ISSN 1831-2020

Biennial report on social services of general interest

European Commission

Biennial report on social services of general interest

European Commission
Directorate-General for Employment, Social Affairs and Equal Opportunities
Unit E.4

Manuscript completed in July 2008

Document drawn up on the basis of SEC(2008) 2179, final. Neither the European Commission nor any person acting on behalf of the Commission may be held responsible for the use that may be made of the information contained in this publication.

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Luxembourg: Office for Official Publications of the European Communities, 2008

ISBN 978-92-79-09111-7
DOI 10.2767/39904

Printed in Spain

PRINTED ON WHITE CHLORINE-FREE PAPER

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Executive summary

In line with the commitment of the Commission to establish a monitoring and dialogue tool on **social services of general interest (SSGIs)**, this first **Biennial Report (BR)** provides an overall picture of these services in the European Union. It covers the scope of these services, the situation in some relevant sectors, the way in which they adapt to evolving needs and face up to socioeconomic challenges, and the impact of these changes on the organisation, financing and provision of SSGIs in terms of the application of Community rules.

Overall, evidence presented in this BR confirms that the significance of SSGIs is growing in modern social policies and that SSGIs create opportunities for all within a framework of general access and solidarity. SSGIs therefore play a central role in the implementation of the **Renewed Social Agenda on opportunities, Access and Solidarity**[1]. The BR also confirms that the modernisation of these services primarily aims to secure the highest quality of services for all within financial and human resource constraints. While there are wide differences between the different sectors and the approaches in the Member States, there are common commitments and challenges across the EU. The BR confirms that there is a need, not to change the applicable Community rules, but to provide stakeholders in the SSGI field with practical guidance and support, and that the strategy put in place by the Commission has good results. Striking the right balance between ensuring financial sustainability and the commitment to provide quality services for all is emerging as a central issue for policy-makers at both national and EU levels.

The BR starts by restating the objectives pursued by SSGIs, which are reflected in the way these services are organised, financed and delivered. The BR highlights how crucial these services are in promoting an inclusive society and in enhancing the capacity of individuals to participate fully in society. The contribution of SSGIs to meeting fundamental EU objectives, including a high level of employment, social inclusion and economic growth, is confirmed and illustrated by the analysis in the BR.

SSGIs are an important delivery mechanism for social policies focusing on promoting opportunities for all. This requires, as highlighted in the renewed social agenda, access for everyone to social services, including health services, to help to bridge inequalities in starting points. By ensuring that all citizens can have access to the opportunities presented to them, SSGIs put into practice the principle of solidarity. The recent growth in demand for these services reflect deep-rooted trends in the European economies and societies resulting from demographic ageing, changes in gender roles and family structures as well as technological change and globalisation. An increasing number of people need efficient services that are adapted to diversified needs and choices.

[1] COM(2008) 412

Social and health services as major drivers of employment and social development …

Social and health services represent a major part of the EU economy, particularly in terms of employment, as most of them are labour-intensive. They have contributed significantly to job creation in the EU, especially among women and older workers. While workers in these services are generally better skilled, wage levels have declined relatively, and are now below the EU economy average and well below other non-market services. Working conditions are very demanding and job satisfaction is below that of other economic sectors. Part-time work is widespread, which could explain why the sector continues to attract workers. Not surprisingly, turnover is high, staff shortages are frequent, and the influx of workers from non-EU countries has increased.

In view of structural changes in European economies and societies and of an expected strong increase in the demand for some of these services, it is not clear whether human resource needs will be met in the future. This situation contributes to tensions and reinforces pressures on these services to reorganise.

… require major financial resources

Financial resources on social and health services account for around 9 % of EU GDP and seem to have increased over time. While the private share is slowly increasing, these funds mostly come from the public sector. This makes these services particularly sensitive to short-time financial constraints in public finances whereas service provision requires long-term stability to obtain quality in services and quality in work. Short-time financial constraints might also explain the incidence of temporary employment and pressure on working conditions. At the same time, financial constraints may explain the search for complementary financing and for increased efficiency which are two of the driving forces behind the modernisation of these services. As Member States are committed to providing services in line with the values of universality, equity, solidarity and quality in a period of increasing and diversifying demand, they will be looking for modern proactive welfare strategies to ensure effectiveness and efficiency of social spending. These policies, including promoting inclusive labour markets, prevention and rehabilitation, may require more funds initially, but should lead to cost-savings and improve quality of delivery in the longer term.

Trends in long-term care, labour market services for disadvantaged persons and childcare

The way in which adaptation and reorganisation of these services are taking place varies between Member States, which is reflected in differences in national institutional frameworks.

The adaptation process is influenced by the inner logic of each policy field and by socioeconomic factors that impact more on certain services than others. The BR looks at three sectors where the impact of socioeconomic factors is particularly strong: long-term care, labour market services for disadvantaged persons, and childcare. These three sectors also illustrate the contribution of SSGIs to employment growth in the EU. The BR analyses the role of these services in European societies, presents an overview of service provision and expenditure, and describes the modernisation process in these three sectors.

Long-term care systems have undergone major changes over the past decade in terms of planning, provision and financing as well as quality development. The expected increase in demand is a major policy challenge for many Member States, as supply already is considered to be insufficient to meet present needs. The sector relies heavily on the participation of private households, which still provide the bulk of care in all Member States and often have to shoulder a large financial burden in cases where out-of-pocket payments and co-payments for formal care are required.

Labour market services for disadvantaged people are a key instrument of the European employment strategy, which places particular emphasis on the integration of disadvantaged people. Given the prospect of a shrinking labour force and the EU policy agenda of promoting higher economic growth, competitiveness and social cohesion, it is crucial to implement active labour market policies targeting disadvantaged people.

Childcare services have rapidly expanded in many Member States due to increased labour market participation of women. Moreover, quality childcare can foster healthy development, socialisation and education of children, enhance social cohesion, and facilitate the integration of children from disadvantaged socioeconomic backgrounds. The supply of childcare services has become more diversified in recent years.

