of their legal status, objectives or characteristic. EU competition rules do not take social concerns and objectives as well as the logic of not pursuing profit, (which is one essential character of most social services of general interest) into consideration.

The presence of an element of solidarity, the pursuit of social objectives or the non-profit nature of the provider does not rule out the possibility of carrying out an economic activity. Non-profit-making entities may compete with profit-making undertakings and may therefore constitute undertakings within the meaning of competition rules.

The general prohibition of state aid (Article 87(1) EC) is followed in Article 87 (2) and (3) EC by a catalogue of derogations compatible with the common market such as aid having a social character granted to individual consumers, provided that such aid is granted without discrimination related to the origin.

Are existing financing mechanisms compatible with European rules?

Financing social services rests at first hand on finding the necessary public (and private) funds and means to do so. But the existing modes of financing may not all be compatible with the European rules. The concern of public authorities and providers is to ensure the general interest character of social services on the one side, while securing the necessary financial means on the other. Many stakeholders' organisations expressed concerns not being able to pursue existing modes of financing social services, because these do not fully respect the conditions foreseen for state aid.

In relation to state aid and subsidies as way of financing social services of general interest, some open questions therefore remain:

Open questions regarding state aid and subsidies

What happens, for instance, if there is no explicit definition of the mission, no official entrustment or delegation act, or when the rules to calculate cost compensation are not determined? It is also a question what recourse to subsidies is thus still admitted to finance de facto numerous proximity social services to individuals without having recourse to public procurement procedures? This mainly concerns services that are offered on personal initiative, i.e. they have not been delegated or mandated by public authorities, but need public subsidizing or private support to be rendered. Their providers ask the state and other public authorities for recognition and for (in cash and in kind) support to help delivering those services. Further clarification is needed.

Public procurement as a new mechanism to provide social services poses new challenges

Public procurement is a very recent issue for social services.

Public procurement is a very recent mechanism with regard to providing social services (and more precisely the transfer of tasks/delegation of services by public authorities to third parties following the EU rules). The main difficulty encountered up to now is with respect to whether and when EU public procurement rules should be applied to the provision of social services, under what circumstances and according to which set of rules. This applies to existing national rules as well as to EU rules that have to be

transposed into national legislation.

Defining the social and/or general interest task to be performed can be complex and needs experience…

If public procurement procedures are correctly understood by the competent public authorities and once their conditions of application are clarified, the next challenge is to define precisely what task should be performed and how this task can be readjusted once a contract is established with one provider chosen following the tender procedure.

…since quality and trust are often difficult to formalise.

Indeed, social services cannot be implemented in a standard manner as most of them need to be adapted to individual situations and needs. The quality of the relation and trust are important factors that are very difficult to express within the terms of a contract.

Uncertainties…

…as well as over-simplification…

…need to be avoided.

Following the stakeholder enquiry, organisations pointed several times on unintended impacts, for instance the fact that despite the non-applicability of EU-legislation, municipalities would apply the public procurement rules in any case to be on the safe side. This trend pushes to apply the same rules to all cases despite the differences amongst them. In the end, the consequence thereof could well be that quality criteria used are very limited in number and reach (which already seems to have happened in some cases).

How to improve the tender process or delegation more generally?

A better knowledge and awareness about the possibilities offered through variants or alternate proposals that can be inserted in a call for tender could meet some of the challenges, answer open questions and take away concerns expressed. The effective use of existing mechanisms and devices foreseen within the public procurement directives (such as a two-steps procedures or the introduction of several weighted criteria, negotiated procedures and competitive dialogue) might furthermore bring some solutions. This calls for sufficiently qualified and trained personnel to apply these complex and difficult devices, - a demand also expressed by stakeholders.

Further clarification and explanation at European level is needed

Governments, regulative bodies and stakeholders from many Member States expressed in the 2004 enquiry of the SPC on SHSGI that they consider the existing European and national regulation insufficiently adapted for SHSGI. They perceived a need for further legal clarification creating certainty for the provision of SHSGI, e.g. based on communications or on further legislative steps, for example by a (framework or sector-oriented) directive. The study results also confirm the expressed demand for more explanation on existing EU rules and on their application to social services, in particular those provided on a local basis by small providers and not-for-profit organisations.

Cross-border service provision

What is the role for cross-border service provision and use?

Even in the border regions, which are most open and suitable with respect to internal market rules, health care and social services have up-to-date encountered comparatively little demand on a cross-border basis. First insights (as of spring 2007) from the recent consultation on health services suggests that except for border regions in some continental countries and Luxembourg, the financial flows related to patient mobility currently are estimated or calculated to less or about 1% of all expenses in health care (including cases related to holidays abroad).

Comparable data for (personal) social services in the sectors covered in this study are currently largely missing. Cross-border co-operation has furthermore most often taken place in pilot programmes/projects These lead, however, increasingly to more sustainable structures of co-operation and co-ordination. Cultural aspects as well as values linked to some social services may well be seen as a factor hindering cross-border provision and consumption of personal social services.

What can be done to improve the quality of social services ?

Quality deficits in social services are receiving more attention...

The attention of public policies in Member States for the quality of social services is growing. This is not only due to a number of scandals that were covered by media. As a result of public inspection, quality problems have been reported in particular in care services for older persons. This includes deficits in nutrition and hydration, staff shortages as well as care planning and documentation.

...for more responsive and effective services...

…and as tools to increase accountability.

There is a general trend to complement traditional control and inspection mechanisms with a variety of quality assurance methods that are deemed to be more adequate for quality development, also in the area of social services. Though quality management had originally been developed in industry and manufacturing, the methods were increasingly adopted and used as a tool to describe, to steer and to improve social services. Furthermore, the increasing financial pressure on the welfare schemes prompted an intense search for effectiveness and efficiency. This has led to greater awareness of the difficulties to prove and evaluate the results and outcomes of respective measures and reforms. In some Member States, providers have already introduced quality management. But inspections are still the predominant approach in others. The emergences of specific standards and quality frameworks have been reported but many countries have only started to discuss the

basic issues regarding quality improvement. Communication problems between the different professional discourses can also be reported.

Member States are at different levels of introducing new quality management strategies…

In some Member States quality management approaches have been triggered by privatisation strategies and the introduction of quasi-markets that called for accreditation criteria for non-profit or commercial providers. Both public purchasers preparing calls for tender in public procurement processes and the newly arising providers are often facing difficulties in describing the quality of services and respective standards.

…and still face important challenges.

There is thus ample need for mutual learning and exchange of practice as already promoted by projects in different EU Programmes. Issues of 'good practice' in public procurement as well as the development of specific quality management instruments for the social service sector call for further investment in methods, institution-building and training of staff to realise improvements in accountability and user-friendliness of social services.

Monitoring SHSGI at EU level: Some conclusions on the methodology and on the involvement of stakeholders

What role for a stakeholder enquiry?

As key element of the study, the stakeholder enquiry was aimed at supporting stock-taking and fact-finding and designed to allow stakeholders to directly contribute with information and own views to this project. It was also intended as a 'pilot activity' to collect experiences with regard to the dialogue part of the planned monitoring and dialogue tool on SHSGI in the future.

What are the limitations?

The enquiry, however, is for a number of reasons not - representative. The pieces of information received can only in a limited way be compared, aggregated and generalised, not least given their often country- or sector-specific character. This is even more so due to a need to conceptualise them (in specific institutional settings, regulatory frameworks, country-specific social and economic conditions, etc.) in order to interpret them correctly and to be able to draw conclusions.

The various types of users need to be better and directly involved in the consultation

Another limitation is due to the fact that users and organisations representing them and supporting their interests were not approached directly. This would have needed additional instruments (e.g. surveys at different levels), a longer time horizon for the study design (in different languages), and the resources to organise and

process.

analyse such a survey. Most importantly, other issues (e.g. user's expectations and assessment of service quality, choice of provider, service level, instruments, etc.) would then need to be investigated, whereas the study focused on questions of direct relevance for regulative bodies and providers.

What were the main results?

The answers given to questions contained in the questionnaire already provided valuable insight with regard to aspects related to employment and employment conditions in the field of social services (esp. staffing, remuneration), to their organisation, regulation, provision, and financing as well as to service quality (in both a more technical but also in a broader and value-driven context).

The documents provided contain several examples presented as good or less successful practice in one or the other way. They report on the interplay of EU policies and rules with policies, traditions, rules etc. within Member States and on direct impacts, indirect backwash effects and more general influences from EU legal and political framework.

In this context, the main concern about competition that is exclusively based on prices without taking into account the specific characteristics of the services and their users. The replies also clearly pointed to the risk of downgrading of employment conditions for employees with negative consequences for personnel-intensive social services branches.

What to include in an EU monitoring and dialogue tool for the future?

In order to enhance the dialogue between EU institutions, Member States and stakeholders in the framework of multi-actor and multi-level governance of SSGI, it would be beneficial to optimise the accountability and transparency of institutional frameworks as well as the data base of the sector and its individual areas. Attention is also needed for the description of quality indicators to support the role of citizens as users, beneficiaries and customers in the definition, planning, assessment and monitoring of service quality.

How to improve information on social services for a European exchange?

How to fill gaps and improve cooperation on information?

International comparative information systems on the situation of social services in the European Union are still largely in their infancy. Moreover, detailed comparative data on a regional and local basis (e.g. to show discrepancies between cities and rural or less-populated

areas) is broadly missing. This is the case for all the sectors studied in depth in this study but in particular the case for long-term care, social integration, and drug services.

Member States can also benefit from active involvement by improving their national systems.

The main challenge for the future will be to avoid that resources are invested in 'insular' data collections on some aspects or sub-sectors of social services without overall consistency and a common frame of definitions and concepts.

Existing reporting systems are incompatible between each other…

The task of defining functions of social services and to monitor these separately has become increasingly difficult because of modernisation trends that aim at improving services by better integration of services, no least across the health-versus-social boundary. But where functional categories are used, such as in social and health accounting (ESSPROS, health accounts) and in descriptive systems like MISSOC, these should be consistent with each other, which is currently not the case.

…and more survey data are needed.

But there are analytical limits of (semi-) aggregate statistics on social services that can only be overcome if population surveys that cover social issues become more routine, such as on the situation of older persons with care needs and their families.

Introduction

The term "services of general economic interest" refers to Art.86(2) in the Treaty which allows for certain exemptions from EU law, in particular from the rules on competition, for those services that are recognised by public authorities as fulfilling a task or mission of "general interest". Much of the discussions on this concept, as well as initiatives of the Commission, and its dialogue with Member States, initially had a focus on services of general economic interest of the big network industries (such as transport, water, gas and telecommunication).

It was only in recent years that social services have increasingly played a role in this discussion. This was both driven by reforms in Member States that granted a more active role to (quasi-) markets and private sector involvement more generally, and by an increasing body of European Court of Justice (ECJ) case law, of which a majority had a focus on health care provision and on social security programmes. There is now the concern among service providers and public authorities that these cases might only show the tip of an iceberg of potential wider applications of EU-level regulation and ECJ case law to a broad range of social services in the future. There is in fact much uncertainty about the full extent to which this might be the case, as well as about the consequences this might have for the organisation and financing of social services at various levels of government.

Overview on the scope and methodology of the study

Against the background outlined above, the European Commission plans to establish a monitoring and dialogue tool in the form of biennial reports from 2007 onwards. These reports will be established in order to improve the knowledge of both service providers and stakeholders on the one hand and of the Commission on the other, of the situation of social and health services in the EU and the application and impact of Community rules on the development of these services, in particular in so far as they are recognised as "services of general interest".

The study has not only been concerned with issues of competition law, such as with state aid for service providers in the SSGI sector, but will also concern the application of internal market rules (especially the principle of freedom to provide services and freedom of establishment) and of public procurement rules.

The study provides an important input to this initiative by:

- Mapping the situation of social and health services of general interest within the European Union;
- Describing the on-going evolutions within these services across the European Union;
- Reporting on the uncertainties and debates on Community legislation and case law, and its application;

- Mapping initiatives regarding the establishment of quality standards throughout the European Union.

- Illustrating good practices within the European Union.

The importance of the study is also highlighted by the fact that it has been announced in section 3.2 "Monitoring the situation regarding social services of general interest in the European Union" of the recent Communication "Implementing the Community Lisbon programme: Social services of general interest in the European Union" (COM(2006)177) of 26 April 2006.

Among the main elements covered in this study are:

- Identification of the state-of-the-art of social and health services of general interest with respect to modernisation and employment issues, debates regarding the application of Community law and policy, and the development of quality criteria;

- In-depth analysis of these issues in eight selected Member States, demonstrated and analysed on the basis of developments in different fields (as listed in the next section);

- Comparative analysis of modernisation trends;

- Gathering of expert views and reviews of debates on the application of Community rules, ECJ jurisprudence and related policy issues, with a focus on missions of general interest and public service obligations, the modes of organisation and the modes of financing of social and health services of general interest;

- Comparative analysis of the development of quality criteria and exchange of good practice examples.

The project has started in April 2006 and was presented at a Conference on Social Services of General Interest in Brussels, on June 4, 2007.

Social services covered in the study

The study has a focus on social services that are directly provided to persons, but it also deals with social services in a more general sense, as set out by the European Commission in its recent Communication on Social Services of General Interest. This more general notion of "social services" includes social insurance and social protection programmes, both in their role as financing agents and as purchasers of services. Moreover, the study looks into a broad range of questions of the interplay between the way social services are organised and financed in countries on the one hand, and EU rules and case law on the other, that go beyond the questions of Community law, referred to above.

For personal social services, the study has a focus on the following five social service sectors:

- Long-term care, care for the elderly, care for disabled persons;
- Social integration and re-integration with a focus on migrants and on users of illegal drugs;
- Labour market services focusing on disadvantaged and disabled people;
- Childcare with a focus on services offered to families for children before they enter kindergarten and on afternoon care for children at school-age;
- Social housing.

The first four items on this list are covered in detailed country studies. Social housing has been analysed in a separate study, and a special case of social integration services, – that of services for drug addicts (on illegal drugs) - has been analysed based on a comparison of the situation in six European cities (Frankfurt, London, Rotterdam, Stockholm, Vienna, and Warsaw).

Health care, which is a vast sector of social service industries and one that was subject to a number of European High Court rulings, will not be analysed in depth in the study. For health care services, the Commission has separately launched on 26 September 2006 a public consultation on how to ensure legal certainty regarding cross-border healthcare under Community law, and to support cooperation between the health systems of the Member States.[1]

Health care will mainly be covered in this study where aspects of this sector, such as relevant European rulings and case law probably will become of relevance for other social sectors, such as for long-term care. Moreover, long-term care services are in many cases a joint responsibility. This is even more the case for drug and addiction services. Health care as a social programme can therefore not be fully excluded from the study, given current trends to better integrate health and long-term care organisation, provision, and perhaps even their financing in some time in the future.

In-depth country studies on eight EU Member States

The study comprises eight in-depth country studies covering the Czech Republic, France, Germany, Italy, the Netherlands, Poland, Sweden, and the United Kingdom. These country studies have been conferred to experts or expert teams from research institutes in the countries covered (see the Annex on project partners). Besides the reports itself, country experts have filled in detailed questionnaire tables for cross-country comparisons on main policy trends, the structure of care provision, the nature of reform initiatives, and on quality of services.

[1] See Communication from the Commission "Consultation regarding Community action on health services", http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/comm_health_services_comm2006_en.pdf

These country studies are structured around three sectors of social services that are studied in depth for each country. For each of these sectors, all aspects of the study are covered, in particular questions of recent and ongoing reform initiatives, quality assessment and monitoring, and good practice examples.

An enquiry under the study addressed to European-level stakeholders

In order to obtain up-to-date information and opinions, a questionnaire has been distributed that addresses a wide range of EU-level stakeholders. These have been invited to activate and take on board the broad knowledge and experience available in their respective networks, i.e. within their national, topic- or group-specific member organisations. Stakeholders at national level interested in participating in the enquiry were invited to support the fact-finding exercise of this study and to voice their opinions and expectations.

The invitation to this questionnaire was disseminated to a wide range of EU-level stakeholders, and was also posted on the European Centre web pages (Stakeholder Questionnaire) with an accompanying letter (Accompanying Letter to the Stakeholders Questionnaire). The enquiry has been launched at the end of July 2006 with a second round in October and November 2006.

Part I: Overview on social services in the European Union

Table of Contents

Social services have been identified as essential part of the vision of the European Social Model. In Chapter 1, we briefly present the overall architecture in which social services find their place. Chapter 2 provides an overview on employment and expenditure trends of SHSGI during the past 10-15 years. Chapter 3 finally explains how the study fits in and relates to the ongoing consultation process of the Commission with Member States concerning SGI and SHSGI.

Boxes

Figures

Chapter 1: The role of social services as a core element of social policy

This first Chapter presents a general overview of concepts and issues linked to the organisation, the provision, and the financing of social services. The understanding of these basic concepts under the present study will be the object of Section 1. How these services fit into the overall architecture of social protection schemes – also in the sense of social rights and entitlements – as well as the organisation, provision and financing modes of social services are then outlined in the Sections 2 and 3. They review core concepts that will be further analysed in Parts III and IV of the report .

1. Basic concepts

Social services – personal social services: terminology and scope of study

Various definitions exist for the term "social services"[2]. The present study builds on the terminology presented in the Communication on Social Services of General Interest of 26 April 2006[3]. The document distinguishes three broad categories – (i) "health services", (ii) "statutory and complementary social security schemes" and (iii) "other essential services provided directly to the person". The latter two fall under the scope of this study (for details see Chapter 3). It focuses on five sectors that come under the third category listed above.

Personal social services: Objectives, roles and characteristics

The ultimate objective of social services is both to improve the quality of life of citizens and residents (e.g. by providing childcare, home care and nursing, residential care, education and training, labour market information and placement, consumer information and protection etc.) as well as to provide protection and assistance to vulnerable individuals or to persons experiencing a range of special challenges: illness, old age, handicap, difficult family situation, and social risks such as unemployment, poverty, social disintegration, criminality, drug addiction, etc. Social services answer social needs and relate to the life of individuals within a society. Social services can be collectively organised, as is notably the case for the services offered by social insurance and social assistance systems. Many risks are not foreseeable at an individual basis and society can offer social protection and support to deal with such risks and needs. This refers to the "general interest" a society acknowledges of being its responsibility[4]. In this perspective the state assumes the

[2] See e.g. European Institute of Social Services, 1993: ii; ILO, 1998: 14; European Foundation for the Improvement of Living and Working Conditions, 2001: 3; Anheier in Institut für Sozialarbeit und Sozialpädagogik (Ed.), 2003: 15.
[3] Commission of the European Communities, 2006a: 4.
[4] Two types of contribution to the "common good" or welfare in general can be identified: first, the socialised form, which is put into practice by the public authorities or by entrusted para-state institutions or intermediary organisations on the basis of laws and statutes and in a regulatory

role of guarantor of social rights and organises monetary transfers/cash benefits, fiscal welfare, benefits in kind and personal social services to ensure all kinds of social infrastructure for all citizens. For most of the EU Member States, e.g. the replies to the SPC questionnaire on SHSGI of 2004 (see Maucher, 2005) and the Country Studies prepared under this study (with several examples reported in Part IV) provide illustrations on how "general interest" is understood and/or recognised in the field of social (and health) services (see also Chapter 3).

Personal social services, the main focus of this study, are principally delivered locally on a "proximity" basis. They are characterised by an interactive relationship between the person providing the service – herself/himself normally employed and paid by a public or private provider, both embedded into a broader institutional and regulative framework – and the user and/or beneficiary of the service which usually makes the co-operation of the user necessary. This proximity is not only geographical, but also essentially "relational", often based on trust. Because information asymmetry between providers and users occurs frequently, mechanisms have often been put in place to secure the quality of the services and the protection of the persons receiving them.

Personal social services may concern all members of a society by supporting individuals and families faced with particular life situations during the life course (e.g. the need of childcare or long-term care for older people). The specific and often multifaceted needs of people who are potential clients of social services will, thus, mostly be of temporary nature, but they can occasionally also tend towards more long-term, even life-long support. In both cases, personal social services are targeted at persons or groups with low or insufficient income, with a handicap or that are socially disadvantaged or excluded. In some instances social services respond to deficits or problems that the society itself generates, for example in the form of risks linked to people's workplace.

Social services of general interest

(Public) social services of general interest are provided on the basis of three premises:

1. The fact that modern, urban populations are particularly dependent on certain services;

2. The concern that "the free forces of the market" are not able to provide all of these necessary services (because of market imperfections or market failures) or to provide them in the socially desired manner, i.e. not in sufficient quantity, quality, or price, or with an adequate degree of reliability, affordability or accessibility; and

3. The recognition that the state has an ultimate (though transferable through delegation) responsibility for avoiding or eliminating deficits of this kind, and that it is obliged to ensure that these services are provided in an

framework. Second, the voluntary form, which is based on voluntary or spontaneous solidarity, often institutionalised in one or the other way later.

appropriate manner and in sufficient quantity – if necessary by providing them itself.[5]

Recently, several definitions of "social services of general interest" have been suggested in order to illustrate and clarify the link between "social services" and "general interest" and to contribute to the process of developing a Community framework for social and health services of general interest[6].

The 2004 consultation process on SHSGI (see Chapter 3) provides evidence that core elements of these definitions (such as "codified social rights"; "solidarity"[7]; "meeting essential social security needs at all times or appropriate at different stages in the life cycle" or "meeting group-specific needs"; "availability, accessibility, continuity, affordability of social services provision"; "institutionalised structures and organisational arrangements with qualified personnel") and the conceptual framework (e.g. "link to social protection schemes", "contribution to economic, territorial and social cohesion"; "contribution to inclusion and participation in society") they are embedded in, are shared by a large majority of Member State governments and other stakeholders at European and national level. Intensive discussions on the specificities of social and health services of general interest and on adequate instruments to acknowledge them at Member State and Community level have produced a rich body of comparable and additional elements and explanations for the "general interest dimension" of social services. This is again exemplified based on statements and illustrations contained in the replies received in the framework of the stakeholder enquiry (see Part VI and SHSGI Policy Paper No. 2).

2. Organising and financing social services (level of schemes)

Objectives and functions – risks and contingencies

This study focuses on personal social services for the functions "long-term care", "family", "employment/professional training" (and to some extent also "invalidity/disability") of often complementary nature to the above-mentioned monetary transfers and benefits in kind. For most European welfare states, especially in Continental Europe, there is clear evidence for a generally increased emphasis on personal social services and a shift of resources in this direction to the detriment of monetary transfers (or fiscal welfare, if used as functional equivalent to cash benefits),

[5] Paragraph adapted by the authors from Schulte, 2007: 3 (SHSGI Policy Paper No. 1).

[6] SHSGI Policy Paper No. 2 on the stakeholder enquiry under the present study in Chapter "Need for Terminological Clarification" (Herrmann, 2007) refers to three of them, all proposed by third sector organisations, cf. Platform of European Social NGO, 2003; Eurodiaconia 2005: 34; CEDAG 2006). Whereas the first example refers to "social services of general interest", the second and third have particularly been elaborated focusing on "personal social services (of general interest)".

[7] The "solidarity dimension" is being considered a key "indicator" for considering and acknowledging them as "social services of general interest". More precisely, an orientation toward (at least partial) equalisation of risks, non-exclusion of bad risks, sharing of financial burdens or income redistribution making effective (concepts of) "solidarity", is basically reflected in core modalities of the organisation and financing of social protection schemes or specific (bundles of) social services (see e.g. Commission of the European Communities, 2004d and 2006a, Maucher 2005, Country Studies under this study).

in particular in the field of "public welfare" for families and children (see also the overview on spending trends in Chapter 2)[8].

Personal social services are (i) provided in response to demand from a target group that frequently cannot or can only partly afford to pay for them and (ii) characterised by an informational asymmetry between provider and beneficiary, which means that certain procedures need to be established to guarantee the quality of the services and the protection of these beneficiaries. (iii) Social services also generate external effects at the level of society as a whole (see also Section 4 of this Chapter). (i) and (ii), of course, apply to personal services in general including commercial ones, and not only to those of general interest.

Personal social services can cover single risks and provide answers to specific situations or risks, sometimes in a targeted but short-term orientation. Or they are of a cumulative and multifaceted nature, implying that the answers to provide assistance and help are integrated in a chain of activities and support mechanisms involving many providers in order to encompass the complexity of the problems.

Instruments of social protection schemes

Five instruments usually support social protection schemes:

- Cash benefits/monetary transfers,
- Tax benefits (either as tax allowance or tax relief),
- Benefits in kind,
- Personal social services,
- Time-rights (see special periods of (paid or unpaid) leave to take care of children, to look after sick children, to care for elderly).

In this study the focus is on personal social services for the five sectors under scope (see Part II for detailed sector descriptions). To some extent (and particularly so in the in-depth country studies) related or functionally equivalent benefits in kind or cash benefits are analysed as well. Systems of income protection and other cash benefits have not been studied in any detail in this project.

Principles and structures of organisation of social services

In the field of social protection the principle of solidarity is implemented either through social insurance schemes or universal coverage. The two major types of social protection schemes[9] to be distinguished in a cross-country comparison are

[8] E.g. in Germany this issue currently is gaining more awareness and weight in political debates also dealing with the question to which extent the shares attributed to child benefit payments (implemented as either monetary transfer or tax benefit) on the one hand and to childcare services (in the form of personal social services or benefits in kind in case of voucher systems) on the other, need to be re-balanced in the light of measures to more effectively facilitate the reconciliation between employment and family.

[9] Used as generic term, equivalent to the entity of all national social welfare systems. The ILO (ILO, 1998: 9) uses the term "social security" and explains that its is composed of several different elements

social insurance schemes (statutory and complementary) on the one hand, and social assistance schemes (based on a means- or an income-test) on the other hand. Social insurance schemes function according to the insurance principle, while social assistance schemes function based on an acknowledged specific demand for support or need for help. Whereas the former are financed, at least conceptually and empirically also still to a considerable extent, by social contributions to be paid by employers, employees and/or self-employed (to be supplemented by tax revenues or earmarked charges if need be), the latter are (basically) financed from national, regional or local tax revenues. Social assistance schemes can be considered as universal systems, extending their coverage to all citizens or even residents. Whereas social assistance schemes follow a logic of finality, insurance-based schemes apply a causal logic. In both types of schemes eligibility and entitlement conditions may also depend on additional criteria such as e.g. the degree of disability or the extent of nursing needs.

Both categories are additionally characterised by an organisation along functions. This entails – at least initially – a fragmented social service provision, because both benefit design and financing responsibilities as well as reimbursement rules normally obey to the rationale of functionally specialised institutions and their organisational boundaries. This study dedicates a Section to the issue of integrated provision of personal social services (see Chapter 10.5) for which an increasing need has been identified, e.g. related to services in the fields of long-term care, rehabilitation, detoxification of drug addicts and over-indebtedness. The in-depth country studies report on examples of how and to which extent this type of services has already been successfully put into place.

This study is only partly concerned with social insurance-based services, particularly in the sectors of long-term care. Employment services for persons with disadvantages might be provided in the general framework of the unemployment insurance; the financial means to pay for them, however, also stem to a considerable degree from tax revenue, dedicated to measures for specific groups and/or facilitating or preparing their inclusion into the regular or "protected" (so-called) secondary or third labour market. In several countries, the majority of personal social services covered are organised other than through social insurance systems.

The sectors "social integration and re-integration" and "social housing" are strongly influenced by or function according to main principles of social assistance schemes. Childcare services as covered by this study do not fit well to either the one or the other logic, because they are financed by a mix of taxes and parents' contributions or direct payments to providers. However, special needs play a certain role e.g. with regard to access and affordability conditions to institutionalised or home-based childcare (in the sense that single parents are often to be treated preferentially compared to two parent families).

(i) social insurance, (ii) social assistance, (iii) benefits financed by the general revenues of a country, (iv) family benefits, (v) provident funds. (vi) employers' liability schemes and (vii) social services.

Needs, rights and entitlements in the context of (personal) social services

Claims in the context of social policies can be justified as rights in a number of ways, the most important being on the basis of needs and on the basis of merit[10]. The main principles with regard to the entitlement to social services are "equality of treatment" (given needs, resources, etc.) and "affirmative action" or "positive discrimination". Governments have the principal obligation to ensure that these needs are met; at least to the extent that society is able to do so. Some social services are obligations linked to other social rights, as is the case for activating measures such as work for welfare or RMI (*revenu minimum d'insertion*) in France.

The fact that social services are in many cases based on defined rights[11] has several consequences:

- All individuals fulfilling the eligibility criteria are entitled to the services and the public authorities are responsible for (co-)financing and either organising those services or guaranteeing for their delivery.
- This de-couples social expenditures from revenue and makes social spending structurally and functionally rather independent from state household income (and "*einnahmenorientierte Ausgabenpolitik*", except in the long-term, very difficult)
- Given the fact that demand can and normally does exceed budget constraints, public authorities have often chosen to implement rationing procedures in order to allocate resources and contain costs, also on the basis of planning and monitoring procedures for needs and costs.
- The reality and actualisation of social rights is depending on the amount of resources allocated to the services.

A crucial factor determining access conditions to social services is the eligibility criteria applied in specific social protection schemes (e.g. "Is there a means- or income-test") as well as the concrete entitlement conditions to a single benefit/service. They also play an important role in view of the adaptation to new needs and demands. Chapter 10.4 contains an overview on main factors that might impede access to social rights and insofar also to social services.

Financing modes and sources of funding

One can distinguish a number of financing modes at the level of providers of social services, among them for instance: (i) direct financing through the state budget; (ii) the use of specific financial dedicated funds; (iii) the granting of special or exclusive rights implying cross-subsidisation within the provider organisation; (iv) tariff averaging/generalised equalisation of charges; (v) solidarity-based financing, particularly in the case of non-market social services; (vi) market prices or contributions made by market participants; (vii) cost-sharing by users, etc.. Several

[10] Merit-based rights are founded on the view that some quality or activity of a particular group imposes an obligation on society to provide them with certain services, for example motherhood or disability deserving social support.

[11] Social rights are closely linked to principles of social justice. Equality has been one of the principal foundations of rights claims in social policy debate, so that citizenship in itself justifies rights to welfare, as this is principally the case in social assistance schemes.

financing schemes may be used simultaneously or in interaction with one another in order to maintain a sustainable financial equilibrium (for more details see e.g. Obermann et al., 2005).

In the framework of this study, the issue of cross-subsidisation has increasingly come under close scrutiny at EU level. Against the background of recent Community regulations, this has become of special importance for a wide range of providers of (personal) social services. At the level of service provision, the question of cross-subsidies has to be considered under conditions of competition for service delivery or users (see Part IV). It is also linked to mechanisms preventing providers of social services from restricting access to potential users based on individual characteristics (income, degree of handicap, place of residence, etc.). Or it is linked to regulations enabling them either to exclusively or preferably provide services to (more) profitable users (mainly in the sectors long-term care and childcare) or presumably less complicated cases (e.g. in the field of employment services for persons with disabilities or socially disadvantaged persons); and/or to offer them better terms and/or quality. And reaching beyond the enterprise level, this question also has an impact on financing modalities primarily designed to promote economic, social and territorial cohesion.

In terms of final financing sources, the above listed modes mainly correspond to four sources: (i) the general taxpayer; (ii) the taxpayer facing a local, sectoral or specific tax base; (iii) the user of the service, in the form of fees; (iv) social insurance contributions. Concerning possible fees paid by users and/or taxpayers, they may on their turn take numerous direct and indirect forms ranging from additional charges for the user of (possibly fiscally encouraged) service cheques/vouchers (see Chapter 11 as to this device for market-oriented regulation). If social services consumption is to be encouraged – as it is the case for example with childcare and home care – tax expenditures and grants are often used[12]. The implications of Community Law particularly related to the latter instrument are dealt with in Part IV.

3. Organising and providing social services (level of service delivery)

The architecture of provision of social services

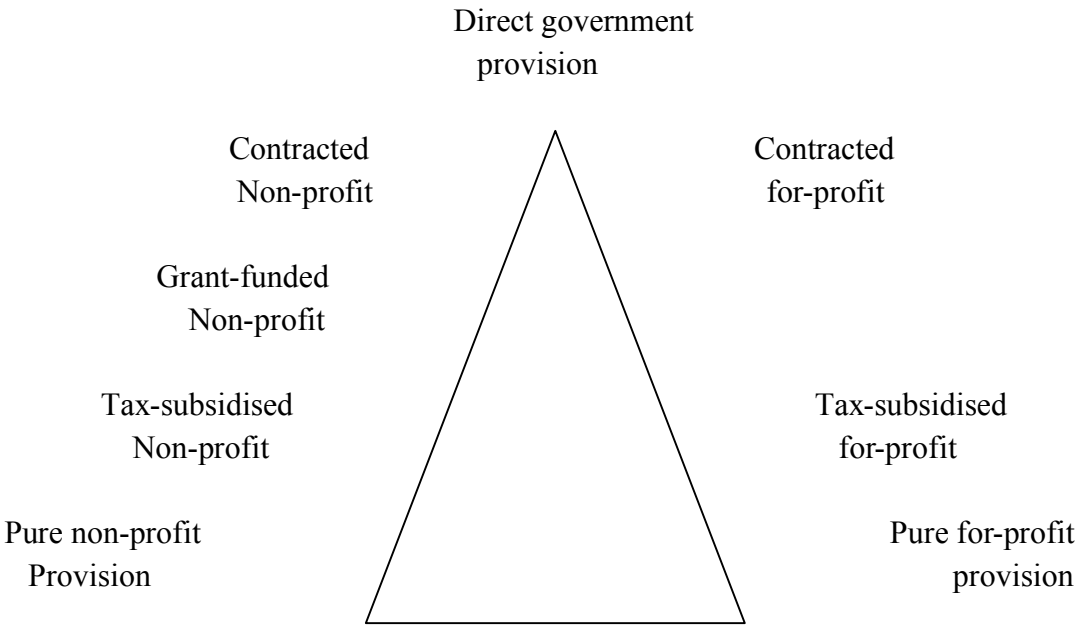
The variety of available service-delivery options lies in the spaces among three forms of service provision: direct provision by government, provision by the private for-profit sector, and provision by the non-profit/social economy sector.

Figure 1.1 represents the range of available delivery options and is proposed as (basic) analytic grid for basic elements of the architecture of service delivery systems in the field of (particularly personal) social services.

[12] A grant is a payment from a donor government to a private (for-profit or non-profit) provider. A tax-expenditure is a provision in tax law that gives incentives to individuals by reducing their tax obligations. Under a grant arrangement the producer of services is a private enterprise (either for-profit or non-profit) and a governmental agency participates in the provision of services while leaving to an external entity the task of actual performance. The effect of grants is to reduce the price of the services for eligible consumers. Tax-expenditures may benefit either the consumer or the producer and aim at reducing the price paid by the consumer.

Each form of service provision presents advantages and shortcomings. The first option is for the government to provide SHSGI. Government provision can be conducive to achieving public concerns relative to equity, accessibility and fairness in the delivery of SHSGI. It may help to avoid, but also increase the risks of opportunism, fraud and corruption. However the effectiveness of direct government delivery has been put into question for leading to institutional inertia, for lacking innovative spirit and for being unresponsive to new needs. In addition direct government provision lacks performance incentive mechanisms what is generally considered to favour inefficiency.

Figure 1.1: Range of available delivery instruments



Source: Adapted from Panet/Trebilcok, 1998: 233

The second option is for the private for-profit sector to provide social services, either through markets or through competitive tendering. Private for-profit provision is sometimes considered as more efficient because of the performance incentive mechanisms it entails. However, when it comes to social services, for-profit provision can pose a number of challenges and face certain difficulties. First, financing services on a purely individual basis, i.e. without publicly funded financial support is problematic since those most in need for the services are generally those with the least ability to pay for the services. Second, due to informational asymmetries for-profit providers have an incentive to downgrade quality and to cream-skim the beneficiaries, but this risk may occur with other providers (for other, functionally equivalent reasons) as well[13].

[13] "The incentive structure characterising the non-profit organisational form (absence of residual-claimant, non-profit distribution constraint) attenuates the potential for opportunistic behaviour in the presence of informational asymmetry. However, the absence of residual-claimant reduces incentives to

The third option is to rely on the non-profit sector for providing SHSGI.[13] Non-profit organisations can rely entirely or partially on private contributions (including volunteer work) and/or collective-funding agreements (especially "mutualities") and on public funding (contracts or grants). Governmental regulation tends to generate processes of institutional isomorphism leading non-profit organisations to mimic either public organisations by introducing public sector standards and increasing professionalisation" or to mimic private business enterprises and their corporate culture.

Chapter 11 sheds light on the changing forms of regulation and governance which are closely related to the main "combinations" of social service delivery instruments, both in a systematic-conceptual manner and by referring to illustrations from the countries covered by this study. With regard to the regulatory framework for quasi market or market provision of personal social services, Chapter 11.2 elaborates on correcting methods and devices of relevance in view of more choice or better service quality. These and other user-oriented and -focused measures across countries are framed at the level of social protection schemes by a range of regulations and mechanisms to prevent from a risk- or income-based selection of (potential) users and to set clear limits for a risk averse behaviour of providers of personal social services.

Various modalities of organisation and provider types in the field of social services

One can distinguish the following modalities of organisation[14]

- A public provider with legally defined tasks;
- A co-operative or partnership relationship, with a specific contractual allocation[15] to the partners of the respective missions, tasks and associated financial risks. Public-private partnerships (PPPs) in a narrow sense, however, are currently hardly found as providers of personal social services;
- The public regulation of private not-for-profit and for-profit organisations/enterprises, e.g. those operating on so-called quasi markets. These are considered to be part of the "social economy sector"[16] (including co-operatives, mutualities, associations and foundations) and have been labelled as "civil society organisations". These might be able to activate volunteer work to a larger or lesser extent, also depending on the sector under investigation, e.g. of higher importance in the field of "social integration and reintegration" compared to "childcare" or "social housing";
- More or less regulated or unregulated competition between providers;
- Voluntary provision of services by providers or initiatives that are usually locally or regionally based, competing for social reputation or intangible benefits.

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control costs and to optimise performance and may facilitate organisational slack." Quote from a draft contribution (as of 15 December 2006) prepared by Bernard Enjolras under this project.

[14] To these, in particular in care-intensive sectors, the often substantial work of family members has to be added to obtain a comprehensive picture.

[15] The contractual or governance instruments (which may be obtained through a bidding process following a public procurement or otherwise) are specific funding mechanisms, concessions, leasing contracts, management contracts. Such mechanisms will be explained in Part III of this report.

[16] See for more details e.g. Defourny/Monzón, 1992; Evers/Laville, 2004.

However, it is rather difficult to estimate and assess their relative importance in terms of equivalent paid work and in terms of added value to the economy[17].

In this context, replies in the framework of the stakeholder enquiry (see Policy Paper No. 2) claim that actually the opening of social services of general interest to mechanisms of financing via market mechanisms has as actual consequence the closing of the market and the restriction of service providers to a small number. Especially where organisations in question and their service provision are integral part of an overall service governance strategy, it had been mentioned that the pluralist structure of provision cannot be maintained under market conditions.

Welfare mix and configurations of provider types

The relative role and mix of provider types[18] depends very much on the historical, cultural, and socio-economic context and may differ according to the services provided, as is also illustrated by the findings in the SHSGI Country Studies.

The country studies provide examples for various forms of co-operation or partnerships between providers to offer social services (also see Chapter 11.3). The configuration of provider types and the interaction with the various stakeholders, especially public authorities and users, with respect to planning, providing, financing and controlling social services (also see Chapter 11.4 under the issue of "modes of governance") strongly depend on the way government is organised in individual countries, as either more centralised or more decentralised systems.

4. Contribution of social services to economic, social and territorial cohesion

All European Member States recognise that social services are a core part of social policy and important instruments to foster economic, social and territorial cohesion, either in their constitution, in specific laws, or in practical terms in the form of ex ante or ex post recognition of this role via subsidisation and financing.

Social cohesion can be understood[19] as the capacity of a society to ensure welfare for all its members (which implies the need for and guarantee of universal services and comprehensive coverage of social risks and a broad scope of social protection schemes) with the aims of (i) minimising disparities[20] and (ii) reducing/avoiding

[17] To this wide range of provider types, one needs to add organisations or individuals working in the "black market". Indeed, as will be shown through the country studies and in Chapter 5, in some countries elderly and long-term care noticeably is to a certain extent dependent on this black market because of either insufficient workforce, but especially because of the too high costs related to such assistance and support service for the families and the individuals, if they were to be paid for via the regular (insurance or assistance) systems, at least in basically all Western European countries.

[18] See e.g. Evers/Olk in Evers/Olk, 1996: 9-60; CIRIEC, 2000: 111; Evers/Laville in Evers/Laville, 2004: 14ff

[19] See for details of this approach developed by the Council of Europe (Council of Europe, 2004).

[20] This e.g. refers to divergent levels of income redistribution, the availability of infrastructure across a given territory in a unbalanced way, not least in view of social and health services. This in turn involves a need for planning of demand and steering of offer as well as for the regulation of markets for providers as to access and delivery (security standards, qualification level of staff, quality) of services.

polarisation[21] together with the capacity to generate and strengthen bonds in society and amongst citizens and associations. In this last respect, social services also have an important preventive role with respect to individual social exclusion or marginalisation.

Social cohesion depends on a complex set of conditions, including relative income levels, security of employment, and equality of treatment, as well as the availability and accessibility of services such as healthcare, childcare, long-term care and social housing. Furthermore, cohesion aspects are important with respect to the territorial dimension of societies and countries, since there is the challenge to adequately meet the needs of persons living in remote, rural and less populated areas with respect to a large range of available public (including social) services.

But this also means the measures to counter discrimination and unequal opportunities, e.g. in view of access to education, employment, health care, housing, etc.

[21] This in turn relates e.g. to the danger of a ghettoisation of ethnic groups/minorities or of an institutionalisation of people with disabilities. But it also refers to a drifting apart of urban areas/agglomerations and rural areas/sparsely populated areas. It also covers the lack of possibilities of persons or social groups to participate in one or more areas decisive for quality of life, calling for their re-integration into society. Insofar "social inclusion" is seen as one dimension of "social cohesion".

Chapter 2: Employment and expenditure trends in health and social services

Growth in service industries is the main driver of job creation in EU countries. Among these, health and social services have been a particularly dynamic sub-sector, the "real job machine" in many countries. This section provides an overview of the situation on employment in health and social services in the European Union. In a first step, it will analyse the current situation of employment in the sector and how it has developed in the past decade, both for EU and for groups of individual Member States. Then, in a second step, it will compare these trends with other main sectors of the labour market. Finally, the section will briefly look at how the sector has contributed to employment growth by age and sex, and to other structural trends.

Box 2.1: Measuring health and social services in international comparisons

Cross-country comparisons of economic activities need standardised classifications of the sectors, and of all activities carried out in a sector. The central standard tool to enhance the quality of such comparisons is the United Nations International Standard Industrial Classification of All Economic Activities (ISIC), which is used in a European version (NACE) also by Eurostat.

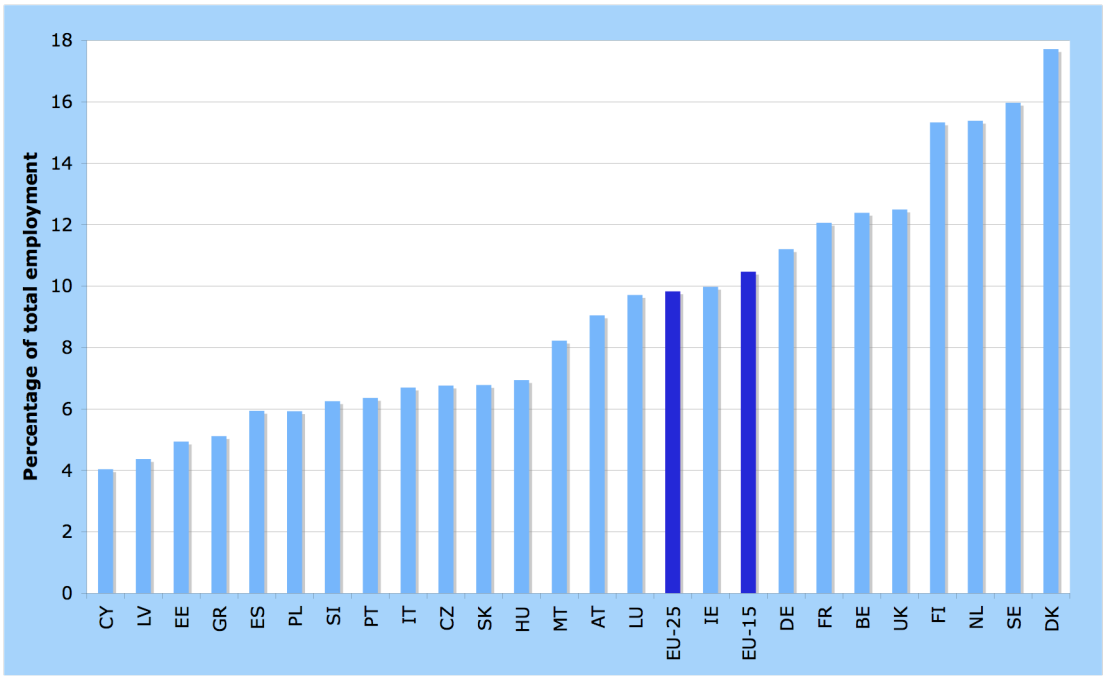
The ISIC divides economic activities into three main sectors: agriculture, industry and services, which contain different sub-sectors. The services sector is split into fifteen sub-sectors, which classify all public and private activities in the sector.

Within health and social services, there are again three different main classes of activities, such as: human and health services, veterinary services and social services. Health and social services accounts for all economic activities from hospital services, medical and dental services and other human health services; to veterinary services for pet animals, veterinary services for livestock and other veterinary services; and for different social services with or without accommodation.

1. Employment trends in health and social services

The share of employment in health and social services in total employment is very different throughout the European Union. Figure 2.1 shows that the share of employment in health and social services was relatively small in Southern and Central and Eastern European countries, while it was high in some Northern and Western European countries. Employment in the sector ranged from about 4 to 6 per cent in Cyprus, Latvia, Estonia, Greece, Spain and Poland to almost three times that level in Finland, the Netherlands, Sweden and Denmark.

Figure 2.1: Employment in health and social work 2006 (percentage of total employment)

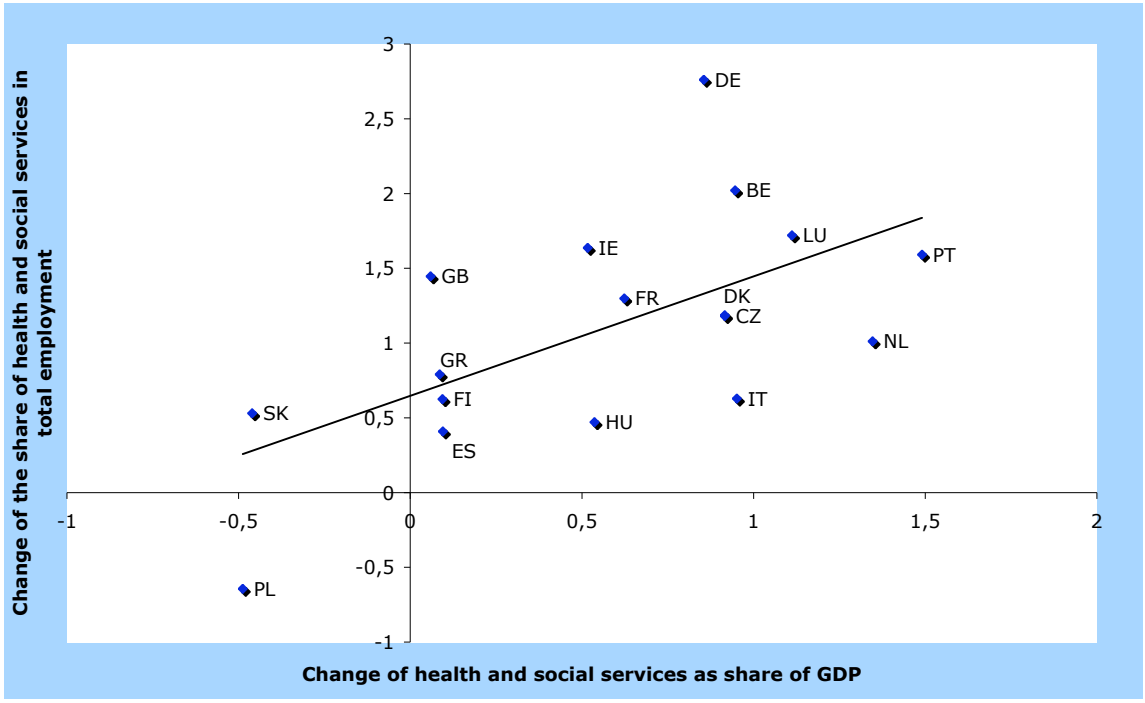


Source: Eurostat, LFS spring 2006 results

Member States are therefore at different stages of development of comprehensive systems of health and social services, which is also illustrated by the different share of value added for which this sector accounts as share of the total economy. Figure 2.2 shows, however, that the link between employment dynamic and the growing value added for which this sector accounts in the total economy, is far from perfect. To a substantial extent this might be due to the limited harmonisation of these data in currently available international data sets (see Chapter 16 on a discussion of this and other methodological questions of employment data).

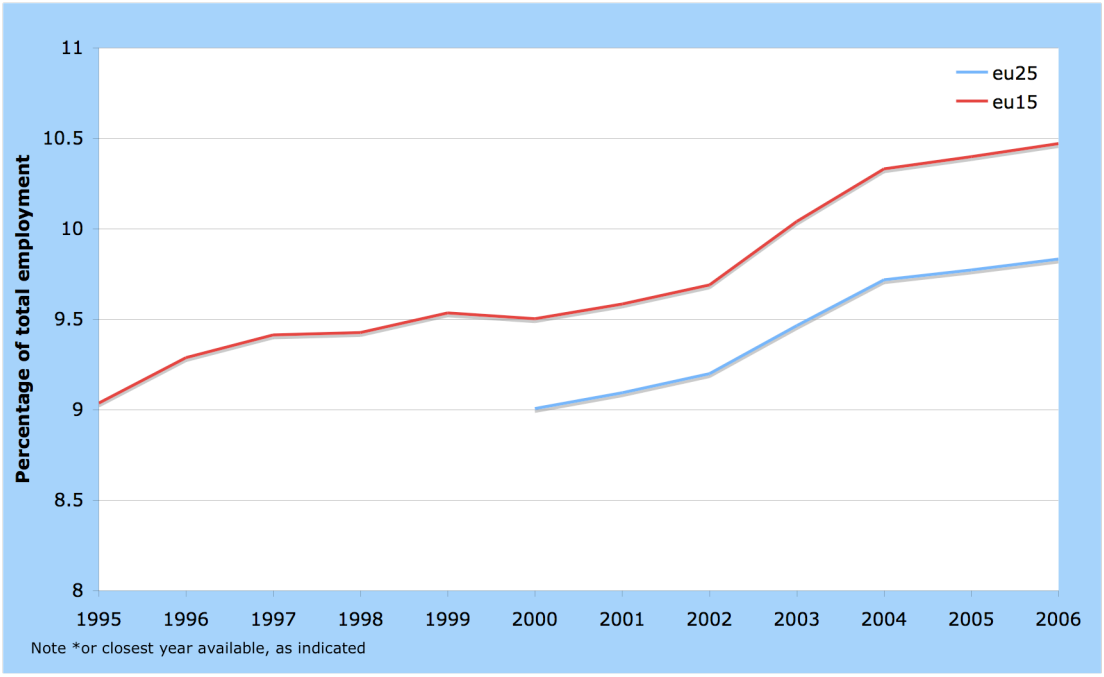
As social services expanded over time, employment has substantially increased in this sector for the EU on average (Figure 2.3). For the EU-25 the sector's share in total employment grew from 9.0 per cent in the year 2000 to 9.8 per cent in 2005. The same trend can be observed for the EU-15, where employment in health and social services grew from 9.0 per cent in 1995 to 10.5 per cent in 2005. The data for the EU-15 show that the growth of employment in health and social services was a consistent trend over the past decade. Different growth rates over time are partially due to the fact that this was a period of strong overall economic growth in the first five years and a period of slow growth in the second half.

Figure 2.2: Change of value added in health and social work as a share of GDP and change of health and social work as a share of total employment 1995 to 2004 (or closest year available)



Source: OECD detailed National Accounts

Figure 2.3: Trend of employment in health and social services as a percentage of total employment



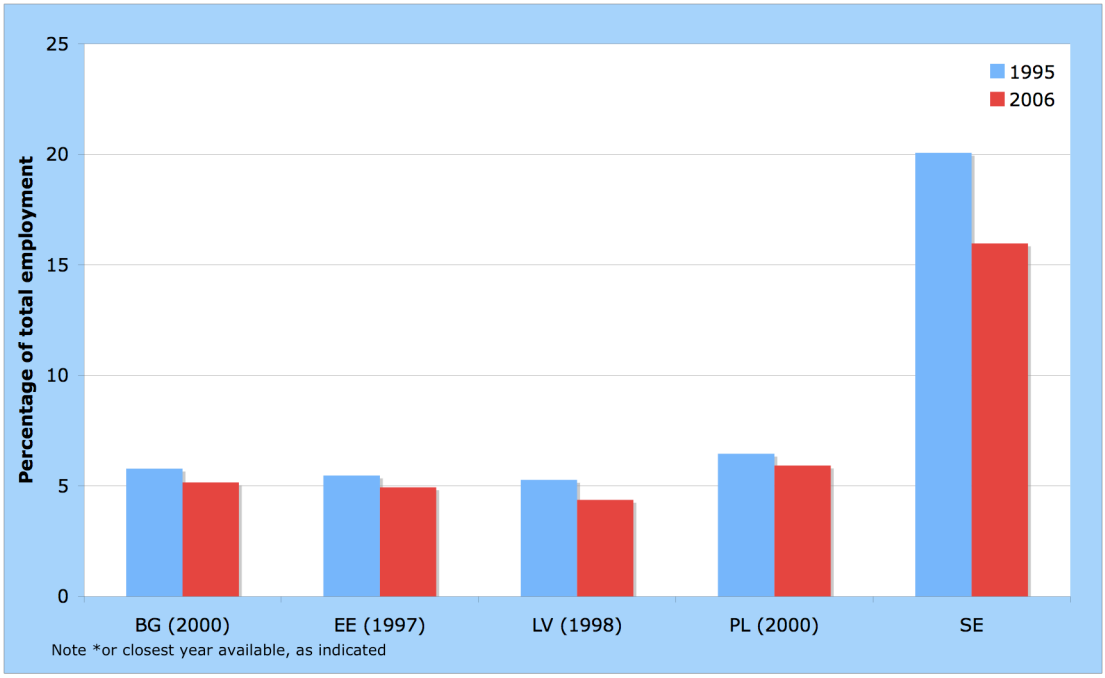
Source: Eurostat, LFS spring 2006 results

Data for individual countries reveal that many countries experienced different trends across the EU area compared with this overall picture. There were both countries with a growing employment in health and social services during the past decade, as well as countries with a shrinking share of this sub-sector in the labour market. The following section identifies three groups of countries that experienced different developments during the late 1990s and the first five years of the new millennium.

Countries with a shrinking share of employment in health and social services

There is a distinct group of EU Member States with a shrinking (or at least stagnant) share of employment in health and social services. Figure 2.4 shows the development of employment in health and social services for Bulgaria, Estonia, Latvia, Poland and Sweden from 1995 until 2006.

Figure 2.4: Countries with a shrinking employment in health and social services (1995 and 2006)*



Source: Eurostat, LFS spring 2006 results

There are three countries in this group that joined the EU in the 2004 extension round. At the beginning of the observation period, the share of employment in health and social services in total employment in the new Member States was, with values from 5 per cent to 7 percent, already to be found at the lower end compared to other EU Member States. At the end of the observation period, the values were again between 0,5 and 0,9 per cent lower than in the beginning.

The first four of these countries went through a transition process since the beginning of the 1990s. For them, the past one and a half decade was a time when they had to reform their whole economy, including the entire public sector, facing

budgetary constraints and several risks for the future sustainability of the system, due to expected demographic changes.

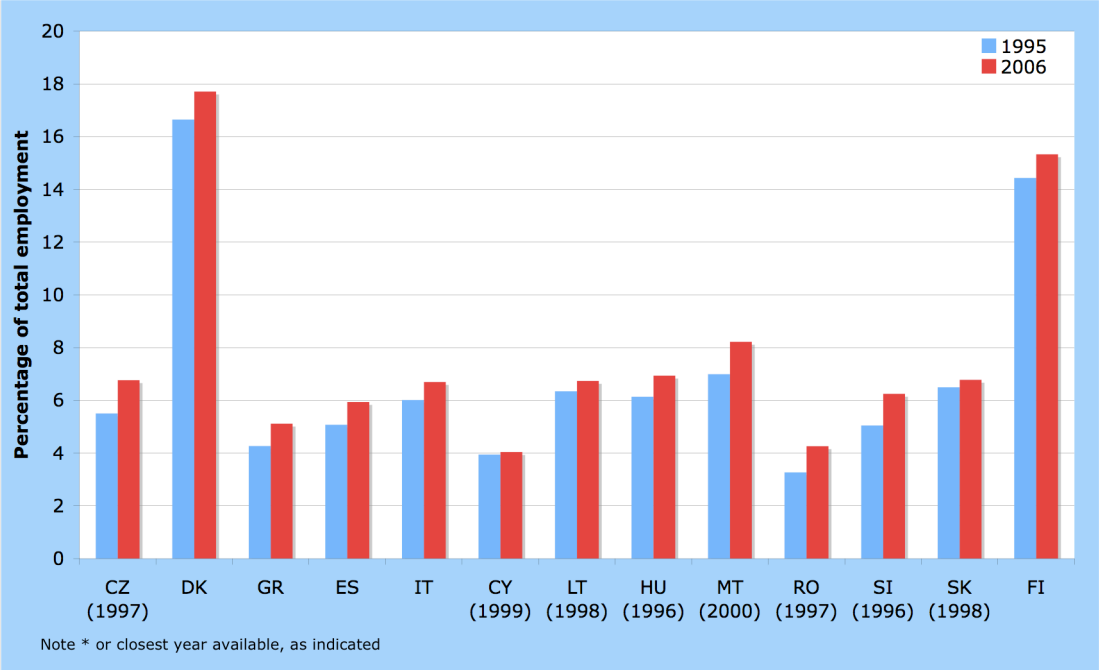
The last country in the above figure is Sweden, which joined the EU in 1995. Sweden is in many aspects considered to be the model of the social-democratic welfare state, as the other Scandinavian countries and Finland. In Sweden, employment in health and social services as a share of total employment was in 1995 just over twenty per cent. This was indeed by far the highest value across the EU for the period observed. Even after lowering the share sharply, Sweden is, with just below sixteen per cent still among the countries with the highest share of employment in health and social services in total employment. In the Swedish case the cut in employment in health and social services is a result of a massive restructuring and cutback process of public sector activities. This process started in the late 1980s, when the extended government sector was regarded to be challenging financial sustainability.

Countries with moderate growth in employment in health and social services

Among the EU-25 countries there are twelve countries that show only a moderate growth in employment in health and social services for the period from 1995 (or closest year available) to 2006. The growth in employment in health and social services was from 3.2 (Cyprus) to 26.4 (Slovenia) percentage points higher than total employment growth. Again, with the Czech Republic, Cyprus, Latvia, Hungary, Malta, Slovenia and Slovakia, this includes a predominant number of countries that joined the EU in the extension round in 2004.

In most of these countries, the share of employment in health and social services in total employment was relatively low at the beginning of the observation period with shares between just below 4, for Cyprus, to just below 7 percent, for Malta. The growth of employment in health and social services in this group of countries varied with very low values, like Cyprus, with an increase of the share of just 0.1 per cent compared to the 1999 value, while the share in Czech Republic grew by 1.3 per cent since 1997.

Figure 2.5: Countries with a moderate growth of employment in health and social services (1995 and 2006)*



Source: Eurostat, LFS spring results

Four out of these new Member States have a similar history as most of the countries that experienced shrinking shares of employment in health and social services during the past decade, while Malta and Cyprus represent the southern European countries, which often show lower employment in health and social services as a rate of total employment, than the countries in Scandinavia and Western Europe. As the growth in the sector was relatively low, the gap in employment in social services of these countries has widened in comparison with the countries that experienced a dynamic growth in the sector (see below).

Five countries in this group joined the EU already in earlier extension rounds, or have even been among the founding members, like Italy. These countries increased the share of employment in health and social services at similar rates as the above-cited new Member States, but they have to be separated into two sub-groups again.

On the one hand, there are Southern European countries, like Greece, Spain and Italy, which show relatively low shares of employment in health and social services in total employment by the middle of the 1990s, ranging from 4.3 per cent in Greece to just above 6 per cent in Italy. During that period, health and social services' share has been growing to values between 5.1 per cent in Greece and 6.7 per cent in Italy.

On the other hand, with Denmark and Finland we have two Nordic countries in this group. Starting in the middle of the 1990s with an already relatively high share in total employment (16.6 per cent in Denmark and 14.4 per cent in Finland), they kept increasing the rate during the reported period.

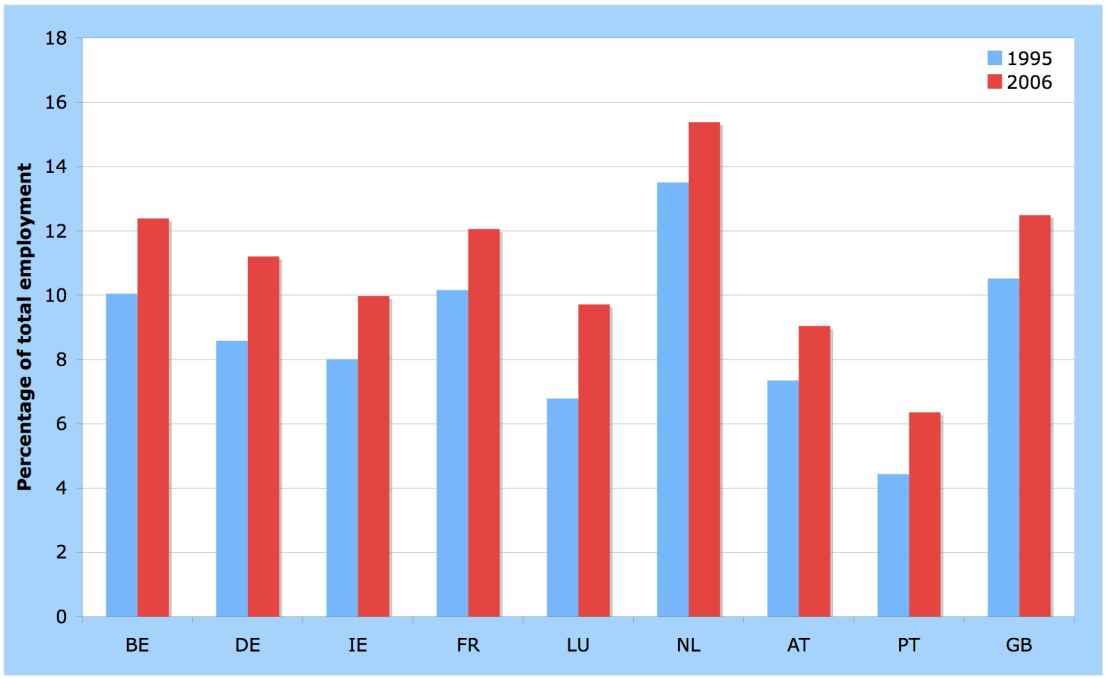
With 15.3 percent, Finland reports for 2006 the fourth-largest share of health and social services in total employment, and Denmark overtook, with 17.7 percent, the

position that Sweden had in 1995. It is now the country with the highest share of employment in health and social services in total employment in the EU.

Countries with strong growth in employment in health and social services

Countries in the last group reviewed here all had a strong growth in employment in health and social services. It was around 17 (the Netherlands) to over 50 (Luxembourg) percentage points higher than total employment growth. With Belgium, Germany, France, Luxembourg and the Netherlands this group is dominated by founding members of the EU. In addition, Ireland, Austria, Portugal and the United Kingdom are countries that joined the EU between 1973 and 1995.

Figure 2.6: Countries with a strong growth of employment in health and social services (1995 and 2006)



Source: Eurostat, LFS spring results

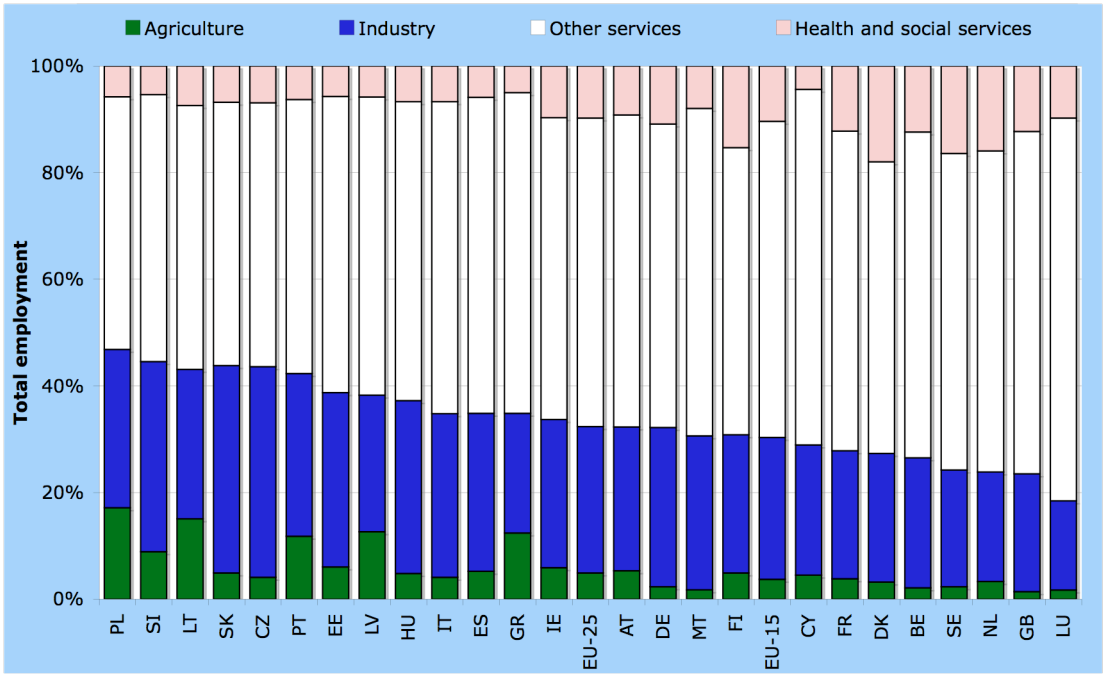
Apart from Portugal, which represents with just 4.4 per cent the traditional southern European countries, all countries in the figure reported medium shares for 1995, ranging from 6.7 per cent in Luxembourg to 13.5 per cent in the Netherlands.

The increases of the share in total employment lies in a range from 1.7 per cent in Austria to 2.9 per cent in Luxembourg, resulting in 2006 in values ranging from 6.4 per cent in Portugal to 15.4 per cent in the Netherlands. With its strong growth, the Netherlands in 2006 became the country with the third-largest share of employment in health and social services (see Figure 2.1), taking over Finland's position of 1995.

2. *The role of services in general and health and social services in particular in employment in the EU*

The last section looked at the country-specific and Europe-wide share of employment in health and social services in total employment. This section will first discuss the relation of employment in the three main sectors of the economy in relation to each other with a special focus on the health and social services sub-sector.[22] It will then examine in more detail the contribution of the sector to structural changes in the overall composition of employment, which again will highlight the role of the sector as driver of structural change and job growth.

Figure 2.7: Share of main employment sectors in total employment 2006



Source: Eurostat, LFS spring 2005 results

As shown in Figure 2.7, the importance of the different sectors in 2005 differed widely across the EU area. The data for the EU show that the importance of agriculture (the green section of the bars) is lower in the EU-15 (3.7 percent) area than it is in the EU-25 area (4.9 percent). Some countries still have a much higher share of employment in agriculture, such as Greece, with 12.4 percent, Latvia, with 12.6

[22] NACE or ISIC classifications use the term "industry" for all fields of activity. The term as it is used here is adapted from the use in the Labour Force Study, which defines three main sectors of economic activity: Agriculture, Industry and Services. Agriculture includes Agriculture, Hunting and Related Service Activities; Fishing and Forestry. Industry is an aggregation of the following three basic fields of economic activity: Mining and Quarrying; Manufacturing; Electricity; Gas and Water Supply and Construction. Services is an aggregation of: Wholesale and retail trade of motor vehicles, motorcycles and personal and household goods; Hotels and Restaurants; Transport, Storage and Communication; Financial Intermediation; Real Estate, Renting and Business Activities; Public Administration and Defence, Compulsory Social Security; Education; Other Community, Social and Personal Service Activities; Private Households with Employed Persons; Extra-Territorial Organisations and Bodies and Health and Social Work.

percent, Lithuania, with 14.8 percent, Poland, with 17.1 percent, and Portugal, with 11.8 percent. In general, employment in agriculture tends to be more important in new Member States that joined the EU in 2004 and in classical southern European countries than in the other EU Member States.

The data for the share of industry (the blue section of the bars) in total employment do not show such wide differences across the EU, but still, the share of employment in this sector is in the Czech Republic (39.5 percent) more than twice as high as in Luxembourg (16.6 percent). The share of employment in industry is again high in Member States that joined the EU in the 2004 round and in southern European countries. Even classic "industrial countries", like Germany (29.9 percent) or the United Kingdom (22.1 percent) have now relatively low to medium values in industrial employment.

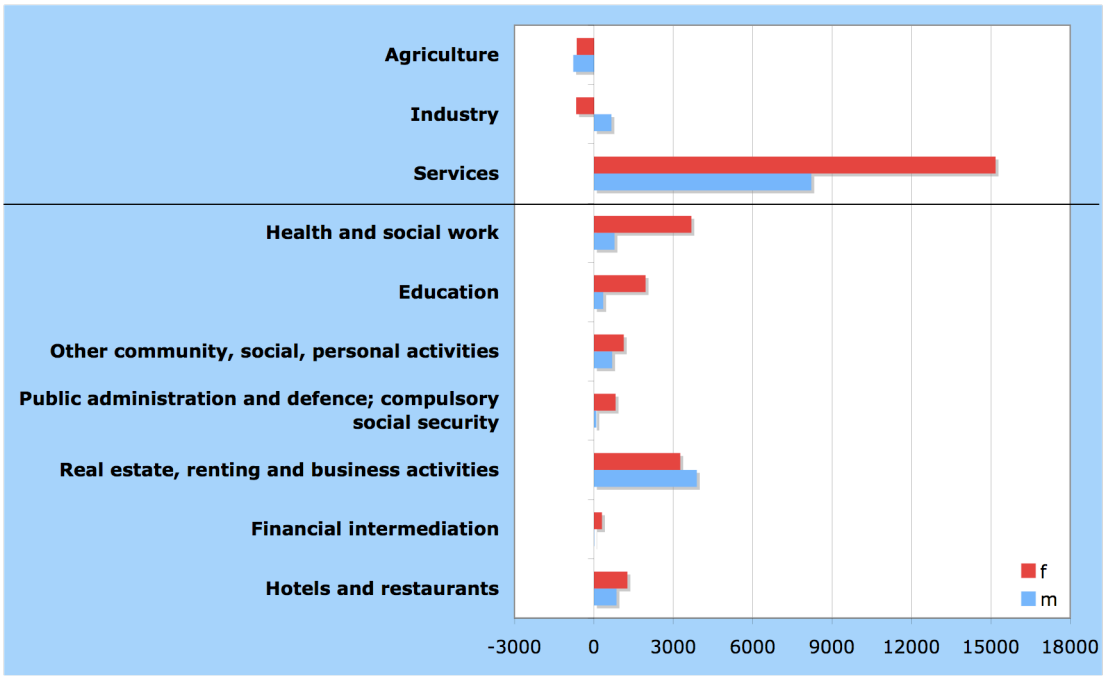
Employment in Services

Whereas the other two sectors were particularly strong in the new Member States and in southern European countries, other services (white bars) as well as the health and social services sector (the light red section of the bars) together represent by far the biggest part of the labour market in the old EU states. The sector is especially important in Northern and Western European countries. Luxembourg (81 percent), the United Kingdom (76.5 percent), the Netherlands (76 percent), and Sweden (75.8 percent) show strong values. Employment in services tends to be rather low in countries like Poland (53.1 percent), Slovenia (55.6 percent), Lithuania (55.9 percent), the Czech Republic (56.4 percent), and the Slovak Republic (56.6 percent).

3. The contribution of the sector to structural change in employment

This section will discuss the developments in employment in different sectors. As already mentioned above, some of the classical employment sectors are actually shrinking. Due to increasing wage levels, low-skilled manual work in agriculture and industry is becoming too expensive in highly developed industrial countries. Figure 2.8 underlines this development for the EU-15 for the period 1995 to 2006.

Figure 2.8: Change in sectoral employment for the EU-15 1995 to 2006 (in thousands with gender breakdown)



Source: Eurostat, LFS spring 2005 results

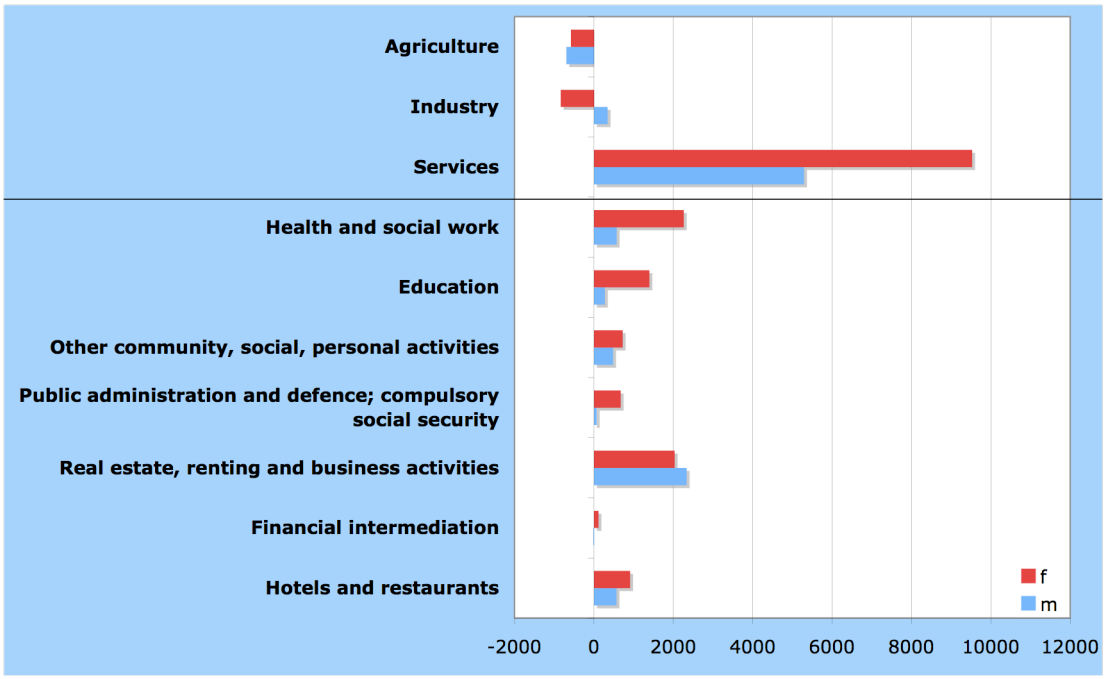
The data show for the industry and agriculture sectors a real loss of employment in the above-mentioned period. In total, there was a loss of about 3 million jobs in these sectors.

At the same time a number of sectors showed a remarkable increase in employment opportunities. Not surprisingly, the most important for the EU-15 was the services sector, which produced more than 23 million new jobs during that period. And health and social services as part of the services sector turned out to be also very dynamic. This sub-sector alone with more than 4.4 million new opportunities represents about a fifth of the growth of the whole services sector.

The growth in services in general is more than five times bigger than the loss in employment in other sectors. The growth in health and social services alone more than compensated the job losses in the other sectors.

The picture for the EU-25 for the period 2000 to 2006 looks similar to the one for EU-15. The data in Figure 2.9 show that more than three million jobs have been lost in the traditional sectors during this period, while services have grown strongly. Again, the growth in employment in services more than compensated the cumulated loss in other sectors.

Figure 2.9: Change in sectoral employment for the EU-25 from 2000 to 2006 (in thousands with gender breakdown)



Source: Eurostat, LFS spring 2005 results

The main finding from this comparison is that – within the continuous shift towards a service economy – health and social services is one of the best performing sub-sectors in terms of employment creation since 1995.

After looking at the general development of employment in health and social services and its relation to the main sectors of the labour market, the following briefly looks at specific effects of the employment increases in health and social services on structural changes in employment patterns by age, sex, and education.

While aging societies are facing problems of economic growth and financial sustainability of their social insurance schemes due to increasing age-dependency ratios, it has become a priority of employment policies to increase participation of groups that are currently underrepresented in the labour market.

Since EU Member States all face the consequences of demographic aging, the goal of an increased labour market participation of these groups is part of a comprehensive strategy to enhance the Member States' labour markets in line with the Lisbon strategy.

With the exception of a number of Northern European countries two major groups are underrepresented at the labour market in most EU Member States. First, women at all ages are showing lower labour market participation rates than men. The other group are older workers.

In order to achieve both, a higher employment of women and of older workers, the further development of the services sector in general and the health and social services sector in particular, are prime candidates for driving these structural changes.

Figure 2.8 also shows the development of employment in different sectors by gender. While the employment growth in services in the EU-15 in the period from 1995 to 2006 was with 52.4 per cent of the additional jobs already dominated by females, women made even 82.7 per cent of the additional new jobs in health and social services.

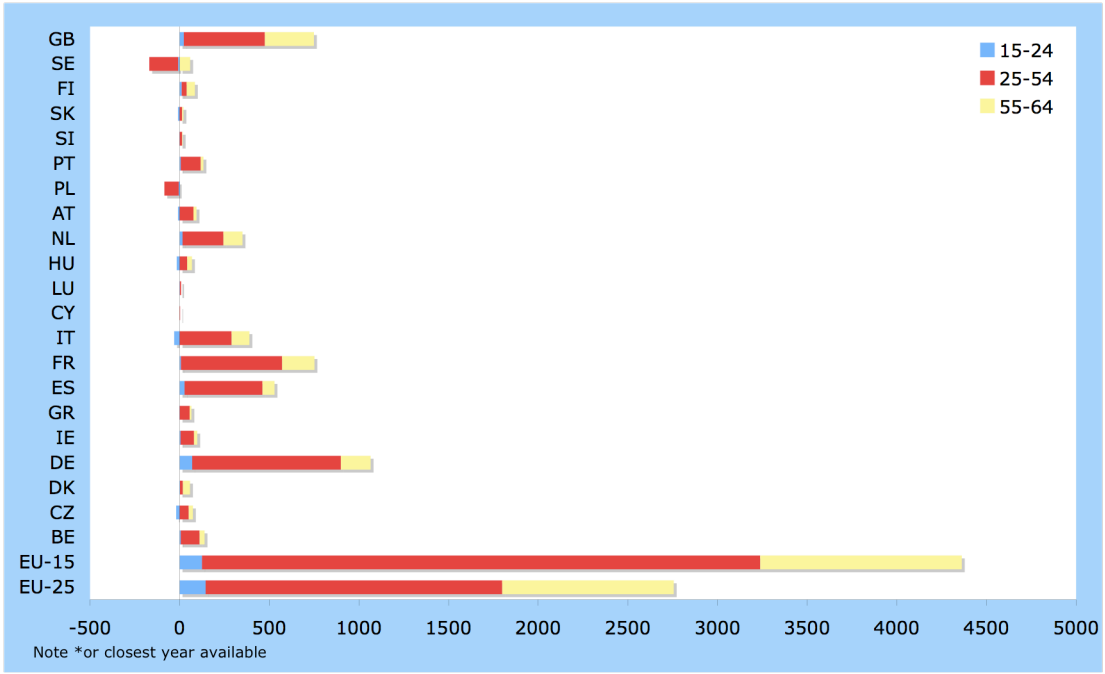
Figure 2.9 illustrates that the same is true for the EU-25 in the period from 2000 to 2006. New employment opportunities for women in services easily outnumber the already remarkable gains for men in the services sector. And also in the sub-sector of health and social services, the gains for women are again much bigger than those for men.

Figure 2.10 shows the employment creation in health and social services for the three main age groups: younger workers (age 15-24), prime age workers (age 25-55) and older workers (age 55-64) for the EU area and the individual EU Member States.

The group of prime age workers has the biggest share of the growth in employment in health and social services for the period from1995 to 2006. But also the group of older workers gained a remarkable share of the additional employment opportunities, while the share of younger workers increased only relatively.

This development has been observed for both the EU-15 and the EU-25 on average. Looking at the individual Member States, the data show variations. While most of the countries followed this pattern, Sweden and Poland show a shrinking number of employment opportunities for prime age workers. In Sweden this job loss for prime age workers was, however, accompanied by an increasing number of employment opportunities for older workers.

Figure 2.10: Employment creation in health and social services by age group (1995 to 2006)*



Source: Eurostat, LFS spring 2005 results

4. Employment trends within the health and social services sector

One of the main findings of the earlier parts of this section was that health and social services was one of the strongest sources of employment growth in the European Union during the last one and a half decades. This section will shed more light on structural trends within the health and social services sector.

As a main sub-sector of services, health and social services itself is an aggregation of three different fields of economic activity, namely: human health activities, veterinary activities and social work activities. This part of the section on employment in health and social services discusses the development of employment in these three sub-sectors, taking into account findings from Eurostat's Labour Force Survey (LFS).

It should be noted here, that the available data for the three sub sectors are much less extensive than those reported for the whole sector. In addition, the reported data refer to the period from 2001 to 2005 and to just six EU Member States. Due to these differences and some methodological issues concerning the split into the different fields of activity, the findings of this section should be regarded as useful additional information but they have to be evaluated carefully (see Box 2.2 for more information on methodological issues and the data from national sources presented below).

Box 2.2: Challenges for a consistent classification of services within health and social services

ISIC provides for most sectors a well-structured definition that allows a relatively straightforward classification of all economic activities. But finding clear-cut divisions of services within the health and social services sub-sector becomes much more difficult. Many health and social services are inextricably linked. Therefore it becomes sometimes very difficult to classify a service as activity belonging solely to one of the sub-fields of activities that the health and social services sector offers. Two relevant fields of activity – namely human health activities and social work activities – are in many cases both offering a possibility that seems to be a valid classification. The field of long-term care services offers many examples that illustrate this situation.

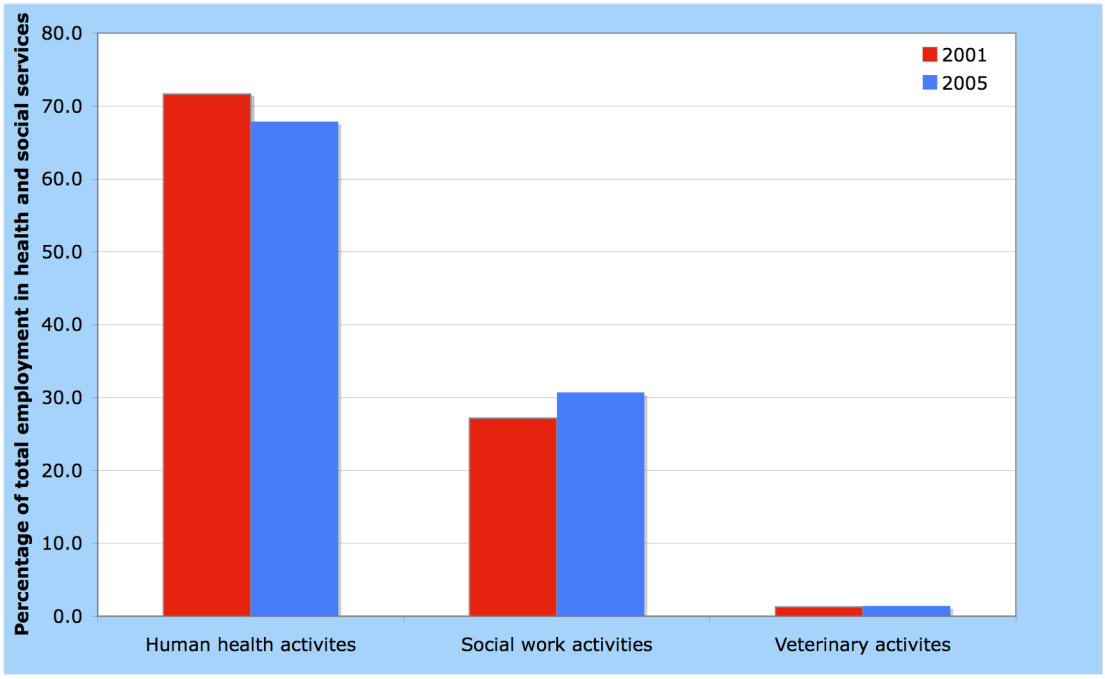
This part of the employment section will first look at the general composition of the health and social services sector. In a second step it will discuss some data on the absolute change of employment in health and social services and some developments in employment within the sector. Finally it will look at detailed data on health and social services in relation to total employment.

Composition of employment in health and social services

As mentioned above, health and social services comprises three fields of economic activity: human health activities, veterinary activities and social work activities. As Figure 2.13 shows, human health activities are in terms of employment by far the biggest field of activity within the sector.

In 2001 (the red bars in Figure 2.11) it made up 72 per cent of all employment opportunities in the sector. The second-largest field of activity was social work activities, which accounted for some 27 per cent of all jobs. Veterinary activities constituted only a rather marginal part of all employment in health and social services, accounting for about 1,3 per cent of total employment in health and social services in 2001.

Figure 2.11: Share in total employment in health and social services by field of activity (2001 and 2005)



Source: Eurostat, LFS

The data for 2005 (the blue bars in Figure 2.11) still show the same order in terms of the size of the three fields of activity. But there has been some fluctuation in the relatively short observation period from 2001 to 2005.