The main modernisation drivers for the three sectors appear to be threefold: (i) ageing is the main challenge for long-term care services; (ii) labour market services have to adapt to the changing labour market needs; and (iii) the development of childcare services is a response to emerging needs resulting from gender equality policy objectives and changes in family structures.

Common trends in modernisation

In spite of the diversity across Member States, some common trends regarding the organisation, management and governance of social services can be identified: modernisation is a response to the social and economic challenges that all EU societies are faced with (ageing, changing gender roles and the quests for social integration, labour market flexibility and greater cost efficiency, etc.). The need to adapt to changing needs, which cannot be dissociated from the search for quality improvement, efficiency and cost containment, represents an important driver of modernisation. In a context where the need for services is becoming increasingly sophisticated and complex, it is essential to promote stronger user orientation and user empowerment and to enhance access to social rights.

Common features can also be identified in reforms of the organisation and management of SSGIs across Member States: the general aim of increasing efficiency and effectiveness of service provision translates into: (i) increased utilisation of performance measurement tools, (ii) user empowerment and user involvement mechanisms, (iii) integration of services, and (iv) decentralisation. The BR also observes a shift from public programming towards a market-based regulation approach and the use of corrective methods.

Consequences of national modernisation processes in terms of applicable Community law — the need for more practical guidance and support

As the BR documents, national modernisation processes are a response of Member States to evolving needs and structural changes and not a consequence of EU policies. They may, however, result in the application of Community rules. As a result of the State becoming less of a direct service provider but increasingly of a regulator/guarantor, while remaining an essential source of financing, there are questions concerning the applicability of Community rules.

As announced in the 2006 Communication([2]), the BR reports on the consequences of national modernisation processes in terms of applicable Community law and on the strategy put in place by the Commission to provide stakeholders in this field with guidance and support.

The consultation process has shown that, at this stage, the difficulties experienced in the application of Community rules are not caused by the rules themselves but rather by the fact that these rules are not well known and not applied by public authorities and service providers and that the possibilities they offer are not fully exploited. In its communication on services of general interest of 20 November 2007([3]), the Commission committed itself to providing stakeholders with necessary guidance. In addition to a series of clarifications provided in the communication itself, two staff working documents, dealing respectively

([2]) COM(2006) 177 final.

([3]) COM(2007) 724 final.

with public procurement([4]) and state aid rules([5]), provide answers to the most frequently asked questions in the social field during the consultation process.

Moreover, an 'interactive information service' (IIS) launched by the Commission in January 2008 provides concrete guidance to citizens, public authorities and service providers by answering their questions posted on a dedicated webpage. Even if it is too early to evaluate the IIS, the first results are positive and show that the IIS meets an existing demand satisfactorily.

Attention to SSGI quality

Finally, increased attention to the issue of SSGI quality has emerged at various points in the analysis. This confirms the timeliness of the Commission's intention to promote, within the Social Protection Committee, an EU quality framework for SSGIs. This, together with a more general analysis of quality issues, will be the focus of the 2010 SSGI Biennial Report.

([4]) SEC(2007) 1514, of 20 November 2007.

([5]) SEC(2007) 1516, of 20 November 2007.

1. Introduction

Social services of general interest (SSGIs) play a vital role in European societies: they contribute to enhancing the capacity of individuals to participate in society, enabling them to fulfil their economic and social potential and guaranteeing that they can enjoy their fundamental rights. These services are an important delivery mechanism for social policies focusing on promoting opportunities for all to participate in society and a strategic field in the implementation of the **Renewed Social Agenda**. Indeed, given the very different starting points and huge inequalities in European societies, it is crucial to ensure that everyone has access to the services needed in order to fully participate in social life and in employment. The modernisation of social services is an important facet of the more general process of modernisation of the welfare state, in which the EU Member States are engaged in the face of new social challenges and major structural changes.

In the context of the Agenda, the Commission looks at SSGIs in several ways. The social Open Method of Coordination (OMC)([6]) will look at the role of social services in promoting social inclusion and access for all to quality health and long-term care. Within the Social Protection Committee (SPC)([7]), the Commission will promote a European framework for SSGI quality. The role of this **Biennial Report (BR)**, the first of its type, is to sketch a broader picture of what SSGIs are, what they do and how they are evolving. The BR examines this sector by showing how these services function and by highlighting their socioeconomic importance. It describes the ongoing modernisation processes in the Member States and the main issues at stake, with a view to facilitating the dialogue between the Commission, public authorities and stakeholders in this field.

1.1. The debate on SSGIs at EU level

With the Green Paper of 21 May 2003([8]) the Commission launched a broad debate on services of general interest([9]). The Green Paper raised considerable interest from stakeholders active in the social field. The White Paper adopted in May 2004 therefore paid specific attention to SSGIs and underlined the interest in developing a systematic approach towards them in order to identify their main characteristics.

The Communication on SSGIs of April 2006([10]) (hereafter referred to as the '2006 Communication') made a first step in this direction. Based on an extensive consultation of Member States, social partners and civil society organisations in the area of social services, it provided a description of SSGIs in the European Union. In addition to health services, which were not covered in the communication, two groups of services, albeit with varying functions and forms of organisation across the EU, were identified: on the one hand, statutory and complementary social security schemes covering the main risks of life and, on the other, those services provided directly to persons and playing a preventive and socially cohesive role, such as social assistance services, employment and training services, social housing, childcare and long-term care services.

The consultation process that followed the 2006 Communication included: (i) responses to a questionnaire prepared by the SPC in September 2006([11]); (ii) a study on health and social services of general interest commissioned in 2006 and finalised in 2008([12]) (hereafter referred to as the '2008 SHSGI study'); (iii) the results of a peer review on long-term care organised within the framework of the OMC by the Belgian authorities in May 2007; and (v) the opinions of the European Parliament([13]), the European Economic and Social Committee([14]) and the Committee of the Regions([15]) on the 2006 communication.

The 2007 Communication([16]) crystallised the results of this consultation process, especially in relation to the main organisational characteristics set out in the 2006 Communication. It listed (see box) a number of specific objectives that social services are often meant to achieve and explained how these objectives are reflected in the way services are organised, delivered and financed.

([6]) Set up at the Lisbon European Council of March 2000, the open method of coordination provides a framework of political coordination where Member States agree to identify and promote their most effective policies in the fields of social protection and social inclusion with the aim of learning from each other's experiences.

([7]) The SPC is a committee created by Article 144 of the EC Treaty. It has three tasks: (i) monitoring the social situation and the development of social protection policies in the Member States and in the Community; (ii) promoting exchanges of information, experience and good practice between Member States and with the Commission; (iii) preparing reports and formulating opinions at the request of the Council and the Commission, as well as on its own initiative. It is made up of two official delegates per Member State (plus two alternate members). The Commission is a full member of the committee and provides the secretariat.

([8]) COM(2003) 270.

([9]) SGIs cover a broad range of activities: e.g. large network industries (energy, telecommunications, audiovisual broadcasting and postal services), water supply, waste management, education, social or health services.

([10]) Commission's communication 'Implementing the Community Lisbon programme: Social services of general interest in the European Union', COM(2006) 177 final of 26.4.2006.

([11]) The questionnaire was addressed to Member States, social partners and European organisations representing civil society. The answers to this questionnaire are summarised in a feedback report. See: http://ec.europa.eu/employment_social/spsi/docs/social_protection/2008/feedback_report_final_en.pdf

([12]) The study was carried out by a consortium formed by the European Centre for Social Welfare Policy and Research (Vienna), the International Centre of Research and Information on the Public, Social and Cooperative Economy (CIRIEC, Liege) and the Monitoring Unit of the Observatory for the Development of Social Services in Europe at the Institute for Social Work and Social Education (ISS, Frankfurt am Main). See: http://ec.europa.eu/employment_social/spsi/docs/social_protection/2008/study_social_health_services_en.pdf

([13]) FINAL A6-0057/2007.

([14]) CESE 426/2007.

([15]) CoR ECOS-IV-006.

([16]) Communication on 'Services of general interest, including social services of general interest: a new European commitment', COM(2007) 725 of 20 November 2007. It accompanies the communication 'A single market for 21st century Europe', COM(2007) 724 final.

Objectives and principles of organisation of social services

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

– they are person-oriented services, designed to respond to vital human needs, in particular the needs of users in a vulnerable position; they provide protection from general as well as specific risks of life and assist in personal challenges or crises; they are also provided to families in a context of changing family patterns, support their role in caring for both young and old family members, as well as for people with disabilities, and compensate possible failings within the families; they are key instruments for the safeguard of fundamental human rights and human dignity;

– they play a preventive and socially cohesive role, which is addressed to the whole population, independently of wealth or income;

– they contribute to non-discrimination, to gender equality, to human health protection, to improving living standards and quality of life and to ensuring the creation of equal opportunities for all, therefore enhancing the capacity of individuals to fully participate in the society.

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

– in order to address the multiple needs of people as individuals, social services must be comprehensive and personalised, conceived and delivered in an integrated manner; they often involve a personal relationship between the recipient and the service provider;

– the definition and delivery of a service must take into account the diversity of users;

– when responding to the needs of vulnerable users, social services are often characterised by an asymmetric relationship between providers and beneficiaries which is different from a commercial supplier–consumer relationship;

– as these services are often rooted in (local) cultural traditions, tailor-made solutions taking into account the particularities of the local situation are chosen, guaranteeing proximity between the service provider and the user while ensuring equal access to services across the territory;

– service providers often need a large autonomy to address the variety and the evolving nature of social needs;

– these services are generally driven by the principle of solidarity and are highly dependent on public financing, so as to ensure equality of access, independent of wealth or income;

– non-profit providers as well as voluntary workers often play an important role in the delivery of social services, thereby expressing citizenship capacity and contributing to social inclusion, the social cohesion of local communities and to intergenerational solidarity.

Source: 2007 communication

The 2007 Communication acknowledged the difficulties experienced by public authorities and service providers active in the social field in understanding and applying Community rules and launched a strategy to provide stakeholders with the necessary guidance.

On top of a series of clarifications provided in the communication itself, two staff working documents respectively dealing with public procurement([17]) and State aid rules([18]) provide answers to the most frequently asked questions in the social field during the consultation process.

Finally, as announced in the 2007 Communication, the Commission launched in January 2008 an 'interactive information service' with the aim of providing concrete guidance to citizens, public authorities and service providers by answering the questions they post on a dedicated webpage. Since its launch, this information service has satisfactorily met an existing demand.

([17]) 'Frequently asked questions concerning the application of public procurement rules to social services of general interest', SEC(2007) 1514, of 20 November 2007.

([18]) 'Frequently asked questions in relation with Commission decision of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to undertakings entrusted with the operation of services of general economic interest, and of the Community framework for State aid in the form of public service compensation', SEC(2007) 1516, of 20 November 2007.

1.2. The structure of the BR

This BR builds on the debate launched after the adoption of the White Paper on services of general interest in 2004([19]), and the consultation process that took place between 2006 and 2007 as well as on the crucial steps represented by the 2006 and the 2007 communications.

Following this first part, which recalls the evolution of the debate on SSGIs at EU level and reviews the main steps taken over the last four years, Chapter 2 gives an updated overview of social and health services from an employment and economic perspective. Chapter 3 analyses the diversity of national organisations and the drivers of modernisation in long-term care, labour market services for disadvantaged people and childcare. Finally, Chapter 4 describes in more general terms the modernisation processes on which Member States have embarked and analyses the impact of these changes on the legal framework applicable to SSGIs.

([19]) COM(2004) 374 final.