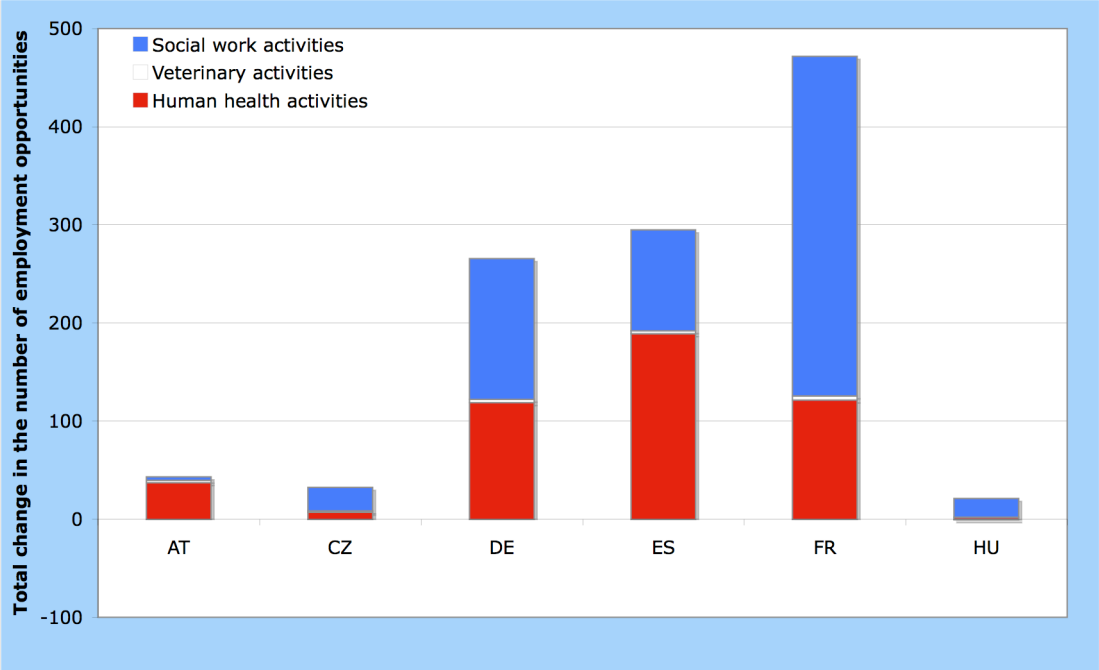
Human health activities were still by far the biggest field of activity in 2005, when they accounted for some 70 per cent of total employment in health and social services but this is a loss of three percentage points of total employment in health and social services compared to 2001. Social work activities gained with about three percentage points approximately what human health activities had lost during that period, and accounted for 30 per cent of total employment in health and social services.

Changes by field of activity

Figure 2.12 shows how many jobs have been created in health and social services, with a split into the three fields of activity comparing the values of 2001 and 2005. The changes of the relative sizes of the two main fields of activity that were discussed above suggest that employment in social work activities should have grown faster than human health activities.

Generally, employment growth was not limited to a single field of activity. The data show that the growth took place in all fields of activity for almost all countries. In the Czech Republic, Germany, France and Hungary social work activities turned out to be the driving force behind employment growth in the period from 2001 to 2005, whereas human health activities was the fastest-growing field of activity in Austria and Spain.

Figure 2.12: Absolute growth of employment in health and social services, full-time equivalents in thousands (2001–2005)



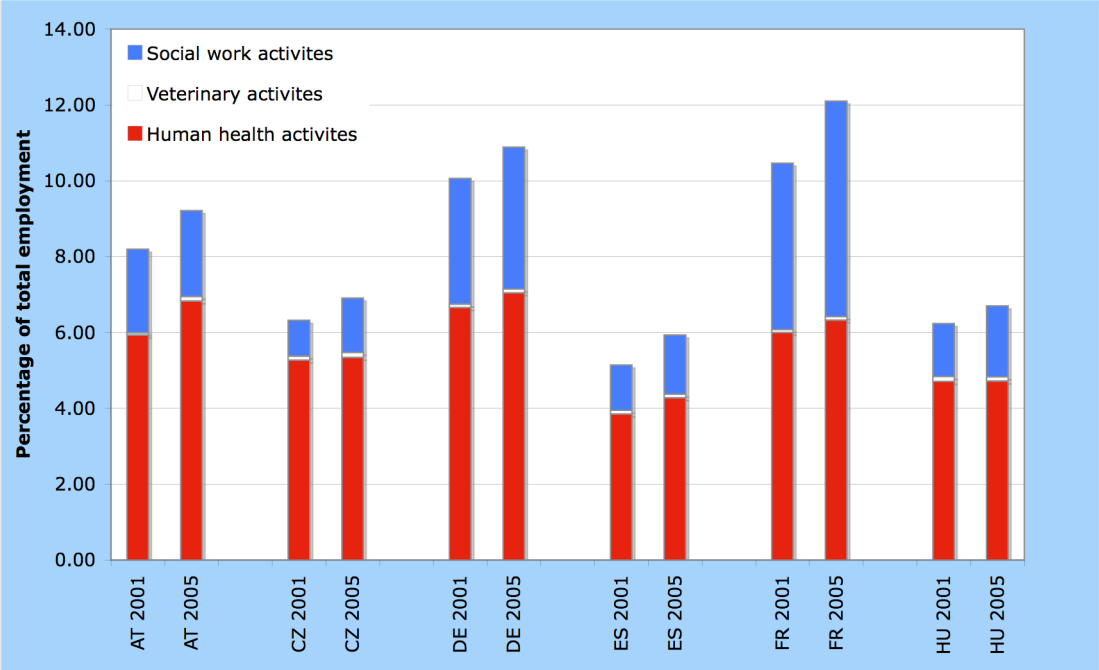
Source: Eurostat, LFS

Figure 2.13 shows that during the observed period the dynamic growth of employment in health and social services was not only impressive in absolute numbers but also compared to the development of total employment. In all countries that reported such detailed data for employment in health and social services, the sector grew faster than the rest of the economy.

The share of employment in health and social services in total employment grew between 2001 and 2005 from about 0.5 per cent in Hungary to 1.6 per cent in France. In 2005, the health and social services' share in total employment ranged from 5.9 per cent in Spain to 12.1 per cent in France.

Representing already the biggest share of employment in health and social services in total employment, France also reported the strongest growth rate. These developments in France are also confirmed by the French in-depth country study. The main drivers here are the positive trends in life expectancy on the one hand and the relatively high birth rates on the other.

Figure 2.13: Employment in health and social services as a share of total employment (2001 and 2005)



Source: Eurostat, LFS

The first of the two developments created an employment growth in the elderly care sector. During the period from 2000 to 2005 this sector created 130,000 new employment opportunities, which is 40 per cent of the number of employment opportunities in 2000. 55 per cent of this growth was created in new residential care facilities, the rest in home care services.

The second development led to an employment boost in childcare services. In addition, services targeted at social integration were, due to a sustained growth in public financing, another source of job creation in France. As a result even only the number of employment opportunities in services targeted at social integration increased by 3000, a 30 per cent increase of the value of the year 2000.

The in-depth study for the United Kingdom indicates similar trends of growth in employment in health and social services. Due to methodological differences in the collection of data and to regional differences, there is no national estimate available, but there are similar observations for different parts of the country available.

In England for instance the number of full-time employment opportunities has been growing since the beginning of the millennium – after a period of decline. There were about 132,000 full-time employment opportunities in 1995, 125,000 in 1998, 128,000 in 2000 and almost 138,000 in 2005. The number of part-time staff has been decreasing in the same period from about 180,000 in 1995 to about 140,000 in 2005.

The numbers mostly reflect only the developments in the public sector. But in England the biggest share of employment in social care has been shifted from the public to the private sector, for which there are hardly any data available. The British

Labour Force Survey estimated the total workforce in social care to be about 930,000 people, of which 608,000 were providing services to older people.

In England many of the public social service departments closed down during this period, which led to a shrinking number of employment opportunities in social care in the public sector. Also the number of care home staff in public nursing homes was affected by the changes in the sector. These homes have been closed since a growing part of the care services is provided at home by providers from the voluntary and the private sector.

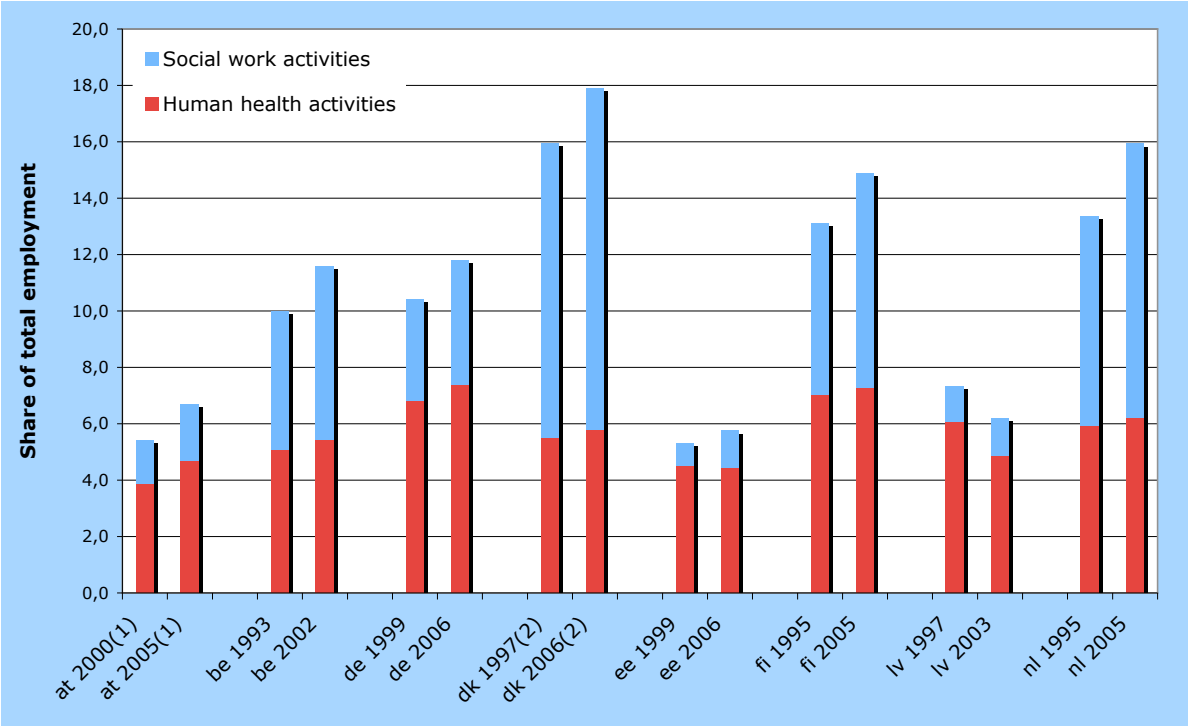
Therefore local authorities increased the proportion of central and strategic staff, which indicates that the public sector activities are being professionalised and as such are concentrating on supervision and quality control, while private companies are providing the services.

In addition to the detailed data from the Eurostat Labour Force Survey (LFS) discusses above, there usually exists a range of national data sources for employment data that provide the three-digit breakdown that is needed for analysing trends in health and social work separately. As Figure 2.14 shows, these data confirm the employment trends discussed in this section based on the Eurostat LFS. Austria, Belgium, Germany and the Netherlands show a relatively strong growth of employment in health and social services, as reported in Figure 2.6. Denmark and Finland show, compared to the already relatively high share of employment in health and social services, a moderate growth, as reported in Figure 2.5, while the share in Latvia is shrinking (see Figure 2.4).

For the growth in employment in health and social work separately, the main observation is that social work activities have in all countries contributed more to the employment growth than health, with the exception of Austria. In analysing these trends, one needs, however to keep in mind that there are differences in the methods of data collection and estimations applied that limit the international comparability of these data with respect to absolute levels of employment shares (see Box 2.3).[23]

[23] Chapter 14 discusses ways ahead to improve availability and data quality for employment in social services in international comparisons, based on recent experience and progress in the health area.

Figure 2.14: Employment in health and social services as a share of total employment (from national sources)



Source: see Box 2.3

Box 2.3: Sources and comments on employment data from national sources

Data sources for Figure 2.14

Austria: Association of Scial Insurance Institutions (Hauptverband d.ö. SV-Träger)
Belgium: DBRIS - Database de redevables d'information statistique (National Office of Social Security): http://www.onssrszlss.fgov.be/onssrsz/ge/home.htm
Denmark: Danmark Statistik: http://www.statbank.dk/ras9
http://www.dst.dk/HomeDK/TilSalg/doga.aspx
Estonia: Statistics Estonia, Employed persons by economic activity
http://pub.stat.ee/px-web.2001/Dialog/varval.asp?ma=ML200&ti=EMPLOYED+PERSONS+BY+ECONOMIC+ACTIVITY&path=../I_Databas/Social_life/09Labour_market/04Employed_persons/02Annual_statistics/&lang=1
Finland: Statistics Finland, Population Statistics / Employment and Dwelling; Metadata: http://tilastokeskus.fi/meta/til/tyokay_en.html
Germany: German Employment Agency, "Sozialversicherungspflichtig Beschäftigte nach Wirtschaftsgruppen"
http://www.pub.arbeitsamt.de/hst/services/statistik/detail/b.html
Latvia: Annual survey of enterprises and institutions.
Netherlands: Centraal Bureau voor de Statistiek (in Dutch), Statline
http://statline.cbs.nl/StatWeb/Table.asp?LA=nl&DM=SLNL&PA=7313mtsr&D1=a&D2=0,555-657&D3=a&STB=G1,G2&HDR=T

Notes for Figure 2.14

Austria: Data from LFS include self-employed and civil servants, therefore higher than the data from social insurance records
Belgium: New data collection currently being put in place for 2003 ff.
Denmark: Minor differences in national adaptation of NACE for "Health and social services"
Latvia: Annual averages; End of year data from 2004 ff.

5. Trends in expenditure

After having looked at employment trends in health and social services this last section of Chapter 2 analyses trends in social spending on health and social services, by analysing the distribution of social spending by functions of social spending as recorded in the Eurostat database on *European System of integrated Social Protection Statistics* (ESSPROS).

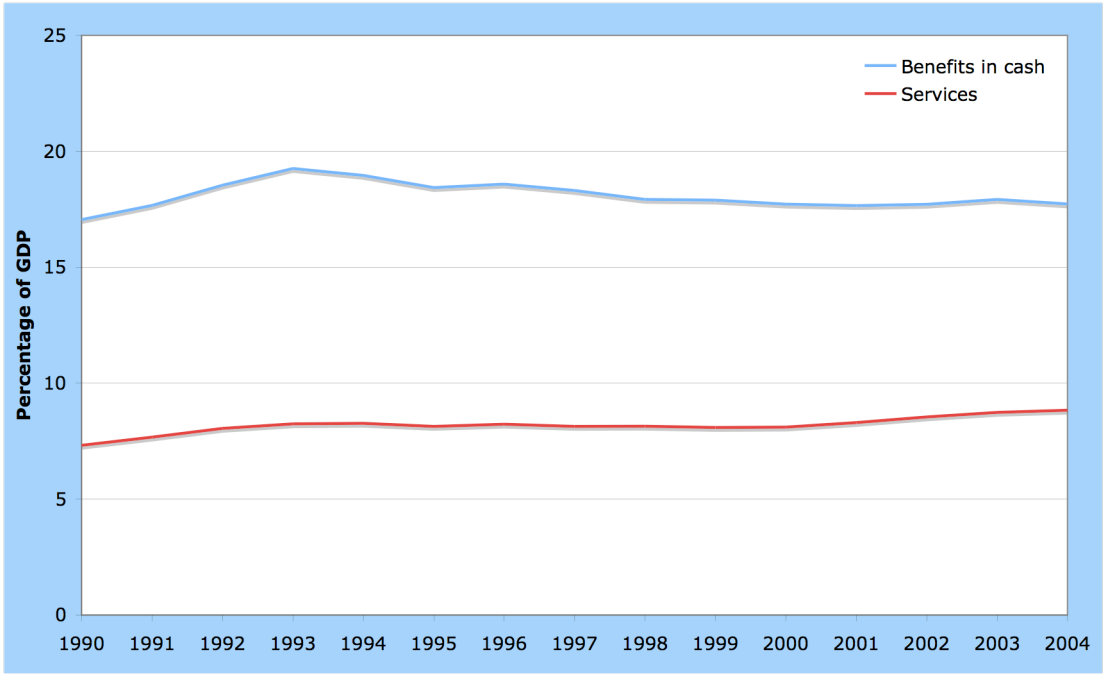
Social expenditure in ESSPROS includes all publicly provided services plus cash benefits targeted at people in need or for the achievement of social policy goals. Among others this includes services such as childcare and care for the elderly and disabled, and cash benefits like pensions, maternity payments and social assistance.

Figure 2.14 shows that during the past 15 years, public spending trends in cash benefits and services for the EU-15 on average were fluctuating only slightly and seemed to be much dependent on developments of the economic cycle, while public policy in many countries was concerned with containing growth in social expenditure as part of public budgets.

Benefits in cash, among which pensions are by far the largest spending item, developed differently in the past decade than spending on services (benefits in kind), the bulk of which is on publicly funded health care. Benefits in cash accounted for 17,0 per cent in 1990 and went up to 19,3 per cent in 1993. In the subsequent decade, benefits in cash as a share of GDP were shrinking and came back to a level of 17.7 per cent of GDP in 2004.

The development of expenditure on services, however, rose slightly in the same period as part of total GDP. After 7.3 per cent of GDP in 1990, services accounted for 8.8 per cent of GDP in 2004. There is a trend from cash benefits to more spending on social services that have increased their share in social spending in many countries. In 2004 total public social spending ranged from about 12 per cent of GDP in Latvia (12.2) and Lithuania (12.9) to about 30 per cent of GDP in Denmark (29.8) and Sweden (31.7).

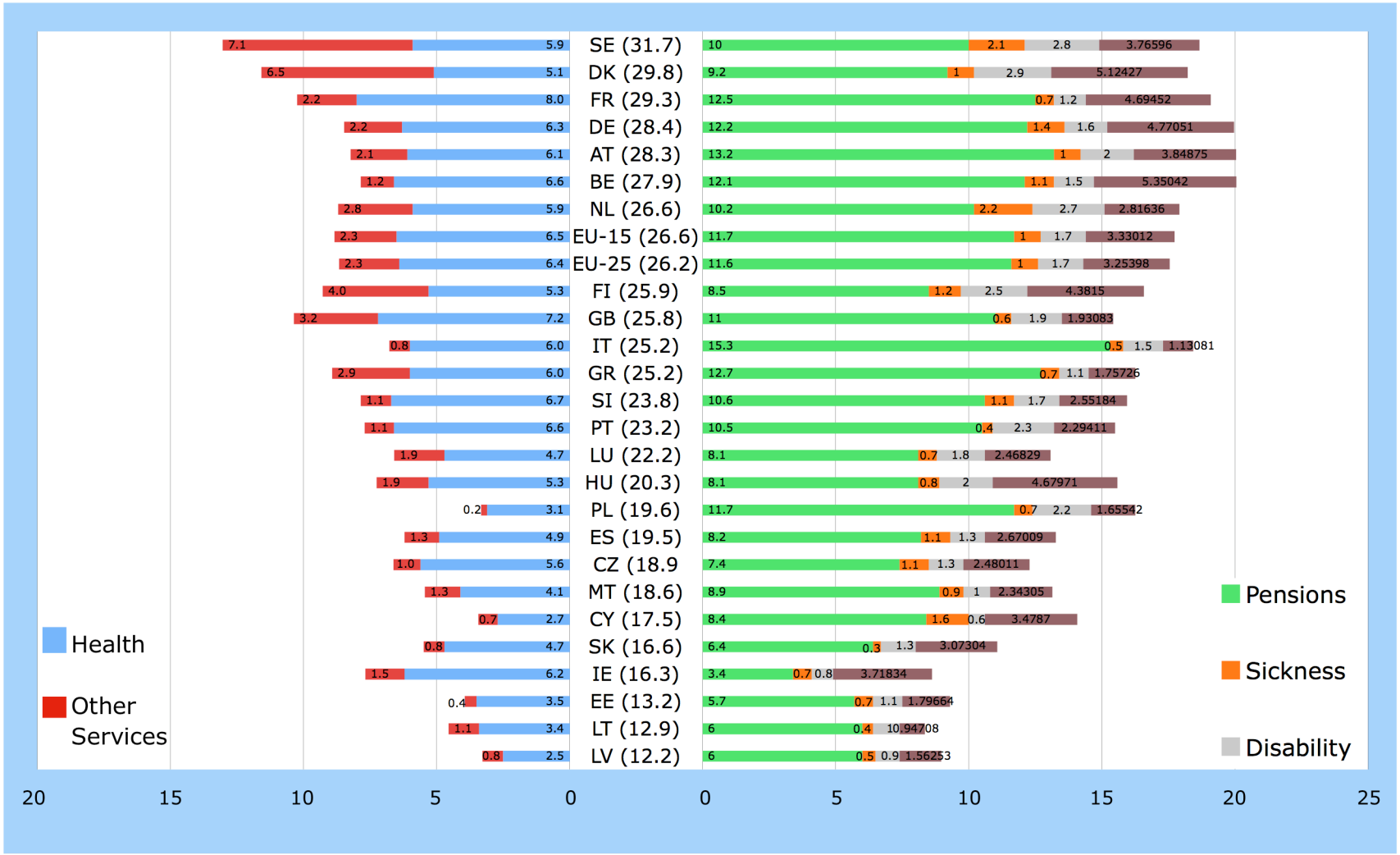
Figure 2.15: Trend of social expenditure for the EU-15 from 1990 to 2004



Source: Eurostat, ESSPROS social expenditure database (accessed Jan 2007)

According to the Eurostat data presented in Figure 2.15, public social spending is distributed as follows. Spending on services was generally lower, accounting for 24 per cent (in Cyprus) to about 90 per cent (in Ireland) of the spending that went to cash benefits. Spending on services (on the left side of Figure 2.14) is dominated by health services. Public spending on health services (as defined and measured in Esspros) ranges from 2.5 (Latvia) to 8 per cent of GDP (France). Other services ranged from as low as 0.2 (Poland) to over 7 per cent of GDP in Sweden. Health accounts for substantially larger shares of social spending than all other social services together (defined as all other public social expenditure in kind). There are two exceptions: spending on other services is bigger in Sweden and Denmark.

Figure 2.16: Public social expenditure by broad social policy area, in percentage of GDP, in 2004



Source: Eurostat, ESSPROS database (accessed Jan 2007)

The bulk of cash benefits (the right side of Figure 2.15) is spent on pensions that account for more than 50 per cent of total spending on cash benefits in all countries, with the exception of Estonia. As a share of GDP, pensions represented from 3.4 per cent in Ireland to 15.3 per cent in Italy.

Spending for disability-related cash benefits ranged in 2004 from one per cent of GDP in Cyprus to almost 3 per cent in Denmark. Cash benefits on the sickness function (mainly allowances for sick leave) accounted for a smaller share of total spending on cash benefits. In 2004 it ranged from 0.3 (Slovakia) to 2.1 per cent (the Netherlands).

It is increasingly acknowledged that a core challenge for social and health policy is to put the right mix of services in place and to better target services in order to contain the growth of disability and sickness benefits by better integrating health and social services to enable more people to stay active in the labour market, which is what a majority of people prefer over being temporarily and permanently excluded from work life.

6. Conclusions

The developments discussed in this section underline the important contribution of health and social services in the European Union to job creation and structural change, namely to the increase of female employment and of the employment of all age groups.

The sector performed remarkably well in terms of employment creation in times when other sectors were shrinking. The observation period used here was a period of fast economic growth in its first half and of slower growth in the second part. The growth in social services employment, however, continued throughout both phases.

Especially the findings of the final part show that a further development of the sector would enable the EU countries to serve the needs of their aging societies and to activate groups that are still underrepresented at the labour market.

Employment in health and social services: A perspective of sustained growth?

The results of this section show that further development of health and social services could become a key tool to achieve the goals of the Lisbon strategy. In the past one and a half decades health and social services created an impressive employment growth that helped to raise the labour market participation rates of groups that did not gain from past periods of employment growth, older workers and especially women should be noted here.

As the ageing process of European societies will continue there will be the potential of sustained employment growth in the sector. If more services that focus on the frail elderly but also on young children are offered, the sector itself has good chances to grow. Additionally it will offer many family care-givers and young mothers that look after their children an alternative, since they can now choose between carrying out services in their families or taking up employment.

But there are also a number of challenges to continued growth of employment in social services. As the sector provides services to individuals' non-standard working hours are more frequent. Compared to 17-18% of all employees, 28% of those employed in health and social services work during the night and 32% in shifts leading to substantial pressure on workers. This finding is underlined by results based on the European Establishment Survey on Working Time and Work-Live Balance 2004-2005. The sector "Health and social work" (NACE N) ranks second out of 13 sectors as to the share of unusual working hours (required from at least 20% of employees) for night work, Saturday work and Sunday work. The sector "Other community, social and personal services" (NACE O) is on rank 5 for night work and on rank 3 for both Saturday and Sunday work (European Foundation for the Improvement of Working and Living Conditions, 2007:21)

In contrast to the above-average educational levels and the higher share of non-standard working hours, gross hourly earnings are below average in those countries for which data are available. This is in line with the findings of many studies on the gender pay gap that sectors with high female shares in employment are characterised by wage penalties. However, this results from a wide variety of working conditions and wage levels in health and social services. They comprise high-quality, high-wage employment but also many workers at low wages and in unstable employment as illustrated by a relatively high incidence of temporary contracts in most of the western European Member States.

Most of the in-depth country studies indicate that the focus on sustainable funding and a growing demand for health and social services has led to low wage levels in the sector. The possible consequence of these developments is that it becomes increasingly difficult to attract qualified employees in the future, which could lead to staff shortages or a shrinking quality of services and this is already a frequently mentioned concern of policy analysts and stakeholders.

Chapter 3: Social services of general interest: an emerging EU policy topic

1. Introduction

Services of general interest (SGI) are generally seen as a key component of the European model of society. Although a number of approaches exist to describe the concept of a European Social Model[24], there seems a broad consensus that SGI constitute a core part thereof and cannot be provided without state involvement. They add to other core elements as e.g. the concept of a social market economy, the subsidiarity principle in varying degrees of application, the existence and guarantee of social rights, social dialogue within the scope of social partnership and dialogue with civil society.

The concept of SGI is based on a common set of values and goals, which include: universal access for all (social, spatial and financial), affordability, quality of services, the guarantee of a continuous service and sustainability of service provision, as well as responsiveness to the needs of users and to their preferences, including consumer protection. SGI are entrusted within Member States by public authorities with specific service missions. Their providers have to fulfil public service obligations defined by public authorities in order to guarantee the realisation of the service-specific general interest missions. Moreover, SGI are usually subject to (sector-)specific regulations (which might in addition differ for specific services) to pursue their mission, originating from national, regional or local legislation within Member States. Depending on the sector they might in addition or predominantly stem from Community law. National regulations concerning their providers add to this set of rules, again impacted on by Community rules as the functional approach with regard to enterprises and economic activity or existing and evolving European statutes for enterprises of different legal status.

SGI contribute to economic, social and territorial cohesion within the Member States and across the European Union. Given their infrastructure character and their often enabling and facilitating role for other economic processes and the labour market, their smooth functioning is expected to also help increase the competitiveness and growth of the economy at both Member State and Community level.

Social services of general interest (SSGI) can be identified as a key element of all European welfare states to realise social, health and employment policy objectives. The European Union' integration has been mainly driven by the step-wise development of the internal market and the Economic and Monetary Union, framed by the regulative concept of an open market economy with free competition. This also involves a tendency to attribute a basic rights character to the fundamental economic freedoms and strongly increases the importance of Community competition law. The current challenge consists in finding an adequate balance between these dynamic processes on the one hand and national concepts, traditions and structures of

[24] Some even contest that such a model exists, given the difficulty of defining the social profile of the European Union and analysing its complex influences on the variety of national social and health systems.

organising, regulating, providing and financing SSGI on the other. This implies a legal and political framework at Community level allowing for their smooth and effective functioning in view of realising their general interest objectives and functions. What this should mean concretely is not least determined by a sector- and even measure-specific understanding and implementation of the solidarity principle which allows for strengthening the role of social law and social, health and employment policy aims and concerns. In this context national governments and public authorities (but also service providers and their national federations) normally argue that Member States not only are best placed, but also claim that they have the competence for defining their missions and principles of organisation, regulation, delivery and financing.

Among the drivers that might underpin a more important European approach in the field of SSGI are increased economic integration and the trends towards cross-border activities of social protection schemes, with exports of benefits and inflow of patients or vice versa in specific national social protection schemes.

After providing an overview on the conceptual framework and important technical terms, this chapter reviews the European discussion on SGI with a specific focus on SHSGI, which considerably accelerated and deepened since 2004, retracing main steps in chronological order. Selected results of an enquiry by the SPC in the second semester of 2004 are recalled to facilitate the link both to the current "reference document", the Communication on SSGI of 26 April 2006 (of which main contents are reproduced), and to ongoing debates in the field of SSGI. Sub-section 5 finally sketches out related topics and processes at Community level and endeavours to highlight some points of contact with SSGI.

2. *Conceptual framework: Services of general interest – services of general economic interest – social (and health) services of general interest*

Services of general interest and services of general economic interest

Services of general interest cover a broad scope of economic and non-economic activities and sectors, ranging from large-scale network industries such as transport, water, gas, electricity, telecommunication, postal services that to a large extent are operating or organised across borders, to small-scale, very often locally or regionally organised personal services particularly in the fields of social welfare, health, culture and sport.

In its Article 86 (2), the European Treaty explicitly refers to services of general economic interest (SGEI)[25]. The jurisprudence and the ruling of the European Court of Justice (ECJ) propose the relevant working definitions in order to determine the respective competence of European authorities on the one hand and Member States and public authorities therein on the other. They also define the relations between public services of general (economic) interest and Community competition law, internal market regulations, public procurement rules and the like. One should take note of the evolving European legal framework that increasingly entails written

[25] The glossary contains further explanations on the terms of main relevance in this regard.

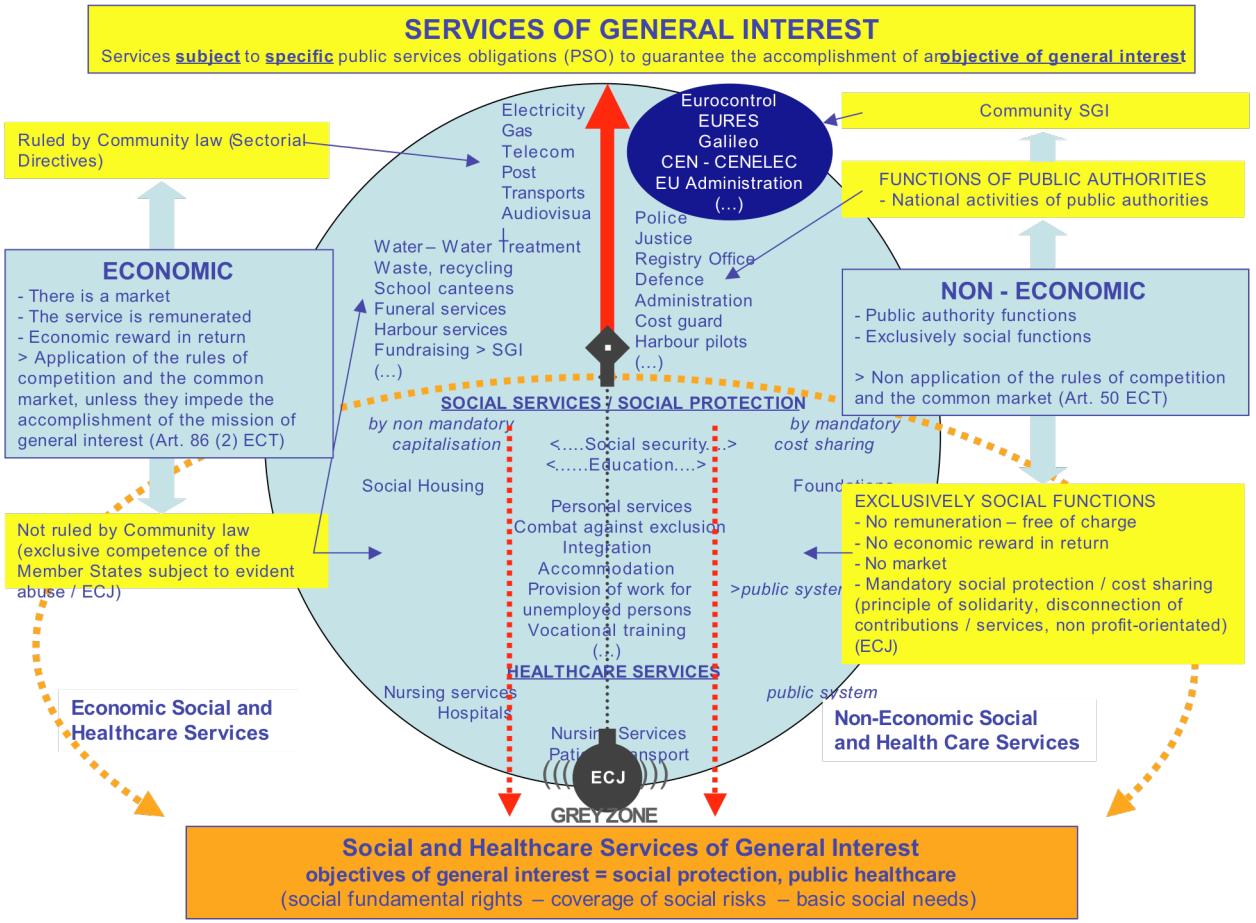
prescription of the missions of general interest (including the public service obligations) and tasks to be performed in the framework of services of general interest, in order to create transparency and non-discrimination vis-à-vis all the possible providers of such services (cf. for details on this see Part IV).

Graphical illustration of the conceptual framework

Figure 3.1 gives an illustration of this diverse and multifaceted landscape. As illustrated in this graph, economic and non-economic services blend into one another, particularly in the field of social and health services of general interest (SHSGI). Grey zones in view of the applicability of Community rules and legal uncertainty within the Member States as a result of this exist for specific issues which change across time (see Part IV for more details on current topics and aspects). They are closely related to prevailing modalities to organise, provide and finance SHSGI within Member States or innovations in this regard.

Non-economic services are mostly those offered on a solidarity basis (and not on a commercial one). Furthermore, they are frequently provided by public authorities or para-state agencies such as compulsory social insurance funds which do not seek profit and – with regard to their legally defined obligatory tasks – do not exert a commercial activity. In most Member States, numerous non-profit organisations and voluntary initiatives at least partly subsidised by public authorities stand in for the latter to complete the offer and provision.

Figure 3.1: Conceptual framework: SGI, SGEI, SSGI, SHSGI



Source: Laurent Ghékière, with minor terminological adaptations by the authors

Social and health services of general interest

Even though there is no shared definition or description[26], there seems to be a broad consensus across Member States as to the sectors which make up for the "core" of SHSGI, namely social insurance schemes, health (care) services, social assistance/welfare schemes, personal social services, and social housing. In other words they comprise the compulsory (basic and complementary) social insurance schemes covering contingencies such as old age, invalidity, work accidents, health and long-term care, maternity, unemployment (and sometimes family allowances/child benefits), often organised on the national level and covering broad categories of the resident population, as well as personal social services.

It is broadly recognised that social and health services of general interest are different from other SGI. They are distinguishable by additional objectives (mainly of social policy) or functions (for societal and labour market integration), particular aspects of governance and elements of service quality, not to forget specific characteristics of their users. Being part of the overall social protection system a common cross-country feature is that they guarantee access to entitlements of (individual) social rights and equal treatment, at least once users/beneficiaries are eligible to a specific social protection scheme. The solidarity dimension with regard to their organisation, regulation and financing is probably the most distinguishing factor from other services.

In this context, vivid discussions and various attempts to define these specific characteristics and to design an appropriate Community framework have been going on for several years. Both are the key components of the current process to further a systematic approach in this field, launched with the White Paper on SGI in 2004 (see below).

Not least the discussions on the (revision of the) Services Directive have highlighted the importance of recognising the specific role of social and health services of general interest especially compared to network-based services of general economic interest. Among these particular characteristics their close link to fundamental social rights and to overarching goals of social cohesion seems to be generally acknowledged. Their organisation and financing usually involves an element of solidarity. SHSGI regularly receive support from the voluntary participation of citizens. Particularly personal social services are being developed and planned as closely as possible to the users, which explains why local authorities play an important role in this regard.

Currently discussed questions relate to the following three topics:

- Specific characteristics of SHSGI: "Which criteria or elements are needed to grasp the specific characteristics of SHSGI?"; "Are additional elements compared to the list established in the Communication on SSGI needed – and if yes, which ones?"; "By which instrument and at which level should the

[26] Most Member States reported that there, however, exist specific definitions explicitly specified for particular sectors or implicitly deduced from a long-standing shared perception of the meaning of the concept "SHSGI" at national level.

specific characteristics of SHSGI be recognised?"; "Who should be responsible for their implementation – public authorities within Member States, Community institutions, both jointly" and "Which (legal and political) consequences and implications would a recognition at Community level entail?"

- Conceptualising general interest: "Is there a Community concept of 'general interest' or 'the common good' to be explicitly formulated for the policy areas of 'social affairs and health'?"; If so "What aspects should be determined at Community level?"; and "Would a definition made at Community level be of a purely 'orienting' (and thus not legally binding) nature? Or would it be of a 'monitoring nature' or unfold other effects?"

- Application of Community rules: "Is there leeway for a certain degree of flexibility of Community law in the areas of health and social services, particularly in order to do justice to the specific characteristics of SSGIs and their users and particularly with regard to state aid rules and public procurement procedures?"

General interest in the framework of social and health policy

There seems to be a shift during the last decade from an institutional view on SGI, SSGI towards a more functional perspective, closely related to the functional approach of Community law with regard to concepts such as "economic activity" and "undertaking" and its neutrality with regard to the legal status and type of the provider of SGI and SSGI. Insofar an explicit definition of what is understood by "general interest" and a transparent documentation of specific general interest missions and related public service obligations making SSGI distinguishable from other services becomes a necessity of prior importance in the context of immediate applicability of Community rules or their indirect impact on the organisation, regulation, provision and financing of social services. In recent times a greater need to rebalance general interest concerns with the dynamics and effects of economic integration is perceived.

Since several years we witness ongoing discussions about the concept of "general interest"[27] also for the field of social services. They concern the meaning of the term and elements of this concept, the decision on the competent authority/institutions to define missions of general interest and the form in which these and public service obligations need to be explicitly and transparently defined ex ante. This is relevant when public authorities decide to deliver (social) services by themselves or when they opt for delegating them to private (not-for profit or commercial) providers.

Defining the "general interest" and specific public service obligations for various tasks or sectors always implies a broad political and thus societal consensus, even though this consensus cannot always be explicit or defined in all its aspects. The issue

[27] In this context, the term "public interest" is also used – by some in an interchangeable way with "general interest" by others with a different connotation. The issue does become less complicated when other languages than English are used. E.g. in German the translation of "general interest" is "Allgemeininteresse" whereas rather often also the term "Gemeinwohl" is used to designate. What exactly is meant with one or the other term often is not made explicit and also is difficult to define in general.

in question mainly depends on the preferences and direct needs of the population or of the "general public", whether in a national, regional or local context, or also of a specific subgroup of the resident population albeit of importance for the whole society and insofar "in the general interest". What is understood by "general interest" in the field of SSGI strongly depends on national traditions, welfare state structures, cultures but is also influenced by divergent terms and notions linked to them in the different languages. The understanding also changes across time.

In his contribution to the 2004 conference "Social Services of General Interest in the European Union – Assessing the Specificities, Potential and Needs", B. Enjolras writes: "There are three definitions of general interest:

- General interest as the sum total or aggregate of individual interests. Apart from the fact that this concept raises methodological problems (how does one create an aggregate of individual interests?), it yields but a minimalist concept of general interest;

- General interest as the common interest: this concept excludes from general interest all areas where interests do not converge;

- General interest as the interests of society or the community: in this case, general interest exceeds and may indeed stand in opposition to the interests of individuals.[28]"

Following the latter concept of general interest – general interest as the interest of society – we can identify four characteristics of services of general interest:

- What is in the general interest is not absolute; it is a social construct, i.e. a common good that is defined in a given society at a given moment. Concepts of general interest therefore vary in time and space.

- For the most part, services of general interest involve the implementation of activities of an economic nature, but the objectives of these activities are not purely economic. In other words, the economic activities of these services generate external effects that serve the whole of society or the community (for instance social cohesion, territorial development, equality of access to services etc.).

- There are several "levels" of general interest depending on the criteria used to define "society". A society can be geographically defined, and general interests can thus be local, regional, national, supranational, etc. A community can also be defined in terms of its "solidarity perimeter", a border within which a particular identity is shared.

- As a result of these characteristics, the market fails to produce general interest, and there is a need for non-market institutional mechanisms."[29]

[28] Enjolras, 2004: 110 in ISS (Ed.) 2004
[29] Enjolras, 2004: 110f in ISS (Ed.) 2004

He then concludes that "social services are services of general interest to the extent that they contribute to the realisation of certain "common values" that characterise European countries:

- They contribute to the maintenance of social cohesion in a society;
- They contribute to the establishment and guarantee of a minimum of security for all members of a society;
- They contribute to the guarantee of human dignity without which the idea of citizenship would be a mere illusion"[30].

The evidence from the stakeholder enquiry under this study has confirmed that it is the integration of a multiplicity of aspects that qualify a social service as a social service of general interest. Respondents underlined that the provision of social services of general interest is in principle as well an economic service, inextricably associated with non-economic dimensions. Finally it was added in several replies that the strong orientation on including social services of general interest into the strategy of developing the single market is not least seen as undermining the development of civic engagement and the voluntary sector as service provider.

The 2004 enquiry of the Social Protection Committee gives evidence of a lack of a cross-sector definition of "general interest" and consequently also for SSGI or SHSGI in legal documents of the Member States. However, a considerable number of Member States mentioned national sector-specific (framework) legislation comprising direct or implicit descriptions of the term "social services". And these regulations also contain references to their respective general interest dimension and the functions they have in order to realise the determined general interest objectives.

According to the country reports of this project, we can identify three "bridges" between the concept of general interest and social services. Referring to how general interest concerns are reflected in national social protection regulations country experts mention three aspects: They are "set equal to" either (i) social policy objectives or (ii) social rights or (iii) an (implicit) assumption is made that certain (sub-)sectors or benefits are a priori of general interest. This, however, only is done if such defined sub-sectors of the social protection system, e.g. "social housing" in France, reflect core modalities of organisation, regulation or financing allowing for such an attribution. This comprises e.g. a solidarity-based financing or regulations to guarantee access and quality of social services for users as well as regulations concerning the delivery of services (e.g. on quasi-markets) and their providers.

[30] Enjolras, 2004: 111 in ISS (Ed.) 2004

3. *The European discussion on services of general interest and the specific focus on social and health services of general interest*

The interest of European institutions in services of general (economic) interest came up since the mid-1990s with two Communications in 1996[31] and 2000[32] of the same name. They described, among others, the interaction between the community rules in fields of competition and free circulation of goods and services on the one hand, and public service missions on the other.

The Green Paper and the White Paper on SGI

In spring 2003, the Green Paper on SGI[33] put a clear emphasis on network-related industries and services (such as transport, water, gas, electricity, telecommunication, postal services). Social and health services are mentioned, but not dealt with separately and/or in detail.

The successive White Paper on SGI[34], published roughly one year later, again mainly focused on network-based industries and services and on Community principles, regulation and framework conditions for their functioning. A core Community notion developed in this regard is the universal service concept which can be understood as a set of general quality guidelines for SG(E)I, such as universality, accessibility, affordability, continuity, security, transparency, user and consumer protection.

In this document, the European Commission, however, devoted a specific chapter to the social and health sector and introduced the concept of social and health services of general interest (SHSGI). It also announced a Communication on SHSGI to describe the way in which they are organised and financed and to further systematise approaches on Community rules and the contribution of these rules to the modernisation process of social and health services and to improve knowledge of the actors in this field on their organisation, regulation, delivery and financing.

Linked to the two documents mentioned above, the European Commission launched a broad debate on the future of SG(E)I in Europe, contributing to a comprehensive review of its policies in this field. The stakeholders at European and national level were and are being involved in the reflections. The Green Paper on SGI was followed in 2003 by a questionnaire-based consultation process, resulting in a large number and range of replies, statements and opinions elaborated by stakeholders at EU and national level[35]. The White Paper did not lead to a second comparable broad consultation process.

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[31] Commission of the European Communities, 1996
[32] Commission of the European Communities, 2000
33 Commission of the European Communities, 2003
[34] Commission of the European Communities, 2004c
[35] For results see the report on the public consultation, Commission of the European Communities, 2004d, with section 4.4.3, "An interest in the clarification of the situation of organisations providing social services", p. 15, being devoted to the field of interest of this study.

For the field of social and health services, the Commission, in 2004 and 2005, used a different double-track strategy to prepare the communication on SHSGI announced in the White Paper on SGI. On the one hand it co-organised a conference which provided a forum for national and European stakeholders, especially governments and non-governmental organisations from the social and health policy areas, to voice their positions, fears and expectations related to the communication itself, but also to various questions concerning the legal and political framework for services of general economic interest and services of general interest at EU level. On the other, in order to gain additional information concerning policies and approaches, a questionnaire was distributed by the Social Protection Committee (SPC) to the Member States, to be answered by December 2004.

The 2004 SPC questionnaire on SHSGI

The SPC questionnaire proposes a rather broad concept of "social services" which is not confined to any of the terms "social protection", "social security" or "personal social services" or to other common concepts as used in the Member States. SPC and DG Employment and Social Affairs had proposed to delimit the scope of the 2004 SPC enquiry on social and health services of general interest to the following fields and systems: statutory social protection schemes, supplementary social protection schemes, health and social care services, support for families (e.g. childcare facilities or services), services to promote social integration and to provide personal support (e.g. in cases of homelessness, drug dependence, disability, mental or physical illness), social housing and other services with similarities to social and health services or active labour market measures (e.g. access to placement services or education and training).

The insight gained from the analysis of the replies to the questionnaire by all 25 Member State governments and of a series of European-level and national stakeholders as well as first conclusions were summarised in the feedback document "Social services of general interest and health and long-term care services within the European Union"[36] (18 March 2005). This paper served as a background document for a seminar (1 April 2005) to discuss the issues with all Member States' governments and selected European umbrella organisations representing the social partners, the social economy and the civil society (NGOs in the social and health policy field), in order to "conclude" the consultation process launched by the White Paper on SGI.

Selected central insights from an analysis of the 2004 SPC enquiry on SHSGI

The enquiry gives evidence[37] of commonalities shared by basically all Member States:

- There seems to be a broad consensus as to the sectors which make up for the "core" of SHSGI, namely social insurance schemes, health (care) services, social welfare institutions and services, and social housing.

[36] Cf. http://www.europa.eu.int/comm/employment_social/social_protection/docs/background_en.pdf
[37] The following strongly builds on or is copied from Maucher, 2005. This study can also be consulted for more details with regard to facts, opinions and assessments (i.e. on possible future steps to be taken at Community level) provided by the 25 Member States' governments.

- The entitlement to (individual) social rights is considered to constitute one basis of many SHSGI by the big majority of Member States.

- All Member States apply legally fixed quality standards for (the vast majority of the) SHSGI – or are in the process of implementing them. As a rule the quality standards are defined on a sector-specific basis covering aspects such as qualification of personnel, infrastructure of premises, security norms, effectuation of tasks and carer-user-ratios, which are monitored by public authorities.

- A number of Member States highlight that service quality is understood in a broad sense – covering aspects such as access to SHSGI and SHSGI as instruments to realise human dignity and social justice – as one major point of reference for the design of SHSGI at national level.

- The need to clearly define the public interest dimension of SHSGI and to ensure – by public authorities – that public policy objectives are upheld is generally acknowledged.

Almost all Member States support the argument, that SHSGI are different from other SGI, that they have a particular character in several ways. According to replies given by the national governments, SHSGI

- Are a part of the social protection system;

- Guarantee access to entitlements and equal treatment, with the solidarity dimension as the probably most distinguishing factor, not only shaping the benefits, but also the management of social SGI (generally not-profit-making), regardless of their public or private provision;

- Support the realisation of the general quality guidelines of SGI – such as universality, equal accessibility for all, affordability – and other fundamental principles – such as solidarity, equity, human dignity, human rights, children' rights;

- Promote social cohesion, social justice, solidarity and fundamental human rights such as human dignity, equal opportunities, etc., as mentioned by some Member States especially with regard to low-qualified persons and the underprivileged;

- Are often intimate by nature, provided in a close personal contact. SHSGI have additional special connotations directly related to their characteristics, as in the case of health care e.g. the relationship doctor-patient, the principle of autonomy, the confidential character, the professional ethics. Socio-medical services are also to a large part negotiated with and co-produced by the beneficiary. In the delivery of social and health services, personal interaction, respect for human values and valuations as well as an ethical dimension are highlighted. SHSGI focus on the individual case without disregarding the public interest.

- Protect persons and groups needing assistance and respond to social needs which may not be addressed by the market in an efficient and satisfactory manner. As a consequence, other rules than market/competition rules have to be applied as well. Otherwise this would entail a real risk of undermining the fundamental rights of all citizens with regard to equal access to basic services. Also, the SHSGI must be capable of responding continuously and very sensitively to the individual and changing needs of each user by adapting to her/his current conditions.

- Personal social services are often intertwined with both formal and informal networks existent within the respective local community, while an important role in their provision is played by families, friends, neighbours and other communities. The proximity/accessibility of the services vis-à-vis the users – an aspect closely linked to territorial planning for social and socio-medical institutions and services – also constitutes a characteristic trait.

The elements mentioned for a description of the cross-country specificities of SHSGI at the European level refer to principles underlying SHSGI, their objectives, the aspect of their governance, and specific characteristics of their users. In detail, Member States named

- The objectives of SHSGI which aim at the realisation of human dignity, solidarity, social rights, social cohesion and welfare, social capital, enforcement, consumer's participation, consumer protection

- The principle of (comprehensive) solidarity, based on enforceable individual rights and in line with the objectives of social cohesion

- The principles of quality of social services, user participation, equal access for providers (including non-governmental not-for-profit organisations)

- The link between vulnerability, service need and inability to (as a rule fully) pay for the service consumed

- The principle of non-discrimination and equal opportunities

- The predisposition to market failures, requiring that state agencies intervene

- The specific relationship between service provider and beneficiary, which is not comparable to the relationship between the provider and consumer in a market

- The specific character of the users/patients of SHSGI: an emphasis has to be placed on high quality, accessibility in terms of geography and price as well as on adjustment to local public policy. Service beneficiaries consequently cannot be defined simply as customers, clients or consumers. They must be perceived and addressed as the public consisting of citizens with specific social rights and needs

According to the replies from national governments, grey zones with regard to the applicability of EU competition, state aid and internal market regulations (back in 2004) existed with regard to the following aspects: the distinction between SGI and

SHSGI (related to the principle of neutrality towards the nature of the provider/undertaking); Member States' competence to define public interest missions/tasks and their form of execution; their competence to define preferential treatment for each type of provider; and "in-house provision". They have also been most often located in the following sectors: health insurance and health services, long-term care; youth welfare services and childcare services (with regard to state aid); ambulant services; social housing and services of re-integration/reinsertion into the labour market. The identification of these fields of SHSGI also co-determined the selection of sectors to be studied in-depth in the framework of this study.

Member States also informed about issues or fields they considered problematic or challenging with regard to Community internal market and competition (including state aid) rules. Actual or potential difficulties perceived here related to (i) territorial planning and quality assurance, (ii) public procurement procedures, particularly the a priori clear and comprehensive definition of all conditions for call for tenders and (iii) the need to separate services provided by NGOs into "non-business" and "business" activities. Another issue identified was (iv) state guarantees for institutions in the field of social housing entrusted with a public interest mission. Governments also mentioned (v) the impact of Community rules on the intended balance between competition and solidarity (according to national and regional legislation) designed in view of a specific relationship between public/state agencies and NGOs and (vi) implications for integrated social service systems/networks, based on public-private co-operation in the fields of planning and provision and the principle of horizontal subsidiarity.

4. The Communication on social services of general interest

On 26 April 2006, a Communication on social services of general interest (SSGI) was adopted. It further addresses the mutually linked issues of how European law affects general and sector-specific modernisation trends and the rapid changes in "social services of general interest", in order to further systematise approaches in this field and to improve knowledge of the Commission and of the actors in the field.

Definition of scope

According to the Communication on SSGI, in addition to health services, which are not covered by this communication, two main categories of social services are distinguished (cf. p. 4):

- Statutory and complementary social security schemes, organised in various ways (mutual or occupational organisations), covering the main risks of life, such as those linked to health, ageing, occupational accidents, unemployment, retirement and disability;

- Other essential services provided directly to the person. These services that play a preventive and social cohesion role consist of customised assistance to facilitate social inclusion and safeguard fundamental rights. They comprise, first of all, assistance for persons faced by personal challenges or crises (such as debt, unemployment, drug addiction or family breakdown). Secondly, they

include activities to ensure that the persons concerned are able to completely reintegrate into society (rehabilitation, language training for immigrants) and, in particular, the labour market (occupational training and reintegration). These services complement and support the role of families in caring for the youngest and oldest members of society in particular. Thirdly, these services include activities to integrate persons with long-term health or disability problems. Fourthly, they also include social housing, providing housing for disadvantaged citizens or socially less advantaged groups. Certain services can obviously include all of these four dimensions[38].

Specific characteristics of SSGI

The Communication on SSGI enumerates the following six organisational features SSGI present in the performance of their general interest functions (one or more of them). The list (cf. pp. 4-5) is largely based on the results of consultations with Member States' governments as well as with national and European-level organisations of civil society and social partners:

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

Planned monitoring and dialogue tool

In section 3.2 the Communication on SSGI announces a biennial monitoring and dialogue tool, to be set up before the end of 2007. Building on the consultation processes launched since 2004, it should serve to further a systematic approach for social services, "improve the reciprocal knowledge of operators and the European Commission of questions concerning the application of the Community rules to the

[38] Education and training, although they are services of general interest with a clear social function, are not covered by this Communication

development of social services and (...) deepen the exchange of information between operators and the European institutions" (p. 10). It will bring the results of the current study and the synthesis from a parallel SPC enquiry[39] together and take on board conclusions and recommendations from both "inputs". It will serve to re-examine the situation of SSGI or certain sectors among them in the light of Community law being applied.

The consultation processes on SHSGI 2004 and SSGI 2006 at Member State level

Two examples from Germany and France illustrate how the consultation processes related to SHSGI (in 2004) and SSGI (in 2006) are taken up and accompanied at different levels and by different actors.

Box 3.1: Organisation of the consultation processes to support the drafting of the German Federal Government's reply related to the SPC inquiries on SSGI

The SPC launched two questionnaire-based inquiries with Member State governments on S(H)SGI, the first in 2004, the second in 2006. In both cases, the elaboration of the Federal Government's reply to the SPC was accompanied by a broad consultation process involving all relevant actors concerned. Instruments used in this regard were the involvement of permanent committees, the organisation of forums for exchange (seminars, conferences), requests for written contributions (elements to be taken into account when drafting the replies, opinions and statements) and the possibility to comment on (parts of) draft replies. This process mainly concerned the central organisations of district and municipal authorities, social partners and the (organised) civil society, here mainly the national federations of the not-for profit providers of social services.

In addition, Germany – as a federal state – is characterised by a constitutionally defined obligation for consultation and co-operation between the Federal Government (*Bundesregierung*) and the 16 State governments (*Landesregierungen*) on issues of shared competence – social services principally fall under this category. Procedures to co-ordinate positions and to elaborate joint replies have been established, not least by involving permanent committees, e.g. an extended and regular working party of the Ministries of labour, social affairs, health and family affairs of the 16 State governments to deal with European social, employment, health and family policy (*Große und Kleine Länderarbeitsgruppe Europäische Arbeits- und Sozialpolitik*).

For the field of (personal) social services, this reflects the endeavour to implement a core principle of good governance, namely the involvement of all parties concerned. Based on a political will to broadly consult, this is facilitated by existing structures of national federations or umbrella organisations for all relevant (groupings of) organisations. These also can build on permanent working parties or expert committees for European social policy and law or as a rule are able to mobilise

[39] Parallel to this study, the SPC had launched a consultation with EU Member State governments on a number of questions on the current national understanding, concepts and characteristics of social services of general interest and on possible further steps regarding them at Community level. [add web address]

resources to set up ad-hoc working groups to deal with specific topics and questions and to prepare written contributions to government replies, be this in their own capacity or by joining forces with other federations of organisations.

Box 3.2: Collectif ssig-fr – building a dialogue tool on SSGI at national level in France

From 2005 on, several French national associations of social and health services of general interest (SSGI), service providers and beneficiaries have decided to act together at various levels to launch initiatives in favour of social and health services of general interest. The setting up of the "collectif ssig-fr" resulted from the awareness of French actors that neither the principle of subsidiarity as such nor the possibility for social and health services to be recognised as non economic would keep such services out of the sphere of EU legislation.

In view of the vote in first lecture of the "services directive" by the European Parliament (Strasbourg, February 16th, 2006), the "collectif ssig-fr" launched an appeal in favour of the exclusion of the SSGI from the scope of application of the Services Directive with other co-signatories. The co-signatories reminded that the legislative framework of these social and health services is based on the objectives of general interest clearly defined by the Member States and acknowledged by the Court of Justice of the European Communities in terms of social protection, satisfaction of fundamental social needs and public health. In addition, this legal framework is based on the efficient implementation of the fundamental social rights acknowledged by the Constitutions of the Member States, the European Charter of Fundamental Rights, the Social Charter as revised by the Council of Europe and the Universal Declaration of Human Rights.

The "collectif ssig-fr" organised various colloquiums (notably in Paris on May 30, 2006), built an Internet platform (in French: wwww.ssig-fr.org) to exchange news and information (mainly from European sources, but also at GATS and WTO levels). They also provide tools and clues for the understanding of the complex issues at stake, by explaining the legislative process (with all the committee work throughout the various institutions of the European Union and the succession of amendments) under way at the multiple levels. Through those tools, the "collectif ssig-fr" succeeded in explaining to the French European citizen how the legislative process functions, how definitions and concepts are being built and appear. By doing so, they are raising the societal awareness of this topic at French and European level, but also allowing the citizen to take part in the debate. Moreover, the discussion among actors thus found a place for expression.[40]

[40] Recently a publication has documented these discussions: Les *Services Sociaux et de Santé d'Intérêt Général - Droits fondamentaux versus marché intérieur?* (Ed. Bruylant, November 2006).

5. *Related topics and processes*

Consultation process on health services

Most closely and directly related and of mutual influence, not least as a consequence of the scope of SSGI as defined in the Communication on SSGI of 26 April 2006 (see above), are distinct initiatives on health care services under the auspices of DG Health and Consumer Protection. For health care services, the Commission has separately launched on 26 September 2006 a public consultation (with the closing date 31 January 2007) on how to ensure legal certainty regarding cross-border healthcare under Community law, and to support co-operation between the health systems of the Member States.[41]

This initiative also builds on results and recommendations of the so-called high-level processes on patient mobility and health care developments. In response to the first high-level reflection process terminated with a report in December 2003, the Commission adopted a Communication[42] and established a second high-level group on health services and medical care to work on practical aspects of collaboration between national health systems in the EU (started in July 2004). Both reflection processes dealt with a range of specific topics in view of their trans-border dimensions, particularly related to quality and access in cross-border care, to safety and efficiency issues and to information requirements for patients and health professionals. They insofar concerned patient mobility and the freedom to receive and provide services in the internal market or with regard to better policy co-ordination and the usage of sophisticated health care infrastructure. Having also shed light on the more general and highly political question of how to reconcile national policies and structures with European obligations in general, the two high-level processes also served to prepare and define contents of the OMC in the field of health care and long-term care.

In its 2007 Annual Policy Strategy the Commission developed a Community framework for safe, high quality and efficient health services by also referring to the issues of a reinforced co-operation between Member States and more legal certainty as to the application of Community law to health services and healthcare.

The new streamlined Open Method of Co-ordination

Assuming a broader perspective the legal analysis should also take into account the Open Method of Co-ordination (OMC). It is an independent political mechanism that supplements other Community instruments such as law-making, financial instruments like the structural funds, the various EU programmes, co-operation between Member States at government level, etc. As a political strategy it forms an alternative to European law making in these areas. The OMC aims at strengthening co-operation between Member States through an exchange of experience on "best" or "good practices" and persuading the Member States to agree voluntarily on joint

[41] See Commission of the European Communities, 2006b
[42] Commission of the European Communities, 2004b

objectives and guidelines. The European Commission has defined the OMC as follows (see Box 3.3):

Box 3.3: The Open Method of Coordination (OMC)

"The open method of coordination means that all countries fix common objectives in a given policy area, prepare national action plans, examine each other's performance with Commission guidance, and learn from their successes and failures. It is a new way of working together in the EU – no longer only through legislation, but through a flexible yet structured cooperation among Member States. It is now being applied to social protection."

Source: European Commission/Employment and Social Affairs, Social Agenda, April 2002, p. 7.

Since 2001, the OMC was implemented as a political strategy for three main areas of social protection, namely "social inclusion", "pensions/social security in old-age" and "health and long-term care", in the latter field taking up impulses from two high-level processes on patient mobility and health care (see above). The OMC has been introduced based on various legal provisions in social policies such as the modernisation of social protection systems (Article 137 k EC), the Social Protection Committee (SPC) (Article 144 EC) and provisions with regard to specific policy sectors, i.e. the integration of persons excluded from the labour market (Article 137 h EC). Accessibility, quality and financial sustainability are common objectives in the OMC processes concerning fields of social protection. The OMC is a process of policy-making that does not lead to legally binding legislative measures nor requires Member States to change their law.

The OMC aims to spread information on national policy objectives and the way they are implemented (also involving detailed descriptions of selected measures), statistical data and indicators as well as examples of good practices. One aim is to achieve greater convergence of national policies and monitoring strategies and instruments towards the main EU goals. This might – in a middle- and long-term perspective – also favour a convergence of social protection schemes and of modalities how cash benefits, benefits in kind and personal social services are organised, provided and financed. The OMC demands co-ordinated and joined action by the Member States, based on jointly decided policy objectives and a process of exchange of information and experiences. It is being based on country reports by Member States – as a result of a participatory process within each Member State – and joint reports, elaborated by Community services. The OMC insofar reflects an increased political integration within the EU in central policy fields of SSGI.

The Commission adopted in May 2003 a communication entitled "Strengthening the social dimension of the Lisbon strategy: Streamlining open co-ordination in the field of social protection". The document proposed a re-organisation of the policy co-operation in the different fields of social protection (social inclusion, pensions, health care and making work pay), with a twofold aim: Streamlining of processes should help enhancing the visibility of social protection within the Lisbon Strategy by creating better links with other co-ordinating processes such as the Broad Economic Policy Guidelines and the European Employment Strategy; and it should facilitate

more synergies between the monitoring and reporting processes for the single fields of social protection. Based on a Joint Opinion of the Social Protection Committee and the Economic Policy Committee, the European Council in March 2006 adopted the new framework of a "streamlined" OMC for social protection and social inclusion. It entails a new set of overarching objectives as well as in addition more specific common aims for the formerly separately covered policy fields[43]. The streamlined OMC for social protection and social inclusion has already been implemented. In March 2006 a second Joint Report on Social Protection and Social Inclusion[44] was issued drawing on the National Strategy Plans or National Action Plans and policy statements produced by the Member States during 2005.

The streamlined OMC concerns core fields of social protection and insofar a broad range of systems, policies and single measures covered by the definition of SSGI as e.g. proposed in the questionnaire of the 2004 SPC enquiry or the Communication on SSGI of 26 April 2006 (see Section 3 of this chapter). Not only did the two SPC inquiries of 2004 and 2006 related to S(H)SGI contain questions[45] to learn more about the opinions of Member States governments and European level stakeholders in view of the role of the OMC or similar processes in the field of S(H)SGI. Due to its function as a tool to encourage participatory processes of policy design and evaluation within Member States and to promote Community-wide objective- and indicator-based policy monitoring and assessment, it can be expected that insights and results from the streamlined OMC in the field of social protection and social inclusion will also influence conceptual and methodological aspects of the monitoring and dialogue tool to be implemented in the field of SSGI.

The revised Lisbon Strategy and the Social Policy Agenda

Both the initially implemented (2000) and the revised (2005) Lisbon Strategy endorsed at the Spring Summit 2005 based on a mid-term review, summarised in a report of November 2004, the ambitious reform agenda for the decade 2000-2010 for economic, social and environmental changes constitute a broader framework also for the Community development on SGI. The central goal of creating growth and jobs is linked with and has to be aligned to economic, social and environmental goals. The Lisbon strategy also defines general employment and social policy goals, also expressed in the European Employment Strategy: full employment, better job quality and labour productivity, and strengthening of social cohesion.

In order to strengthen social cohesion the following goals were also defined: (i) Reduction of the proportion of early school leavers to 10 percent, (ii) Endeavouring a reduction of the number of persons at risk of experiencing poverty; (iii) Strengthening equal opportunities for persons with disabilities; (iv) Promotion of gender equality; (v) Promotion of corporate social responsibility; (vi) Adaptation of social security systems such as care of the elderly and healthcare.

The second, third and last element can be identified as the ones most closely related to SSGI and their objectives and functions.

[43] See Commission of the European Communities, 2006c, p. 3-9 and p. 10-14
[44] Commission of the European Communities, 2006c
[45] These questions asked for both the application of the OMC in the social protection fields already covered and a possible extension to additional sectors of social and health services.

Even though network-based SGEI in the fields of transport, water, gas, electricity, telecommunication, and postal services as well as their regulators and providers are more directly and more comprehensively concerned, the strengthened focus on economic growth and adaptable and inclusive labour markets in the revised Lisbon Strategy also entails repercussions on Community action related to S(H)SGI. This is made explicit not least by the Communication on SSGI itself, with its title reading in the first place "Implementing the Community Lisbon programme". The work on a Community legal and political framework for SSGI consequently has to be seen on the one hand as an important element and major step to help implement the revised Lisbon Strategy and insofar (to be) embedded into the broad strategic objectives and policy guidelines. On the other this link underlines an increased interest in and importance of SSGI to realise the Lisbon goals.

The economic, social and political dimensions of European integration become more and more intertwined. As a general rule, the economic integration supersedes via the internal market construction. Effects here are both more dynamic and far-reaching and considerably delimit the space and margin of manoeuvre for political integration.

For the period between 2005 and 2010, the revised Social Policy Agenda – as the central strategy paper and programme in the fields of social and employment policies for 2006–2010 – has established "combating poverty" and "creating equal opportunities" as priorities on an equal footing with "employment". These priorities also include the objective of supporting Member States in their efforts to reform their pension and health systems, particularly in the framework of the OMC. The priorities should be implemented based on legislative acts, Community Action Programmes, the social (and civil) dialogue and the OMC. The Social Policy Agenda underscores the importance of non-profit services in the health and social sector for the achievement of objectives in this area.

Services directive

For observers of the legislative process for the Directive on Services in the internal market since 2004, particularly during 2005 and 2006, it became evident that concepts, definitions, distinctions of relevance for (social and health) services of general interest also are of crucial importance in designing an appropriate regulatory framework for services in the internal market. This in particular holds for the distinction between economic and non-economic services and the delimitation of the scope of "social and health services" (or to be more exact of "social services" and of "health services") – determining the applicability or non-applicability of principles and specific regulations of Community law – as well as for regulations directly or indirectly impacting on the service quality.

Referring to a political agreement from end of May 2006, adopted by the Council in a common position on the services directive on 24 July almost unanimously – only Belgium and Lithuania abstained –, the following services are among others excluded from the scope of the directive: non-economic services of general interest; healthcare services whether or not they are provided via healthcare facilities, and regardless of the ways in which they are organised and financed at national level or whether they are public or private; social services relating to social housing, childcare and support

of families and persons permanently or temporarily in need which are provided by the State, by providers mandated by the State or by charities recognised as such by the State. The adoption by the Parliament took place on 15 November 2006, approving the Council common position with minor changes, followed by the adoption by the Council. The Services Directive (as of 12 December 2006) has been published in the Official Journal L376/36 of 27 December 2006 and will enter into force three years after its publication, i.e. on 28 December 2009.

Other fields of policy

In the framework of the stakeholder enquiry it had been frequently mentioned that a positive influence comes from European policies – equal opportunities, anti-discrimination policies and the like were mentioned. In other words, general normative frameworks and strong political messages are regarded as influential. An interesting question arising from here is that such influence – and its positive recognition – had been mentioned both by organisations that are in favour of European interventions in the service sector (e.g. in the form of European quality standards) and by organisations that are more hesitant as far as such interventions are concerned.

Part II: Five sectors of social services in focus

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Overview

This part analyses the situation of social services for five sectors in detail. These chapters mainly draw on in-depth country studies from eight European Member States. This is complemented by other comparative data and information, as far as these are currently available, and by references to the European policy background on social policies linked to these services.

It was initially suggested that each country study should cover four of the five sectors with one sector (social housing) being covered in a separate cross-country analysis. Ideally, each sector would then have been covered by six countries. Available expertise in the contracted teams, however, was distributed unevenly for the sectors in the study so that only five country teams were able to cover labour market integration for disadvantaged people, and only four could covered social integration services that proved to be especially challenging, due to the great heterogeneity of this sector which would for more in-depth analysis require a more specialised research group.

Moreover, no all countries were able to provide sufficient material for all case-vignette, in particular for integration services, which explains why some countries are missing from the analysis of some case vignettes at some instances in Part II of the report, although they are listed in the following Table 4.1 that shows the mapping of sectors to countries that resulted from the available expertise and expressed preferences of country expert teams. As a compensation, all teams covered long-term care, for which therefore a very rich cross-section of national reports is available that covers a broad spectrum of national and European policy issues in this field.

Sectors of social services covered in national reports

	Long-term care	Child care	Labour market intergration	Social Integration
Czech Republic	▨	▨	▨	
France	▨	▨		▨
Germany	▨	▨	▨	
Italy	▨	▨		▨
Netherlands	▨	▨		▨
Poland	▨	▨	▨	
Sweden	▨		▨	▨
U.K.	▨		▨	

All sector studies in this part were confronted with the fact that the comparative study of social services is still in its infancy and there are notably important gaps in data on European level and in comparative information more generally. In order to meet these challenges, the sector studies in this part to a large extent build on case vignettes that describe typical “cases”, or situations in which people need these social services. This has helped greatly to understand the wide variations in service organisation, supply and the different experiences of their users, that often substantially differ not only between countries but also across regions and cities, because social services are often organised on the regional level and it is at that level, that access to services is frequently defined, depending on local budgets.

For specific services, general information on beneficiaries, scope of services, trends in employment, staffing and salaries, cost-sharing, and the basic links to informal provision and the role of families will be sketched, based on country studies and available recent European research or emerging information systems. When statements are made in Part II that refer to the situation in one of the eight countries studied in detail but without quoting a reference or source, this generally means that the corresponding country report is the source of information.

This part starts with Chapter 4 on long-term care for older persons. Chapter 5 provides insight for two types of social integration services that are currently under-researched in international comparisons: services for migrants (including asylum seekers) and for users of psychoactive substances, with a focus on illegal drugs. Chapter 6 reviews social services that are tailored to support the integration of persons with severe disadvantages, such as disabled people n the labour market. Among childcare services, services for children aged 3 to 6 are the most common services in all countries, but there are big differences and frequent shortcomings when it comes to services for children below the age of three, and for after-school services for school-aged children. These are analysed in Chapter 7. Social housing policies and services in Europe are finally described in Chapter 8.

Chapter 4 Long-term care

1 Introduction

The emerging long-term care (LTC) systems in European countries that operate at the boundaries between health and social care have undergone major changes during the past decade in terms of financing, planning, provision and quality developments. New schemes such as the LTC insurance in Germany or personal budgets in the Netherlands were introduced and there is growing awareness in Member States that LTC will be a major challenge during the next two decades, notably in view of the ageing of the population, the shortage of professionals, and the need to improve quality of care, infrastructure and working conditions.

Social policy in Member States is for these reasons confronted with a number of challenges. How will additional investments and further improvements - that are certainly necessary in this sector - be financed and distributed to guarantee equal access and sustainability? How should the mix of available long-term care services evolve and which roles will the users of these services and their families play?

The findings from eight in-depth country studies confirm that Member States differ widely in their response to these challenges. This is the case for all the core aspects of long-term care: access to services and their financing, the role of families and of informal care, as well as the quality of care. Better integration of or cooperation between health and social services remains an important challenge in most countries.

The role of long-term care services in an ageing Europe

Member States are currently at different stages of developing coherent and more comprehensive policies and care provisions for persons in need of long-term care. As with childcare, this sector of social services very much relies on the participation of private households that still provide the largest share of care hours in all countries. In many cases these households have also to shoulder a large burden of financing in case formal services are needed.

Demand and expenditure for long-term care services is expected to grow substantially in the future when the number of very old persons will grow rapidly, staff shortages will become even more acute, and the dissatisfaction of citizens with the number and quality of available public services will keep growing. Demand for long-term care on average increases exponentially in the highest age groups that are currently the fastest growing segments of the population (OECD, 2005, Long-term care for older people).

According to the latest Eurostat demographic projections, the number of very old people (80 years of age or older) will increase over the next two decades by over 50% in most EU countries and will have more than doubled in all of the EU-25 countries, the only exception being Sweden which already has the highest share of older people in the world. By the year 2050, the number of very old people will have almost tripled or grown even more in 12 EU countries. In Italy, the share of persons aged 65 and over

was 16% of the total population in 1995 and it grew to 19% in 2005, compared to EU-15 and EU-25 averages of 15% and 17%, respectively. Italy, together with Germany (19%) and Greece (18%), is the Member State with the highest proportions in 2005, while those with the lowest were Ireland (11%), Cyprus and Slovakia (both 12%). According to Eurostat projections for 2050, the share of persons aged 65 and over should rise to 30% both in EU-15 and EU-25 and to 35% in Italy (Eurostat 2006a).

At the same time, age-dependency ratios will have increased steeply, posing limits on the growth of public budgets that depend on contributions of the working-age population. In Sweden, for example, the years between 2020 and 2030 are estimated to be especially tough when the large generation born in the 1940s gets older while the working-population is decreasing. The share of the population aged 85+ is forecasted to reach 2.2 million by 2026.

Older people are, however, not only living longer lives, there is also evidence for at least some countries that people stay healthy longer, and that the onset of severe disability is more and more delayed. This means that people can live independently longer, which would mitigate the demographic effect of higher absolute and relative numbers of very old persons in the population. But the evidence on this trend is currently mixed (Box 4.1). As a recent OECD study puts it "it would not seem to be prudent for policy-makers to count on any further reduction in the prevalence of disability among older people to offset the rising demand for long-term care that will result from population ageing" (Gaétan et al., 2007). There is, however, some evidence that there is much room for improving prevention strategies that could help postpone or mitigate health and disability problems among the elderly. These uncertainties together with the well-documented risks of future life-expectancy estimations, make the business of projecting future long-term care a difficult task (see the section below on expenditure projections).

Box 4.1: What do we know about disability trends among older people?

There is still much uncertainty about disability trends among elderly people, as a new study by the OECD has recently revealed (OECD, 2007, forthcoming). These findings have partially cast doubt upon earlier, more optimistic, findings (e.g. Jacobzone et al., 1999). Of the sub-sample of eight European countries studied in this new report, there was evidence of a reduction in severe disability among people aged 65 and older for only about half of these countries (Denmark, Finland, Italy and the Netherlands). Disability rates have been stable in France over the past ten years, and been reported to be rising for Belgium and Sweden. The picture for the UK is currently inconclusive, with contradicting results from two different surveys, which illustrate the severe data problems in this field of analysis. It is important that countries step up investment in surveys that allow for valid comparisons over time in order to better monitor disability trends in the population, in particular for older people.

Source: Gaétan (2007) Disability trends among elderly people: re-assessing the evidence in 12 countries, Paris.

The reported life-time risk for receiving nursing home care depends not only on the age-structure of the population but to a larger degree on the design of national care systems (such as available supply and the division of labour with informal family care). In Germany for example, this lifetime risk is about 35%. However, the age of entry has

increased over time, while the average length of staying in a nursing home has decreased. Of the age group 70 to 74 years, only 5% need help, while in the age group above 90 years, dependency on help reaches 57%. Similar trends have been observed in other countries, however, not uniformly.

In addition, there is no uniform trend across EU countries illustrating the share of persons cared for at home versus those cared for in nursing homes, despite the growing number of countries with active policies to enable frail older persons with disabilities to stay at home as long as possible. In some cases, there has even been a recent tendency observed towards more care in nursing homes (e.g. in Germany). Studying the factors underlying these trends (health trends, demography, availability of informal care) is currently hampered by the lack of adequate data, such as for age-standardised numbers of care recipients under public programmes, and for person-centred records that would allow to monitor the trends in family care and for tracing "patient careers" of persons with long-term care needs.

The findings from the eight countries studied in depth under this project confirm that concerns about the impact of demographic trends, financial constraints, and quality of services. Moreover, the need for better adapting them to users' needs is at the top of social policy agendas for long-term care services (Figure 4.1). These come in addition to other frequently mentioned concerns, namely staff shortages and improving staff qualification, although this seems to be more an issue for countries where public supply of services and their public funding is further developed (Germany, the Netherlands, Sweden and the UK).

A recurrent theme from the country studies under this project is a concern about current staff shortages that are likely to become even more acute in the mid- to long-term (5 to 20 years). This is not only driven by new demand, but also due to concerns about low pay, high staff turnover and difficult working conditions. Moreover, the work force is aging as well, so that a large number of persons will retire in the coming years (e.g. in France). In general, there is growing competition from the health care sector, where staff shortages (in the nursing professions) are a growing concern as well (OECD, 2005).

There is some awareness about potential frictions with EU-law and the implementation and/or repercussion from ECJ jurisprudence in Germany, France and Sweden, and to some extent in the Netherlands, but overall, these concerns currently rank much lower compared to other trends in long-term care (Figure 4.1, and further evidence from country studies).

Figure 4.1: Main issues at stake for long-term care services

Main issues at stake	Country						
	CZ	DE	FR	IT	NL	SE	UK
Demographic trends and other (macro) socio-economic developments	1	1	1	1	1	1	2
Financial constraints on budgets of public territorial authorities (on national, regional, local level)	1	1	2	1	3	3	1
Availability of a sufficient quantity of good quality services	1	3	2	1	1	2	2
Need to adapt to the evolution of users' needs or to better tailor the supply of services	2	1	1	4	2	2	1
Structural reforms in view of organisation, regulation, financing	2	2	1	4	1	2	2
Problems with low-quality services	3	2	3	3	1	1	2
Availability and qualification of personnel	4	2	3	4	1	1	1
Co-existence of different types and status of providers	1	1	3	2	2	3	5
Concerns about financial sustainability of service provision	1	3	5	4	1	2	1
Affordability of services for private households (e.g. avoiding high cost-sharing requirements)	2	2	3	1	3	3	3
Introduction or extension of new regulatory or administrative measures	4	2	1	4	2	2	3
Implications of introduction of (quasi-) market or of competition from private for-profit providers	3	2	2	4	2	3	3
Cost cutting and/or effects of measures to increase efficiency	3	2	4	4	3	4	1
Potential frictions with EU-law and the implementation and/or repercussion from ECJ jurisprudence	5	3	3	5	4	3	5

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5

Source: Questionnaire for in-depth country studies

In response to these challenges, most Member States have initiated reforms of long-term care systems or are in a process of further developing the range and mix of services available, often with a special focus on quality assurance and improvement initiatives (Figure 4.2). In some cases this went hand in hand with expanding the scope of available social services, and with increasing the range of service options (care packages) available, including the expansion of respite care and the introduction of more services in support of family care and independent living.

Figure 4.2: Main evolutions in long-term care services

	Country						
Main evolutions	*CZ*	*DE*	*FR*	*IT*	*NL*	*SE*	*UK*
Structural reforms in view of organisation, regulation or financing	2	2	1	3	1	2	2
Quality assurance and improvement initiatives	3	1	2	4	2	2	2
Introduction of new types of services or programmes	4	2	3	3	3	2	2
Cost containment measures	4	2	5	4	2	4	2
Substantial change in private cost-sharing	3	4	3	3	4	2	4
Substantial changes in the scope of public service provision and of public funding	4	4	5	5	1	4	4

Note: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

How is long-term care covered in this study?

The services of long-term care that are analysed here, fall under three broad groups: (1) services for elderly persons with severe functional limitations receiving care in institutions; (2) services for persons with moderate to severe functional limitations who receive care in the community (at home), often as a mix of informal and formal care; (3) social services to support care in the community, such as respite care, day care, counselling and the like for both care recipients, their families and other volunteers. The integration – or fragmentation – of service provision, also at the boundary between curative health care, rehabilitation and long-term care, has received special attention.

2 Overview on service provision and expenditure

The interaction of different levels of government in organising and funding long-term care is often complex while regulating, financing or provision of these services is in most cases a shared responsibility (Figure 4.3). Framework legislation is often enacted at the national level, while detailed regulation and the organisation of services is frequently delegated to the regional and local level.

Figure 4.3: Competent public authorities in long-term care services

Competent public authority	Country							
	CZ	DE	FR	IT	NL	PL	SE	UK
National government	4	3	1	5	1	3	2	3
Regional territorial authority (state; province)	1	1		1		2	2	4
Local territorial authority		1				1		1
• District			2	4			2	5
• Municipality	2			3		1	1	1
Social insurance agency		1			2		2	5

Note: Ranking from 1 (Most involved) to 5 (Least involved)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

In some cases, the devolution of competencies of organising long-term care to the local level has resulted in differences in the way care assessment is implemented, and in differences in the generosity of services, also in response to what local budgets can afford. It is a common theme of the country studies that the experience of users and of their families can as a consequence depend on the community in which they live, and this needs to be taken into account when aggregate statistics are analysed. This is, for example, the case for Italy and Sweden. There are also fundamental differences in the way long-term care is provided and funded in the constituting countries of the United Kingdom.

Where much of the competence for long-term care has been delegated to local authorities, it may be difficult to analyse long-term care in detail, because essential information may rest with the local level and no longer be reported to the central level or be generally available, such as in the form of aggregate statistics. This has also to be kept in mind in the more detailed analysis of the case vignettes below (under 4.3).

Table 4.1: Organisation of services provision in long-term care services

	Country							
	CZ	*DE*	*FR*	*IT*	*NL*	*PL*	*SE*	*UK*
Approximate "market" shares								
Public	80%	5%	42%	30%	0%	na	70%	10%
Non-profit	15%	50%	51%	50%	80%	na	10%	10%
For-profit	5%	50%	7%	20%	20%	na	20%	80%
Mode of governance								
Market				x		x	x	x
Quasi-market (competition between providers and purchasing by a public agency based on regulations)		x			x	x	x	
Planning	x		x	x	x		x	
Other (please specify)								
Service cheques for purpose of services							x	
User and worker's cooperatives								
Type of regulatory mechanism								
Related to authorisation regimes for service providers	x		x					
• Accreditation	x				x	x	x	x
• Certification	x						x	x
Related to service provision requirements		x					x	

Source: Questionnaire for in-depth country studies

There is now considerable competition among different types of suppliers of long-term care in many countries, which has in some instances helped to drive the agenda of assuring internal quality management and increased reporting to the public (see also Part V on quality). But value-driven competition (linked to quality of services) is currently underdeveloped, which is a problem conceived in a number of countries (e.g. Germany).

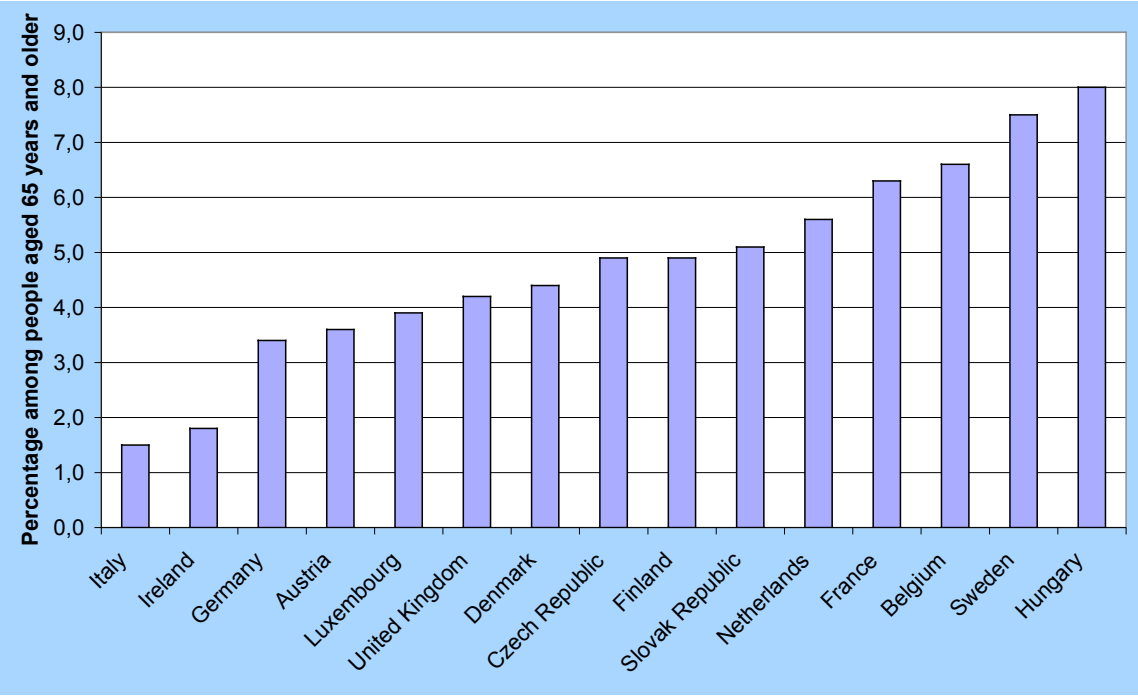
Long-term care recipients

This section briefly reviews the evidence on the size of long-term care provision in international comparison, based on information from an emerging OECD data set that is the most comprehensive that is currently available. This is complemented by a comparison of the latest available projections for long-term care expenditure in the future. Long-term care expenditure is expected to increase steeply in future decades, but the drivers behind currently observed differences in the number of people receiving care and in expenditure are mainly due to differences in the state of development of publicly-

funded long-term care, and to a lesser degree to differences in demography or health status (OECD, Long-term care or older people, 2005).