2. Health and social services from an employment and economic perspective

This chapter describes the weight health and social services have in our economies in terms of employment and the financial resources devoted to them. The first section deals with employment trends and characteristics. The second deals with the financial resources devoted to these services. Where possible, healthcare and different social services are distinguished, although specific information on the different sub-sectors is scarce, particularly on employment.

The analysis made in Chapters 2 and 3 is based on statistical information from Eurostat or the OECD on health and social services in general. It is important to note that this analysis therefore covers all service activities in these sectors whether or not they are considered by Member States as serving a general interest mission. In practice the great majority of social and health services are considered by Member States as being of general interest.

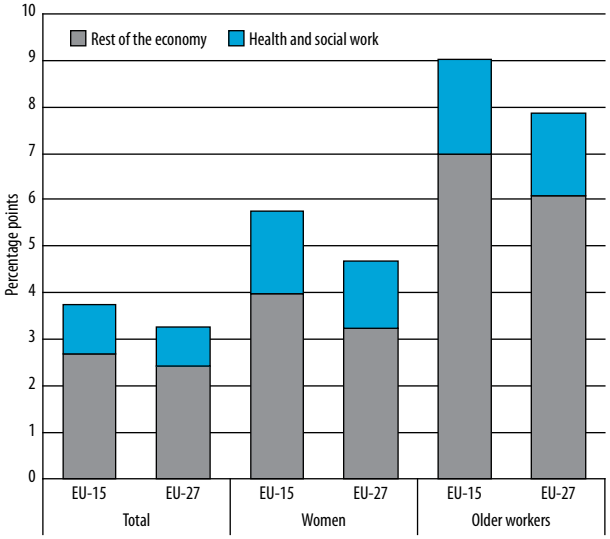
2.1. Employment trends

Growth in service industries is the main driver of job creation in the EU Member States. Among these industries, health and social services are a particularly dynamic sub-sector, one element in the 'European job machine' (OECD), in many Member States. The analysis in this section is based on statistical information from the European labour force survey and refers to the 'health and social work sector' in the Statistical Classification of Economic Activities in the European Community (NACE), Rev. 1.1([20]). It looks at employment trends in the sector and its contribution to the overall employment rate and to employment growth, also in comparison with other sectors. Due attention is paid to the gender aspect, as this is a sector that predominantly employs women. Finally, the specific characteristics of the jobs in health and social work are analysed, some of which could undermine its potential as a driver of future job creation and sustainable employment.

2.1.1. Employment trends in the health and social services sector

Between 2000 to 2007 the total employment rate in the European Union (EU-27) increased by 3.2 percentage points (p.p.) from 62.2% to 65.4%, the female employment rate by 4.6 p.p. from 53.7% to 58.3% and the employment rate for older workers by 7.8 p.p. from 36.9% to 44.7%. Of this increase in the total employment rate, 0.8 p.p. are explained by the growth of employment in the health and social work sector (EU-15: 1.0 p.p). For women and older workers, the creation of jobs in this sector accounts for 1.4 p.p (EU-15: 1.8 p.p). and 1.8 p.p. (EU-15: 2.0 p.p), respectively, of the rise in the employment rate, as Figure 2.1 shows. Hence, the contribution of this sector to the progress towards the Lisbon targets, i.e. an overall employment rate of 70%, 60% for women and 50% for older workers, is particularly strong for women and older workers.

Figure 2.1: Change in the employment rate, 2000–07



Source: Eurostat (LFS).

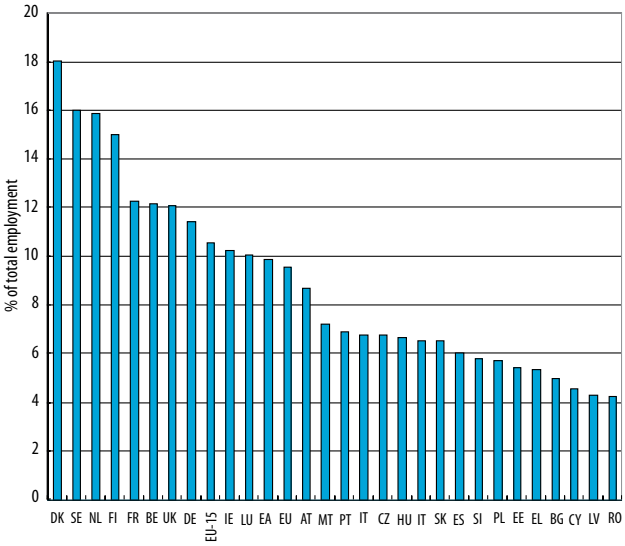
In the EU-27 the share of employment in health and social work, calculated as the number of persons employed in the sector relative to the total working-age population, rose from 2.4% to 2.7% for males and from 8.4% to 9.8% for females between 2000 and 2007, showing a striking gender gap. This is also observed in the EU-15, where the increase was from 2.8% to 3.1% for males and from 9.3% to 11.1% for females during the same years. The proportion of working-age women employed in the sector is especially high in Denmark, the Netherlands, Sweden and Finland, where around one fifth of all working-age women are employed in health and social services. Along with employment, the gender gap in the sector is also rising and it is highest in the same countries where female employment is highest, which makes the already existing segregation in the labour markets more pronounced.

Employment in health and social services as a proportion of total employment differs widely throughout the European Union. As shown by Figure 2.2 below, it is possible to distinguish between three groups of Member States. In the first group, which includes Romania, Latvia, Cyprus, Bulgaria, Greece, Estonia, Poland, Slovenia, Spain, Slovakia, Lithuania, Hungary, the Czech Republic, Italy, Portugal and Malta, the employment share of health and social services is in the 4%-8% range, lower than the EU average (9.6%). In the second group, with employment shares ranging from 8% to 13% of total employment, we find Austria, Luxembourg, Ireland, Germany, the United Kingdom, Belgium and France. In the third group, we find Finland, the

([20]) Activities in the health and social work sector – defined as division 85 of NACE Rev.1.1. – range widely, from healthcare provided by trained medical professionals in hospitals and other facilities, through residential care activities that still have a healthcare component to social work activities without any involvement of healthcare professionals.