The numbers of dependent older people that receive long-term care in institutions range across Europe from below 2% (in Italy and Ireland) to more than 7% in Sweden and Hungary. But, the mix of services typically received in countries and the type of institutions that are behind the aggregate numbers of Figure 4.4. are clearly not the same between countries. Intensity of care, for example, will be on average higher in Sweden than in Hungary, and the comfort of living conditions is much higher in Sweden, where practically all nursing home inhabitants have a choice of a single room or service-apartment, whereas many nursing home inhabitants will have to share rooms in most other countries. With the exception of Sweden and Norway where choice of a single or double room in care in institutions ranks as a social right, the average number of persons per room in a nursing home typically ranges from 1,4 (Germany, UK) to 2 (in the Netherlands) or more in other countries (OECD, 2005).

Figure 4.4: Long-term care recipients in institutions, 2004



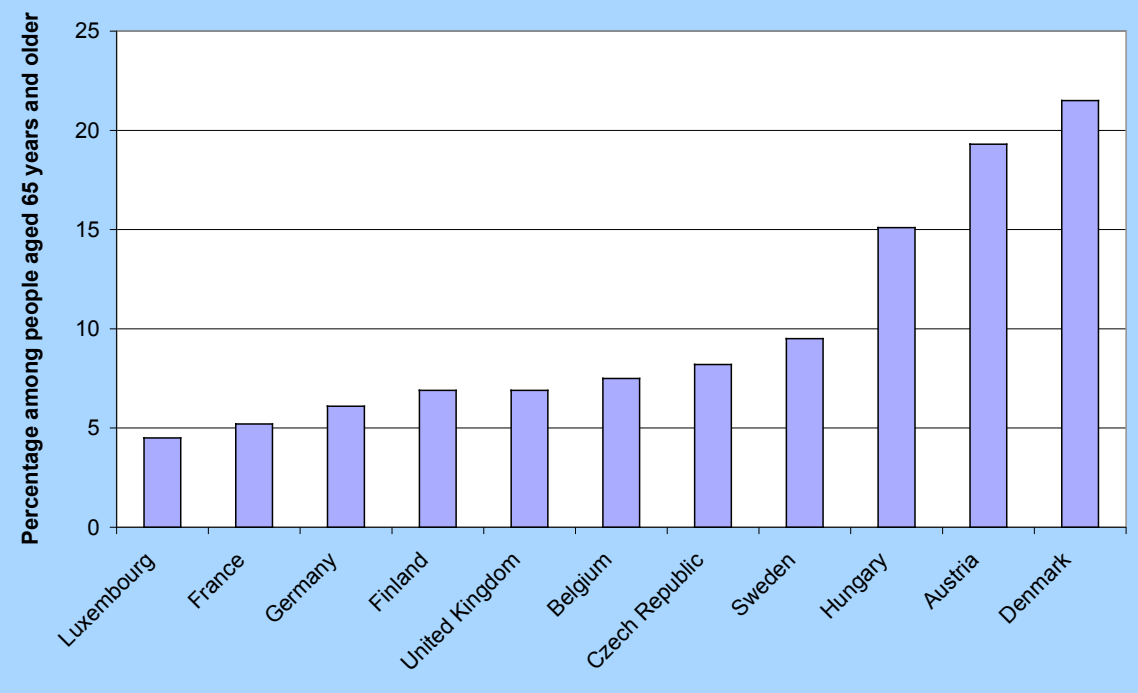
Source: OECD Health Data 2006

The factors that explain why some countries have lower numbers of reported older people living in institutions are manifold. Caring for frail older persons is still predominantly a family responsibility in some countries (Italy and Ireland), and public policy has only recently become more active in complementing family care with more publicly available care alternatives in these countries. For other countries, there is a combination of a continuing family tradition in care and an increasing supply of home care alternatives, sometimes also supported by public programmes that allow families to decide on how to spend publicly provided funding for long-term care (e.g. the care allowances in Austria and Germany).

There is also greater disparity between countries in the share of older people who receive care in the community (where people who are cared for at home and that receive

social benefits in the form of care allowances are included in the care ratios shown in Figure 4.5). Comparing aggregate care ratios between countries, and interpreting differences between countries correctly, is even more challenging in the case of home care than it is for care in institutions. In Austria, for example, the large number of care recipients includes many people that receive relatively modest monthly payments, whereas the entitlement conditions, (combination of functional restrictions and number of hours of minimum care needs), in Germany result in fewer people getting over the threshold of the entry category of care allowances (or, alternatively, of professional home care services).

Figure 4.5: Long-term care recipients in the community (including care allowances), 2004



Source: OECD Health Data 2006

The boundary between "institution" and "home" is increasingly getting blurred where public long-term care programmes have aimed at creating "home-like" environments for persons who need long-term care. In Denmark, for example, many "nursing home places" have been converted to "service apartments" that are now served by the same providers that are also active in home care. These now show up in statistics either under "institution" or under "home" (see also the expenditure statistics in Table 4.2).

There is also a general trend towards integrating health and long-term care provision, and of "continuing of care" across living at home with or without services, towards more intensive services, including short stay in institutions, or longer stay in nursing homes. These trends that aim at improving the quality of care and of the care experience at the same time make it increasingly difficult to draw the boundaries, such as between residential homes for older people, assisted living arrangements and service departments, and "nursing homes" (which increasingly are integrated as care wards in other institutions). Integrating care options in independent-living environments that are specially adapted to the needs of older people also has the advantage that the social and

health risks of the transition to more intensive care (such as that needed for bed-ridden persons) are mitigated.

Expenditure on long-term care

There are many factors other than demographic ageing that will determine growth in long-term care expenditure under public budgets in the coming decades. Among these are (see, e.g., OECD, 2005, 2006, ECFIN 2006):

- The availability of informal care by family, friends, and the voluntary sector;
- Cost-containment versus more generous public funding of long-term care;
- Public pressure to put public long-term care programmes in place, where these are currently rudimentary, with some convergence in options available and living standards of older people to be expected in Europe;
- The cost of increasing quality of care, both for better trained and paid staff, more attention to quality strategies, and improved infrastructure (including more amenities in nursing homes and substantially better life-style of people living in institutions).
- Cost-pressures that will arise from staff shortages;
- Trends in disability that are currently uncertain (e.g. will the increasing number of people with obesity become more dependent in old age – or will they die before they become frail older persons?);
- Trends in living conditions of older people, such as income levels, the increasing share of older people living as couples, where partners are able to support each other in case of care needs.

All estimations of future long-term care spending seem to agree that substantial additional investment in long-term care will be needed in response to the growing number of very old persons in the 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, and increase by two thirds in the reference projections for the Commission (Table 4.2).

These projection exercises also illustrate that more investment in basic data will be needed to better monitor the development of long-term care expenditure in the future and also to improve international comparability. As Table 4.2 illustrates, the uncertainty about current spending levels in international comparisons can be of the order of magnitude of the expenditure growth projected in the future (e.g. for Austria, where the 2004/5 number in the AWG reference projection is around 50% below the number used in the OECD projections).

Table 4.2: Estimated expenditure on long-term care and projections until 2050

	AWG reference scenario (ECFIN)			OECD estimates		2050 projection			
Country	2005	2050	Change (2004-2050)	2004 (Health Data 06)(*)	2005(**)	Cost-pressure	Change (2004-2050)	Cost-containment	Change (2004-2050)
BE	0,9	1,8	1	0,8	1,5	3,4	1,9	2,6	1,1
DK	1,1	2,2	1,1	1,7	2,6	4,1	1,5	3,3	0,7
DE	1	2	1	0,9	1	2,9	1,9	2,2	1,2
GR	na	na	na	na	0,2	2,8	2,6	2	1,8
ES	0,5	0,8	0,2	0,4	0,2	2,6	2,4	1,9	1,7
FR	na	na	na	0,3	1,1	2,8	1,7	2	0,9
IE	0,6	1,2	0,6	na	0,7	4,6	3,9	3,2	2,5
IT	1,5	2,2	0,7	na	0,6	3,5	2,9	2,8	2,2
LU	0,9	1,5	0,6	1,4	0,7	3,8	3,1	2,6	1,9
NL	0,5	1,1	0,6	1,1	1,7	3,7	2	2,9	1,2
AT	0,6	1,5	0,9	0,7	1,3	3,3	2	2,5	1,2
PT	na	na	na	0,0	0,2	2,2	2	1,3	1,1
FI	1,7	3,5	1,8	0,4	2,9	5,2	2,3	4,2	1,3
SE	3,8	5,5	1,7	0,7	3,3	4,3	1	3,4	0,1
UK	1	1,8	0,8	0,4	1,1	3	1,9	2,1	1
EU15	0,9	1,5	0,7	0,7	1,3	3,5	2,2	2,6	1,3
CY	na	na	na	na	na	na	na	na	na
CZ	0,3	0,7	0,4	0,1	0,4	2	1,6	1,3	0,9
EE	na	na	na	na	na	na	na	na	na
HU	na	na	na	0,2	0,3	2,4	2,1	1	0,7
LT	0,5	0,9	0,4	na	na	na	na	na	na
LV	0,4	0,7	0,3	na	na	na	na	na	na
MT	0,9	1,1	0,2	na	na	na	na	na	na
PL	0,1	0,2	0,1	0,4	0,5	3,7	3,2	1,8	1,3
SK	0,8	1,3	0,6	na	0,3	2,6	2,3	1,5	1,2
SI	1	2,2	1,2	na	na	na	na	na	na
EU25	0,9	1,5	0,6		na	na	na	na	na

(*) BE 2003, UK 1999, CZ 2002; (**) estimated start value for projections

Source: ECFIN 2006, OECD 2006, OECD Health Data 2006

In interpreting these projections correctly, it is important to keep in mind that these are mainly driven by demographic changes and by changes in the relative prices of care services compared to overall economic growth. The likely "catch-up" effects of countries that currently start at relatively low levels of public expenditure, such as for countries that have joined the EU in recent years, have not been modelled in these projections.

Spending trends in individual countries

The country reports under this project provide additional evidence on recent expenditure trends and their current drivers, including changes in policy. In France for example, expenditures of health insurance for the elderly in institutions and at home increased at an annual rate higher than 9%, in current €, between 2000 and 2005. In England, net expenditures on social services for older people have risen steadily in recent years, increased by 114% (in nominal terms) during the period 1994 to 2004. Similarly, total expenditures on health services for older people increased by 50% (in nominal terms) between 1999 and 2003.

Expenditure growth also went hand in hand with strong job growth in the sector – both in institutions and in home care services. Budget constraints and decreasing

employment in community services was, however, observed in several new Member States, for example, in the Czech Republic.

Rapid growth of expenditure relative to GDP occurred mainly in periods when governments substantially expanded the publicly funded benefit package or changed eligibility criteria, for example by shifting to a universal system (e.g. in Germany and Luxembourg). For some countries, public expenditure ratios to GDP remained remarkably flat over the past years (after the phasing in of public programmes), mainly due to the fact that public spending was capped in various ways, for example by not adjusting the level of care allowances to inflation or to increasing salaries in long-term care (Austria, Germany) less than in other industries. As a result, over an extended period, this reduces service availability, affordability, and might put pressure on increased private spending.

The structure of spending and financing

In all EU Member States, private households heavily share the burden of care, first by providing the majority of hours of care that people with long-term care needs receive, second by making substantial co-payments or out-of pocket payments for care provided under public programmes. Unfortunately, aggregate information on private spending is even more scarce than information on public programmes.

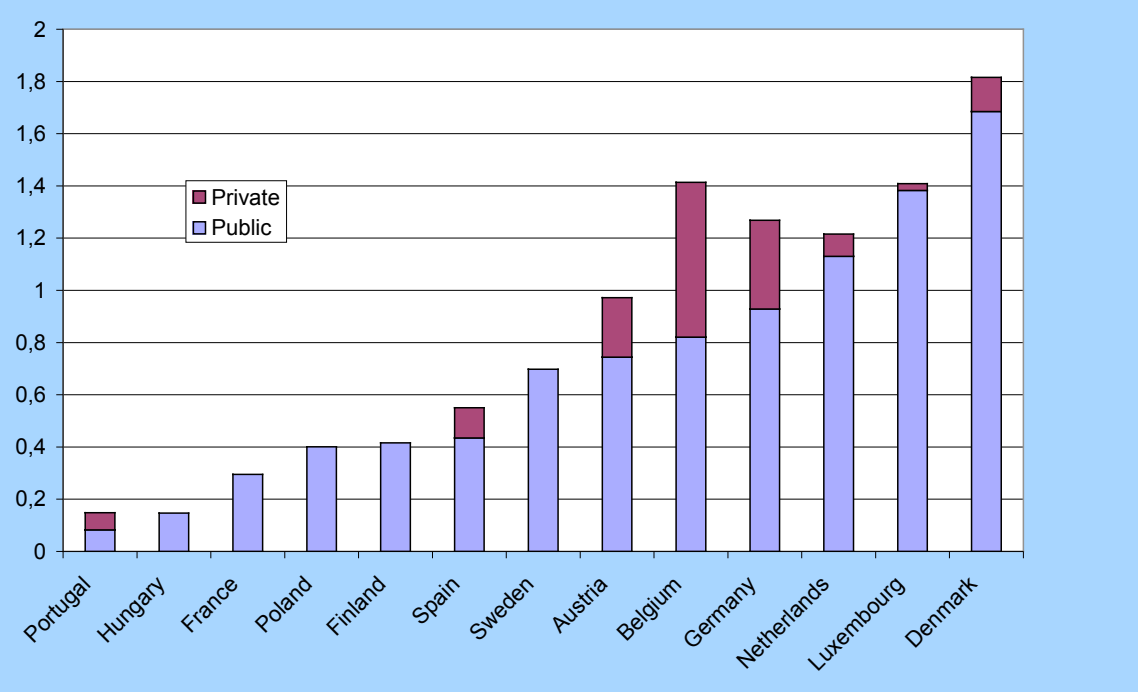
Total expenditure on long-term care in the EU-15 ranges from below 0.2% of GDP to around 1.8% of GDP (OECD Health Data 2006, see however Box 4.2 on data issues). About half of all EU countries for which data are available have overall public spending of 0.7% of GDP or more (Table 4.2, Figure 4.6).

Box 4.2: A note on long-term expenditure estimates

This section is based on data from OECD health accounts, as published in the OECD Health Data 2006 database. These numbers include only part of all spending on long-term care. Most importantly, many of the lower care levels of services, such as help with household work, are not included and therefore much of home care spending is excluded. As Table 4.2 illustrates, these OECD estimates are consequently usually substantially lower than other estimates. This data source has nonetheless been chosen here because this is currently the only regular data source that reports both on public and private expenditure, and has a basic breakdown by type of services (home care versus institutions).

In other sources, such as in the Esspros database, “long-term care” is not a separate category at the basic level of classifications. Social expenditure on long-term care is found in Esspros for individual countries under either “disability” or under “old age”, or has been split between both. It is a difficult task to isolate and aggregate these for international comparisons (see also Chapter 16 on further recommendations).

Figure 4.6: Expenditure on long-term care (in %GDP), 2003/2004



Source: OECD Health Data 2006

Private households are in many cases requested to make substantial contributions to the financing of long-term care, either in the form of co-payments to publicly provided care, or as out-of-pocket spending for care for which no or only very little public funding is provided. This can also be the case for systems, where access is universal, but where funding is restricted to only part of the total care needs (Figure 4.6). In Germany, for example, long-term care insurance only insures the risk of spending on personal services for nursing home residents and these have to pay for the cost of boarding and lodging out of their own pocket.

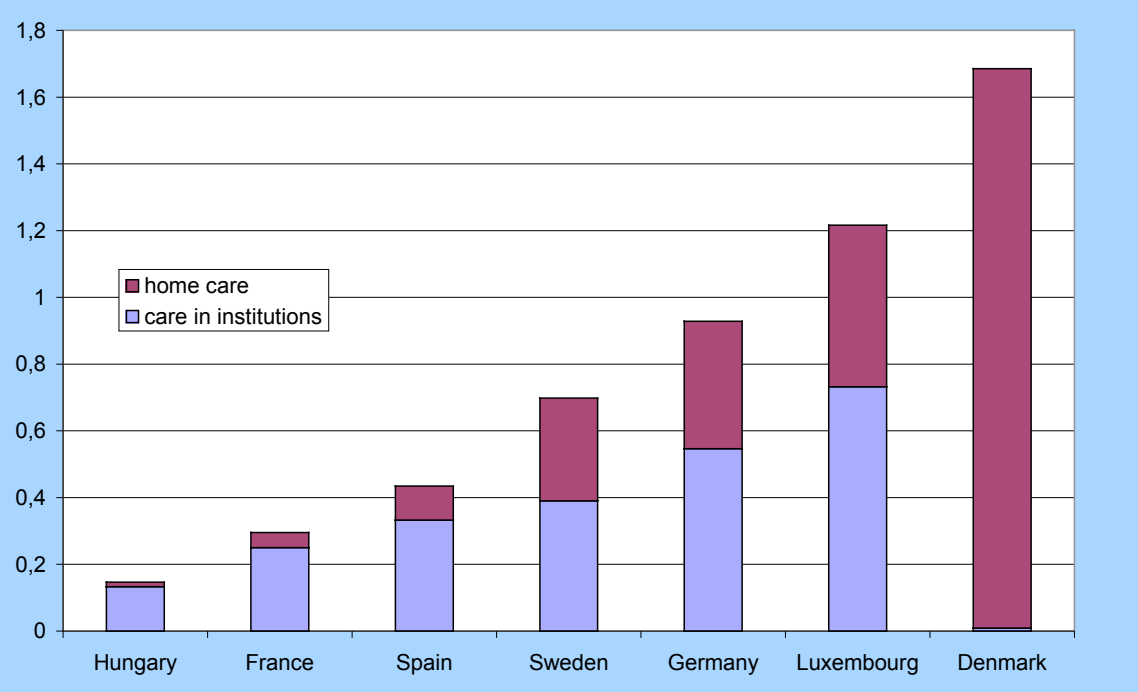
As there are many pensioner households in all countries that do not have the financial means to cover considerable monthly payments to care providers, social assistance remains in many cases an important source of funding. The share of private funding in total long-term care can also be high for some countries where long-term care provision is currently small (e.g. Portugal, Spain). Information on private spending is missing and difficult to estimate for a number of countries (e.g. Hungary, France, Poland and Finland in Figure 4.6).[46]

For all but one country (Denmark), spending on care in institutions accounts for over half of public spending on long-term care (Figure 4.7). Where data are available, there is evidence that the publicly supported home care sector is still small in many countries (e.g. in the new Member States). As the majority of home-care recipients in addition will have access to publicly provided care, family or other volunteers who support them by providing additional hours of care (usually unpaid), home care is often a lower cost alternative to care in institutions (OECD, 2005:28). As has been explained above, Denmark is a special case, where the high share of "home care" corresponds to a

[46] More detail on private cost-sharing was reported in the country studies for the case vignettes in 4.3.

new philosophy towards service apartments within what, in the context of other long-term care systems, would be regarded as "institutions".

Figure 4.7: Home care (in % of GDP) has become an important component of publicly funded long-term care for some countries



Source: OECD Health Data 2006

3 Lessons from country studies

The in-depth country studies provided a wealth of information on long-term care services, documenting the increasing interest and active policies in many countries to tackle problems of gaps in services, improve quality, and prepare for demographic changes in the future. Services have in fact been strongly expanding over the last 5 to 10 years in a number of countries, including France, Germany, and UK. In other countries, long-term care has become more targeted for those most in need (e.g. in Sweden). Availability of high quality and affordable services is much more restricted in countries like the Czech Republic and Poland, as well as for Italy.

The description of the social situation and service availability for the three individual in the following case vignettes is a novel way of looking at long-term care systems in more detail. It has helped to identify gaps in services and in quality, and to make the interplay between the role of the family situation, (including the income and wealth of households in which older people live), with the care system more transparent.

Box 4.3: LTC case vignette A: assistance at home care, respite care and rehabilitation

Ms A, aged 70 with family support (daughter aged 50 living in the neighbourhood who looks regularly after her, although working full-time) had for two years ongoing need for help (at least three times per week) with a number of instrumental activities of daily living (such as shopping, gardening, home making) due to severe arthritis of her hips. What kind of support from the social sector is available in addition to the informal help that Ms A receives from her daughter? What about respite care when her daughter becomes ill? Are there any other day care social activities available? What would be the case if no informal carer were available? After a recent fall, Ms A received replacement of one hip and has just left the hospital. In a mid-term perspective she has a good prognosis for recovering to at least her former functional status. What kind of services for the intensive care needed for the coming weeks is available? Examples are rehabilitation, help with both activities of daily living plus help with IADL that clearly are more demanding than what her daughter can provide in case she does not quit her job.

For the type of low-level care (help with instrumental activities of daily living) that Ms A needs publicly funded social services are in many countries limited. Care provided by family members, neighbours or other volunteers play consequently an important role in all countries studied, even in those where care services are overall generous and well developed, such as in Sweden. Privately organised and funded support services exist in many cases but these are naturally restricted to households that can afford them. These privately organised services may receive some public support in the form of tax deductions on corresponding household expenses, e.g. in **France**.

Throughout Europe, a range of privately organised (and paid) support and assistance, such as meals on wheels (but also a broad range of commercial catering) and the possibility of shopping over the Internet increasingly contribute to providing help for older people that have the capacity of using these.

Who is eligible for home care services under public programmes and what is the user's participation (co-payment and means-testing)?

Eligibility criteria in the countries studied often set a threshold of service needs that is above the care needs of Ms A. In **France**, services are available under a number of public programmes, but co-payment can be important. Under the **German** long-term care insurance, Ms A is only entitled for low-level home-care services in combination with care for more severe limitations. In **Italy**, Ms A will also be likely to have no access to publicly funded home care services, depending on where she lives. In the **Netherlands**, home care services are subject to income-related co-payments, but can be funded from a personalised budget, if the care assessment grants such a benefit in cash. In the **Czech Republic**, there is no general public programme to receive community home care service. Availability of services depends on the region in which Ms A lives.

In **Poland,** eligibility for services depends on the family situation (are informal carers available or not?) but the exact way in which case assessment is done depends on

the local authority in charge as each local authority refers to their own set of criteria in order to decide whether Ms A will or will not have access to home help. In many cases the actual access of the service will be rationed by service availability that is based on annual budgets. This has also been reported for countries that otherwise differ greatly in their overall availability of services (e.g. for **Italy** and **Sweden**).

What kind of services are available and who organises them?

In the **Czech Republic** there are a (limited) number of community home care service centres that are operated by community offices, municipality-established social service institutes, public benefit organisations or are usually church-run nongovernmental non-profit organisations. In **France**, Ms A is entitled to services managed by associations, or community centres or, in some cases also by companies. This kind of assistance will be particularly adapted if a member of her family can give complementary help, but services are often restricted to a very limited number of hours per week.

Depending on where she lives, Ms A will have access to some home care services in **Italy**. The latter are generally more developed in Northern and Central Regions compared to Southern Regions. Moreover, even within those regions where services are more developed, their availability varies greatly between municipalities. Even in **Sweden**, where service availability is more advanced, the services provided clearly differ depending on where Ms. A lives. But in general she would be entitled to sufficient care so that her daughter can continue working.

In **Poland,** day care centres provide some services in the community but their availability is limited and there are barriers of access in areas where corresponding transport is not provided, which is an issue for areas outside of big cites. Care that is provided in the home is usually limited to 2 to 4 hours a day, because of cost and shortage of qualified carers.

As Ms A has no need for personal care she would be very unlikely to be offered any statutory services by the local authority in the **UK** (England). Most Local Authorities offer services to those falling into the critical or substantial bands of the FACS. However, if she or her daughter rang the Adult Services department of their local council to request help, Ms A would be offered a screening assessment. In certain local authorities she might be able to access an Internet-based self-assessment council website. It is most likely they would be given some form of written information on sources of help, both voluntary and private, for shopping/gardening/homemaking.

What are the conditions for home care (opening hours, cost-sharing)?

Access to home care services is often limited by opening hours of care centres and ambulant carers. In the **Czech Republic,** for example, the nurse usually visits her/his client only on weekdays, once or twice during the working day, i.e. usually from 7 AM to 5 PM. For regions in **Italy**, where home care is available, Ms A will probably receive 1-2 visits per week for 2-3 hours of support in total, as her care needs are relatively modest. A home helper will provide her with home making, less likely with gardening and shopping. Most likely, this home help will be employed by a cooperative to which

the municipality has externalised home care services. Depending on the specific rules applied by the municipalities, she will or will not have to contribute to the cost of the service with a co-payment.

Prices for home care service are usually more expensive (and less affordable if paid for privately) for professional services by special trained and certified nurses than if directly employed care assistants provide them. For example in **France** the price for (low-level) home care services is between 12 and 16 Euros per hour from service providers and from 10 Euros for direct employment.

How does the situation change if Ms A's daughter becomes sick?

France: When her daughter is sick, Ms A has access to home assistance for essential personal care: cleaning, washing, meals and possibly toilet assistance, and assistance with shopping. The price of these services is between 16 and 25 Euros per hour. If Ms A is mobile enough, she can also choose to receive day-care services in establishments that accommodate for one or more days per week, where a range of services can be given including physical exercises, memory and sense workshops, but also creative workshops and the like.

In the case of hip-replacement: how does the interface between acute care and long-term care work?

France: After a short stay in a rehabilitation establishment for functional recovering, Ms A will be able to receive home care services (so-called Home Medical Care) that is supported by the health insurance. These services could be complementary to the home services described above.

The situation of Ms A after the accident is clearly defined in **Germany** but not without some practical problems of case management at the inter-section between hospital care, rehabilitation and organisation of independent living in a private household after rehabilitation. In Germany, geriatric rehabilitation shows some deficits. Not in all cases is the rehabilitation located close to the private household and to Ms A's networks. This can have a negative impact on the quality of rehabilitative care and of the possibilities of co-production by relatives. Help from the long-term care insurance is only available if the measured need for nursing care is stable over a time-span of more than 6 months.

Italy: The availability of rehabilitation services is highly variable throughout the country. Rehabilitative residential and semi-residential care is provided in specialised institutions within the National Health Service. Where services are available, there are sometimes waiting lists. Moreover, home care services for rehabilitative purposes are usually provided by local health authorities. Nevertheless, rehabilitative home care services tend to be highly specialised (nursing, physiotherapy) and usually do not cover personal care needs, which means that a significant number of hours of support will have to be organised either through informal care or from the private market. The link between home health services provided by the health sector and home care services provided by the municipality is a particular challenge: the increased social care needs are not likely to be covered by social services.

For the **UK** (England), there are two basic scenarios:

1. If Ms A's house is not accessible/suitable, or, on assessment prior to discharge she is deemed not safe to be on her own at night, or has expressed a lack of confidence in going straight home, she might be offered so-called Residential Intermediate Care, in which case she could stay up to 6 weeks in some form of residential care, which might be in a community hospital, or care home (or in rare cases she might be offered Intermediate Care in "extra care" housing, but this is not widely available). Intermediate Care (IC) can be offered free of charge via the council for up to 6 weeks (typically IC services are to some extent organised jointly by health and social care agencies).

2. If Ms A was, (on assessment prior to discharge), deemed safe to be on her own for some periods of day and all night, or if her daughter had volunteered to stay with her or Ms A were to stay with her daughter, she would be offered a comprehensive care package at home, including 1-2 home care visits per day, plus Meals On Wheels, and about 2 hours a week of services of assistance with other tasks. She would likely receive a visit from a community nurse to follow up on medication and wound care and some community rehabilitation (Physiotherapy and possibly Occupational Therapy) while her hip heals, to try to restore her to her previous level of mobility – perhaps 1-2 visits in the first 3 weeks, and tailing off after that. She is likely as well to receive some outpatient Physiotherapy and possibly hydrotherapy. After a month to 6 weeks she would be reassessed by a care manager and if she required (and were eligible) for more than 6 weeks of statutory services, she would from that time onward be charged at a means-tested rate.

Is respite care generally available?

France: If necessary, Ms A can be accommodated in a short-stay care centre and this kind of service has been developing fast over past years in response to the need to compensate for temporary absences of family care. It can also constitute a progressive transition before having to live permanently in an institution, such as in an old people's home.

In **Germany,** respite care is covered under long-term care insurance, but only if the care needs include severe ADL-deficits, not only IADL-aspects. It is unlikely that Ms A has access to respite day care or residential care in **Italy**, as her disability is limited. Respite care services are hardly present and home care services are in general quite rigid in their organisation and are not able to provide a large number of hours of help. A few cases of respite home care can be considered more experimental than actually structured services and they are located in very specific territories only.

Access to respite care is also limited in other countries. In the **Netherlands**, for example, respite care could be available, but in cases where it is limited to basically domestic tasks, it might be difficult to find these. In Poland, respite care units (linked to public residential institutions) are only accessible in big cities and they usually must be paid for privately.

Sweden: In the case of Ms. A there are differences between municipalities, but Ms. A would receive mobile home service or a number of hours per week of both personal services and assistance with daily activities. Some (mainly larger municipalities) provide care to elderly people based on a model of user choice with a "voucher" system that grants access to different public and private providers licensed by the local authority through a procurement system or by agreement. In any case, the aim of publicly provided care will be making it possible for Ms. A to stay in her house as long as it's possible.

Besides, if a family member is severely ill, Ms A will receive for a maximum of 60 days a caregiver's allowance provided by the Swedish Social Insurance Administration. In general, there is a trend towards long-term care provision that is more focused on the user's freedom of choice but the exact way this is implemented differs between municipalities.

In the **UK** (England), Ms A will not be offered respite care if her daughter became ill as she would not meet the criteria for dependency/risk under FACS. If no informal carer were available, in some local authorities, this would increase her chances of receiving help with shopping and homemaking (for which she would be means-tested and charged accordingly). Ms A might find it affordable to pay for shopping/gardening/homemaking privately.

Box 4.4: LTC Case vignette B: severe dementia (Alzheimer)

An elderly couple lives in the capital (Mr B, aged 80, his wife aged 78). Mr B has dementia of the Alzheimer type with severe mental restrictions and needs practically constant supervision (wanders around, leaves water tap open, forgets to take live-saving medication etc.) but otherwise has full control over all body functioning. Which support is available? What would happen if his wife suddenly dies and no other informal carer is available?

The need for intensive family care for Mr. B also raises the question to which extent social benefits to improve Mr. B's situation can be "exported" to another country, if his family situation would make this an option. In case the (now widowed) Mr B is invited to move to southern France to live with his 50-year-old daughter an her family. Which public support (benefits from public programmes) could be "exported" (that is would be reimbursed by the system and country of origin)?

As the **French** country study observes, the majority of professionals and experts today place much of their hopes in the development of local networks of coordinated devices, for comprehensive care of people having dementia of the Alzheimer type and of their family. These networks would coordinate medical aspects (diagnostic assessment, treatment of the behavioural problems, and risk prevention) in the form of teams for close coordination between doctor/hospital, assessments at home and social aspects, such as homecare services provided within the families.

But this vision is currently far from implementation in many countries and people who suffer from dementia of the Alzheimer type are confronted with a much more limited scope of available services. For example, there remains much to be done to improve cooperation between the medical and the social sector.

Specially tailored services, such as access to geriatric evaluation and care, specialised day care centres, temporary residence in institutions and respite care, support of families and carers are often insufficient and not sufficiently diversified. A more widely available support to people suffering from dementia and for their families is provided throughout Europe by Alzheimer Associations, usually in the form of information, counselling and advice.

Day care centres to support care in the community

These service providers usually provide care during weekdays only. In the event of the carer's death, the patient can be transferred to a residential ward. However, this capacity is restricted (e.g. in the **Czech Republic).** Providing formal care to Alzheimer patients is quite expensive in terms of funding and human resources. As with long-term care for Ms A and Mr C, access problems will be even more severe for those living in rural areas. In **Sweden,** Mr. B. would be supported by the home care services available in their municipality and these services differ but the general way is that someone comes to their home and relieves the pressure on Mr. B. Some municipalities offer daily care for elderly and disabled where Mr. B. can spend time and participate in group activities. More over, Mr B's family would be entitled to group therapy for relatives of severely sick people in some communities (e.g. in Umeå, in northern Sweden.

Care provided in nursing homes

In the case of an informal carer's death the only solution in most cases seems to be urgent placement in a nursing home because home care services are usually not providing assistance at home on a 24/7 basis. The following examples illustrate this.

France: If his wife dies, Mr. B will be probably accommodated in an establishment for the dependent elderly. A large majority of professionals and associative actors in France indeed consider that there is no possibility to stay at home for disorientated persons that do not live with family members.

In **Germany**, dementia is currently not covered by the definition of nursing need. If the wife dies suddenly and no other informal carer is available there is a real danger of getting trapped in a "no-care zone". The probability is high for Mr B to become institutionalised, with social assistance having to cover the cost after Mr.B's income and assets have been spent down.

Italy: Services provided in residential care vary greatly depending on where Mr B lives. In several regions, specialised services for Alzheimer patients are available. Nevertheless, their supply is far lower than demand. In other words, older people with dementia very often stay in nursing homes without specially tailored services for them. On the other hand, as Mr B is in good functional condition and needs constant supervision he is not likely to be placed in a "normal" nursing home (that will rather host older people with dementia that are completely immobile) and waiting times may be quite long. The cost of residential care for Mr B depends greatly on the region of residence and on the type of structure he enters. It can range between 1.000 and 3.000 Euros per month in a nursing home that is accredited by the regional health system.

Can care allowances be claimed while living in another EU country?

The **German** long-term care insurance is obliged to finance cash benefits from Germany to France if the care need is estimated by the Medical Service of the health care insurance (MDK) and the conditions for entitlements (in Germany) were met. In some cases the long-term care insurances have even made direct contracts about in-kind transfers with providers of nursing and social care in other countries.

For the case of **Italy,** the "Indennità di accompagnamento" can also be exported. In **Sweden**, the question whether it is possible to receive elderly care abroad has been discussed in several municipalities, Spain and Spanish islands is the main focus at present. No national guidelines in these matters have been found. If Mr B's lived eg. in the municipality of Huddinge (a suburb of Stockholm) such financial help would be granted. The **UK** carer allowance, however can only be claimed within the country, and this has been confirmed by a case that had been brought up to the ECJ.

Box 4.5: LTC Case vignette: The transition from hospital to nursing home

Ms C, a frail elderly woman aged 85 lives alone with modest pension benefits in a small apartment that she owns. Ms C is unable to live alone any longer due to the onset of at least two or three severe functional restrictions (including severe difficulties moving around and incontinence). She currently stays in hospital where she recovered from a severe influenza episode that was complicated by a severe case of pneumonia that has resulted in a further deterioration of her functional status. Ms C now needs urgent placement in a nursing home. What are her choices and who helps to manage the transition?

In the case of multi-dimensional (somatic, cognitive and other) deficits regarding the possibilities of independent living conditions in private households, the research on the risk factors or predictors of institutionalisation is evident: With-out comprehensive social support systems the way into the long-term nursing home is determined.

Access to services

France: According to her level of dependence and resources, she will be able to be supported by the IAA for expenditures related to the social accompaniment of her dependence, and possibly, according to her resources, by the departmental social assistance for the accommodation expenditures. Care expenditures will be supported by the health insurance.

Waiting lists are a problem in some countries and areas. In Italy, for example, Ms C will either have immediate access, will have to wait or to opt for a nursing home that is relatively far away from home, depending on the (regional) availability of places.

Poland: In a case when permanent intensive care is needed there are three possible solutions (1) care in health centres (funded from the National Health Fund), (2)

residential homes (organised by the local department of social services), and (3) wards for rehabilitation in hospitals.

Affordability of nursing home care and private cost-sharing

The intervention of the social assistance to accommodation is thus essential for a great number of people entering in a nursing home.

In **France**, the average daily cost-sharing required from the elderly is approximately 43 Euros, that is to say a monthly expenditure of 1 300 Euros (before the intervention of the social assistance to accommodation), comparing with the average retirement pensions of the 85 year old people and more: 908 Euros on average in 2004.

For the case of **Germany**, the place in the nursing home has to be financed by a mixture of long-term care insurance, private incomes (pension) and private wealth (Ms C would, e.g., be required to sell her apartment). Any remaining funding gap would have to be covered by social assistance.

The situation is somewhat different in this respect in **Italy**, where the cost for Ms C's place in a nursing home will range between 1.000 and 3.000 euros per month depending on the region of residence, on the type of home and the services available. If her pension, plus the national care allowance (Indennità di accompagnamento) is not enough to cover the fees and assuming that she has no relatives at all (probably her relatives would be asked to contribute to the cost - based on a highly debated and changing rule), the municipality will complement the resources needed in order to pay for the nursing home's fees. The access to these contributions is regionally very diverse and often highly discretionary.

Alternatives to care in a nursing home: the role of the informal sector

Families of frail older people that cannot get all the care needed from public programmes, and that are no longer able or willing to provide by themselves the – often extensive- care needed, increasingly are looking for care alternatives on a growing informal market where care assistance offer their services at very low prices, often without formal working relationships and frequently as migrant workers, with or without a legal work permission in the country where they provide these services. This is illustrated in Box 4.6 for Italy, but informal (and in a strict sense illegal) employment in home care is increasingly an issue in other countries that provide benefits in cash (care allowances) to dependent older people and their families. Examples are Austria and Germany.

Box 4.6: Alternatives to nursing home care: the case of Italy

In **Italy**, the only alternative to a nursing home is to be taken care of at home by a paid live-in worker. Nevertheless, some informal care (at least in terms of supervision and organisation) would be needed in order to make this option viable. Mr B. may be entitled to a care allowance: the Indennità di accompagnamento that is intended to cover care needs of very dependent people (of all ages and independently from their economic conditions). In 2006 the allowance is worth 450 euros per month.

Additional regional or local care allowances may be available (in some cases also specifically for Alzheimer patients living at home), depending on the region/locality, on personal and household income, on the degree of dependency. The amount is highly variable.

For Ms A, it is most probably her daughter who will have to organise her own substitution, asking other relatives for help or arranging paid care for a period of time. In the last case she will probably pay a woman (either an Italian pensioner or housewife or a migrant domestic worker) for a certain number of hours of help. This person will be found through word of mouth, but also through volunteers associations and social services. The cost will be approximately of 7-8 per hour.

The situation may be different for Mr. B. Possibly, after a period in which Mr B's wife manages all the care on her own, they will opt for a live-in paid worker. It will probably be a woman from South Africa or Eastern Europe, sometimes undocumented and generally with no working contract (or a working contract the corresponds to a part time job). The cost of the service in big cities and in the North of the country would be around 800 per month in the grey market, plus bed and board. The cost would go up to 1.200 euros per month, plus bed and board, if the working contract were partially regularised (including social contribution, taxation, paid leave, holidays, etc.).

4 Conclusions

There remain many challenges of better integrating care for older persons between health and social services. Frail older persons have complex service needs that often combine acute health care (in particular for chronic conditions), rehabilitation, nursing care and other social services. Provision across this range of services is typically fragmented. Services of prevention and rehabilitation that could contribute to preventing or postponing dependency and functional limitations that lead to the need for long-term care services are still underdeveloped in many countries.

Home-care services are in many cases less developed than care provided in institutions such as nursing homes. Dementia patients face in many cases more severe problems of access to care than people with long-term care needs of a somatic nature.

Part-time inpatient and short-term care facilities (e.g. respite care to relieve caregivers during holidays or illness) are underdeveloped in many cases. They may be

almost non-existent in other cases, namely for several of the new Member States, and for Southern European countries.

Moreover, access to service within a country can vary substantially depending on where one lives. The spread of social programmes for dependent older people in the form of cash-programmes (such as care-allowance) raises a number of issues, including the (illegal) employment of migrant carers at very low wages on a black or at least "grey" labour market for care assistants.

Chapter 5 Social integration and re-integration

1 Introduction: A diverse sector with multiple objectives

In many countries, a broad range of social services is in place, which pursue the goal of preventing, mitigating or overcoming social exclusion of individuals and families with special social needs, or that are at specific risks (including specially targeted services for migrants and asylum seekers). These are services that are frequently organised on the local community level. They cover a broad range of risks and possible interventions, including:

- Services in response to specific needs of migrants and asylum seekers;
- Action to prevent educational failure and to prepare for measures of professional (re-) training in view of social skills and behaviour (closely linked to labour market integration services);
- A broad range of programmes and benefits to promote participation in all spheres of society for handicapped persons (also here there is overlap with labour market integration);
- Measures for drug abusers/addicts;
- Measures to support and give shelter to homeless people (this can comprise the following situations: roofless, houseless, living in insecure housing, living in inadequate housing, outside flats classified as "social housing");
- Measures to fight over-indebtedness and exclusion from financial services.

From this list, a small sample of interventions will be analysed more in detail in this study, first, services in response to specific needs of migrants and asylum seekers, second, services for drug addicts.

A crucial and urgent problem that all Member States share and have to tackle is the concentration of multiple disadvantages in particular communities and geographic areas, both urban and rural, and among some groups (cf. those listed above) where many people, including migrants, are confronted with deep-seated factors of exclusion that tend to be transmitted across generations. Another issue is social assistance levels, which have dropped in a number of Member States below the at-risk-of-poverty line. Across all Member States, many migrants are at risk of social exclusion. This is often a result of an inadequate access to employment, education and training, housing, transport or healthcare.

For the field of social (re-) integration services, a number of shared policy aims can be identified in the European Union. Among these are:

- Establishing links with measures focusing on inclusion based on employment;
- An emphasis on preventive action;
- Overcoming diverse forms of discrimination, especially for people with disabilities, ethnic minorities and immigrants, also taking account of diversity based on a pluralistic service offer;
- And the promotion of concepts of inclusive communities (e.g. in Germany as one form of urban regeneration activities in the framework of a joint Federal and State programme "Social Cities" – "*Soziale Stadt*"; and regional drug policies).

This last policy aim refers to (social) services of general interest geared at local communities and the whole population living there (and not primarily focusing on individuals and their needs), and is also highlighted by the Dutch country report (see Chapter 1.3.1 of the Dutch country report, SHSGI Country Study No. 5). They mainly build on empowerment and capacity building, participation and decision-making at a local community level especially for young people and marginalised groups. Such an approach also favours "active citizenship" for individuals, by also involving NGOs from the social and health field.

How is this sector covered in the study?

For the purpose of the study, a few services had to be selected for detailed study. These are services for migrants and asylum seekers (see section 5.2) and services for drug addicts with a focus on illegal drugs (see section 5.3). The latter have been covered by a separate multi-city study covering the situation in six capitals, in order to reduce the burden and workload for national experts in charge of in-depth country studies under the project.

2 Social integration of migrants and asylum seekers

Social integration of migrants: The social policy issues

Social services for migrants have often been put in place with a direct link to work migration (planned and based on bilaterally agreed contingents). The concept of "temporary migration to a host country and re-migration after a certain period of time, at least at retirement age to one's country of origin" seems to become of minor importance in the traditional (work) immigration countries, such as Austria, Belgium, France, Germany, the Netherlands, Sweden and the United Kingdom. A current policy focus across all countries under scrutiny is on questions of cultural integration and of the promotion of language proficiency to facilitate a full integration into the societies of the host countries. The Dutch country report provides an illustration for this trend, also

touching upon the issue of "steered" international migration policy with the example of language courses to be passed abroad to qualify for work migration.

As Table 5.1 shows, social services for migrants and asylum seekers are currently undergoing important reforms in at least three of the four countries who analysed this sector in depth, which often is in response to growing concern about current socio-demographic trends of uncontrolled migration in Europe.

Table 5.1: Main issues at stake for social integration and reintegration services

	Country			
Main issues at stake	*FR*	*IT*	*NL*	*SE*
Structural reforms in view of organisation, regulation, financing (including changes in entitlement conditions for users of services)	2	3	1	2
Introduction or extension of new regulatory or administrative measures	2	3	1	2
Demographic trends and other (macro) socio-economic developments	1	3	2	3
Financial constraints on budgets of public territorial authorities (on national, regional, local level)	1	2	4	3
Availability of a sufficient quantity of good quality services	1	2	5	3
Need to adapt to the evolution of users' needs or to better tailor the supply of services	1	3	5	2
Problems with low-quality services	3	3	5	2
Implications of introduction of (quasi-) market or of competition from private for-profit providers	5	4	2	3
Concerns about financial sustainability of service provision	5	2	5	2
Potential frictions with EU-law and the implementation and/or repercussion from ECJ jurisprudence	4	3	3	4
Co-existence of different types and status of providers	5	2	5	3
Cost cutting and/or effects of measures to increase efficiency	3	5	5	3
Availability and qualification of personnel	5	3	5	3
Affordability of services for private households (e.g. avoiding high cost-sharing requirements)	4	5	5	3

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5

Source: Questionnaire for in-depth country studies

Not covered by the categories above, the Dutch and Swedish country report underline the increasing importance attributed to comprehensive approaches in the framework of urban regeneration policies to counter ethnic and social problems, spatial segregation and ghetto formation, and to promote social integration in metropolitan areas[47].

Policies for migrants, amongst them social services, are as a rule and across the countries covered, a rather strongly politicised issue, sometimes overarched by non-migrant concerns and objectives. Strategies and policies tend to be more discontinuous than in other fields, depending on political majorities, their agendas and options to realise them. This also has backwash effects on the (often unstable and insufficient) financial basis of social services for migrants.

Social integration of migrants: Lessons from country studies

As is illustrated by Table 5.2, based on the four-country sample, changes and evolutions considered of high importance in social services for migrants basically are related to organisational restructuring and reforms of regulation and financing as well as to the implementation of new types of services or programmes, also responding to changing needs within the target group.

Table 5.2: Main evolutions in social integration and reintegration services

	Country			
Main evolutions	*FR*	*IT*	*NL*	*SE*
Structural reforms in view of organisation, regulation or financing	1	3	1	2
Introduction of new types of services or programmes	3	3	1	3
Quality assurance and improvement initiatives	3	5	4	3
Cost containment measures	3	5	5	3
Substantial change in private cost-sharing	5	5	2	4
Substantial changes in the scope of public service provision and of public funding	5	3	5	4

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5

Source: Questionnaire for in-depth country studies

[47] The Dutch country report highlights the role social housing corporations play in this context and field of (social) services of general interest, partly taking over the role that was traditionally in the hands of these welfare institutions. The resurgence of the community development work is encouraged at national level, where government provided the bigger cities with the possibilities to implement "selective settlement policies" to prevent neighbourhoods from turning into multi-problem communities.

All other issues are being seen as of medium, low or no relevance, with the exception of an increase of costs to be borne privately reported for the Netherlands which seems to be strongly related to an emerging market for integration education (see Chapter 4.3.1 of the Dutch country report, SHSGI Country Study No. 5). The Dutch report also highlights an issue not explicitly covered by the service categories proposed, albeit of importance across the EU Member States, i.e. a growing need to counter tendencies of social and spatial segregation of population groups also based on urban rehabilitation measures and a mix of measures (housing, education, professional training, labour market services), not least based on community-based measures and initiatives.

Dealing with the services of social integration for migrants and asylum seekers and re-integration in the framework of the in-depth country studies – covered in the country studies of France, Italy, the Netherlands, Sweden – turned out to be a rather challenging exercise. The sector descriptions therefore differ to some extent with regard to the issues focused on and the detail of statistical coverage. There are several reasons for this.

First, the target group, "migrants", is subject to a different understanding from one country to another. Country-specific concepts of who is considered to be a migrant are also influenced by different national histories, distinguishing countries with a colonial past, such as France and the United Kingdom, from those without such a legacy[48]. The French country report gives evidence for this issue of different conceptualisations as it quasi exclusively deals with asylum seekers and persons needing (temporary) housing in emergency situations.

Second, social services for migrants set up with a direct link to (planned) work migration as the dominant form between the 1950s and 1970s in many continental countries can be rather well identified. However, dealing with persons of migrant origin (and their descendants) already living for years or even decades in the host countries and this very often with a perspective to stay there, implies a shift to the "general" social services across all fields for policy and research[49]. There are, however, no statistics to cover these aspects and related "sub-groups" in a systematic way. Issues currently on the agenda in many Member States are e.g. to which extent "migrant-specific" aspects and offers should be integrated e.g. in elderly and long-term care, with concepts taking account of different cultural and religious backgrounds of elderly

[48] In countries like Germany the term "migrant" is even increasingly replaced by the term "persons with a migration background" (*Personen mit Migrationshintergrund*). One reason is that this enables to overcome "artificial" distinctions based on citizenship, on the backdrop of a rather recent policy encouraging nationalisation (as this is the case, however, differently contextualised, e.g. in the Netherlands termed "civic integration"). Using this term also allows to broaden the range of attention to persons already living for years or even decades in the country (as well as to their descendants of second and third generation), however, still characterised by specific "migrants"-specific problems hindering them from a comprehensive integration into the society and labour market of the host country (which often has become their home country)

[49] In other words, "migrants" – an internally also increasingly heterogeneous group as to "classical" socio-economic characteristics – have become much less a specific target group of social policy and related social services (contrary to education policy, including professional training and labour market policy, also comprising language courses). And should (social) services provided focus on newcomers, first-generation migrants, second- or third-generation migrants? Additionally on high-skilled migrants? The Dutch country report e.g. also introduces the distinction between "legal and illegal migrants" by referring on the issue of how to facilitate access to care for those without legal residence and to "regulate" reimbursement of costs for providers on backdrop of the new health insurance law (ZVW, in force since 2006) that has led to a stricter regime for hospitals and requires hospitals to ask for identification papers.

persons to be cared for. Another issue where social integration of migrants and child care (cf. Chapter 7) interrelate is how to integrate (pre-)school children requiring special care.

Third, the Italian report e.g. clearly explains the importance of local conditions and frameworks for the implementation of social services for migrants. As a consequence it is of no surprise that they show a degree of diversity with regard to availability, accessibility, quality and integration with other group-specific policies clearly above the average compared to the other fields of social services covered by this study[50].

Fourth, the country reports also illustrate the difficulty of obtaining specific statistical material for social services for migrants, first because the majority of services is implemented locally (and it is therefore difficult to obtain – at a national level – a clear-cut and comprehensive picture of cases dealt with, public and private money spent, personnel employed, etc.), second because these services as a rule are part of social assistance activities and not necessarily reported on separately in local or regional social assistance statistics. The same holds true for financial support given by public authorities to not-for-profit providers of services.

Finally, in some countries national action plans or comparable instruments have been or currently are being (e.g. Germany intends to come up by mid 2007 with a *Nationaler Integrationsplan*) elaborated in the field of migration and integration policy or policies for migrants. However, a set of broadly shared objectives by the relevant stakeholders for specific (social) services for migrants and asylum seekers (services which also have to respond to often multiple, complex needs of "persons with a migrant background") is often missing. Insofar, evaluations of social services for migrants and asylum seekers are a thorny issue, more so at the national level than on a regional or local scale. And not least therefore, no good practice examples were identified for this sector in the framework of this study.

As to the modernisation of social services for migrants and asylum seekers, the main issue seems to reflect a more general tendency also for other sectors of (personal) social services, namely the cross-country trend towards decentralising responsibility to the regional and/or local level. This, in turn, has a considerable potential for a more integrated delivery of social (re-) integration services and thereby also for better taking into account needs of specific "types" of migrants. As illustrated by the Italian country report, several regional territorial authorities seem to move into this direction. Provinces coordinate local level actions and manage funding; municipalities release detailed territorial plans and coordinate the implementation of integration measures. However, fragmentation, localism, delegation, delayed responses still are the rule in this field.

[50] The Swedish country report hints to the existence of regional differences with regard to the availability of offers with – contrary to what could be expected – a more extensive and personalised support in rural areas with a lower share of migrants.

Social integration of migrants: An illustrative case vignette

Typical services analysed in the country studies in more detail notably deal with the services that are relevant for the following case vignette.

Box 5.1: Social integration: Case vignette D (services for migrants)

Ms D has a residence permit but not the citizenship of an EU Member State. She does not sufficiently understand the national language and now needs juridical assistance to fill in administrative forms in order to receive social benefits.

What support is available in this case? What general services for special language training and labour market integration – regulated by public authorities at national, regional or local level – would be available?

For this sector the case vignette from the Italian country report was retained because it well combines institutional information with information on how concrete measures are being available, accessible and implemented for the case described.

Box 5.2: Services for migrants: the case of Italy

The situation of Ms D can be quite different depending on the place of residence and the (type of) organisations involved. Immigration offices are quite widespread all over the country, especially in Northern and Central Italy, where immigrants are a more substantial share of the population. Usually, it is possible to find such offices in provincial chief towns, and also in medium-sized municipalities. These offices can be managed in-house by municipalities with their employees: this happens especially in medium and large cities with a long tradition of services dedicated to immigrants and a number of employees with different assignments. Anyway, often these offices are managed in a more mixed way (by civil servants for administrative matters plus "tendered" intercultural mediators) especially because of the problems of recruitment. Or the task is completely delegated, e.g. to cooperatives, usually two or three (this market is very segmented and local-like), and bids are usually cut out for the desired one, according to a distributive policy that tries to cover all suppliers included in a sub-cultural pillar (Catholic, left). Local authorities have an agreement with a network of immigration offices set on a voluntary base by trade unions, employers' associations, non-profit organizations. These organisations have an important orientation role.

Ms D is likely to meet one of the networked immigration offices (since they print also multilingual leaflets, it is quite easy to be aware of their existence). In a trade union office, if she (or her husband, if she is married) is employed and affiliated to a trade union, the trade union itself – as it happens for Italian workers – could help her to fill in the forms, against payment for covering expenses (it changes from union to union, but is around 10-30 euros, according to stamp and registration dues). If she (or her husband, if she is married) is not affiliated, she will be asked to affiliate before (affiliation requires a payment). An employers'/self-employed association office will manage her case only if she (or her husband, if she is married) is an entrepreneur or self-employed. Otherwise she will be sent to a trade union or municipal office. For some social benefits (e.g. family allowance) also the employer (in case she is employed – or her husband, if

she is married) is bound to provide some information to fill in the form, hence often providing her a sort of informal help also for other aspects. In a Caritas office (or office of a similar organisation) they will send her to a (Catholic) trade union office or municipal office. In any case, it is likely that they call a trade union office and/or municipal office to report the case and give her further information. Finally, at a municipal office they will help her with an intercultural mediator and the support of the proper office that has to receive her application (the municipal immigration office is mainly an information desk; then the application has to be given to the proper office), activated by the intercultural mediator.

3 Social integration of drug users: lessons from a study of six European cities

Services for drug addicts have been covered in this project in a separate study that compares the situation in six cities: Frankfurt, London, Rotterdam, Stockholm, Vienna and Warsaw. Addressing the problems of drug addiction is considered an important policy challenge in all six cities.

The information brought together in the following tables relies on a multitude of sources and partially reflects important differences in measurement and concepts, as noted in these tables, as these kind sof detailed international comparisons are still in their infancy. The findings highlighted in the following are also a test and pilot for further work in the field that is needed for shedding more light on these policy topics that have recently received increasing attention.

Consumption of psychoactive substances and especially illicit drugs is higher in metropolitan areas than in rural and provincial ones and the burden of substance-related problems is therefore heavier for big cities. On the other hand, big cities have often more resources to manage these problems and therefore have accumulated more experience and competence. Their capital of competence should be shared across Europe and to facilitate this process, more systematic studies are needed.

The new challenges for social and health policy besides other things were met by the establishment of diversified drug services – in the big cities more than elsewhere in the countries – aiming at the re-integration of drug users. The drug services of metropolitan areas therefore are an excellent starting point for investigation when it comes to understand the efforts to (re)integrate drug consumers, their development and their rationales.

The six European cities selected for this small study differ largely in population size, though the differences are not easy to quantify (see Table 5.3). If the “inner” cities are considered, London is four times as big as Frankfurt. But the population size of the “inner” city depends as well as that of the “larger” city – the “inner” city plus environment – on historically grown local definitions of city and environment. Thus it is not possible to define the area of reference in common geographical and population terms.

The next problems arise when drug consumption is considered: the epidemiological data differ largely. In the two smallest cities – Rotterdam and Frankfurt – data on drug consumption are not available on city but only on national level. In most of the other

cities – in Warsaw, Vienna and in Stockholm - the data presented measure life time prevalence ("ever used in life"), but for London they refer to the prevalence of drug consumption in the past year, which of course should be much lower than life-time prevalence. Moreover: the age brackets differ substantially. Interpreted very cautiously, it seems that illicit drug consumption is quite high in London and in Frankfurt – in the biggest and in the smallest city – and "medium" in the other four metropolitan areas. But more analysis is needed.

More analysis is also needed with the next results, the estimates of the trends of the consumption of different drugs (see Table 5.4). The estimates partly depend on the surveys quoted in Table 1a, partly they refer to earlier (comparable) surveys and they also rely on the knowledge gained from other sources: All researchers who participated in this study are working in the field of drugs for a long time and are familiar with the drug situation in "their" cities. Only two of all substances seem to share one fate in all research areas: Cannabis consumption is increasing in all sites, LSD consumption is probably stable. Alcohol, opiates including heroine, amphetamines, and ecstasy show different trends in different sites. Also, the general trends concerning illicit drug consumption are not uniform but seem to decrease in the high consumption areas.

Table 5.3: Overview on demography and the consumption of psychoactive substances: prevalence figures (in percentage)

	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
Inhabitants						
in the city	2,8 mio (Inner L)	na	1,651,437 (2005)	771,038	599,859	648,241
city plus environment	7.4 mio (Greater L.)	1,700,000	1,825,287 (2001)	1,889,945	1,355,767	3,769,593
(year)	2001	2006		2005	2006	2006
Consumption of substances						
Type of measurement (best and/ or last survey)	crime suvey-persons reporting use in last year	general population - random sample life time prevalence	representative sample-life time prevalence	national population survey - life time prevalence	national data - life time prevalence	national data - population survey: lifetime prevalance
Age bracket	16 - 59	18 - 50	15+	18 - 69	15 - 64	18 - 59
Year	2002/03	2002	2005	2003	2005	2003
Alcohol	excluded		93	94	85.4 (last year)	97
Cannabis (marihuana, hashish)	14.7 (1)	25,1	17	15	22.6	24.5
Amphetamines	1.3	6,4	2		2.1	3.4
Opiates (inclusive heroin)	---	0,6	2		0.6	0.6 - 1.2
LSD	---	5,1	na		1.4	2.5
Cocaine	4.5	2.4	2		3.4	3.1
Ecstacy	2.6	3,2	2		4.3	2.4
Other illicit drugs	> 2.4	6	2	6		3
Any illicit drug	> 35.6 (2)		na			25.2

Notes: (1) the percentage refers to cannabis only (2) national data, London higher than that

Source: Questionnaire on six-city study

Table 5.4: Overview on current trends of consumption

Source	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
	Britisch Crime Survey 2003/ 04 and before, national data, life time prevalence	Comparison of survey 1997 and 2002, life time prevalence	Trends showing in monitoring since 1993, life time prevalence	Diverse studies inclusive youth studies	National data, comparison, life time prevalence	National data, comparisons, life time prevalence
Alcohol	---	Increasing	decreasing	Increasing	decreasing	decreasing
Cannabis	---	increasing	increasing	Increasing	increasing	increasing
Amphetamines	---	stable	stable	---	stable	increasing
Opiates (inclusive heroin	---	decreasing (heroine)	decreasing (heroin)	increasing	increasing	stable
Cocaine	---	---	stable	---	increasing	increasing
Ecstacy	---	stable	stable	---	increasing	---
LSD	---	stable	---	---	stable	---
Any illicit drug	increasing	---	---	decreasing	---	increasing

Source: Questionnaire on six-city study

Among users of psychoactive substances, heavy users, or so-called "problem" or "risky" users are of special concern for public policy. Table 5.5 shows the number of risky or problem users, and this table more clearly than the one before demonstrates how much the definition of drug consumption and drug-related problems differs from city to city: In the cases of London and Frankfurt, the problem user is defined by the use of a drug defined as risky (in the case of London by the law: a substance subsumed to "class A"), in the case of Warsaw and Stockholm it is a person adhering to a certain drug consumption pattern (the pattern defined by substance and/or frequency and/or quantity and/or mode of consumption), in Vienna and in Rotterdam it is a person with a certain consumption pattern plus consequences, the consequences in Vienna being formulated in medical terms ("acute"/ "dependency") whereas in Rotterdam being formulated in "nuisance", i.e. social terms ("criminal activity" / "nuisance causing life style" / "homeless").

Though especially in the field of drug services, the EU has been quite active to promote common approaches for these services, the mix of measures taken still varies considerably between the European countries due to deeply rooted cultural differences in dealing with drug addiction. Beside other differences, the special alcohol and drug services traditionally belong to diverse societal systems and diverse professions are involved (private/ public, local/state level, social care/ health/ labour market/ juridical-penal).

Table 5.5: Overview on the consumption of psychoactive substances: estimates of risky/problem users

	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
For the year/ years	2002/2003	2006	2002	1998	2003	2004
Method	crime survey	capture - recapture	national capture - recapture (city estimate)	national capture-recapture	estimate	estimates
Number in city	5.5% of 16 - 59 years old	2,034	7,500 - 10,000	4,800	3,000	6,000 - 10,000
Definition	use of any class A drug during last year (cocaine, crack, ecstasy, LSD, magic mushrooms, opiates inclusive heroin and methadone	heavy opiate users	persons "suffering of acute problems cuased by a dependency syndrome or opiate misuse developed by the consumption of illegally acquired opiates	heavy drug abusers = intravenious or daily/ almost daily use	problematic hard drug users = persons using opiates, cocaine, amphetamines and other drugs since at least one year frequently (at least 3 times a week during the last month), combined with either (1) criminal acitivy in order to make money and/or (2) psychiatric diagnosis; (3) nuisance causing life style; (4) homelessness	drug dependents= users of hard drugs as heroin and other opiates, cocaine, crack etc. cannabis is excluded
Trend			incrasing since the mid of the 1990s	increasing until 2002, decreasing since then		

Source: Questionnaire on six-city study

The municipal drug services developed in response to drug-related problems are as manifold as the definitions of the drug problem and they in some cases very obviously are much in accordance with the prevailing definitions of problem users (see Table 5.6). As for instance in Rotterdam: Plenty of consumption rooms, shelters, residential treatment, substitution programmes and syringe exchanges seem to be very well suited to keep the nuisance caused by drug consumers using drugs in public as low as possible. But almost all other services as well – including those of social reintegration, working projects and day care – are well developed contrary for instance to London, a city with a presumably higher drug consumption. In London the "conventional medical" as well as "social medical" responses seem to be extended – residential and outpatient treatment, substitution and day care – and it in this respect resembles Vienna, though in the latter some "preventive" and "social responses" – as for instance syringe exchange and working projects – are better developed. In Frankfurt the focus is on the low threshold responses, whereas in Stockholm it is on in-patient care, which in this case is placed within the social sector. Warsaw, the city with the presumably lowest number of problem drug users and also a city in which the drug services only developed in the first half of the 1980s seems to have the least extended drug services.

Table 5.6: Availability of special drug or addiction services for clients with alcohol and drug problems

	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
Referral	++	++	+++	++	na	++
Residential	+++	++	++	+++	+++	++
Outpatient treatment	++	++	+++	++	++	+++
Day care	+++	+	++	+	++	na
Substitution programme	+++	+	+++	++	+++	++
Working projects	+	+	+	+	++	++
Outreach services	+	++	++	+	++	++
Shelter, special housing	+	+	++	++	+++	+++
Syringe exchange	+	++	+++	(none)	+++	+++
Consumption rooms	(2)	(none)	(none)	(none) (3)	+++	++

Note: Degree to which services are appropriate for demand:

Advanced	+++	na	Not available
Fair	++		
Low	+		

Notes: (1) Hardly any intravenous users
(2) Not available (against the law)
(3) Not permitted

Source: Questionnaire on six-city study

Looking at the different integrative responses/ response patterns to drug-related problems is it therefore to be assumed that they are shaped by historically grown and culturally different definitions of substance-related problems (including the degree of stigma attached to them) and of respective reactions towards them. This assumption is reinforced by the results of the city studies presented in Table 5.7: Whereas the drug services in Stockholm are intensively amalgamated with the services for alcoholics and are strongly integrated in the general health and social services, they are much more at the edge ("excluded") of all kinds of other addiction, health and social services in the case of London and Warsaw. The services in Rotterdam, Frankfurt and Vienna are medium integrated, with the drug services in Rotterdam being more intensively interwoven with the alcohol and social services.

Table 5.7: Number of clients of drug and addiction services

	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
Year	2005/06	2004	2004/05	2005/06	2005	2003
In structured treatment	32,629 (increasing)	> 6,000	> 6,500 in 2004 (increasing)	ca. 4,100 (increasing)	3,846 (city) 7,587 (city plus env.)	~ 2,500 (increasing)
Detoxification	na	977 (increasing)				~ 1030
Rehabilitation	na	274 (decreasing)				
Outpatient		6,000 (increasing)		2,600 (increasing)		
In substitution programme	na (1)	436 (stable)	ca. 5,800 in 2005 (increasing) (2)	ca. 1200 (increasing) (3)	1851 in 2004 (decreasing)	~ 1500 (increasing) (4)

Notes:
(1) Nearly all clients in structured treatment are on a substitution programme
(2) About 40% of the clients in drug services are in the substitution programme
(3) Figures are overlapping since detox is a prerequiste to substitution and the latter should be combined with psycho-social treatment
(4) Substitution should go with psycho-social treatment

Source: Questionnaire on six-city study

Table 5.8 shows the number of clients of the drug and addiction services. Again, some caution is necessary: The numbers of clients in structured treatment (beside those of syringe exchange programmes or day care for instance) often overlap with those of a substitution treatment programme. In London it is about 100%, in Vienna around 40%, but it is unfortunately still unclear for the other cities. For this reason the numbers of clients in structured treatment and in substitution programmes had to be looked at separately.

Table 5.8: How well are drug and addiction services integrated with other services?

	London	Warsaw	Vienna	Stockholm (1)	Rotterdam	Frankfurt
Integration with alcohol services	+	+	+	+++	+++	+
Special provision within health care	+	+	++	+++	+	++
Special provision within social services	(none)	+	++	+++	+++	+++
Special provision in prisons	+	++	++	++	++	++

Note: Degree of integration:

strong	+++
Fair	++
weak	+

Note: (1) The "abuse units" and the "dependence departments" are integral parts of the social and health services

Source: Questionnaire on six-city study

Calculating the clients in structured treatment in the "inner" cities, London is by far the leading one with about 1170 drug consumers per 100.000 inhabitants, whereas the other cities are rather close: Rotterdam has some 640 clients per 100,000 inhabitants, Stockholm 530,Vienna 400 and Frankfurt 390.

Since there are no population figures for "inner Warsaw" it is not possible to calculate the respective figures. If the inhabitants of "greater cities" are considered, what presumably makes more sense, because the municipal services usually also serve clients who do not live in the city, the cities differ more, with Rotterdam as the leading one with 560 clients in structured treatment per 100,000 inhabitants, followed by London with 440, Vienna with 360, Warsaw with 350, Stockholm with 220 and Frankfurt with 66. The substitution programme changes the picture again: Greater London (440) is again at the top, now followed by Vienna (320), the rest of the cities including Rotterdam (140) have very low figures reflecting the restricted programmes (Stockholm: 60, Warsaw 26, Frankfurt 40).

To conclude: London and Rotterdam have the most extended structured drug services – though they are very different by nature – whereas the structured drug services in the other cities are much less extended, what in some cases can be explained by a relatively low drug consumption and in others by a focus on unstructured service responses. If substitution is considered – which in most cities should go together with psycho-social care – the picture changes slightly: It is again London were substitution treatment is extended the most, but is now followed by Vienna. Concerning the relatively poor extension of the maintenance programme in Rotterdam it has to be kept in mind that there are only a small number of injecting opiate users, who are the main target group of the substitution services.

Table 5.9 finally depicts the expenditures on the municipal drug services on the different levels as far as possible. Historically grown structures again determine the picture: In Rotterdam, for instance, the budget for the drug services is part of the national as well as the municipal budget for mental health and social services and thus integrated as the drug services themselves. In other states and cities, the drug budget is organised as a special budget on national and municipal level as is the case in Austria and Vienna, though it by far does not cover all expenses concerning drug services. Another main difference concerns the location of the main source for the drug services, which in more cases seems to be at the national level and not at the municipal one. But there is one common trend to be observed: Even if the main source for the drug services is located on the national level, the municipal becomes more and more important. In other words: the cities have increasingly also to carry the fiscal burden of the (global) drug problem.

Table 5.9: Expenditure on drug and addiction services

	London	Warsaw	Vienna	Stockholm	Rotterdam	Frankfurt
Year		2004	2006	2005	2005	2003
Funding from:						
National budget	increasing	increasing	0.15 health/ rsp. social affairs justice (decreasing)	increasing	317 (2)	20 (stable) (3)
Regional/State budget	does not apply	increasing	11 (increasing)	35 - 40 (increasing)		8.4 (slightly decreasing)
Municipal budget	increasing	increasing	--- (1)	45 - 50 (increasding)	47.7 (2)	7.4 (slightly increasing) (4)

Note: absolute numbers need to be recalculated: e.g. as Euro per capita
(1) Vienna is a state
(2) Includes addiction care, mental health and social services
(3) Earmarked for prevention and drug research directly sponsored by the Ministry of Health
(4) Budget only for the drug treatment system in the city excluding costs which are covered by Statutory health and pension insurance or State Welfare institutions

Source: Questionnaire on six-city study

4 Conclusions

The influence of EU-level regulations and ECJ ruling

The complex and often fragmented range of services to promote social integration and reintegration into society do not seem to be strongly affected by either of the core issues of EU-level regulations and ECJ ruling on competition or internal market rules. The country reports underline the important role that not-for-profit providers play in this field, because the provision of such services for users with often multiple needs is often not attractive for commercial enterprises. Specific issues relevant for social integration services include the free choice of providers and in some countries the application or applicability of public procurement rules (in the fields of social assistance legislation, as e.g. discussed in Germany), not least based on rulings of Social Law Courts (*Sozialgerichte*) and decisions of Public Procurement Chambers (*Vergabekammern*).

An interesting finding in the framework of the stakeholder enquiry is the fact that many organisations on the national level are not aware of 'European influences' or at least do not consider them as being of immediate relevance as far as competition law, financial conditions etc. are concerned. If influences are seen they are frequently considered as something like secular trends, expression of 'the times we are living in'. However, on the other hand it had been frequently mentioned that a positive influence comes from European policies – equal opportunities, anti-discrimination policies and the like had been mentioned. In other words, especially general normative frameworks and strong political messages are seen as being influential.

Services for drug addicts

In analysing the situation of services for drug addicts, it is important to keep in mind that these three core aspects of services (health, social, criminal system) are closely integrated for a large number of available service options for many users.

Special alcohol- and drug-related services have been strongly expanding during the past three decades due to increasing undesirable consequences of the consumption of psychoactive substances in industrialised countries, but also due to the changing socio-political and professional understanding of the problem: Addictions are more and more considered to be a chronic illness and has to be dealt with by special interventions. Moreover, the consequences of substance use other than addiction itself have become more important.

According to the new understanding of the problem, the services have been diversified during past decades and, beside care and cure, today they include primary prevention for the whole population almost everywhere in Europe, and low threshold services for socially disintegrated consumers that aim at harm reduction for them as well as for their environment and social re-integration services for long-term addicts by housing and vocational training programmes.

Chapter 6 Labour market services for disadvantaged persons

1 People with labour market disadvantages constitute a sizeable segment of European societies

The objective of provision of labour market services is to promote equality of opportunities and also to facilitate access to rights for all disadvantaged persons. There are numerous international, European and national laws that protect human rights and fundamental freedoms of the vulnerable groups. For instance, since its start in the late 1990s, the European Employment Strategy has placed a particular emphasis on the integration of disadvantaged persons in the labour market. In particular, persons with a long-standing health problem or disability are considered a group at high risk of being excluded from the labour market.

Persons with disabilities constituted 16.2% of the working age population[51] in EU-25 and 17.8% within EU-15 during 2002.[52] The disability prevalence rates differ considerably across countries: Finland (32.2%), the United Kingdom (27.2%), and the Netherlands (25.4%) had the highest rate and Romania (5.8%) and Italy (6.6%) had the lowest rate of working age persons reporting disability (see Table 6.1).

It is not surprising to see that the disability rate is higher for the inactive and the unemployed as compared to the employed. Although there appears to be little difference between males and females for the employed population, the disability rate is considerably higher for males in the inactive population in almost all Member States. Moreover, the disability rate is generally higher among those with lower education, and among the widowed and divorced. The incidence of disability also increases with age (about two-third of disabled people are over age 45) and this implies that the majority of disabled people are not born with a disability but acquire it during their working life.

Altogether, nearly 45 million (i.e. one in six) working age persons in EU27 have reported a long-standing health problem or disability, and a large majority of them are either inactive or unemployed. The inactive and unemployed with disability (as well as those with other forms of disadvantages, e.g. those with low education and long-term unemployed with low work experience) are the main target groups of the labour market services that are offered under national labour market public policies and are undertaken by working with numerous other social partners.

[51] Working age population is persons aged 16-64 years, who are living in private households. Persons carrying out obligatory military service are not included in this count.

[52] These results are drawn from the ad hoc module on employment of disabled people of the Spring 2002 round of the Labour Force Survey. Persons with disability are defined as those who stated that they had a long-standing health problem or disability for 6 months or more or expected to last 6 months or more. Therefore, caution is necessary in interpreting the differences across countries and across subgroups, as survey-based results are affected by how respondents perceive and reply survey questions on disability and health problems.

Table 6.1: Percentage of working age population with disability, by sex and activity status (2002)

	Employed			Unemployed			Inactive			All		
	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females
EU25	12,3	12,1	12,6	16,0	17,2	14,8	24,9	31,0	21,6	16,1	16,3	16,1
EU15	14,3	13,8	14,8	16,6	17,9	15,3	26,0	32,1	22,8	17,8	18,0	17,7
Belgium	12,8	13,8	11,5	22,4	21,6	23,3	28,0	32,4	25,3	18,4	17,9	18,9
Czech Republic	14,5	14,0	15,1	28,4	31,0	26,2	32,2	35,8	30,2	20,2	21,2	19,2
Denmark	13,6	13,6	13,7	19,9	21,5	18,1	45,0	45,7	44,6	19,9	21,1	18,8
Germany	7,3	7,6	6,9	15,8	17,2	14,0	19,7	27,1	15,4	11,2	10,3	12,2
Estonia	18,3	17,5	19,0	24,9	27,1	22,1	34,9	37,5	33,3	23,7	24,2	23,1
Greece	6,5	6,2	7,0	6,5	8,0	5,6	17,0	22,5	14,6	10,3	10,6	9,9
Spain	4,2	4,3	3,9	6,0	7,6	4,9	17,4	28,7	12,5	8,7	8,0	9,4
France	21,3	21,5	21,1	26,7	25,8	27,7	31,4	33,1	30,3	24,6	24,8	24,3
Ireland	6,7	7,0	6,2	10,1	10,7	9,2	20,7	30,1	16,4	11,0	10,5	11,6
Italy	4,4	4,6	4,0	4,9	6,2	3,8	10,2	13,9	8,5	6,6	6,3	7,0
Cyprus	8,3	9,6	6,7	19,6	27,1	13,7	21,5	29,6	18,1	12,2	11,1	13,4
Lithuania	2,9	2,9	2,8	6,2	6,2	6,1	21,2	24,3	19,2	8,4	8,5	8,3
Luxemburg	8,7	10,0	6,9	:	:	:	17,7	27,7	12,8	11,7	9,6	13,7
Hungary	2,3	2,0	2,5	4,4	3,5	5,7	25,5	31,5	21,5	11,4	11,4	11,3
Malta	4,9	5,6	3,3	:	:	:	13,6	27,3	9,5	8,5	7,3	9,7
Netherlands	19,8	20,2	19,2	32,4	30,6	34,2	42,8	48,6	40,1	25,4	26,4	24,5
Austria	9,4	10,3	8,3	17,1	17,9	15,9	20,9	28,0	17,0	12,8	11,6	14,0
Portugal	15,7	14,7	16,9	21,3	20,9	21,6	30,8	32,7	29,8	19,9	21,5	18,3
Slovenia	14,2	14,4	14,0	25,0	30,7	18,9	30,1	32,8	28,0	19,5	19,1	19,9
Slovakia	2,7	2,6	2,8	5,2	5,5	5,0	20,4	25,7	17,2	8,2	8,2	8,1
Finland	27,1	25,1	29,2	26,0	24,2	28,2	51,6	55,5	48,4	32,2	33,6	30,7
Sweden	19,5	17,5	21,8	20,7	19,9	21,7	21,0	20,4	21,5	19,9	21,7	18,2
United Kingdom	20,4	20,2	20,6	28,0	28,7	26,9	48,7	58,1	43,6	27,2	27,8	26,7
Romania	2,5	2,4	2,7	3,1	2,4	3,9	12,0	12,1	11,9	5,8	6,5	5,0
Norway	10,0	9,2	10,8	16,1	18,4	13,5	46,4	52,4	42,4	16,4	15,5	17,4

Notes:
(1) Results are not available for Cyprus, Poland, and Bulgaria.
Source: Eurostat's Labour Market Policy Database (results based on the 2002 LFS disability module)

Source: Eurostat Labour Market Policy Database (Labour Market Policy Interventions, 2004)

Severe forms of disability render these persons highly vulnerable to exclusion from the labour market and contribute to their relatively low labour market participation rate: 78% of the "very severely" disabled, and 49% of the "severely" disabled working age persons[53] in the EU were inactive in 2002, against 27% for the non-disabled. Overall, the employment rate of persons with disabilities is 40%, against 64.2% of non-disabled persons, and the inactivity rate of disabled persons is twice that of non-disabled persons.[54] Most notable reasons underlying low participation rates among the disabled in most Member States are their low employability, benefit traps (i.e. risks of losing benefits on starting work) and the reluctance of employers to recruit disabled workers. Critically, some 43.7% of respondents believe that they could work if they had adequate support, and only 15.7% of disabled persons who need assistance to be able to continue working actually receive it.[55] Given the demographic phenomenon of shrinking labour force in the future, and given the EU agenda of promoting higher economic growth, competitiveness and social cohesion, it is now more important than ever to make full use of the available working capacity of disabled persons and other such disadvantaged persons.

[53] "Very severe disability" applies to those who replied 'considerably' or 'to some extent' to all three questions on restrictions in (1) the kind of work that can be done, (2) the amount of work that can be done, and (3) mobility to and from work. "Severe disability", on the other hand, applies to those who replied 'considerably' or 'to some extent' to two of the three questions.
[54] Eurostat News Release, 142/2003, 5 December 2003.
[55] Op. cit.

The integration of disabled persons into the regular labour market calls for individual services of counselling, care and support. The interface between the education sector and training programmes and job take-up is a key element to the successful labour market integration. In many cases, the transition from education and training programmes to labour market participation also goes hand in hand with a suitable adjustment of social protection programmes. One of the main challenges of labour market integration for disabled persons in a number of countries is the fact that many persons work in sheltered workshops who would be able to participate more fully and take up work in the regular labour market, but that corresponding job offers do not exist, are not functioning properly, or are not available in sufficient numbers.

2 Integrating people with disadvantages into the regular labour market remains a big challenge for Europe

Early retirement and invalidity pensions constitute one of the biggest challenges in the framework of activating social policy in Europe. As a rule, there exists a broad range of curative, rehabilitative and caring services which – following an illness or an injury – aim at restoring the physical functioning to the largest extent possible. In many cases, however, illness or injuries result in permanent restrictions requiring specific adjustments in professional/working life, such as reduced or flexible working hours, the take up of physically less demanding work or functional adaptations of the workplace or of individual tasks. Depending on the degree of illness or injury, a lack of appropriate social services may cause these persons to enter into early retirement, invalidity pensions or out-of-work income support schemes. Moreover, in many instances when the service is available, the reorientation towards labour market reintegration may not be successful entirely due to the lack of a suitable infrastructure (e.g. lack of accessibility to the publicly built environment and information).

New partnership models and modes of provision have seen the participation of several types of stakeholders and providers, sometimes with somewhat different objectives, but all working towards the central objective of professional reintegration. It is nowadays more the chain of actors intervening and the synergy generated in this work reintegration process that matters, rather than the input of each provider taken individually. Competent public authorities remain responsible for the process of work integration as a whole at their respective level, but the provision of services that constitutes the elements of this process can be done by numerous actors and combine various types of resources.

However, the coexistence of providers with different statutes may entail difficulties since the provision and financing conditions for those different types of providers may not be the same. In this context, the question to examine is rather the conditions of cooperation than those of a public-private-partnership, since it is not the outcome (selling a product or a service that matters) but the process of reintegrating disadvantaged persons that counts. Thus the new governance modes set in place (essentially cooperation), the coordination and the chain of public, private for-profit and not-for-profit actors intervening in this process, (establishment of "paths" to be followed), constituting a key factor.

Regulatory and administrative constraints and different framework conditions for different work integration systems or mechanisms may create a problem passed from

one reintegration measure to the other. The main responsibility for ensuring the coherence and the finalisation of a "path" or succession of steps followed by an individual person usually remains within the competent public authority. But the control of such processes with numerous different types of actors intervening in the chain generates more difficulties than beforehand that also entail transaction costs. Those are however very difficult to determine precisely and to evaluate.

Finally, the participation and motivation of the beneficiaries (e.g. the clients) in the management or in the organisation of their reintegration process is a particular challenge, in order to enhance their self-confidence and their own capacity to reintegrate into the regular labour market. Given the characteristics of the beneficiaries, this participation is often quite difficult to achieve. The degree to which this is achieved is an important indicator for the quality (and outcome) of the services provided.

3 How is this sector covered in the study?

In the course of this study, we concentrate on work integration services whose main purpose is to integrate disadvantaged persons into the regular labour market, by enhancing their employability. This goal is mainly achieved through creating job opportunities and training in sheltered conditions and experiences with on-the-job training in order to improve both the social but also the professional abilities of disadvantaged persons and increase their skill levels and opportunities to an extent that they find jobs in the regular labour market.

The providers of services that will be taken into consideration in the study are those which offer “work integration” services in a stable and continuous activity for a large category of beneficiaries, and do not concentrate on particular sub-categories of specifically disadvantaged people only, such as former prisoners, or drug addicts, or only severe mentally disabled, neither on very particular types of professional training, such as the construction sector only, for example. Thus, enterprises and organisations are analysed that offer various support and assistance services with the aim of reintegrating in a permanent and stable way disadvantaged persons back into the labour market.

4 Overview on service provision and expenditures

Labour market policies are essentially the responsibility of individual Member States, and all EU countries have programmes in place to make the labour market inclusive by targeting labour market measures at groups of persons with difficulties in the labour market.[56] In 2004, the total public expenditure on all labour market policies was 2.3% of GDP in EU-25, but with considerable differences across countries with respect to level of expenditures and distribution over expenditures on services of public employment agencies, active labour market policy measures and passive labour

[56] In broad terms this covers people who are unemployed, people in employment but at risk of involuntary job-loss, and inactive persons who are currently not part of the labour force (in the sense that they are not employed or unemployed according to the ILO definitions) but who would like to enter the labour market and are disadvantaged in some way.

market income support policies. For instance, in five EU countries the share of GDP spent on labour market policies was in excess of 3%: Denmark (4.4%) leads the way, and the Netherlands (3.7%), Belgium (3.6%), Germany (3.5%), Finland (3.01%) are slightly behind Denmark. In contrast, many countries spent less than 1% of GDP, most notable being Estonia (0.2%), Lithuania (0.3%), the Slovak Republic (0.5%), Latvia (0.5%) and the Czech Republic (0.5%) – see Table 6.2.

Table 6.2: Active Labour Market Expenditure by categories, as a percentage of GDP (2004)

	LMP Services	LMP active measures						LMP support	Total
	1	2	3	4	5	6	7	8/9	
EU25	0,21	-	-	-	-	-	-	1,42	2,26
EU15	0,22	0,26	0,00	0,12	0,12	0,10	0,04	1,46	2,32
Denmark	0,16	0,54	-	0,46	0,52	0,00	-	2,67	4,35
The Netherlands	0,32	0,36	0,00	0,03	0,56	0,18	-	2,23	3,67
Belgium	0,23	0,20	-	0,15	0,11	0,46	0,00	2,41	3,56
Germany	0,29	0,36	0,00	0,08	0,15	0,13	0,13	2,31	3,45
Finland	0,16	0,41	0,05	0,12	0,10	0,09	0,02	2,07	3,01
France	0,25	0,31	-	0,10	0,09	0,23	0,00	1,72	2,70
Sweden	0,20	0,35	0,01	0,19	0,43	-	0,03	1,32	2,52
Spain	0,05	0,12	0,01	0,24	0,07	0,08	0,03	1,50	2,10
Austria	0,17	0,28	0,00	0,06	0,05	0,04	0,00	1,39	1,99
Portugal	0,11	0,29	0,00	0,17	0,05	0,04	0,00	1,32	1,98
Ireland	0,20	0,18	-	0,07	0,04	0,20	-	0,90	1,59
Italy	0,04	0,23	0,00	0,25	0,01	0,01	0,05	0,76	1,35
Bulgaria	0,07	0,06	-	0,02	0,01	0,37	0,01	0,27	0,82
The United Kingdom	0,36	0,13	-	0,00	0,02	0,00	0,00	0,28	0,80
Romania	0,04	0,00	-	0,06	0,00	0,05	0,00	0,57	0,72
Hungary	0,10	0,05	-	0,09	0,01	0,05	0,01	0,38	0,69
Greece	0,02	0,03	-	0,04	0,03	-	0,06	0,45	0,64
Czech Republic	0,12	0,02	-	0,05	0,03	0,03	0,01	0,26	0,51
Latvia	0,04	0,03	-	0,01	0,01	0,05	-	0,38	0,51
Slovak Republic	0,08	0,01	-	0,01	0,00	0,04	0,02	0,32	0,47
Lithuania	0,04	0,06	-	0,04	0,00	0,05	0,00	0,11	0,31
Estonia	0,02	0,03	-	0,01	-	0,00	0,00	0,18	0,24
Norway		0,09	0,00	0,03	0,54	0,00	0,00		0,66

Notes:

Category 1: All labour market services undertaken or contracted by the Public Employment Services
Category 2: Training
Category 3: Job rotation and job sharing
Category 4: Employment incentives
Category 5: Integration of the disabled
Category 6: Direct job creation
Category 7: Start-up incentives
Category 8/9: Out of work income support and maintenance" + "Early retirement"

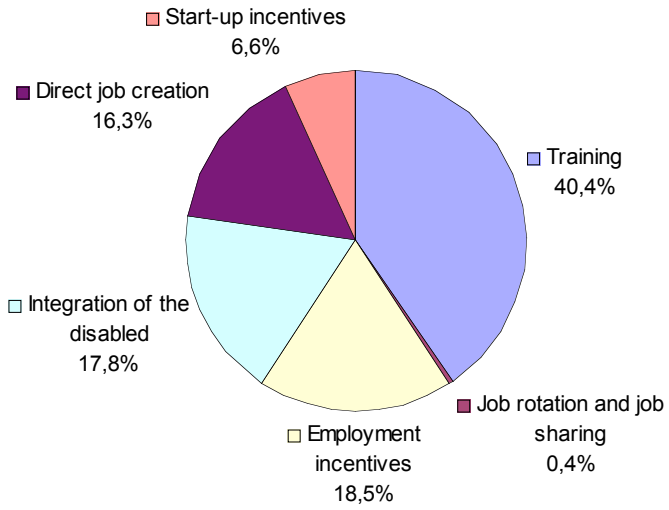
Results for Latvia and Romania refer to 2003.
Results for Cyprus, Malta, Luxembourg and Slovenia are not available.