Netherlands, Sweden and Denmark, where the employment share of the sector in total employment ranges from 15 % in Finland to 18 % in Denmark. These countries have a highly developed welfare state which puts a special emphasis on the provision of health and social services.

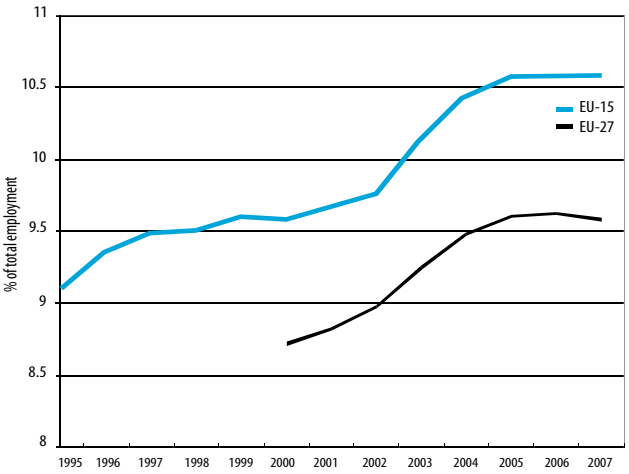
Figure 2.2: Employment in health and social work, as a % of total employment, 2007



Source: Eurostat (LFS).

As social services have expanded over time, employment has substantially increased in this sector for the EU on average (see Figure 2.3). For the EU-27, the sector's share in total employment grew from 8.7 % in 2000 to 9.6 % in 2007. The same trend can be observed for the EU-15, where employment in health and social services grew from 9.1 % in 1995 to 10.6 % in 2007.

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



Source: Eurostat (LFS).

The share of this sector in total employment increased more strongly during 2002–04, a period when overall economic and employment growth was weak, and then slowed in the following years, when economic and overall employment growth picked up (2005–07). Similarly, economic and overall employment growth was strong in the boom years 1997–2000, but this coincides with a rather stable share of the health and social work sector in total employment. That employment in this sector is less cyclical than in the overall economy is not surprising, since it is largely financed by public funds, as will be shown later in this chapter.

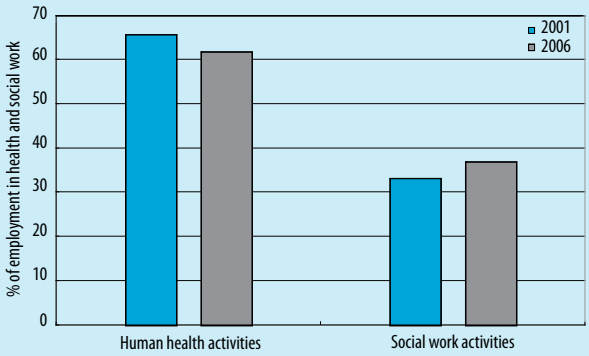
Box 1: Breakdown of employment in health and social services

The health and social work sector comprises two major fields: human health activities and social work activities (the sector also includes the very small veterinary field), so it is important to look at the relative weight and development of health and social work separately. Even though the breakdown is available only for 1/3 of the Member States (Czech Republic, Germany, Spain, France, Italy, Hungary, Austria, Poland and Portugal), it covers, however, almost 2/3 of total employment in the EU. The left panel in Figure 2.4 shows a rebalancing of employment from human health to social work activities between 2001 and 2006. In that period, the share of employment in human health activities, the biggest field of activity within the sector, fell from 65.7 % to about 62 %, while the share of social work activities rose from 33 % to around 37 %.

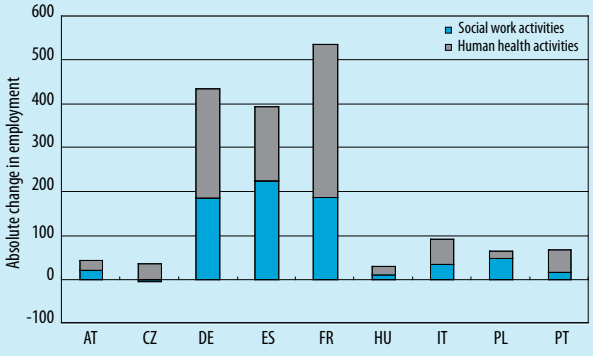
Figure 2.4 shows differences among Member States: social work activities turned out to be the driving force behind employment growth in the health and social services sector in most Member States, namely the Czech Republic, Germany, France, Hungary, Italy and Portugal, in the period between 2001 and 2006, whereas it was human health in Poland. In Spain and Austria, the two sub-sectors contributed roughly equally to employment growth.

Figure 2.4: Share and absolute growth in health and social services by field of activity (2001 and 2006)

Share of employment by field of activity (percentage points)



Growth in employment by field of activity (thousands of persons)



Source: Eurostat (LFS).

NB: The change for Italy and Poland is between 2004 and 2006

The 2008 SHSGI study reports that France, which already had the biggest share of employment in health and social services among the countries for which data were available, also exhibited the strongest growth. The main drivers are likely to be the positive trends in life expectancy coupled with relatively high birth rates. As a result of increasing life expectancy, 130 000 jobs were created in the long-term care sector between 2000 and 2005; 55 % of the new jobs were in new residential care facilities, the rest in home-care services. The high birth rate boosted employment in childcare services. In addition, social integration services were expanded due to the sustained growth in public financing, another source of job creation in France. The number of jobs in such services rose by 3 000, a 30 % increase compared with 2000. All in all, between 2000 and 2007, 727 000 new jobs were created in health and social work, 634 000 being taken up by women.

While the share of health and social services in total employment in the EU-27 grew as illustrated above, we can observe three different trends across the EU. One group of Member States (Bulgaria, Latvia, Malta, Poland and Sweden) shows a fall in the share of this sector in employment between 1995([21]) and 2007, a second group (Denmark, Estonia, Italy, Cyprus, Lithuania, Hungary, Slovenia, Slovakia and Finland) shows a moderate increase and a third group (Belgium, Czech Republic, Germany, Ireland, Greece, Spain, France, Luxembourg, the Netherlands, Austria, Portugal, Romania and the United Kingdom) shows strong employment growth in the sector.