Source: Eurostat Labour Market Policy Database (Labour Market Policy Intervention, 2004)

The European Employment Strategy and the OECD Job Strategy call for a higher share of the labour market policy expenditures to be made on LMP active measures, mainly for the fact that active measures target specifically labour market reintegration for disadvantaged groups. However, over the past decade, European countries have not made any significant progress in shifting resources from passive to active measures (despite the fact that many governments had declared their intentions to do so). In fact, in the majority of the Member States, the spending on active measures is less than one-half of those made on passive LMP income support policies. The Netherlands, Sweden and Denmark stand out as the countries that spent a relatively higher share of their spending on active measures that aim to promote the integration of disabled persons into the labour market.

In 2004, out of the total expenditure on Active Labour Market Policies (ALMP) in EU-25, 17.8% of the expenditures were targeted towards integration of persons with disabilities alone[57] (see Figure 6.1). Other major categories of expenditures are training (40.4%), direct job creation (16.3%) and employment incentives (18.5%), and it can be expected that in the majority of Member States the disabled persons (along with other disadvantaged groups) will also benefit from these other work integration programmes. It is notable that the distribution of expenditures on these measures differs considerably across EU Member States (see Table 6.3). In the majority of cases, the largest share of expenditures is made on training programmes to improve the employability of the unemployed and other target groups (category 2 in Table 6.3). In the United Kingdom, over 80% of all spending on the active labour market measures are devoted to 'Training'. Estonia (76.9%), Austria (64.8%) and Finland (51.9%) are the other countries that spent a disproportionate amount on training. Sweden and the Netherlands spent a relatively high share of their budget on active labour market measures towards integration of disabled, 43% and 49.7% respectively.

Figure 6.1: ALMP expenditures by category in EU-25, during 2004



Source: Eurostat Labour Market Policy Database (Labour Market Policy Interventions, 2004)

[57] This includes expenditures towards regular and sheltered employment and other rehabilitation and training programmes.

Table 6.3: Share of different categories of ALMPs, 2004

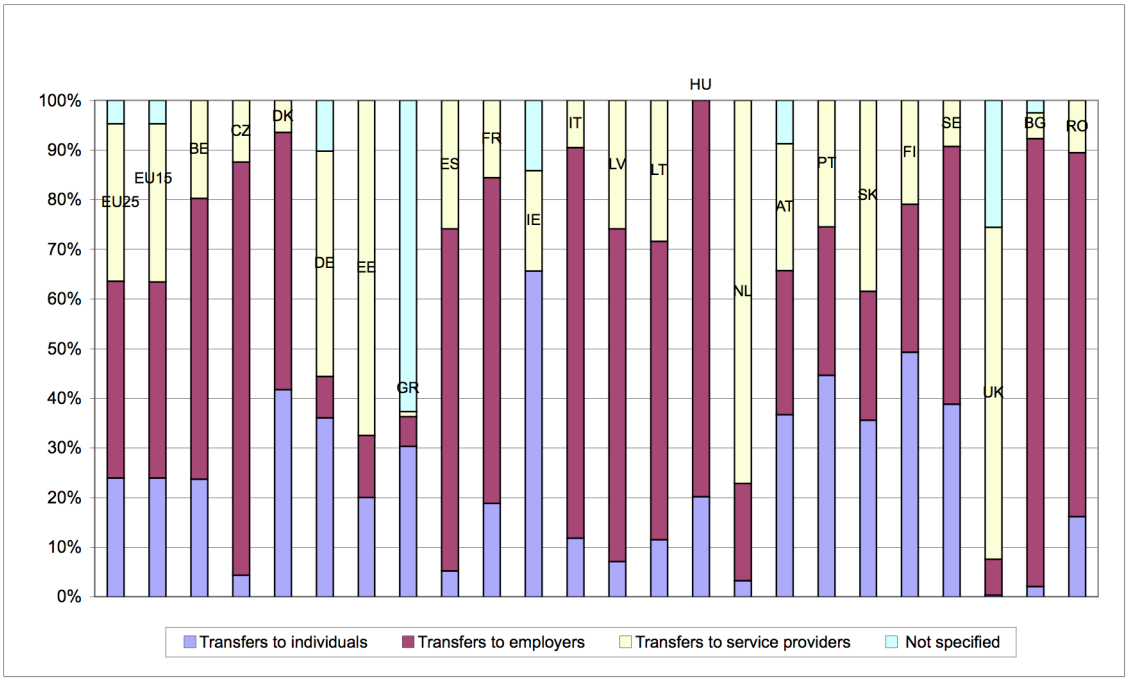
	Categories of ALMP expenditures						
	2	3	4	5	6	7	Total
EU25	40,4	0,4	18,5	17,8	16,3	6,6	100,0
EU15	40,6	0,4	18,2	18,0	16,2	6,5	100,0
Belgium	21,3	0,0	16,5	11,8	50,0	0,4	100,0
Czech Republic	12,8	0,0	35,7	25,0	22,7	3,8	100,0
Denmark	35,5	0,0	30,3	34,2	0,0	0,0	100,0
Germany	42,5	0,2	9,9	17,2	15,1	15,3	100,0
Estonia	76,9	0,0	12,8	0,0	0,0	10,3	100,0
Greece	18,5	0,0	25,3	19,6	0,0	36,6	100,0
Spain	22,2	1,5	42,7	12,8	14,7	6,1	100,0
France	42,5	0,0	13,6	11,7	31,7	0,5	100,0
Ireland	36,8	0,0	14,6	7,1	41,5	0,0	100,0
Italy	41,4	0,5	45,5	1,2	1,8	9,6	100,0
Latvia	33,3	0,0	7,1	8,3	52,4	0,0	100,0
Lithuania	39,8	0,0	25,4	1,1	33,3	0,0	100,0
Luxembourg	0,0	0,0	51,8	22,1	25,4	0,7	100,0
Hungary	22,3	0,0	45,6	4,5	24,9	2,7	100,0
The Netherlands	31,8	0,0	2,6	49,7	15,9	0,0	100,0
Austria	64,8	0,0	12,9	11,9	9,5	0,9	100,0
Portugal	52,8	0,0	31,0	8,3	7,4	0,5	100,0
Slovak Republic	14,2	0,0	10,9	1,3	48,5	25,1	100,0
Finland	51,9	6,5	15,9	12,8	10,9	1,9	100,0
Sweden	34,6	0,6	18,5	43,0	0,0	3,3	100,0
The United Kingdom	82,6	0,0	1,0	13,6	2,5	0,3	100,0
Bulgaria	12,6	0,0	5,1	2,2	78,4	1,8	100,0
Romania	2,6	0,0	53,7	0,4	42,9	0,4	100,0
Norway	13,9	0,0	4,2	81,4	0,1	0,4	100,0

See notes for Table 6.2.

Source: Eurostat Labour Market Policy Database (Labour Market Policy Intervention, 2004)

In terms of the typology of expenditures on ALMPs, they are made either in the form of direct transfers to individuals, employers or service providers, and EU Member States differ considerably with each other in their allocation of these expenditures. For example, in excess of two-third of these expenditures in the Netherlands and the UK are direct transfers to service providers, whereas over two-third of these expenditures in Italy, Latvia, Hungary, Bulgaria and Romania are transfers to employers. In Ireland (65.2%) and Finland (49.2%), a high proportion of all expenditures on ALMPs are direct transfers to individuals (see Figure 6.2).

Figure 6.2: ALMP expenditures by type across EU-25 during 2004



Source: Eurostat Labour Market Policy Database (Labour Market Policy Intervention, 2004)

In terms of coverage, only 15.7% of working disabled persons in the EU-15, and 11.4% of those in the new Member States, were provided with some assistance to work in 2002 (see Table 6.4). In the EU-15 countries, the assistance provided most often concerned the kind of work to be performed (37%), support and understanding by superiors and colleagues (15%), or the amount of work to be performed (13%). In the new Member States, the assistance provided concerned the kind of work (52%) and the amount of work to be performed (33%).

Table 6.4: Working age disabled persons receiving assistance to work, 2002

	EU15	**NMS***
% receiving assistance to work	15,7	11,4
Type of assistance provided to work		
Kind of work	37,1	51,5
Amount of work	13,1	33,3
Mobility to get to and from work	6,4	1,6
Mobility at work	2,7	3,3
Support and understanding by superiors and colleagues	14,8	6,1
Other	26,0	4,2
All	100,0	100,0

* Excluding Latvia, Poland and Bulgaria

Source: Eurostat News Release 142/2003 - 5 December 2003

Source: Eurostat News Release 142/2003 – 5 December 2003

Within the EU we can identify a large variation of national policies and programmes to improve the labour market participation of persons with disabilities. A

review of services on offer is provided in Table 6.5 below. If there are tangible tendencies, they can be synthesized as follows:

- Labour market services for persons with disabilities are based largely on legal acts and regulations. In the process, many acts have been launched or updated, enhanced or revised so as to ensure disability equality and antidiscrimination in all areas of life.
- Programmes are developed by national authorities and implemented more and more by regional or local agencies. The EU-level initiatives (e.g. Disability Action Plan, and the European Employment Strategy), on the other hand, provide guidelines on specific issues and ensure a coherent policy follow-up to the European Year of People with Disability in 2003.
- The agencies at work are mostly public agencies, however there is increasing evidence that in many countries private, semi-private and other social partners join hands with the public employment agencies.
- There is a shift from welfare provision to self-reliance (of the kind called 'Welfare to Work' and followed in the UK and US) and it involves stronger involvement and participation of the users.
- Despite calls for an increasing role of active labour market policy measures, many countries have not made any significant progress on this front.
- The small budgets and lack of service providers and expertise required in dealing with specific needs for persons with disabilities appear to be major obstacles in providing adequate services in promoting employment for persons with disabilities.
- Mainstreaming of disability issues is often sought in the broad range of Community policies that facilitate the active inclusion of persons with disabilities. This strategy involves all relevant Ministries and other levels of government to take into account disability in all their policy domains. This makes disability mainstreaming concrete to the policy-makers, but also assumes that the primary responsibility for mainstreaming lies with them, within their own respective domains.

Table 6.5: Examples of services to promote integration of disabled persons into the labour market

Country	Labour market services to promote employment among disabled persons
Belgium	• Several active measures are in place, including job coaching; a new service to promote diversity plans; and the introduction of 'diversity consultants'.
The Czech Republic	• A new Employment Act in 2004 introduced several new instruments on vocational rehabilitation, training and employment including personal development plans. The initiative 'Supported employment for persons with disabilities' targets severely impaired persons who receive long-term support during their job search. The Transition programme (launched in 2001), as part of the Supported employment programme, has as its main target group the final year students of special schools. The programme is implemented in the Olomouc region. • The Training and Information Centre of the Czech Union for Supported Employment launched a 9-day course for employment consultants, with regard to disabled persons.
Denmark	• In 2004, the Ministry of Employment launched a new employment strategy "Disability and Jobs", which aimed at increasing the number of disabled persons on the regular labour market. The strategy's twelve specific initiatives (including employment and accessibility) is a part of a wider disability policy of the Danish Government adopted during 2003. The broad objectives pursued: the number of disabled persons in the labour market should increase by 2000 every year; and the number of organisations employing disabled persons should increase by 1%. In 2005, the government earmarked an additional 10 million euro for these activities. • The 'Vision Partnership in Denmark', a follow-up to a successful EQUAL project 'Handeplan', focuses on the integration of the visually impaired into the regular labour market. A rehabilitation expert and a visual expert coordinate the individual's participation. The objective of another EQUAL-financed project 'EQUAL Partnership' is to help marginalized groups enter the labour market through the employment of modern technology, notably a portable device that can be instantly consulted when facing a cumbersome situation.
Germany	• In 2004, a nation-wide joint initiative "JOB – Jobs Ohne Barrieren" (jobs without barriers) was launched, through a cooperation between the German government, regional and local authorities, employers, trade unions, disability associations and rehabilitation institutions as well as other types of social partners who promote the training and employment of disabled persons. The JOB initiative follows an earlier campaign "50.000 Jobs for Disabled People" during 1999-2002, which aimed at reducing the number of unemployed disabled persons by 24%. • In 2004, the German government launched another reform that allows disabled persons to receive a personal budget, which replaces the relevant benefits and gives the persons greater responsibility and control.
Estonia	• A case management approach was developed for people with disabilities under the framework of an EU-PHARE Twinning Project between Estonia and the United Kingdom (during 2003-2004). Within the project, officials of institutions providing labour market services at the local level were trained to better target the promotion of people with disability in employment. • In 2004, the Ministry of Social Affairs, in cooperation with various stakeholders, prepared a new concept of labour market policies, within which a new draft law of Labour Market Services was prepared and discussed in the parliament.
Greece	• The Greek Manpower Employment Organisation is implementing special employment measures, such as the Subsidy Programmes for New Jobs and for New Entrepreneurs and the "STAGE" Work Experience Programme in order to integrate persons with disabilities (and other such vulnerable persons) into the labour market. Accompanying

Country	Labour market services to promote employment among disabled persons
	Support Services are also provided to these groups through the Operational Programme "Employment and Vocational Training". Persons with disabilities also participate in special EQUAL actions designed to support their integration into the labour market.
Spain	• In 2004, the government launched the 'Aid for Job Creation' initiative, increasing the 2% target employment quota in the public sector to 3-5%. Income tax credits are also granted to disabled workers. The National Disability Council was established with activities aimed at integrating disabled persons into the labour market within the framework of the Second State Action Plan for People with Disabilities (2003-2007). • In Aragon, through the project INEM, the ESF co-financed subsidies addressed to companies offering a long-term contract (over three years) to a person with any disability. • In 2000, the regional Ministry for Social Services of the autonomous community of Madrid launched a project that aims to integrate disabled persons into the labour market, focusing particularly on persons with intellectual disabilities. An essential part of this integration strategy has been the so-called "labour trainer", charged with the task of mobilizing resources for the purpose of the labour market integration.
France	• A number of services are on offer, and they are outlined in the 2004 National Action Plan on employment. The objective of reducing the unemployment of disabled workers is also set out in detail in the Bill on Equal Opportunities and the Participation and Citizenship of Disabled Persons, adopted by the National Assembly in 2004. The Bill sets out ways to improve professional integration and vocational training levels for disabled persons by making these aspects a compulsory subject for collective bargaining. The Bill also reinforces the need for public and private employers to comply with their obligation to employ disabled workers.
Ireland	• The Supported Employment Programme is an open labour market initiative, which provides support to persons with disabilities. The programme is carried out by sponsor organisations on behalf of the Irish public employment agency. The sponsor organisations employ Job Coaches who provide a range of services tailored to individual needs of jobseekers with a disability. Another special grant is available for employers in the private sector, aimed at retaining workers who acquire a disability in the course of their working lives so that they can continue to work in the same company. • The Workway project is an initiative by the social partners, whereby local networks (comprising of employers, union representatives, persons with disabilities and relevant service providers) provide a forum for the sharing of knowledge of the local employment opportunities for persons with disabilities and to enable solutions to remove employment barriers that exist.
Italy	• There is a close cooperation of public employment agencies with private and semi-private employment agencies to integrate disabled persons into the labour market. At the centre of all labour market services, there is the reform package that has increased flexibility in the labour market, promoting "welfare to work" policies. • The 2003 mid-term review of European Social Fund programmes increased funding devoted to persons with disabilities (and other such disadvantaged persons). In addition to the regional programmes, two national programmes finance services in this field, in particular specific information, training and support to employment services and awareness raising activities on the opportunities provided for by the national law. The Legislative decree 276/03 (reform of the labour market) provides new paths to widen opportunities for access to the labour market for persons with disability, with stronger involvement of social cooperatives alongside enterprises. • Furthermore, according to a monitoring report conducted by ISFOL, 81% of the Provincial Employment Services in 2003 provide specific services to deliver information on focused employment. Data regarding the involvement of disabled

Country	Labour market services to promote employment among disabled persons
	persons in the EQUAL programme for the period 2003-2004 indicates that almost 6,000 disabled persons have been participating in EQUAL projects related to employability and employment, adaptability and equal opportunities promotion.
Latvia	• The European Social Fund supports the integration of disabled persons into the labour market, through (i) training for groups at risk of labour market exclusion, including ICT support for disabled persons; (ii) subsidised employment and the development of entrepreneurship and self-employment; (iii) widening the scope of social rehabilitation programmes; (iv) development of pedagogical correction programmes; (v) integration of young persons with special needs into the general education system. • Additional activities to improve the situation of persons with disabilities in the labour market are taken under the EQUAL initiative. For example, the EQUAL programme co-finances the project 'Silent Hands' implemented by the Latvian Association of Deaf People. The project intends interventions in all spheres and systems connected to the employment of deaf persons, and to develop preconditions for the social reintegration of women with hearing disabilities. • In 2005, the Policy Guidelines for Reduction of Disability and its Consequences for the years 2005-2015 were approved by the Cabinet of Ministers. There are four main ways of action in the Policy Guidelines regarding the policy on persons with disabilities: (i) employment of persons with disabilities; (ii) prevention of the disability; (iii) new approach to assignation of disability; (iv) new social services and social protection measures for persons with disabilities. • The activities under the measure “The Development of Education, Health Care and Social Infrastructure” promote the accessibility and equal quality of the employment, social assistance, and health and education services in all regions by enhancing service institutions.
Hungary	• The employment of disabled persons in public administration is promoted by the Equal Opportunity Plans, which assist the integration of disabled persons into the regular labour market with several ministries having appointed equal opportunities officers for this purpose. • Two measures within the Human Resources Development Operational Programme are specifically focused on the improvement and employability of disadvantaged persons and on the promotion of social inclusion through the training of professionals working in the social field. • In addition, an EQUAL project entitled "Chance for Normal Life" has aimed at enhancing equal labour market chances for the mildly mentally disabled and disadvantaged young Roma people.
Malta	• Through the Employment and Training Corporation and the European Structure Funds, a scheme has been introduced whereby persons with a disability are given specialized and personalized long-term support in order to enter and be retained in the labour market.
Netherlands	• The Ministry of Health, Welfare and Sport has also developed a Disability Mainstreaming Checklist (‘Handreiking’) that has been distributed to all Ministries. The objective is to assist other Ministries and other levels of government to take into account disability in all their relevant policy domains. • In addition to all disability mainstreaming policies, the integration of disabled persons is also carried out through a number of EU-funded projects. For example, the project 'Tante Truus' (Aunt Truus) is aimed at the integration of disabled persons with mental health problems into the labour market through practical training and education.

Austria	• The 'Clearing' initiative is an innovative solution, as it focuses on the period between the school end and the first job and establishes detailed personal development plans to increase employability. • Furthermore, the Federal Disability Equality Act shall ensure disability equality and anti-discrimination in all areas of life. The act has come into force on 1 January 2006. The federal government also aims to increase the employment rate of disabled persons through its Employment Offensive for People with Disabilities (Beschäftigungsoffensive). The Employment Offensive of the Austrian Government for persons with disabilities, which started in 2001, has a strong impact for combating unemployment among disabled persons and is increasing their labour market participation. A large number of measures and projects are promoted throughout the Employment Offensive.
Poland	• In consultation with the social partners, a National Social Inclusion Strategy was adopted in June 2004, setting out clear objectives and quantifiable targets of the social inclusion policy until 2010. Several projects aimed at the integration of disabled persons into the regular labour market have been launched within the framework of the Polish Sectoral Operational Programme for Human Resources Development. • The Polish Association for Persons with Mental Disability has also been implementing a project entitled 'Raising skills of personnel providing services to persons with disabilities'. The Institute of Public Affairs Foundation manages a project focusing on the development of various flexible forms of employment and vocational training for disabled young persons. • Through the project 'To job without words', the University of Information Technology and Management is preparing 10 regional branches of the Polish Association of Deaf People to make the labour market integration of disabled persons more effective.
Slovenia	• The Act on Vocational Rehabilitation and Employment of Persons with Disabilities adopted in 2004 will help create suitable work places and conditions for work, and relocate the resources from passive to active measures in the area of employment. The Act brings in place a range of financial incentives for the employment of disabled persons such as: (i) subsidising wages of persons with disabilities, (ii) payment of the costs for the workplace adjustment and means of work, payment of the costs for the services in supported employment, (iii) dispensation of the costs for the pension and disability insurance of persons with disabilities, (iv) rewards to the employers for exceeding the quota and yearly rewards for good practice in the field.
Finland	• The Act on Social Enterprises, coming into force on 1 January 2004, aims at promoting the employment of the disabled and the long-term unemployed. A corporation, a foundation or any other registered trader may apply to enter in the register of social enterprises. A disabled person and a long-term unemployed person are included in the percentage of placed employees for as long as subsidies are paid towards their wage costs.
Sweden	• Government adopted a three-step model in order to enhance the effectiveness of the measures for the occupational disabled. Initial vocational guidance will be followed by rehabilitation located in the workplace if considered necessary by the Public Employment Service and regular work has still not been found. Sheltered work at state owned Samhall AB or another employer would also be possible.
United Kingdom	• In 2005, the 1995 Disability Discrimination Act was extended and amended, conferring additional rights concerning employment and education and reinforcing the anti-discrimination law. In January 2005, the Prime Minister's Strategy Unit called for an ambitious vision towards greater inclusion of disabled persons in the labour market and in the society. Other examples of work integration of disabled include an award recognising those employers that have adapted good practice in the employment of

	disabled persons in terms of recruitment, retention and participation policies (applicable in Northern Ireland only). Another example is that Essex County Council has established an Independent Advocacy Service staffed largely by disabled persons. This body is involved in policy-making at County Council level, including holding the Council to account on issues such as its target for employment of disabled persons.

Source: Communication from the Commission to the European Parliament, the European Economic and Social Committee and the Committee of the Regions. "Situation of disabled people in the enlarged European Union: the European Action Plan 2006-2007", Annex 3.

5 Lessons from case-studies undertaken within this project

Five countries have been chosen for in-depth country studies of several aspects of labour market services for disadvantaged workers. These countries are the Czech Republic, Germany, Poland, Sweden and the United Kingdom. National experts generated the national reports and they addressed a number of interlinked aspects of labour market services available to disadvantaged workers in their country.

The five country studies show that the need to adapt to the evolution of users' needs, structural reforms in view of organisation, regulation or financing and concerns about financial sustainability of service provision are the main issues at stake for the labour market integration of disadvantaged persons (Figure 6.3). In contrast, the affordability of services for private households and potential frictions with the EU-law and the implementation and/or repercussions from ECJ jurisprudence are not a dominant issue in the countries in question. Another recurrent theme is a concern for the availability of a sufficient quantity of good quality services (this is true in all countries except the UK).

In addition to issues outlined in Figure 6.3, some of the common themes emerging from the country studies are:

- Government agencies need to avoid potential conflicts between their policies (an example is the potential tension between the Department of Work and Pensions and the Department of Education and Skills in the UK).
- Larger contracts and cost-cutting initiatives drive out local third-sector providers, thus endangering local tailor-made policies and delivery of products.
- National targeting of priority groups is not always relevant locally (certainly not to all local authorities).
- The decentralisation of statutory bodies to the local level is lacking in many countries.

In addressing the issues outlined in Figure 6.3, the UK and Germany have initiated several reforms in the provision of labour market services to disadvantaged persons. The costs containment has been a very important factor in the UK, and the same consideration is not very important in the Czech Republic (see Figure 6.4). Germany and the UK have also assigned more importance to the introduction of new types of services or programmes and to substantial changes in the scope of public service provision and of public funding.

Figure 6.3: Main issues at stake for labour market integration of disadvantaged persons

Main issues at stake	*Country*			
	CZ	*DE*	*SE*	*UK*
Need to adapt to the evolution of users' needs or to better tailor the supply of services	2	2	2	1
Structural reforms in view of organisation, regulation, financing (including changes in entitlement conditions for users of services)	3	1	2	2
Concerns about financial sustainability of service provision	2	2	2	4
Cost cutting and/or effects of measures to increase efficiency	4	2	3	1
Financial constraints on budgets of public territorial authorities (on national, regional, local level)	5	2	3	1
Implications of introduction of (quasi-) market or of competition from private for-profit providers	5	2	3	1
Introduction or extension of new regulatory or administrative measures	4	2	3	2
Availability of a sufficient quantity of good quality services	2	2	3	4
Problems with low-quality services	2	2	3	4
Co-existence of different types and status of providers	4	3	2	3
Availability and qualification of personnel	3	4	3	2
Demographic trends and other (macro) socio-economic developments	2	4	3	4
Affordability of services for private households (e.g. avoiding high cost-sharing requirements)	3	4	3	
Potential frictions with EU-law and the implementation and/or repercussion from ECJ jurisprudence	4	4	4	3

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5

Source: Questionnaire for in-depth country studies

Figure 6.4: Main evolutions in labour market integration of disadvantaged persons

Main evolutions	Country			
	CZ	DE	SE	UK
Structural reforms in view of organisation, regulation or financing	4	1	3	1
Cost containment measures	4	3	2	1
Introduction of new types of services or programmes	4	2	3	2
Quality assurance and improvement initiatives	4	3	3	2
Substantial changes in the scope of public service provision and of public funding	5	2	4	2
Substantial change in private cost-sharing	5	4	3	

Note: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

In most cases, the regulation, financing and delivery of these labour market services are shared responsibilities between national, regional and local authorities (see Figure 6.5). The framework legislation is often formulated at the national level, while detailed regulations and the delivery of services are frequently delegated to the regional and local level.

In the Czech Republic, Germany and the UK, the national government is most involved, whereas the national government is least involved in Sweden and Poland. Poland and Sweden stand out as the most decentralised countries, as the district authorities are most involved. In all countries, the regional level authority has some degree of involvement in the provision of labour market services to disadvantaged persons. As for the long-term care services, the devolution of competencies of organising labour market services to the local level has resulted in differences in the way service delivery assessment is implemented, and in differences in the generosity of services, due to differences in local budgets available. This is, for example, the case for Sweden and Poland.

Figure 6.5: Competent public authorities for labour market integration of disadvantaged persons

	Country				
Competent public authority	*CZ*	*DE*	*PL*	*SE*	*UK*
National government	1	1	3	4	1
Regional territorial authority (state; province)	3	2	2	3	3
Local territorial authority		3			
• District	4		1	1	4
• Municipality				2	3
Social insurance agency		3		5	
Note: Ranking from 1 (Most involved) to 5 (Least involved)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

Ensuring provision of services in the labour market integration of disadvantaged persons is obviously a complex phenomenon, and it has been undertaken by means of delegation in all countries (except the Czech Republic). Almost all countries had in place legal stipulations valid for all types of providers (the only exception is Germany). Tendering is also very common in Poland, Sweden and the UK (see Figure 6.6). Quality control is ensured only in the UK and Sweden.

Figure 6.6: Ensuring provision of services in labour market integration of disadvantaged persons

	Country				
Form of intervention	*CZ*	*DE*	*PL*	*SE*	*UK*
Accreditation	x			x	x
Delegation		x	x	x	x
Tendering			x	x	x
Public-Private Partnership (PPP)					
Subsidies	x	x		x	
Legal stipulations valid for all types of providers	x		x	x	x
Quality control				x	x

Source: Questionnaire for in-depth country studies

In almost all countries, the mode of governance in the provision of services is quasi-market, one in which there is considerable competition among suppliers, who are public, private-non-profit and private-for-profit organisations. The UK exhibits a relatively large share for the public organisation (60%), and the rest is divided equally between the two types of private organisations (see Figure 6.7). In other countries (Sweden, Germany and the Czech Republic), public institutions take up the major market share of the service provision activities (in excess of 80%). All forms of regulatory mechanisms (viz. accreditation and certification and those related to service provision requirements) are observed in Sweden. Other countries restrict themselves to either certification only (Germany) or to service provision requirements only (Poland and the Czech Republic).

Figure 6.7: Organisation of services provision in labour market integration of disadvantaged persons

	Country				
	CZ	*DE*	*PL*	*SE*	*UK*
2.4.1 Approximate "market" shares					
Public	90%	90%		80%	60%
Non-profit	5%			10%	20%
For-profit	5%			10%	20%
2.4.2 Mode of governance					
Market	x				
Quasi-market (competition between providers and purchasing by a public agency based on regulations)	x	x		x	x
Planning	x		x	x	
Other (please specify)					
Service cheques for purpose of services					
User and worker's cooperatives				x	
2.4.3 Type of regulatory mechanism					
Related to authorisation regimes for service providers					x
• Accreditation				x	
• Certification		x		x	
Related to service provision requirements	x		x	x	

Source: Questionnaire for in-depth country studies

There could be various types of requirements that suppliers have to satisfy in attaining public financial support in providing labour market services to disadvantaged persons (see Figure 6.8). Almost all countries require an annual activity and financial report (with or without separate accounts) – the only exception is Poland. A license (e.g. for authorisation, agreement, and/or accreditation) is required in the Czech Republic, Sweden and the UK. In Poland and Sweden, the bidding procedures imply that the service contract is offered to those who provide a service with the least financial support requested from the public purse, and this method has important implications for the quantity and quality of services provided.

Figure 6.8: Requirements for public financial support in labour market integration of disadvantaged persons

	Country				
Type of requirement	*CZ*	*DE*	*PL*	*SE*	*UK*
Authorisation/agreement/accreditation/ licence	X			X	X
Annual activity and financial report (with or without separate accounts)	X	X		X	X
Simple one-shot demand					
Recurrent (annual) demand	X				X
Bidding procedure to offer/provide a service with the least financial necessary support requested			X	X	
Integration into provision/supply plan (social planning)	X			X	X

Source: Questionnaire for in-depth country studies

In the in-depth country studies, very useful information is available on how labour market services will be provided to three typical disadvantaged individuals. These case vignette studies shed important light on how provision of services functions in the countries in question. The prototype individuals (Mr. E, Ms. F and Ms. G) are all seeking to find a suitable job for themselves and have different forms of labour market disadvantages. Mr. E, who is aged 17, has a low education, no work experience and distant residence disadvantage. Ms. F, who is also aged 17, is quite similar to Mr. E but she also has a learning disability. Ms. G, on the other hand, is a professional accountant with a good deal of work experience; she is aged 44.

Boxes 6.1, 6.2 and 6.3 below provide more details on the characteristics of these individuals and also report on how they will be treated in four countries (the Czech Republic, Germany, Sweden and the United Kingdom) in terms of labour market services.

Box 6.1: Labour market services focusing on disadvantaged persons: Case Vignette E

Mr E, aged 17 did not finish elementary school, or only with a degree that clearly shows that his educational achievement is below the level that is usually required on the labour market (for example he has deficits in basic literacy), given the overall difficult situation on the labour market for young persons. He has no professional experience, and did not succeed in entering the job market as trainee. Mr E is now deeply de-motivated with finding a job, especially because he already received numerous negative answers to his applications. He has now effectively stopped pursuing an active job search. Mr E lives with his parents, who are both long-term unemployed in a medium-sized city in a rather sparsely populated area and is dependent on public transportation. What services are provided, offered, or at his disposal to "activate" his job-search? Do local or pilot projects exist to offer him first work experience?

The United Kingdom: Mr E would be a prime target for New Deal for Young People where he would probably enter the Gateway phase. NDYP starts with a period known as the Gateway. On the Gateway participants receive up to four months of intensive, personalised help and support, initially designed to help find an unsubsidised job. From there his Personal Advisor might either direct him to a low-skilled job or he might be moved into a job and training programme – the latter to address his literacy and low skills. He could possibly claim fares for interviews, as transport is difficult to and from his distant residence. However, he has not worked and is de-motivated, so even if he entered a job or training scheme he might not be able to sustain this. If he dropped out without good reason he might face a benefit reduction as one of the sanctions available to the Job Centres. Provision for 'difficult clients' who are at some distance from the labour market is probably not as effective as for those close to the labour market under standard programmes and it has been noted that there is much 'churn' of young people in particular. He might be fortunate to have an active neighbourhood organisation in his area with a youth outreach team – these might be able to provide more informal and individualised support to him. He might be assessed by his **Personal Advisor** to be distant from the job market and so directed to the Job Centre's 'Step up' programme; or the Training for Employability option that would aim to enhance his basic skills prior to him making applications for work. Alternatively he might decide to 'drop out' of the system for a while by not claiming benefits. Living at home might be feasible although it would probably put a strain on the families' finances. The NEET (Not in Employment, Education or Training) group of young people is being recognised as a small but important problem. Some young people in this category gain an income from working in the informal or unofficial economy.

Germany: With the age of 17, vocational school attendance would be compulsory for Mr E in Germany. For adolescents who come under the compulsory school attendance and who are neither in an apprenticeship nor have a job, a year of vocational preparation (Berufsvorbereitungsjahr) is offered. The vocational preparation is a professional school, which is organised as a yearlong full-time school and is regarded as a full-time vocational school (Berufsfachschule). The students can broaden their general educational background and are supported in the acquirement of key qualifications. Furthermore, the vocational preparation imparts basic knowledge in up to three occupational areas and therefore facilitates orientation during the process of occupational decision. At the end of the vocational preparation, students who choose to pass an additional exam acquire a degree equivalent to a certificate of secondary education (Hauptschulabschluss). The year of vocational preparation is, however, not credited against a following apprenticeship. The requirement for admission to vocational preparation is eight years of attendance in school of general education. If Mr E does not find a job or apprenticeship after the vocational preparation, he is entitled to an unemployment benefit (Arbeitslosengeld II, ALG II). According to the social legislation (SGB III), all job applicants in need between 15 and 65 years who are living in Germany have a right to basic financial security. Details are explained in legal terms in SGB II. However, according to § 2 SGB II, Mr E has to "*seek to end or reduce their need for help in every possible way*" (own translation), i.e. he has to actively look for an occupation. With his passive attitude, Mr E would thus lose his entitlement to ALG II.

The Czech Republic: Mr E belongs to a group of job seekers requiring increased attention. Working in conjunction with Mr E, the labour exchange could devise an individual action plan. This plan will set the progress and timetable of implementing individual measures to improve Mr E's chances to enter the labour market in line with his qualifications, abilities and potentials. Since 2004, the nationwide (all Czech labour exchanges) "First Chance" individual action programme has been applied to under-25 job seekers registered by the labour exchanges for not more than six months. Its objective is to offer jobs or to raise the employability of the job seeker through consultations, training, requalification or internship. Depending on his domicile, Mr E could be included in a targeted regional employment programme (43 regional projects were underway in 2006). His labour exchange could offer Mr E with a requalification and consultation programme. Requalification means acquiring new qualifications or extending existing ones. The content and scope of requalification is determined by the existing qualifications, health condition, abilities and experience of the job seeker. Labour exchanges can buy consultative services from other organizations. The public agency, through the labour exchanges will play the leading role in the case of Mr E. By international comparison, however, their capacity and personnel is insufficient.

Sweden: For young people (below 18) the parents are responsible for Mr E's support and he is not entitled to the "Youth Guarantee" or a "Youth Programme" (two measurements to integrate young people on the labour market) until he is 18. Measurements are taken to integrate young people such as the Apprentice programme that the Swedish Employment Agency introduced in the beginning of 2006. The target group is young people without degree and professional experience. The aim is both to integrate persons like Mr E so that they will have work experience, and to contribute to the industry's needs of labour force. But, one has to be between the age of 20 and 24 to be entitled to this support.

Box 6.2: Labour market services focusing on disadvantaged persons: Case Vignette F

Ms F, aged 17 has a severe learning/mental disability. She is now above the age of compulsory school attendance. She has attended either a school for pupils with learning/mental disabilities or an integrated school. Ms F has no school-leaving certificate and is not able to read and write. However, with sufficient training she is able to use the local public transport system. She likes basic handcraft and household work. She has a fair ability to express herself, however, stutters. Her parents would like to support her and look for suitable job offers. Which services in form of counselling for labour market integration, professional orientation and qualification are available? What are potential employers and which type of financial support is provided? Which public authorities or providers are responsible to deliver the service, which are responsible to co-ordinate them? The parents are not sure if their daughter can actually be integrated into the regular labour market. They therefore intend to obtain more clarity in this regard. Are the services offered identical for different types of handicap (especially for mentally and physically handicapped persons)? What are the effects on the entitlement for cash-benefits (social support) from taking up an employment?

The United Kingdom: New Deal for Young People might be able to help Ms F gain a low skilled job and some training. However it is more likely she would enter the New Deal for Disabled People due to her learning difficulties – a more flexible programme delivered by specialist providers (often third-sector organisations on contract). There have been reports by such specialist third-sector agencies that people with learning difficulties are hard to place as employers tend to be reluctant. She might, alternatively, also be offered the Training for Employability Skills to improve her general skills and confidence around the workplace. Her supportive parents might be able to assist and support her with assignments or homework. She might be fortunate to live in an area where there is a dedicated social enterprise, such as a Social Firm or other Work Integration Social Enterprise, which takes on people with disabilities and their special skills. Such a 'protected' employment or training project could benefit Ms F but this would not necessarily be available in the area Ms F resides in.

Germany: Disabled persons in terms of the social legislation are people, whose chances to participate in working life are not only temporarily but permanently reduced because of the type and heaviness of their disability (§ 2 Abs. 1 SGB IX) and who are therefore dependent on aid. Also learning-disabled persons fall under this definition. For this reason, Ms F is disabled according to SGB IX. The benefits in order to support the participation of disabled persons in working life in Germany are distinguished as follows: There are so-called general benefits and special benefits. Part of the general benefits is notably the support of professional training of young and adult disabled persons. Part of the special benefits of the promotion of employment are, amongst others, the provision of a training benefit (Ausbildungsgeld), a transition benefit (Übergangsgeld) or the refund of the costs of special training courses for disabled persons. A training benefit is provided during apprenticeship, vocational preparation or a training course in an accredited workshop for the handicapped. Ms F could take advantage of this training benefit and acquire a certificate for her talent for handicraft. The training benefit is based upon age, family status and living situation of the disabled person and is dependent on their income or the income of their parents or partner. After the apprenticeship or advanced vocational training, Ms F is entitled to a transition benefit.

The Czech Republic: Ms F would be eligible for a contribution under the Social Services Act according to the ascertained state of dependence. She would probably also receive at least a partial disability pension, and possibly also other social security benefits. These benefits are financial and do not involve services to assist labour market inclusion. The Czech labour authorities provide special services to assist the labour market inclusion of disabled people according to the type of disability – work rehabilitation, preparation for jobs, specialized requalification courses, individual action programmes, and mediation of jobs in protected workplaces or workshops. The purpose of work rehabilitation is to help the clients to acquire and retain suitable employment. Work rehabilitation comprises job selection consultations, theoretical and practical preparation for a job, and creating favourable conditions for the discharge of jobs. The labour exchange either provides work rehabilitation or may authorize another person or organization to provide this under a written contract. The labour exchange will work with Ms F to produce an individual plan of work rehabilitation. Preparation for a job entails training Ms F for a suitable job on the basis of an agreement with the labour exchange. Preparation for a job may proceed with the help of an assistant. This period shall not exceed 24 months. The protected workplace means a job created by

the employer for Ms F under a written agreement with the labour exchange for a period of at least two years. Alternatively, Ms F could benefit from a socially suitable job with a subsidized wage. This service, including the wage subsidy, is also provided by the labour exchange. Socially suitable jobs are created by employers under an agreement with the labour exchanges and are filled with the job seekers that cannot get work in any other way. Labour exchanges keep records about disabled persons, specifying their health limitations. In the non-profit sector, Ms F could avail herself of the supported employment services currently offered by 42 Czech providers (nongovernmental non-profit organizations). Supported employment is a temporary service to people with individual needs due to their reduced ability to find and keep suitable jobs (disability, drug addiction, release from jail, etc.), which nonetheless seek paid jobs in a normal working environment. Within the framework of these services, Ms F would be offered help in finding individually a suitable job "made to measure", either directly at her workplace through work assistance or by means of long-term support outside the realm of her workplace (legal advice, training to acquire necessary skills, etc. Supported employment is provided for a maximum of two years. This period may be extended only in justified cases

Box 6.3: Labour market services focusing on disadvantaged persons: Case Vignette G

Ms G, aged 44 has for 18 years been successfully working as an accountant. Some weeks ago, during work, she suffered a stroke attack. The treatment and rehabilitation have meanwhile been completed. Ms G is currently bound to a wheelchair and has a linguistic impairment to express herself but otherwise could fulfil her former job requirements with the PC as main tool. Due to her invalidity Ms G receives an early retirement pension (or social assistance benefits). She has two children and is divorced. She looks for a new job, either as accountant or as administrative assistant. Ms G would clearly prefer to do telecommuting, however, would also accept to work part-time outside the house. Which forms of support are available for Ms G? Which are the criteria to distinguish between an entitlement to an early retirement pension or to social assistance benefits? What are the consequences of any employment with regard to a possible withdrawal of social benefits for the woman and her children?

The United Kingdom: Ms G would receive some basic support from the Job Centre – directing her to touch screens and job vacancies and advising her on the local job market. However she is a professionally skilled worker and, in this case, would probably know her own field and the opportunities as well if not better than the Advisors. She would be better to seek the specialist support available from the New Deal for Disabled. Here she would, voluntarily, see a Job Broker who will be a worker from a specialist agency – possibly a third-sector or for profit agency - appointed on contract from the Job Centre. There is likely to be a range of different Job Brokers in her area and they will be able to offer different services. With the Broker she should get support to think through the kind of work she could now do, what steps she might need to take to get her closer to a job and what the Job Centre could offer. For example she – or her future employer – could get some support for aids and adaptations, either

in her home or in the employer's office. A previous programme offered 'work trials' whereby a disabled person could try out working for a short while without losing benefit if she later had to withdraw because she could not cope. At a second stage she could get help matching her skills to local employers, identifying any training needs and assistance with applying for jobs. There could also be support – in the form of visits – during the first 6 months she was in employment. Changes to the rules around Incapacity Benefit in 2007 could mean the voluntary element of such programmes could end and she could expect to face greater encouragement by the Job Centre to gain work or take pro-active steps towards employment.

Germany: In Germany, early retirement as a consequence of unemployment or a reduction of the earning capacity is generally possible. In order to be entitled for an early retirement as a consequence of unemployment, the following requirements have to be met: The person concerned has to be insured for at least 15 years (Wartezeit), eight years of compulsory contribution during the last ten years before the commencement of retirement are required, a specific age has to be reached and the person has to be either unemployed on retirement or be unemployed at the age of 58 years and six months for 52 weeks. Insured persons who were born before 01.01.1952 may generally draw on a pension according to early retirement as a consequence of unemployment. Insured persons below this age are not entitled to this type of retirement. Ms G, who is 44 years old, is thus not entitled to an early retirement as a consequence of unemployment. Entitled to a disability pension are persons whose earning capacities are partly or fully reduced. It is required that they have been insured for at least five years (Wartezeit) and have contributed at least for 36 months during the last five years. According to the German public pension insurance (Deutsche Rentenversicherung), a reduction in the earning capacity is defined as a limited performance due to illness or disability. Persons whose earning capacities are partly reduced are distinguished from persons whose earning capacities are fully reduced. A partly reduced earning capacity is ascribed to those who are able to work between three and six hours per working day under the ordinary conditions of the labour market. A full reduction in earning capacity is ascribed to those who for an indefinite time-period cannot work for three hours per working day. Ms G is not entitled to a disability pension, because she is able to work full-time as an accountant. First of all, Ms G would be entitled to unemployment benefits ("Arbeitslosengeld I"). Entitled to unemployment benefits are unemployed persons who have applied for unemployment benefits at the Federal Employment Agency (Bundesagentur für Arbeit), have completed the qualifying period (i.e. in the last two years before applying for unemployment aid they have worked for at least twelve months in a job liable to insurance deductions). The duration of entitlement to "Arbeitslosengeld I" is one year. After this period, Ms G is entitled to "Arbeitslosengeld II". In case that Ms G likes to work part-time, she would have to consider the conditions under which an additional income is possible for beneficiaries of "Arbeitslosengeld II". Currently, three income levels are distinguished: In case of a gross income of less than 400 €, 15% of the net income is not credited against the benefit. In case of a gross income of between 400 and 900 €, 30% of the net income is not credited against the benefit and in case of a gross income of between 900 and 1.500 €, again 15% of the net income is not credited against the benefit.

6 Conclusions

People with disabilities, while experiencing difficulties in finding suitable work, are a vital source of untapped potential for enhancing economic growth in EU countries. It is therefore crucial to implement on all levels of labour market policy "active inclusion" of people with disabilities, especially with a better access to services and programmes that will help them to get a job in the open labour market or in sheltered workshops.

It is obvious that people with disabilities require more assistance in developing their skills and abilities. Thus, advisers and trainers need to be better trained so that they understand how each client learns best and tailor their teaching and support to the disabled person's individual needs. To make these strategies increasingly successful, a new and more effective kind of partnership between the stakeholders involved is crucial and dialogue should take place on all levels of implementation. Moreover, in many instances when the service is available, the activation policies towards labour market reintegration will have to accompany creation of a suitable infrastructure ensuring accessibility to the publicly built environment and information.

The interface between the education sector and training programmes and job take-up is a key element to successful labour market integration. Moreover, in many cases, the transition from welfare benefits to labour market participation also requires a suitable adjustment of social protection programmes. One other challenge arises out of the labour demand side, as in a number of countries many persons work in sheltered workshops who would be able to participate more fully and take up a work in the regular labour market, but corresponding job offers do not exist, are not functioning properly, or are not available in sufficient numbers.

Finally, the participation and motivation of the beneficiaries in the management and organisation of their reintegration process remains a particular challenge. The degree to which the reintegration process can enhance their self-confidence and their own capacity to reintegrate into the regular labour market is an important indicator for the quality (and outcome) of the services provided.

Chapter 7 Childcare

Childcare services play a crucial role for a number of policy targets. The most important goals are to foster healthy and sound development, socialisation and education of children on the one hand and to help parents to reconcile work and family life on the other. Childcare also contributes to a number of overarching goals such as strengthening social cohesion and inclusion, gender equality, raising female labour market participation and improving the quality and productivity at work. Thus, access to childcare services is essential both for the well-being of children, families and the community and a productive and growing economy. Ensuring suitable childcare services scores high on the social agenda of the European Council and the European Commission and represents a policy priority in practically all Member States (European Foundation for the Improvement of Living and Working Conditions 2006a; OECD 2006a).

1 Childcare services: challenges and objectives

Childcare services have in recent years experienced a rapid growth in many Member States, a trend that was mainly due to the increased labour market participation of women. For the countries covered by the in-depth analysis in this study, this holds particularly true for France and the Netherlands, but also Germany and Italy saw some growth in the sector. There are, however, notable exceptions, namely several countries in Eastern Europe where the overall number of childcare services declined during the transformation process. The main reasons for this development were financial difficulties of local governments, a decrease in the demand for childcare services due to very low birth rates, as well as high unemployment. In addition, in the Czech Republic the extension of the parental leave to three years and in Poland the privatisation of enterprises – employers were relatively active in the organisation of childcare before the transformation process – led to shrinking supply.

Hand in hand with the overall growth, the recent years are characterised in many European countries – in particular in the EU-15 – by a diversification of the supply of services in childcare. This was the case for the types of providers, the type of financing and the way these services are regulated. A progressive shift from a Welfare State to a Welfare Mix provision occurred. Taking into account the answers from the in-depth country studies, the main evolutions in childcare services comprised of structural reforms in view of organisation, regulation and financing, of the introduction of new types of services or programmes, and of quality assurance and improvement initiatives (for more details see the sections below).

Table 7.1: Main evolutions in childcare services

Main evolutions	Country				
	CZ	DE	FR	IT	NL
Structural reforms in view of organisation, regulation or financing	3	1	1	3	1
Introduction of new types of services or programmes	4	1	2	3	2
Quality assurance and improvement initiatives	4	2	3	3	3
Substantial change in private cost-sharing	4	3	3	4	2
Substantial changes in the scope of public service provision and of public funding	5	4	3	5	2
Cost containment measures	5	3	4	4	4
Note: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

Current childcare systems across Europe show a variety of provision. The core services for children below three years of age are family day care, collective crèches and integrated centres. These services are often complemented by drop-in centres for families and parent-led playgroups. For children between three years to compulsory school-age usually a broad system of kindergartens or pre-schools is available. In many Member States, childcare for school-age children is organised around activities provided in schools or in centres to complement school lessons. Frequently, out-of-school provision is loosely regulated offering a range of different services. In the absence of other services, childminders are a flexible form of care for children in several age groups. This is a common form of private childcare provision in many Member States (European Foundation for the Improvement of Living and Working Conditions 2006b, 36/39; OECD 2006a, 82ff).

In order to remove disincentives to female labour force participation, the Barcelona European Council agreed to the goals of providing childcare by 2010 to at least 33% of children under 3 years of age (and to at least 90% of children between 3 years old and the mandatory school age) in each Member State.[58] In practice, the level of childcare services differs considerably in the EU 25, but in most countries it is still insufficient to reach the Barcelona targets, notably for children below 3 years of age.

The underdevelopment of childcare services for children up to three years old – with the exception of the Nordic countries, the Netherlands, France and the Anglo-Saxon countries – is connected with traditional views on childcare: a huge part of care

[58] Childcare services can be seen as a very effective labour market policy instrument as they create employment both on the supply-side (increased labour market participation of women) and on the demand-side (increased number of jobs in childcare services).

responsibilities for small children is (still) delegated to the families. Crèches and nurseries are connected mainly with urban areas and are a (last) resort for working parents. On the contrary, kindergartens or pre-schools for the age group 3 to 5 were developed with a clear educational approach, thus almost universal access was realised.

Denmark, Sweden and Ireland are the countries with the highest proportions of children under 3 that receive formal child-care (40% or more) followed by Finland, the Netherlands and France (30% or more). Much lower proportions can be observed in the Southern and Central European countries. In Italy and Germany the public supply of early childcare services has traditionally been very low, in the Czech Republic and in Poland the low rates are also consequences of the transformation process.[59] For the age group 3-5, the coverage is much higher in general, reaching 90% or more in several countries. For this age group, service availability is also more uniform across countries (OECD 2006b, 35).

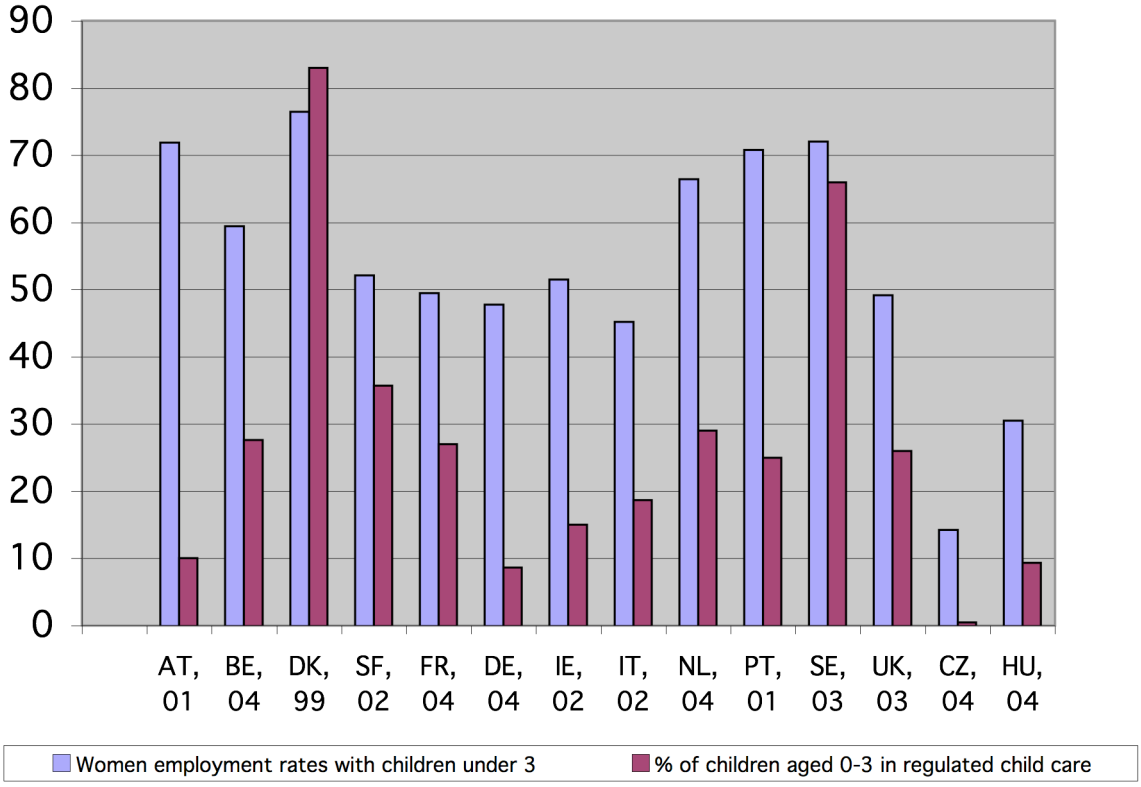
The picture is again different for services for school-aged children (6 to 11 years): similar to care for children below 3 years of aged and out-of-school care provision is still in the development stages in most of the EU Member States (European Foundation for the Improvement of Living and Working Conditions 2006b, 34). More adequate caring ratios for this age group are provided in the Northern countries (Denmark and Sweden 40% or more), in the Southern countries (Italy and Spain 35% or more) and partly in the new Member States (Czech Republic and Poland 20% or more). As with formal services for pre-school children, Central European Countries also lag behind for this service category (Eurostat 2004, 29f; OECD 2006a).[60]

If we look at enrollment rates of children below the age of 3 and employment rates for women with children under the age of 3, there is a clear positive correlation: higher enrolment rates coincide with higher employment rates. As the latter share is in many countries higher than the former, one can assume that a lot of informal care and/or part-time working of women is the case, as not all children of working mothers are in formal childcare (OECD 2006a, 86f). Although part of this may be due to voluntary solutions, a kind of hidden demand for childcare resources, even among already working mothers, is indicated.

[59] The enrolment rates for the countries covered in-depth in this study: Netherlands 31%, France 30%, Germany 10%, Italy 6%, Czech Republic 3%, Poland 2% (Eurostat 2004; OECD 2006b; Country Report Poland).

[60] The enrolment rates for the countries covered in-depth in this study (no figure for France): Italy 47%, Czech Republic 36%, Poland 20%, Germany 13%, Netherlands 8% (Eurostat 2004; OECD 2006a; Country Reports Czech Republic and Poland).

Figure 7.1: Employment rates for mothers with children under 3 and access rates for children under 3 in licensed ECEC services



Source: OECD: Starting Strong II, 245

Due to the increasing participation rates of women and the wide spread of part-time and irregular working times, not only the "quantitative" availability of childcare facilities is of importance, but also the extension and flexibility of opening hours, which have large implications for working parents. Roughly speaking, across Europe crèches provide for full-day care throughout the year[61] whereas kindergartens/ pre-schools are partly characterised by a half-day system.[62] A problem of after-school care centres, which cover usually at least the office hours, is that they frequently close during holidays. There are, however, many countries where substitutional childcare facilities provide services during the holiday season (Eurostat 2004, 34ff). In general, there is a trend of extending the opening hours of childcare facilities.

In terms of employment, there is a general tendency of an increase in the number of jobs in childcare services, following the overall growth in service supply. In some EU-15 countries this has even led to shortage of professionals in childcare services due to the growing demand for childcare places. In France, in particular employment for specialised educators for young children and for childminders increased. Given the

[61] The only exception among the countries covered in-depth in this study is Germany, where many crèches in Western Germany provide only for half-day care.

[62] Among the countries covered in-depth in this study this is especially the case in (Western) Germany, also in Italy kindergartens are partly only half-day. In France pre-schools are open till 4.30 p.m. (except on Wednesday), but out-of-school nurseries cover times outside school hours. Also in the Netherlands primary schools (for 4 to 6 years old) feature a half-day system, but after-school centres are available. In the Czech Republic and in Poland kindergarten opening hours are usually full-time.

retirement of qualified staff in addition to the growing demand for childcare places, the supply of professionals in childcare services falls already short. The exception to this trend is again a number of Eastern European countries, among them the Czech Republic and Poland, that saw a decline in childcare services (European Foundation for the Improvement of Living and Working Conditions 2006b, 63).

The educational level of key staff and qualifications requested in the childcare sector vary. On the whole, the childcare workforce does not represent a highly trained sector. Concerning children below school age it is usually at the level of secondary vocational level but not on academic education levels. However, in many countries, progress is being made in redeveloping the curriculum to a higher competency-based profile. Thus, younger educators have become more qualified, increasingly with university degrees. In childcare for school-aged children many jobs are teaching posts or similar positions in after-school programmes (Eurostat 2004; European Foundation for the Improvement of Living and Working Conditions 2006b; OECD 2006a; OECD 2006b).

In **Germany**, certified childcare workers for the age group 0-3 receive a 2-year secondary vocational training. The qualification of kindergarten teachers is not based on academic education (3-year secondary vocational training plus 1-year internship, only 2 to 3% hold a tertiary degree). However, currently a discussion on the higher qualification of staff takes place.

A diploma of a nursery nurse (nurse or midwife diploma plus one additional year of studies) is required to be primarily responsible for children in collective and parental crèches in **France**. Pre-school teachers must have a tertiary degree.

In **Italy**, the qualification requirements for employees in crèches' vary, for certified childcare workers a secondary vocational diploma is required. Due to budget constraints, there are not enough resources available for qualified younger staff to be hired with suitable working and pay conditions. A new law requires pre-school teachers to hold a tertiary diploma in the future.

At present, the educational level of group leaders in childcare is mostly three years of secondary vocational education in **the Netherlands**. For certified childcare workers for the age group 0-4, a 2-year post-18 training is compulsory, for teachers in primary school (4-12 years) a 3-year vocational higher education. In general, the curriculum is adapted towards higher competences.

In the **Czech Republic**, crèches are staffed by medical personnel only. Pediatric nurse courses are currently delegated from secondary health schools (4 years) to higher special schools. Qualifications of pre-school teachers comprise of a 4-year secondary pedagogical or a 3-year tertiary education.

In **Poland**, for teachers in kindergartens the same qualification requirements apply as for schoolteachers. The government is currently planning to improve the education programmes at the universities.

In many European countries the average pay of trained staff in childcare facilities is clearly below the salary of primary teachers. A huge number of community or voluntary providers are unable to offer higher remuneration due to financial

restrictions. However, in most cases, workers in public facilities are better paid than those in private facilities as many private providers drive down labour costs. Unless childminders operate in a market with high demand, incomes in this field are also considerably low. In agency-supported services, usually a small wage is provided to the carer. Where out-of-school childcare is mainly provided by teachers, the pay is usually higher (European Foundation for the Improvement of Living and Working Conditions 2006b, 70; OECD 2006a, 168f).

In Italy a public crèche educator disposes of a similar salary as a state teacher. However, private crèches compress the labour costs to make the activity profitable. Pre-school teachers are paid as primary school teachers.

Trained staff in centre-based childcare receives about the same salary as primary teachers in the Netherlands. However, there are different payment systems, whether it is childcare or playgroup work. Especially in the latter relatively low pay is usual.

In the **Czech Republic** the average monthly pay of kindergarten employees is lower than the national average wage (in 2004: 77%). However, in the last years an increase against the national average was recorded. Trained staff in centre-based childcare is remunerated with about 75% compared to the salary of primary teachers.

In **Poland**, low-income levels are reported for the childcare sector in general (European Foundation for the Improvement of Living and Working Conditions 2006b, 40; Eurostat 2004, 69; OECD 2006a, 159f).

A problem of attracting adequately trained staff to the sector might be that there is a relatively high share of part-time and short-term jobs. This holds especially true for out-of-school care provision and countries with a pre-school system on a half-day basis (e.g. Germany).

In almost all European countries, the share of female employees is very high (close to 100%) in the childcare sector. Relating to children below 6 years of age, this is the case in Germany (96%), France (97%), Italy (close to 100%) and the Czech Republic (close to 100%). In the Netherlands the share is 75% in primary education as a whole but very high with 4- to 6-years old (OECD 2006a, 159f).

It can be concluded that the childcare sector does not have an image of offering high-quality employment. The work is often only part-time, salaries are relatively low across Europe. These factors contribute also to a predominantly female workforce in the childcare sector (European Foundation for the Improvement of Living and Working Conditions 2006b).

2 How is this sector covered in the study?

"Childcare", in the more narrow sense analysed in this report, is part of the broader child and youth welfare sector. It focuses on institutions and services that are providing care for children below 15 years and that are of special importance for allowing reconcilliation of work and family life. These institutions and services basically comprise the following types: crèches, kindergartens, preschools, (after school) day care centres, childminding services. This range of basic and generally

accessible services also contributes to facilitating social integration, including fostering the integration of children of migrants.

The following services have **not** been analysed in detail in this study:

- Preschools, whether they are part of the national education systems (French *école maternelle*) or not (German Kindergarten);
- Targeted assistance for children and adolescents with specific needs or at special risks, such as those with disability, or with highly specialised care needs (e.g. adoptions, foster children, guardianship and assistance in cases coming before guardianship courts, educational assistance for handicapped and socially disadvantaged children and young persons, educational assistance in youth service centres and institutions providing social services for the young, social enquiry in juvenile cases);
- Childcare related programmes, for example to organise leisure time and school holidays, including recreational programmes for children and young persons or educational programmes for the young, guidance and leisure time provision.

3 Overview on service provision and expenditure

In all of the countries included in the in-depth analysis of this study, there are legal stipulations for childcare. France and the Netherlands recently released own laws on childcare services. In the Czech Republic and in France childcare services are explicitly part of social services of general interest. Also government proposals in Italy from 1998 described crèche services as a service on individual demand to an educational and social service of public interest (OECD 2006a, 88). Basically, in all countries the legal stipulations provide a framework which regulates the tasks of public authorities on various levels. Also the delegation of tasks to non-profit as well as for-profit providers, (for example by assigning public contracts and the provision of grants and subsidies), are usually regulated.

The main missions of childcare services concern the upbringing, education and care of children on the one hand and the reconciliation of work and family responsibilities on the other hand. However, in current policy debates most childcare considerations are set in an economic context and the primary feature is the focus on facilitating participation of women in the labour market (European Foundation for the Improvement of Living and Working Conditions 2006b, 69). The focus on childcare from the perspective of harmonisation of professional and family life is also a topic gaining importance in the Eastern European Countries. Concerning the perspective on childcare, an interesting development can be observed in the Netherlands: in 2002 childcare policy was transferred from the Ministry of Health, Welfare and Sports to the Ministry of Social Affairs and Employment reflecting the view on childcare to be a labour market instrument. However, in recent public discussion childcare seems to shift from an instrument of labour market policy and more to a goal in itself that plays an important role in the development of children and has an added value to childcare at home. Furthermore, issues of improving social cohesion and integrating children with a disadvantaged socio-economic background gain importance across Europe.

Childcare services are largely regulated at the central level, but the framework leaves scope for the final implementation by regional and local authorities (Table 7.2). Usually the regions and municipalities are in charge of the organisation and running of childcare services, providing the accreditation and the control of childcare services as well as financing, possible tendering and delivering public subsidies according to the central regulation. They are also responsible for planning and assessing the demand for childcare services.

In recent years, in many European countries in the field of childcare the delegation of powers from the national government to regions and municipalities is to be observed. This includes the decentralisation of organisation, management and funding but also of legislative competences, while the regulative function of the legal framework remained in the hands of the state.

In **Germany** the legal framework of childcare is defined in the German social legislation but childcare is in general the responsibility of the Länder (Eurostat 2004, 54). Local communities are in charge for providing public day care. The youth welfare offices are ultimately responsible for planning, and the assessment of demand is often delegated to the communities, too.

Pre-elementary schooling comes under the responsibility of the Ministry of Education in **France**. Although childcare services are still centrally regulated, departmental and local authorities share important responsibilities to develop and control. Local agencies are in charge of delivering public subsidies according to the central regulation; the departmental authorities' main mission is to deliver the accreditation and the control of formal childcare services. Municipal authorities are the first providers of collective childcare services.

In **Italy** childcare arrangements fall under the auspices of the Ministry of Welfare though the responsibility for the creation and management of crèches is entirely of the municipalities. For pre-schools the Ministry of Education is responsible (Eurostat 2004, 68). Concerning kindergartens, the State took over the direct management of most existing municipal structures during the 1980s, enlarged them and created new structures. The constitutional reform of 2001 provided the regions with exclusive legislative competences in the field of social policies while the State kept only the framework regulation. Since the reform the regional laws specify quality criteria, the provincial offices define the strictness and frequency of controls.

In **the Netherlands** the national government decides on the distribution of tasks in the childcare sector. The local governments and authorities are strongly involved in subsidizing and organising childcare and in possible tendering. The municipalities are responsible for the quality of childcare centres and for their inspection.

In the **Czech Republic** childcare is regulated by the Social Services Act, which specifies the respective tasks of the government, regions and municipalities. The legal framework is generally governing the field of provision of services of general interest by other than the public authorities, assigning public contracts and the provision of grants from the national budget or regions. The introduction of regions as higher territorial administration units in 2000 and the abolition of state administration district offices in 2003 prompted the delegation of powers from the state to regions and municipalities.

In **Poland** the Education Act is the most important document for regulating education and childcare. The act contains a framework for the responsibilities in providing childcare (European Foundation for the Improvement of Living and Working Conditions 2006b, 30). The organisation and financing of pre-school services are the tasks of the municipalities. After the fall of communism, a process of decentralisation of organisation, management and funding took place in the childcare sector. In 1990, commune governments were held responsible for the creation and management of childcare services, only the regulative function (legal framework, definition of standards) remained in the hands of the ministry.

Table 7.2: Competent public authorities for childcare services

	Country					
Competent public authority	*CZ*	*DE*	*FR*	*IT*	*NL*	*PL*
National government	4	3	1	5	1	3
Regional territorial authority (state; province)	2	1		3		2
Local territorial authority		1			2	1
• District			2	4		
• Municipality	1		3	1	1	1
Social insurance agency		5	2 (CNAF)			
Note: Ranking from 1 (Most involved) to 5 (Least involved)		1	2	3	4	5

Source: Questionnaire for in-depth country studies

In order to encourage the creation of new services, and the diversification of services, and to limit public expenditure there is a move toward the delegation of public services to the private sector (OECD 2006a, 115). In many European countries, the provision of childcare services is already, in principle, open to private providers, including for-profit enterprises.

In **Germany** either the municipalities provide childcare facilities, or they allocate subsidies to non-profit organisations, which in turn provide day-care facilities. Since 2003, childcare services can be provided by private organisations in France, among them also for-profit enterprises. In **Italy** the development of for-profit private actors began at the end of the 1980s following a significant lack of public provision especially in early childcare. Since the end of the 1990s, public support to private childcare is provided, mainly at lower public costs. In the **Netherlands** a multitude of legal frameworks for providers exists already, from foundations to pure business models. In the **Czech Republic** the not-for-profit providers are still in their formative stages. The bulk of private for-profit service providers is designed for afternoon- and

holiday-care for school-aged children. In **Poland**, a law from 2003 regulates the use of activities of NGOs to carry out public tasks. In the future it is to be expected that NGOs will have a special role in running childcare centres.

Thus, a number of reforms of regulatory mechanisms have been introduced in the past years. Collective and individual services are usually submitted to an accreditation process. Certain stipulated quality requirements frequently have to be met (pedagogical project; capacity to reach a set target like number of children, opening hours, care ratios, budget proposal, etc.). If these conditions are fulfilled and the services receive a positive evaluation by the authorities, investment subsidies can be granted for their creation. Often these contributions to the start-up are allocated on the basis of bids after the organisation of an open call by the municipalities. Also the contracting out of services happens more and more through a bid.

In **Germany**, since 2005, private day-care requires authorisation that involves the documentation of certain qualifications. Besides adequate accommodation, professional competence and the willingness to cooperate with parents and other day mothers has to be demonstrated.

In **France**, since 2000, a new regulation of quality requirements (pedagogical project, relationship with external organisations, etc.) both for collective services and individual services is in place with the aim to improve the recognition of childcare professions and their quality. A law for childminders that clarifies the agreement procedure, the employment status, wage and work conditions, the relation with the parents and the obligation to follow professional training was adopted. Private services receive investment subsidies at their creation. Some municipalities also organise open calls to create childcare services at the local level.

In **Italy** the public financing of private crèches is typically a contribution to the start-up. In recent years some funds available through tenders were provided for their creation. Non-profit actors are mainly managing outsourced public services: The contracting out is usually organised through a bid published by the municipalities which is based on the pedagogical project, a budget proposal and the capacity to reach a set target (e.g. number of children to be cared for, opening hours, etc.).

In **the Netherlands** the providers of childcare facilities have to meet the municipal statute in order to get a permit (Eurostat 2004, 77).

The registration process is the same in the **Czech Republic** both for public and private organisations. All facilities must meet requirements concerning their capacity and staff qualifications, as well as financial and technical requirements.

In **Poland** private childcare centres can be established if they comply with some conditions specified in the Act on the Educational System (educational programme, adequate staff qualifications, adequate operation conditions, etc.) and after receiving positive evaluation from the superintendent of schools. Also for-profit centres can be created. No tender procedure is in operation for starting non-public pre-schools.

Usually private enterprises have also access to public support for the current costs if they meet some specific criteria and requirements (e.g. quality, final account, etc.).

In **France**, since 2004, crèches managed by private enterprises are also entitled to receive direct public subsidies if they fulfil some stipulated requirements. In Italy, state and regional funds are also available for church-run pre-schools (Eurostat 2004, 69). For private crèches public financing is usually not available for the regular management. In the Czech Republic, only not-for-profit providers (since 2005) are eligible to state grants. The Ministry sets the requirements for the subsidy (e.g. final account). In Poland private childcare institutions established according to the stipulated criteria are entitled to subsidies provided by commune governments amounting to 75% of the current costs of public kindergartens per child.

In addition, there are also demand-side subsidies in form of tax deductions for private enterprises. For example in France, since 2004 for-profit enterprises can deduct 60% of their expenses for the creation of childcare services or for the reservation of childcare places in existing services. In Italy, tax reductions were introduced in 2002 and 2003 for employers paying the crèche fee for their employees, or building or renovating company crèches. Italy and Poland provide special income tax- or value added tax rates for non-governmental organisations that are active in the field of childcare.

Moreover, public-private partnerships are in a number of cases facilitated by the possible association of non-profit or for-profit organisations with public authorities to ensure the provision of childcare services. However, there have not been a lot of advanced forms of public-private-partnership cooperation in the field in the sense of complex contractual relationships between public authorities, profit-making firms and private non-profit organisations.

The only exception is **Germany** with its long-standing cooperation between public authorities and non-profit organisations in the childcare sector. Although in **France** public-private partnerships are encouraged through the possibility of associating non-profit or for-profit organisations to the *contrat enfance* (for the definition see below), so far very few of them were also signed by non-profit or for-profit organisations. In **Italy** public-private agreements with non-profit organisations play a certain role for parenthood support initiatives. In the **Czech Republic** there have not been any advanced forms of public-private-partnership cooperation in the childcare sector. In **Poland** there are some examples for the cooperation between commune governments and non-governmental organisations for kindergarten education in rural areas.

Table 7.3: Ensuring provision of services in childcare

	Country					
Form of intervention	*CZ*	*DE*	*FR*	*IT*	*NL*	*PL*
Accreditation	x		x			
Delegation		x		x		
Tendering				x	x	
Public-Private Partnership (PPP)		x				
Subsidies	x	x	x	x	x	x
Legal stipulations valid for all types of providers	x	x	x		x	x
Quality control	x		x		x	x

Source: Questionnaire for in-depth country studies

As with the state of development of privatisation processes, the organisation of the provision of childcare services differs across countries. In principle, the sector has seen a trend toward the emergence of new kinds of providers (e.g. third-sector organisations, commercial providers, enterprise-based services, user cooperatives, and the like). In some countries these have in past years substantially increased their share of service provision. In other countries, the spread of these new forms of providers is still in its early stages.

Public authorities, especially regions and municipalities, however, still remain the predominant providers of childcare in many cases. One of the exceptions is **Germany**, where – in accordance with the principle of subsidiarity – the current regulation foresees that public sponsoring bodies (Länder, municipalities) shall only become active if the supply by independent sponsoring bodies is inappropriate. Generally, the share of both non-profit and for-profit private providers is growing in all countries.

In **France**, two thirds of the publicly funded crèches are managed by local authorities and the remaining third by private organisations (Eurostat 2004, 61). While the majority of collective childcare services is still in public management (municipal or departmental), the proportion of non-profit organisations increased substantially in the last 20 years.

In **Italy**, for-profit private actors are particularly active in early childcare provision. Public crèches make up for 60% of all crèches, the share of private crèches (mostly provided by for-profit actors) increased in recent years. Public pre-schools (state and municipalities) account for 73% of total pre-schools. The remaining quarter is operated by the private sector, including religious institutions (Eurostat 2004, 68f).

Public authorities, especially regions and municipalities, are the main providers of childcare in the **Czech Republic**. The not-for-profit providers are still in their

formative stages. The bulk of private for-profit service providers is engaged in afternoon- and holiday-care of children of school age.

In **Poland**, an increased share of private providers can be observed in the field: a huge share of this is developing spontaneously in non-profit as well as for-profit sectors. However, in 2005 public crèches (the main providers are local governments) constituted 88% of all crèches, 8% were run by for-profit providers and 4% by non-profit providers. This is similar to the composition of kindergartens providers: local government made up for 87%, for-profit organisations for 8% and non-profit organisations for 5%.

Table 7.4: Organisation of service provision in childcare services

	Country					
	CZ	*DE*	*FR*	*IT*	*NL*	*PL*
1. Approximate "market" shares						
Public	80%	40%	64,3%	60%		na
Non-profit	12%	60%	31,0%		50%	na
For-profit	8%		4,7%		50%	na
2. Mode of governance						
Market			x	x	x	
Quasi-market (competition between providers and purchasing by a public agency based on regulations)		x			x	x
Planning	x	x	x	x		x
Other (please specify)						
Service cheques for purpose of services						
User and worker's cooperatives						
3. Type of regulatory mechanism						
Related to authorisation regimes for service providers	x		x			
• Accreditation	x		x		x	
• Certification						
Related to service provision requirements		x			x	x

Source: Questionnaire for in-depth country studies

Allthough there usually exists a growing private market, childcare services are still characterised by strong public regulation. A further introduction of market mechanisms is to be expected, but for reasons of equity and efficiency a certain level of regulation and funding of services by public authorities will also be indispensable in the future.

The growing marketisation of the sector led to the problem of the organisation and coordination of the different providers in order to harmonise strategies in accordance with education and labour market requirements, demographic trends and interest and demand by citizens. Thus, for the development of childcare in practically all countries new planning and coordination mechanisms have emerged that take into account the new interactions between public authorities (on various levels), the for-profit sector, non-profit organisations and the civil society (see Table 7.4 (2)). The new coordination tools can be seen as examples of innovative practices in terms of their regulatory design.

In **France**, e.g. the municipalities and the local authorities are the signatories of a coordination mechanism called *contrat enfance*, which formalises the planning for the development and financing of childcare. In addition, the 2002 institutionalised departmental commission on childcare defines the needs and the priorities of the department and develops these services accordingly.

In **Italy**, networking in social services was institutionalised by a legislative tool in 1997 at first. Local institutional and non-institutional actors now need to prepare a joint project to be eligible for financing. In the **Czech Republic** in the accreditation process for child-care facilities, the long-term plan of education, requirements for the labour market and the demographic trend are taken into account. In **Poland**, the development of childcare centres in local strategies should in the future take place in accordance with objectives defined in the new National Social Integration Strategy.

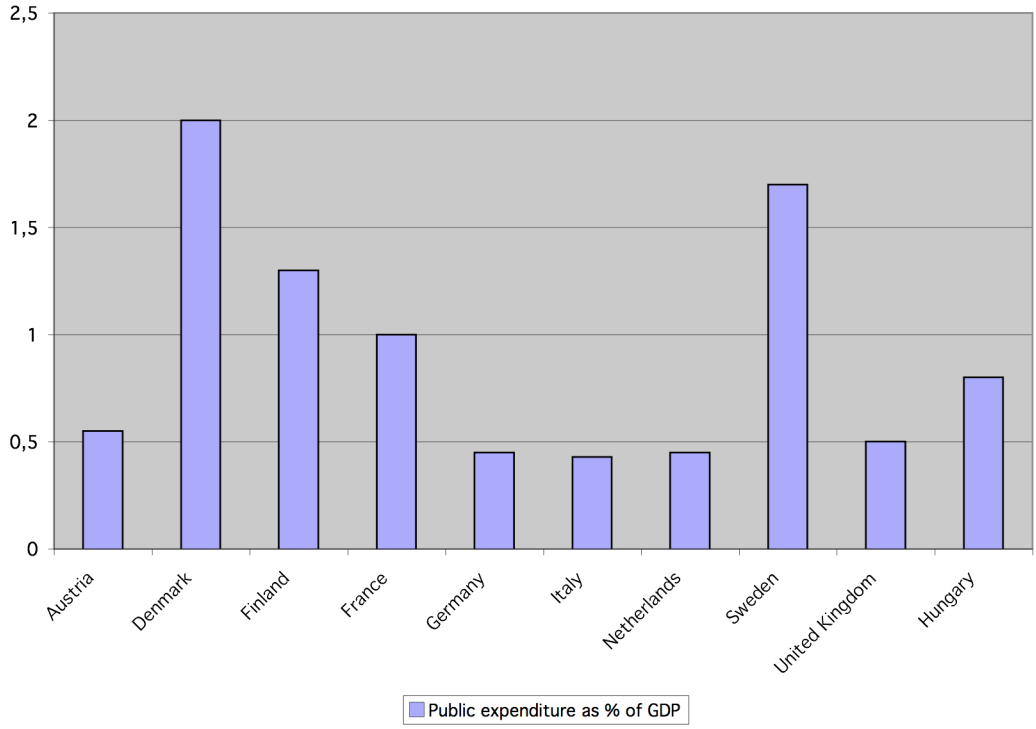
Trends in expenditure

Overall, governments contribute from about 66% to 90% of the total childcare costs in Europe (OECD 2006a 113f). Public expenditure on early childhood services (0-6 years) ranges from 2% of GDP in Denmark to about 0.4% in Italy. In France the expenditure reaches 1% of GDP, whereas it is only slightly higher in Germany and the Netherlands than in Italy. (According to the country report of the Czech Republic, the total amount of expenditure for kindergartens [3-6 years only!] is 0.4% of GDP.) A number of countries with comparatively low public expenditure (among them Germany and the Netherlands), however, have in recent years significantly increased their spending levels (OECD 2006a, 246). In Italy the expenditure has shown some stop-and-goes, rather than a steady growth due to severe budget constraints.

As a rule, local communities (municipalities, regions) are responsible for financing childcare. Partly there are also subsidies from the central budget. In **Germany**, the local communities are in charge for financing public day care. The funding of childcare is legislated by the Länder.

In **France**, the costs of childcare services are mainly covered by local municipalities and the local agencies of the "family branch" of the social security system (CAF) that deliver public subsidies according to the central regulation. Furthermore, public authorities subsidise services also through employer contributions (OECD 2006a, 84).

Figure 7.2: Public Expenditure on ECEC services (0-6 years)



Source: OECD: Starting Strong II, 246

In **Italy**, crèches are financed by municipalities through State transfers, transfers from regions and their own fiscal resources. For pre-schools state and regional funds are available (Eurostat 2004, 69). Like in France also employer contributions contribute a part of the childcare bill (OECD 2006a, 84).

A special regime was established in the **Netherlands**, where the labour-market perspective led to a substantial co-funding of childcare by employers (in 2005 around 20%). Previously the government funds went directly to the childcare facilities. Now government funding takes place through special income-related allowances for parents through the tax office.

In **the Czech Republic** kindergarten funding is divided among municipalities and regional offices. Grants for childcare are also partly assigned from the national budget. Financial means are distributed under directions set by the Ministry. In Poland, the main source of the income of crèches and kindergartens are subsidies from public resources (both local governments and the central budget).

Another income source is the contributions by parents. To provide more incentives to use child-care services and to improve parental choice, childcare should be affordable. In general, parents' contributions are derived from their incomes, low-income families have to pay only possible meals if at all. Fees for private services are usually higher than fees in the public sector. In general, parents contribute less than a third to childcare costs in Europe (OECD 2006a 113). In several countries, e.g. France (from 2 years), Italy and the Czech Republic (from 3 years) and the Netherlands (from 4 years), pre-schools/kindergartens are free (OECD 2006a 113).

In **Germany**, in 2002, the financial contributions by the parents as a share of the regular costs amounted to 22%. Although fees should be charged according to the household income of the parents, the financial contributions may bar families with low incomes from accessing childcare.

In **France** in 2004, 27% of the costs of childcare services were covered by parents. The share tends to increase given the operating costs of private services that are only partly covered by public subsidies.

In **Italy**, parents' fees in public crèches are income-related, with a ceiling of 20% of family income (Eurostat 2004, 69). However, for private services families' contributions to the costs are higher: as there is no public funding for the regular management of private crèches, private providers are forced to complement the public funds with fees oriented on the market price.

After the change to government funding through special income-related allowances for parents through the tax office in **the Netherlands**, the new system led to low-income parents hardly paying any fees, whereas those in the higher income groups had to pay substantially higher amounts. Most of these effects were balanced later, when the government added a further funding which aimed at accommodating middle and higher-income parents. In 2005, the payments by parents amounted to 37% of the total childcare costs.

In the **Czech Republic** parents need not pay more than a ceiling of 30% of the full costs for childcare, contributions are derived from the incomes. However, fees for public services are substantially lower than fees in the private for-profit sector.

Because of financial problems, local governments introduced or increased fees for childcare services during the transformation process in **Poland**. Nowadays parents' fees make up for 29% of the income of crèches and kindergartens. Although the contributions of parents are in general income-related, the introduction and increase of fees created a barrier for less affluent families. Private childcare is more expensive than public childcare as subsidies to private institutions cover 75% of the current costs and the difference to the full costs have to be covered by the parents.

OECD research (Immervoll/Barber 2005) suggests that even after deducting all relevant types of government support, typical out-of-pocket expenses for two pre-school children can add up to 20% and more of total family budgets. For families who make the transition from out-of-work to labour market participation, the combination of additional tax payments, the loss of social assistance or other benefits and of even limited out-of-pocket expenses on childcare can leave families with less disposable income than if they were to stay at home.

4 Lessons from country studies

Childcare services were analysed for the situation of four countries: the Czech Republic, Germany, Italy and Poland. The information is based on these country studies that have provided sufficient detail for analysis..

Box 7.1: Childcare: Case Vignette H (Care for children below the age of 3)

Ms H, a single-earner aged 29 years lives with her almost 2 years old son in the countryside. Of her relatives, only her father is living in the same village, but he is working full-time. Ms H works in an automobile factory that is situated 45 km away in the suburbs of a big town. Currently she is on parental leave and receives childcare benefit. However, the parental leave will end when the child reaches his second birthday. After that date she has to take up her work again as she will not be protected against dismissal any longer.

Is there likely a child-care facility available in the village or nearby that also attends children below 3 years or might her employer be likely to offer such services near the work place? To make ends meet Ms H will have to work full-time. Do child-care facilities usually stay open until at least 5 p.m.? Does the child-care facility provide adequate caring standards for two-year-old children? Does Ms H get a reduction in the parental fee, as she is a single earner with a small income? In case there is no suitable child-care facility available, is there a special cash benefit available for mothers who are not able to work because they have to care for children themselves?

With the exception of Italy (4 months maternity leave after birth, 6 months parental leave for each parent), Ms. H could take parental leave until her son is 3 years old. In the Czech Republic, in Germany (until the child is 2 years old,[63] in some Länder until the child is 3 years old) and in Poland (means-test) she would also be entitled to a kind of child-raising allowance till the child is 3 years old. In Italy, after expiry of the parental leave (combined with an income-related benefit), no special cash benefit is foreseen for mothers who are not able to work because of care responsibilities.

Childcare services up to three years of age are quite limited in all of these four countries, especially in rural areas and in addition in Germany in the old Länder (if nevertheless there is a crèche in the municipality, it is very likely to get a place, being a single working mother). Thus the chances of Ms. H. to find a childcare-place for her son are better in the big town of her workplace. However, if the employer itself does not offer company day care (in all of the four countries few but if provided, then by big enterprises), the problem with a public crèche in Italy and Poland would be that users from other municipalities have to pay the highest fee level. In all of the four countries alternatives to collective crèches, e.g. childminders, family crèches, etc. have usually no nationwide supply and are often relatively expensive.

[63] Has been replaced in January 2007 to 1 year (new allowance in form of temporary compensation of former income).

In Italy, the Czech Republic and Poland crèches are usually open till 5 p.m. (about 10 hours per day and more), thus "regular" office hours should be covered. However, if Ms. H. has to work also beyond this time there might be a problem. The situation is different in Germany, where in Western Germany mostly only a half-day care is secured (Eurostat 2004, 36).

The fee is in all four countries are usually derived from the family income. However, in private crèches, the fee amounts to somewhat of a market level.

Collective services, especially public ones, are exposed to rather severe quality controls. Thus, there should be adequate caring standards for children below 3 years of age. Quality standards of childminders and family crèches, on the other hand, could be lower and also be less controlled (in Italy they are not even submitted to any regulation).

In all of the four countries children over three years of age can attend a vast and fairly accessible network of kindergartens. In Germany, Italy and Poland there is even a legal right for a day-care slot from the age of three. However, in Poland there is a lack of kindergartens in the countryside, also parents are partly not aware of the resulting benefits for children from collective care.

The opening hours in the Czech Republic and Poland cover the regular working day (till about 5 p.m.). In Italy there is partly a half-day and partly a full-day system, in Germany the traditional half-day system remains a problem.

Box 7.2: Childcare: Case Vignette I (Afternoon care for children at school-age)

The 6 years old daughter of Mr. and Ms. I, both aged 37 years, will soon attend primary school. Every day the class will end around noon. Currently the father works full-time and the mother works part-time, but she plans to increase the working hours when the daughter goes to school.

Is there a day care centre in or nearby the school that provides also a meal for children? Does the day care centre also offer care during the summer holidays, and if not, is there a substitute facility nearby where the children can be cared for? Are there qualified personnel who support the children in doing their homework? Are there opportunities for sports or other programmes for leisure time?

In the Czech Republic, Family I would have a quite an extensive supply of afternoon care programmes for its daughter. All primary schools operate school clubs to take care of children before and after classes. In Poland, more than half of primary schools organise common rooms for children in the afternoon. In Germany – characterised by a half-day school-system –areas and the new Länder offer an adequate net of after-school day-care centres. This is similar to Italy, where three quarters of the primary school classes are half-day. Afternoon services are only available occasionally, often in the form of services that are self-organised by the third-sector.

Concerning care after noon, Family I is best situated in the Czech Republic, where lunches are served by integrated school canteens. In Poland, almost 50% of primary schools have their own lunchrooms. As is the case for most of the remaining aspects of the vignette, childcare facilities in Germany differ concerning the supply of care after noon. (Thus in the case of Germany no concrete answers to this and the following questions of the vignette can be given.)

In all the countries studied, the afternoon care programmes last till around 5 or 6 p.m. However, in general they are closed during the holidays. But there is at least partly a supply of substitute facilities: In the Czech Republic, the daughter of Mr. and Ms. I can use the services of the leisure time centres run by regions or municipalities. In addition to the public-sector services, leisure time activities are offered by the private non-profit or for-profit sector, especially in urban areas. Summer holidays are generally covered by municipal or third-sector initiatives in Italy. In Poland, some schools, community centres, and other sports or leisure centres organise various classes for children. However, there is a lack of such activities in rural areas.

The school clubs in the Czech Republic and the common rooms in schools in Poland employ skilled personnel (educators or teachers). On the contrary, personnel in Italy are mainly made up of students and volunteers. In all the countries homework assistance is a main activity carried out. Opportunities of doing sports or other programmes for leisure time vary among services but are usually offered in a broad range.

5 Conclusions

The most important functions of childcare services are to foster healthy and sound development of children and to help parents to reconcile work and family life. Due to increasing labour market participation of women and changing family structures but also a wider orientation towards the early socialisation of children, childcare services have in recent years experienced a rapid growth in the European Union. The ongoing process aims both at the quantitative and qualitative extension of childcare. Thus, especially a number of countries with comparatively low public expenditure have in recent years significantly increased spending levels on childcare.

Accompanying the overall growth, a modernisation and diversification of the supply of childcare services concerning the types of regulations, the types of providers and the types of financing took place. Thus, for example the decentralisation of powers from the national government to regions and municipalities, a move toward the delegation of public services to the private sector (both non-profit and for-profit with an increasing share of individual services) and the introduction of demand-side subsidies can be observed. However, the influence of the legal and political context of the European Union on these developments, is currently regarded by observers as being relatively low.

For users the modernisation trend in childcare led to an increase in the supply of childcare services. However, in most of the Member States the EU-Barcelona targets (providing childcare by 2010 to at least 33% of children under 3 years of age and to at least 90% of children between 3 years old and the mandatory school age) are far from being reached, in particular for the younger age group. Also concerning the afternoon

care of school-aged children there is still a lot of unsatisfied demand. In addition, childcare services are not always affordable (especially in the private sector) and the opening hours of childcare facilities (in particular kindergartens are frequently characterised by a half-day system) do partly not correspond to working times of parents.

Given the diversification of childcare services and the fragmentation of responsibilities, the problem of a lack of coherence and governance arose. Specifically quality control procedures are more difficult to implement given the increasing number of independent childminders and of for-profit providers. Some childminders of family crèches are not even submitted to any regulation. OECD research suggests that only by sustained public funding and investment in policy, services and management, can both affordability and quality of services be secured in the future (see also part IV and V of the report).

Chapter 8 Social Housing

Social housing is at the centre of a range of social policy goals. The provision of good quality, affordable housing directly impacts not only social inclusion but also cohesion, sustainable community development through mixed urban renewal schemes, and the environmental impact of housing through environment-friendly solutions, and social diversity. Thus when considering social housing, one has to bear in mind other public and social policies that are closely inter-related with social housing.

Social housing in the European Union is characterised by a wide diversity of national housing situations, approaches, welfare traditions and policies across Member States. There is for this reason no common definition of 'social housing' at European level. However, there seems to be consensus that the primary role of social housing is to help households that experience difficulties with access to decent housing on the regular market and that may not be able to find accommodation. It is worth noting that, although social housing is generally understood to refer to social rental, social housing also comprises the provision of affordable dwellings for sale to households to establish ownership. This is increasingly complemented by numerous other complementary services[64], notably by social services for the tenants that aim at facilitating their integration.

The regular private housing market in many cases meets only certain needs, and appropriate housing responses are needed for specific needs, such as for people with disabilities, elderly persons, etc. or in response to local market shortages. Housing markets themselves may be flawed in many ways. Tight markets may result in a shortage of affordable housing and social segregation in some districts. These are examples of market failures that social housing can address in different ways but always in response to the special local environment.

The present Chapter is essentially based on the SHSGI Policy Papers No.1 on Social Housing in Europe. The European Social Housing Observatory has produced this sectoral paper. It presents a detailed overview on social housing policies in five countries that were selected to have a representative overview of various trends in Europe: the Czech Republic, France, Italy, the Netherlands and Sweden. Social housing has been tackled through an in-depth transversal paper rather than in the in-depth country studies. Its authors cooperated closely with the European Social Housing Observatory. Other documents published by the European Social Housing Observatory, which is the research branch of CECODHAS (the European Liaison Committee on Social Housing, an NGO created in 1988 to be an umbrella for all social housing providers) were also used. The Observatory's aim is to produce research and trends analysis on housing and social housing in Europe, as well as to develop strategic thinking in the field. The Social Housing Observatory is thus the main European data producer in this field.

Finally, information has been drawn from the latest available report[65] on the Housing Statistics in the European Union 2004[66]. Despite the fact that Housing is not a

[64] See Figure 8.1 below.

[65] The Housing Unit, *Regular National Report on Housing Developments in European Countries - Synthesis Report*, Department of the Environment, Heritage and Local Government, Dublin, Ireland, November 2004, 178 p.

European policy matter, since the early 1990s, the Housing Ministers of the European Union meet regularly and established on a voluntary basis and with rotating responsibility synthesis reports on housing matters and related statistics. The latter are collected by the "focal points" serving as contact bases within each respective competent housing administration at national and/or regional level in each Member State of the European Union.

1 The diversity of providers and the role of local markets

Overall, what characterises the social housing sector across Member States is its diversity in terms of:

- Size of the sector (i.e. share of social housing stock in the total stock in the country[67]);
- Legal and organisational forms (operators ranging from public companies to co-operatives and not-for profit organisations, amongst others);
- Forms of 'social tenures' (rental housing, affordable ownership, co-ownership, co-operative housing, shared ownership, etc.);
- Procedures and control authorities (e.g. agreements, registration, administrative and financial audits, etc.);
- The overarching housing policy framework (national, regional and/or local) within which they operate.

Social housing in Europe nowadays is provided by a combination of publicly managed housing stock (owned and managed by central or local governments, depending on the country) and a range of voluntary or not-for-profit associations and foundations, public or private not-for-profit companies, co-operative organizations and private investors that provide social housing. The SHSGI Policy Paper No.1 on Social Housing in Europe gives some insight on this diversity in the five countries under review.

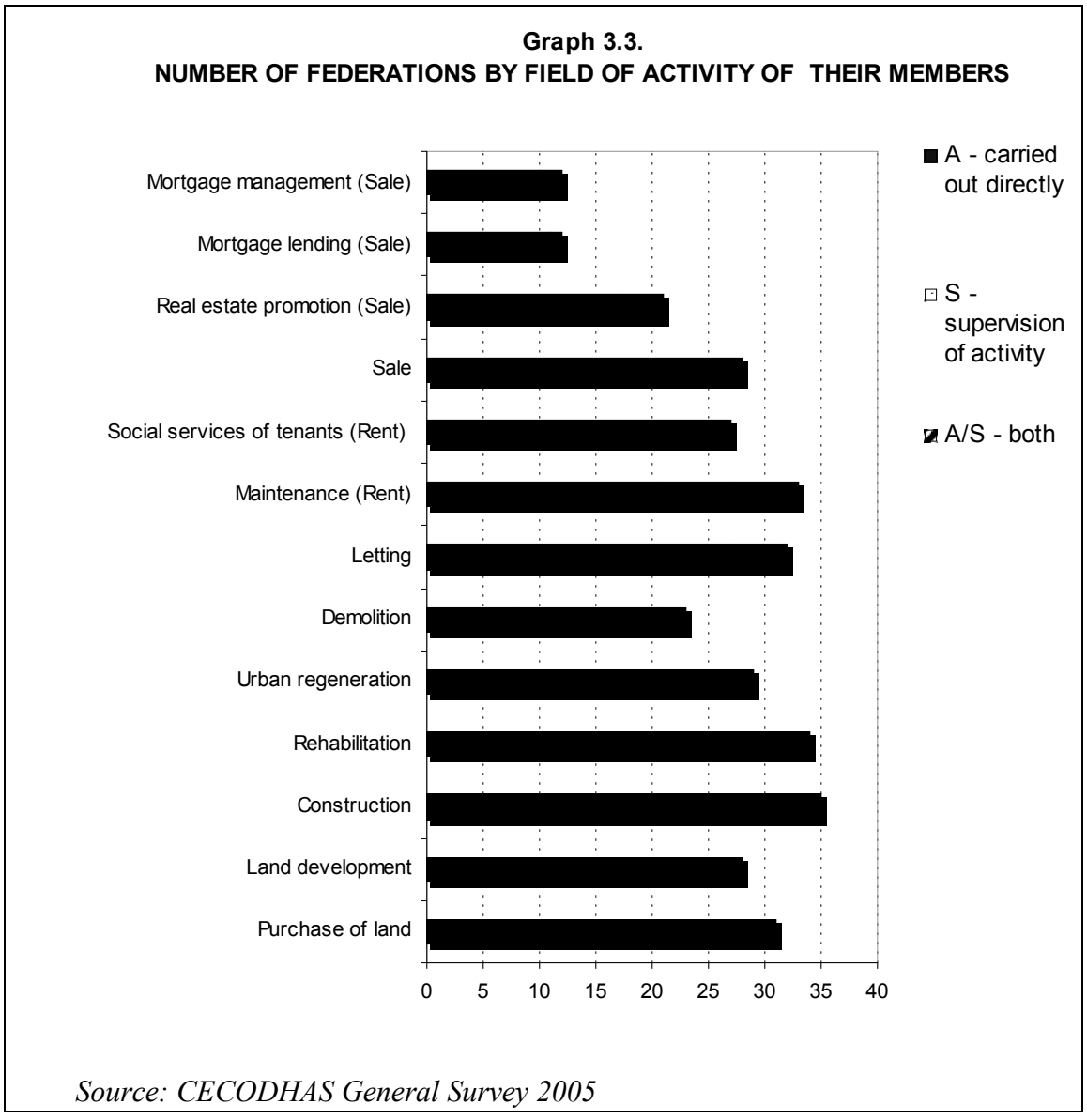
While the Czech Republic, for example, features a relatively higher percentage of social rental housing than Italy (the former composed of the municipal and the cooperative rental sectors), in practice the Czech Government has acknowledged the need to put in place a sound and efficient not-for-profit rental sector to ensure the provision of affordable housing to lower income groups for whom the ill-defined municipal rental sector is not delivering. The Czech Government supports the construction of cooperative flats to support potential users of cooperative housing, namely households with medium incomes that can make a financial contribution to the acquisition of housing and are capable of paying rent, but that do not have sufficient income to finance privately owned housing via a mortgage. However, seen individually with respect to one housing association, public financing is limited: based

[66] National Board of Housing, Building and Planning (Sweden) & Ministry for Regional Development of the Czech Republic, *Housing Statistics in the European Union 2004*, February 2005.
[67] See Table #8.1# further below

on the expected amount of allowed state aid[68], it was estimated that the Czech Republic could grant state aid to one cooperative for the construction of 12-15 new flats in a period of three years. Interestingly, these two attempts to build an appropriate regulatory framework for the provision of affordable rental housing take place against the backdrop of a housing policy that relies primarily on market mechanisms to fulfil the housing needs of the population.

Finally, one should also be aware of the wide-ranging scope of activities of social housing organisations as pictures in the following illustration. Several of these activities also include for example energy savings initiatives and sustainable housing construction, local and neighbourhood development.

Figure 8.1: Various activities of social housing organisations



Source: CECODHAS General Survey 2005

[68] See Chapter 10 - Section 2 for developments on state aid limitation due to European legislation. This calculation was made by the Czech State with respect to the former limitation of state aid, i.e. limited to 100,000 EUR.

Italy is currently facing two key trends in this field: on the one hand, the widening of activities towards new target groups (elderly, immigrants, students), and on the other hand, the need to diversify activities (a similar trend in other countries, such as the Netherlands, United Kingdom, etc.). It can also be mentioned that in the Netherlands, there is a recently emerging trend of engaging on cross-border housing markets.

2 Various types of approaches of social housing policies

In analysing social housing, one should take into account the various governance regimes used to provide social housing that can range from organised public provision on the one hand (public financial support for the construction of social housing, where needy people have to go, with some policy of territorial planning and "social mixing" preventing the development of "ghettos") up to the free choice on the market on the other hand, which can be organised by distributing housing vouchers that allow people to freely choose, but then on a totally private housing market.

The outcome and results of using one model rather than another may entail consequences for other social public policies closely related to social housing. When public authorities are directly responsible for social housing, they may easily combine various public policies to try to reach several goals at once. Rehabilitating housing in deprived areas by installing "mixed" households from an income and/or ethnic perspective, stimulating and supporting environment-friendly energy usage in those rehabilitated houses and flats, and/or associating young unemployed tenants to the rehabilitation process by integrating them in the renovation project and offering them training places in the construction sector.

These intrinsically associated activities to social housing can have various consequences that procure positive externalities: favouring local development, stimulating social cohesion, contributing to sustainable development, supporting the path back to employment and economic integration. On the other end of the scale, when vouchers are distributed without possibility to exert a direct influence on the quality of housing, on its integration within existing territorial and social facilities, or on integrating young tenants in their own neighbourhood, (in order for them to respect it), some households can be located in badly isolated high-energy consuming constructions, in suburbs located far outside, not necessarily having public transportation facilities or social infrastructures directly available, and with unemployed young tenants feeling even more isolated and excluded. This will bring additional burden on the expenditures related to housing, and also on social allowances that public authorities might have to pay for in the end anyway.

In the Netherlands, it was found that no matter how good the properties are, factors such as unemployment, truancy at school, disability, pollution, isolation and insecurity do also influence the attractiveness of living in a particular neighbourhood. Associations aim nowadays to meet these aspects and housing associations are also working with other parties to enhance the quality of life and the surrounding environment of their estates. To gain an impression of how an area is changing or developing, some associations have a 'neighbourhood thermometer'. This consists of components such as social cohesion, security, traffic nuisance and economic strength

that give an indication. In the United Kingdom also, the importance of neighbourhood policies directly associated to social housing is stressed.

Despite the uniqueness of the institutional and policy framework in each country, there are similarities in much of Europe in the overall allocation of responsibilities for providing social housing between the state, the private sector, voluntary organisations and households. Some broad national guidelines or goals are set which are implemented on the local level, accompanied in some federal States by additional regional rules or policy orientations.

Two main approaches can be distinguished with respect to the scope of social housing policies, which have been called the 'universalistic' and the 'targeted' approach.

The 'universalistic' model of social housing provision (also called 'housing of public utility') stems from a particular conception of social welfare that aims at providing the whole population with housing of decent quality and at an affordable price. Therefore, in this model, housing is considered a public responsibility and is delivered either through municipal housing companies (e.g. in Sweden) or through not-for-profit organisations (in Austria, and in the Netherlands). The key objective of housing provision in this model is to ensure a social mix, i.e. to try and avoid the formation of ghettos of lower-income groups or ethnic minorities as a way to prevent spatial segregation and to foster social cohesion.

The 'targeted' approach, on the other hand, is based on the assumption that the objectives of housing policy will be met predominantly by the market (i.e. through the allocation of the supply of housing according to demand) and that only those households for whom the market is unable to deliver housing of decent quality at an affordable price will benefit from social housing. Within this approach, however, there is a wide range of variations in terms of the type and size of the social housing sector, as well as regards the criteria used to allocate this type of housing. Therefore, it is possible to distinguish two sub-types of this second approach, namely:

- *Social housing for the employees/working classes* according to the original tradition of social housing in Western Europe (i.e. housing for middle-income groups, which includes a contribution from their employers), and

- *Social housing for the most vulnerable*, usually very vulnerable households who are heavily dependent on state benefits (e.g. unemployed, disabled, elderly, lone parents, etc.).

The following classification allows visualising commonalities and differences between the different approaches in each country. This classification takes two axes of analysis: 1) Allocation criteria; and 2) Size of the social housing stock.

Figure 8.2: Approaches to social housing in the Member States of the EU

Allocation criteria / Size of the social housing sector	Universalistic	Targeted	
		'Working class' or 'Employees'	Most vulnerable
>= 20 %	**Sweden** **The Netherlands** Austria Denmark	Austria Poland	United Kingdom
11 % – 19 %	Finland	**Czech Republic** Finland **France**	France
< 10 %		Belgium Germany Greece **Italy** Luxembourg	Belgium Estonia Germany Hungary Ireland Portugal Spain
Note: Countries marked in **bold** are those studied in the in-depth report on social housing.			

Source: CECODHAS European Social Housing Observatory

With respect to the categories of the classification depicted in Figure 8.2, the five countries studied in depth in the SHSGI Policy Papers No.3 on Social Housing in Europe (Czech Republic, France, Italy, the Netherlands and Sweden) represent different 'groups' of countries. While Sweden and the Netherlands represent the 'universalistic' approach (i.e. a relatively large and broad-based sector aimed at providing social housing for the whole population as a means to implement the right to housing and to achieve socially integrated neighbourhoods), the Czech Republic and France own a moderately-sized stock and respond to allocation criteria which favour certain target groups (including middle-classes, so-called "key workers"[69], lower-income households and other groups with special needs). Finally, Italy represents the group of countries with a small social housing sector, strongly targeted but with remnants of the tradition of social housing for workers or employees – albeit with an increasing need to provide social housing for specific groups such as immigrants.

But the overall objectives set to social housing, either explicitly or due to historical and cultural features, can cross those classifications attempts. For example, France is classified as 'universalistic', but considering the detailed definition of social housing in this country, the housing policy in France clearly fits in the general framework of strengthening social cohesion, achieving a social mix and ensuring a diversity of habitat.

[69] Key worker housing refers to accommodation for public sector or essential service employees (nurses, teachers, policemen, firemen, etc) unable to afford to buy or rent housing locally on the open market. The difficulty to find decent and centrally-located accommodation at an affordable price near their workplaces poses a severe problem for other areas of policy, for example health, education and safety, especially in large cities where these services are in shortfall.

Another way to illustrate major structural differences in housing policy is the classification proposed by Kemeny (1995)[70] that is based on theoretical analysis of welfare regimes. He distinguishes the 'dualist' versus the 'unitarist' rental systems:

- In the dual system (such as in the UK, Finland or Italy, according to Kemeny, 1995), the State takes on the direct responsibility to provide rental housing for households in need. The regulated market for social housing - which has a clear social profile - is clearly separated from the private market.

- In the unitary system (represented by countries such as Austria, Denmark, Germany, the Netherlands or Sweden (according to Kemeny in 1995), the State does not have a direct responsibility of providing rental housing and access is not limited to households in need. In these countries, housing policy is not a social policy aimed at vulnerable households but rather an integrated part of the welfare state. The non-profit sector competes with profit-rental housing companies on the open market. The relative size of the not-for-profit sector varies considerably across countries, but its average size is larger than in most dualist systems.

Thus, in some countries, social housing can be seen as an instrument to regulate markets (e.g. in the Netherlands): social housing is open to all and not only to the most vulnerable. In other countries, social landlords may be compelled to concentrate specifically on low-income households; the social housing sector then acts as a safety-net for those households that are not capable of securing a dwelling elsewhere in the housing market. Depending on the countries and their respective housing policies, the landlords may be more or less free to act at their discretion to allocate units. Landlords may for instance be subject to market mechanisms and have societal obligations which can (or not) be supported by ad hoc subsidies. Municipal housing (as e.g. in Sweden) may also have an influence on the overall housing market. [71]

3 How is this sector covered in the study?

Although the concept of "social housing" has no consensus definition – partly due to the wide variety of national contexts in which it is applied – the primary role of social housing is to help households with difficulties in gaining access to decent and affordable housing on the market to find accommodation in an adequate social and urban mix (to prevent "social ghettos"). The "social housing providers" refer to organisations (central or local governments, depending on the country, and a range of voluntary, not-for-profit and cooperative organisations, social agencies, etc.) whose main purpose is to accomplish this mission.

Following this view, the common feature of social housing in the Member States is the existence of rules for allocating housing to benefiting households for which market instruments are unable to fulfil the above goal. Defining these rules for allocating housing is the responsibility of the Member States and their public

[70] Kemeny Jim, *From Public Housing to the Social Market: Rental Policy Strategies in Comparative Perspective*, Routledge, London, 1995

[71] For more developments, see e.g. Van der Heijden Harry, "Social Rented Housing in Western Europe: Developments and Expectations", *Urban Studies*, Vol. 39, No. 2, 327–340, 2002.

authorities. It is worth noting that, although social housing is generally associated to social rental, a number of social housing providers do also build (and sometimes even manage) dwellings for affordable ownership.

4 Overview on service provision and expenditure

"In recent years new housing output across Europe has been dominated by the private sector and there has been an associated decline in social housing construction in both relative and absolute terms."[72]

"In many of the 15 long-standing EU members, housing policy currently places significant emphasis on expanding the stock of private rented housing, which is recognised as an important resource, particularly in the major cities where rents are high and housing affordability is consequently lower. ... The management of social rented housing and its increasingly residual nature in socioeconomic terms is also identified as a key issue in housing policy statements in many of the long-standing EU members."[73]

The lack of standardised definitions of social housing across the EU – and the resulting absence of common methods and cycles of data collection in all member states – makes it difficult to establish meaningful comparisons, given the disparity in terms of indicators, methods and cycles of data collection.

Statistical overview on the main features of the social housing sector

Based on surveys and research undertaken by various research institutes under the coordination of Housing Ministries throughout the European Union, some figures could be collected on the relative share of social housing versus the normal private housing market. The following table from the latest Housing Statistics in the European Union 2004[74] shows the importance of social housing with respect to the rental sector and the total housing stock.

[72] The Housing Unit, *Regular National Report on Housing Developments in European Countries - Synthesis Report*, Department of the Environment, Heritage and Local Government, Dublin, Ireland, November 2004, Section 1 - Introduction and Summary.
[73] The Housing Unit, *Regular National Report on Housing Developments in European Countries - Synthesis Report*, Department of the Environment, Heritage and Local Government, Dublin, Ireland, November 2004, Section 1 - Introduction and Summary.
[74] National Board of Housing, Building and Planning (Sweden) & Ministry for Regional Development of the Czech Republic, *Housing Statistics in the European Union 2004*, February 2005.

Table 8.1: Social housing in % of rental sector, housing stock and new dwelling completions, 2003

	Social housing in % of			
	rental sector	**total housing stock**	**new completions in rental sector**	**new completions in the total housing sector**
Austria	35,4	14,3	na	na
Belgium	23,0	7,0	25,0	6,0
Cyprus	na	4,6	na	na
Czech Republic	80,0	20,0	99,0	25,5
Denmark	43,0	20,0	75,0	40,0
Estonia	na	3,0	na	na
Finland	50,0	17,2	na	17,0
France	45,5	17,5	40,0	13,0
Germany	12,5	6,5	12,2	3,2
Greece	0,0	0,0	0,0	0,0
Hungary	na	4,6	82,5	4,5
Ireland	45,0	8,0	na	9,0
Italy	na	na	na	na
Latvia	1,5	0,1	0,0	0,0
Lithuania	27,0	3,0	0,0	0,0
Luxembourg	6,4	1,9	0,9	0,6
Malta	na	na	na	na
Netherlands	76,8	34,6	77,0	18,3
Poland	na	23,4	na	6,8
Portugal	15,8	3,3	na	na
Slovac Republic	54,0	4,5	100,0	28,0
Slovenia	72,7	6,6	na	na
Spain	11,6	0,9	na	1,3
Sweden	45,0	21,0	54,0	18,0
United Kingdom	na	na	na	na

Source: Housing Statistics in the European Union 2004, Table 5.5

There is no comparative statistics about the public expenditure with respect to social housing subsidies and financial support in the strict sense. The Housing Statistics in the European Union 2004[75] only give an approaching overview of the characteristics of the social housing sector with respect to cost and financing. The following table shows that in most countries (apart from Greece, where there is no concept of social housing[76], and Latvia), there is a public support to social housing.

[75] National Board of Housing, Building and Planning (Sweden) & Ministry for Regional Development of the Czech Republic, *Housing Statistics in the European Union 2004*, February 2005.
[76] In Greece, what could be understood as social housing organisations dispose of own social funds.

Table 8.2: Characteristics of the social housing sector

	Housing construction is directly supported from public resources (subsidies, soft loans, interest subsidies, guarantees)	Management is supported from public resources (operating subsidies)	Rent control is applied (cost rents, rents based on tenants' incomes etc.)	Dwellings are explicitly targeted at groups of people with limited incomes or socially vulnerable housholds	Tenant protection in this sector is stronger than in the privat (profit oriented) rental sector	Tenants do not participate financially in the construction cost	Tenants have to move when they no longer fulfil the criteria for belonging to the targeted groups
Austria	•	-	•	•	•	-	•
Belgium	•	•	•	•	•	•	•
Cyprus	•	•	-	•	-	-	-
Czech Republic	•	•	•	•	-	-	-
Denmark	•	-	•	•	•	•	-
Estonia	•	-	-	•	•	•	-
Finland	•	-	•	•	+/-	•	-
France	•	•	•	•	•	•	-
Germany	•	-	•	•	-	-	-
Greece	-	-	-	-	-	-	-
Hungary	•	•	•	•	•	-	-
Ireland	•	•	•	•	•	•	-
Italy	na	na	na	na	na	na	na
Latvia	-	-	•	•	•	•	•
Lithuania	•	-	-	•	•	•	-
Luxembourg	•	-		•	-	•	•
Malta	•	•	•	•	•	•	-
Netherlands	•	-	•	•	-	•	-
Poland	•	-	•	•	•	•	-
Portugal	•	•	•	•	•	•	-
Slovac Republic	•	-	•	•	-	•	-
Slovenia	•	-	•	•	-	•	•
Spain	•	+/-	•	•	•	•	•
Sweden	•	-	•	-	-	•	-
United Kingdom	na	na	na	na	na	na	na

• := correct - =: not correct

Source: Housing Statistics in the European Union 2004, Table 5.7

On the other hand, the Housing Statistics in the European Union 2004[77] did also compile subsidies to the housing sector in general (not specifically related to 'social' housing) as pictured in the next two tables: supply side and demand side subsidies.

[77] National Board of Housing, Building and Planning (Sweden) & Ministry for Regional Development of the Czech Republic, *Housing Statistics in the European Union 2004*, February 2005.

Table 8.3: Supply side subsidies, public loans and public credit guarantees in the housing sector (Million Euro), 2003

	Direct supply side subsidies for housing	Thereof (%) from		Newly provided public loans for housing	Thereof (%) from		Total out-standing public loans	Public sector guarantees
		State budget	Regional or local budget		State budget	Regional or local budget		
Austria	87,1	0,0	100,0	2939,6	na	na	na	Yes, regional gov.
Belgium	460,7	0,0	100,0	564,8	15,5	84,5	5637,5	Yes, regional gov.
Cyprus	na	na	na	na	na	na	na	na
Czech Republic	658,0	100,0	0,0	17,2	100,0	0,0	203,0	No
Denmark	592,1	77,3	22,7	94,2	0,0	100,0	2153,2	Yes, local gov.
Estonia	5,3	100,0	na	0,0	0,0	0,0	0,0	Yes
Finland	107,0	100,0	0,0	401,0	100,0	0,0	10400,0	Yes, central gov.
France	1800,0	100,0	na	4200,0	100,0	0,0	79320,0	Yes, local gov.
Germany	na	na	na	110,3	100,0	na	na	Yes, central+regional gov.
Greece	0,0	na	na	1125,6	100,0	0,0	na	Yes, central gov.
Hungary	na	na	na	2,8	na	na	4,8	Yes
Ireland	112,6	86,6	13,4	214,3	0,0	0,0	2700,0	Yes
Italy	na	na	na	na	na	na	na	na
Latvia	0,0	0,0	0,0	na	na	na	na	No
Lithuania	0,0	0,0	0,0	3,7	100,0	0,0	4,7	Yes
Luxembourg	15,5	100,0	0,0	1,0	100,0	0,0	na	Yes, central gov.
Malta	6,3	100,0	0,0	na	na	na	na	Yes
Netherlands	1062,0	100,0	0,0	0,0	na	na	0,0	Yes, central gov.
Poland	173,2	100,0	na	208,0	100,0	na	931,9	Yes, local gov.
Portugal	177,9	100,0	na	208,0	100,0	0,0	287,6	No
Slovac Republic	36,5	100,0	0,0	68,5	100,0	0,0	392,1	Yes, central+local gov.
Slovenia	7,3	100,0	0,0	12,7	na	na	225,8	Yes, central gov.
Spain	na	na	na	0,0	0,0	0,0	0,0	No
Sweden	194,9	100,0	0,0	0,0	0,0	0,0	0,0	Yes, central gov.
United Kingdom	na	na	na	na	na	na	na	na

Source: Housing Statistics in the European Union 2004, Table 5.2

Table 8.4: Demand side subsidies in the housing sector

	Total volume of direct demand side subsidies	Thereof (%) from		Total volume of indirect support
		state budget	regional or local budget	
Austria	na	0,0	100,0	na
Belgium	139,1	0,0	100,0	na
Cyprus	na	na	0,0	na
Czech Republic	89,0	100,0	na	41,4
Denmark	1318,9	69,1	30,9	40,4
Estonia	11,0	100,0	0,0	11,0
Finland	924,0	100,0	0,0	390,0
France	18300,0	100,0	0,0	9300,0
Germany	na	na	na	na
Greece	na	na	na	3,9
Hungary	na	na	na	na
Ireland	3,8	100,0	0,0	212,6
Italy	na	na	na	na
Latvia	na	0,0	100,0	0,0
Lithuania	33,5	100,0	0,0	4,3
Luxembourg	69,0	95,8	4,2	133,6
Malta	1,4	100,0	0,0	na
Netherlands	1658,1	100,0	0,0	2360,0
Poland	463,5	56,0	44,0	1320,8
Portugal	467,8	100,0	0,0	357,0
Slovac Republic	97,7	100,0	0,0	0,0
Slovenia	3,5	0,0	100,0	na
Spain	480,0	100,0	na	4402,0
Sweden	1592,4	100,0	0,0	1446,7
United Kingdom	na	na	na	na

Source: Housing Statistics in the European Union 2004

Table 8.5 finally provides an overview on spending under the social benefit function "housing" in ESSPROS. It should, however, be noted that the Housing Statistics in the European Union are not recurrent standardised statistics collected and produced by Eurostat. ESSPROS (European System of Integrated Social Protection Statistics) on the contrary offers regular statistics, but those are less detailed. The following table presents the quite constant remaining share (with respect to GDP) of expenditure, in the form of payments of social benefits, devoted to housing.

Table 8.5: Social benefits for the function: Housing (as a % of GDP)

	1990	1995	2000	2004
Belgium	0,6	:	0	0,1
Czech Republic	0,2	0	0,1	0,1
Denmark	:	0,8	0,7	0,7
Germany	0,6	0,2	0,2	0,2
Estonia	0,5	:	0,1	0
Ireland	0,1	0,6	0,5	0,5
Greece	0,8	0,6	0,8	0,6
Spain	0	0,2	0,2	0,2
France	:	0,9	0,9	0,8
Italy	:	0	0	0
Cyprus	:	:	0,5	0,4
Latvia	0	:	0,1	0,1
Lithuania	:	:	0	0
Luxemburg	:	0	0,1	0,2
Hungary	0,3	:	0,5	0,4
Malta	0,1	:	0,2	0,3
Netherlands	0	0,4	0,4	0,3
Austria	:	0,1	0,1	0,1
Portugal	:	0	0	0
Slovenia	0,2	:	:	:
Slovakia	1	0	0,1	0
Finland	1,3	0,5	0,4	0,3
Sweden	:	1,1	0,6	0,6
United Kingdom	0	1,8	1,5	1,5
EU25	0,3	:	0,5	0,5
EU15	:	0,6	0,5	0,5

Source: Eurostat, ESSPROS social expenditure database, accessed Jan 2007

Changing demand for social housing

In the European Union the current trend is towards smaller households and it is predicted that in 2010 around one third (32%) of the EU-15 elderly population (aged 65 and over) will be living alone. In some countries[78], an ageing population with fewer resources and increasing need for social care will bring additional challenges to social housing. Apartments thus need to be adjusted to their special conditions with access to good services and extra support to allow them to remain independent in their own homes.

Challenges also arise from the need to respond to a new profile of social housing tenants. There are important shifts from the traditional model of nuclear family as the 'typical' tenant, towards new so-called 'patchwork' families (product of higher rates of divorce and re-composed families), to lone parents, and towards large or extended families of immigrants and ethnic minorities. In addition, there are the difficulties

[78] This was notably mentioned in the SHSGI Policy Paper on Social Housing in Europe with respect to the Czech Republic and Italy.

experienced by an increasing number of young households in the housing market (whether rental or owner-occupied) and these have become one of the key target groups of social and housing policies in many EU Member states. And finally, support services and shelters are increasingly needed to enable people who have experienced major personal or social distress to reintegrate into community life.

Trends in housing markets and policies

Throughout Europe, provision of social housing has declined in most countries – except for those where the increase in supply of social housing is a key priority, such as Spain, France, Hungary, United Kingdom, Ireland, amongst others. In relation to this, the involvement of the private sector in providing and managing social housing, among others by means of public-private partnership arrangements, is an ongoing trend in several of the long-standing EU member States.

Supply subsidies to social housing have been complemented in many countries by demand-side subsidies through housing benefits and vouchers. Overall, housing has in many cases become more market-oriented, competitive and opened up to economic pressures. There has been a trend towards the sale of the public rented stock either through right-to-buy-type policies to sitting tenants – started in the 1980s by the Conservative government in the UK and followed by some other countries, and most recently seen in the massive sale of housing to sitting tenants in Eastern European countries – or through stock transfer operations (e.g. devolution of social housing stock to the corporations in the Netherlands; and stock transfer from local authorities to housing associations in the UK). Another example is the recent large-scale selling of local public housing companies in Germany to foreign private pension funds as a way to reduce the public debt of local authorities.

In those Member States, where policies of sale of social rental housing have been implemented on a large scale (such as in the UK), privatisation processes have caused the share of social housing in the total housing stock to be reduced. As a consequence, social housing has tended to become increasingly targeted at narrower sections of society, i.e. a process of 'residualisation' of social housing is taking place. While some actors believe that targeting lower-income groups is a more efficient way for the social housing sector to operate, evidence shows that by focusing on low-income groups, this type of housing becomes increasingly stigmatised. Thus, in order to prevent stigmatisation and spatial segregation, some believe that it is advisable to have a broad-based social rental sector with a diverse dwelling stock and a differentiated resident profile – an approach now reflected in the 'universalistic' model of social housing provision explained above.

Recent evolutions in response to financial challenges

Waiting lists, demographic trends, urban regeneration policies, lack of financial resources are only some challenges that face social housing organisations and the public authorities implementing the respective public policy in this sector. It is now recognised that social housing would require major public or private investment in

order to maintain or improve the quality of housing stock and to adapt it to changing and expanding needs.[79]

In order to be able to fulfil their social obligations to provide homes for the most vulnerable groups and meet new challenges arising from the socio-economic development of societies (see Part IV), additional financial means are needed. Many social housing organisations are increasingly diversifying their portfolios and undertaking so-called non-landlord activities as a means to cross-subsidise their social dwellings via the development of profitable activities (e.g. building of commercial properties).

In Italy, following the decentralisation of responsibilities, the regions and municipalities gained important responsibilities with respect to social housing. Depending on the trend and policy chosen, traditional housing organisations were transformed into companies (looking for more profit-making activities) in some Italian regions (e.g. Emilia Romagna and Toscana), while in others (mainly in the South) traditional public organisations remain. The latter do not have the obligation of having a balanced budget and thus limit their activities to the traditional tasks of the social housing sector. The majority of the social housing providers tend to defend this traditional role while some are undergoing an evolution and strive for continuing innovation, in order to compensate the structural deficit of the management of the social park (where the rents are very low).

However, when such commercial activities are allowed, they are framed by rules. In the Netherlands, the profit independent private housing organisations gain from profit-making activities must be deployed for social housing activities. In Sweden, following the Swedish Local Government Act (kommunallagen), which does not apply to other housing companies that are not owned directly or indirectly by municipalities, municipalities may only engage in a business activity if it is conducted without a view to profit and is essentially concerned with providing municipal amenities or services for the members of the municipality.

5 Lessons from European comparisons

"Unbalanced housing demand and supply, and related affordability problems particularly in the major cities, is currently the focus of policy initiatives in the vast majority of European countries. However, the extent and nature of this problem varies between countries as do the policy interventions it has inspired."[80]

In the Eastern European States, the main concern is related to the "effects of the sale of formerly State-owned housing. One of these effects is a shortage of social rented units in many CEE countries, which policy makers are attempting to address by increasing the output of dwellings in this tenure. The private rented sector in many of these countries is also very small and, in the view of many policy-makers, its further

[79] See Section above on Changing demand for social housing.

[80] The Housing Unit, *Regular National Report on Housing Developments in European Countries - Synthesis Report*, Department of the Environment, Heritage and Local Government, Dublin, Ireland, November 2004, Section 1 – Introduction and Summary.

development has been impeded by rent control measures."[81] Several Governments are trying to address these issues and are currently envisaging potential reforms.

Because of the large diversity of policy orientations, one has to be cautious in drawing conclusions on the possible successes or failures of social housing policies when one compares situations between countries. Further, policy directions can change rapidly from one government to the other. In Sweden, for example, up until the last government (social-democrats), municipal companies had access to very few direct subsidies (mainly for new construction and rehabilitation), since the trend was on demand side subsidies. On the basis of the announcements made by the recently elected right-wing government, there will be cuts in the subsidies for social housing providers, which are expected to bring along many changes in the Swedish social housing sector.

It is important to stress the fact that urban segregation in large scale neighbourhoods where social housing was built in the 1960s and 1970s faces today the same trends of "ghettoisation" in terms of socio-spatial segregation irrespective of the initial conception of social housing, i.e. either "universalistic" or "targeted". Thus even if the policy goal was 'universalistic'-oriented, the achievements did not necessarily follow. Therefore, these "ghettoisation" and segregation problems exist in the countries pertaining to both categories in the above[82] classification.

The main trends and recent evolutions in the five countries studied in depth are the following ones:

Table 8.6: Trends and recent evolutions in social housing

Country	*Trends and recent evolutions*
Czech Republic	- Ongoing privatisation - Diversification of market and financing schemes - Sharp increase in elderly population looking for affordable housing
France	- General insufficiency of supply and reduction of public financial support - Persistence of unhealthy dwellings and large dwellings built in the 1960s and 1970s in need of rehabilitation - Strong increase in prices of the housing market in general and in the prices of social housing charges - Strengthening of social exclusion (especially young immigrants)
Italy	- Widening of activities of social housing toward new target groups - Diversification of activities of social housing providers to

[81] The Housing Unit, *Regular National Report on Housing Developments in European Countries - Synthesis Report*, Department of the Environment, Heritage and Local Government, Dublin, Ireland, November 2004, Section 1 - Introduction and Summary.
[82] See Section 1.

	facilitate the integration of tenants, but also towards for-profit activities - Decentralisation and new financing modes
The Netherlands	- Important and large political discussion under way about the scope and content of social housing - Enlargement and diversification of activities of social housing providers (commercial activities, portfolio management, involvement in related housing markets [also cross-border], neighbourhood development) - Limitation of state support to social housing and changing financing mechanisms
Sweden	- Shifts in subsidisation mechanisms - Increased social segregation - Demographic changes (elderly, immigrants) - Lower income and higher unemployment of tenants - Rising costs of social housing (maintenance)

6 Conclusions

In order to face increasing housing costs in the market and due to financial constraints, there has been a growing emphasis on targeting the provision of social housing at certain groups with special needs (e.g. disabled, elderly, young families, etc.) or on the basis of their relatively low incomes. In addition, the shortage of supply in many countries (Ireland, United Kingdom, France, the Netherlands, etc.), together with the general trend towards rent liberalisation and the increase of house prices above the price of inflation (e.g. France, Spain, Ireland) are some of the factors which have worked against housing affordability – thereby putting pressure on governments to put in place effective policies to mitigate this shortage of affordable supply, increasingly also for "key workers" and the middle classes. In this context, social housing organisations are facing greater demands in those cases where they keep a predominant role to fulfil this mission, and in cases where there is a weak social housing sector (e.g. Hungary, the Czech Republic, Spain, etc.), discussions are in place amongst government, social and academic actors to establish such a sector.

Finally, it is worth noting that while in France and Italy there is a strong trend towards decentralisation of housing provision, in Sweden and in the Netherlands the local level remains the one where the provision of social housing has taken place for a long time.

Part III. Modernisation and the quest for good governance

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Overview

Social services are currently undergoing many changes in the quest for improving social and economic outcomes. This part provides an overview on main trends in modernisation of social services. However, if it is possible to identify common trends across countries, the transformations take place in existing institutional contexts and are partially conditioned by the cultural, institutional and political features characterising each national setting. The authors of this study conclude that many trends and developments analysed in this part are likely to be reinforced by the growing influence of the direct and indirect impact of competition rules and the gradual strive to realise an internal market, impacting also on social services if and when "defined" as economic services according to Community law and ECJ jurisprudence.

Modernisation is a contested process and involves stakeholders that often have different views about as well as different stakes in the reforms to be implemented. As underlined by the stakeholder enquiry under this project (see the SHSGI Policy Paper on this matter) this also entails different assessments of its outcome, based on (at least partially) divergent concepts, interests and values. This and the fact that many of the reforms have not systematically been evaluated make the cross-country analysis a difficult task. Modernisation is driven by the search for efficient and effective provision mechanisms but also for new solutions in order to meet new or changing needs. It takes place at different levels of the delivery system, such as the levels of organisational design, of regulatory mechanisms and of governance forms. The focus of this Part therefore is on developments and innovations in specific modes of organisation and management, on new market-based regulatory and budgeting mechanisms, and on new forms of partnership and co-operation[83].

This Part starts with setting out the context for the modernisation debate in the field of SHSGI. It next provides an overview of modernisation trends that addresses the most important issues at stake, such as changes in management, organisation, financing, access, and user-orientation, regulatory mechanisms and governance of SHSGI that are analysed more in depth in Chapters 9, 10 and 11, respectively. Chapter 12 finally provides detailed examples for the most significant recent developments in the five sectors covered in-depth in this study (Table 12.1).

The analytical sections of Part III build on the in-depth country reports, statistical information, synthesis reports that have been elaborated in the framework of the OMC and on recent European comparative studies. A concluding section summarises the core issues and innovative trends to be learnt from this analysis, with a view to identify trends for regular monitoring and evaluation in the future. The articulation between Community law and policy, and its reflections in national policies and law on the one hand, and the different forms, modalities and instruments characterising processes of modernisation on the other, is highlighted in Part IV

[83] Cf. for overview information on the historical perspective e.g. Donzelot, 1984; Esping-Anderesen, 1990; Evers/Laville, 2004; Ewald, 1986, on drivers of modernisation e.g. Enjolras 1995; Evers/Svetlik, 1993; Rhodes, 1997; Taylor-Gooby, 2004; Walker, 1996; WRAMSOC-Projekt and Chapter 9.4.

Chapter 9 The context of the modernisation debate

1 Introduction

Modernisation is a multifaceted concept that has been used differently in national and European economic and social policy contexts. Before analysing the modernisation trends that currently characterise SHSGI in Europe it is necessary to clarify what is meant by modernisation in this study, as well as to sketch the contours of the institutional contexts in which modernisation processes take place. This Chapter will argue that the variety of the national institutional frameworks in which the provision of SHSGI is embedded constitutes an important explanatory factor of the variety of modernisation processes that can be observed for social services.

2 The political context of modernisation

The term 'modernisation', as used in a number of Commission documents, has a varying focus. Moreover, there are also different connotations for this term in national policies and in the understanding among the various stakeholders and observers of social services. This section starts by briefly reviewing the context of the modernisation debate at European Union level.

In the line of the Lisbon strategy and the goals of the European internal market the Commission considers economic growth and an increase in employment as the major goals of a general modernisation process. As has been shown in Chapter 2, social services are an economic sector of growing importance. Moreover, it is also widely recognised that social services and social protection contribute in different ways to economic growth and a more productive economy (see for example the study of Fourage, 2003, commissioned by the Commission).

Financial sustainability, accessibility and quality of social protection are important policy goals for the Commission when modernising theses schemes[84]. These overarching objectives have been developed in the framework of the Open Method of Coordination (OMC) in the fields of social inclusion, pensions and health and long-term care.

Coping with social, demographic, and economic changes is another issue. This demands attention and reform efforts in the fields of childcare, care for the elderly and care for disabled people. Strongly interconnected is the need to improve the work/life balance in particular for families. Education, including professional training, is another topical issue in modernisation strategies, closely interrelated with the demand for more flexibility such as in the framework of "flexicurity arrangements".

From the Commission's perspective enhancing social cohesion and political legitimisation, implying active involvement of citizens, are also crucial in modernisation processes.

[84] See e.g. Commission of the European Communities (2004b) and Commission of the European Communities (2006c).

For the fact-finding exercise of this study, it is important to use the term 'modernisation' in a broad sense, which captures a wide range of actual reform trends that social services are currently undergoing, including the many changes in the quest for improving social outcomes. The term modernisation takes into account the variations with regard to the changing role of public authorities and existing as well as evolving modes of governance in the field of SHSGI. Moreover, there are often important differences within countries between local and regional territorial units as well. This may be structural or due to differences in the stages of implementation of existing laws, rules and procedures. The evolution of European legislation and its translation into national laws does also interplay in the modernisation processes, by changing part of the regulatory framework.

3 The institutional context of modernisation

The modernisation of SHSGI takes place in an institutional context structured by at least three elements: the division of competencies and responsibilities between the different levels of government, the type of entitlement associated to the services (see also Chapter 1), and the mode of organisation of the provision of services (see also Chapter 1). The existing institutional contexts – usually firmly established and anchored in the cultural and normative foundations of the countries – that define national frameworks help to explain and are among the drivers of the diversity of the observed modernisation trends in the Member States. These changes are often path-dependent, i.e. conditioned by the existing institutions and the cultural context. But they are also influence by exogenous factors (e.g. cross-country trends in economic or budgetary policies) as well as by processes of policy diffusion across countries[85].

3.1 Division of competencies and levels of governance

In nearly all Member States at least three levels of governance characterise the vertical organisation of government: the central national level, regions and/or provinces and municipalities. This three-level division prevails for example in Finland, Norway, Sweden, and Spain. In some countries, like in France, Italy and Poland, a fourth level exists between the central government and the first or second sub-national level. The designations for these levels of government differ between countries. In addition, several Member States count with institutions (particularly social insurance agencies), which cross-cut the vertical scales, i.e. they are mostly established at national level, but their tasks may differ according to the different administrative levels of government. Non-governmental non-profit or for-profit organisations, that provide a variety of services in the fields of health, social welfare and employment, can operate at all levels.

This is illustrated by Tables 9.1 and 9.2 which give an overview of the regulating bodies for two of the sectors covered in-depth by this study: long-term care and childcare services.

[85] In this regard, activities and interventions of supra-national bodies such as the EU, OECD or ILO exert an increasing influence on the shaping of national, regional or local social policies or play a role in the operation of programmes (for example the Community Action Programme on Social Inclusion 2002-2006).

Table 9.1: What is the regulating body for long-term care?

Competent public authority	Country							
	CZ	DE	FR	IT	NL	PL	SE	UK
National government	4	3	1	5	1	3	2	3
Regional territorial authority (state; province)	1	1		1		2	2	4
Local territorial authority		1				1		1
• District			2	4			2	5
• Municipality	2			3		1	1	1
Social insurance agency		1			2		2	5
Note: Ranking from 1 (Most involved) to 5 (Least involved)				1	2	3	4	5

Source: Questionnaire for in-depth country studies

Table 9.1 shows a relatively diverse pattern between countries regarding responsibilities of different administrative levels for the regulation of long-term care services. Regional government is the dominant regulator in the Czech Republic, Germany and Italy, with an equally important social insurance agency in Germany. The district and the social insurance agencies are prominent in the UK whereas the national government is the main regulator in the Netherlands and in France, with districts ranking second only. Poland, Sweden and the UK appear as the most decentralised countries. Basically all countries are characterised by the involvement of a plurality of actors and regulatory levels.

Compared to the pattern characterising long-term care, Table 9.2 shows only for Poland a similar pattern for childcare services. In France, the national government is the main regulator, with the social insurance agency – a sector-specific national social security agency (CNAF, *Caisse Nationale d'Allocations Familiales*) with regional branches (CAF, *Caisses d'Allocations Familiales*) – as a country-specific feature and the local level (district and municipality) ranking second and third. In the Netherlands, the national government has been attributed the same importance as the municipalities. The Czech Republic, Germany and Poland can be characterised by a shared main responsibility of public authorities at local and regional levels. In Italy, the local territorial authorities (here: districts) play the most important role. As above for the sector of long-term care services, no predominant pattern can be identified for the childcare sector. Rather we are again faced with a diversity of country-specific patterns of shared responsibilities and the involvement of a plurality of actors.

Table 9.2: What is the regulating body for childcare services?

Competent public authority	Country					
	CZ	DE	FR	IT	NL	PL
National government	4	3	1	5	1	3
Regional territorial authority (state; province)	2	1		3		2
Local territorial authority		1			2	1
• District			2	4		
• Municipality	1		3	1	1	1
Social insurance agency		5	2 (CNAF)			
Note: Ranking from 1 (Most involved) to 5 (Least involved)		1	2	3	4	5

Source: Questionnaire for in-depth country studies

The central/national level

In all countries under scope, the national level lays down basic social, health and employment policies, corresponding legislation and establishes regulatory powers. Further, with few exceptions, the state carries responsibility for the mandatory components of national social protection schemes[86], the extent and the design of which vary from one country to another. The national reports illustrate the diversity and the complexity of these schemes.

The regional levels

In cases where countries have embarked on a process of decentralisation, the centralising power of the state began gradually to be reversed and responsibilities to be transferred to sub-national authorities such as regions and, frequently even more so, to municipalities. It is at the regional level that differences between countries appear to be most pronounced. Some countries distinguish two types of sub-national authorities between the state and the local (municipal) level.

[86] There are rare exceptions such as unemployment insurance in Sweden which, unlike other insurance schemes, is voluntary and administered by funds that are usually connected with a trade union and based on members' contributions and state subsidies. The design of these institutions varies since they are woven into the social welfare fabric of each country.

This is the case for example for:

- France: regions and departments or counties (*départements)*
- Germany: regions or states (*Länder*) and counties (*Land-/Stadtkreise*), the former bestowed with considerable legislative (as well as independent constitutional) powers, not least in the field of personal social services
- Italy: regions and provinces
- Poland: regions or provinces (*voivod*) and counties (*poviat*)

The competencies conferred to the regions of these countries differ considerably. In France for example, the 22 regions are responsible for the whole public programme of apprenticeships and vocational training. In Italy, after the constitutional reform of 2001, the 20 regions have, just as the central state, legislative powers which means that they can legislate on all matters that are not explicitly of the state's competence. Among these matters are social welfare that also includes the organisation of social services, labour market policies and employment within the framework of state regulations. As a consequence, in Italy, the regions have become the pivot of decentralisation in these fields. Yet one of the major problems encountered are the great discrepancies between the regions in health care, social welfare services and employment levels, due to the so-called North-South divide, a trend that is reported to be growing.

In Poland, the regions (*voivod*) have mainly a programming and co-ordinating role in regional development that includes, among other things, the promotion of health, social welfare and family protection services. Through labour councils – which exist at all levels – they assume a supervisory function in the area of employment policy.

The second type of sub-national authority in the four-tiered structures e.g. in France, Italy and Poland corresponds in many instances more closely to that of the regions in the countries with a three-level territorial organisation although there are considerable differences in design, status and competencies. This fact seems to render any attempt of grouping these countries difficult though at best they could be divided into those where sub-regional authorities – apart from municipalities – have been conferred major competencies such as the *départments* in France, the *Länder* in Germany, the regions in Italy and the cantons in Switzerland and those where they play a relatively minor role such as the provinces in Italy and Spain, the regions in Norway, Sweden and Finland and the counties in Poland.

The local/communal/municipal level

It is at this level where the principle of subsidiarity is likely to find its most appropriate exemplary application. In most countries the local level constitutes the basic element of the system of governance. It may also be less subject to fluctuations as it could be the case with other sub-national levels or the national level itself, though it is affected by a redistribution of responsibilities to other levels. There seems to be a tendency that the decentralisation process has expanded the responsibilities of the local or municipal level, particularly in the social welfare field. An exception is France where the Decentralisation Act 2 (2003-2004) considerably strengthened the departments' scope for social action but not that of the municipalities.

3.2 Rights, obligations, entitlement

Issues of rights and citizenship are crucial to modernising social services, particularly when it is about newly defining them or to adapt them to changing needs and demands. Questions related to social rights, entitlements, citizenship and social justice impact on the way social needs are met in a society. Whereas Chapter 1 sketches basic concepts in this regards, Chapter 10.4 will deal with eligibility criteria and entitlement conditions which strongly determine conditions of having access to social rights – and in this relation also – to social services. Modernisation strategies that aim at promoting access to social rights include in particular user orientation, empowerment and quality improvement strategies.

4 Drivers of modernisation

Modernisation processes start from different levels and follow various motives within different political, economic and cultural contexts. In the framework of the study the following set of important drivers of structural reform processes in the field of social services was identified:

- New solutions in order to meet new or changing needs (amongst other linked to a better reconciliation of work and family life);
- The search for efficient and effective provision mechanisms and cost containment;
- Promotion of access to social rights;
- The search for quality improvement;
- The quest for stronger user orientation, empowerment of users (strengthening of self-help potentials) and more choice for users;
- The quest for improving social/societal outcomes.

These drivers have backwash effects on different levels and aspects of the delivery system, such as the levels of organisational design and management, of regulatory mechanisms and of governance forms. Across Europe new market-based regulatory and budgeting mechanisms, as well as new forms of partnership and co-operation are appearing. The modernisation of modalities of organisation and management of social services, however, started from different levels of government in individual countries, depending on the political, historical and cultural context, following different drivers of reforms. Moreover, moves for modernisation may be steered by the providers themselves, by public authorities, based on the assessment of users' expectations, stemming from the increased integration in the framework of the internal market and overall globalisation of the economy or from technological developments, or induced by new laws or regulations.

The drivers and dynamics of the modernisation process have evolved and the structural changes were implemented on national levels. Since most SHSGI are classified as “economic activities” and their providers categorised as “undertakings” according to both Community law and ECJ rulings, many trends and developments analysed in the study are likely to be influenced by Community rules also. The impact from EU level increasingly affects national systems and measures in the field of social services in ways that have often not been foreseen. When national systems and measures were originally designed, recent evolutions that are based on ECJ rulings

and Community legislation could not be anticipated and consequently were not taken into consideration. National governments, regulative bodies and public authorities did (for a long time) not consider possible backwash effects stemming from this, also when enacting structural changes with in-built elements of market-based regulation and reforms designed with the clear intention to allow for or increase competition amongst providers in the field of social services.

5 Modernisation as a contested political process

Modernisation of social services is a contested process involving different stakeholders, reflecting different interests as well as concepts on the architecture and modes of organisation of service-delivery. One matter that increases the complexity of these reforms is that the nature of the policy instruments implemented has an impact on how (social) policy objectives are met in general. This is particularly the case when it comes to the provision of services by voluntary organisations and organisations in the social economy. These organisations argue that they not just provide services, but contribute, through their particular organisational features, to developing solidarity, social networks, voluntary activities, democracy and participation, cultural specificity, etc. Many civil society initiatives and the voluntary organisations providing social services claim that they have a 'civic added value' that contributes to social policy objectives like social integration, empowerment and social participation. From this viewpoint, market-based allocation mechanisms are sometimes seen as undermining the specificity of the social contribution of these organisations.

Another characteristic of modernisation in this field is that a given policy objective can often be realised through different policy instruments reflecting different basic normative (culturally and historically conditioned) concepts and values relative to the organisation of social life. For example the objective of beneficiaries' empowerment can be realised by giving individuals more rights, more purchasing power or more participation opportunities in decision-making.

Finally, in organising social services public authorities are confronted with the trade-offs between the different policy objectives, e.g.:

- Favouring access to social rights and assessment of eligibility;
- Favouring responsiveness to needs;
- Cost control and budget balance;
- Discouraging dependency on social services and fostering empowerment;
- Integration of services in order to address the totality of the person's problems/ difficulties/social situation;
- Tackling informational asymmetry, preventing abuse, guaranteeing protection of the users and quality of the services.

Enhancing access to social rights may for example undermine the objective of keeping social budgets under control. Guaranteeing rights may provoke dependency on social services in the long run. Keeping costs under control may contribute to quality downgrading, etc.

Modernisation can in this respect be viewed as public authorities' attempts to find new solutions to the dilemma and trade-offs that characterise the organisation and provision of social services.

At the end of this section some assessments and opinions will be presented as they were raised in the framework of the stakeholder enquiry (see also Executive Summary of Policy Paper No.2).

Stakeholders from the third sector often approach "modernisation" from a citizen-approach, whereas the general notion of the word's current use carries a different understanding. The debate in political science and the more practical discourse point to a redefinition of citizenship along a line of customer relations. The second box under "Need for Terminological Clarification" in Policy Paper No 2 further illustrates this statement. This is closely linked to a broader understanding of quality. This is especially true for stakeholders which are of a 'hybrid' type, being at the same time service providers, representatives of users, employees and free-lancers, engaged in economic and non-economic activities etc. In consequence, many of the generally used concepts as measuring input versus output, process versus product quality and the like are difficult to apply.

Stakeholders in the enquiry frequently highlighted that the interpretation of modernisation seems to neglect the specific character of social services of general interest, i.e. the fact that they cannot easily be divided into different components, as it is usually their holistic character that specifically qualifies them. Furthermore they argue that such a conceptualisation contradicts the fact that we are actually not concerned with "customers", since people using these services are actually dependent and restricted in their freedom of choice (due to material circumstances, information restrictions) and/or are co-producers of the service.

Finally, the implicitly mentioned danger of a division within the system of service provision is explicitly mentioned in the reply from a European umbrella association of not-for-profit organisations providing services on a large scale, referring to the situation in France: "Competition in France is strong and following the logic of the market it is expected that providers from the social-economy will take care of 'people unable to pay'. Herewith, financing quality social services for all is in danger." And: "The statutory public process of planning is being replaced by an orientation on the demand side, for instance in the hospital sector. The construction of care and nursing homes is initialised by investors, in other words, it is not planned; founding care services follows the same pattern. There is a trend to follow market rules; the state and municipalities only act in cases of under-supply."

6 Conclusions

The nature of the modernisation process as well as the complexity and variety of the national and sector-specific institutional settings entail a multiplicity of modernisation trends in the countries and sectors under review in this study that makes the task of identifying common trends across Europe difficult. The institutional settings mainly differ along the following dimensions: "distribution of competencies and responsibilities for the organisation, regulation, provision, financing and evaluation of social services at national, regional and local level", "main design

parameters of social protection systems in which a social service is embedded" (e.g. social insurance vs. social assistance schemes), "entitlement conditions for specific benefits/design parameters for social rights", "landscape of providers" (welfare mix), "financing modes", "sources of funding" (respective shares of taxes, social insurance contributions, payments by users, donations, own financial resources of providers, etc.), "extent of user participation in social service provision and evaluation", and "implementation of consumer protection mechanisms" (see also Chapter 1). To these local welfare cultures (as explained e.g. in the Italian country report) and values attached to the provision of public services, amongst them social services of general interest (see e.g. Van de Valle, 2006) can be added as "softer factors". Different pathways of structural reforms and the shaping of modernisation processes in different countries and sectors of social services are also influenced by the extent to which marked-based instruments of social service provision and financing (see Chapters 11 and 12) are already used more wide-spread and considered effective and efficient. It is however possible to identify topics and issues that are common across sectors and countries, and that are subject to modernisation reforms, even if the paths and instruments of modernisation differ.

It should be recalled that the relative importance of major trends and of the modalities, instruments, and procedures presented differs. This holds true for the sectors and for the eight countries under scope in this study. E.g. whereas instruments such as vouchers, increasing users' choice and shifting the focus from social infrastructures to social services needed, are far from being the dominant form in all sectors and countries covered in case they are made use of, we can conclude that accreditation, delegation and tendering of services are widespread across all sectors and in countries. In this regard it seems important to underline that all country reports for all sectors state that the legal stipulations in place are basically valid for all providers independent of legal status and ownership. From the country reports it became obvious that planning is also generally used.

In the two following chapters two levels of modernisation are distinguished: the level of services organisation and management on the one hand (Chapter 10) and the level of services governance and regulation on the other (Chapter 11).

Chapter 10 Modernisation in social service organisation and management

1 Introduction

Modernisation strategies within the field of SHSGI are part of a broader trend of modernisation of the public sector during the past 20 years. Traditionally public sector management had focused on compliance with rules and regulations. This type of management has been criticised for focusing more on processes than on results and for its lack of incentives to use resources efficiently (Osborne/Gaebler, 1993). Performance management, including methods such as performance measures, benchmarking and outcome evaluation, are now increasingly used within the field of SHSGI in order to increase efficiency and effectiveness.

In personal social services, many countries have shifted towards a stronger focus on tools to improve efficiency. Strategies to achieve this include the strengthening of user orientation and consumer protection as well as introducing procedures to measure and evaluate effects, which in some cases has led to targeting. Furthermore, management tools from the private sector have been introduced and partly adapted to the characteristics of SHSGI. Among the most important tools were quality management, controlling, outcome-oriented evaluation and the development of indicator systems for benchmarking.

This has also sharpened the view on how to define efficiency for monitoring that goes beyond narrowly defined monitoring of direct economic cost and includes secondary effects, such as unemployment and poverty traps and other undesirable outcomes and threats of permanent exclusion or increasing health costs. This focus has led to reforms, involving rescaling of governance and integration of services, that aim at increasing effectiveness of service provision.

This chapter focuses on four major trends characterising modernisation of services organisation and management, namely performance management, user and consumer orientation, integration of services, and rescaling of governance levels.

2 The quest for more efficiency and effectiveness in the organisation and provision of SHSGI

Under the influence of New Public Management ideas, public management reforms over the last two decades have been oriented towards enhancing efficiency and effectiveness. A key feature of these reforms has been the increased measurement of performance. The main steps in measuring performance consists in (i) developing a consensus on missions, goals and objectives[87], (ii) implementing performance measurement systems including performance indicators, and (iii) using performance information as a basis for decision-making. Three types of performance measurement

[87] It is important to note that finding this consensus does not necessarily imply that the missions, goals and objectives are clearly written down and translated into quantitative criteria.

tools are usually used in order to assess the performance of social services: performance indicators, benchmarking and outcome assessment.

Performance indicators

Implementing performance indicators in social services can be challenging. The difficulty often consists in linking inputs (resources used to produce care), activities (operative procedure), and outputs (package of care which may require a bundle of activities) to outcomes (the characteristics of the outputs that affect the beneficiaries' utility and well-being). Outcomes measure effect and impact whereas outputs measure the level of service production. If evaluating outcomes is to be preferred to evaluating outputs, the link between outputs and outcomes needs to get more attention in the design of services, also because the same resources, service configurations or caring environments can affect different people in different ways (Knapp, 1984). The same considerations apply to the linkage between quality of care and outcomes. The level of provision and the quality of care only provide a basis for performance measurement if a significant correlation with outcomes has been established.

Box 10.1: Inspection of long-term care: the case of England

In England, the system of inspection and regulation of long-term care services is now intimately related to the assessment of services' and councils' performance. The Commission for Social Care Inspection (CSCI) is the single, independent inspectorate for all social care services in England. Through its general function to encourage improvement in the provision of council social services in England, it is charged with addressing amongst other things the quality and effectiveness of the services, the efficiency of service provision and its "value for money". Its key functions are quality improvement through the following regulatory and inspection mechanisms:

- Registration of all care services;
- Inspection of all care services;
- Inspection of councils;
- Independent review of complaints concerning local authority social service departments.

The CSCI also has a key role in the assessment of services and is responsible for providing councils with so-called star ratings. These are published annualy and are provided for child's and adult's services separately. They provide information on how the council is performing (0-3 stars) and what potential the council has to improve. Star ratings are based on the following ways of information gathering: meetings with councils, inspections of council social care services, looking at detailed council statistics (from performance indicators), and how well councils have met their own plans for improving their services.

Performance indicators form a key part of the star ratings and the full set of these indicators form the Performance Assessment Framework (PAF) indicators. They provide a view of how local councils are serving their residents with respect to social services and highlight progress councils are making in improving services and

meeting national objectives. Up to know, no final assessment of how well this framework works is possible.
Source: SHSGI country studies: UK

Benchmarking

Benchmarking can be defined as a means to find and implement best practices. It is possible to distinguish different types of benchmarking: process-benchmarking, results- (performance)-benchmarking and standards-benchmarking. Process-benchmarking is concerned with the processes and activities that are used to transform inputs into outputs. This technique is directed towards identifying best practices. Results-benchmarking aims at comparing organisational performance by using proxies in order to determine efficiency and effectiveness. Standards-benchmarking specifies performance-norms or standards to be achieved. In this case benchmarks are measurable standards that reflect the level and quality of services that users can expect to get.

Box 10.2: Benchmarking public services: the case of the Czech Republic

The Czech Republic has implemented a benchmarking project of costs for performance in state administration. Its aim was to use benchmarking in order to seek and find the best way of safeguarding services within a region from the viewpoint of quality, availability, demand (by users, potential users and the public), and funding. Specific goals were the application of benchmarking to selected public services, writing suitable information system software, and drafting proposals/ recommendations on optimising a network of selected public services on the basis of application of benchmarking steps. The target groups comprised founders, customers and providers of selected public services. In 2005, social services were compared in view of associated health services within the framework of the project. A survey of public services suitable for standardisation contained a list of about 75 services. The project examined key services in terms of costs, the number of users, and their influence on society and the local community. With the process of defining criteria for benchmarking operations still only in its early stages, the project focused, at this stage, on two target groups: senior citizens and persons with multiple disabilities. As above, to date no final assessment of the benefits and shortcomings of this project can be made.
Source: SHSGI country studies: Czech Republic

Outcome evaluation

Outcome evaluation can be defined as 'the retrospective assessment of the merit, worth and value of administration, output, and outcome of government interventions' (Vedung, 2000:3). If public administration is considered as a system aiming at converting inputs into outputs that produce outcomes (when the outputs reach the addressees), impact evaluation aims at assessing the outcomes of a public action whereas implementation evaluation is concerned with the processes by which inputs are converted into outputs. Evaluation is a contested field since controversies may develop concerning (i) the values and objectives of policies and services and (ii) the

nature of the information collected (indicators) in order to make a value judgement. In addition, cross-national evaluative studies are made complex because of the diversity of institutional contexts and dynamics characterising each country and within countries each sector and type of providers.

Identifying "Best Value" and monitoring cost-effective care implies that the outcomes of care are defined and measured. The evaluation of social outcome therefore necessitates the elaboration of adequate evaluation instruments. An example of such an instrument in the field of social care for older people is given by the work carried out in the UK by the Personal Social Services Research Unit (PSSRU, 2002). The instrument identifies five domains as the key areas of outcome of social care:

- Food and nutrition;
- Personal care;
- Safety;
- Social participation and involvement;
- Control over daily life.

The results of a study carried out by the PSSRU using this instrument indicated that the most important domain was personal care, followed by social participation and involvement, control over daily life, food, and finally safety issues.

The introduction of performance measurement tools within the field of social services constitutes an improvement in assessing those services in the direction of measuring efficiency and effectiveness and not only inputs, processes and compliance. However, assessing effectiveness can be methodologically and politically challenging. There is a risk of focusing too much on outputs (e.g. cases completed) at the expense of outcomes (e.g. satisfied users). If this kind of management technique can sharpen the performance and the user orientation of the services it can also lead to undesirable effects where focus on measurement distorts the service activities in an undesirable way, for example by leading to cream-skimming in order to improve results, and finally not or not sufficiently addressing those that could be most in need of the services.

3 The strengthening of user orientation and consumer protection

Getting users more involved in social services is one of the general trends of modernisation across Europe. More user involvement is seen as a strategy to not only enhance both the quality and the efficiency of social services but also, ultimately, user satisfaction. Many social services aim at improving and restoring the autonomy of the beneficiaries given the difficulties they encounter due to illness, old age, handicap, family situation, and social phenomena such as unemployment, poverty, social disintegration, criminality, drug addiction, etc. User involvement appears therefore as a means, beside the assistance provided by social services, to increase users' autonomy.

In addition, user involvement contributes to increased responsiveness and quality enhancement, by establishing a direct feedback between users and providers. However, there exist different ways of implementing users' participation, each of them echoing a distinct strand of thought in social service organisation and design

(Evers, 2003). User involvement schemes may consider the user as a citizen with rights, as a consumer with choice and exit possibilities or as a co-producer who influence the services according respectively to the *welfarist*, *consumerist* and *participationist* conceptions of social service organisation. Strategies of user involvement and choice are often a mix of these concepts.

Table 10.1: User involvement in social services. Various strands of thinking, elements and tools

Welfarism	**Consumerism**	**Participationism**
• Hierarchical governance of service systems • Full coverage/ uniform services • Equal standards • Boards and commissions for corporate governance • Quality control by state inspection • Social rights and patients' charters	• Competition • Individual choice • Market research (by or for providers) • Vouchers • Customer orientation • Consumer lobbying • Consumer protection	• Collective self-help • Volunteering • Strengthening user and community based service providers • Strengthening local embeddedness • Orientation towards empowering users • More service dialogues • More user control in designing and running services

Source: Adapted from Evers, 2003:4

An example of increased user orientation based on a consumerist approach is given by the 'direct payment' scheme introduced in long-term care services in the UK (England) (see Box 10.3)..

Box 10.3: Providing more choice: the case of care allowances in England

The 'direct payment' scheme in long-term care services in the UK (England) was introduced in response to the low-level of responsiveness to service users' preferences, which was a recognised weakness in the system of contracting in England. Care managers and service users would jointly agree on a plan for the number of hours of care allocated. Local authorities admitted that these arrangements tended to be risk-averse and not innovative when it came to designing care packages. Service users complained about poor timekeeping and lack of continuity of care, which were factors that local authorities tried to specify in contracts on the one hand, but over which they had little ability to control on the other. Lack of service user responsiveness was and is a particular concern of the government, both with respect to growing public expectations on services and regarding concerns on the efficiency and effectiveness of services.

The key strategy for tackling both the perceived gap between services and needs and the need to optimise service efficiency has been to introduce cash equivalents of care-packages (known as 'direct payments'): clients could pay for home-based care and thus the care user becomes the direct 'purchaser'. Implementation of direct payments was inconsistent in the beginning. This led to becoming it a mandatory duty for local authorities to offer direct payments to all eligible in 2003. Direct payments have since been widely promoted on the grounds that they provide greater control to people in need of social care or support. Direct payments have been identified as a key part of the agenda for the developing the social care system.

Successful implementation of direct payments is considered to rely on access to advocacy, brokerage and support with accounting and recruiting aspects of managing a direct payment. Currently these services are provided mainly via the voluntary sector (the oldest schemes having roots in local independent-living activism). Promotion of such schemes has become a priority and funds were made available to around 68 per cent of local authorities in England between 2003 and 2004 to develop 'direct payments' support. Nonetheless there remains considerable disparity in the provision of direct payments, as well as growing concerns regarding the calculation of direct payment rates (Davey et al. 2006, Fernandez et al. 2006). Relinquishing control is seen to be an issue for care managers.

More recently the Government has set up 13 pilot schemes of individual budgets. Individual budgets offer a way of matching services to needs. The new model entitles each service user to an individual budget equal to the level of funding required to commission services that would meet his/her (assessed) needs. Each service user chooses how to administer his/her budget. As yet the pilot schemes have focused their efforts on extending the use of direct payments to include non-social care (e.g. housing support funds) in order to tie up the various income streams that may contribute to a person's support. Up to date no in-depth knowledge is available about how well these pilot schemes function. In less populated areas, those options may however be limited.

Source: SHSGI country studies: UK

Another example of consumerist user orientation is given by the 'personal budget' scheme implemented by the **Czech Republic** in the field of long-term care. On the individual client level, the basic tool of modernisation is the introduction of a social care contribution tallying with the personnel budget logic. This contribution introduces a market element into the service provision system and enables the individual to freely choose among the available options.

In **the Netherlands**, an important development in long-term care provision, which also reflected a consumerist orientation, was the introduction of a personalised budget (PGB) within the framework of the AWBZ (the Law for Exceptional Medical Expenditure). The personalised budget puts clients in the driver seat, making them the manager of their own care (however, the PGB is only aimed at non-residential care). This seems desirable although it could also lead to unintended situations (where the client, for instance, is actually put under physical or mental stress to [continue to] hire this particular care-provider). In 2007, the personalised budget scheme was transferred to the WMO, the new Social Support Act, which now governs its implementation. Different from the AWBZ, the implementation of the WMO is

municipality-based. During the parliamentary process, it became clear that the transfer of household care from the AWBZ-scheme to the WMO-scheme should be organised in a way not that client should not "suffer" from the consequences of this reorganisation process and that these clients will hold their entitlements. For new clients, however, the situation will change even though the parliament made clear that a PGB ought to remain available, also under the new WMO-regime. Nevertheless until now it is still uncertain how household-care will be delivered under the new (municipality-) regime of the WMO.

In **Germany**, a paradigm-shift from welfare (*Fürsorge*) to self-determination that has been legally implemented is expressed through the new possibility to receive a personal budget (*Persönliches Budget*). This enables disabled persons to organise and purchase just the services they want as long as they are within the range of their budgets instead of using inflexible compact offers by stationary, partly stationary or ambulatory institutions. Thereby, the principle of transfer in kind is being displaced since it limits self-determination. The legal right to obtain a personal budget will be established in the beginning of the year 2008, although already now a number of successful pilot projects exist in several federal states.

Consumerist users' orientation is also an element in the provision of long-term care in **Italy**. The Lombardy Region, for example, has established a quasi-market for the provision of social and health care where users get vouchers allowing them to buy services and to choose their provider.

Implementing such a consumerist approach does not create any particular problem with EU legislation, since aid to individual consumers that has a social character is not classified as state aid.

In **France**, the recent reforms in the field of residential care inscribe themselves into a *welfarist* logic by reinforcing the users' rights. A recent law (2002) has imposed several obligations to the services providers, in particular:

- The provision of information to the beneficiaries, envisaged in a regular manner: handing-over of a booklet of reception, etc;
- The establishment of a contract between the service supplier and the beneficiary ('contract of accommodation') which aims making the actors responsible;
- The obligation to set up a 'council on social life', which brings representatives of the beneficiaries, their families, the personnel and the management of the organisation together. This 'council of social life' can discuss questions concerning the functioning of the structure, i.e. internal organisation; nature and price of the provided services; therapeutic activities and services; relations between participants, as well as substantial modifications concerning the conditions of the care provided..

The *participationist* model seems to be privileged in **Italy** with respect to user involvement in childcare. Public childcare facilities have a parents' committee that sometimes have a small budget allocated. Participation of parents has increasingly become a crucial issue on their agenda. The services try to enhance parents' participation through meetings, individual interviews, parties, etc. High quality private childcare services are reported to follow the example of public ones in this respect.

The different models of user involvement are based on different principles, namely 'rights' (the welfarist model), 'exit' (the consumerist model) and 'voice' (the participationist model). These models, however, have in common that they assume the autonomy of the user as well as that the user is informed (on his needs, the providers, the possible choices, the quality of the services, etc.). Most of the beneficiaries of social services are however in a dependency situation and they often do not have the necessary information to make informed choices. In addition, the relationships between users and providers and between users and case-managers are characterised by informational asymmetry, entailing a trade-off between objectives such as user involvement and empowerment on the one hand and user protection on the other hand. Consequently, the nature of social services requires support mechanisms to make user orientation effective. This is the case for example in the UK, where volunteers assist users in managing direct payment schemes.

4 Access to social rights: Eligibility criteria and entitlement conditions

Beside users' involvement another avenue of modernisation consists in ensuring access to social rights. Social rights constitute the foundation of the European social model and shape social services delivery. But if social rights determine who is eligible and the conditions of eligibility to social services, access to social rights is critically influenced by the architecture of social provision. Access to social rights is usually considered to depend upon:

- The institutional embedding or type of the right. The framing or form of a right includes its legal character, and the structural and other aspects of social provision that give effect to it. It is important to point out in this regard that access to social rights cannot be read off from the legal framing or status of the right (even where a right is established by legislation). Hence, the legal position has to be looked at in relation to key aspects of the structure and design of programmes.

- The process and procedures set up and the resources made available, so that entitlements can effectively be accomplished. This concerns public social provision and whether it realises and exercises the programmes, conditions and resources necessary for social rights. The ways services and benefits are financed and delivered to people, come to the fore in this regard. Relevant factors include the procedures for accessing and claiming rights and benefits, the manner in which services are managed, organised and delivered (including their quantitative and geographical availability), the degree of enforcement and how communication about benefits, services and procedures is arranged. Matters relating to the training of staff and the provision of information to potential holders of rights are also relevant issues here.

- The capacities of the potential rights claimants.

According to the Council of Europe (2002) there are several types of obstacles to social rights that can be summarised as follow:

Table 10.2: The main types of factors impeding access to social rights

Type	Obstacles
Specification of right and adequacy of legal and other provision	Lack of precision in the specification of the right or entitlement Rights limited to particular segments of the population Gaps in the social safety net Lack of specification of a basic threshold or minimum standard Exclusive conditions of access or entitlement Mismatches between the nature of provision and need
Inadequate monitoring and enforcement	Inadequate monitoring Inadequate protection against the non-realisation of rights Discrimination and/or differential treatment Inadequate responsibility to users
Resource shortages	*For providers*: Insufficiency of a range of resources (funding, staffing, facilities, equipment) Failure to guarantee or provide resources on a long-term basis Imbalance in resources between levels of administration *For users or rights claimants*: Insufficiency of a range of resources and capacities including: Financial resources, educational capacities, personal resources, social skills and contacts
Management and procedural arrangements	Fragmentation between levels of administration and among services Inadequate integration of and consultation with NGOs and users Complexity of procedures Obstacles arising from the mode and practice of service delivery
Information and communication	Insufficient stock and flow of high-quality information Inappropriate form and nature of information provided Under-use of "new" or alternative channels

Psychological and socio-cultural obstacles	*On the side of providers*: Negative expectations of and predisposition towards certain groups Stigmatisation of certain groups Lack of understanding of minority cultures *On the side of users or right claimants*: Fear and insecurity induced in and by public procedures and settings Low self-esteem Cultural obstacles
Inadequate attention to vulnerable groups	*Vulnerable groups*: The existence of vulnerable groups which may lack the "resources" to claim benefits and services The existence of overlapping difficulties among these groups of the population *Vulnerable regions*: The existence of regions or localities which are multiply-deprived Lack of investment in certain communities and localities Climatic and geographical obstacles which act to cut off areas or regions

Source: Council of Europe, 2002: 35

Modernisation strategies that aim at promoting access to social rights include in particular user-orientation, empowerment and quality improvement strategies.

User-oriented service delivery

The design of user-oriented services contributes to the removal of obstacles to take-up arising from procedural and psycho-sociological barriers. Such service design aims at reducing the effect of organisational barriers to social rights due to fragmentation, compartmentalisation and difficulties in cooperation between agencies and between different geographical levels of administration. Social problems are often connected to each other but differ from person to person. This fact requires service-delivery systems that are both based on a holistic approach (meeting all the needs of users, for example income support, housing, employment etc.) and on a personalised form of support.

Empowerment and capacity building

Empowerment strategies aim at meeting the needs of a person while increasing its capacity and autonomy. Many people need support and assistance in order to claim

their rights. NGOs' role in this respect is fundamental in providing individual support. Empowerment strategies are also aimed at communities and groups.

5 Integration of services

Service integration refers to the process by which a range of social services is delivered in a co-ordinated way to individuals. Such an integrative strategy aims at the coordination of different (social) agencies and actors and follows a holistic approach to social problems. Integration of services and benefits is usually implemented through "integrated gateways to services" and through "service platforms" that make access to services easier to users. An example of service integration is the integration of legal and social consultancy for over-indebted persons with placement services and general social assistance and support services. Health and social services are also in many countries traditionally closely interwoven in the case of services for users of illegal drugs (see Chapter 5.3).

Another example is long-term care where the better integration of health and social care services can take the form of integrated planning, funding and delivery of primary, secondary, residential care and community support services to provide flexible responses to people's varied and changing needs. The importance of providing integrated, holistic, and cohesive care for older people is an important modernising trend within the field of long-term care. Historically, health and social services have been organised by different institutional actors, provided by different professionals, and even fragmented into specialised services. The integration of health and social services is however a complex process where professional histories and practices as well as cultural contexts are often confronted (see Chapter 4 and 14 and Billings & Leichsenring, 2005).

Attempts to integrate social and health services in long-term care have been made in **Italy** through the use of an integrated (social and health) home care voucher recently introduced in the Lombardy Region. This instrument establishes an administrated market of social and health care provision.

In **the Netherlands**, within the field of long-term care, the discussion about the need for integration of services and the necessities to cope increasingly with clients with multiple care needs is on going. One of the means to enhance integration is to share services or even for organisations to merge. This has increasingly been implemented over the last years and has resulted in a wave of mergers between home-care providers, between home-care providers and institutional care (elderly homes, nursing homes) providers, as well as between institutional providers themselves. However, this merger wave is not entirely aimed at answering demand in the care-market. It can also be understood as a more defensive move in view of enhanced competition and the related need to reduce costs in reaction to the entrance of new home-care providers on the market as a result of changing demands in the insurance market and of the introduction of a new legal regime (WMO). The institutional situation has changed rapidly and at present some negative consequences of these transformations seem to be that users have less clarity what their rights are, who are the services providers, and who is accountable in case of complaints.

Labour market policies are another field where integration of services, benefits and agencies is on the agenda. In **Germany** the need to reform the double structure of security payments for long-term unemployed in terms of unemployment assistance (*Arbeitslosenhilfe*) and social assistance (*Sozialhilfe*) – as the universal means-tested "last resort" benefit (either in cash or in kind) – has been on the policy agenda for a long time. In addition, the parallelism of the responsible bodies for the service for long-term unemployed was confusing: unemployment assistance was a benefit paid by the Federal Labour Office (*Bundesanstalt für Arbeit)*, later on: Federal Employment Agency (*Bundesagentur für Arbeit*, BA), social assistance was provided by the municipal governments.

The coexistence of unemployment assistance and social assistance made it possible for one system (and the public authorities or social insurance with budgetary responsibility) to save financial resources at the expense of the other (well illustrated with the term '*Verschiebebahnhof*' in German). The main problem was, however, the division of responsibility concerning the service for long-term unemployed between the Federal Employment Agency and the municipal governments with respect to the type of benefit. This led to shortcomings in effective re-integration into the labour market and to a regionally varying administration of activation policy in the municipalities.

As a consequence of the reform engaged between 2002 and 2004 (Hartz IV legislation), unemployment assistance and social assistance have been pooled together to form the '*Arbeitslosengeld II'* (unemployment benefit II). The pooling of both systems was realised by degrading the beneficiaries of unemployment assistance to persons in need of social assistance. The means-tested system of basic financial security was thus extended to all unemployed who were not (any longer) insured and an integrative framework was created for all employable unemployed who were not (any longer) entitled to '*Arbeitslosengeld I*' (unemployment benefit I). Responsible for the new benefit are the labour agency (*Agentur für Arbeit*) and the municipal governments or the optional municipalities (*Optionskommunen*). The integration of the benefits was however not followed by the integration of the agencies responsible for their implementation. The particular competences of Federal Employment Agency and the municipalities had not been brought together in order to obtain an effective integration policy but remained to coexist without any synergy effect.

The integration of social services is in many areas of social policies a powerful tool for increasing effectiveness of social services and for avoiding undesirable side-effects of social schemes. Tailoring individualised social responses that are adapted to an individual's needs and social situation enhance effectiveness. Side-effects are avoided as a result of the co-ordination of the relevant agencies and professionals. Social services integration may, however, conflict with short-term and partial efficiency goals since it supposes to allocate means to co-ordination and need-assessment tasks.

As also mentioned in the stakeholder enquiry, integration of services may be difficult in case public procurement procedures have to be followed by different types of providers, some of which are not from the traditional social services sector.[88]

[88] For a further development of the potential consequences of public procurement applied to (personal) social services, see Chapter 13.7.

Public procurement procedures may fragment the services tendered for into different components, separating the "core" service from related other services, e.g. social care services. The result might be that additional social care aspects for persons with multiple needs are not sufficiently included or taken care of. Examples already exist in the field of over-indebtedness (e.g. in Germany) where publicly reimbursed service provision in some cases was reduced to the tasks of counselling on financial aspects. Public funding for additional social service offers to promote a (re-)integration into society and the labour market were (considerably) cut down. Based on this and other sources it was highlighted that social (and territorial) planning is needed to support the establishment of integrated (social and health) services chains[89].