The group of Member States where we observe a relative fall in employment includes four Member States that entered the Union recently. Although the weight of social services in all of these countries was at the low end of the European scale, the deep transformation of their economies towards a market economy brought about a sharp reduction in the size of their public sectors in order to get the economy onto a more sustainable path. The last Member State in this group is Sweden, which at the beginning of the 1990s saw a dramatic adjustment to its public sector after reaching a level of public expenditure considered challenging for its financial sustainability. Even after the cuts in expenditure, the share of employment in health and social services in Sweden is still one of the highest in the EU.

In the second group, where the increase in the share is moderate, we first find Denmark and Finland. In these two Member States, the share of employment was already high at the beginning of the period. In the case of Denmark, even this moderate increase means that it has taken Sweden's place as the Member State with the highest share of employment in health and social services in the EU. We also find two Mediterranean Member States (Italy and Cyprus), where the traditional role of the family in care activities is steadily decreasing. Finally, we find a group of new Member States where social services are growing again after the collapse of the system at the beginning of the 1990s.

In the third group, with strong growth in employment in health and social services, we find the 'continental' economies strongly represented, i.e. the three Benelux Member States, France, Germany and Austria. The group also contains Ireland and the United Kingdom, along with three Mediterranean countries, Spain, Greece and Portugal. Employment in Portugal and Ireland was very low at the beginning of the period. Most of these countries have undergone rapid societal changes, such as rapidly rising female participation and the development of new family and household structures leading to stronger demands for such services. In general, this might also reflect the increasing demand pressures arising from an ageing, affluent society.

([21]) Or closest year available.

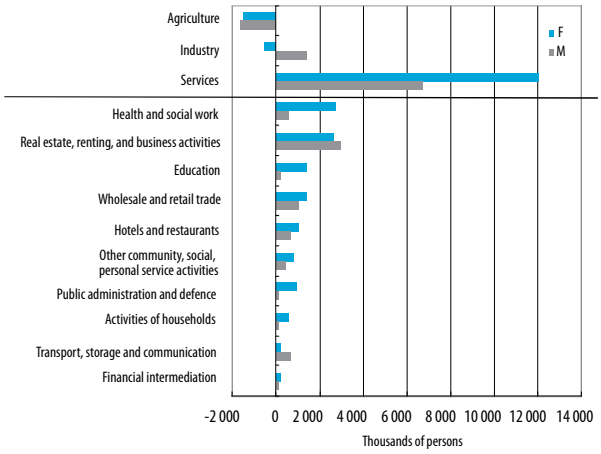
2.1.2. Structural changes in EU employment and the role of health and social services

Employment in the agricultural sector is shrinking, while it is rising very slightly in the industrial sector. Due to increasing wage levels, low-skilled manual work in agriculture and industry is becoming too expensive in highly developed industrial countries. Figure 2.5 below shows that between 2000 and 2007 there was a fall of three million persons employed in agriculture and an increase of less than a million persons employed in industry in the EU-27, when combining the totals for males and females.

At the same time, the services sector saw a remarkable increase in employment, with jobs being created for 19 million persons over the period. Health and social services, part of the services sector, turned out to be one of the most dynamic, just after the real estate, renting and business activities sector. This subsector alone created employment for almost 3.3 million persons, representing about a sixth of the growth in the services sector as a whole.

The growth in services in general was more than nine times greater than the loss in employment in other sectors, while employment growth in health and social services alone offset the job losses in agriculture.

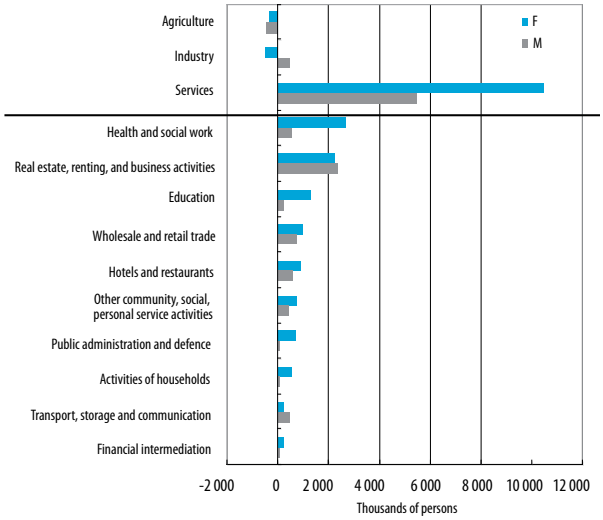
Figure 2.5: Change in sectoral employment for the EU-27, 2000–07 (in thousands with gender breakdown)



Source: Eurostat (LFS).

The picture for the EU-15 for the 2000–07 period looks similar to that for the EU-27; but in this case there is both a fall in the agricultural and the industrial sectors. The data in Figure 2.6 below show that employment in the agricultural and industrial sectors together fell by almost one million persons during this period, while the number of employed persons in services grew by almost 16 million, of which around four million in health and social services.

Figure 2.6: Change in sectoral employment for the EU-15, 2000–07 (in thousands with gender breakdown)



Source: Eurostat (LFS).

The main finding from those figures is that — as part of the continuous shift towards a service economy — health and social services provided one of the main contributions to employment creation from 2000.

The further development of the services sector in general and the health and social services sector in particular is very important in order to achieve higher employment for women of all ages and older workers. These two major groups are underrepresented in the labour markets of most EU Member States.

Ageing societies are facing problems of economic growth and the financial sustainability of their social insurance schemes due to increasing age-dependency ratios; therefore, it has become a priority of employment policies to increase the participation of those groups that are currently underrepresented in the labour market. Since all EU Member States face the consequences of demographic ageing, the goal of increasing the labour market participation of women and older workers is part of a comprehensive strategy to enhance the functioning of Member States' labour markets in line with the Lisbon strategy.