6 Rescaling of governance levels

Generally speaking, the notion of multi-level governance implies that sub-regional, regional, national and supranational authorities interact with each other across different levels of government (vertical dimension) and with other relevant actors on the same level (horizontal dimension). [90] Indeed, the changing division of power between administrative levels (decentralisation, re-centralisation) as well as the appearance of non-profit and commercial service providers in countries where social services were traditionally provided by the public sector (as a result of introduction of New Public Management) created a new setting for policy-making. Since the 1980s, modernisation of social services, in the light of New Public Management, has been focusing on increasing user's choice, quality, effectiveness and efficiency. In this context, governance rescaling, including processes of decentralisation, re-centralisation and subsidiarity, has been considered a central instrument to enhance the quality and efficiency of social services and to adapt the system of governance to the new policy objectives and instruments.

6.1 Decentralisation

There exist several reasons, such as ideological, political, and socio-economic, explaining why countries have initiated processes of rescaling. Ideological reasons are particularly evident in the **Scandinavian** countries in the light of their historical and political development, and their commitment to meet the basic social needs of their population through a universalist system of social welfare. The social policies of these countries have in common that they are 'rights-based', 'financed through general taxation and wholly public in nature'. Another aspect of the ideological stance taken by the Nordic countries is the dominance of the public sector in social welfare provision over the private sector, although this principle is undergoing certain modification. Finally, decentralisation that began in **Sweden** in the 1970s was based on the declared conviction that local government has a better knowledge of its citizens' local needs than central authorities, in anticipation of the principle of subsidiarity, which was to become a guiding principle of European social policy.

[89] With regard to the issues mentioned above, Community law only would come into play if it (directly or indirectly) impeded planning activities as described or if it favoured policy choices referred to.
[90] This section is based on the results of the project "Rescaling in eight European countries" carried out by the European Centre. Cf. Peter Melvyn, 2006, *Rescaling in eight European countries. An overview"*. Vienna: European Centre for Social Welfare Policy and Research.

Other factors such as concern with cost-effectiveness and efficiency were drivers of rescaling.

In, **France**, the move towards decentralisation was originally politically as well as economically motivated inasmuch the highly centralised system was increasingly challenged by the economic crisis of the 1980s on the one hand, and by France's commitment to the European Union on the other. Large-scale unemployment and the resulting social problems were thought to be better coped with by a '*retour au local*', that is by decentralising social welfare provisions.

The decentralisation process that took place in **Italy** was mainly due to mounting demands for autonomy by particular regions. Italy that shared the inheritance of a centralised bureaucracy with France – but without having the same centralised power – moved towards decentralisation in the late 1980s and during the 1990s. This move took place owing to pressures exerted by the European Union's integration process as well as – probably more so – by the considerable inter-regional differences that led to the pull of autonomous regional movements towards a federal-type of reform of the state.

In **Poland**, the collapse in 1989 of the centralised collectivist state had created a vacuum that had to be filled in urgently by a series of political and social reforms. These reforms were to lay the foundations of a democratic system that included political and social rights. Unlike in other Eastern European countries, decentralisation of the public administration was introduced very early (1990) and has been sanctioned in 1997, together with the principle of subsidiarity in the Constitution. Decentralisation of the social protection system followed.

6.2 Re-centralisation

The overall tendency in the reviewed eight countries under this study since the 1980s has been a move toward decentralisation of competencies and responsibilities for social policy from the central state to sub-national authorities. Yet in most of these countries there is evidence that a number of social policy instruments remained to varying degrees in the hands of central governments. Apart from enacting legislation and formulating policy aims and directions, the state has regulatory and control authority over most national social security, social welfare and employment institutions. In a number of instances re-centralisation took place when central governments assumed or reassumed competencies that had at one point been transferred to sub-national authorities. Although the latter have attained much autonomy in decision-making and leeway in the implementation of social welfare services practically everywhere, in a few instances central government has found ways and means to exercise – or regain – control as it is the case in Sweden.

One reason for re-centralisation is to avoid that citizens in need of social services become vulnerable to varying political preferences and to sometimes arbitrary decisions by individual officers as well as preventing the development of unacceptable (territorial) inequalities relative to the content, quality and availability of services at the local level, another for the central government to regain control on budgets and costs.

6.3 Horizontal subsidiarity

Italy is an example of a state constantly challenged to tackle problems of co-ordinating decentralisation and the corresponding territorial organisation. The problems are partly due to the social-economic disparities. The unevenness of public welfare provision seems to have led to a situation where a key role is conferred to a multitude of non-profit organisations with legal status as partners of public bodies in the planning, management and implementation of social policy measures. This 'horizontal subsidiarity' appears to constitute a basic principle in the field of social policy as well as 'multi-level governance', involving vertical levels and horizontal networks. This system is, however, confronted with difficulties regarding resources and governance patterns. As a consequence of regional differences, the economic, cultural and professional resources required by partnership bodies at local level are not equally spread across the country. In addition, the regional diversity produces different governance practices, of a managerial type in the North, and patronage-clientel-based in the South.

The reasons why some countries decided these rescaling reforms appear to be manifold. Even if there are ideological or political grounds at the origin, economic and financial considerations turn out to be among the major driving forces. While in some countries the conviction that citizens' needs are better met on a scale that is closest to them gained ground, in others pressing demands for regional autonomy accelerated the process of decentralisation. An additional major factor is the aim to improve cost-effectiveness and efficiency. In some countries central governments retain or regain regulatory power through enactment of legislation, determination of policies and programmes and fiscal means. In designing the multi-level governance system of social services governments are confronted with two types of trade-off, between adaptation to local needs and universal social rights and benefits as well as between local autonomy (and the risks of inflationary costs) and centralised budgetary control.

The impact of changing EU legislation on regional and local levels is not directly felt in terms of effects, since EU legislation is often translated first into national legislation before becoming effective at decentralised levels[91]. Nonetheless Community competition, public procurement and internal market rules apply and may – sometimes indirectly – have an effect on the organisational management and financial modalities of social services.

7 Conclusions

Four orientations, each of them aiming at increasing efficiency and effectiveness of service provision, characterise the organisational and managerial reforms of social

[91] If competencies in the field of particularly personal social services have been entrusted to regional and local territorial authorities – as this is the case in several countries – regulations (possibly except for a framework legislation) and compensation mechanisms do not exist at the national level. In this regard the ECJ formulation and specific treatment of systems organising and realising "solidarity on a national level" might need to be extended to adequately take into account compensation mechanisms based on solidarity concerns, but only at a sub-national level.

services in the countries under review: performance management, user orientation, integration of services, and rescaling of governance levels.

However, as it is often the case with modernisation reforms, these orientations are not free from contradictions, tensions and trade-offs. The introduction of performance measurement tools contributes to a better assessment of service performance than traditional inputs measures but is challenging and may lead to undesirable side effects by over-focusing on results as captured by performance indicators. User involvement management and tools involve a concept of an autonomous and informed user. But in many cases users are dependent, poorly informed and in need of counselling and protection. Users' empowerment and users' protection objectives may enter in tension. In addition users' empowerment objectives can conflict with managerial costs control goals. Social services integration may also contribute to improving effectiveness by preventing undesirable side effects, but may also increase costs and reduce efficiency. Reforms involving the rescaling of governance levels involve also trade-offs and tensions between different policy objectives and/or different political agendas (when the political majority is not the same at the various levels considered): between adaptation to local needs and universal social rights on the one hand, and between local autonomy and centralised budgetary control, on the other hand. National reforms can be interpreted as attempts to find viable solutions to the contradictions inherent to social policy objectives and implementation of performance enhancing managerial and organisational policy tools.

Social services in Europe are diversified as are the organisational and management strategies implemented in order to increase efficiency, effectiveness and responsiveness to needs. There is no unique solution or path to follow in order to achieve these objectives, but a set of trade-offs that modernisation reforms have to tackle. Outcomes of innovative practices need to be systematically evaluated (what is difficult, resource demanding, and not systematically done) in order to identify best practices. The systematic evaluation of outcomes and the diffusion of best practices constitute an area where a European strategy would improve the situation. But such evaluation needs to be made against objectives to be achieved, and objectives in the field of social services differ across time, location, but also due to political programmes.

Chapter 11 The changing forms of regulation and governance

1 Introduction

Throughout Europe, market mechanisms have been introduced for the provision of SHSGI, in many cases by creating quasi markets that are regulated by public authorities with a broad set of rules about accreditation, pricing and territorial planning. One crucial aspect in this regard is budgeting mechanisms: a more market-based regulation entails an inclination towards needs and users' free choice, contrary to traditional budgeting. The introduction of market mechanisms appears as a way of renewing public sector management in order to reach increased responsiveness and efficiency of service provision and to ensure users' freedom of choice.

However, social services are characterised by *caring externalities* (the fact that people feel concern for the care and treatment of others, even though they themselves are not directly affected) and by *informational asymmetries* (the fact that the provider has more information about the nature and quality of the service than the beneficiary). As a corollary, pure market regulation fails in supplying an optimal amount of these services. Institutional mechanisms of regulation must therefore be established.

There are two main regulatory mechanisms in the area of social services: *public-programming* regulation and *market-based* regulation.

The *public-programming* approach builds on public service programming and accounting for available resources which also comprises deficit financing, if need be. The production of a service is subject to a constraining intervention on the part of the public authority, which acts as 'guardian' of the consumer and the producer to ensure that production and consumption are not ultimately used to satisfy needs which do not require public assistance. The regulation of supply is made in relation to and starts from available resources. The public-programming regulation is based on budgetary, planning, certifying and control procedures (ex ante quality definition and ex post service inspection) that define and assess the needs to be met, authorise the producers, and impose quality and processes standards. This type of regulation involves reimbursed cost contracts between the public authority and the service provider. There can be many provider forms within the scope of public-programming regulation: for-profit organisations, not-for-profit organisations, public organisations (municipal services, for instance).

Budgeting mechanisms building on public service programming and accounting may be exemplified by the French regulatory system within the field of long-term care.

In **France**, for example, long-term care services are regulated through several laws of fundamental importance, setting up basic regulations (*lois fondatrices*), in particular the law concerning institutions and social and health services (for the elderly, handicapped, and for people in difficulty) and the *Code of the social action and the families.* Service programming regulation in France entails a procedure of authorisation or of approval as well as a budgeting procedure based on the principle of fixed-costs reimbursement by the public authorities.

Creation, extension (increase in the capacities of reception) or transformation (change in the type of accommodated people) of an institution or social or health service supposes that the manager (public, private for-profit or private not-for-profit) holds a 'preliminary authorisation' ('authorisation mode'). This authorisation has a validity period of 15 years (before 2002, it was given for an unspecified term and could be registered at any time of the year). The authorisation request can be registered only during some periods of the year that are set each year by a representative of the State in the Region (Prefect). Requests are registered by the President of the General Council and/or the Prefect according to cases. To be able to be authorised, the registered project must:

- be compatible with the objectives and meet the social and health needs based on the social and health organisation schedule elaborated by each department and programmes for urban and regional planning and spatial development co-ordinated amongst departments;
- have a functioning cost which is not out of proportion with the provided service or with the costs of the institutions and services providing similar services;
- have a functioning cost compatible with the budget of the public sector;
- satisfy the rules of organisation and functioning and plan an evaluation process and information systems.

The only exception to this general principle is home-help services for the elderly without a medical or paramedical service. These can be set up by choosing either the previous authorisation arrangement, or a 'mode of more flexible quality approval', with a great tariff freedom of the manager and including less important constraints in terms of quality. This approval has a double effect. On the one hand, like the preliminary authorisation, it allows enjoying a reduced VAT rate and tax cuts for its beneficiaries. In addition, it makes it possible to freely set, for the first year, the price of the services within the contract drawn up between the beneficiary and the provider (whereas tariffs of the authorised services are established by the President of the General Council).

Law and rules precisely anticipate the types of expenditures (in particular workforce costs and the material) that the authorities and Social Security reimburse (on a fixed-cost basis) when the institution or service is authorised to provide social services. In the case of institutions for the dependent elderly, in addition to the costs of running the facility, health insurance finances, on the basis of fixed tariffs, medical and paramedical services necessary to the minimum fare (pays of the doctors, nurses and medical assistants).

On the other hand, a more market-based budgeting entails an inclination towards needs and the creation of quasi markets, contrary to traditional budgeting. Within the scope of *market-based* regulation, the public authority allows competition (for contracts and users between private not-for-profit and commercial providers) and the consumer's and producer's freedom of choice to act, even though the public authority may orient demand, affect price formation or guarantee quality. Quality is also defined by (accredited) providers. Thus, not only the public purchaser would buy services but also the user him/herself has in many cases become a direct customer. This has resulted in a variety of new forms of cash allowances, integrated budgets or vouchers that were used to support the purchasing of services and thus also empower

users of services, e.g. in the Netherlands, Germany, or Italy. As another aspect of market-based regulation, in some instances, intermediary or ancillary services have been outsourced or contracted-out, and in these cases often been transferred to the private sector, including for-profit enterprises. In other instances a quasi-market, consisting in the public authority playing the role of the buyer (on behalf of the beneficiaries of the services) on the demand side and of several providers competing for contracting with the public authority on the supply side, has been enhanced. In this case public authorities implement incentive contracts schemes in order to ensure efficiency. In such a market-based regulative framework, public authorities use different mechanisms in order to correct for market failures.

In addition, there is a general trend in many European Countries from a 'provider state' to a 'guarantor and enabling state'. Consequently, the role of public authorities in providing SHSGI may have shifted, too, from direct public provision toward more delegation of delivery. This is likely to lead to new forms of partnership between public authorities and private organisations, both for-profit and non-profit. And this trend is likely to continue. The delegation of tasks to private providers of SHSGI often demands rather comprehensive framework regulations that can range from technical specifications to quality standards and to how financing of operating expenses as well as infrastructure and investment costs are shared between public authorities and providers.

In several European countries, new forms of governance have emerged. These new forms of governance involve practices of co-ordinating activities through networks, partnerships, and deliberative forums in a participatory framework. Modernisation entails a changing role of the public authorities from hierarchical interventions to network steering and partnership with multiple stakeholders. It also entails new forms of user participation, civic involvement and of dialogue with civil society. Such negotiated social governance embraces a diverse range of actors: the social partners (labour unions, trade associations, firms,), local authority representatives, social entrepreneurs and other NGOs as well as community-based groups, voluntary organisations, self-help initiatives.

This chapter examines the changes characterising the regulation and governance of social services, not least in a multi-level context. Three main orientations are discussed: the increased role of market-based regulation, the introduction of new forms of public-private partnership, and the development of new governance practices.

2 The scope and role of market mechanisms

2.1 Instruments of market-based regulation

Table 11.1 gives an overview of the main instruments used in the field of social services. Quasi-markets and vouchers are explained more in detail immediately below. For the other three instruments listed in the table references to other Chapters and Sections of this study are given.

Table 11.1: Instruments of market-based regulation

Category	*Explanation*
Market regulation	Governments may through such instruments as entry controls, price controls and price distortions and production controls, regulate the way markets function (see also Chapter 10)
Quasi-markets	Governments responsible for the provision of SHSGI have the possibility to contract for the delivery of those services with private firms and non-profit organisations. Quasi-market regulation, by enhancing competition, is expected to lead to lower costs and to increase responsiveness
Public-private co-operation and partnerships	Public-private co-operation and partnerships refer to co-operative relationships between government, profit-making firms and private non-profit organisations to fulfil policy functions (see also Chapter 11.3 and 11.4)
Grants and tax expenditure	Social services can be subsidised through grants and tax expenditures if their consumption is to be encouraged
Vouchers	A voucher is a "subsidy that grants limited purchasing power to an individual to choose among a restricted set of goods and services"

Source: own presentation (by Bernard Enjolras)

Commonly used instruments of market regulation (such as the introduction of performance management – entailing quality management, controlling, procedures to measure effects, outcome-oriented evaluation – and the strengthening of user orientation and consumer protection) have been elaborated on more in detail in Chapter 10 and are also referred to in this Section below. Main forms of co-operation and partnership between public authorities and private, not-for profit and commercial providers of social services, are described and analysed in Sections 3 and 4 of this Chapter 11 as well as in Chapter 1.3. Grants and tax expenditure are different financing modes, also used in the field of social services. A grant is a payment from a donor government to a private (for-profit or non-profit) provider. A tax-expenditure is a provision in tax law that gives incentives to individuals by reducing their tax obligations. Under a grant arrangement the producer of services is a private enterprise (either for-profit or not-for-profit) and a governmental agency participates in the provision of services while leaving to an external entity the task of actual performance. The effect of grants is to reduce the price of the services for eligible consumers. Tax-expenditures may benefit either the consumer or the producer and aim at reducing the price paid by the consumer (see also Chapter 1.3).

In more general terms, quasi-markets pursue the double goal of increasing, on the one hand, the effectiveness (thereby reaping the efficiency gains of markets) and, on the other hand, the responsiveness of the providers and the freedom of choice for consumers. They insofar aim at not losing the equity benefits of traditional systems of public administration and financing which implies the need to set up a comprehensive body of regulation to safeguard amongst others access to social rights, service quality and the financial viability of social service systems. As in an ordinary market, competition exists between various providers for purchasers of their services.

Transposed to the field of SSGI this means competition for users/beneficiaries of (personal) social services. The service providers are, however, not necessarily driven by profit maximisation (as this is the case for NGOs in the social and health services field). On the demand side, the purchasing power as a rule and to a large extent does not come directly from consumers but from the state or public funds which distribute the available budgets for specific types of services. Quasi-markets can lead to problems of cream skimming, mainly depending on the access and financing conditions defined. In this report e.g. the British long-term care system is presented in this Section as an example for quasi-market regulation in the field of (personal) social services.

Finally, vouchers are in general terms to be described as an instrument worth a certain monetary value earmarked for a specific purpose and exclusively to be employed to purchase a specific good or service. In the field of social services they are used e.g. in childcare or home help or handicapped care services. Vouchers are designed as an instrument to hand over to users the decision which provider of social services they want to opt for, thereby increasing users' choice. They are also corrective devices for marked-based steering of supply and demand and aim to promote and subsidise the consumption of social services by increasing their affordability, not least for users not disposing of own sufficient financial means (see also end of this Section and the Country Reports under this study containing several examples of their seemingly increasing use across sectors and countries, e.g. in France, Germany, Italy and the Netherlands). For vouchers as instrument of social service provision and financing, there is no interference with Community law, more particularly state aid rules, because vouchers give purchasing power to users, based on entitlements in social protection schemes. They are no direct or indirect financial transfer to providers. Being "aid having a social character to individual consumers" they fall under the textual exemptions of Art. 87 (2) ECT and need not be notified. In a second step and on the level of service provision schemes, vouchers are expected to help fuel competition amongst providers for users on which, in turn, Community law has an impact by "structuring" and co-determining this competition, particularly concerning modalities of social service regulation and financing. If the use of vouchers were to be restricted to only certain providers of social services for reasons not linked to the guarantee of service quality or other concerns defined by the competent regulatory bodies or related to the realisation of general interest objectives, Community rules aiming at safeguarding undisturbed competition, however, could come into play.

Governments may through instruments such as entry controls, price controls and price distortions and production controls, regulate the way markets function in order to achieve policy objectives such as guaranteeing a minimal level of service quality and continuity, guarantying service accessibility and availability. Within the field of SHSGI tax relieves, subsidies and income allowances are used in order to make the service affordable to the beneficiary. Licensing, authorisation and production controls are used in order to ensure minimal levels of service quality as well as its territorial accessibility.

The introduction of marked-based mechanisms within SHSGI where public-programming regulation was customary is based on the idea that competition enhances, by giving incentives to the providers, efficiency, innovation and

responsiveness. As already mentioned, social services are characterised by caring externalities and informational asymmetries leading to market failures and requiring public regulation of the delivery system of SHSGI. The scope of pure public-programming regulation of social services has been reduced during the last decades in Europe as market-based regulation was expanding. Indeed, governments responsible for the provision of SHSGI have the possibility to contract for the delivery of those services with private firms and non-profit organisations. In such 'contracting-out' of public services government may, since pure market regulation usually fails in the context of social services, use public-programming regulation and market-based regulation, with which we have dealt with in the Introduction of this Chapter. The public-programming regulation is based on budgetary, planning, certifying and control procedures that define and assess the needs to be met, habilitate the producers, and impose quality and processes standards.

The legal conditions and ways to set-up and organise such contracting-out will directly be affected by European public procurement rules if the relevant conditions and thresholds are met. The consequences of EU legislation in this respect have not yet been systematically and comprehensively studied since their application is to be seen as a fairly recent trend, but also because of legal uncertainties concerning the scope of application of those rules. The potential and foreseen related challenges in the field of social services are presented in Chapter 13, Section 7.

Table 11.2 gives an overview on methods and devices for ensuring provision in the sectors of long-term care and childcare for the eight respectively six countries for which these sectors are being covered in the in-depth country studies.

Table 11.2: Methods and devices for ensuring service provision

Ensuring provision of services in long-term care

Form of intervention	*Country*							
	CZ	*DE*	*FR*	*IT*	*NL*	*PL*	*SE*	*UK*
Accreditation	x		x	x	x	x	x	x
Delegation		x		x	x		x	
Tendering				x	x	x	x	x
PPP							x	
Subsidies	x	x		x			x	
Legal stipulations valid for all types of providers	x	x	x		x	x	x	
Quality control	x	x	x		x	x	x	

Ensuring provision of services in childcare

Form of intervention	*Country*					
	CZ	*DE*	*FR*	*IT*	*NL*	*PL*
Accreditation	x		x			
Delegation		x		x		
Tendering				x	x	
PPP		x				
Subsidies	x	x	x	x	x	x
Legal stipulations valid for all types of providers	x	x	x		x	x
Quality control	x		x		x	x

Source: Questionnaire for in-depth country studies

Accreditation[92] is used in basically all countries under review as regulatory mechanism for long-term care services whereas only France and the Czech Republic take recourse to it when it comes to childcare services[93]. Most countries subsidise both long-term care and childcare services. Tendering is more used in long-term care than in childcare. Only the Czech Republic, Germany and France do not use tendering for long-term care services whereas in the sector of childcare services this instrument is only employed in Italy and the Netherlands. In general, market-based mechanisms (involving tendering) seem to be more prominent in long-term care than in childcare.

[92] Accreditation mechanisms may, in certain ceases, be challenged by EU legislation if they lead to potential discrimination towards non-national. One should note, however, that a broader use of those tendering mechanisms is relatively new and there is no quantitative assessment of their importance.

[93] Accreditation and authorisation are also a key requirement to receive public support, as stated in all country reports under this study. To this normally also add annual activity and financial reports. Other conditions mentioned such as the participation in public tenders or the integration of the institution or service into a supply plan for a given territorial unit are also referred to, but less frequently and with a different importance for the social services sectors covered by this study.

That has to be related to the issue of informational asymmetries and the different ways to deal with it. Case management, individual needs assessment and vouchers are ways of reducing these informational asymmetries.

2.2 The increasing importance of market-based regulation

Market-based regulation, by enhancing competition, is expected to lead to lower costs and to increase responsiveness. However, insufficient competition among suppliers due to high entry costs and dependency upon public funding, as well as limitations on performance evaluation may limit the efficiency of competitive regulation. The increased usage of public tendering is one source of transaction costs that should be integrated in the analysis when comparing the efficiency of various provision modes. In addition, since continuity is an important consideration in the context of social services, long-term relationships usually develop between providers and the public regulator, limiting the effect of competitive tendering and contracting. The difficulties of performance and service quality evaluation within the field of SHSGI (the effects of interventions are usually appearing only on the long run, outcomes and service quality measures are complex and costly to obtain, informational asymmetries between provider and regulator limit the regulator's ability to assess performance, quality and costs) may also limit the effectiveness of market-based regulation.

Quasi-market regulation may be exemplified by the **British** regulative framework within the field of long-term care services. Long-term care services in the United Kingdom are financed and organised differently according to whether they are classified as health care or social care. Health services are funded by central government from tax revenues. Social care services are funded by local governments (known as local authorities) that generate revenue from local taxes (known as council tax) and user charges in addition to receiving central government grants.

Since the 1980s there has been a shift away from services that are free at the point of delivery towards services that are means-tested, as long-stay hospital provision has declined and residential care and nursing home provision have increased. The process of accessing public services involves an assessment of care needs and arrangement of a package of care required to meet those needs. A care manager (typically a social worker employed by the local authority) may be involved in co-ordinating the assessment and organisation of care. Users, their families and potential providers are all involved in the process of decision-making. Once a care package has been agreed, the user is means-tested. People assessed as eligible for a package of care can instead opt for a direct payment that they can use to buy equipment or services themselves. Not every demand for care is mediated by public authorities. People can also directly approach independent sector home care providers or care homes, but there are no public subsidies (other than a contribution to nursing home fees, funded by the NHS).

Since the early 1990s there has been a shift in the balance of service provision for older people from largely publicly provided care to services predominantly provided by the independent sector. Similarly residential care has increasingly been provided by the independent sector. Commissioning involves decisions about the types of services required to meet local needs, decisions regarding the service and sector

balance in order to ensure the supply of required services, and the quality assurance aspects of care provision. There has been an increasing focus on the significance that partnerships have to play in securing services to meet local needs. Successful commissioning largely depends on whether there are well-established and mature relationships between providers and local authority commissioners, generally adopting a partnership approach. A drive towards integrated commissioning between health and social care has been one of the major policy agendas aimed at improving the co-ordination of care packages for dependent people. This drive to integrate commissioning functions has been accompanied by an increasing emphasis on the delivery of person-centred care.

The majority of services are contracted following a formal tender procedure.[94] Prior to the new regulatory framework for providers of social care, most local authorities operated their own accreditation procedures. Accreditation with local authorities has developed to encompass relevant aspects of the new regulatory regime such as criteria for minimum standards and a minimum level of training among staff members but also follows the dynamics built up within local authorities. Once accredited, contractors negotiate contracts with providers ranging from block and spot to call-off contractual arrangements. Bids to provide services are reviewed according to predominantly cost, geographical coverage and past performance. A particular concern of local authorities is the financial sustainability of providers due to the problems associated with sudden loss of supply due to bankruptcy.

In a reply from a **German** supra-state social insurance agency in the framework of the stakeholder enquiry it has been mentioned, that costs are only one of the criteria applied in awarding public tenders in the field of labour market services – and actually not the most important: "According to figures released by the *Bundesagentur für Arbeit* (Federal Labour Office) 40% of the orders do not go to the cheapest supplier. It is planned to develop these indicators of success further in order to optimise them and furthermore frequent inspections will be undertaken throughout the process of fulfilling the work." However, an analysis of original tender documents on a case-to-case basis would be necessary in order to dispose of rather precise information on the relative weight of different criteria in tenders as cited above also for other sectors or measures.

Market-based and quasi-market regulation is extending its scope in the countries under review in this report. In the field of long-term care, market-based regulation has been introduced in the UK, France (home-help services), Czech Republic and Poland (as a result of the de-institutionalisation of public care services), Germany, Italy, Sweden, and the Netherlands. Market-based mechanisms are implemented for the regulation of childcare services in France, Italy and the Netherlands. They are also used for the regulation of labour market services in the Czech Republic, Germany, the UK and Sweden. However, no statistics feature their relative importance with respect to other forms of regulation and social services provision.

[94] One should note that this organisation mode, common in the UK, is not yet (widely) developed in other countries.

2.3 Correcting methods and devices for market-based regulation

The experiences of market-based regulation in different countries show that pure market mechanisms are not applicable in these sectors and correcting methods and devices of market steering have been developed and implemented. Three main correcting methods and devices, i.e. case-management, individual needs assessment, and vouchers, are used in order to correct the deficiencies of market-based regulatory mechanisms in the field of social services stemming from the problems of asymmetric information between users and providers.

Case management

Case managers act as co-ordinators to help clients obtain home and community care services. They determine the nature as well as the intensity and duration of services that would best meet clients' needs and arrange their services. The case manager stays in touch with the client to arrange care services and make any adjustments necessary in the event their care needs change. Case management is a collaborative approach to providing and co-ordinating health and social care services. The case manager serves as the client's advocate and makes the liaison between the client and all providers of health and social care services. In a market-based health and social care environment, it can be too demanding for the client to navigate in the system. The case manager bridges the gap between the client and the services providers. Additionally, the case manager provides linkages to other resources and services to assure that the clients' needs are met (see examples given in Chapter 10.3).

Individual needs assessment

The assessment of individual needs has come about after an increasing focus on care in the community. Research showed the assessment of individual needs, particularly unmet needs, was strongly related to an individual's health-related outcome and other important outcome measures, such as quality of life. Needs has since been investigated and instruments have been developed to assess met and unmet needs. Plans for care based on unmet needs have many benefits for individuals and health care professionals, such as user involvement in their care and establishing relevant outcomes for individuals. Needs-assessment instruments provide comprehensive and holistic evaluations incorporating the physical, social, psychological, and environmental needs of the older person. By identifying the presence of met and unmet needs such procedures help prioritising plans for care provision and defining an individual's care package (See examples given in Chapter 10.3).

Vouchers

As stated earlier in this Chapter (see 11.2), vouchers have a double function: they are a market-based instrument but also are being used as corrective devices for market-based steering of supply and demand. A voucher is a subsidy that grants limited purchasing power to an individual to choose among a restricted set of goods and services. Like grants, vouchers aim at subsidising the consumption of particular

services but unlike grants that restrict the consumer's choice to subsidised producers, vouchers subsidise the consumer and allow him to choose among the producers in the market place. However the subsidy, contrarily to what is the case with a cash allowance, has to be used to pay for a given type of service (such as housing, education, etc.). Vouchers enhance and limit consumers' choice at the same time.

New budgeting mechanisms or instruments are often predominantly applied in specific sectors. E.g. vouchers have become increasingly common in the fields of childcare. An example is the allowance granted for contracting a childminder in France. Another example is the form of job placement and care offered to handicapped persons in Germany in the form of personal budgets that was recently introduced.

3 New forms of public-private partnership

Public authorities and non-governmental organisations or private enterprises may engage in complex contractual relationships that are in many cases defined in a middle or long-term perspective, e.g. when new facilities for care in institutions are created. These contractual relationships call for new bi- or trilateral configurations of actors that are continuously evolving and include different constellations: be it public/not-for-profit, public/for-profit or possibly even public/not-for-profit/for-profit. In this context of new types of partnerships and co-operation, non-governmental organisations – i.e. third sector organisations with the legal status of mutual society, co-operative, association or foundation, at European level often 'pooled' under the label 'social economy' – may have a crucial role to play. Consequently, new types of organisation have emerged with a specific legal status as innovative responses to existing and evolving social problems.

A specific form of partnership and co-operation between public authorities and private organisations are public-private partnerships (PPP). They refer to co-operative relationships between government, profit-making firms and private non-profit organisations to fulfil policy and economic functions. Beside contracting-out and quasi-market regulation, partnerships represent the second generation of efforts to bring competitive market discipline onto public policies. Partnerships differ from contracting-out to the extent that they involve sharing both responsibility and risks, and involve co-financing. PPP are complex organisations that institutionalise collaborative arrangements between private (profit-making firms and non-profit organisations) and public sector organisations[95].

The analysis of the replies of the Member States to the SPC questionnaire of 2004 (that was circulated for collecting input for the drafting of the 2006 Communication on Social Services of General Interest) did not provide evidence for widespread usage of either contractual or institutional public-private partnerships in the field of SHSGI. However, several Member States (including Austria, Ireland,

[95] The effects and effectiveness of PPP – particularly the comparative evaluation of a PPP project against the alternatives of using conventional public financing and procurement for construction and conventional public sector delivery of service – are complex and the subject of considerable debate (see e.g. a recent paper by the International Monetary Fund (IMF), *Public-Private Partnerships*, Washington, March 2004, http://www.imf.org/external/np/fad/2004/pifp/eng/031204.htm).

Poland, and Spain) informed about their intention to make increasingly use of PPP-type models in the future, albeit, as a rule, limited to selected sectors or tasks. Apart from the field of social security, this mainly concerns the sector of social housing. More generally, PPP are most probably restricted to service infrastructure and to construction activities and less frequently used as a model for service provision. Insofar PPP are used or foreseen, Member States underlined their rationale to organise a task sharing with a strong public partner in view of generating public interest-related advantages/benefits.

Given the growing impact of market mechanisms and herewith a growing interest of private partners in the field of the organisation of social and health care services, much attention is paid on the eventual added value such PPP constructions could offer. PPP models seem to have a specific relevance for the social housing sector. This is however essentially true with respect to the construction of housing establishments, not with regard to the operation of social housing or related services. Public-private partnerships are indeed only likely to be used or needed where there is a very large capital expenditure involved. They are not likely to be needed for the operation of a service, as most authors and experts agreed.

Partnerships and cooperation modalities are frequently encountered in the provision of social services, mainly due to the shifting role of public authorities and to the development of "mixed" enterprises or cooperation between the public and the private sector, the for-profit and the not-for-profit sector as well as between the public sector and third sector and volunteer organisations.

The national reports of the countries under review in this study show that PPP, involving co-sharing of financing and of responsibilities and risks, are very rare in social services[96]. This type of PPP has however to be differentiated from co-operative local partnerships between public authorities and private actors in the co-ordination and strategic planning of services provision. An example of PPP, albeit limited in scope, can be found in **France** in the field of childcare. In France a type of public intervention within the field of childcare takes the form of financial contribution through subsidies granted by the CAF (*Caisses d'Allocations Familiales*) that now finances up to 3.52 € per hour per child to childcare services, be it public or non-profit. For-profit organisations, '*crèches d'entreprises*', are entitled to receive public subsidies. Tax deductions can also be claimed by parents and by private enterprises for their expenditures toward childcare. These types of funding schemes create incentives for private actors (essentially private corporations) to engage in public-private-partnerships in order to start up a childcare facility (*crèches d'entreprises*) benefiting mainly the employees of the corporation[97].

[96] This is also underlined by the stakeholder enquiry. A reply from Germany states that in the social and health sector the concept of PPP currently is basically being dealt with on the planning level and only slowly starting to gain attention in the health care sector, e.g. with regard to partnership models between hospitals and (self-employed) doctors and further related service offers.

[97] Issues to be further investigated in relation to PPP also exist in the social and health services sector, e.g. related to efforts of a (local, regional or national) government to implement new or further regulation, e.g. minimum standards for nursing homes at a point when the private sector already has a certain share of a market. Which safeguards have been implemented to support their implementation and a continuous service delivery by the private sector providers?

4 New governance practices and co-operative partnerships

The development of the regulative state as well as the new institutional landscape characterising the provision of services of general interest that has emerged have contributed to shift the focus of attention from the internal working of public organisations to the network of actors on which they increasingly depend and to the issue of governance.

The new governance paradigm has contributed to transform the understanding of policy making as well as policy implementation processes. The dominant view of the policy process has long been that of pluralism. In the pluralist perspective, power is not hierarchically arranged, but stems from a bargaining process and competition between numerous groups representing different interests. Policy is made in a complex setting in which many actors and networks interact. The policy network approach underlines the interactive nature of policy processes as well as the institutional context in which these processes take place.

The concept of governance has multiple meanings and there is a good deal of ambiguity as to the ways it is used (Pierre, 2000). However, most of those meanings cluster around a search for effective regulation and accountability. Indeed, the privatisation of publicly owned industries and public services, and the consequent need for regulating service providers to ensure service quality and service compliance with contractual terms as well as the introduction of commercial practices and management styles within the public sector have contributed to generate a new model of public service distinct from that of public administration under hierarchical control and directly answerable officials (Rhodes, 1997: 48-60).

Often this concept also involves a different conceptualisation of the relationship between 'customers' and services providers from the conventional view of the relationship between citizens and the welfare state (Pierre, 2000). At the same time, new practices of co-ordinating activities through networks, partnerships, and deliberative forums have emerged replacing centralised and hierarchical forms of representation. Such negotiated social governance embraces a diverse range of actors: labour unions, trade associations, firms, local authority representatives, social entrepreneurs, civil society organisations and community groups. Governance focuses on various forms of formal and informal types of public-private interactions and on the role of policy networks.

According to Rhodes (1999: xvii) governance refers to 'self-organising, inter-organisational networks with the following characteristics:

- Interdependence between organisations. Governance is broader than government covering non-state actors.
- Continuing interactions between network members, caused by need to exchange resources and negotiate shared purposes.
- Game-like interactions, rooted in trust and regulated by rules of the game negotiated and agreed by networks participants.'

Traditional public management, with its focus on the operation of public agencies, emphasises command and control as the modus operandi of public programmes. While stressing the continued need for an active public role, however,

the new governance approach acknowledges that command and control are not the appropriate administrative approach in the world of network relationships that increasingly exists. Given the pervasive interdependence that characterises such networks, no entity, including the state, is in a position to enforce its will on the others in the long run. Under these circumstances, negotiation and persuasion replace command and control. Public managers must learn how to create incentives for the outcome they desire from actors over whom they have only imperfect control. Civic involvement might also need to be linked to or even integrated into this public-private tissue of service provision.

In order to implement such policy changes governments need intermediaries close to the ground and to engage relevant stakeholders with whom they can work in partnership. The renewal of governance entails that governments, rather than acting alone, must increasingly engage in co-regulation, co-steering, co-production, co-operative management, and other forms of governing that cross the boundaries between government and society as well as between the public and the private sectors (Kooiman, 1993:1). These governance shifts are reflected in policies based on 'partnership' that offer means of developing 'joined-up solutions' to complex social, and welfare problems[98]. Solutions to such problems cannot, according to proponents of the new governance paradigm, be found by governments acting alone, but depend on a wide range of actors working together across boundaries and drawing in actors from the civil society.

The modernisation of governance in the context of SHSGI emphasises the role of social investment and the need to build a flourishing civil society. Civil society, government and the economy are viewed as interdependent. Several initiatives in the countries under review in this report indicate a shift towards new forms of local governance of social services.

In the **UK**, in the field of long-term care, new types of agreements between local authorities and the national government have been developed in recent years, focusing on the promotion of well-being, co-ordination of local service delivery and joined-up working by local partners. In addition these agreements provide a new framework for the relationship between central and local government aimed at improving local public service delivery. The *Local Strategic Partnership (LSP)* mechanism is particularly important within this delivery framework. This is a single body that brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors. The body is responsible for developing the local vision for the area across all public services, including social care and health services.

In the field of labour market services, new governance practices that aim to link services and create more horizontal integration – this has been especially true in health and social care but there is a connection of work to other social issues (for example the importance of childcare for parents seeking work) – has meant the need for more partnership working across previously firm institutional boundaries. LSPs tend to bring third sector and state providers together around skill and training of new

[98] As was also underlined in replies received by stakeholders, an increasingly competitive environment at local level to which providers have to adapt not only their structures but also their behaviour might, however, partly impede and counteract to innovative co-operation- and partnership-based approaches.

partnerships (e.g. Nottingham and Bristol). The changed policy environment has emphasised the development of more horizontal connections between those organisations engaged in combating poverty. This can be seen, for example, in cross-cutting initiatives to bring the previously separate arenas of health and care together; partnerships involving different providers of social projects – particularly local government and third sector organisations – and a move from 'reducing poverty' to the more complex idea of 'combating social exclusion' which has implied a wider range of actors being involved in planning services (Kendall 2003:59).

This has meant a range of government initiatives: imperatives to develop 'compacts' to agree about the principles of the relationship and roles between the municipal and third sector; the growth of joint planning through Local Strategic Partnerships; area initiatives around employment and urban regeneration (including government-funded New Deal and Neighbourhood Renewal programmes). In fact Stoker (2004) suggested as many as 5,000 such partnership bodies had emerged in the delivery of public services. Overall this was an emergent form of governance characterised by the state (local or national) having a weaker role in delivering services while retaining a strong strategic planning role.

In **France**, in the field of childcare, shifts in the role of public authorities characterise emerging new forms of local governance. Along with the diversification of providers that characterises the development of this sector, more emphasis is put on the role of public authorities in terms of co-ordination and governance. This movement was already present since the decentralisation process of the 1980s, but co-ordination becomes more crucial given the increasing role of non-profit organisations, the involvement of private enterprises and the expansion of the number of childminders. From this perspective, the recent institutionalisation of the departmental commission on childcare appears to be an interesting tool that remains to be analysed. At the municipal level, a new co-ordination function, that of childcare co-ordinators, has been created. Their role is to facilitate the implementation of the '*contrats-enfance*' and to support the development of common culture of childcare at the local level. They mainly work with non-profit organisations that are part of the '*contrat-enfance*'. Locally, these institutional tools are implemented in different ways, leading to forms of governance that vary greatly from one territory to another.

In **Italy**, special rules and arrangements have been introduced in order to support civil society initiatives within the field of childcare. The Lombardy Region, for example, has defined through a regional law a new juridical subject, the 'associations of social solidarity', and self-help associations of families, also called Fourth Sector, to whom a part of Regional funds is often reserved already in the laws or in the bid criteria. According to the Regional law on family policies, for instance, in 2000 more than 48 million Euro were devoted to the creation of services to families (family crèches, company crèches, childminders' lists, time-bank, parenthood support). In the bid, 50% of these were reserved for social solidarity associations, which were invited to formally come together to create family-crèches.

5 Conclusions

The regulation and governance of social services in Europe is experiencing transformations. The first major trend that emerges from the analysis of the in-depth country studies in this report is the expansion of market-based regulation in most of the sectors under review as well as the consequent reduction of the scope of public-programming regulatory mechanisms. Market-based regulation, as a means to allocate resources within the field of social services, seems to supplant public programming. Market-based regulation, however, requires usually the use of corrective mechanisms in order to tackle market failures arising from asymmetric information that often characterises social services.

The second main conclusion is the fact that public-private partnerships do currently not play a significant role in modernising social services in Europe. A major reason is that social services do not constitute a solvable market and that consequently few private actors are willing to invest money and to take risks in activities that are mainly publicly funded and where the profitability is not existing or minimal.

The third main finding is that, beyond the introduction of market-based regulation, social services require new forms of governance in order to promote co-operative and strategic partnerships between a manifold of actors, to enhance horizontal co-ordination and to foster civil society initiatives. These new forms of governance entail the development of institutionalised partnerships where the role of public authorities is transformed from hierarchical centralised command to horizontal more complex and multi-faceted network-based co-ordination.

Chapter 12 Trends of modernisation in selected sectors of social services

1 Introduction

Chapter 12 illustrates the trends and categorises the main forms of the modernisation process for four of the five sectors covered by the study. Table 12.1 gives a broad overview of the examples by country and sector.

2 Long-term care

For long-term care, the trends of modernisation presented in Table 12.1 are confirmed by the replies to the corresponding question on main drivers of modernisation that was raised in the country questionnaire. Demographic changes of an ageing population, a stronger focus on service users, and budgetary constraints rank high in these country replies (Table 12.2). The EU legal and political context was ranked as important in four: the Czech Republic, Germany, Poland and Sweden.

Modernisation within the field of long-term care is driven by socio-economic transformations that affect both the needs for care and the needs for financing. One of the main issues for the long-term care sector is the demographic change that most European countries face. In Sweden for example, the years between 2020 and 2030 are estimated to be especially tough when the large generation born in the 1940s gets older at the same time as the working population is decreasing. Population aged 85+ is forecasted to reach 2.2 million by 2026 (see also Chapter 4.1 and Figure 4.1).

With the increase in the number of dependent people, the level of dependence and the poly-pathologies of the elderly, the needs for long-term care and adapted social housing (to avoid residential care) are likely to increase strongly in the coming years. In France, for example, the number of beneficiaries of long-term care services has increased by nearly 50% since 2000. Demographic changes and increasing future demands on the long-term care sector will have also impacts on the demand of qualified labour-force in caring activities.

Changing needs

In addition to demographic changes, the needs for care are also changing. Twenty years ago, institutions and services were mainly addressed to people experiencing social difficulties (insufficiency of resources or absence of family environment). Today, long-term care services are requested to provide more professional and often more medicalised services to a broader and more differentiated segment of the population. Their function now is not only to help people at risk of poverty but also to offer social protection against potentially over-proportional expenditure (affecting the bulk of both a pensioners' income and household assets) on it, in particular when care in a nursing home is needed. In addition, changing needs have led to the development of new types of services that are tailored to meet evolving and differentiated medical and social needs, at home and in institutions.

Table 12.1: Modernisation processes and the quest for good governance: Examples

CZ	DE	FR	IT	NL	PL	SE	UK
Long-term-care							
Benchmarking of costs for performance in state administration Introduction of na-tional quality stan-dards	Introduction of mar-ket mechanisms Personal budgets (supplemented by professional case management) Integration of services for the care for disabled persons with long-term care and medical services (integrated care) Spatial governance (strengthening the municipality level) Governance modes empowering the users	Residential care: Re-inforcement of users' rights, information of the beneficiaries, contract between supplier and benefici-ary, council of social life Universal voucher ear-marked to pay employment related to care and support services. Setting up of plans and co-ordination mechanisms to support the availability of measures for disabled and dependent persons without big regional differences	Introduction of market mechanisms, care allowance for heavily dependent elderly people in difficult economic conditions and living at home introduced by some regional authorities (with a negligible effect on the development of an administered care market up to now, however). Integrated (social and health) home care voucher (Lombardy). Participative proce-dures in local pro-grammes	Personalised budgets (clients managing their own care)	Deinstitutionalisation of public long-term care, development of community-based care occupations Lifting up standards Monitoring and evaluation of the actions	Collaboration of governmental agencies countries and NGOs aiming at developing competencies and availability of personnel (competence ladder; focus on elderly care and nursing)	Innovation in service delegation: Low level of responsiveness to service users' preferences, lack of continuity of services. Strategy: introduction of cash-equivalents and care-packages known as "direct payment" for cli-ents to pay for home-based care
Social integration							
		Attribution of new organisational responsibilities, with a public organisation now managing a public utility mission	Promotion of users' and civil society's involvement, strengthening of role of civil society in the policy making processes	Introduction of market mechanisms for integration education		Consideration of migrants-related issues in coherent urban (regeneration) policies	

Source: Country reports and sector report on "Social housing" (cf. SHSGI Policy Paper No. 3)

Table 12.1: Modernisation processes and the quest for good governance: Examples (continued)

CZ	DE	FR	IT	NL	PL	SE	UK
Labour market services							
New labour market integration pro-grammes Elaboration of indi-vidual work rehabilitation plans Quality audits for supported employ-ment	Introduction of unemployment assistance with the character of a basic income security Service orientation on the accomplishment of defined target agreements				Implementation of social inclusion , centres and clubs Setting up of social co-operatives and other forms of sup-ported employment	Organisational restructuring (merger of regional social insurance offices into a national integrated government agency)	From passive to active policies (new deal) New forms of local governance and partnerships Contracting-out
Childcare							
Decentralisation	Cross-linking between different forms of childcare , New forms of funding based on the time of care	New forms of local governance, diversification of providers Introduction of market mechanisms in the framework of a new quality process Introduction of alternative forms of increasing the purchasing power of users (e.g. tax relief), Universal voucher earmarked to pay employment related to care and support services	Users involvement, Fostering civil society through contracting out (clauses that give privileges to associa-tions)	Certification (on a voluntary basis) Pre-schools Professionalisation	More freedom to define curriculum at pre-school level More co-decision possibilities of parents		

Source: Country reports and sector report on "Social housing" (cf. SHSGI Policy Paper No. 3)

Table12.1: Modernisation processes and the quest for good governance: Examples (continued)

CZ	DE	FR	IT	NL	PL	SE	UK
Social housing							
		Participation of residents and local public authorities in steering committees Contractualisation Partnership of housing associations/co-operatives with other local and regional agencies to deliver efficient neighbourhood management and to promote societal and labour market inclusion of tenants		System of external performance reviews and benchmarks Partnership of housing associations/co-operatives with other local and regional agencies to deliver efficient neighbourhood management and to promote societal and labour market inclusion of tenants		Consideration of environmental and sustainable development concerns Partnership of housing associations/co-operatives with other local and regional agencies to deliver efficient neighbourhood management and to promote societal and labour market inclusion of tenants	Partnership of housing associations/co-operatives with other local and regional agencies to deliver efficient neighbourhood management and to promote societal and labour market inclusion of tenants

Source: Country reports and sector report on "Social housing" (cf. SHSGI Policy Paper No. 3)

Table 12.2: Drivers of modernisation in long-term care

Type of driving force	Country							
	CZ	DE	FR	IT	NL	PL	SE	UK
Demographic changes	2	1	2	1	1	1	1	3
Stronger concern for taking into account user interests and user choices	2	2	2	2			1	2
Budgetary constraints of public authorities and/or social insurance agencies	3	2	1	4	1	1	2	1
Giving more weight for participatory processes	3	3	2		1		3	3
Evolving concerns/demands (e.g., support to family/informal carers, integrated approaches)	3	2		1	2		4	3
Evolving relationship between public authorities and non-state service providers (based on contracts, with stronger focus on accountability, efficiency, effectiveness and their control)	3	4	2				2	2
Organisational restructuring (e.g. in form of integrated services)	1	3	4	5	2		3	1
EU legal and political context	2	2	3	5	5	2	2	3
Introduction of new public management concepts	4	4	4	5			2	2

Note: Rating from 1 (Very important) to 5 (Not at all important)

1	2	3	4	5

Source: Questionnaire for in-depth country-studies

Decreasing informal care

The ageing of the population takes place in a social context where the structure and the role of the traditional family are undergoing changes in most of the European countries. Traditionally, the family has fulfilled care functions towards the elderly and people with disability or illness. New family structures and relations, processes of individualisation, gender equality, increasing women participation in the labour force, decreases in family size, rising numbers of childless older people, changing household composition of older people, as well as increased life expectancy have affected and will increasingly affect the ability of families to provide care for their members. There is a tendency in European countries to a withdrawal of the supply of informal care that contributes to increase the need for formal long-term care.

User orientation: from public to private provision of services

Personal budgets, supplemented by professional case management, as it is the case in Germany, the Netherlands, the UK (England), appear increasingly to be a way of empowering the users. In England for example, the government introduced in 1997

direct payments which involve cash equivalents of care-packages for clients to pay for home-based care so that the care user becomes the direct 'purchaser'. More recently the Government has set up 13 pilot schemes of individual budgets (see Chapter 10, and Box 10.3 for more detail). Focus on user empowerment is accompanied in most countries by the introduction of market-based regulatory mechanisms that entail usually a move from public provision of institutional or home-based care towards the privatisation of professional provision of care. Private sector involvement of both non-profit and for-profit providers now exist in all countries and play now a more important role in many cases.

Integration of health and social services: from specialised to integrated services

In most European countries the separation of health and social care leads to difficulties in co-ordination of care packages for dependent people. Measures have recently been introduced to favour integration of health and social care services in some cases. For the **UK**, e.g., difficulties of delayed hospital discharge were reported, where older people could not be discharged from hospital because there were no alternative long-term care services in place. Following a model introduced in Sweden in 1992, in 2004 the government introduced a strategy to reduce the number of delayed discharges from acute trusts, which arise when hospital discharge is prevented by lack of suitable social services. Under the Community Care Act 2003, Local Authorities are now obliged to reimburse NHS hospital trusts if delays are caused by inadequate or delayed social care assessments and services, and acute trusts must notify social service departments of in-patients likely to need community care services. Initiatives have been taken to promote the development of intermediate care. These services are intended to prevent hospital admission, assist discharge from hospital and prevent avoidable admission to residential care. They have a strong emphasis on rehabilitation and comprise a short-term programme of rehabilitation in residential or home-based settings.

In **Germany** the question of developing of modern integrated care arrangements is still unresolved. Here, the planned development of integrated health care provision will be potentially influential for long-term car as well. The problem of integrating both sectors also reflects an asymmetry in the political economy between health care and long-term care. New social living and lifestyle arrangements are subject of many experimental projects. However, these have been rather short-lived and consequently they had so far no impact in terms of innovations on the benefit structure and the regional distribution of care.

In the **Netherlands**, a crucial modernisation trend concerns the integration of services as well as the necessity to cope with increasingly complex clients with multiple care needs that result from different medical conditions. One of the means to enhance such integration is to share services, or even to merge them. This trend is currently being translated into a wave of mergers between home-care providers, between providers of home-care with providers of institutional care (elderly homes, nursing homes), as well as between providers of institutional care.

Decentralisation: from national to local organisation of services

As Chapter 10.6 has outlined, national governments have during the 1990s in many cases introduced policy changes in the provision of social services that give the local level more responsibility for organising social services. This trend in shifting responsibility is relevant for all countries under review in this report. The trend towards decentralisation had, however, different outcomes between countries for long-term care services. These range from shifts in the relative weights of institutional care versus community care services, as it is the case in Germany, to a retrenchment of the welfare state as it is the case in Poland.

In **Germany** the community care domain is increasingly organised in terms of competition and of personal autonomy in an economic perspective. Regarding institutionalised services, changes occur more slowly. However, community care has gained importance, because of the withdrawal of supra-local responsible bodies as a result of the law concerning the care for the elderly in the German *Länder* (*Landespflegegesetz*). Local authorities are becoming more and more the centre of governance, even though the nursing/long-term care funds (*Pflegekassen*) have to ensure the individual benefits.

In **Poland**, the administrative reform of 1999 was consistent in its assumptions with regard to the policy of decentralisation of public social welfare programmes that has been widespread in industrialised countries, and has led to a decentralisation of the provision of social services at the local level. The first assessments of the administrative reform implementation have revealed decreasing supply of welfare state provision in the field of social services (welfare state retrenchment). Because of shortage of financial resources for residential homes, local authorities stopped sending their residents to residential homes.

3 Labour market services for disadvantaged persons

Developments in labour market services are influenced by more general trends characterising labour market policies. A general trend is that there are growing requirements for the quality of human capital and a continuous learning while on the job. As a result, during recent years, labour market policies have been evolving from passive to active measures. High levels of unemployment in Europe from the 1970s onwards have called the attention to problems associated with 'passive' benefits: labour market rigidities, moral hazard and dependency on benefits, and poor incentives to come back on the labour market. The focus of labour market policies has then shifted towards 'making work pay', the activation of passive spending and the targeting of services towards risks groups (long-term unemployed, unqualified youth, etc.). Within such a policy context modernisation trends in labour market service provision are characterised by 'welfare contractualism', 'rescaling' in the modes of provision of services, targeting, and increased partnership with civil society and by the contracting out of services.

A similar picture emerges from the replies to the country questionnaire. Budgetary constraints and concern for services that are better tailored to users are reported as important drivers of modernisation. It is less clear how to interpret that concerns about demographic change are reported as less important for the case of

labour market services for disadvantaged persons. The EU-legal and political context was reported an important driver for the two countries that recently became new members: the Czech Republic and Poland.

Table 12.3: Drivers of modernisation in labour-market services for disadvantaged people

	Country				
Type of driving force	*CZ*	*DE*	*PL*	*SE*	*UK*
Budgetary constraints of public authorities and/or social insurance agencies	4	3	1	2	1
Stronger concern for taking into account user interests and user choices	2	2	2	1	4
Evolving relationship between public authorities and non-state service providers (based on contracts, with stronger focus on accountability, efficiency, effectiveness and their control)	4	3		2	1
Giving more weight for participatory processes	3	5	1	2	3
Introduction of new public management concepts	5	3		3	1
Organisational restructuring (e.g. in form of integrated services)	4	3		3	2
EU legal and political context	2	4	2	4	3
Evolving concerns/demands (e.g., support to family/informal carers, integrated approaches)	3	4		3	4
Demographic changes	5	5		3	3
Note: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: Questionnaire for in-depth country-studies

Welfare contractualism

Welfare contractualism refers to obligations that the client of services contracts in exchange for services or for allowance. According to this new strand of development in social policies, opportunity must be combined with responsibility (conditionality of benefits). In addition, welfare contractualism aims at activating social expenses (investment state versus welfare state) i.e. converting passive welfare schemes in order to get people back on the labour market (workfare-like policies, or work for welfare). In this view, state welfare provision should seek not merely to alleviate disadvantage but to build assets so that people are more able to avoid disadvantage.

In the **UK** the New Deal programme initiated by the incoming Labour government of 1997 is the most notable example of active labour market policy. It is

also interpreted as a new departure in UK welfare state provision towards US style 'welfare to work' schemes in that rights to benefits were made conditional on clients taking up certain work integration programmes. The programme has placed large numbers of persons into work and there have been special programmes aimed at different target groups (the New Deal for the over 50s seems to have been particularly successful) nevertheless there has been a high churn with the programme aimed at younger people; there have been dangers of 'losing' people from the system through the welfare to work elements.

Rescaling in provision modes

In a move towards making services more effective, in very many countries the local governments and institutions have been given greater authority and involvement in the choice of services provided and ways to implement service provision. One major challenge in this respect has been highlighted by the experience in **Poland**, where local institutions have been found not to have modern and well developed managerial responsibilities for such additional responsibilities. Monitoring of such institutions is often found to be very difficult in the conditions of autonomy of each administrative unit. Recently, the Polish Ministry of Economy, Labour and Social Policy has carried out integrated training programmes to modernise the functioning of local employment agencies.

In **Sweden**, on the other hand, the trend appears to be a move towards a more centralised administration unit. In 2005, a new integrated government agency replaced the 21 regional social insurance offices. During the past 50 years the regional social insurance offices were independent juristic entities under public legislation with a unique status in the government sector. The new administrative unit will form a single public authority, and the regional offices will be converted into regional branch offices. A more centralised procurement system for purchasing rehabilitation resources from the private sector has been introduced, disadvantaging the local social service provision economy.

Targeting

The policy rationale for targeting is that a major cause of social exclusion is long-term unemployment, although for people facing multiple disadvantages, employment is not the only problem.

In the UK, from the 1990s onwards, labour market provision has been targeted at particularly disadvantaged unemployed people in deprived neighbourhoods. This was undertaken under the City Challenge and then Single Regeneration Budget government programme funding was often combined with European Social Fund money. Child poverty has been a key target of government policy and the approach here has been to devise a system of tax credits for families. Target groups who have featured disproportionately in the unemployed have also been the focus for programmes particularly within New Deal: young people, the over 50s, women with children under 5 years, ethnic minorities, those with low qualifications, people with disabilities, those with multiple social problems (those who are homeless, suffer addictions, or ex-prisoners) or are in households or neighbourhoods where there has

been an intergenerational history of poverty and deprivation from salaried employment.

Partnership with the third sector

Another trend in labour market services is the developing of partnerships with organisations in the civil society, whose role in policy-making and policy implementation and provision of services has been increasingly acknowledged. Efforts have been made in order to build and engage associations within civil society to help address social problems and deliver social services.

In the UK there has been a significant and growing shift to involvement of the civil society and third sector. Civil society's role has been fostered in policy making since the mid 1990s, when civic engagement in regeneration was recognised to be important for sustainable changes in localities to overcome social exclusion. This has been a growing trend. The Local Strategic Partnerships aims to integrate and draw together key statutory and non-statutory actors across a range of service provision at municipal level to plan service delivery.

Contracting out of services

In the UK contracting-out remains controversial in some social sectors (health, housing) while it has become commonplace in others of more economic nature over a longer time scale (waste and recycling collection). The processes are now being extended into labour market areas (around training, advice and placement).

4 Childcare

The great majority of European countries are confronted with the dominant socio-demographic trend of declining fertility rates, changing family structures (less children per family, growing share of single parents) and an increasing labour market participation of women.

The development of childcare policies is linked with these changes. Their focus is on the central issue of the division of responsibility between family and public policies. The argument in favour of public policies is that public childcare is necessary in the educational interest of children on the one hand and in order to facilitate women's participation in the labour market and to foster gender equality on the other. The latter have also been recognised as important strategy to counteract the current declining birth rates and ageing populations in Europe which pose a threat to ensure sufficient labour supply and maintain economic growth in the future (OECD 2006a, 31).

However, due to different cultures and traditions, European countries vary greatly in terms of the degree to which they acknowledge the need to develop public childcare and of the degree to which they consider the family as a 'natural' provider of childcare. Issues affecting the use of childcare services include social perceptions on the family (the roles of mothers and fathers in childcare), on the role of mothers

(views that women with (small) children should not work remain common in some Member States) and on the child (views of the child's role in society.)

The Scandinavian countries for example have a longstanding tradition in gender equality on the labour market and promote almost universal public childcare whereas the German and Italian policy ethos seems still to be dominantly based on the male breadwinner model, assuming that for (small) children women take care primarily at home. Similar perceptions exist in eastern European Member States, where the process of transition has resulted in the closure of many public centres. In addition, governments have provided protected paternal leaves up to 3 years.

Current EU childcare policy remains focused on supporting women to increase their labour market participation. In fact, they often interrupt or even stop employment because childcare facilities are not available, too costly, or of poor quality. However, children's needs and welfare is currently also an issue of increasing concern across Europe. This is due to the high levels of poverty and the continued need for greater social inclusion of children (European Foundation for the Improvement of Living and Working Conditions 2006b, 9; OECD 2006a, 85).

Increasing unsatisfied needs for childcare

As a contribution to the support of the economic activity of women and the progress of gender equality, but also as a possible chance to increase fertility rates in the future, the ongoing modernisation process aims at the quantitative and qualitative extension of childcare for children, in particular below 3 years of age. The most recent trends try to increase parents' freedom of choice and to improve the accessibility to childcare services. Furthermore, the development of childcare services is viewed as an action aiming at providing disadvantaged children (e.g. those with a difficult socio-economic background or living in rural areas) with better conditions and to create equal chances for the future.

In **Germany**, especially with regard to the balance between family and work career and the looming demographic change, the extension of childcare supply recently received much public attention. So far, the supply of childcare places has been insufficient notably in the Western Länder. Furthermore, nonstandard working schedules are on the increase and the demand is becoming more and more diverse. Thus, following a law from 2005 concerning the extension of day care until 2010 there should be a nationwide extension of public childcare arrangements. Childcare is to be provided at least for those parents who are working or enrolled in education.

In **France** the current childcare policies have been shaped by concerns about the birth rate, the economic situation of lone parents and large families, goals for equal opportunities and the changing demands on the labour market. In addition, social exclusion related to increasing ethnic and linguistic diversity in the population is a concern. Despite the recent growth in the number of childcare services – especially a rapid increase in the number of places provided by childminders took place in the last years – also France is still facing an imbalance between supply and demand, leaving an important part of the demand unsatisfied.

In **Italy** – despite the fact that since the 1990ies a growth in the number of children attending a crèche is reported – the lack of services is concentrated on small children (below 3 years of age). The latest policy developments aim at providing families with more freedom of choice and at increasing the access to childcare (e.g. via family crèches). The (limited) modernisation trends in the childcare sector are driven most of all by the growing demand due to increasing (but still comparable low) female activity rates, the concern for low birth rates and a wider orientation towards early socialisation of children.

In the **Netherlands**, especially for children below 5 years of age very often a mixed arrangement of formal and informal care can be found, this is also because of the prevailing part-time patterns. Childcare facilities are increasingly seen as crucial for women to enter the labour market. Parents should be given more opportunities in choosing childcare. Based on the increasing demand and increasing funding from the central government, the growth in the childcare sector – compared to the 1980ies nowadays a tenfold of childcare slots is available – is expected to continue. Since the 1980ies

In the **Czech Republic** the overall number of child care services declined from the early 1990ies due to a fall of the birth rate, the extension of the parental leave to three years and the prevailing public opinion that individual family care is best for the development of small children. Thus, the focus on childcare from the point of view of balance between family and working life is a fairly recent topic. Here with the released Action Plan of Support for Families with Children for the period 2006-2009 a discussion is underway whether to support institutional public facilities for children below 3 years of age or continue with the premise that individual family care is best for the development of small children. However, given the increased labour market participation of women, an increased demand for care-facilities for children below three years of age is to be expected. The most important concerns are the geographic accessibility and the affordability of childcare places.

In **Poland**, the changed macroeconomic conditions, institutional changes in the state, and demographic changes determined the development of the childcare sector in the recent years. Currently the debate on childcare is linked with the goal of equal access for women to the labour market. The National Action Plan for Social Inclusion foresees the development of day care services, which should contribute to the support of the economic activity of women. The need for affordable and good-quality crèches dominates the public debate. Due to traditional views and financial problems of local governments, services for children up to three years of age are weakly developed. There are also some attempts to extend the opening hours of kindergartens according to the parents' needs.

Following the above, in the in-depth country studies the main driving forces behind modernisation trends are seen in an increasing demand for childcare services, the response to increasing female employment rates, flexible labour market requirements and the evolution of family structures. Other factors are the concern for low birth rates and a wider orientation towards early socialisation. The delegation of the provision of services to the private sector is motivated by the benefits expected from greater flexibility and from the innovative capacity e.g. of non-profit providers but also by budgetary reasons. Lower costs for public authorities in case of service delegation to the private sector are associated with the facts that private providers are

required to complete public funds with their own investments, employees are usually less paid and less guaranteed for social risks, and parents' contribution to the costs is higher in the private sector.

Observers currently see the influence of the European Union's legal and political context as relatively low. Here the EU-targets to increase employment and childcare rates, the possibility to use European Social Funds to overcome barriers of financial and organisational constraints and a number of specific regulations that are relevant for the childcare sector (concerning e.g. the safety of children) are seen as the most important factors influencing developments on national level. In France, the European context of the liberalisation of personal services could have consequences for individual childcare services since the new law on the development of personal services in France is influenced by this context and childcare at the home of the child is included in the list of home services activities.

Table 12.4: Drivers of modernisation in childcare services

	Country					
Type of driving force	*CZ*	*DE*	*FR*	*IT*	*NL*	*PL*
Evolving concerns/demands (e.g., support to family/informal carers, integrated approach,…)	3	2	1	1		
Demographic changes	2	1	4	3		1
Budgetary constraints of public authorities and/or social insurance agencies	4	3	2	4		1
Stronger concern for taking into account user interests and user choices	3	2	4	3	2	
Organisational restructuring (e.g. in form of integrated services)	3	2	3	5	2	
Giving more weight for participatory processes	3	3	3			
EU legal and political context	4	3	4	4	2	2
Introduction of new public management concepts	4	3	3	5	3	2
Evolving relationship between public authorities and non-state service providers (based on contracts, with stronger focus on accountability, efficiency, effectiveness and their control)	4	4	2			

Note: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: Questionnaire for in-depth country studies

Diversified forms of childcare in order to meet needs

An effective strategy of modernisation consists in enlarging the scope in the supply of childcare facilities and the coordination and cooperation between different forms of childcare. In France collective services such as crèches can now provide both regular care (on a full-time basis) and occasional care, thus, also children partly cared for in other services were included in the target group. Another possibility are enterprise-based or financed services as a form of supporting employees with childcare responsibilities. For example in Italy, this is partly a solution to the lack of childcare places.

An important role plays the integration of childminders and family-crèches into the existing mix of services. In France, one of the main characteristics of the evolution of the childcare sector is the rapid increase in the number of places provided by childminders in the last years. A part of this is constituted by family crèches: organised family day carers employed by a municipality, an administration or an association, who provide care at their home. The planned extension of childcare places in Germany until 2010 draws heavily on the integration of day-care and institutional care and the general cross-linking between different forms of childcare.

In both countries, since recently day care by childminders underlies an authorisation procedure, which involves the documentation of certain qualifications of the childminders (e.g. professional competence, willingness to cooperate with parents and other childminders, obligation to follow professional training, etc.). On the contrary, a practically unregulated form of childcare subsidised by local public funding developed in Italy: small home-based services, where one or more educators care for up to seven children (below the threshold for the application of the regulations for crèches). No criteria on staff qualification, square meters per child, etc. is required for these services.

As a reaction to a growing demand for care patterns that are not linked to the reconciliation of work and family life but to the socialising effects for children, playgroups or parents' initiatives evolved. In these integrative part-time services, small children with one reference adult come together with other children and adults supervised by a professional educator. This form of childcare is often organised and subsidized by local welfare policy.

The introduction of (partly obligatory) pre-schools aims at the integration of children requiring special care and on children otherwise not reached by formal childcare. In the Netherlands this topic is currently heavily debated, in the bigger cities, pre-school arrangements are already on the rise. Already in 2004, Poland introduced a pre-school preparation for six-year-olds in order to create equal educational opportunities for children from various environments.

There are other innovative practices in terms of accessibility to childcare in a number of countries: The objectives of these initiatives have been to combat the lack of kindergartens in the countryside, and to increase parents' awareness of children's need to participate in childcare. In France, for example, a bus moving from one place in the countryside to another provides collective childcare service for population groups usually excluded. In Poland, the National Social Integration Strategy draws attention to the need of the increase of pre-school availability for children at risk of

social exclusion. There is a pilot programme, where the teachers commute to particular villages to run classes. Furthermore, communal governments and non-governmental organisations already cooperate to provide pre-school education in rural areas where there is no childcare facility. The commune makes available the premises and the organisations provide the teachers.

Out-of-school time provision for children of working parents is still not a policy priority in most European countries (OECD 2006a, 82f). However, there are also measures aiming at improving the supply for children in school age. In Germany, following the disappointing results of the PISA study, the half-day system in the schools has been criticised. Thus, the Federal Government initialised an investment programme that makes available extra funding for the Länder to finance the implementation and extension of all-day schools. In the Netherlands, primary schools will be obliged to organise child support during the lunch-break and after the school hours. As this is currently predominantly organised by parents on a voluntary basis, further professionalisation of care services is expected. In Poland the Education Development Strategy 2007-2013 stresses a range of after-school activities organised in cooperation with educational institutions and non-profit organisations (European Foundation for the Improvement of Living and Working Conditions 2006b).

Another reform trend concerns the involvement of users, thus, in the case of childcare the parents. In many European countries parents' committees or councils were established. The legal rights of these councils vary but there is among others the possibility in the participation in handling internal affairs, to advice the facility or to take part in the decision process (e.g. concerning meals, etc.). In Poland, beside teachers, parents are also the main initiators of new educational programmes (e.g. Montessori classes) and of extended additional classes (e.g. music, sports or foreign language teaching) in pre-schools.

New forms of delegation and financial support

To enhance the creation of new services, the enlargement of access chances, and to lower public costs, a shift towards the delegation of public services to the private sector is to be observed in many European countries. Frequently, the provision of childcare services is already in principle open to private providers.

In **Germany** according to the principle of subsidiarity, public providers shall only be active if there is no appropriate supply by independent non-profit providers. So far, for-profit providers play only a marginal role.

The proportion of non-profit organisations increased substantially in the last 20 years in **France**. The delegation is motivated by budgetary reasons but also to benefit from the greater flexibility and the innovative capacity of the non-profit sector. Since 2003, the provision of childcare services is open also to for-profit providers with the explicit objective of increasing the availability of childcare places. From 2004, crèches managed by private enterprises have also access to public subsidies if they meet specific criteria.

In **Italy**, non-profit providers are mainly managing outsourced public services. For-profit providers are particularly active in early childcare provision. Their

development has started at the end of the 1980ies following a lack of public provision. In particular from the second half of the 1990ies, this development has been accompanied by sporadic public financing.

In **the Netherlands** a multitude of legal frameworks for providers exists, from foundations to pure business models. The last years have seen increased efforts by the government in transforming the child care sector into a market: government funds do not go any longer directly to the child care facilities but are transferred to parents through special income-related allowances from which parents pay the facilities themselves.

In the **Czech Republic** the not-for-profit providers are still in their formative stages and began receiving subsidies from the state in 2005. The main part of private for-profit providers is engaged in afternoon- and holiday-care for school-aged children. For-profit organisations are not eligible to state grants.

In **Poland** private childcare centres including for-profit centres can be established when they comply with some conditions specified in the Act on the Educational System. Private institutions established according to the regulations are entitled to subsidies provided by commune governments. A law from 2003 regulates the use of activities of NGOs to carry out public tasks. In the future it is to be expected that these will have a special role in running childcare centres.

The developments and innovations in the childcare sector have been manifold in recent years. Concerning the delegation of services to the private sector, in several countries local authorities transfer the management of their collective services to private enterprises. For example in **France**, the delegation process is regulated by a specific law that opens a competitive process. Another development in this respect, for example in Italy, is that municipalities "buy" some places from private for profit services by paying the market-level fee. In return, parents pay for the children to the municipality the regular income-related fee.

Unsatisfied demand causes also innovations in the ways childcare services are financially supported. In France in the last years several changes in the regulation of childcare services where introduced. One element of this reform is the change in the financial intervention of the local agencies of the "family branch" of the social security system (CAF). Subsidies are granted up to a maximum ceiling per child and hour and as a complement to the financial contribution of parents. Also in **Germany** (Bavaria) childcare is financed in relation to the hours of care and not according to the number of children, places or groups. This is meant to accelerate the enlargement of the times of care.

Turning to the demand-side, in European countries with "liberal" economies (e.g. Ireland, United Kingdom, the Netherlands) concerning children below three years of age subsidies to parents, such as cash benefits, vouchers, tax reductions, etc. are used more frequently compared to supply-side subsidies paid directly to services. However, also European continental countries, e.g. **France**, introduced vouchers and tax credits to support parents in meeting childcare costs. The rationale behind is that the purchase of services by parents will create more private involvement, new funding and greater flexibilisation into the provision of services. Choices and access chances should be increased if parents have the liberty to choose the kind of service provider that meets

best particular needs. Also public monitoring and supervision is at least partly replaced by the market-based idea that more information to consumers, and competition among providers will secure quality of the services, too. In total, this strategy should also reduce public costs (OECD 2006a, 113ff).

The "free choice" objective is at the core of the recent reform of the allocation system in France. Different financial subsidies or tax deductions are granted for different types of childcare that vary with the revenue of the family. A recent law concerning the development of personal home services encourages the development of childminders with the help of a voucher and tax credits and with the regulation of intermediary structures of home services at the national level. The introduction of a new voucher for parents to pay also their financial contribution to collective services is aimed at the developing of more services. Another innovation is the tax credit for private enterprises which can deduct 60% of their expenses for the creation of childcare services or for the reservation of childcare places in existing services.

The reform of the funding system of childcare in **the Netherlands** was guided by the idea to enhance the position of parents as customers. Efforts were made by the government to transform the childcare sector into a market. Previously the government funds went directly to the childcare facilities. After the reform government funding was transferred to parents through income-related allowances paid by the tax office; thus parents pay the total costs of facilities directly.[99] By paying the full amount, it was intended to increase the market power of parents introducing a kind of delegated role as supervisor of quality.

In **Poland**, the introduction of tax allowances for families related to childcare depends on the decision of local governments. Fee allowances are in operation in about 60% of crèches and kindergartens, approximately 20% of the parents benefit from allowances. The most frequent criteria for eligibility are low income and the number of children.

In **Germany**, demand-side support for parents is not existing, in Italy there are a few exceptions but the subsidies to parents are very low. For specific years, also tax reductions were introduced for employers paying the crèche fee for their employees, or building or renovating company crèches.

Furthermore, the financial contributions of parents have been subject to reform with the goal to reducing the importance of the social and educational background for the accessibility of childcare. For example, the Rhineland-Palatinatean government in Germany plans to gradually abolish fees for kindergarten places until 2010. In the Netherlands during the 2006 election period most important political parties promised free childcare for all. However, experts warned of severe side effects such as long waiting lists and the collapse of the existing system.

[99] Until 2006, parents were required to make arrangements with their employers so that these paid their share in financing childcare. Given the administrative burden for parents and the fact that the (voluntary) contributions of employers were below the expected sums, from 2007 on the government establishes a fund where the employers' contributions are collected and then redistributed to parents.

Outcomes of the modernisation process

For users the modernisation trend in childcare leads to an increase in the supply of childcare facilities and thus to an enlargement of access chances and more provider choice. This holds true both for children of working parents where the reconciliation of work and family life is the priority – here an improvement may also be reached in terms of greater flexibility and wider opening hours – and children of parents with disadvantaged background where the socialisation factor is the priority.

The extension of childcare services has an effect both on the supply-side and the demand-side of the labour market, as it facilitates not only the labour market participation of parents, especially mothers, but also creates an increasing number of jobs in the childcare sector itself. Some private providers, e.g. with a special pedagogical plan, contribute also to an improvement in care quality. For governments a rationale behind the marketisation of childcare is also to complement or even reduce public expenditure and to introduce competition into the provision of services (OECD 2006a, 108).

However, although public policy to encourage the development of private childcare provision led beside a supplement in public spending in fact to an increase in the number of available places and to a more rapid service provision (especially due to small family day carers), an important part of the demand is still unsatisfied, the objective of "free choice" is still far from being reached. Territorial inequalities in the access to childcare services may even be reinforced by market mechanisms.

The diversifying childcare services and the fragmentation of responsibilities can result in a lack of coherence and governance. Especially quality control procedures are more difficult to implement given the increasing number of independent childminders and of for-profit providers. Partly childminders or family crèches are not submitted to any regulation. Parents are often not prepared to take up the role as a supervisor of quality and can for lots of practical reasons not easily force a change or change the provider of childcare. Public authorities could also tolerate lower quality, in order to lower the pressure on the public services. This might also be the outcome of tendering processes with assessing criteria heavily related to the price.

As private providers are usually required to complement the public funds, the services are often more expensive than the public ones. The higher fees may bar low-income families from accessing childcare. Finally, one can question the consequences of the emergence of a business orientation in childcare services that consider childcare as other normal consumption goods.

OECD-research (2006a, 118f) suggests that only by sustained public funding and investment in policy, services and management, both affordability and quality of services can be secured. Public authorities need to fund and regulate private providers. Market regulation is insufficient as the elimination of poor quality takes a relatively long time. The outcomes of unregulated marketisation can be serious for the education and development of children. However, the benefits of increased supply and choice should be considered. The stagnation and inadequacy of public services for children below 3 years of age and school-aged children in some European countries need to be overcome in the future (OECD 2006a, 118f).

5 Social housing

The examples sketched out below are mainly based on the sector report on social housing (SHSGI Policy Paper No. 3) and partly also refer to an analysis of the replies of the Member States to the SPC questionnaire of 2004 to prepare a Communication on Social and Health Services of General Interest (Maucher, 2005) which both helped to identify some issues to be analysed more in-depth with respect to social housing.

Forms of co-operation, partnership and networking

The sector study on social housing underlines that social housing operators are expected to work in partnership with other local and regional agencies to deliver efficient neighbourhood management in the face of demands for the effective social inclusion of tenants via the facilitation of access to training and to the job market for these residents. In many parts of Europe, social housing providers are expected to take the lead in this field (e.g. the Netherlands, UK, etc.). Several Member States informed in their replies to the SPC questionnaire in late 2004 about their intention to increasingly use public-private partnership models, albeit, as a rule, limited to selected aspects or tasks.

Anticipating a future use of Community Structural Funds which are expected to be extended to social housing and modernisation of housing stock, in the **Czech Republic** also especially to buildings constructed with the prefabricated panel technology, a cross-national project has been prepared with the objective to prepare a model contractual system which will provide a general solution to the relations between building owners, suppliers, financial institutions, and institutions providing guarantees. The proposed conditions should be attractive enough to allow access to long-term loans with low financing cost thanks to reduced heating costs and a stable system of guarantees.

Diversification of portfolio – financing/cross subsidies – supervision and evaluation

Moreover, in order to be able to fulfil their social obligations to provide homes for the most vulnerable groups, many social housing organisations are increasingly diversifying their portfolios and undertaking so-called non-landlord activities as a means to cross-subsidise their social dwellings via the development of profitable activities. In some countries, housing associations are required to pursue a commercially sound policy and risk management, surplus resources must be used for the benefit of social housing.

As regards the usage of market mechanisms, the recourse to private capital is used for the construction of non-profit rental social housing. In the sector of social housing and urban regeneration, market mechanisms are also vital elements for housing associations and agencies in the area of urban regeneration to fulfil their tasks.

Dutch Housing Associations are expected to develop a system of external performance reviews and benchmarks, of independent and authoritative nature, with first tests started in the course of 2006.

Decentralising decision making powers and funding

In **France**, so-called Local Habitat Programmes have been set up, allowing for a better response to the nature of local needs in the framework of territorial programming of the supply of social housing. In addition, based on an obligation for the local authorities to dispose of at least 20% of social dwellings they can better influence policies.

User participation

In **France**, new forms of regulatory mechanisms have been introduced, such as the participation of the residents and the local public authorities in the administration councils and the HLM agencies.

6 Conclusions

Beyond common modernising trends analysed in Chapter 12 and relative to the organisation, management and governance of social services, all types of services, in terms of sector, experience transformations that are conditioned by the inner developmental logic of the policy fields in which those services are embedded and by socio-economic factors. Long-term care services have to face the ageing of the population, childcare services have to respond to new demands linked to gender equality and to transformation of the family, labour market services have to adapt to the requirements of the labour market as well as to the changes in labour market policy orientations.

The idiosyncratic character of each sector contributes to increase the diversity and the complexity of the picture. Modernising trends are plural and, even if there are common tendencies, are often influenced by country-specific cultural, political and institutional features that make them path-dependent.

However, in spite of this diversity, the analysis by sector helps making clear how social services are an important part of the 'European social model' and how they are a major response to the main social and economic challenges European societies are meeting: ageing, gender equality, social integration, labour market flexibility and efficiency. Social services are not only a financial expense but also a productive factor to the extent they enhance economic competitiveness by improving the availability and the quality of the labour force.

Part IV. The interaction of Community rules and case law with the evolution of SHSGI

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Chapter 13 The impact of EU rules in five sectors of social services

The present Chapter is mainly based on the country studies and the stakeholder enquiry. In general, it proved to be difficult to find supporting evidence when documenting the impact and consequences of the application of EU rules. This is due either to the fact that experts and persons interviewed were not aware of the EU legislation[100] and its possible effects on their day-to-day provision or use of social services, or because no objective analysis or evaluation has been made to base it upon. Consequently, this Chapter does not aim at exhaustiveness nor at being representative of what can be found throughout the European Union, especially now that it counts 27 Members.

Very few Court cases[101] can be found pertaining to individual social services dealt with in the frame of this study. Indeed, interaction between the implementation of EU rules and the organisation, provision and financing of social services is a very recent field of examination and discussion. The most relevant Court cases for social services are the ones dealing with health and patient mobility[102]. They may be of relevance for other social services provision, especially related to long-term care.

We will first examine how the concept of 'general interest' is understood throughout some countries, before looking at it across the sectors studied in the present report.

1 Introduction: the concept of general interest translated through social services

The importance of defining the missions of general interest and/or public service obligations has already been mentioned earlier in this report. The study authors noted that the notion of 'general interest' is defined very differently: in a quite far-reaching manner, or enshrined in sector- or programme-specific pieces of legislation.

1.1 National illustrations

A few illustrations from some countries are given below, in order to show some possible general or cross-sector definition at national level.

In **Sweden**, the term "social and health service of general interest" (SHSGI) or the concept of general interest is not often used in the vocabulary. Those services are regulated by law and meant for everybody within the framework of the Swedish welfare model. They are provided through state monopoly agencies or are subject to state interventional regulations. Although, the term SHSGI is not used as such in Sweden, social and health-related services such as long term care, social integration

[100] Transposed into national law, the EU legislation does not appear as being European legislation. This might also explain the lack of awareness at national level, but especially at regional and local ones.

[101] Those are notably ECJ Case C-70/95 *Sodemare* 1997 ECR I-3395 and ECJ Case C-475/99 *Ambulanz Glöckner* 2001 ECR I-8089.

[102] E.g. EC Case C-286/03 *Hosse* 2006 ECR I-1771, ECJ Case C-215/99 *Jauch* 2001 ECR I-1901, and ECJ Case C 160/96 *Molenaar* 1998 ECR I-880 focusing on the question under which conditions care allowances (paid in the German and Austrian statutory systems) are exportable.

and labour market integration can to a large or dominating extent be considered "of general interest", meaning they are:

- Regulated by special laws,
- Aimed for everybody who is resident in the country,
- Financed by taxes and subsidies, independent of public or private provision,
- Governed by joint quality rules and guidelines for public as well as for private providers, and
- Governed by joint supervision of public and private services.

Every individual resident of a Swedish municipality, including intermittent long-term visitors, has the right to obtain certain social services on behalf of the general interest. This right is not only a Constitutional right but also a practical, concrete right, e.g. for home services for an elderly person. Every decision by a local authority about the existence and the outreach of such a social right in an individual case can give rise to a court appeal to the County Administrative Court in case the resident claims the decision (refusal of the service or insufficient extent) is wrong.

Since everyone may need help and support from the Social Services (Socialtjänsten, the Swedish term for both the right and the local authority responsible) at one time or another, the Social Services Act (Socialtjänstlagen, SoL) contains regulations regarding the right to financial and social assistance, and regarding the municipal authorities' duties towards residents of the municipality. The Social Service Act has been re-drafted several times since the 1980s and, the latest update was in 2002. Some of the most important changes in the law were that users had a larger right to "appeal decisions about assistance", more strict supervision of the Social Services, and new regulations for fees for disabled and elderly care.[103] According to the SoL, the municipal authorities have special responsibility for certain groups: children and adolescents; people with drug and alcohol addictions; elderly people; people with functional disabilities; people caring for relatives; and crime victims.

All services provided under the Social Services Act are based on free choice and autonomy. These services must be adapted to individual circumstances and the person's desire to change his/her social situation. The assistance provided by the Social Services must be of high quality and carried out by staff with the appropriate training and experience. Consequently, even if the general interest as such is not defined, the social rights attached to the notion of general interest are quite far-reaching compared to other European Member States.

In the **Czech Republic**, the Law 108/2006 Coll. defines social services as an activity or a set of activities to secure help and support to persons with the aim of social inclusion or the prevention of social exclusion. Section 2 Para 2 of its fundamental principles states in particular: *"The scope and form of assistance and support provided by means of social services must honour the human dignity of persons. Assistance must ensue from the individually determined needs of persons, must have an active effect on persons, stimulate their independence, motivate them to*

[103] See: http://www.sos.se/fulltext/114/2002-114-9/2002-114-9.pdf#search=%22lagrummet%2Bsocialtj%C3%A4nstlagen%22 accessed 2006-10-08

such actions that do not result in the long-term persistence or deepening of an adverse social situation, and strengthen their social inclusion. Social services must be provided in the interest of persons and in a manner always consistently ensuring the observance of the human rights and fundamental liberties of persons." [104]

Although the services of general interest are not codified in general terms, the Czech legal framework specifies missions of general interest and public obligations. These binding rules are defined in writing (customary law is not usual in the Czech Republic).