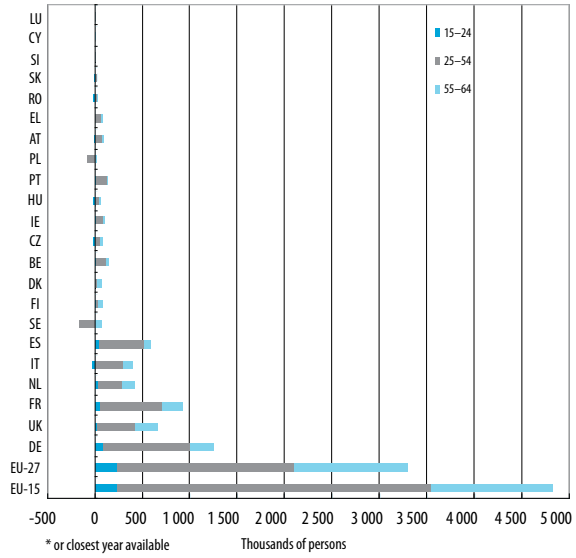
Looking at the development of employment in different sectors by gender, we see that in the EU-27 women obtained 60.5 % of all the new jobs created between 2000 and 2007, while they occupied 82.5 % of the additional new jobs in health and social services (see Figure 2.5 above).

The same is true for the EU-15 in the 2000–07 period yet slightly more pronounced. The new jobs for women in services easily outnumber the already remarkable gains

for men in the sector. In the subsector of health and social services, the gains for women are again much bigger than for men (see Figure 2.6 above).

When looking at employment creation in health and social services over the 1995–2007 period (see Figure 2.7), broken down by age group, we see that the group of prime-age workers accounted for the biggest share of the growth in employment in health and social services, whereas the increase of the group of older workers was truly remarkable in relation to its overall size.

Figure 2.7: Employment creation in health and social services by age group (1995*– 2007)



Source: Eurostat (LFS).

2.1.3 Features of employment in health and social services

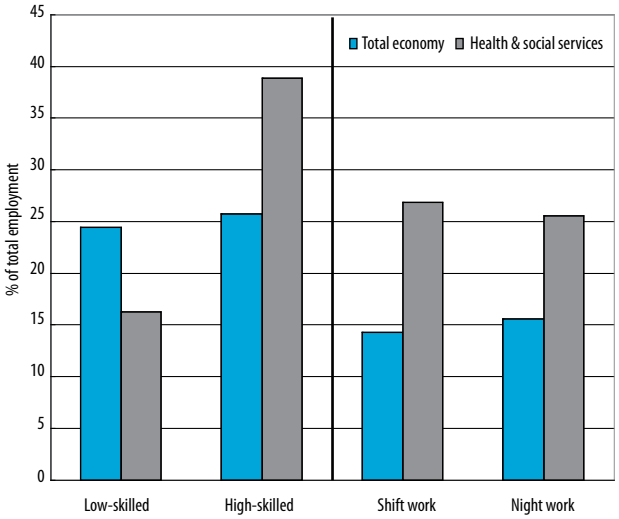
Employment in the health and social sector presents some special characteristics compared with the rest of the economy.

First, as seen in Figure 2.8, the proportion of high-skilled workers([22]) in health and social work (doctors, nurses, people with pedagogical training, social workers) is higher than in the total economy and the proportion of low-skilled workers is lower. In 2006 the share of low-skilled workers was 24.5 % in the total economy, compared with 16.3 % in the health and social work sector. In contrast, the share of high-skilled workers was 25.7 % in the total economy, but 38.8 % in the health and social sector. In recent years, moreover, the proportion of high-skilled employees in health and social work has been rising faster than in the total economy.

([22]) Skills level is defined by level of education or training successfully completed.

Second, regarding working times, the usual average weekly working hours for full-time employees in the sector are for almost all Member States lower than in the rest of the economy. Working hours are lowest in Italy, Ireland, Spain and Denmark and highest in Austria, Malta, Slovenia and Latvia. The difference with other sectors is highest in Greece, Spain, Italy and Portugal. But, due to the very nature of the work, i.e. the provision of services to individuals, non-standard working hours are more frequent than in the total economy. As shown in Figure 2.8, the proportion of people doing shift work (26.8 %) or working night hours (25.6 %) is higher than in the total economy, where the comparable shares are 14.3 % and 15.6 %, respectively.

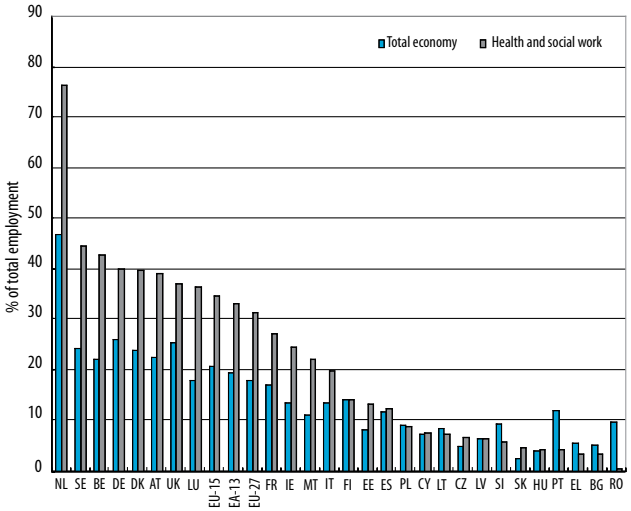
Figure 2.8: Skill levels and working patterns in health and social work, 2006



Source: Eurostat (LFS).