The Bill of Fundamental Rights and Liberties, which is a component part of the Constitutional Order of the Czech Republic includes a large number of fundamental social rights[105]*. General interest missions and services are thus rooted in human rights, and specific sector laws are the instruments of the rights implementation. Furthermore, the Laws on regions (129/2000 Coll.) and municipalities (128/2000 Coll.) oblige regions and municipalities to take care of the all-round development of their territories and the needs of their citizens. It has to take the legal framework governing the field of provision of services of general interest by other than the public authorities into account: assigning public contracts (Law 137/2006 Coll. on public contracts; Law 250/2000 Coll. on budgetary rules), providing grants from the national budget (Law 218/2000 on budgetary rules), and the administrative regulation of awarding grants by individual ministries and regions.*

Since 2000, the national framework Law 320/00 on social services of **Italy** aims at recognising the specificity of social services in terms of general interest, e.g. their fundamental role as a tool to guarantee social cohesion. At the same time, the law recognises a central place and role to non-public actors (in particular the third sector[106]) to provide services of general interest and to participate, at policy level, in their design, planning and organisation. It introduces some market criteria (efficiency) in the regulation of the social sector and delegates responsibilities to the regional (and local) levels.

The law states that the sole responsibility left to the Italian State is to define the "*essential levels for social assistance services*" (LIVEAS)[107], which however so far has not happened. But, from a formal point of view, Italy did strictly follow (or even precede) the guidelines and prescriptions to implement various European directives.

The Netherlands does not have an explicit concept of "general interest" as such, also not in relation to social services.

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[104] Law 108/2006 Coll. on social services. Collection of Laws of the Czech Republic, Part 37, p. 1257

[105] e.g. the right to increased health protection at work and special working conditions for women, juniors and disabled persons; the right to special protection in industrial relations and assistance to the preparation of juniors and disabled persons for work; the right to adequate material security in the event of work disability; the right to the protection of health; parenthood and family are protected by the law and juniors are provided special protection; care for children and their upbringing is the right of the parents, children have the right to parental education and care; the right of parents to receive state assistance.

[106] The third sector is notably exemplified as being non-profit organisations, voluntary and social cooperatives.

[107] LIVEAS: Livelli essenzialli delle prestazioni socio-assistenziali.

Whereas the **United Kingdom** does not have a written constitution containing exact obligations of the state with regard to the provision of social services of general interest, statutes and case law and a series of regulations set out the legal, regulatory framework for such services. However, the notions of 'public service obligations' and 'missions of general interest' are not well understood in the UK in relation to social services. Rather, various statutes or contracts guided by statutory requirements set out policy obligations.

1.2 Additional elements of delimitation of general interest services

Following the stakeholder enquiry, many organisations emphasise that the character of being a 'general interest' service is actually due to the multitasking/multi-target character of the services. In other words: to the fact that these services are geared to direct person-oriented support (i.e. 'person-centred'), community-oriented enhancement and wider social and societal integration.

In **Sweden**, there are rather sharp borders between social and health care with respect to political responsibility and administrative levels, but the different social and medical professions collaborate in negotiations about resource distribution as well as the individual cases to be handled in practice. The outcome for the individual person is to receive a better-integrated service answering various needs.[108]

General interest may also be featured in the territorial cohesion policy of a country. The Swedish central government's grants for example, are to some extent based on a reallocation of resources among municipalities and counties to be able to provide the same level of social services regardless geographical location or economic income. This reallocation is based on demographic, geographic and socio-economic factors and aims at making it possible for all Swedish residents to receive the same services regardless of location and income.

As illustrated above, the responsibility for defining 'general interest' or 'social services of general interest' depends on the distribution of competences between the various levels of governments[109]. It also depends on various national (but also regional and local) policy settings. In some countries, the link between fundamental or constitutional rights and social services is explicitly made.

2 Long-term care

The long-term care sector, which is closely related to the health sector, constitutes the main sector of social services where cross-border provision of services is starting. It is particularly in this sector (and in the social housing sector – see Section 6 of the present Chapter) that several questions with respect to the EU legal framework applicable to social services are coming up.

[108] In other countries there is no strict boundary between social and health services; both are being treated by the same Ministry or legislation, or are dealt with by cross-cutting legislation, e.g. on socio-medical action in France.

[109] See Chapters 1.1, 3.2 and 9.3.

2.1 Definition of long-term care services with respect to 'general interest'

Depending on the countries, one can find more or less precise definitions that may (or may not) include a reference or an explicit formulation of the "general interest".

In **France**, social services are considered as a category of public social policies and regulated by several laws, in particular the law n° 2002-2 *rénovant l'action sociale et médico-sociale* concerning social and socio-medical residential care and home care services (for the elderly, handicapped, for people in difficulty...) of 2 January 2002. However, the concept of service "of social general interest" is not defined as such.

But for the residential care and home care services for the elderly, the French *Code of the social action and the families* specifies that social and socio-medical action "*is part of missions of general interest and social utility*". This code precisely defines these missions through listing six categories[110]:

- The evaluation and prevention of the social and socio-medical risks, information, investigation, advice, orientation, training, mediation and reparation;
- The administrative or legal protection of the elderly;
- Vocational, medical, therapeutic, pedagogical and training actions for the needs of a person, her age, development potentiality and evolution of her characteristics;
- Actions of social and professional integration, adaptation, re-adaptation, information and advice to work;
- Actions of assistance in the everyday life, of sustain, support, of care and accompaniment, even in a palliative way; and
- Actions to contribute to social and cultural development and to professional integration.

In France, regulatory text provides for the general scheme of definition of general interest and social utility. For each social or socio-medical support, and for each type of structure or service, texts present constraints for all providers of social services. They present architectural and security norms to respect, sometimes the rates of managerial staff and the level of qualification of employees, the user's rights and modality of financing. These texts can be completed by interpretation texts (circulaires) and/or by good practices guides.

Considering all those various types and pieces of legislation in France, the missions of "general interest" with respect to elderly care[111] are defined in a very wide-ranging manner.

[110] Article 5 of the law n° 2002-2 of January, 2 2002, reforming the social and medico-social action.
[111] But this is also the case for childcare (see Section 5 of the present Chapter).

In **Sweden**, on the other hand, 'general interest' is not referred to. But the Social Service Act from 1982: *"…covers the duty of municipalities to provide social services and care for older persons. Under this act, any person who is unable to provide for his needs or to obtain provision for them in any other way is entitled to assistance towards their livelihood and towards their living in general."*[112] As was shown in Chapter 13.1, this a priori simple way of expressing obligations nevertheless leads to far-reaching rights for the elderly citizens.

2.2 Accreditation mechanisms: preliminary authorisations and agreements

Accreditation and authorisation agreements are described in Chapter 11.2 of the present study (see also Table 11.3). They can be set up by competent State authorities at different levels.

With respect to legal aspects, such devices have numerous functions: in general, defining the regulatory framework for service delivery and provision. More particularly: delimitating the market (for example reserving some provision to specific providers), regulating quality ex ante or providing for a possibility to introduce ex post verification of quality requirements, controlling the access to the market, limiting the provider types that may have access to public financing, (partial) re-funding, and controlling through ex ante territorial planning the financial consequences of the service provision, etc.

Preliminary authorisations and agreements can be found in all Member States in one form or another with respect to providers of long-term care. The main question with respect to EU rules is the one of compatibility of these with the competition and internal market rules. EU rules on competition and internal market will only apply if there is (potentially) affect on trade in the internal market or with respect to a non-national. In **France**, for example, the authorisation modes for elderly homes entail tax advantages (reduced VAT rate and tax cuts). The question is whether such advantages are also (or would be) given to non-national providers established in France or when services are offered on a temporary basis.

The new approval procedure (law n° 2002-2 *rénovant l'action sociale et médico-sociale*) of 2 January 2002 in France makes it possible to increase the introduction of market mechanisms in the field of social services, allowing prices to be freely established and escaping the preliminary step of needs assessment based on a territorial analysis for supply and planning. Associations for the elderly however are concerned that the apparent simplification of the process of development of these services might decrease quality of the provided services and coherence of social policies (for example, since these services are not controlled any more according to the departmental scheme).

The opportunity to create a home care service for the elderly on the basis of a quality agreement that is not founded on a needs assessment (a "soft" quality agreement), is linked to the opening of markets introduced in the field of social services of general interest. It is a way to have more flexibility in the conditions for creating and regulating these services with less public control on quantity and quality. The representative associations of people with disabilities are afraid of the

[112] http://www.sweden.gov.se/content/1/c6/04/49/83/34a6f5bd.pdf (accessed 2006-11-20)

reinforcement of the tendency toward more market-oriented mechanisms of service regulation and planning (see developments on those tendencies in Chapters 11.2 and 12.1 notably). They argue that simplification is synonymous to less quality and protection for vulnerable beneficiaries; this would also be due to the softer control procedures. In their view, in comparison to the former authorisation/agreement procedure, the overall service quality seems thus to be at risk.

Possible other consequences could also appear due to the non-accreditation of non-national long-term care service providers or because of the non-compliance with national agreements and conventions that organise reimbursement schemes for special long-term care services. Indeed, social security and health systems were originally conceived on a national scale. National (and regional) legislation needs to be adapted to a new reality with foreign providers and with people seeking services abroad or from non-national providers. This takes time, but may also be the source of problems for the financial sustainability of national social security systems. Since long-term care is intrinsically linked to health, those implications need to be better and further studied with respect to practical implementation of rules and regulations.

2.3 Public procurement

In several countries, the new provision mode of social services via public procurement raises questions and uncertainties on the side of several stakeholders. This is not specifically related to health care or limited to this sector but strongly interrelated with growing needs in the long-term care sector and with its financing problems.

In **Italy**, delegation and tendering are the most traditional forms of intervention used by public authorities in order to ensure the provision of home care services, in the social sector as well as in the health sector. The development of these services has occurred since the 1980s through the externalisation of tasks to non-profit organisations, especially to (social) cooperatives. This outsourcing tendency often presented as a way of making services more flexible and responsive and to appraise the resources of the cooperative movement, is openly recognised by key actors as a way of reducing costs. This was possible due to the availability of a labour pool at lower cost and which was less protected compared to the public sector. Nevertheless, this cooperation - also sometimes regarded as a form of public-private partnership in the provision of services - should be considered as a traditional feature, rather than a recent development in Italy. Indeed, in these contexts, the cooperatives' employees (and their coordinators) work in a strong relationship with the local authority, sometimes as if they belonged to the same body. Sometimes, associations receive a subsidy from local authorities when they provide services (instead of cooperatives). There has been quite a debate on the impact of subsidies to volunteer organisations as a possible means of financing low costs services (hiding informal employment) at the expenses of employment growth. The possible qualification of 'state' aid for such subsidies to associations must also be questioned.

Public procurement, as presumably applied by a considerable number of municipalities in **Sweden**, favours generally price over quality and other social criteria, or even considers only price. This has consequences for non-profit providers and those from the social economy sector in general that might have other priorities and objectives, for example to provide community services or social cohesion.

Box 13.1: What were the implications of public procurement in the Swedish long-term care sector?

The closing down of a social care co-operative - The case of public procurement of social home services for elderly and other people -in need in the City District Snopptorp, City of Eskilstuna in 2005.

Hemservice Eskilstuna User Cooperative (Home Service) that had operated since 1991 servicing some 300 users with 30 employees and an annual turnover of appr. 8 Mill. €, lost its contract in 2005 and closed its home care for elderly persons. The appeal to the Regional Administrative Court was refused and the cooperative could not afford costs of a lawyer for further appeal to a higher court.

Misinterpretations of the Procurement Act by the local authority led to the opinion that the provision of the service had to be subject to a public tender. The tender evaluation produced the firm Attendo Care as the winner, despite the fact that, compared to Hemservice Eskilstuna, it had a larger central overhead and more expensive management, appr. 30 % less care personnel and it was involved in appr. 20 public complaints all over the country due to negligence of patients.

The tender evaluation document stated, among others, that Hemservice Eskilstuna (and three other tenders) was disqualified because of "not acceptable tender prices", and that Attendo Care "has achieved the highest level of quality and has offered the lowest price out of those tenders being finally evaluated".

However, according to some Swedish legal experts, next to competitive tendering ("purchasing goods or services from third parties"), the public authority could have chosen another way of organising the service provision, i.e. via a cooperation agreement or a delegation system. It appeared indeed later on that a tender procurement procedure would not have been needed: a running co-operation agreement with the co-operative in Snopptorp, in force before the introduction of the Public Procurement Act in 1995 was legal. And if the Procurement Body, the City of Eskilstuna, nonetheless wanted to opt for a public procurement procedure, it could have drawn up the specifications in such a way that management integration of different professions, voluntary work and user participation could have been taken into consideration.

Source: based on information from LL.M. Per-Olof Jönsson - HCM Health Care Management and Medicoop of Sweden

This is only one documented example, but misinterpretations related to the generalised compulsory recourse to public procurement seem to be widespread within municipalities and regional authorities in Sweden. They also seem to consider the price criterion only, where other considerations could be taken into account. Being afraid of the additional administrative burden (especially in these cases among small municipalities) and the potential judicial litigations, they self-limit their freedom to make policy choices. Raising awareness about the exact contents and application conditions of public procurement rules following EU Directives seems necessary.

Outcome evaluations (in terms of user satisfaction, consequences on employment and working conditions or total final cost for the public authorities) following those

new modes of organising the provision of long-term care have so far not been realised. The only noted consequence is the reduction in (and the suppression of) local employment. In some cases of mismanagement or bad quality in attending the elderly, Swedish municipalities cancelled contracts and took over the operation of the home services for elderly persons themselves again.

With respect to residential care, it has been reported that in order to reduce costs, large multinational for-profit actors standardise services[113], concentrate service provision in one spot and tend to close down smaller facilities that they had taken over. This is especially the case in more remote and less-populated areas. Families consequently have longer distances to visit their relatives in residential facilities. But no study or assessment has been made on these consequences for the users or the employees.

Other developments can be found in the **Netherlands** and in **Belgium** following the use of personalised budget schemes[114] or the "service vouchers"[115] and the opening up to competition of domiciliary (household) care. Local authorities experienced many difficulties in adjusting to the EU legal framework, as far as European tendering was concerned. Local communities, not used to the EU-level rules, had to understand these in order to develop EU-sustainable tendering procedures. Several times they were taken to court because of lack of transparency of the procedures and the criteria used to choose the tenderer. More than once municipalities lost the court case, especially when facing a multinational company. In other cases, a re-tendering procedure had to be implemented. This created additional costs, including transaction costs (such as setting up the procedures, hiring lawyers, supervision and control of the procedures, etc.).

Another issue linked to public procurement and delegation of missions is the discussion about the German *"sozialrechtliches Dreiecksverhältnis"* with regard to the implementation of EU rules. This particular German concept is presented in the Box below.

Box 13.2: An illustration from Germany on a conceptual discussion

The issue refers to the triangular relationship between a funding agency, a provider and a user of a given social service based on a system of service concessions for the providers. The main questions are i) how this triangular relationship has to be assessed with respect to EU rules (mainly dealing with issues related to competition and concessions) and ii) if it is compatible with these rules. The discussion of the acceptability of special contractual relationships and organisational conditions related to this "construct" (as stipulated in German social legislation and referred to with the technical term *"sozialrechtliches Dreiecksverhältnis"*), building on partnership and co-operation and implemented in Germany for decades, mainly seems to concern the regulators, financing bodies and providers in this country. However, the triangular relationship as such seems to be of a more general nature across Europe.

[113] From the user/beneficiary perspective, standardised services and processes would very often not meet the various particular individual needs of the user/beneficiary and his/her family.
[114] See Chapters 11.2, 12.1 and 12.2 for further explanations.
[115] In Flemish: "dienstencheques"; in French: « titre-services ».

Particularly German not-for-profit providers of social and health services (of general interest) consider an organisational construct and related legal relationships that are a core element of (personal) social services provision – (the above-mentioned "*sozialrechtliches Dreiecksverhältnis*") – to be challenged by the application of EU public procurement rules. They claim that the German system, where the provision of large shares of (personal) social services is conferred to private providers (of which the majority not-for-profit with different legal status, mainly associations) is conceptualised as a model based on service concessions for authorised service providers. This would enable user choice from of a plurality of service providers (favoured by such a model) and competition amongst them based on quality and trust (and not exclusively or dominantly based on price). It is also highlighted that providers in this system have no guarantee that the services, places, beds, etc. they offer are actually used and that they consequently yield income, since public authorities are not obliged to attribute users to specific existing services or institutions ("*fehlende Beleggarantie*"). Such an approach focusing on the providers differs from a model building on the delegation of specific services by public authorities, – as a rule following a public tender procedure, – and on their entrustment with explicitly defined public service obligations providers have to fulfil.

This discussion refers to specific and complex legal questions (all of which are not yet answered, depending on the understanding of the concepts and modalities at stake and on the interpretation of relevant EU rules), which, however, all refer back to the central question which authority should have the competence to decide on the modalities of organisation and financing in the field of social services and which rules to be applied.

To better illustrate the issues at stake, central aspects to be clarified are:

- Do national (here: German) or European public procurement rules oblige public authorities to have recourse to public tenders in the fields of child and youth welfare and social assistance law?
- To which extent is national public procurement law applicable in the field of social and health services provision?
- How should one legally classifythe "*sozialrechtliches Dreiecksverhältnis*" related to the application of national or European procurement rules?
- How are related contracts to provide a specific social service which specify the content, extent/scope, quality and reimbursement rules – "*Leistungsvereinbarungen*" – of this task (which is to be assumed to be in the general interest), to be interpreted in national and EU rules?
- Are these contracts to be seen as public service contracts ("*Öffentlicher Auftrag*") according to anti-trust rules? This would imply the applicability of a "purchaser model" ("*Einkaufsmodell*") – where the financing body purchases social services (e.g. a number of beds and related care work) and guarantees both an attribution of users and the reimbursement to the provider that has no direct contractual relationship with the user (whereas this is the case in the "*sozialrechtliches Dreiecksverhältnis*") sketched out above. Or are they rather to be defined as service concessions? If yes,

which EU rules are to be applied and what does this mean for the acceptability of the current system based on the "*sozialrechtliches Dreiecksverhältnis*" and related "*Leistungsvereinbarungen*" if EU rules were to be applied?

- To which extent are planning activities related to offering social services compatible with constitutionally specified rights, particularly in view of the liberty to exert a profession, as stipulated in Art. 12 of the German Basic Law or laid down in EU rules concerning the freedom to provide services and the freedom of establishment?

Source: Own compilation based on Engler, 2007; Brünner, 2005; Cremer, 2005; Philipp, 2005; Neumann/Nielandt/Philipp, 2004.

In addition, the phenomenon of splitting up a market into smaller lots to ease the work of municipalities when implementing public procurement procedures has been noted. Local communities started public tendering procedures, particularly emphasising the price criterion whereas other (quality-related) criteria were only considered to a limited extent. This has led to some peculiar situations. In several cases, cleaning companies associated with large care providers responded to calls for tender, in order to be able to bid at a lower price. This seemed to be essentially done because of different collective wage agreements that allow lowering the production cost when workers from the cleaning sector are associated. Apart from surveying some individual case situations concerning the lay-off of personnel once a bidding contest is lost by traditional care providers, (since their employees have no guarantee to be hired by the winner of the contest, and if it is the case, their working conditions and wage levels might be less attractive.[116]), no outcome assessments - especially with respect to quality and treatment of patient complaints - of such public procurement procedures have been made yet.

As stated by the Economic Advisory Group for Competition Policy of the Commission, "the suitability of open tenders should be carefully assessed according to the circumstances of the SGEI[117] in question, as well as to the bidding process it is likely to generate. If the SGEI is beset by significant problems of defining quality of service, it may be more appropriate to negotiate quality standards directly with interested parties rather than engage in a tender that may give excessive incentives for bidders to compete purely on price"[118].

3 Social integration and re-integration

In the field of social integration, the impact of EU rules is not yet clearly visible. The EU social inclusion strategy stresses the importance of promoting participation in employment as a means of preventing and alleviating poverty and social exclusion. It also recognises that holding a job is not always sufficient to escape poverty for specific groups of persons or for people at a certain age (children; adolescents below

[116] See Chapter 2 -Section 6 and Chapter 13.
[117] SGEI : Service of general economic interest
[118] Document on the internet site of DG COMP: Services of General Economic Interest – Opinion prepared by the State Aid Group of the Economic Advisory Group for Competition Policy (EAGCP), June 29, 2006, p. 7. See: http://ec.europa.eu/comm/competition/state_aid/legislation/sgei.html

the age of labour market entry; young people with educational and social deficits preventing them from working in paid employment in a middle- and long-term perspective; disabled and handicapped persons; persons at or some years below statutory retirement age).

In which regard and to which extent current EU policies and Community rules impact on the structure, the mode of organisation and the mode of financing of social (re-) integration services is very difficult to assess. The fact that non-national providers are entering the market of social integration services is very recent. For example, a UK provider started recently to deliver addiction care services in the Netherlands under the framework of the AWBZ (the Exceptional Medical Expenses Act).

Currently, the complex and "scattered" range of services[119] to promote social integration and reintegration into the society seems not to be strongly affected by either of the core issues of EU level regulations and ECJ ruling on competition or internal market rules.

Specific issues relevant for social integration services include the free choice of providers and public procurement rules. The repercussions thereof are however not yet visible. And according to the information from stakeholders, the consequences of the full implementation of existing EU rules, notably concerning state aid, have not yet appeared in the sector of social integration and re-integration.

The theoretical case situation below, concerning services for immigrants in a multi-ethnic city, illustrates some particular problems and questions that appear in relation to (re-)integration services for migrants. These issues do not necessarily arise with other types of social services.

Box 13.3: How do EU rules apply and how will they possibly impact on existing practices in local democracy? The (theoretical) case of a multi-ethnic city

The case refers to a larger multi-ethnic city in which integration of migrants and high unemployment are essential problems. This city has a considerable number of right-extremist voters and representatives of right-extremist parties are at the city council. They do not possess the majority, but have a considerable influence on the attitudes and decisions taken by the city council.

Up to now this city subsidises in different ways at various levels (without clear rules and depending notably on the political etiquette of the organisation) and/or indirectly helps or supports several organisations and enterprises active in the field of social integration, support to employment and activities for migrants. These organisations and entities vary in size, type (private for-profit, non-profit, public and mixed entities), religious and cultural orientation and offer various types of support and integration services (in different languages and respecting various cultural feelings and behavioural attitudes) to several types of immigrants present in the city (including illegal ones).

[119] A development on this range of services is presented in Chapter 5.

The activities and services provided by these associations, entities and enterprises contribute to the policy objectives of the city and some of these organisations are coordinating their actions to achieve better results. The support to most associations is easily (depending however on the city budget) renewed on a yearly basis and control of the correct use of funding is exercised: subventions can be cut if associations or entities misuse the subsidies and support measures. Encouragement for coordination between the various actors and additional grants or help for this coordination or collective action is also ensured by the city, with a view to favouring overall integration in the city and responding to particular sub-local or temporarily arising needs.

The city policy is one of spreading subsidies and of offering in kind support on a tailor-made, non-egalitarian and somehow clientelist basis (through rooms or public employees of the city set at disposal of one or the other organisation). This way of supporting organisations has come up in the course of time, responding either to requests to receive support or to suggestions from the city to create such entities (that would then be subsidised) to tackle specific problems in specific areas of the town. Furthermore, giving official support to migrants is a highly sensitive issue, considering the presence of right-extremist voters and city counsellors. The city noted that acting in a rather hidden manner and not openly and publicly discussing such subsidising and support strategies at the city council did enable this policy to continue. In this way, it could respond to several social needs in various suburbs targeting different types of populations with different integration or support needs. The question is how this city can continue with this policy in the future?

Can the city pursue its policy, aiming at maintaining diversity in the provision of services and types of answers given, and at the same time avoid discussing this matter openly and thus prevent the implementation of public procurement procedures that would clearly put the debate in the open space? How should EU rules apply, considering that some of the entities that receive support are large ones (e.g. churches and large organisations active at supra-city level), that in-kind support from the city could be considered as state aid, and that other large private for-profit organisations as well as associations from the right-extremist wing are seeking the same type of support?

If it turns out that public procurement is unavoidable, the city will be challenged to define the goals and missions of social services of general interest in more detail. Some types of questions to be answered in this context may for example be:

- What type of support services should be organised for illegal immigrants?
- Which help is exactly needed for Muslim women not speaking the language and having cultural and religious difficulties to leave their house on their own?
- How to define what activities should be organised to decrease tensions and/or violence between ethnic communities and how should a call for tender list activities that are all rendered for now?

These issues would probably raise considerable debate in the city council as well as amongst and between ethnic and religious communities, since everyone would seek to receive as much support as possible. Allocating this support according to objective

criteria may therefore prove difficult. Indeed, how to count how many illegal immigrants do live in the city? How to objectively assess for example the importance of support needed for the social integration of Muslim women versus the support to young Bulgarian and Romanians seeking a job in the city? It appears that objective non-discriminatory criteria are difficult to set when pursuing specific political goals in this sub-sector of social services.

If we suppose that the city wishes to continue supporting a larger number of organisations, it might well be that the city will have to tailor a high amount of (more specific) calls for tender, considering that public procurement needs to be implemented. At least two contradicting questions appear:

- How "vague" can the description of expected services be, since the city might have difficulty determining what type of services will be the most helpful to the specific type of migrants?
- How "precise" does the description of the beneficiaries of the services need to be, in order to be sure that all types of migrants that the city wants to support will indeed receive tailored services adapted to their needs?

Finally, the main question relates to the relative non-transparent character of subsidisation policy that the city wants to apply with respect to social support services to migrants. This refers to local democracy and transparency but also questions the strategy and the means to use in such a political situation.

Source: own compilation

4 Labour market services for disadvantaged persons

Employment services are often identified as a sector where Member States have allowed for and encouraged competition, especially during the last decade. The introduction of market elements has often been implemented in a twofold way: on the one hand by opening up the market for placement services and professional training for private, for-profit and not-for profit enterprises, on the other by introducing voucher systems to be used by unemployed persons (sometimes also with a choice among placement services) and by private placement agencies, financed from public funds (i.e. general tax revenue) or social insurance contributions (to the unemployment insurance).

In some Member States (notably the United Kingdom, but also Germany, Poland and Sweden), there is already experience with new organisational forms, modes of governance and instruments for placement services in the framework of active labour market policies as defined in national legislation and set out in national policy strategies.

Issues relevant for labour market services for disadvantaged persons are in particular:

- The free provision of services and free establishment of providers;

- Competition rules with respect to temporary work agencies and placement services;

- Public procurement rules.

Selling products and services produced in a professional reintegration process may entail problems related to competition rules. They are often sold on the market at a lower price than similar goods and services proposed by commercial for-profit enterprises because of subsidies and public support. Other providers (especially from the SME sector) therefore sometimes esteem that production under sheltered conditions and public financial support to reintegrate workers via sheltered employment creates unfair competition conditions. An analogous criticism could also occur with respect to exemptions granted to sheltered job facilities in terms of social security contributions or with respect to volunteer work that is offered to accompany such work reintegration experience.

Entrusting specific enterprises and organisations with the provision of goods and services to allow a professional reintegration experience for disadvantaged persons might also not be compatible with public tendering procedures. This would need verification for each type of existing measure or public support mechanisms regarding selection of operators. In the same vein, the procedures followed - be they explicitly foreseen or not - to set up such experiences also need to be carefully analysed. Indeed, the types of partners associated as well as the choice and selection modes of such partners, the selection criteria for possible calls for tender or calls for projects, their transparency, the mode of financing or subsidising of such cooperation or (pilot) projects, the foreseen duration of projects/experiences/measures are all aspects – that are currently mostly achieved on a bilateral (or multilateral) cooperation base – that need to be scrutinised with respect to EU rules.

Another important issue in the near future will most probably be whether traditional state or public authority funding mechanisms (essentially public subsidies - including exemptions from social security contributions - and grants) will need to be transformed into contractual systems. The close interaction with social welfare policies as well as with particular social security schemes or specific advantages might not be upheld because of potential unfair competition conditions or non-respect of public procurement procedures.

5 Childcare

The analysis of the replies of all 25 EU Member States' governments to the 2004 questionnaire of the Social Protection Committee, shows that the issue of current and probable future shifts in the "welfare mix" of childcare provision seems to be of prior importance in view of the EU legal and political framework.

5.1 Definition with respect to services of general interest

In the **German** federal system, childcare arrangements are different in each one of the Länder. The legal framework of childcare is defined in the German social legislation (SGB VIII). This framework leaves some scope for the final implementation by the Länder, which takes place through the respective

implementation laws (Ausführungsgesetze). The design of the SGB VIII is heterogeneous since the Länder do not cover each field to a similar extent.

The SGB VIII governs the relation between public and independent sectors of childcare. According to the principle of subsidiarity, public sponsoring bodies should only be active if there is no appropriate supply by independent sponsoring bodies (§ 4 (2) SGB VIII). If an independent sponsoring body ceases to perform its task, public sponsoring bodies have to step in and maintain the necessary care structure .

Furthermore, the recent legal act concerning the extension of publicly provided daycare (Tagesbetreuungsausbaugesetz, TAG), which became effective on 1 January 2005, aims in particular at a qualitative and quantitative extension and improvement of care arrangements for children under three. Legislation of the Länder, that goes beyond the scope of the TAG (as in the Länder belonging to eastern part of Germany), cannot be curtailed by referring to the lower standard set in the TAG.

The German Child and Youth Welfare Law (Kinder- und Jugendhilfegesetz (KJHG) determines the notion of 'general interest' implicitly through specific paragraphs in legal documents and implementation law. They determine for example the accessibility conditions or availability. With regard to children under the age of 3, the amendment of the SGB VIII with the TAG has for instance specified the legal obligation that childcare is to be provided at least for those parents who are working or currently enrolled in education (§ 24 (3)).

In **France** social services are part of social policies as defined in the Law n°2002-2 of 2002 on social and socio-medical structures. However, the notion of general interest in the case of social services is not yet defined. Childcare services are part of the social action services (as classified in the French national nomenclature) but they have their particular legal stipulations.

Apart from pre-school services (for children from 3 to 6), there is no legal obligation in France or Germany to provide childcare services for younger children or to guarantee their fulfilment. There are only incentives to encourage their development and to come closer to the objective of universal access. However, childcare services generate important benefits for the society as a whole. Childcare services are therefore generally considered as social services of general interest that need to be regulated and subsidised for their general interest mission.

In France, the main legislation of childcare collective services is the decree of August 2000 concerning childcare services for children under six (*Décret no 2000-762 du 1er août 2000 relatif aux établissements et services d'accueil des enfants de moins de six ans et modifiant le code de la santé publique*). This decree is part of the Public Health Code. Childcare services are part of the Family Branch of the Social Security system. Missions of childcare collective services, defined in this decree, concern the health, security, well-being and development of children. These services should contribute to social integration of disabled or chronically ill children. They also support parents to combine work and family.

In addition, the objective of equal opportunities for all children has always been present in French childcare policy. Mothers (working or not) and children are under the protection of the State to guarantee the "free choice" of parents and in particular

for mothers to have opportunities to work. The principle of public policy is to be neutral with regard to the choice of parents, whether they prefer to stay home (to take care of their children) or to work. The mission of general interest takes diverse orientations to guarantee the parental choice, such as the reconciliation of family and work, the development and socialisation of young children, gender equality and to promote social inclusion. However, in practice, given the shortage of childcare places, childcare services prioritise to fulfil their mission of reconciliation of family and work.

Social integration in favour of children in difficult situations (socially or physically) is not a priority of French public policy at present. There are also problems with equal access to childcare services across each territory (many territorial inequalities and disparities exist), since there is no obligation to increase the territorial coverage. Consequently, even if defined and implemented through law, the achievement of the main objective of "free choice" of the parents in France with respect to childcare is problematic as is its affordability.

In the **Czech Republic**, the Law 10/1966 Coll. on 'popular health care' regulates the provision of childcare services in crèches, which rank among special medical facilities in the Czech Republic. Private childcare facilities are governed by Law 455/1991 Coll. (Trade Act).

In **Italy** there is relatively little about public service missions or obligations and quality criteria related to childcare below the age of three. Following a lack of public provision, the for-profit providers entered the market and public financing is now slowly following notably at the local level.

5.2 State aid, public procurement and/or public-private-partnerships

In none of the six countries included in the in-depth analysis of the childcare sector in this study, potential problems regarding the applications of EU rules have been reported so far. Moreover, public procurement is very seldom used in childcare services. On the other hand, cooperation and partnerships are quite frequent.

Potential discrepancies with EU rules could in particular arise in relation to the compliance with state aid rules and with public procurement rules for child day-care institutions. This is notably the case if a service offered is not recognised by public authorities as being of general interest (e.g. day-care during school vacations offered outside of usual child day-care facilities) and does not fit the Altmark criteria. Another possible discrepancy could arise if a service is supported by a municipality (e.g. through subsidies, free access to the swimming pool and to municipal facilities, free usage of the bus owned by the municipality), only because the city council wishes to engage a specific organisation that provides this service on a local basis and therefore does not consider the provision in another framework, for instance via public procurement Furthermore, a problem may arise with regard to the thresholds of the de minimis rules, which might be exceeded, for example, exhausting all the direct and indirect financial and in-kind support given to one organisation to provide child day-care during the entire summer vacations (6-10 weeks depending on the countries) with all the personnel needed to do so.

6 *Social housing*[120]

Social housing has been subject to the attention of the European Union for several years now. Meanwhile several issues (notably with respect to notification of state aid) were clarified. Member States and providers, however, still have to examine the consequences of those clarifications and monitor their implementation.

6.1 Definition with regard to the European Union and its institutions

The field of social housing belongs to the competence of the Member States and their different governance levels: the European Union has no direct competence concerning social housing as such.

National definitions and approaches of social housing vary considerably across Member States as shown in Chapter 8 of this report. In the Czech Republic and Italy, for example, the term "social housing" is not officially used or defined, except for lower VAT rates.

In **Sweden**, responsibility for housing is given to municipalities with the general aim of providing good housing for the whole population rather than to target specific groups. The obligations with respect to municipal housing companies - which are not required to be done in writing - vary throughout the country and can include: to counteract segregation and increase security; to supply affordable housing for rent in good quality estates; to strive for a sustainable development and social responsibility for the housing market in the municipality, etc.

In **Italy**, social housing providers expect the government to define social housing as a service of general interest in the near future so that the actors in this field can benefit from the exemption of notification for state aid.

Nevertheless, for several decades the European Union has sought to define, qualify or delimit the concept of social housing. Such definitions appear in directives, decisions and communications.

The attempts to define what belongs to the field of social housing, or what can be recognised and qualified as being social housing depends on the context and the European institutions. The question of defining social housing at the European level appeared in the seventies, when a unique reduced VAT rate was sought throughout the Member States for certain pre-determined goods and services "of first necessity" or having a social goal. A range of reduced rates was finally adopted in the frame of the fiscal Community policy.

Decision 2005/842/CE of the Commission[121] qualified social housing as being a service of general economic interest in case a particular mission of general interest is defined. The European Commission formulated an explanation of social housing enterprises entrusted with the task of services of general economic interest as being

[120] The present section is essentially based on the Policy Paper No.1 on Social Housing annexed to the present report, but also on some other documents, among which a foreseen publication by Laurent GHEKIERE: *Le logement social dans l'Union européenne : intérêt général et intérêt communautaire*, Editions DEXIA, forthcoming (September 2007).

[121] Decision 2005/842/CE, Official Journal L 312, 29.11.2005, § (16).

"undertakings in charge of social housing providing housing for disadvantaged citizens or socially less advantaged groups, which due to solvability constraints are unable to obtain housing at market conditions". This definition limits the perimeter of social housing to financial accessibility problems and requires a condition of entrustment of a particular general interest mission. Other objectives of social housing (discrimination linked to handicaps, family size, social mix and integration of ethnic groups) or those not explicitly defined seem therefore not to be considered by the European Commission.

The Court of Justice has so far not had a specific occasion to deal with the mission of social housing; however in related cases, the ECJ stated that proportionality and respecting the fundamental freedoms was necessary.

Regarding definitions and positions, the European Parliament was at the origin of excluding social housing within the scope of the Services Directive. The present debate on the matter shows that the concepts of social housing vary throughout the Union, and that the concepts are not limited to housing for disadvantaged persons or those having financial accessibility problems.

Moreover, there are still some uncertainties linked to the qualification and treatment of social housing in relation to the Services Directive. Are social housing services simply services of general interest, services of general economic interest, or social services of general interest? Legal uncertainties in this sector concern the conformity of financing mechanisms and schemes within EU rules such as the possible infringement of Community rules by special loan and credit conditions – or tax exemptions – offered to public housing funds for example.

6.2 State aid and public service compensation

Social housing is essentially financed by public resources. One of the main issues concerns the notification of state aid to the Commission, in order to verify if such advantages are compatible with the EU rules. Following the provisions of the Commission Decision, which will be evaluated in 2009, state aid to social housing does not have to be notified if all the conditions of the Commission Decision are respected, notably the one on entrustment (see Article 4 of the Decision): "In order for this Decision to apply, responsibility for operation of the service of general economic interest shall be entrusted to the undertaking concerned by way of one or more official acts, the form of which may be determined by each Member State. The act or acts shall specify, in particular:

(a) The nature and the duration of the public service obligations;

(b) The undertaking and territory concerned;

(c) The nature of any exclusive or special rights assigned to the undertaking;

(d) The parameters for calculating, controlling and reviewing the compensation;

(e) The arrangements for avoiding and repaying any overcompensation."

In June 2006, the Czech government approved a new system of subsidies aimed at new rental constructions targeted at specific groups (defined according to social criteria), that are open to any physical or natural person, if such an investor builds and provides (for at least ten years) housing for cost-rents only for households with lower

incomes. This system has to be notified to the European Commission, however, from the "state aid" point of view, because some of the conditions of the Decision are not fulfilled.

The European Commission considers the renting of residential accommodation as an economic activity, which is being performed in competition, including if it concerns not-for-profit legal persons, charities, etc. Therefore, such economic activity may, according to the EU rules, have effect on competition and on intra-EU trade since state support given to social housing organisations for the construction or refurbishment is considered as "state aid such as compensation of SGEI".

With regard to the notion of economic advantage conferred by public support to social housing, the conformity of financing mechanisms and schemes with EU state aid rules such as, the possible infringement of Community rules by special loan and credit conditions – or tax exemptions – offered to public housing funds, is subject to discussion. Some Member States provide guarantees for institutions in the field of social housing entrusted with a public interest mission, enabling them to operate at preferential conditions on the credit market (an advantage "re-invested" into the social housing sector they are responsible for). More legal certainty for those who raise funds, who provide funds and who use the funds to provide social housing would need further clarification.

6.3 Other issues

A complicating factor is the differentiated view that different European institutions seem to have on the social housing sector. The absence of a common definition on what social housing is does not just relate to different models of provision, but also vis-à-vis different policy areas. Social housing is defined differently depending on the field of EU competence (e.g. competition[122], internal market[123], VAT directive[124], social inclusion, anti-discrimination, energy saving, sustainable urban development, regional development[125], etc.). This makes a coherent response, in order to keep performing its mission in line with EU rules, rather difficult.

A number of other issues concerning the social housing sector may also be of importance but they were however not dealt with in the study. Therefore we only can list these themes as possible issues to be considered. These include:

[122] Decision 2005/842/CE, Official Journal L 312, 29.11.2005, § (16).
[123] Communication from the Commission of 26 April 2006, Implementing the Community Lisbon programme: Social services of general interest in the European Union, Brussels 2006 (COM (2006) 177 + SEC(2006) 516.
[124] 6th VAT Directive 77/388, annex H category 9.
[125] Regulation (EC) No 1080/2006 of the European Parliament and of the Council of 5 July 2006 on the European Regional Development Fund and repealing Regulation (EC) No 1783/199

- Accreditation mechanisms: as for long-term care (see Section 2), preliminary authorisations and agreements allow public authorities to ensure that pre-established criteria are met before organisations start social housing activities and provide related public service missions;

- Public procurement and the notion of 'in-house' given the numerous partnerships that are established to provide social housing in a financial sustainable way;

- The application of the principle of freedom of establishment and the requirements a provider needs to fulfil to provide social housing;

- The compatibility of financing modes with the transparency and non-discrimination rules with respect to any type of provider;

- The compatibility with respect to transparency and proportionality of a wide range of different support measures, standards, registration systems, controls, etc.

7 Conclusions: Need for further legal clarification and possible additional regulation at the European level

This last Section of Part IV aims to summarise the main points of discussion with respect to the interaction of European legal rules with the evolution of social (and health) services of general interest. It also lists open questions and considerations in order to highlight and summarise existing uncertainties and potential tensions in applying relevant European rules to social services. Without being exhaustive, these questions and considerations will certainly play a central role in discussions and debates in the future.

7.1 Terminology and definition of social services of general interest

The country study experts and stakeholder representatives have highlighted the many differences in understanding as well as the difficulty delimitating the field of social services of general interest within each country. Member States define missions of general interest or public service obligations at the respective levels of competence of the public authorities in charge of social services (national, regional or local) as explained earlier in this report. 'General interest' is as a rule only implicitly defined in legal documents. On the other hand, several European rules have given precise indications what the definition should embrace and what elements it should contain. But, according to country experts and stakeholders of several countries, the European understanding of the concept and/or the terminology as such of 'social (and health) service of general interest' – that embraces the notions of missions of general interest and public service obligations – in many cases do not necessarily fit with the realities of social and health services in Member States. Especially obligations specifying the way in which the concept should be defined in case of the delivery of a particular (personal) social service are as a rule not found as such, neither in one of the sectors of social services nor in any of the EU Member States.

Adapting to such requests of rendering explicit and expressing in detail the missions and goals of social services of general interest, requires political transparent discussion and parliamentary or governmental decision[126]. Social services often aim at satisfying several needs in an integrated way, which is different if compared with many other market or pure economic services. The outcome of such a clarifying exercise might be particularly useful for evaluation purposes, for example in view of constructing indicators with respect to objectives to be achieved with the provision of a social service.

Finally, it is generally considered by authors, experts and stakeholders that many interlinkages, cross-sectoral and cross-cutting relations exist between social and health services when it comes to 'general interest' and legal implications. They therefore consider it more useful to deal with these services in tandem than to separate them.

7.2 Lack of effective illustrations concerning the implementation of EU rules to social services

The debate regarding the impact and consequences of European ruling for social services (of general interest) is of a rather recent date and therefore only a few European stakeholders and experts, who followed closely the European legislative evolution concerning services of general interest, were aware of the highly disputed issues that would arise in the field of social services.

This also explains why it was difficult to find illustrations and concrete examples of situations where EU rules have an impact on the organisation of social services, illustrating challenges we may expect in the future. Also stakeholder representatives underscore the absence of such illustrations (see Chapter 15). In addition, it became clear that evaluation and impact assessment studies of the outcomes of new provision and organisation modes of social services (of general interest) are basically still absent.

The Sodemare[127] case is the only one in the specific field of health services that could be of direct interest for social services, but is however not typical. Several legal experts question whether the ECJ would take the same decision were the case to be reconsidered.

An important body of Community rules that is important for social and health services is either not yet applicable (e.g. Services Directive) or has only recently been transposed into national legislation (e.g. state aid package and public procurement rules) recently. The effects therefore are currently only starting to be (partially) monitored and a comprehensive analysis of the interaction of European rules and the evolution of SHSGI is still rather difficult at present. The unclear situation creates uncertainties among legal experts with respect to different ways of interpretations as well as among providers and stakeholders.

Some uncertainties relate to the field of application of the Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in

[126] This also comprises the regional and municipal levels.
[127] ECJ Case C-70/95 *Sodemare* 1997 ECR I-3395.

the internal market[128], which states that (see article 2):"This directive shall not apply to the following activities: (a) non economic services of general interest; ...; (e) services of temporary work agencies; (f) healthcare services whether or not they are provided via healthcare facilities, and regardless of the ways in which they are organised and financed at national level or whether they are public or private; ...; (j) social services relating to social housing, childcare and support of families and persons permanently or temporarily in need which are provided by the State, by providers mandated by the State or by charities recognised as such by the State". According to several legal experts, this will have an impact on several social (and health) services that are on the borderlines of its scope.

It is currently unclear if the following services are for example excluded or not from the scope of the "Services Directive":

- Assistance and support services provided to immigrants to find a job;
- Cultural socialisation and language courses to help immigrants to integrate themselves in a community;
- Services provided by non-profit associations that help or assist the public employment agencies and that are not mandated or recognised by the State to provide those services;
- Childcare facilities offered by childminders or providers that are not charities, but are however subsidised by the State (e.g. via tax exemptions or specific subsidised work schemes) while not being mandated or explicitly recognised by the State?

Different interpretations currently exist depending on the legal experts.

7.3 Cross-border service provision

Based on Article 49 EC nationals of EU Member States enjoy, *inter alia*, a right to receive services under the free movement of services, i. e. the right to use services in another Member State without any restrictions and in particular without being discriminated against when compared to nationals of the state in question. The freedom to provide services clearly covers a wide range of circumstances.

The principle of non-discrimination is not restricted in the area of services to clear incidences of discrimination founded on nationality or establishment and residence. It also prohibits all forms of 'disguised' discrimination which lead to the same result (indirect or covert discrimination). As regularly stated by the ECJ[129], national legislation restricting the free movement of workers, the right of establishment and the freedom to provide services within the Community is not compatible with the EC Treaty if restrictions could result in the discrimination of persons or services from other Member States or could restrict the access to the profession to a degree which goes beyond what is necessary. As a reminder, the provisions of the EC Treaty on freedom to provide services do not apply to activities of which relevant elements are confined within a single Member State.

[128] OJ L 376, 27.12.2006, p. 36–68
[129] See notably ECJ Case 96/85 *Commission v France* 1986 ECR 1475, at 11.

So far, main cross-border developments have been noted in the field of health care, but they are not of high quantitative importance. Health care and social services have until now encountered comparatively little demand on a cross-border basis.[130] None of the national country studies have mentioned important developments in this respect.

Cross-border co-operation[131] between operators and providers of services has also remained comparatively infrequent and has most often taken place in pilot programmes/projects. This is not only due to the "territorial separation" of national social protection systems, but must also be attributed to the specificities of these services as such, having a regional/local aspect and being language-based. Moreover, they often exhibit the especially distinct personal and cultural nature of social and health services, which limits their "exportability" and usually also makes their "import" appear less appealing.

The cultural aspects as well as the values linked to some social services are also seen as factors hindering cross-border provision and consumption of personal social services. Many families and persons benefiting from childcare or long-term care for the elderly will prefer the cultural environment and the values that belong to a given society. It might thus be assumed that that cross-border provision or cooperation will not effectively affect trade between Member States in the near future.

Particularly public and regulatory authorities on the one hand, and the users/beneficiaries on the other, would need to examine users' empowerment and user' rights in relation to cross-border service provision. Questions that can be raised at national, regional and local levels include the following: What type of control procedures will be set up with regard to non-national providers which do not or would not have to possess an agreement or authorisation from a public authority? How will user complaints related to quality of social services offered by non-national providers be treated?

7.4 Competition and state aid rules

Most social services of general interest can be qualified as being 'economic' in the perspective of EU competition rules. Not pursuing profit, which is one essential character of most social services of general interest is not taken into consideration as such within the EU rules. Competition and state aid rules apply as soon as private commercial providers offer similar services on a market. If non-profit organisations want to offer services on the market where private for-profit enterprises now operate and offer similar services, they will be subject to the competition rules of this market.

In view of the entrance of for-profit and of non-national enterprises, public authorities are induced to set pre-defined qualitative criteria (which apply for example for staffing, qualification of staff, premises) for all operators. This is particularly interesting in relation to the entrance of newcomers that have developed new quality criteria that may set some innovative standards in this respect. On the other side, this

[130] In terms of quantitative importance, it appears that cross-border health services represent only some 0.5 % of health related total payments in Germany for example. Similar estimations are found in other Member States.

[131] e.g EUREGIO cross-border cooperation programmes.

may rise problems for non-profit entities (e.g. 'social economy' providers) that were not set up and organised with a competition objective, which pursue additional objectives in service provision than those set by public authorities (for example in answering specific needs and/or needs of specific types of beneficiaries that were not encountered sufficiently either by the private for profit sector or by the public sector), and which have difficulty adapting to the competitive environment. Moreover, the long-standing tradition of partnerships and cooperation in the non-profit sector may be more difficult to pursue in an increasingly competitive environment with full application of EU competition rules. This has been for example illustrated with respect to the German 'triangular relationship' ("*sozialrechtliches Dreiecksverhältnis*": see Box 13.2 in Section 2).

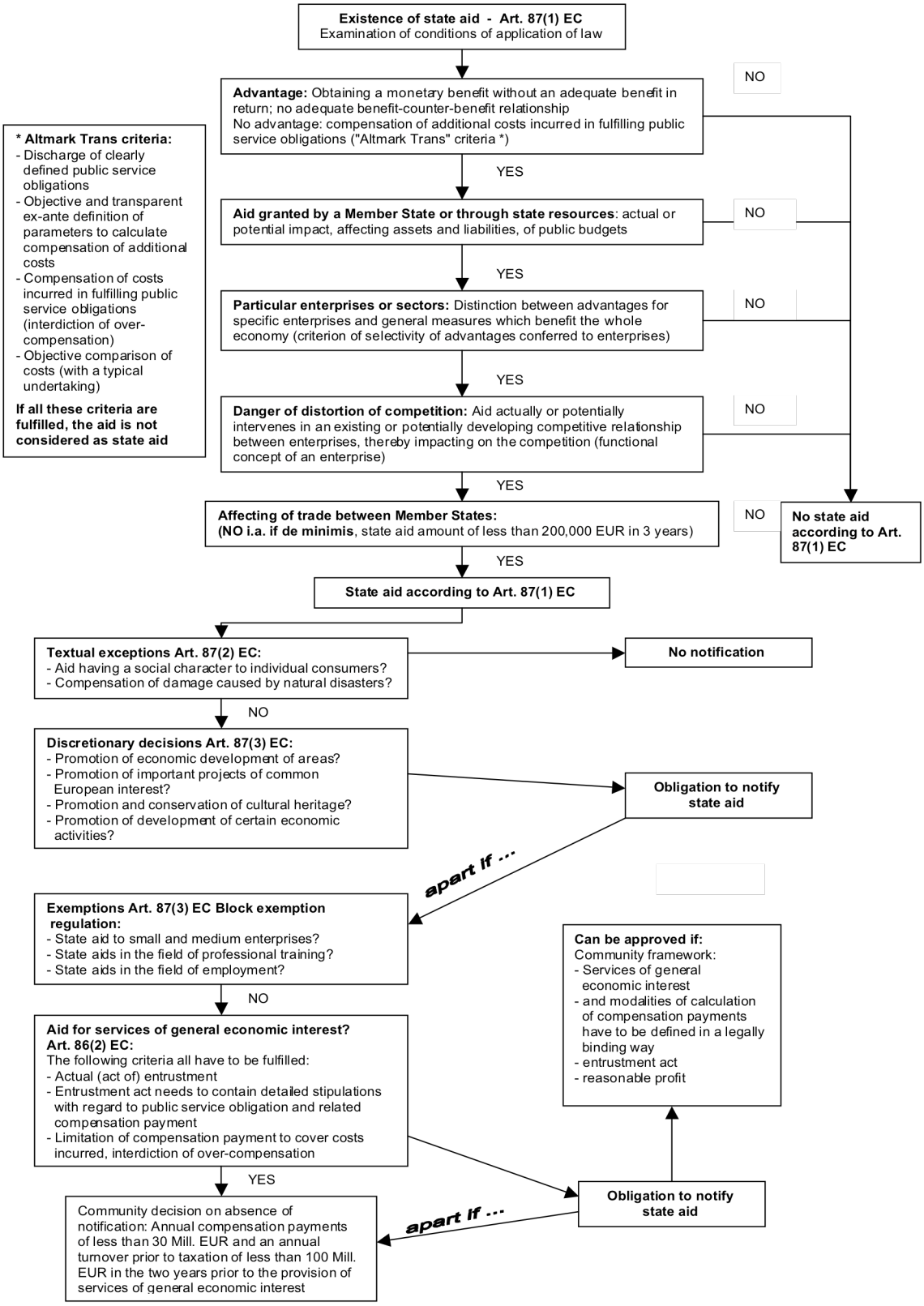
In relation to state aid and subsidies as way of financing social services of general interest, some open questions remain, for instance, what happens if there is no explicit definition of the mission and/or no official entrustment or delegation act existing. According to the ECJ (and applied to the Altmark Trans criteria), such a definition and an entrustment/delegation act are necessary. What happens when the rules to calculate cost compensation are not determined? It is also a question what recourse to subsidies is thus still admitted to finance de facto numerous proximity social services to individuals without having recourse to public procurement procedures? These issues come to the fore mainly is cases where missions pre-existed to the state and if services are offered on personal initiative, i.e. they have not been delegated or mandated by public authorities, but need public subsidizing or private support to be rendered. Their providers ask the state and other public authorities for recognition and for (in cash and in kind) support to help delivering those services. However, direct attribution to a provider with adequate support must be considered as infringement upon existing state aid rules.

Exceptions linked to state aid rules already exist. In the same vein as de minimis rules apply, in the view of the authors, precise and specific exceptions and derogations relevant for services of general interest[132] could probably be considered and find application to such social services which do not comply with all the conditions of existing derogation possibilities. Otherwise, taking the Altmark Trans criteria into account, such not fully defined social services would then be fully subject to the Services Directive.

The following figure gives an overview of state aid qualification, but also of the complexity of analysing whether a state subsidy linked to the provisions of a social service is or not a state aid that has or not to be notified, and/or that can or not be accepted.

[132] See Articles 86(2) and 16 EC.

Figure 13.1: Overview on state aid qualification and control at Community level



Source: Ministry for Employment, Health and Social Affairs of the State of North-Rhine Westphalia (Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen) - original language: German

7.5 Public procurement

Issues related to public procurement rules, more precisely the transfer of tasks/delegation of services by public authorities to third parties following the EU rules, only recently appeared with respect to social services. The main challenges encountered up to now are when they should come into play, under what circumstances, and according to which precise set of rules. This applies to existing national rules as well as to Community rules that have to be transposed into national legislation[133].

If public procurement procedures are correctly understood and once their conditions of application are clarified, the next challenges are to define precisely what tasks should be performed and how these tasks can be readjusted once a contract is established with one provider chosen following the tender procedure.

There is so far little documented evaluation and analysis of the outcomes of setting up public procurement procedures in the field of social services. Some repercussions of some European rules could be noted on the ways public authorities and providers (especially large ones) act as shown earlier in this Chapter by the description of cases in Sweden (see Box 13.1) and the Netherlands (Box 13.4).

Price and cost-efficiency are the most often applied criteria in public competitive tendering procedures, but they will not necessarily be sufficient criteria to determine whether one social service provider is better suited than another to render those services. The application of competition and public procurement rules tends to lead to a stricter delimitation of social services of general interest and to more fragmentation of services and the orientation on single acts, rather than to the consideration of the multitasking/multi-target character of integrated social services. With the applicability of procurement law, the question arises to what extent contracts for the provision of social services may be awarded by also taking 'social' criteria into account.

Such social criteria may involve the promotion of certain groups on the labour market, e.g. women, people with disabilities, the long-term unemployed or elderly employees, and the promotion of enterprises, which hire trainees or people with disabilities. This could also probably meet the expectations of many local public authorities, which seek to maintain local employment on the one hand and particular types of providers who see to (re-) include persons with difficulties to access the normal employment market on the other. The difficulty is to express and define those criteria in objective and non-discriminatory terms and manner – e.g. criteria that can be translated into indicators and measurable variables, in order to compare the offers – in a transparent way.

A better knowledge and awareness about the possibilities through variants or alternate proposals that can be included in calls for tender could maybe meet some of the uncertainties that have been raised. The effective use of existing mechanisms and devices (although rather complex) foreseen within the public procurement directives (such as a two-steps procedures or the introduction of several weighted criteria, negotiated procedures and competitive dialogue) might also bring solutions.

[133] Cf. e.g. for Germany "Beschluss der Vergabekammer bei der Bezirksregierung Münster in dem Nachprüfverfahren wegen der Durchführung von Leistungen nach dem Bundessozialhilfegesetz VK 10/04" of 28 May 2004.

Following the stakeholder enquiry, organisations pointed several times on unintended impacts, e.g. on the fact that despite the possible non-applicability of EU rules, municipalities would apply the public procurement rules in any case to be on the safe side. This is due to a lack of awareness on the need (or not) to apply these rules as well as to a trend towards simplification of administrative procedures. This trend pushes to apply the same rules to all cases and all types of public procurement procedures despite the differences among them. In the end, the consequence thereof could well be that quality criteria used are very limited in number and reach (which already seems to have happened in some cases).

In a context to reduce the complexity of public procurement or even in order to avoid having recourse to it, a particular side-effect has been noted, namely the splitting-up of the service provision into different 'lots'. This allows either to stay below the thresholds to organise a public procurement, or to limit the number of competitors by specialising the markets, dividing the market according to the entitled beneficiaries and dividing the tasks between several providers. The consequence could be the splitting up of the provision of formerly integrated or coordinated services which would largely reduce integrative approach vis-à-vis the individual person.

On the other hand, splitting up the markets may allow smaller providers to have access to the competition by only having to propose responses to small lots of services, which their size would allow. This is particularly true for social enterprises, which can enter a market and find an outlet for services provided by them as a particular type of providers (e.g. bringing back persons in sheltered conditions to work).

Most stakeholders report uncertainties about consequences that could possibly follow a European Court of Justice decision, which would render tendering procedures in all sectors of social services compulsory. This in turn could lead to a far ranging modification of existing provision or financing modes of social services. However, providers feel that they are not ready to cope with such potential structural changes and the possibly far-reaching consequences on the immanent structure of the social services as these are conceived at present.

The repercussions of new procedures that need to be adopted to decide who in the end will provide a service need to be better examined, not least on the backdrop of the generally accepted goal to sustain a plurality of providers (i.e. a diversity of the organisation, provision and financing modes) throughout the Member States. The lack of impact studies of the new organisation modes of the service provision is to be deplored.

Part V: Strategies for monitoring and improving quality of services

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Overview

Social care services have been moving from traditionally implicit codes of practice that defined service quality by professional ethics towards more explicit statutory regulation as well as mutually agreed guidelines and quality management on the level of branches and individual providers. This part of the study, first, describes the status of quality assurance policies and quality control mechanisms in Member States, and how a wide range of methods and regulations are applied. Secondly, examples of innovation in quality improvement, organisational development and quality management will be presented, with special emphasis on the areas of childcare and long-term care services.

Before doing so, it is essential to underline that quality initiatives in social care services are inextricably linked with the modernisation processes described above (see Part III). *First of all,* the increasing financial pressure on the public sector in general and on welfare schemes in particular prompted an intense search for effectiveness and efficiency. This has led to greater awareness of the difficulties to demonstrate and evaluate the results and outcomes of respective measures and reforms. For this purpose, quality management approaches that had originally been developed in industry and manufacturing were increasingly adopted and used as a tool to describe, to steer and to improve the production of social and health services.

Secondly, in the context of new public management mechanisms, the notion of 'quality' has become more significant when it comes to purchaser-provider split, outsourcing, 'contracting-out' or 'competitive tendering' that often involve additional, partly new actors in organising and delivering these services. Purchasers increasingly want to know what they buy in terms of "value for money" and thus define requirements more in detail. Moreover, bidders are now interested in describing what they are offering, and to provide clients with information about what kind of service options are available for them and whether these satisfy their expectations. *Thirdly,* citizens, the growing number of service users and other stakeholders involved, increasingly demand that social rights are defined, in order to move away from provision of services that in the past have too often shown significant shortcomings, such as structural quality deficits or in terms of violence, neglect and discrimination, in particular in the area of long-term care for older persons as has been repeatedly reported in "scandals" in the media.

Quality management approaches define quality as the decent delivery of a mutually agreed product or service, i.e. with respect to expectations, requirements and views from the different stakeholders involved. It can be distinguished between structural, process and result quality (Donabedian, 1966) to show the efficacy, efficiency, acceptance, legitimacy and social impact of social services and their individual activities. Public debates on expectations of citizens, the involvement of users, and political as well as administrative measures to define and monitor service quality are therefore important aspects in developing quality.

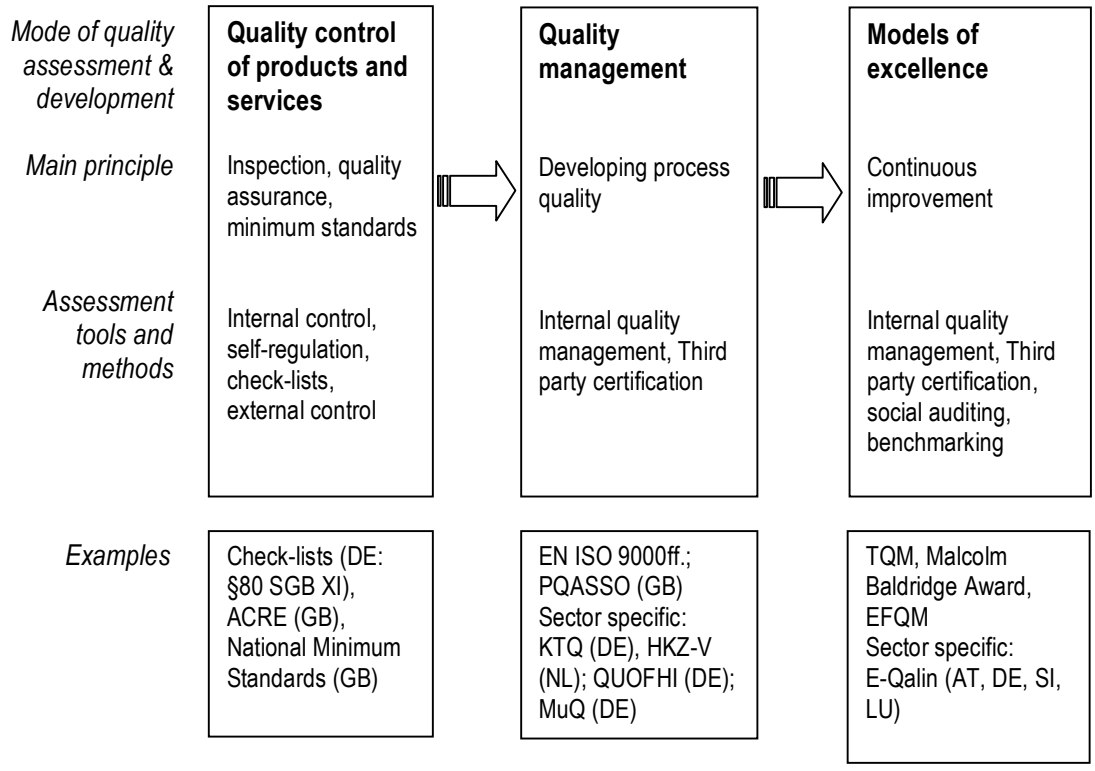
As has already been stated in this report, the situation, the range and extent of social services are dependent on the socio-economic status, welfare traditions, the role of the family and of voluntary organisations etc. While quality standards and criteria

have, for a long time, been defined by professional ethics in terms of staff qualification and/or by the public administration, e.g. in the form of structural standards of premises, the guiding principle of these processes had been mainly *trust* between public financing bodies and public providers or private non-profit organisations (in the case of countries with a longer tradition of third sector organisations).

With the entrance of new and additional providers, such as new forms of social enterprises or commercial providers, and with the movement towards 'informed clients', new principles of planning, defining, describing, monitoring and controlling quality were introduced. Thus various stakeholders now get involved in agreeing upon the decency of a service, as usually purchasers and customers/users are not the same person, and various new providers are reimbursed or co-financed by public purchasers.

Figure 14.1 outlines different modes of quality assessment and development. Though the application of the different instruments is far from showing an evidently linear development, it seems that there is a general tendency towards models of continuous improvement, with the involvement of relevant stakeholders as a bottom-line for successful certification and acknowledgement.

Figure 14.1:Outline of modes and methods of quality assessment and development



In reality, these different approaches to quality assessment and management are overlapping. Sometimes they exist side by side, sometimes they interact and influence each other. This situation obviously triggers new kinds of (professional) languages, definitions of terms, and training needs. For instance, the term 'standard' may be understood differently – from an inspection's point of view – as a legally

defined structural standard (e.g. in a nursing home there must be at least 15 m^2 at the disposal of each resident) or – from a quality management stance – as a set of measurable and verifiable criteria that allow to assess the quality of the service provided (e.g. reduction of falls; number of preventative home visits etc.). While legal standards are clearly defined by laws and regulations, quality management standards are often "market-driven" requirements in which all the interests of stakeholders are taken into account.

The variety of quality control and quality development tools currently applied is reflected in the different ways of how the extent and quality of service provision is being made explicit and documented in Member States. Due to the still scattered and uneven application of methods to assess the outcome quality of social services, benchmarking which is an ultimate element of quality management is thus far from being applicable with respect to social services within the European Union, in most cases not even within Member States. A remarkable exception in this respect is the United Kingdom, where the Performance Assessment Framework provides an overview of council policies' performance by means of defined indicators so that each interested citizen may retrieve his/her council's performance and compare it to others in terms of single indicators or as an aggregate star rating system.[134] These performance assessment framework indicators are a collection of almost 50 performance indicators which provide insight in how local councils are serving their residents (children and families, adults and older people) and to which extent they are making progress in improving services and meeting national objectives, for instance, in relation to caring for people in home settings rather than residential care or providing people with the services they want. Complementary to the councils' self-assessment, social services departments are carrying out routine surveys of users' experiences of personal social services – also these results are available on a nationally comparable basis (see also Box 14.2 below).

Another instrument that is to support the description and reflection on contents and potential improvements in the area of social services is social accounting as a way of measuring and reporting on an organisation's social and ethical performance. Increasingly also public authorities,[135] private enterprises,[136] the third sector,[137] and single organisations providing social services are making themselves accountable to their stakeholders. Exposing an organisation to a social audit and following its recommendations makes activities more transparent, helps to reflect on their social impact and contributes to improvements if recommendations of an audit are followed (Zadek et al, 1997).

The development of new ways of defining and reporting on social services will certainly help improve the availability of data in general and, in particular, of comparative data in terms of benchmarking in the future if Member States worked towards developing and implementing these approaches. The framework of the Open Method of Co-ordination could play an important role in this respect.

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134 See http://www.csci.org.uk/care_professional/councils/paf.aspx and http://www.csci.org.uk/care_professionals/councils/star_ratings.aspx

135 See, for instance, the French legislation: http://www.dgcl.interieur.gouv.fr/bases_juridiques/bilan_social/accueil_bilan_social.html

136 See, for instance, for Italy: http://www.bilanciosociale.it

137 See, for instance, Social Enterprise East Midlands, 2005.

Chapter 14 Quality assurance in social services: state of the art and current trends

1 A wide range of quality assurance policies and quality control mechanisms in Europe

Conditional upon the different welfare traditions, the status of social and economic development, and a number of additional aspects, we can observe a wide range of quality assurance policies and quality control mechanisms in Member States.

Self-regulation of professionals

Self-regulation of professionals has always been a basic principle in the development of social services since the origins of social work, akin to medical and other personal service professions. This principle will certainly remain to be important – for instance concerning the pedagogical quality in childcare or the chosen care model in long-term care facilities – but it is increasingly being complemented by other mechanisms of quality assurance. Within several professional federations this challenge has led to developing more "evidence-based" professional approaches that will help improve general quality frameworks. However, evidence-based long-term care is still at the very beginning, and it takes a long time until evidence from scientific research reaches the daily practice of services, e.g. concerning the most basic measures to prevent falls or dehydration.

Quality assurance and service inspection

The *inspection* of structural quality features by public authorities is the traditional and still most frequently found way of controlling social services. This includes criteria such as, for instance, square metres per child; quality of spaces to sleep, to eat, to play, hygiene measures in kitchen and bathrooms or criteria for quality of meals. Quality assurance, however, is only of limited relevance in social services as it focuses on revealing errors and the enforcement of requirements, while more active quality management would try to plan, steer and monitor the quality of service to prevent errors and unintended effects of activities.

Still, in many Member States even this most basic instrument of quality assurance has not yet been put into practice nation-wide. For instance, the Polish national control agency found in a recent study that more than 55% of residential homes had an insufficient number of bathrooms and toilets, more than 52% had architectural barriers, 57% lacked a fire alarm system, and almost all residential care homes (92%) had a too small number of staff, including therapists and professional carers (NIK, 2006). Still, more than 70% of these institutions will not be able to comply with the ongoing upgrading programme and many regional offices *(voivodas)* did not even have means to supervise and control the repair programmes with the

result that more than 200 commercial residential homes operated in 2005 without any registration (NIK, 2006).

Similar structural shortcomings are reported from a number of Member States. As an example, the following Table 14.1 shows a ranking of quality deficits according to the quality control of the German MDK[138] (BMGS, 2004: 90; Roth, 2002).

Table 14.1: Ranking of the ten most frequently perceived quality deficits in residential as against community care in Germany

Rank	Community Care	Residential Care
1.	Lack of implementation of care process and documentation	Lacking implementation of care process and documentation
2.	Deficits in staff planning (shifts)	Deficits in decubitus prevention and therapy
3.	Lacking implementation of care concept	Deficits in nutrition and hydration
4.	Deficits in nutrition and hydration	Deficits in staff planning (shifts)
5.	Deficits in further training	Lacking implementation of care concept
6.	Deficits in decubitus prevention and therapy	Deficits in care for geronto-psychiatric persons
7.	Deficits in incontinence care	Deficits in staffing
8.	Deficits in staffing	Deficits in incontinence care
9.	Passive care	Lacking offers of social care
10.	Deficits in care for geronto-psychiatric persons	Deficits in use of pharmaceutical drugs

Source: BMGS, 2004: 90

Authorisation and accreditation

In particular in those countries, where new private providers and/or new kinds of services have gained ground during the past two decades (e.g. the Czech Republic, France, Italy and the UK), we have witnessed the development and/or introduction of specific authorisation and accreditation mechanisms. In general, it has to be distinguished between the accreditation of (a) professionals, (b) education and training institutions, (c) types of services that can be provided or (d) service providers. Respective concepts are part of the chosen governance concept in different Member States and result in considerable differences concerning the treatment of, for instance, old and new or private and public providers. In particular in residential settings it is obviously necessary to allow for relatively extended interim periods in order to adapt premises and procedures to new regulations.

The introduction of quasi-markets has seen the development of more targeted funding and made principles of organisation and reporting mandatory, which is, by definition, linked to more systematic approaches of quality assurance.

[138] *Medizinischer Dienst der Krankenkassen*: this is the agency responsible for needs assessment and quality control in the framework of the German Long-term Care Insurance.

For instance, in the UK all care services now need to register. This involves providing the competent authority with information about their organisational principles and about the type of service they plan to provide. Although registration involves some degree of checking that certain standards are met, there is no formal accreditation by a third party. During inspections, data is gathered from staff, services users, reviews of paperwork and observation. The information is assessed against the National Minimum Standards for care services (see Department of Health, 2002, 2003b), which are statutory instruments and form the criteria against which the Commission for Social Care Inspection (CSCI) determines whether an agency provides personal care to the required standard.

In France, only authorised and publicly controlled individual (childminders) or collective (crèches) providers that meet defined quality criteria (e.g. 1 trained staff member per 5 toddlers), are able to access public subsidies or reimbursements. Similar requirements exist in Italy, Germany (in the context of the Long-term Care Insurance), and the Czech Republic.

Particularly in those countries and sectors, where still about 80% of services are publicly provided, which is true for both crèches in France and long-term care facilities in Sweden, it is still supposed that public providers require less control. However, privatisation processes in other countries resulted in the fact that, in specific sectors, a majority of services are now provided by private (commercial or non-profit) organisations. Existing registration and inspection arrangements were thus deemed inadequate so that new kinds of quality standards, e.g. for residential and nursing homes in the UK, were introduced during the past few years (Davis et al, 2004). In the context of national and EU competition regulations, it is to be assumed that, in the future, all providers – be they public, private non-profit, commercial, international, national or local – will have to be treated in each single country on equal terms and thus by means of at least regionally or nationally identical authorisation and accreditation mechanisms.

Accreditation processes are in general based on a quality management approach in that they require mission statements, structural quality criteria, procedural specifications and expected output criteria from the organisation to be accredited. The realisation and documentation of this process calls for special skills and knowledge of managerial staff, for the involvement of both staff and other stakeholders, and thus for investments in terms of time and money on the side of provider organisations. In many cases, providers of social services are frequently either overburdened with such a task or simply not ready to realise such a process without receiving additional training or external support and advice. Particularly smaller providers might have difficulties to hire specialised staff (such as quality managers and accreditation officers).

For instance, in France, many childcare facilities that, according to a decree from 2000, would be obliged to generate a so-called "*projet d'établissement*" with the above mentioned features, are still struggling to do so, while others have improved the quality of service by using this legal impetus to start a participatory process involving all staff. Moving towards quality management thus implies the necessity of further training and guidance which, for instance in the Czech Republic, has led to respective activities by the non-governmental providers themselves (see Box 14.1).

Quality management and certification by third parties

In many Member States *quality development* has become an intrinsic concern of provider organisations. On the one hand, quality management tools are introduced as an internal steering instrument with the aim of continuous improvement. On the other hand, certification by third party auditing serves as a marketing tool to gain competitive advantages in (quasi-)markets. Such endeavours, however, are voluntary, currently not widely spread and still mainly based on 'classical' quality management systems such as the norms of the *International Standards Organisation* (usually the ISO 9000 series) or the model of the *European Foundation for Quality Management (EFQM)*. Both systems were originally developed for manufacturing and commerce and needed adaptation to be applied in the area of social services. Still, most of these applications are voluntary and certification alone does not guarantee specific outcome quality in social services.

Box 14.1: Monitoring and supporting the quality of social services provided by non-profit organisations in the Czech Republic

The information and training activities of the Information Centre for Non-profit Organisations (ICN; see http://neziskovky.cz/cz/icn) comprise seminars for non-profit sector workers devoted to quality certification of non-profit organisations, support in introducing the most frequently used instruments of measurement and improving the quality of the organisations' activities. (ISO 9000, ISO 14000, EFQM, CAF model of public administration). The ICN also runs seminars on PAN (Process Analysis of Non-profit Organisation) to map, identify and analyse specific procedures pursued by a non-profit organisation in order to support effective management of such organisations and the development of decent quality standards for social services. Furthermore, ICN supports non-profit organisations in assessing staff's training needs and fosters education programmes tailored to the individual requirements.

Other sector-specific instruments to assess, measure and compare service quality

Apart from providers of social services with ISO-certifications or EFQM awards, there are new kinds of initiatives of service providers that have started off with developing quality criteria, indicators or even standards between themselves on a European level or initiatives of specific sectors that went ahead to introduce a kind of benchmarking on local, national and European levels. One example for the development of transnational quality standards, developed by and with providers, was the European project "Quality in Practice" (www.quip.at) which aimed at defining relevant quality criteria in Supported Employment from the point of view of the respective stakeholders. The project highlighted a dilemma that personal social services often face when evaluating their results, not to speak of their outcomes. Concerning Supported Employment, for instance, it is recognized that a holistic view of the job seeker is very important and that his/her relationship with the job coach is key to the whole process. Also, it is useful for the job seeker to have one main support

and contact person, rather than having to deal with several professionals. On the other hand, the focus on aspects other than finding a job can lead to delays and the loss of focus. Though the project has shown the importance of focusing the Supported Employment process on finding a job, quality criteria thus cannot be restricted to pure quantitative indicators (e.g. the number of job seekers having found a job within three months) as these depend, among others, on the availability of other suitable services within a given region (see www.quip.at).

It might therefore be helpful to apply quality management tools that help providers develop their own standards for a given range of sector-specific criteria (www.e-qalin.net; Bungart, 2003) by involving relevant stakeholders and their different perspectives. Given the relatively recent set off of these approaches to quality development in social services, there is still a large scope for innovation in terms of outcome indicators and the analysis of results with a view on continuous improvement. While structural and process standards seem to be the easier exercise – with most criteria that can easily be shared between stakeholders – this is much more difficult when it comes to measure output, outcomes and key indicators (Eisenreich et al., 2004).

In general, the advance of quality management approaches, models of excellence and the ideas of benchmarking between providers are clear signs for changing awareness and strategies, but they are only slowly spreading across Europe. Still, in some Member States the ideas of quality management, an outcomes focus and stakeholder transparency have gained increasing currency over the last 10 years within government departments, the voluntary sector, and with funding and regulatory bodies (Cairns et al., 2005).

A problematic issue in this respect becomes visible in connection with public tendering (procurement) of social services as, in most Member States, both public authorities and providers still are in a pioneering phase in defining and analysing quality criteria. This situation is particularly challenging for the Third Sector if public authorities rely mainly on price as a criterion, rather than other quality indicators. This is why currently two EQUAL development partnerships are working toward strengthening mutual understanding and learning between potential providers, in particular the social economy, and the public authorities. Both the Austrian "IMPROVE" and the British "BEST Procurement", for example, are trying to develop quality standards for procurement processes by learning from best practice and by entering into a dialogue between stakeholders to achieve better outcomes.[139] In this context, good practice will have to be developed by further training of stakeholders and by installing and maintaining a dialogue to agree upon fair and sustainable criteria that apply equally to all potential providers, both in tendering procedures and in connection with accreditation mechanisms.

2 Quality assessment and monitoring in selected sectors

Quality of services has been one of the most contentious issues in long-term care during the past decade, starting off with a long list of problems and scandals that revealed the existing gap between the expectations and requirements of clients/users

[139] For further information see: http://www.seem.uk.net; http://www.improve-info.at.

on the one hand, and the quality offered by the existing services on the other hand. These shortcomings are reported to be partly due to the consequences of the above-mentioned modernisation and privatisation trends, and partly to the changing values of a new generation of social service clients. Though general surveys on user satisfaction with social services (see European Foundation, 2005) still show a high percentage of appreciation, single services and institutions are confronted with increasing aspirations of users. Future users of social services, however, will be better informed, they will be used to choose between different alternatives and they will call for more control and own involvement in decision-making, rather than traditional provision of welfare charity (Evers, 2006).

Tables 14.2 and 14.3 provide a general overview of methods to assess and develop quality and their coverage in the areas of long-term care services and childcare facilities according to country experts.

Table 14.2: Methods to assess and improve quality of services in long-term care

	Country						
Methods	*CZ*	*DE*	*FR*	*IT*	*NL*	*SE*	*UK*
Inspection of structural and legal regulations	50%	< 50%			>50%	100%	100%
Accreditation mechanisms							
• of individuals/professionals	30%			<5%	<50%	<50%	60%
of institutions and organisations	80%	100%	100%		>75%	>50%	
Public procurement (tendering) with respective quality criteria/indicators and standards	20%				>50%	>50%	40%
ISO 9000ff. certification	5%	< 5%	<5%		<10%	<30%	
EFQM, TQM or other QM methods		< 5%					
Specific QM systems developed for a single type of social service	50%	<10%			<30%		100%
Measures for consumer protection or client participation	80%		100%		>75%		100%
Performance indicators							100%

Source: Questionnaire for in-depth country studies; DE: own estimates

Table 14.3: Methods to assess and improve quality of services in childcare facilities

Measures to assess and improve quality of services	*Country*		
	FR	*IT*	*NL*
Inspection of structural and legal regulations			>50%
Accreditation mechanisms			
• of individuals/professionals		<5%	<10%
of institutions and organisations	100%		>50%
Public procurement (tendering) with respective quality criteria/indicators and standards			
ISO 9000ff. certification			<50%
EFQM, TQM or other QM methods			
Specific QM systems developed for a single type of social service			
Measures for consumer protection or client participation			100%

Source: *Questionnaire for in-depth country studies*

Long-term care

A common policy objective all over Europe in long-term care is to avoid or postpone institutionalisation and to support living at home for as long as possible. Still, long-term care systems are only just about to be shaped in most Member States in terms of financing, infrastructure, professional education and quality development. General shortcomings in this sector are reported from all Member States, to list but a few:

- Access to and choice between services and between providers is limited due to a lack of information, a lack of specific services, and provider monopolies; particularly in rural or less populated areas citizens have restricted access to long-term care facilities and support services;

- Complex needs that are specific to long-term care are not met adequately as health and social care, residential and community care providers, and single professionals are not sufficiently co-ordinating their interventions (Leichsenring/Alaszewski, 2004; Billings/Leichsenring, 2005);

- Users refrain from complaints about care staff as they fear sanctions from the very same staff;

- Users and their families are insufficiently involved in the development, implementation and monitoring of individual care planning;

- Furthermore, there are shortcomings in technical quality of care in nursing homes that include pressure sores, inadequate drug use, malnutrition and dehydration, neglect and abuse (Roth, 2002; see also OECD, 2005).

- Concerning staff's working conditions, tight time schedules, the absence of social and economic recognition, responsibility for large groups of users and the lack of possibilities to adequately take care of patients who suffer from dementia, are only some selected conditions that result in burnout-syndromes and health deterioration. Given that the quality and safety in long-term care is highly dependent on professionals' actions, scarce labour conditions also result in inadequate care or even abuse of users.

Initiatives to improve quality development and monitoring in long-term care are still rather sketchy, fragmented and often on a project basis within, and even more so between Member States. In addition, existing regulations do not always result in the realisation of intended results.

- The most comprehensive advance to put in place a system for improving quality and protection in long-term care (and public services in general) can be reported from the **UK**, where specialised agencies (see Box 14.2) were set up to further develop the regulation, inspection and review of services, performance assessment, access to information about services as well as regulation and training of the workforce. Following a series of reform steps during the past ten years, the thrust of measures now seems to be on the development and implementation of outcomes-driven performance indicators across the health and social care divide. The performance outcomes framework will be the basis of new so-called Key Lines of Regulatory Assessment (KLORA), which have been developed in consultation with residents, providers of services and inspectors to replace the National Minimum Standards.

- National standard setting by respective legislation in 2000 is the main instrument for quality assurance in **Poland**. In this country, the link between quality of services and the availability of resources becomes more evident than for any other of the eight countries studied here in detail. Residential care institutions that did not meet the codified, mainly structural quality standards had to work out an upgrading plan. However, according to a report of the National Control Agency (Najwyższa Izba Kontroli, 2006), more than 70% of these plans have not yet been implemented as even the most basic structural requirements (fire-alarm system, escalators, trained staff) were not met. Furthermore, as already mentioned above, local authorities where not able to realise inspections so that, to date, more than 200 private residential care homes are operating without any authorisation.

- It is interesting to see that, in the **Czech Republic**, the very same approach as in Poland – quality assurance by means of National Quality Standards defined in the Czech Social Services Act 2006 – has been interpreted in a slightly different way. Above all it has been accompanied by additional measures to support the implementation of such standards, namely the training of quality control officers in the field of social services, and of so-called 'Guides to Good Practice'. The latter are specially trained persons to support both users' access to services and providers in developing more adequate and user-oriented services. It will be interesting to monitor the implementation of this approach over time and in the different regions.

- In **Sweden**, initiatives are focused on the development of quality indicators for social services[140] with the aim to include users and representatives from local public administration in this exercise. The ongoing project, carried out by Socialstyrelsen, aims at an open process of comparing quality indicators, which will have to be defined, between providers and between municipalities.

- In the **Netherlands**, national legislation has recently defined standards and procedures on the quality of care institutions, which are based on quality management approaches and put special emphasis on the client perspective. Furthermore, policies to improve quality in long-term care strategically focus on supporting and training professionals working in this sector ("Zorg voor beter") to integrate care and housing in specific neighbourhoods, and to use technology to improve the efficacy of care interventions.

Box 14.2: Institution-building to guarantee quality assurance and development in the UK

Modernising, regulating and monitoring social services calls for the development of an institutional infrastructure the extent of which is often being underestimated. In the UK, for instance, the following entities have been established:

- An independent Commission for Social Care Inspection (CSCI) to regulate all care homes, private and voluntary health care, and a range of social care services in accordance with national minimum standards.

- A General Social Care Council (GSCC) to raise professional and training standards for the million-strong social care workforce.

- The Training Organisation for Personal Social Services (TOPSS, now "Skills for Care"), to improve both the quality and quantity of practice learning opportunities for social work students.

- The Social Care Institute for Excellence (SCIE), to act as a knowledge base and to promote best practice in social care services.

In 1999, a reform on tariffs of old age and nursing homes in **France** introduced also a systematic self-assessment process that has to be carried out by the provider organisation with the objective to install a participative process of continuous improvement. The respective self-assessment instrument (ANGELIQUE) contains more than 100 items and may be complemented by an external evaluation which, however, does not replace the usual inspection procedures that are mainly focusing on residents' rights.

[140] See National Board of Health and Welfare and Swedish Association of Local Authorities and Regions (http://www.socialstyrelsen.se/Amnesord/socialtj/sostjanst_kvalitet/index.htm).

The instrument is to assess the strengths and weaknesses with respect to six key areas of concern:

- The respect of ethical rules, in particular with respect to rights and liberties of the residents
- The satisfaction of implicit or explicit needs of residents, in particular of persons in need of care and their families
- A better management of the organisation, in particular to guarantee a secure functioning
- The improvement of human resource management
- The improvement of the image of residential care, based on an improved quality
- A better management of financial costs that are linked to malfunctioning

In **Italy**, the regional government of the Veneto Region, is promoting processes of continuous improvement in the areas of health and social services to guarantee equal access and appropriate services. Based on a law from 2002 standards for authorization and accreditation have been developed that will be binding from July 2007. Authorized services means services that are authorized to provide services to the public. Only accredited services, however, are entitled to reimbursements and/or to be contracted by public authorities, in particular the National Health Service. Respective standards have been defined for each type of service: authorization standards draw mainly on structural quality standards, while accreditation standards also ask for the introduction of general quality management processes. authorisation standards for child care facilities (0-3 years) include, for instance, the following features:

- Space that is exclusively dedicated to the child must not be inferior to 6 mq
- There must be 1 staff with educational functions for every six children below the age of 12 months and 1 staff with educational functions every 8 children above the age of 12 months

Providers that want to get an accreditation have to prove the accordance with of a number of additional procedural standards, e.g. in child care facilities:

- The provider has to guarantee the involvement of staff concerning strategic issues of service provision, decent information concerning the educational and care mission, and the involvement of staff in programming and defining the service objectives.
- The provider has also to guarantee that there is an educational project for each section or subsection of the service.

An autonomous regional authority has been founded in 2002 (see www.arssveneto.it) to technically support the introduction of the accreditation and authorization system, in particular by providing training, support and consultancy to providers, to elaborate on the instruments and standards as well as on the implementation process of external evaluation (selection and training of evaluators)

Childcare

The multiple and complex functions of childcare facilities – education, social integration, creation of equal opportunities for children at risk, facilitating labour market participation of parents (especially mothers), health promotion etc. – are only to some extent reflected in existing tools to develop and monitor their quality. Though depending on national policies and the division of competences between ministries and statutory levels, it seems that, apart from structural quality features, still mainly the educational aspect is being assessed in crèches, kindergartens or pre-school facilities. In some countries, for instance in the Czech Republic, crèches are part of the health care system and thus guided by completely different rationales than, for instance, in France, where they are part of local social policy and national family policy. Furthermore, while in Italy and other Member States pre-school facilities for children from 3 to 6 are part of the education system, in Austria, Germany and other Member States they basically are part of the social welfare services system.

User satisfaction and the orientation towards user's needs have become issues of growing importance during the past few years in all countries. New quality initiatives in the field of childcare focus mainly on raising the quality of learning and development opportunities (by introducing more educative elements and by promoting a set of competences already at early childhood) on the one hand and on ensuring that services are inclusive (for children with special education needs, e.g. a speech and language therapy, or children with disabilities as well as for children of migrants) on the other.

In particular in relation to the objective to increase women's labour market participation rate, the following aspects are currently at stake in many countries:

- There is a search for opening hours that respect both the needs of parents who increasingly work during so-called atypical working hours, and of children who should not be left in institutional settings for too long hours.

- While (apart from the general lack of places) opening hours in facilities for children below the age of 3 are usually compatible with normal working hours, the pre-school or kindergarten-system in many countries is still characterised by only half-day-care. For children at school age, a major difficulty is represented by the closure in the holiday season, and the pre- and after-school hours, as schools often open after parents' working time starts and close before parents' working time ends.

- These requirements are not easily compatible with the rights of workers in childcare facilities, mainly women, and the management of working time models.

- Diversification and flexibility of services provided do not always meet the expectations of users as both public and private supply have developed on a traditional pattern of collective childcare, with conventional, rather rigid opening hours, demanding a continuous, generally full-time attendance.

Due to these problems, and as a solution evolving to a large degree from civic commitment, additional services and acknowledged professional profiles have emerged such as, for instance, childminders (e.g. Austria, Belgium, France, Germany, Italy, Luxemburg, Sweden). In this context, the role of intermediary structures to support individual childminders and parents in matching supply and demand has to be mentioned.

In France, so-called *Relais d'assistantes maternelles* also help childminders receive further training, find a place to exchange experiences and organise replacements in case of sickness. Similar tasks are fulfilled in Austria by a specialised private non-profit association with regional and local branches.

Another development towards new ways of describing and assessing professional skills needed in this very sector are so-called *"référentiels de metiers"* (inventory of professional competences) that are increasingly used in France. Also in the Netherlands the growth of the sector led to the call for professionalisation. In 2000, one of the trade unions developed a professional code for group leaders.

Quality certification by third parties has not played a prominent role in childcare provision up till now although some ISO-certification of childcare facilities was reported. The main trend still seems to be on inspection and accreditation.

In general, the increasing proportion of for-profit providers and independent childminders in the field of childcare poses serious questions to the meeting of quality standards. Although in several countries (e.g. France, Germany, Netherlands) a new regulation of quality requirements (pedagogical project; networking with other social services; supervision; involvement of parents, etc.) was adopted which includes also individual childcare, in some countries private childminders or family *crèches* are not submitted to any regulations.

Furthermore, quality control procedures are more difficult to implement in this field due to the diversity of childcare providers. Frequently the implementation is still local and lacks clear national guidance. In a situation where the supply of childcare needs to be enlarged rapidly and is accompanied by financial constraints, quality control might also be carried out with a certain sense of tolerance by local administrations. Thus, it is partly up to individual facilities and their operators to monitor and improve the quality of services, as also parents are not able to properly evaluate the quality.

Other sector-specific experiences

Within the sector of residential and nursing home care there is a trans-national initiative developing a specific model of excellence for this sector in the framework of the EU Programme Leonardo da Vinci (see www.e-qalin.net). This model is particularly focused on involving relevant stakeholders in assessing and improving the

quality of services concerning structural and process criteria as well as the quality of results. For instance, applicants are stimulated to describe their results from a residents' and a staff's perspective as well as from the management perspective, the social context and concerning the future orientation.

From the UK, a plethora of sector-specific standards and quality frameworks has been reported, e.g. the Charities Evaluation Services' PQASSO quality framework, social auditing developed by the New Economics Foundation or ACRE minimum standard guidelines which have been proposed by the National Association for Voluntary and Community Action (NAVCA). There is also a range of monitoring and assessment tools being developed or used for particular constituencies which outcomes approaches might inform: Asset Based Community Development/ABCD (Scarman Trust), LEAP (Community Development Foundation), VISIBLE (Community Matters), Organisational Health Checks (Development Trusts Associations).[141] These latter are additional methods and instruments (planning and evaluation cycles) that may guide councils and/or single organisations in reflecting the aims, strategies and results of their activities, to identify their assets, and to bring about positive change. This shows the strong move to a range of processes and systems concerned with measurement, accountability, quality or demonstrating results which are being developed in and around the sector and which have become a norm in the sector (Paton, 2003). Providers, in particular Third Sector organisations, may need to adopt a variety of different quality processes if they provide services to various purchasers each of which requires a set of diverse norms. With all the associated transaction costs the question arises whether such processes actually benefit users (Cairns et al., 2005).

While 'traditional' types of social services are often reluctant to adopt quality assessment and management methods, this is far less the case for newly emerging services and providers. An outstanding example for this assertion is the area of supported employment where both national and European initiatives have led to the elaboration of quality standards by a trans-national initiative supported by the European Commission (www.quip.at) and their national specification, e.g. in the Czech Republic (www.unie-pz.cz), where annual quality checks are performed in order to evaluate the compliance of the supported employment services. This includes, for instance, the outcomes quality of the paid job found on the ordinary labour market (valid contract, adequate wage, stable job), the match with skills and preferences of the employee, team membership and career development.

3 Conclusions

General modernisation trends and, in particular, the opening of (quasi-)markets to new kinds of providers called for the introduction of mechanisms and methods to assess, document and demonstrate that these providers, be they voluntary non-profit organisations, commercial enterprises or other agencies, are effectively run and delivering what they promise. This applies also to the social service sector and is particularly true for countries where traditional state-third sector relationships were weak and/or where private non-profit organisations were not acting at all as providers

[141] See www.visiblecommunities.org.uk; http://leap.scdc.org.uk/leap-framework;

of social services. In the traditional subsidiarity-based welfare states (France, Germany, Netherlands, Austria), accreditation systems might lead to a replacement of "trust" as a central feature of service delivery by third parties with 'normal' purchaser-provider relations. In other countries, the diversity of methods and tools used to assess and manage quality of services might help increase the transparency of all social services delivered.

It is essential, however, that relevant stakeholders start to use existing instruments for mutual learning within and between countries and sectors of social service provision. Opportunities for such exchange and training of personnel have to be developed and will, among other, call for additional investment.

In the future it will also be necessary to balance out the requirements of quality management tools with the specific organisational framework of social services. In this respect all providers – public, private non-profit, commercial – have to be offered equal opportunities and small organisations should be prevented from being discriminated.

In general, all service providers acknowledge the need for additional quality development, quality management and quality assurance. However, there are concerns that only bureaucratic and administrative tasks will increase, rather than user-oriented concerns. Service providers argue that a mere legal definition of (minimum) quality standards will not trigger a competition about quality, but rather on prices. Initiatives that promote the dialogue between potential providers and public authorities, e.g. to mutually agree upon quality criteria for accreditation or tendering purposes should therefore be supported.

Professional ethics remain a decisive factor to distinguish social services of general interest. It will therefore be of utmost importance to facilitate the development and to use the intrinsic resources of the sector, rather than destroy the social fabric in which these services are interwoven. This means to adapt existing tools to assess and develop quality of services by involving relevant stakeholders, in particular users and their families.

Finally, it should not be forgotten that most of the above mentioned tools and methods usually apply to individual organisations and/or federations. The quality of social services of general interest in a given territory, however, is not only dependent on the performance of individual providers or a specific service unit but on the interplay between providers and their networking activities. It is thus necessary to integrate all providers in processes that facilitate guidance and the management of such networks. In the perspective of multi-level governance this means that steering processes as well as tender specifications have to be co-ordinated between governing bodies. These activities, however, are often not remunerated and will call for additional funding in the context of quality management and increased transparency of social services. The dilemma of resources will thus remain a critical factor in quality development.

Part VI: Monitoring SHSGI at EU level: conclusions on methodology

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Part VI: Monitoring SHSGI at EU level: conclusions on methodology

This part reflects on the experience gained during this project with the methodology that has been proposed and tested for this study and comes up with conclusions and suggestions on how to improve an information and dialogue tool on SHSGI in the future. Chapter 15 reports on the stakeholder enquiry that was a key instrument for a broad European dialogue on SHSGI.

Chapter 16 provides conclusions and recommendations on the tool of in-depth country studies and the availability and quality of comparative statistical information on social services on EU level. What are among the most important statistical tasks that Europe faces for this difficult field of comparative study?

Chapter 15 The stakeholder enquiry

1 Introduction

This enquiry – which was addressed to a broad range of European-level stakeholders – was a central element of this study. The entire exercise was aimed at stocktaking and fact-finding. It has to be seen in the context of the future dialogue component of the regular dialogue and monitoring tool on SSGI that the Commission will set up from the end of 2007. Primarily, it was designed to allow stakeholders to directly contribute to the project and thereby to the final report. In a wider perspective it has a more ambitious objective. The enquiry was conceived to test one major channel of consultation of stakeholders in view of a future implementation as well as to gain additional insight as to the appropriateness and "informational potential" of specific topics and issues in view of their further consideration. And this is in the framework of a presumably more continuous structured process of monitoring the SSGI sector.

A detailed analysis of all forms of input received in the framework of the stakeholder enquiry is available in a study prepared by Peter Herrmann, under this project (Herrmann, 2007, SHSGI Policy paper No.2). This document can be read as a stand-alone study and is one of the components of the SHSGI project. Main messages and central conclusions are contained in an executive summary. This final report, however, contains several quotes from the above-mentioned analysis in basically all parts as well as references to it. The analysis builds on the written contributions (questionnaires partly or more comprehensively filled in, comments, position papers, analysis provided, letters and email) as well as on a number of interviews and conversations held by the responsible researcher.

2 *How was the stakeholder enquiry implemented in the framework of this study?*

In order to obtain up-to-date information, as well as concerns and opinions from a broad range of actors in social services, a questionnaire was distributed to a pre-selected list of about 70 EU-level stakeholders. They have been invited to consult with and take on board the broad knowledge and experience available in their respective networks, i.e. within their national, topic- or group-specific member organisations. Stakeholders at national level interested in participating in the enquiry were invited to support the fact-finding exercise of this study and to voice their opinions and expectations. In its final version of 12 July 2006, the questionnaire comprised 28 questions. They were attributed to five thematic fields. The concluding "open question" 29 was reserved for additional information and comments. Here stakeholders were invited to provide information and comments of a more general nature, including information concerning the Community processes related to SSIG, as well as feedback on the concept and implementation of the SHSGI study, its content and the methodology of the enquiry.

The main purpose of the stakeholder enquiry was to support the fact-finding exercise of the study. A first section was devoted to employment trends. Under the heading "The process of modernisation", Section 3 brought together questions about modalities of organisation, regulation, provision and financing of services and related trends of structural change. Section 4 comprises issues concerning service quality. Finally, several questions and issues raised were designed to particularly shed light on the possible impact that existing or evolving Community rules and recent ECJ jurisprudence could have with respect to services of general interest – notably at the local level or more generally with regard to service organisation, regulation, provision and financing – on social and health services, especially if they qualified as "economic" services. On this backdrop, responding organisations were asked to devote due attention to Sections 2 and 5 of the questionnaire that deal with the legal regulations and the institutional framework within the Member States and with the actual and potential impact of Community rules. Except for the last topical section on the impact of Community law, the final question in all sections addressed the issue of good practice (examples).

The questionnaire mainly contains open-ended questions (in total 25) asking for qualitative information and, especially in Section 1 on "employment conditions", also for quantitative data. Four questions have been included where respondents were asked to choose from pre-defined categories or to tick (yes/no) boxes. Due to methodological considerations, separate answers were asked here for the five sectors under study and also for the "social and health services of general interest" in general, the latter category also in order to allow for cross-sector information where respondents were not able to provide sector-specific information.

The questionnaire was disseminated end of July, with an original submission date for handing in completed questionnaires of 16 October. Taking account of various feedbacks, the deadline for submission of written contributions was prolonged to December. The questionnaires were sent out with a cover letter and two reminders were sent to the (about 70) European umbrella organisations that were addressed, with additional explanations and clarifications on the process, content and context of the stakeholder enquiry. The questionnaire was only available in English. Respondents

were explicitly informed of the possibility to send in replies and other material also in French, German, Dutch, Italian, Portuguese, Spanish, and Swedish, and twice encouraged to do so. Only French and German were used. All pieces of information distributed to the stakeholders contained a reference to the project-related web site (cf. http://www.euro.centre.org/shsgi) set up on a trilingual basis (English, French, German) as early as May 2006 and currently updated. They were also posted to these web sites that also provide for all relevant information and documents concerning the stakeholder enquiry.

In addition to partly critically assessing the technical character as well as specific aspects of the conceptualisation and issues of the questionnaire (see Section 5 below and SHSGI Policy Paper No. 2), the stakeholders also gave feedback on the organisational framework of the enquiry. They often mentioned difficulties caused by the relatively short timeframe as seen against the background of considerable information and "activation" work that was necessary to come up with answers, illustrations and examples for individual questions, in particular because these often had to be having collected from national member organisations. Moreover, there was often the needed to co-ordinate their positions in a participation-based process. Some organisations that were addressed decided not to answer the questionnaire (in part or as a whole) or to contribute to the enquiry in other forms, such as with separate papers or statements.

The participation rate to the enquiry under this study was also influenced by the parallel second enquiry co-ordinated and launched by the Social Protection Committee on SSGI as one element of the follow-up process to the Communication on SSGI (see also Chapter 3.4). Both provider and users organisations active in the field of social and health services at national and European level dedicated considerable time and co-ordination efforts in elaborating replies to the SPC enquiry, (in the third and fourth quarter of the year 2006 or in contributing to the replies of European umbrella organisations of which they are member). The explicitly political character, the embedding into an "official" consultation process and the timing of the SPC questionnaire-based consultation, (after the enquiry), under this project (with both a later start and deadline, which also gave more time to European umbrella organisations and their national members to prepare answers and co-ordinated positions) also led to a situation where – against the backdrop of continuous high work load and co-ordination work of all (European level and national) stakeholders – more emphasis was given to the latter.

3 Summary statistical info on the feedback received

From around 70 questionnaires sent to stakeholder organisations, 10 were completed and returned in their original format, with two more replies closely following the structure of the questionnaire. 16 organisations that had been contacted replied in different forms, 12 by sending comments on specific issues (including references to various difficulties faced with the questionnaire). Five replies were in the form of general policy statements, six provided extensive information packages or documentation. Moreover, eight organisations not on the original list, volunteered to provide information.

Focusing on the return of questionnaires (partially or comprehensively completed and, designed as main tool to support the fact-finding exercise), the following summary information can be provided: four replies originated from European umbrella organisation, eight from national federations of not-for profit organisations or central organisations of public authorities. Five replies used the English language (four of which from countries, none of which with English as official language), three were in German language (one of which an European umbrella), and two in French (one of which a EU-level peak organisation). The non-English replies contained an especially rich body of information with detailed explanations, including many of the examples and illustrations analysed in this study. Nine of the ten questionnaires were filled out for at least half of the 28 questions, although with a sometimes varying degree of detail. In these nine replies, also the questions with pre-defined categories or tick (yes/no) boxes were completed, at least for individual issues or selected sectors.

However, the low total reply rate and certain gaps in the replies do not allow for a quantitative analysis, neither for an aggregation for selected countries or sectors, nor a cross-country analysis. The same difficulties of aggregation of information received for individual questions were even more obvious for the open-ended qualitative questions. Also, given the fact-finding intention of the questionnaire – it was not possible for European umbrella organisations to aggregate facts across countries, building on replies from member organisations from different Member States. That restriction is most obvious for the tool of tick-boxes and pre-defined categories. [142] As a mirror-image effect, other pieces of information gathered cannot be clearly attributed to specified national contexts. "Although in some cases answers had been specified in national terms [in a form as: 'as our member organisations in … stated], in most of the cases no such attribution is made."

Overall, the team entrusted with the realisation of the SHSGI study has nonetheless received a considerable amount of information, valuable in its own right, even if comparability is limited as well as the possibility to, aggregate and generalise, the sector-specific and country-specific the information received.[143] This is even more so due to a need to contextualise most of the pieces of information (in specific institutional settings, regulatory frameworks, country-specific social and economic conditions, etc.) in analysing them and to draw conclusions.

No doubt, the questionnaire designed can be characterised as demanding for potential respondents, as to expertise and time needed to fill in answers and evaluations. Two organisations therefore decided not to answer to specific questions, but to rather elaborate replies, statements and examples per section.

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[142] The above-said is well illustrated by one reply: "This questionnaire is designed for representatives at a national level. It is therefore very difficult if not impossible for European stakeholders to answer the questions properly. Any attempt to fill in the tables or to answer the questions could result in confusion and misunderstanding." This difficulty seemingly would have only been possible to overcome if more time could have been dedicated for distributing, replying to and recollecting questionnaires, then aggregating information received by national member organisations at European level for certain questions and summarising it and if the questionnaire could have been made available also in other languages than English. Both desiderata obviously could not be realised under this study.

[143] E.g. knowing about the growing importance of public procurement is indispensable information. But as a second step, only structured, detailed and comparable information on the modalities used and central contents of typical public tenders in a specific social services sector will allow for well-grounded assessments of the consequences of their increased usage on the organisation, financing and quality of the social services delivered.

Looking at the geographical "spread" of responding organisations, there is a clear bias in favour of federations/national umbrellas from France and Germany. Also represented are organisations from the Nordic countries and from several of the Central European Member States that joined the EU in 2004. Contributions from Southern European countries[144] have been totally lacking as well as input from the United Kingdom (see the study by Peter Herrmann).

This might be attributable to different levels of awareness of the whole SSGI process at European level, different evaluations as to the extent of being concerned by them, and variations with regard to resources (expertise and time to dedicate to such an exercise). But the observed pattern of responses seems to also hint at different degrees to which national social service systems actually are concerned and (with regard to some aspects and modalities even fundamentally) challenged. On the one hand, it seems to reflect different structures of interest representation and on the other hand, more specifically the non-existence or the existence of national federation and the degree of cooperation between regions. The latter is the case e.g. in countries such as Austria, France, Germany, or Sweden. These reflect specific governance structures, closely involving NGOs in social service provision, as a rule, in close co-operation with local public authorities.

As to the "type" of organisations, questionnaires and other replies could be collected from NGOs, like third sector/social economy organisations (about half of all questionnaires and two third of the replies and reactions), from local public authorities (municipal and district), and from social partners, (in this case from the trade union side). Amongst the organisations which have filled out the questionnaire (at least partially), the vast majority can be classified as provider organisations (including public authorities) – two of which are predominantly lobby organisations –, none of the respondents represent users organisations (such as self-help organisations).

Under the stakeholder process replies to questionnaires were received that helped shed light on the situation in countries not covered by in-depth country studies, such as Denmark, Estonia, Latvia and Lithuania, which all came from the association of local territorial authorities. Moreover, it helped to gather a wealth of information of different types, such as enquiry-related email communication, position papers or other "political" documents sent in, analysis put at disposal or, not least, direct contact (interviews, talks and the like) of the responsible researcher with organisations interested in contributing to the study. In this regard, some additional information could be included from Austria, Finland, Hungary, Ireland and Slovakia. Finally, the stakeholder enquiry allowed to include information that came directly from organisations that work at the "grass-roots level" of service provision.

[144] With the exception of one regionally based Italian social co-operative, more exactly from Southern Tyrol (*Südtirol*) and contributing to the reply of an umbrella of NGO providers of social services in German language.

4 Results

The answers given to questions contained in the questionnaire allowed gaining important – albeit selected[145] insight with regard to aspects related to employment and employment conditions in the field of social services (esp. on staffing and on remuneration),[146] on their organisation, regulation, provision, and financing[147] as well as to service quality[148] (in both a more technical but also in a broader and value-driven context). They contain several examples presented as "good practice" in one or the other way. A major concern, mainly raised by NGOs, is the issue of competition and the question on which criteria it should be based while keeping in mind that the main production factor in the social and health services sector is labour and that consequently a price competition essentially would be a competition on wages and labour conditions (e.g. working hours, shift work, part-time work).

The questionnaire also reports on direct impacts, indirect effects and more general influences from Community legal and political framework. Some of them are especially rich and instructive and help to illustrate what actually are or potentially could become advantages. However, more often mentioned are challenges, concerns, problems and inconsistencies for SHSGI, their providers and users deriving from the interplay of Community policies and law with regulations, policies, traditions, etc. within Member States.

The bulk of the answers and facts given refers to national conditions and regulations, only partly and increasingly superseded by Community rules and/or the

[145] Even though the examples were given by umbrella organisations in one Member State, it is highly plausible that those listed above are also of relevance in a number of others.

[146] Central organisations of regional and local territorial authorities mention the following issues currently dealt with or high on the agenda, related to difficulties to recruit and retain high-quality, motivated staff in the care sector and the need to improve training and qualification structures, career opportunities, working time arrangements: 1) focus on ongoing supplementary training and education for the different professionals in order to increase the effectiveness and quality of care, but also in order to create a higher degree of job satisfaction (Denmark); 2) conclusion of a framework agreement on a social chapter on how to create jobs locally for persons who cannot meet the ordinary requirements in a normal job because of their reduced working capacities or for unemployed persons (Denmark); 3) elaboration of an agreement on integration and training jobs to create special job positions locally and regionally in an attempt to recruit foreign born personnel (Denmark); 4) staff shortage in the social service sectors which is most likely to decrease (Latvia); 5) below average wage payment in the social and health services sector and the wage gap compared to sectors with high pay (Czech Republic, Estonia, Latvia).

[147] Central organisations of regional and local territorial authorities refer to the following issues currently dealt with or high on the agenda: 1) application of public procurement and definition of precise procedures, criteria, etc. (Latvia, Sweden) 2) financing modes to increase the financial autonomy of municipalities and districts (Sweden); 3) evaluation of effects (cost; quality; user satisfaction; co-operation amongst providers – which currently seem to have become of poorer quality with the extension of short contract periods and frequent changes in care providers; short contract periods involve the risk that the ability of care providers to provide good care on a continuous basis is impaired and consequently the realisation of the legally fixed objectives and general interest missions of the sector concerned) of marketisation of care services (Sweden)

[148] Central organisations of regional and local territorial authorities mention the following issues currently dealt with or high on the agenda: 1) continued qualification of staff (all countries); 2) implementation of local social inclusion strategies in terms of quality, proximity, accessibility, availability, affordability (taking up an impulse from Community-based policy processes and action plans (Latvia);

economic and political integration of the internal market in a direct but much more often indirect way (see also SHSGI Policy Paper No. 2 in this regard).

5 Conclusions on challenges and recommendations

In addition to the points raised in the report on the stakeholder enquiry, another challenge needs to be addressed. Although stakeholders, especially the providers of social services, are generally well situated to know about challenges and problems with regard to social service organisation, regulation, delivery and financing and principally have been interested and willing to contribute to the study, it is not evident that they, more precisely their national federations, are also the adequate addressees for fact-finding on the issue in question in one or the other way. One issue in this regard is a certain, also understandable reservation to report in a written form and in detail on concrete examples, which could later cause problems, uncertainties, and frictions. This also holds for issues for which a lack of legal certainty – due to whatever reason or framework conditions – is being perceived. And this is even more the case with regard to open questions or cases currently under investigation by Community services, such as the DG Competition or the ECJ, given their vested political and economic interests "at stake".

The researchers entrusted with the realisation of the study have been fully aware of the fact that terms and concepts used in questionnaires, even more in a cross-country context, be it political or scientific, inherently are subject to certain ambiguities and open to a certain interpretation by respondents. Their understanding and usage will principally be determined i.e. by a given professional background, the function played representing an organisation within one Member State or at EU-level, by interests currently at stake, etc. The researchers therefore encouraged respondents to highlight possible concerns and stimulate respective considerations on their side, which can be a meaningful input, enabling them in turn to improve the evaluation and interpretation.

As could be expected, at least to some extent, the issue of presumed interpretations of terms and concepts – expected by several stakeholders to also favour a shortened and one-sided understanding and usage in the discussion at European level – ranked amongst the most prominent concerns raised by respondents to the enquiry. In simply accepting a certain framing, stakeholders would – as they expressed it – support an assumed dominant "direction of impact" and contribute, partly or fully against their will and interests, to producing replies which could not grasp problems and phenomena in a satisfactory way or grasp their complex, multi-faceted nature and inter-relatedness[149]. Another issue mentioned relates to the problem of having asked for good practices, but not for less positive or even negative

[149] In the cover letter accompanying the questionnaire and in a second letter used as clarifier and reminder it was stated that in the questionnaire some terms are used in a very specific understanding, arising from the political and administrative context in which this research is undertaken, for instance with regard to terms such as modernisation, rationalisation, efficiency, quality, accessibility which were "declared" as not being unproblematic: "There may be different understandings, overlaps and lacking distinctions. The questionnaire had been elaborated not least aiming on gaining a general insight. Occasionally it was necessary to use some general terms and refer to a "mainstream understanding" which is not necessarily shared by everybody. Please, feel free to make respective comments where you think they are helpful, clarifying specific issues."

experiences, which might cause a lack of information and consequently an incomplete analysis of the current developments in the social services sector.

It should be highlighted that a dialogue with stakeholders seems to be most promising if a maximum transparency is achieved about the participants, including the number and scope of organisations to be represented, their respective roles, and the channels of communication to be employed. Should there be direct contact between national stakeholders with EC or via EU umbrella organisations to serve as "filters" and facilitators bringing together contributions? What role should national regulatory bodies play? What will be the objectives (e.g. input into political process; exchange on information and experience) and the contents (e.g. definition of common objectives; indicator development; legal impact analysis)?

User involvement in a monitoring tool

Another limitation is due to the fact that users and organisations representing them and their interests were not approached directly. This would have needed additional instruments (e.g. surveys at different levels), a longer time horizon to design (in different languages), organise and analyse such a survey. Furthermore other issues (as e.g. user's expectations and assessment of service quality, choice of provider, and service level) will then need to be investigated, whereas the study focused on questions of relevance for regulative bodies and providers in line with the objectives and methodology of the study.

Many user organisations find it difficult to contributed to issues of organisation, regulation and financing of schemes and the impact of Community rules on national systems and modalities in the framework of a cross-country study. There is also the need that these facts, concerns and demands of relevance for them have to be analysed and assessed in the context of specific national, regional or local contexts, perhaps even with a link to specific living and income conditions to make them understandable and useful in a comparative perspective. This will need a different study design.

In summary, there is the need to clarify at an early stage the questions "Who will define the objectives and the topics of the monitoring and dialogue process?" and "Who will decide about the institutional embedding of this tool and the procedures (e.g. a European observatory as co-ordinating office, also entrusted with the assessment; working groups on specific topics; role of external consultants, e.g. scientists) to make it work?"

Chapter 16 Reporting on social services in Europe: ways ahead

Based on the results of the study and the methodology used, this Chapter draws conclusions and recommendations for a broad range of information-gathering issues that are relevant for the future design of the monitoring and dialogue tool as announced in the Communication on Social Services of General Interest of 26 April 2006. This includes a number of observations on ways ahead to improve information on social services in Europe more generally.

A monitoring exercise realised at the level of the European Union needs to carefully consider the objectives set, the criteria used and the main perspectives. Such an evaluation of inputs, outputs and outcomes should be relevant for a broad range of potential users that include regulating agencies, financing bodies, service providers, and users.

The outcome of the monitoring and dialogue will critically depend on the institutional setting and the actors involved in the assessment process, and how well it is linked to broader strategies and other ongoing or emerging initiatives to improve the information basis for social services in Europe and in Member States.

A broad view on social services is needed in particular as the goals defined for social services and the general interest missions, as a rule, are decided upon by the competent public authorities at different levels within the Member States. The ways these are addressed, however, can vary to a considerable extent and are expected to differ across time and space. A monitoring instrument should, however, include a stable core of quantitative information that allows to changes over time to be monitored, and this stable core must not become a moving target.

1 Introduction

The evidence gathered under this study has confirmed that comparative information systems on the situation of social services that are of the type needed for monitoring these services in the European Union are still largely in their infancy. This is the case for all the sectors studied in depth in this study.

Better quality data and more detail are needed at all levels of information, from the local to the national, and the European level. Moreover, data limitations currently not only prevail for the sub-sector analysis illustrated in Part II of this study, but also for aggregate information on overall employment trends, wage levels and expenditure (value of services production) (see Chapter 2). These aggregate data are both important for monitoring aggregate trends in their own right, but also as denominators for analysing trends in social services designed for a specific target group (e.g. socially disadvantaged persons, disabled persons, refugees and asylum seekers).

Moreover, the study has also confirmed how important it is to put statistical data in the context of their legal and regulatory framework. Because there are often marked regional differences and regulatory competencies that operate at the regional level, there clearly is a need for more regional data to enable cross-regional comparisons.

Sub-regional data, even if they were rough estimations, would, for example, allow for the assessment of the situation in rural versus urban areas and agglomerations.

International comparative data and improved consistency of information gathering

Information on health and social services is currently fragmented and lacks a coherent information strategy in many countries, which often is due to the fragmentation of public responsibilities for these services and their provision across various levels of government. For the sub-sectors of care that have been analysed in this study, comparative data collections and agreed upon framework concepts on the EU level have in many cases only recently been emerging but are sometimes not compatible with each other.

Where international guidance is now available, such as for the ESSPROS social expenditure statistics or the System of Health Accounts (OECD), much remains to be done to improve comparability and other aspects of data quality and to harmonise these with other information that is regularly collected, such as in MISSOC or in the form of other more descriptive information, including the country profiles and structural information that is now routinely collected by the Social Protection Committee under the Open Method of Coordination. The following sections provide comments on some of the most important steps needed. This will be done both for aggregate data but also for sub-sectors, with a focus on long-term care services.

2 Monitoring employment trends in social services

The employment trends based on international sources that are described in Chapter 2 of this study can only provide a broad-brush summary picture of social and health services taken together under the corresponding headings in the international industry classification (ISIC, and NACE). Availability of separate data for health and social work in international data sets is currently limited. This section discusses ways forward to improve the data availability and quality for employment in social services, including from recent experience of the OECD with a new database from national census data.

Besides data from Labour Force Surveys, there is a usually a range of relevant national data sources on employment in social services available. The most important are:

1. Census of all employers and jobs covered by social insurance (e.g. unemployment insurance). These statistics can exclude a number of self-employed, students, or public employees under special schemes, which may underestimate the number of people employed in social services.

2. Business surveys. Social service "industries" may not be (sufficiently) covered by these surveys, which tend to focus on manufacturing and business services.

3. Data from business registers requested by public administrations for certain sectors of social services, for example for long-term care providers. These statistics have been put in place by some European countries, to monitor the implementation of comprehensive public programmes. These systems are very limited (e.g. to certain types if public institutions) for many European countries.

4. Public sector employment statistics. These naturally present a limited picture on social services, which, as this study has shown, are diversifying with an increasing private sector involvement in most countries.

5. Ten-year (big) census data. These provide the most detailed picture of employment by industries that are usually available in countries. However, they are only conducted every ten years, and statistical classifications may have changed between the 1990 and 2000 waves.

Replies to the questionnaire and template for in-depth country studies have confirmed that data which are more detailed than the three-digit NACE breakdown are currently fragmented in countries, in particular when it comes to a common picture on both public and private providers.

There are basically three ways on how to improve international data on employment in health and social services:

1. Increase the sample size of Labour Force Surveys in order to have more reliable numbers on the three-digit level of service industries. The costs to do so are certainly high, and the main impetus for such a reform might have to come from other industries and analytical interests than for services.

2. Include health and social work in business surveys of the "service industry". Again, this is a costly vision for the mid-term future, difficult to implement because of the many small providers. In addition there are issues of how to cover the self-employed.

3. Estimate national data on employment in social services based on a commonly agreed European framework, where each Member State is invited to make the best use of all available data sources, and to develop a country-specific methodology on how to fill gaps, and to reconcile data from different sources. Corresponding statistical frameworks now exists for a few international data collections, such as on education and research and development and these are currently under discussion for the field of health care (see Box 16.1). Such a framework would include a methodology on how to "bridge" in nation estimates between points in time, when data are not available from certain sources.

Box 16.1 International frameworks for measuring employment and human resources in specific fields

There has recently been progress to complement health expenditure data (see Dubois and McKee, 2006) with a systematic account of human resources in health care, for which the OECD manual "A System of Health Accounts" provides a systematic framework in its Annex A.1 Measurement of Human Resources in Health Care (OECD, 2000), following a similar approach to that used in the OECD/Eurostat *Canberra Manual on the Measurement of Human Resources Devoted to Science and Technology*. For the – very heterogeneous – field of social services, however, no such international framework exists currently. Moreover, only very few countries have started comprehensive data collections on this topic for their national purposes.

An important data source that could potentially be used to provide input data for estimating such a comprehensive account on human resources in social services, are the very detailed data from the 10-year census waves that provide a sufficiently detailed picture to answer for census years a number of important analytical and policy questions on social services, including trends in employment, occupation, educational attainment, or employment by country of origin. The challenge no doubt is then to develop ways to "bridged" between census years with the help of data from other sources, including administrative data on social service providers. The OECD Secretariat has started to collect detailed data from the 1990 and 2000 census rounds, and shown some promising results in how to use these for the purpose of international comparisons, most importantly for estimates of foreign born population numbers (see Lemaitre and Thoreau, 2006). There potential use for health labour accounts has also briefly been studied (OECD, 2002).

Any such system and framework for social services will need to address the crucial question of the overlap with health labour accounts, as long-term care is partially a health responsibility, with the risk of double counting, if data from both systems should be compared or aggregated. It also would include the important task of considering the ling to NACE, as more than the three-digit categories on "social work" may be relevant for inclusion is such a detailed system of labour accounts for social services.

3 Analysing public expenditure on social services

The *European System of integrated Social Protection Statistics* (ESSPROS) is the main information source for public expenditure on social services (see Chapter 2). As the final report under this project has illustrated, there are, however, currently competing data sources for a number of public spending categories, and social service categories, perhaps most importantly for long-term care services (see Chapter 4). Moreover, the way member countries classify social protection schemes may need further harmonisation, and future revisions of the basic ESSPROS functional classification should be done with a view towards better harmonising this data collection with other sources of routine information, including qualitative information regularly brought together in MISSOC, the *Community information system on social protection*, that annually reports on the situation of social protection systems in the Member States of the EU. For example, it would be highly desirable that long-term care became a separate component in the ESSPROS classification, in order to both

make spending for this important policy field under the OMC process more transparent, but also to more fully be able to map information from MISSOC to the data available in ESSPROS see also 16.7 below in LTC in more detail).

In order to avoid double work in National Statistical Offices, and to fully profit from methodological advances in the concepts and estimation techniques available in National Accounts Divisions, and from the comprehensive databases on public expenditure collected there, it is important that the role of the central statistical framework for all economic statistics, which is the System of National Accounts, becomes a stronger role as unifying methodological guide for any future revision in (public) social expenditure statistics.

Very few data are currently available that would allow for monitoring private expenditure on social care services, such as long-term care or child-care that can impose significant financial burden for private households, in particular for expensive care and accommodation in nursing homes that is only partially covered under public programmes for most countries (see Chapter 4.3). Other services can be means-tested, requesting that households spend down their own resources. Household surveys include questions for spending on health care, but usually not for social services. And where such a question is included, the national sample is usually too small to include a significant number of households with a family that needs. For example, long-term care. Specially tailored surveys on the demography and living conditions of older persons would therefore be needed.

Regular business statistics for all social care providers, on the other hand, irrespective of their being publicly or privately governed could provide a picture of the full output and expenditure of this sector and this could be done either from business surveys or from regulated data requirements that currently only the public sector has to meet in most cases.

4 Reporting on institutional changes in organisation and financing of services

In the fact-finding and descriptive sections (particularly in Part III on Modernisation), as well as in the questionnaires and templates used, the present study focuses on modalities of organisation and financing, instruments used for regulation, steering and planning as well as on modes of governance. This information is conceptually and analytically linked to institutional characteristics of the sectors of social services covered and to developments and impacts of demographic, economic and political nature.

Evolutions and innovations in the social services sector described at an instrumental level – in a specific country but even more so in a cross-country perspective – can, however, only be correctly understood and assessed if a set of structural background information in several dimensions is taken into account. These include among others:

- Main institutional characteristics of Member States (e.g. distribution of competencies, budgetary responsibilities);

- Social protection schemes (eligibility; entitlement conditions; degree of decentralisation of decision-making and budgets, etc.); and

- Sector-specific regulations and organisation of providers.

These are therefore indispensable elements for the monitoring and analysis of specific SHSGI. Bringing these together in a cross-country perspective can and will bring important added value at European level.

To compile these pieces of information and to update them from time to time is a non-trivial task due to the current lack of comprehensive national and European information systems containing data of this type in sufficient detail. In addition there is the need to set up systems that are feasible, and not too time-consuming or costly and that are presented and accessible in a clearly structured way. Moreover there is a clear trade-off between this need to limit the scope and complexity, and the need to adequately account for the complexity of modes of organisation, regulation, provision and financing of social services across Europe and their institutional embedding.

Building on the present study, a first step therefore should consist in identifying the aspects and issues of core importance (e.g. "public authority having the regulatory power" – as illustrated in Table 9.1 on "methods and devices used to ensure the provision of social services" – as shown in Table 11.3). In the second step it needs to be decided if this piece of information can be "condensed" in form of an indicator and which categories are needed and also can be fed in, based on available data or qualitative information. A third step could then consist in proposing indicators or summary information which cannot yet be reported using available and easily accessible sources, at least for a larger number of countries, but which seem useful for a future monitoring.

The need for a further annotated and illustrated glossary

An important part of the study methodology that was provided as an annex to the questionnaires and templates used in this project was a detailed glossary of terms used. For many of the core terms, however, a common (English) language to talk about changes in social services in a comparative perspective is only emerging.

From the replies received by the country experts and in the framework of the stakeholder enquiry it became clear that different organisations and their representatives as well as researchers still have a different understanding of concepts (e.g. of "general interest" or "quality") and technical terms (e.g. of "quasi market", "delegation", "concession", "public-private partnership"). This is partly attributable to the fact that concepts and terms are used in different ways in a given national context compared to their prevailing or dominant meaning in Community law or interpretation by European institutions.

If a monitoring of direct and indirect impacts of Community law and of Community policy on the organisation, regulation, provision, financing and evaluation of social services within Member States is to be continued, some categories used in the study (e.g. "tendering") will even need to be refined to better grasp the

diversity of national ways of implementation and thereby to more exactly understand potential and actual consequences.

As a consequence and to avoid confusion and misinterpretations, a future monitoring tool should be accompanied by detailed explanations of all technical terms. This can build on the glossary used under this study, which itself builds on a number of European Community documents, such as the definitions used for the questionnaires of the SPC enquiries of 2004 and 2006. It also seems recommendable to complement this in the future with more illustrations for a number of categories (e.g. "public authorities at local level") of the "variables" used (e.g. "competent public authority" or "competitive regulation") and this should be based on examples from different countries.

5 Assessing input, outputs and outcomes of social services comprehensively

One of the most challenging issues in this context is to measure the satisfaction of needs and expectations by (actual and potential) users, but also the availability of services provided, and to look at outcomes for the users/beneficiaries and the citizens in general. Considering the importance of having objective facts and elements in order to analyse the impact of EU law and of processes of modernisation of social protection schemes on the organisation, regulation, financing, provision and evaluation of social services, it is important to devote time and resources to conduct evaluations and impact assessment studies that take into account all parties and stakeholders associated and concerned in this respect.

Assessment criteria ideally need to be cross-referenced. E.g. a price criterion needs to be related to the nature and quality of the social service (access, reliability and continuity of provision, equality of treatment, etc.), to issues of user-orientation, to aspects of territorial coverage (rural versus urban environment) and to possible social clauses defined for the provision, not to speak of the contribution of the service to public policy objectives, i.e. positive externalities.

In the framework of this study it was not possible to establish comprehensive indicator frames for the eight countries covered, systems that would look on social services comprehensively, from access conditions in a legal and territorial dimension, to the affordability and co-payments by users, utilisation of services as well as persons on waiting lists. In most cases corresponding information systems are not yet in place in Member States, responsibility for such a system can be contentious, in particular where responsibility for social services has been decentralised.

These systems are of key importance to more adequately assess the actual situation for regulatory bodies, providers and users of social services. This would also imply focus on sample measures/policy programmes such as home-help services, crèches, flats from the social housing stock for which qualitative indicators as illustrated above would be of added value. E.g. the Czech country report indicates, (in the section on "long-term care services"), that data about facilities enabling care for persons with dementia are available. However, this is not the case for shortages. This lack, however, should be "healed" with the implementation of the Social Services Act coming into force on 1 January 2007 which requires the regions to formulate

intermediate social services, development plans based on the monitoring of the service quality (also taking into account the needs of users based on participatory processes) which also will require information on shortages.

6 *Impact assessment of Community Law on social services is still very challenging*

One of the difficulties encountered in the present study was to find real and already documented examples and illustrations showing how users, providers or public authorities are facing EU rules that are or should be applied in the organisation, provision and financing of social services (of general interest). Those illustrations were also sought to verify how to deal with uncertainties related to the application of EU rules, and how these have to be applied. There were several reasons behind this crucial difficulty:

Frequently, the question had not come up yet since in many cases, public authorities and providers on one side, but also users on the other side are not yet aware that EU legislation actually applies to social services. A deficit of knowledge and of communication has been noted throughout Member States and across sectors. The issues at stake are not easy to grasp for users and small providers. And a certain lack of interest or even indifference was perceived on the side of several stakeholders at national and regional level, who do not (yet) feel concerned.

The stakeholders and users have difficulties in understanding and implementing – if need be – the existing or forthcoming (in the short run) European legislation. The cases, conditions and thresholds to apply European legislation are, however, often unclear and two lines of behaviour can then be encountered:

One option public authorities might follow is to be on the safe side and to strictly copy EU legislation into national legislation (with sometimes remaining difficulties of understanding or remaining uncertainties) and then to refer to the national courts to clarify uncertainties or to settle arguments. But in the strict case of social services (distinct from health services), no actual European Court of Justice[150] case was found to illustrate the aspects studied in Part IV, since the European legislation is only starting to be applied in the field of social services, and complaints did not yet reach the stage of the European Court of Justice level.

The other option is to "stay behind" as long as possible, waiting for the first cases of litigation to be brought forward and then see how to act on a case by case logic. Both municipalities and providers may know that they do not fully respect or apply the legislation in some cases, but think that the matters under consideration are of relatively little importance and little economic counter-value that would not give rise to litigation procedures, since it would not be worthwhile.[151] Thus here especially, no official, documented or written statement exists in this respect.

[150] At national level, they exist; e.g. in Germany related to the application of procurement rules for services under the "Federal Social Assistance Act" (*Bundessozialhilfegesetz*). But to obtain information at the national level, special national studies would need to be realised in this respect.

[151] This exact same behavioural attitude has been encountered in other sectors of services of general economic interest, noticeably with respect to local services such as e.g. local public transportation or

Finally, in some cases, information does exist but only partially, orally and very often on a confidential basis. Some litigations (by users, by potential or actual competitors), questions and procedures on the side of the European Commission are under way, but the questions under discussion, the aspects of legislation and especially the arguments that are developed can not be disclosed.

Considering the above, a monitoring exercise related to the legal issues needs to be aware of those difficulties.

A second difficulty encountered during this fact-finding exercise was that the authors and experts associated to the study have been faced with a lack of mid- and long-term oriented evaluation of implementing new procedures. Those new procedures may follow either national (regional) political decisions or can be consequences of transpositions of EU law into national legislation. It seems indeed too early to have such studies at disposal, since the transposition and implementation process is only starting.

Further, no real assessments have been made of relevant legislative changes at the European level, which are only slowly applied in Member States. Based on this observation, there is a real need to assess the impact of what will still be legally admissible at the national level in the future in terms of subsidiarity, notably in funding and financing aspects.

Whatever the drivers – either modernisation and specific modes of organisation, provision or financing, or the evolution of EU legislation –, the overall macro- and micro-economic consequences of new processes need to be assessed from various points of view: users (availability, accessibility, quality, user-friendliness, overall total cost, relative situation compared to the other citizens, etc.), providers (quality, employment conditions, coverage, price, etc.), public authorities (public finances, complexity, transaction costs, control, etc.) and other stakeholders (including civil society and local communities).

This would be particularly true with respect to public procurement. Only little experience exists regarding the outcome of contracting out social services according to the EU public procurement rules. In particular the evaluation of the service outcomes (in terms of quality, of service characteristics and availability, of user-friendliness, also for the families and relatives of the persons concerned and direct beneficiaries of the services) and of the consequences on employment conditions is missing. Before making new legislative steps that could encompass all types of social services, it seems important to realise ex ante the impact of subsidies on the consequences of a generalisation of public procurement procedures to all social services.

As mentioned, several legal aspects need to be studied more deeply, but this is rather a side-exercise than a part of the monitoring exercise. However, other aspects at the intersection of legal, economic and social issues should be reviewed. This could

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waste collection. After several litigation procedures and Court cases coming up successively in various countries and different legal settings, public authorities and providers became aware of the necessity to look further into these implementation problems. Then, either they strictly applied the EU rules or they started lobbying with a view to modify the existing rules. This was clearly the process that followed the *Altmark Trans* and *Ferring* cases and that finally resulted in the adoption of the "Monti-Kroes"

be the case for transaction costs entailed by new organisation and provision features of social and health services of general (economic) interest. This rather technical issue is insufficiently addressed by literature with respect to new provision modes of social services.

Besides, there are other challenges – at the edge of law and economics – that are probably more important in the field of social services, such as the sustainability of the funding and financing mechanisms of such essential services for the economic growth and well-being of society, as well as the quality of service provisions for the user and citizen. Here again, it appears that literature and impact assessment are lacking in addressing such issues and challenges for the future.

7 Strategies to improve sector specific information

Long-term care services

As a cross-cutting policy issue, responsibility for care for older persons is often shared between different administrations (e.g. Ministries) and levels of governments and the main responsibility for care provision and organisation is frequently with the regional or local level. As a consequence, .existing data from administrative sources, such as numbers of "places" in institutions often provide a partial view, only. "Care" itself can to varying degrees be integrated with other service provision and many persons with care needs may not receive the appropriate type or mix of services, mainly because of shortages of appropriate service infrastructure and due to limited public budgets for funding long-term care services. For example, care may be provided in long-stay hospitals instead of nursing home care; or care is provided in a nursing home, where care could also be provided in the community

This section discusses the current state of long-term care data and makes suggestions on how data availability needs to be improved in this difficult area of study.

Data on care needs and informal care by family and friends

For the overall assessment of care needs, data are needed on overall demographic and disability trends of older persons (trends in ADL and IADL functional limitations, cf. glossary). This includes basic information needed to understand how functional limitations lead to care needs: family and other aspects of living situation, such as housing and aspects of urban (or rural) environment, accessibility to public transport, social events, and the like.

An increasing number are countries is including this kind of information now in occasional or ad-hoc modules of population surveys, and it would be worth collecting these systematically as starting point for a regular monitoring of EU comparisons of family care in particular, where national data should ideally be comparable over time, with surveys every three to five years.

These surveys have often been conducted as complementary modules to existing micro-census or special population health surveys. These surveys provide important information, in particular if they are linked to large-scale surveys such as a micro-census. Survey modules with questions on health problems of older persons and on informal care are less useful if linked to special household or general population health surveys that have small sample sizes (in the per mille rather than the percentage range).

If the design of these surveys does not systematically over-sample households in the older population, or households with frail elderly, the sample will typically contain too few cases for the calculation of meaningful indicators for monitoring over time. The "trend" changes revealed over time are usually much smaller than the confidence intervals for the indicator in question.

For this reason, it is doubtful that the specific questions on (informal) care obligations, and on income from care allowances and the like, that are part of the Common European Household Panel (ECHP) (now replaced by SILC) can provide data for monitoring trends or for comparing countries.

It remains to be further studied to which extent the modules of the new European Health Survey System (EHSS), such as the special five-year modules EHSM and EDM on health and disability, can provide information that will be better suited for the construction of indicators. Moreover, first results from the new European SHARE project will need further analysis to find out to which degree these can contribute to monitor trends in disability and care for older persons.

Indicators for expenditure and financing

The public-private mix of funding and of care provision needs special consideration in the collection of care indicators because the majority of care is in all countries still provided by informal (unpaid) cargivers. Moreover, information on both public and private expenditure is crucial to monitor the financial burden on households that in many cases can be substantial, in particular where access to public long-term care programmes is means-tested or where substantial cost-sharing by households is required, e.g. to cover board and lodging in nursing homes.

Information on expenditure and financing exists on the programme level, and in aggregate form from public sector accounts, health accounts, and other (social) expenditure accounts. There are currently at least two international accounting frameworks that cover (public) long-term care spending. This section will argue that these need further harmonisation both in the ways they are applied for national data collection and international reporting, and to make them more compatible among each other. Moreover, there is the issue of better linking these to the detailed regulatory information on long-term care programmes that is available from the MISSOC database.

In ESSPROS, all expenditure on long-term care under public social programmes should be covered. However, there is no separate functional category for long-term care available under the ESSPROS functional classification of social expenditure.

Expenditure on long-term care in ESSPROS is conceptually split between the "Old age" and the "Disability" category. In principle, the reporting on expenditure on long-term care should be split between these categories following an age breakdown. Long-term care as a social programme, however, is usually granted to the whole population irrespective of age. Countries differ in their accounting practice on how to tackle this challenge. Programmes can be allocated as a whole to either of the two functions, be split between (only few countries do so), or be put under some "other" category (the worst case).

"Long-term care" is also one of the expenditure categories in the joint data collection by Eurostat-OECD-WHO on health accounts. This data collection is based on the OECD manual "A System of Health Accounts" (SHA) that has also been adopted as reference standard by WHO and the World Bank. It should be noted that not all social services for long-term care recipients are included in the definitions of the SHA-ICHA framework and that countries differ in their accounting practice, pending an agreement on where to draw the boundary between long-term care services and other social services. There are currently complex issues of potential overlap and therefore of incompatibilities in reporting between the two data systems, as has recently been illustrated in OECD, 2007. It is urgent that these issues are now also addressed at European level, now that the SHA framework is increasingly used in parallel to the ESSPROS data collection.

Finally, it would in general be highly desirable to report separately on cash benefits for disabled persons with long-term care needs, both in order to harmonise reporting with ESSPROS but also because information on these programmes, (that often entail broader choices for disabled persons and their familie), is important in itself.

Data on care recipients

A minimum set of indicators for data collection on long-term care services would follow a four-dimensional data model on recipients and comprises the following dimensions:

- **Setting in which care is received**: care received at home versus care received as (permanent) resident of an institution;
- Main source of funding of the programme paying for the services: **public versus private**;
- **Age of recipient**: below 65 versus 65+ (for time series information); and the more detailed breakdown for selected years: below 65; 5-year age groups for 65 and older; with a recommended minimum breakdown of at least the following groups: under 65; 65 to 80; 80+;
- **Gender**.

Establishing a regular international data collection on these items has recently been put on the agenda of the OECD Health Division and been discussed in the context of the OECD Health Data statistical data collection. It remains to be seen to

which degree this will result in routinely available data in the future. Having this type of data on a regular basis would allow for the calculation of several derived care indicators, such as the number of care recipients living in the community (as expressed ratio per population aged 80+; or as share of all persons receiving formal care services. In case a more detailed breakdown of care recipients were available, the following indicators would support additional indicator domains proposed in the draft list of care indicators. Number of respite care places per population aged 80+) Number of services, event of counselling on care for family cares (and of other volunteers).

Services for drug addicts

As Chapter 5 of this study has argued, services for drug addicts work across the health and social sector, and the criminal system. They deal with complex inclusion and exclusion problems. Their national and local structures and their aims and targets differ strongly, since they are shaped by culturally determined definitions of dependence and addiction problems, and adequate responses towards them. It is for these reasons that comprehensive documentation and information on services for drug addicts currently is fragmented, with many gaps. Moreover, concepts used in reporting still differ widely corresponding to the "problem definitions" of drug addiction and illegal drugs in individual countries.

In the sub-study carried out in six European cities for the present project, these differences were of main interest. The summary tables put together on the basis of the data collected along common guidelines can be considered as a first attempt to develop response/ service profiles on local/ city level and to discuss their (culturally determined) differences along them but also to understand what they might have in common. This sub-study confirms that especially with complex services it might be of advantage to carry out qualitative studies on a local level and that these should complement any aggregate data on the national level. The methodology of the city-studies developed under this project is a novel way of contributing to establishing these essential links between different types of information and quantifications.

Childcare services

The present study shed light on the organisation and the modernisation trends in the childcare sector as one service of general interest. Overall, the childcare sector can be described as a sector where the harmonisation of comparable figures and data across Europe has only started. For example, in terms of age groups, only fragmented information is currently available on the afternoon-care of school-aged children. Moreover, data on the expenditure on childcare is usually only available for the age-group 0 to 6 years. A breakdown by the major age-groups (0-2, 3-5, 6-14 years) would be an important advancement.

But even for the relatively well-documented age group of children below 6 years of age, more harmonisation efforts are needed, even for basic indicators like enrolment rates or opening hours. For enrolment rates, standardised data collection in the future should be based on harmonised definitions including on individual

childcare services, e.g. in family crèches or by childminders, as this is currently underreported in many countries.

Concerning opening hours, comparable information is only roughly available for several types of facilities (e.g. overall full-time vs. half-time distinction) but not on the exact distribution and the number of children affected. Furthermore, comparable empirical information on quality standards is lacking. This should be available for at least some basic indicators of effective structural quality (e.g. maximum group size, number of children per educator, education level of staff, etc.). In this sense, valuable efforts of collecting comparable data by Eurostat and the OECD should be continued and extended, but also harmonised among each other, as they are partly based on different concepts and definitions.

As a special feature, a European wide parental survey on the need for childcare places could be carried out, possibly integrated into the labour force survey, as the need for childcare facilities is difficult to estimate and subject to controversial debates in the single countries. This could lead to an objectification of the debate on the one hand and bring interesting insights on what developments are needed in the future on the other hand.

Concerning the focus of this study, the organisation, diversification and modernisation of services, a follow-up study could be carried out which examines the relevant developments in those European countries not covered by the in-depth analysis in this study. For the countries already covered, a monitoring of further developments would bring additional information, especially when it comes to the question of the influence of and conflicts with the European Union legal and political context – a topic, which seems to receive only scant attention by stakeholders responsible for the childcare sector.

Labour market services for disadvantaged people

For an evaluation of the effectiveness of the labour market services, it is essential to have a database that reports on services offered, initial attributes of the beneficiaries, and outcomes attained. It is also vital to ascertain the quality of services offered and the response of the beneficiaries. Policy evaluations based on reliable data of this sort should then feed into different policy making and policy implementing bodies. In the majority of countries, such information is readily available in the administrative registers, although they are either not accessible to researchers or there is a lack of commissioning of research into this area.

An EU-wide comparative database, arising out of administrative registers, will go a long way towards identifying good practices and in coordinating cross-national cooperation. Specific national studies should be commissioned, so as to study in-depth issues of relevance for the country in question. The EU-wide databases that are already in existence, such as the Labour Force Survey and SHARE, do not have enough information on labour market services offered (and their possible outcomes). Specialised modules on provision of services and their effectiveness in these surveys will provide greater insights into how best to design and implement effective labour market policies.

8 The role of case vignettes

In the context of the difficult data situation for social services, described in Part VI, the purpose of the case vignette is to analyse in more detail how certain specific needs are dealt with in the framework of given institutional contexts, eligibility for schemes, entitlements for benefits, bringing in the user's perspective and her/his options of choice (of providers, service packages, service quality, etc.). They illustrate well everyday practices of service organisation, provision and financing, and allow the analyses of social services from an user's perspective.

9 Summary conclusions on a future monitoring tool

Working on the study and having obtained feedback from experts from inside and outside it became evident that the main dimensions and aspects of social services of general interest covered correspond to the crucial ones. It is therefore recommended to also take them on board when setting up a monitoring tool. Implementing it at Community level and covering a broad range of Member States (if not all of them for selected aspects), implies the need to focus on a limited range of issues and of quantitative as well as qualitative indicators in an endeavour to reduce complexities inherent to the object of interest, the organisation, regulation, provision, financing and evaluation of social services of general interest.

In designing the questionnaires for both the in-depth country studies and the stakeholder enquiry many of the aspects and categories used to learn more on processes, modalities and instruments related to the process of modernising social services mainly build on information provided and categories reported by the 25 Member States in the 2004 enquiry of the Social Protection Committee (see Chapter 3.3). Their usability and appropriateness have been tested and could to a considerable extent be validated at the instrumental level by this study.

How to improve information on social services for a European exchange?

The task of defining the functions of social services and to monitor these separately has become increasingly difficult because of modernisation trends that aim at improving services by better integration of services, especially across the health versus social boundary. But where functional categories are used, such as in social and health accounting and in descriptive systems like MISSOC, these should be as much as possible consistent with each other.

But there are limits of (semi-) aggregate statistics on social services that can only be overcome if population surveys become more routinely available that cover social issues, such as on the situation of older persons with care needs and their families.

The main challenge for the future will be to avoid resources that are invested in "insular" data collections on some aspects or sub-sectors of social services without a certain consistency and common frame of definitions. Further developing and refining existing international definitions and statistical standards should always be considered first, before new, and often incompatible frameworks are invented.

Investment on the EU level in better information and monitoring systems could create strong incentives to overcome data gaps and fragmentation of information on social services that currently prevail on national level and limit the capacities of policies in Member States to monitor and steer the modernisation process consistently across various government levels.

Finally, the periodicity of the exercise also needs to be carefully thought of. Any evaluation process takes time, essentially if a broad range of stakeholders at national and Community level will to be involved in the process. Considering that the bulk of personal social and health services are rendered at the local level, the local players via their umbrella organisations at national level, should also have their say in the process. Information in quantitative form should be embedded in, and linked to qualitative indicators on structural changes and policies, and terminology (such as that used in the glossary of this study) should be further developed towards a common language in which social services can be analysed in Europe.

Annexes

Table of Contents

Annex I. References

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Annex II. Acronyms

ADL	Activities of daily living
CECOHAS	European Liaison Committee for Social Housing [French (acronym builds on): Comité Européen de Coordination de l'Habitat Social]
CEEP	European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interest [French (acronym builds on): Centre Européen des Entreprises à Participation publique et des entreprises d'intérêt économique général]
CEPCMAF	European Standing Conference of Co-operatives, Mutual Societies, Associations and Foundations [French (acronym builds on): Conférence Européenne Permanente des Coopératives, Mutualités, Associations et Fondations]
CFI	Court of First Instance of the European Communities
CIRIEC	International Center of Research and Information on the Public, Social and Cooperative Economy [French (acronym builds on): Centre International de Recherches et d'Information sur l'Economie Publique, Sociale et Coopérative]
CSCI	Commission for Social Care Inspection (United Kingdom)
ECJ	European Court of Justice
ECJ	European Court of Justice of the European Communities
EFQM	European Foundation for Quality Management
ESA	European System of National and Regional Accounts
ESF	European Social Fund
ETUC	European Trade Union Confederation
EU	European Union
GDP	Gross domestic product
IADL	Instrumental activities of daily living
ILO	International Labor Organisation
IMK	Innenministerkonferenz (Germany) (Standing Committee of Ministers of the Interior at federal and regional, i.e. state (Bundesländer) level
ISO	International Organisation of Standardisation
IT	Information technology
LFS	Labour Force Surveys
LTC	Long-term care
MS	Member States of the European Union
NAPincl	National Action Plans for Social Inclusion
NGO	Non-governmental organisation

OECD Organisation for Economic Cooperation and Development
OMC Open Method of Coordination

PPP(s) Public-private partnership(s)

QM Quality management

SGI Services of General Interest
SHSGI Social and Health Services of General Interest
SME Small or medium(-sized) enterprise
SPC Social Protection Committee (cf. http://ec.europa.eu/employment_social/social_protection_commitee/index_en.htm)
SSGI Social services of General Interest

TQM Total quality management

VAT Value added tax

WHO World Health Organisation

Annex III. Glossary and terminology used

This Annex brings together a number of terms used in the study on SHSGI in the European Union. Terminology in social policy and social services can vary widely between countries. The following set of definitions represents an important step on the way towards a more comprehensive and widely useable set of common definitions that apply to the situation of EU countries with different institutional and organisational settings.

The following table also lists key terms used in the project-related methodological documents or which are of major importance when drafting country and final report in order to facilitate the usage of a common terminology. The second column comprises a definition or explanation. In most cases the source(s) and/or further references are indicated and if available online the respective links are inserted for more detailed information. Major sources of terms are the websites of European Union institutions, documents of these institutions, especially of the European Commission, but also studies and publications of the project partners.

Activities of daily living	Activities of daily living are self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the toilet, and controlling bladder and bowel. *Source:* *OECD (2005) Long-term care for older people, Paris.*
Altmark Trans ruling (ECJ)	ECJ ruling to the effect that financial support that represents compensation for public service obligations defined by a MS does not constitute state aid. As part of this ruling, the ECJ also further developed the substantive test for assessing when state funding of public services does go beyond compensation and then falls under EC state aid rules (in the scope of Article 87 of the EC Treaty). The new test appears to be far stricter than that under earlier jurisprudence. These are further detailed in the (→) state aid package (adopted 13 July 2005, published 29 November 2005), also referred to as "Monti package". *Source:* *http://www.lw.com/resource/publications/_pdf/pub892_1.pdf*

Antitrust rules	Field of competition law and policy. In the EU context, both the rules governing anti-competitive agreements and practices (cartels and other forms of collusion) based on Article 81 of the EC Treaty and the rules prohibiting abuses of (existing) dominant positions based on Article 82 of the EC Treaty are commonly referred to as antitrust. *Source:* http://ec.europa.eu/comm/competition/general_info/glossary_en.html
Authorisation regime	Authorisation regimes are procedures set up by public authorities to regulate service providers to ensure the particular general interest service that this provider will be entrusted with meets certain conditions (e.g. quality standards and financial rules).
Contracting out	A form of (→) Outsourcing
Court of First Instance of the European Communities	The Court of First Instance of the European Communities (CFI) was set up in 1989 to strengthen the protection of individuals' interests by introducing a second tier of judicial authority, allowing the Court of Justice of the European Communities to concentrate on its basic task of ensuring the uniform interpretation and application of Community law. *Source*: http://europa.eu.int/scadplus/glossary/eu_court_first_instance_en.htm
Court of Justice of the European Communities	The ECJ has two principal functions: to check whether instruments of the European institutions and of governments are compatible with the Treaties; to give rulings, at the request of a national court, on the interpretation or the validity of provisions contained in Community law. The Court is assisted by the (→) Court of First Instance of the European Communities (CFI). *Source*: http://europa.eu.int/scadplus/glossary/eu_court_justice_en.htm
Delegation	In this study, this refers to a transfer of a task (such as the provision of a range of social services) for which public authorities principally have the responsible to organise or to guarantee its fulfilment (in case of services: its provision) to an external partner, either a private for-profit or a not-for-profit organisation (see also → outsourcing). *Source*: http://ec.europa.eu/employment_social/social_protection/docs/com_2006_177_en.pdf

Economic activity	Any activity consisting of supplying goods and service in a given market by an (→ undertaking), regardless of the legal status of the undertaking and the way in which it is financed. It is widely recognised that almost all services offered in the social field can be considered "economic activities" within the meaning of Article 43 and 49 of the EC Treaty. *Source*: *http://ec.europa.eu/employment_social/social_protection/docs/com_2006_177_en.pdf*
EFQM Excellence Model	The European Foundation for Quality Management created the EFQM Excellence Model, which is the application of the fundamental concepts reflected in a structured management system: "Truly Excellent organisations are those that strive to satisfy their stakeholders by what they achieve, how they achieve it, what they are likely to achieve and the confidence they have that the results will be sustained in the future." The Model additionally provides organisations that are using it with a common management language and tool, thus facilitating the sharing of 'good practice' across different sectors. *Source*: *http://www.efqm.org*
Eligibility	Set of criteria defining the access condition(s) to a social protection scheme.
Entitlement	Individual right of a person to be beneficiary of a specific programme (including services) provided under a social protection scheme.
Entrustment	Transfer of responsibility for operation of a service of general (economic) interest to an undertaking concerned by way of one or more official acts, the form of which may be determined by each Member State.

European Social Fund	The ESF is one of the EU's four Structural Funds, which were set up to reduce differences in prosperity and living standards, usually referred to as 'promoting economic and social cohesion'. The European Social Fund is the EU's main source of financial support for efforts to develop employability and human resources. It helps Member States combat unemployment, prevent people from dropping out of the labour market, and promote training to make Europe's workforce better equipped to face new challenges (e.g. linked to the usage of IT). *Source*: *http://ec.europa.eu/employment_social/esf2000/introduction_en.html*
Formal long-term care services	Long-term care services supplied by the employees of any organisation, in either the public or private sector, including care provided in institutions like nursing homes, as well as care provided to persons living at home by either professionally trained care assistants, such as nurses, or untrained care assistants.
General interest mission	(→) Mission of general interest
Services of General Interest	This term refers to social (and health) services that are entrusted by a competent public authority with a (→) general interest mission of a social or health nature and that are supported or subsidised by a public authority. They are designed to ensure certain objectives such as high levels of social protection, employment and equality. They usually encompass security schemes, be they statutory or complementary, covering risks such as ageing, retirement and disability, accidents at work or unemployment. In principle, health services are also part. SSGI also include a number of other services directly delivered to persons (also sometimes called "proximity" services such as child care and long term care, but also services supporting families and people in need) and playing a preventive or social cohesion role, such as preventing of or dealing with the consequences of poverty, debt and unemployment, of drug addiction and private life tragedies. Occupational training, language training for immigrants and social housing, for instance, are all social services of general interest. They are frequently provided on a non-profit basis and the service provider is often close to the beneficiary. *Source*: *http://europa.eu/scadplus/glossary/general_interest_services_en.htm*

Home care (in the community)	This term refers to long-term care services that are provided to patients at home or in the community. This includes day-care and respite services and the like. Includes long-term care received in home-like settings, such as assisted living facilities, although statistical systems are in many cases not able to identify these. *Source:* *OECD Long-term care study*
Informal care	Informal care is the care provided by unpaid informal care-givers (also called informal carers) such as spouses/partners, other members of the household and other relatives, friends, neighbours and others, usually but not necessarily with an already existing social relationship with the person to whom they provide care. Informal care is usually provided in the home and is typically unpaid. *Source: OECD Long-term care study*
In house	EU law on (→) public procurement applies when a contracting body entrusts a task to a third party, unless the relation between the two is so close that the latter is equivalent to a so-called "in-house" entity. According to the "Stadt Halle" jurisprudence of the ECJ, the Public Procurement Directives apply whenever a contracting authority intends to conclude a contract with a company, the capital of which is at least partly held by private undertakings. *Source*: *http://ec.europa.eu/internal_market/publicprocurement/ppp_en.htm*
ISO 9000	ISO (International Organization for Standardization) is a global network that identifies what International Standards are required by business, government and society, develops them in partnership with the sectors that will put them to use, adopts them by transparent procedures based on national input and delivers them to be implemented worldwide. The ISO 9000 family is primarily concerned with "quality management". This means what the organization does to fulfil the customer's quality requirements and applicable regulatory requirements, while aiming at enhancing customer satisfaction and achieving continual improvement of its performance in pursuit of these objectives. *Sources:* *http://www.iso.org/iso/en/prods-services/otherpubs/pdf/isoinbrief_2005-en.pdf* http://www.iso.org/iso/en/iso9000-14000/index.html

ISO certification (sometimes also "registration")	In the context of ISO 9001:2000, "certification" refers to the issuing of a written assurance (the certificate) by an independent external body ("third party") that has audited an organisation's management system and verified that it conforms to the requirements specified in the standard. "Registration" means that the auditing body (a "third party" organisation) then records the certification in its client register. *Source:* *http://www.iso.org/iso/en/iso9000-14000/index.html*
Long-term care	This term refers to a range of services needed for persons who are dependent on help with basic ADL. This central personal care component is frequently provided in combination with help with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care. *Source:* *OECD Long-term care study*
Means testing	Means tests are as a rule applied to non-contributory tax-financed schemes. They refer to an investigative process undertaken to determine whether or not an individual or family is eligible to a specific social protection scheme (nomally they are used in social assistance schemes in the broadest sense only) and entitled to obtain a specific social benefit. The amount of the benefit may be differentiated according to the level of need or financial neediness. The means test can consist of quantifying a person's income (from employment, from rent and lease, etc.) or his/her assets or a combination of both.

Mission of general interest	This term refers to a set of explicitly stated, or regulated obligations defined for (→) services of general interest which comprise i.a. the following elements: accessibility, availability, universality, territorial coverage, continuity, affordability, quality, user protection and transparency. The explicit statement or regulation of missions of general interest is particularly important for those social services that fall under the competition rules. Only where the missions of these services have been clearly identified by the public authorities, certain derogations from competition rules can be allowed in order for the missions to be fulfilled. *Sources*: *http://europa.eu/eur-lex/en/com/gpr/2003/com2003_0270en01.pdf* *(Green Paper SGI)* *http://ec.europa.eu/employment_social/social_protection/docs/sec_2006_516_en.pdf*
Monti package	(See →) Altmark Trans ruling (ECJ)
National Action Plans for Social Inclusion	Member States co-ordinate their policies for combating poverty and social exclusion on the basis of a process of policy exchanges and mutual learning in the framework of the OMC on social inclusion. It covers a two years period and outlines MS' priorities within the framework of overall objectives. NAP also comprise a statistical annex with common and country-specific indicators and a certain number of good practice examples. They are assessed by the Commission and flow into a Joint Report on Social Inclusion. These reports assess progress made in the implementation of the OMC, set key priorities and identify good practice and innovative approaches of common interest to the Member States. *Source*: *http://ec.europa.eu/employment_social/social_inclusion/jrep_en.htm*

Non-profit	Non-profit institutions and organisations are defined as legal or social entities created for the purpose of producing goods and services whose status does not permit them to be a source of income, profit or other financial gains for the units that establish, control or finance them. They mainly produce and supply non-market output for individual/household consumption and take their resources mainly from voluntary contributions made by individuals and households as consumers, but also from donations, grants, in-kind resources from voluntary work and income from property in some cases. *Sources*: *John Hopkins Comparative Non-Profit Sector Project (JHCNSP)* *European System of National and Regional Accounts (ESA 95, § 2-87 & 3-31 (+ sector S 70))*
Open Method of Coordination	Under the open method of coordination, MS agree on broad policy goals. Member States in various fields of social protection and social inclusion polices, which may then be translated into guidelines for national and regional policies, such as on the basis of National Strategy Reports or National Action Plans. Moreover, specific benchmarks and indicators to measure good practice may be agreed upon and results be monitored, evaluated and published by European Commission services. The OMC uses a decentralised approach largely implemented by the Member States. In the field of social protection, the OMC is currently applied to the policy fields employment (in the framework of the Eruopean Employment Strategy), social inclusion, pensions, health and long-term care. Work for these three processes (social inclusion, pensions and health and long-term care) will be drawn togehter to one process (streamlining) starting in 2007. *Sources*: *http://ec.europa.eu/employment_social/social_inclusion/index_en.htm*

Outsourcing	Outsourcing (or contracting out) is often defined as the delegation of non-core operations or jobs from internal production within a business to an external entity (such as a subcontractor) that specializes in that operation. Outsourcing is a business decision that is often made to lower costs or focus on competencies. Transfer of a service to a third party, entailing new regulation and possibly more complex supervision processes (and thus transaction costs) since the service is no longer done "in house" anymore, i.e. in the institution or by personnel of the institution which has provided it until now. In the field of social and health services outsourcing refers to transferring to market-based service providers mainly “accessory services", e.g. catering and laundry in case of a hospital or more generally accounting works. It allows the social service providers to focus on their core activities, namely the social personal/individual relationships in the service delivery, and not "loose" time with administrative or tasks "external" to their social role.
Principle of affordability	Services of general economic interest must be offered at an affordable price (that does, for example, not exceed X % of a household's gross income; or that can be paid by Y % of the population) so that it will be accessible for everyone. Affordability is strongly linked to fair, justifiable and transparent prices. *Sources*: *CIRIEC, "Contribution of Services of General Interest to Economic, Social and Territorial Cohesion", report for the European Commission – DG Regio, March 2004*
Principle of continuity	This principle implies that services of general interest must be provided in a continuous and regular way - but also in secure conditions -, without interruption. Cases of “force majeure” or exceptions inducing irregular functioning or interruption of service must be kept to a minimum. *Source*: *CIRIEC-ETUC-CEEP former studies*

Principle of equal treatment	In delegating a social (→) mission of general interest to an external organisation, public authorities need not only to comply with Community competition, public procurement and internal market rules to the extent that they apply, but also with the relevant principles of the Treaty, such as the freedom of establishment, freedom to provide services, equal treatment, non-discrimination, proportionality and transparency. The principle of equal treatment requires that all Community undertakings should be able to bid for services under the same conditions. The conditions and criteria must be objective and applied in a transparent and non-discriminatory manner. *Source*: *http://ec.europa.eu/employment_social/social_protection/docs/sec_2006_516_en.pdf*
Principle of non discrimination	The aim of non discrimination is to ensure equality of treatment for individuals irrespective of nationality, sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation. *Source*: *http://europa.eu.int/scadplus/glossary/index_en.htm*
Principle of proportionality	The principle of proportionality is a political maxim which states that any layer of government should not take any action that exceeds that which is necessary to achieve the objective of government. It is a fundamental principle of European Union law. According to this principle, the EU may only act to the extent that is needed to achieve its objectives. *Source*: *http://europa.eu.int/scadplus/glossary/index_en.htm*
Principle of universality	Requirement for services of general interest to be available of a specified quality to all consumers and users throughout the territory of a Member State, independently of geographical location, and usual at an affordable price. See also (→) universal service. *Source*: *CIRIEC, "Contribution of Services of General Interest to Economic, Social and Territorial Cohesion", report for the European Commission – DG Regio, March 2004*

Provider of a service of social and/or health service of general interest	Any entity or organisation (of private or public law status) directly or implicitly entrusted with the mission of providing a general interest service in the field of social and health services, or any public, mixed or non-profit entity or organisation set up by the competent authority of a Member State to satisfy general interest needs of a social or sanitary/health character.
Public-private partnership	Public-private partnerships (PPPs) are forms of cooperation between public authorities and private enterprises (including non-profit organsiations), with the aim of carrying out infrastructure projects or providing services for the public. PPP are usually jointly planned, financed and implemented. *Source:* *http://ec.europa.eu/internal_market/publicprocurement/ppp_en.htm*
Public procurement	This term refers to the purchases of goods, services and public works by governments and public utilities following an open tendering (or awarding) procedure to collect several offers from providers willing to produce those goods, services and works at a certain price and according to certain conditions and specifications. At EU level, the main legal instrument relevant for social services is the Directive 2004/18/EU of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts (30.04.2004). *Reference*: *http://europa.eu.int/eur-lex/pri/en/oj/dat/2004/l_134/l_13420040430en01140240.pdf* *http://ec.europa.eu/internal_market/publicprocurement/key-docs_en.htm*
Public service obligation	Public service obligations refer to concrete requirements for a service provision deduced from a more general mission of general interest. In cases where public authorities do not carry out the services themselves and consider that fulfilling of the mission of general interest requires the provision of certain services and the general market for services may not result in that provision, they can lay down a number of specific service provisions to meet these needs in the form of service of general interest obligations. *Source*: *http://ec.europa.eu/employment_social/social_protection/docs/sec_2006_516_en.pdf*

Respite care	Respite care is a short-term care arrangement with the primary purpose of giving the carer a short-term break from their usual care commitments. *Source: OECD (2005) Long-term care for older people, Paris.*

Services of general economic interest	This term refers to services of an economic nature that have been entrusted with specific public service obligations by virtue of a (→) general interest mission. The concept of services of general economic interest covers in particular certain services provided by the big network industries such as transport, postal services, energy and communications, but also extends to a broad range of social and health services. *Sources*: *http://europa.eu/scadplus/glossary/services_general_economic_interest_en.htm* *http://europa.eu/eur-lex/en/com/gpr/2003/com2003_0270en01.pdf* *(Green Paper SGI)*
Services of general interest	This term is broader than the term "services of general economic interest", which is used in the Treaty, art. 16 and 86(2). It covers both market and non-market services which the public authorities class as being of general interest and subject to specific public service obligations *Source:* *http://europa.eu/eur-lex/en/com/gpr/2003/com2003_0270en01.pdf* *(Green Paper SGI)*
Social and health services of general interest	This term refers to social (and health) services that are entrusted by a competent public authority with a (→) general interest mission of a social or health nature and that are supported or subsidised by a public authority. They are designed to ensure certain objectives such as high levels of social protection, employment and equality. They usually encompass security schemes, be they statutory or complementary, covering risks such as ageing, retirement and disability, accidents at work or unemployment. In principle, health services are also part. SSGI also include a number of other services directly delivered to persons (also sometimes called "proximity" services such as child care and long term care, but also services supporting families and people in need) and playing a preventive or social cohesion role, such as preventing of or dealing with the consequences of poverty, debt and unemployment, of drug addiction and private life tragedies. Occupational training, language training for immigrants and social housing, for instance, are all social services of general interest. They are frequently provided on a non-profit basis and the service provider is often close to the beneficiary. *Source:* *Communication from the Commission "Implementing the Community Lisbon programme: Social services of general interest in the European Union", 26.04.2006 COM(2006)177 final*

	http://ec.europa.eu/employment_social/social_protection/docs/com_2006_177_en.pdf
Social economy	This term refers to a wide range of private (→) non-profit organisations that, besides providing social services, pursue other democratic and participative values. The legal form of these organisations and enterprises differs from one country to another, but they often take the form of Cooperatives, Mutual Societies, Associations and Foundations. "Third Sector" is often used as a Synonym. *Reference:* *European Standing Conference of Co-operatives, Mutual Societies, Associations and Foundations www.cepcmaf.org)*
Social services	There is no single definition of social services. The understanding of this term varies across countries and depends on the focus of interest (research; policy development; preparation of legislative steps at EU level, etc.) For the purpose of this study, this term refers to the following list of items developed by the European Commission in the framework of preparing its Communication on social services of general interest as well as in the document itself. Some of these fields go beyond "social protection" in the narrow sense. - Statutory social protection schemes; - Supplementary social protection schemes: income protection; - Health and social care services; - Support for families: child care; - Services to promote social integration and to support people in difficulties (e.g. homelessness, drug dependence, disability, mental or physical illness); - Social housing *Source*: *Communication from the Commission "Implementing the Community Lisbon programme: Social services of general interest in the European Union", 26.04.2006 COM(2006)177 final* *http://ec.europa.eu/employment_social/social_protection/docs/com_2006_177_en.pdf, p. 4-5*
Social services of general interest	(See → Social services and → Social and health services of general interest
Sodemare ruling (ECJ)	ECJ ruling that a MS State may consider that, for the purpose of achieving the social objectives of its social assistance system, the scope of the agreements with the social security authorities has to be limited to private operators working on a non-profit basis.

	From this ECJ case law it can be inferred that the free movement principles do not preclude a Member State from demarcating the sphere of providers and suppliers in the context of its social protection system. However, it may not discriminate against them on the basis of nationality or place of establishment. *Source*: ECJ, 17 June 1997, *Sodemare e.a ./ Regione Lombardia* C-70/95 *(Rec._p._I-3395)* *http://ec.europa.eu/employment_social/soc-prot/disable/synt_en.pdf*
Staid aid package	=> Altmark Trans ruling (ECJ)
Subsidiarity principle	Principle whereby the Union does not take action (except in the areas which fall within its exclusive competence) unless it is more effective than action taken at national, regional or local level. It is closely bound up with the principles of (→) proportionality and necessity, which require that any action by the Union should not go beyond what is necessary to achieve the objectives of the Treaty. *Source*: *http://europa.eu/scadplus/glossary/subsidiarity_en.htm*
Territorial coverage	Extent to which a service provision is ensured throughout a given territory. It should thus be measured by the overall service availability in terms of coverage of the given territory (for example, the spatial density of equipments (e.g. hospitals or nursing homes) per square km or per density of population and in terms of possible price differentiation with respect to location (densely populated area versus sparsely populated area). *Source*: *CIRIEC, "Contribution of Services of General Interest to Economic, Social and Territorial Cohesion", report for the European Commission – DG Regio, March 2004* *http://www.ulg.ac.be/ciriec/intl_en/index.htm*
Transparency	The concept of transparency refers to the openness of the Community institutions and to their clear functioning. Transparency is linked to the citizens' demands for wider access to information and EU documents and for greater involvement in the decision-making process which would help foster a feeling of closeness to the Union. Ssource: http://europa.eu.int/scadplus/glossary/index_en.htm

Undertaking	For the purpose of EU antitrust law, any entity engaged in an economic activity that is an activity consisting in offering goods or services on a given market, regardless of its legal status (public or private, including not-for-profit) and the way in which it is financed, is considered an undertaking. To qualify, no intention to earn profits is required, nor are public bodies by definition excluded. *Source*: *http://ec.europa.eu/comm/competition/general_info/u_en.html#t62*
Universal service	The concept of universal service refers to a set of (→) general interest missions and requirements ensuring that certain services are made available at a specified quality to all consumers and users throughout the territory of a Member State, independently of geographical location, and, in the light of specific national conditions, at an affordable price. *Sources*: *http://europa.eu/scadplus/glossary/universal_service_en.htm* *http://europa.eu/eur-lex/en/com/gpr/2003/com2003_0270en01.pdf* *(Green Paper SGI)* *http://www.europarl.europa.eu/charter/pdf/text_en.pdf*

Annex IV. List of reports under the SHSGI project

1 SHSGI Policy papers

These are reports submitted under the SHSGI project to cover in-depth a range of transversal or sectoral topics.

Czischke, Darinka and Nikolova, Mariya (2007) Sector Report: Social Housing in Europe, European Social Housing Observatory at CECODHAS, *SHSGI Policy Paper No.1*, Brussels.

Herrmann, Peter (2007) Social and Health Services of General Interest A Wider Perspective, European Social, *SHSGI Policy Paper No.2*, Organisational and Science Consultancy (ESOSC), Aghabullogue (Ireland).

2 SHSGI Country studies

These are reports submitted to the SHSGI study by expert teams in charge of in-depth country studies for the following eight country cases

Potůček, Martin, Hanušová, Pavla, Kopecká, Petra and Schánĕl, Martin (2007) Czech Republic, SHSGI Country Studies, No.1, Praha

Richez-Battesti, Nadine, Priou, Johan and Petrella, Francesca (2007) France, SHSGI Country Studies, No.2

Schulz-Nieswandt, Frank, Sesselmeyer, Werner, Wölbert, Saskia, Meyer-Rigaud, Remi, Näthke, John F. und Toellner-Bauer, Ulrike (2007) Germany, SHSGI Country Studies, No.3

Kazepov, Yuri, da Roit, Barbara, Sabatinelli, Stefania, Arlotti, Marco and Barberis, Eduardo (2007) Italy, SHSGI Country Studies, No.4

Tjadens, Frits and Meinema, Thea (2007) Netherlands, SHSGI Country Studies, No.5

Balcerzak-Paradowska, Bozena, Golinowska, Stanisława and Krzyszkowski, Jerzy (2007) Poland, SHSGI Country Studies, No.6

Fröbel, Lisa, Jönsson, Per-Olof and Sundén, Eva (2007) Sweden, SHSGI Country Studies, No.7

Spear, Roger Garth, Wittenberg, Raphael, Aiken, Mike, Davey, Vanessa and Matosevic, Tihana (2007) United Kingdom, SHSGI Country Studies, No.8

Annex V. Research affiliates under the study

Experts covering transversal aspects of the study

Task Forces	Members
Country Studies	Manfred Huber, Mathias Maucher, Barbara Sak
Community Law	Bernd Schulte, Barbara Sak, Jan Moens
Modernisation	Bernard Enjolras, Mathias Maucher
Quality Assurance	Kai Leichsenring, Manfred Huber
Innovative Practice	Manfred Huber, Mathias Maucher, Barbara Sak
Stakeholder Dialogue	Peter Herrmann, Mathias Maucher

Experts on sectors of social services

Sector	Sectoral Advisers
Housing	Darinka Czischke, Mariya Nikolova
Disability	Michael Himmer
Alcohol and Drug Addiction	Irmgard Eisenbach-Stangl
Child care	Michael Fuchs
Long-term care	Manfred Huber

Main country experts

Country	Country Experts
Czech Republic (Praha)	Martin Potůček, Pavla Hanušová, Petra Kopecká, Martin Schánĕl
France (Marseille, Paris)	Nadine Richez-Battesti, Johan Priou, Francesca Petrella
Germany (Köln, Landau, Bochum)	Frank Schulz-Nieswandt, Werner Sesselmeyer, Saskia Wölbert, Remi Meyer-Rigaud, John F. Näthke, Ulrike Toellner-Bauer
Italy (Urbino)	Yuri Kazepov, Barbara da Roit, Stefania Sabatinelli, Marco Arlotti, Eduardo Barberis
Poland (Warszawa)	BoĬena Balcerzak-Paradowska, Stanisława Golinowska, Jerzy Krzyszkowski
Sweden (Östersund,Stockholm)	Lisa Fröbel, Per-Olof Jönsson, Eva Sundén
The Netherlands (Utrecht)	Frits Tjadens, Thea Meinema
UK (London, Milton Keynes)	Roger Garth Spear, Raphael Wittenberg, Mike Aiken, Vanessa Davey, Tihana Matosevic