Third, the prevalence of part-time work is higher than for the total economy (see Figure 2.9). In the EU, about 18 % of people are working part-time in the total economy, while the comparable figure for health and social work is 31.4 %. However, there is considerable variation throughout the European Union. In the Netherlands, for instance, where part-time female employment is very common, 76.4 % of people working in health and social work do so on a part-time basis. Other Member States where the incidence of part-time work is high are Sweden and Belgium. In Greece, on the other hand, only 3.5 % of people working in health and social services work part-time, compared with 5.6 % in the total economy. Part-time working in health and social services is also rare in Portugal and essentially non-existent in Romania. The prevalence of part-time work together with the large employment gender gaps illustrate the trade-offs for the different members of the family regarding the choice between participating in the labour market and assuming care responsibilities within the family, i.e. reconciliation of work and family life.

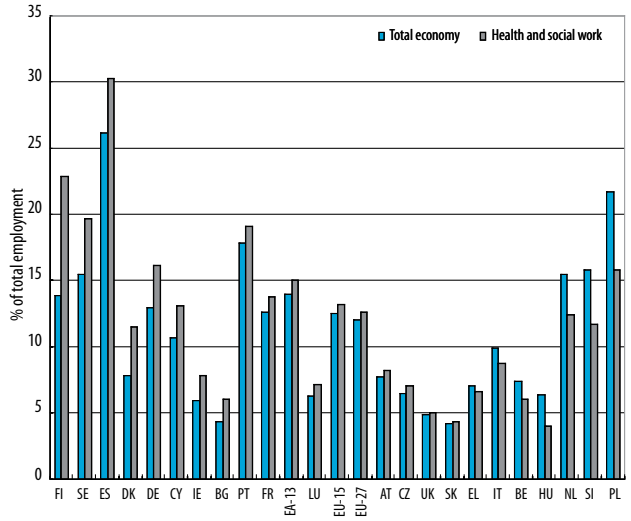
Figure 2.9: Share of part-time workers in health and social work, 2007



Source: Eurostat (LFS).

Fourth, temporary contracts are slightly more common than in the total economy (see Figure 2.10). In the EU, 12.1 % of people have temporary employment in the total economy, while the comparable figure for health and social work is 12.7 %. Again, there are significant differences across the European Union. Temporary work in health and social work is more common than for the total economy in Finland, Sweden, Spain, Denmark and Germany, but not in Italy, Belgium, Hungary, the Netherlands, Slovenia and Poland. A surprising and counterintuitive observation is that on average the incidence of temporary jobs is higher for men than for women.

Figure 2.10: Share of temporary contracts in health and social work, 2007

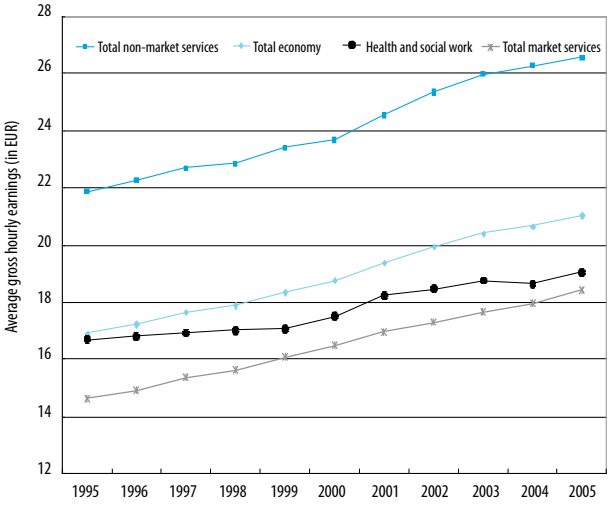


Source: Eurostat (LFS).

Furthermore, gross earnings are lower than in the total economy in most of the Member States for which data are available. This is in line with the findings of many studies on the gender pay gap, showing that sectors with high female shares in employment are characterised by low wages.

When looking at average gross hourly pay([23]) (see Figure 2.11) for different sectors, a gap can be seen between the health and social work sector and the total economy. Starting from comparable levels in 1995, average gross hourly earnings for employees in health and social work have remained fairly stable in purchasing power parity, increasing by around 14 % over the 10-year span between 1995 and 2005, while hourly wages in the overall economy show a much higher increase of 24.5 %. A similar increase is registered in market services: starting from a lower level in 1995, the gap with the health and social work sector in terms of average gross hourly earnings was almost filled by 2005.

Figure 2.11: Wage evolution in the health and social work sector, 1995–2005



Source: EU KLEMS, growth and productivity accounts.

An even more striking difference emerges if average gross hourly earnings in the health and social services are compared with earnings for other non-market services, such as education and public administration: here the gap not only is significant, but widens over time. For example, in 1995 the average gross hourly pay in health and social services was 75.7 % of that in public administration, while by 2005 the proportion fell further to 67.4 %. In other words, average pay in the health and social work sector went from being three quarters of the salary in public administration to two thirds in 2005.

([23]) Due to the unavailability of data on net hourly wages in the various sectors of the economy across Europe, average gross hourly earnings are considered here. These are computed as the total gross pay of employees (before taxes and social contributions paid by employers and employees) in each sector, divided by the number of total hours worked by employees in the sector in question. While this is an approximation, it nonetheless provides an interesting indication of the relative wages paid across sectors.

Only in Malta, Spain and Slovakia are earnings higher in the health and social work sector than in the total economy, a fact that seems associated with the lower incidence of female employment in comparison with other Member States, as seen in Section 2.1.1.

Migration could be seen as a possible explanation for salaries remaining relatively low. Although data from the Labour Force Survey (see Table 2.1) show that the proportion of employed immigrants is still lower than for the total economy, in recent years the increase in the number of employed recent non-EU migrants has been more rapid in the health and social work sector than in the total economy. Nonetheless, the impact of migration in this sector is still rather limited.

Table 2.1: Migrants in the health and social work sector

Economic activity (NACE)	2000		2006			
	Citizens of other EU-15 Member States	Citizens of non-EU-15 countries	Citizens of other EU-15 Member States	Citizens of non-EU-15 countries	of which(***)	
					EU-12 citizens	Non-EU-27 citizens
Share of employed foreigners by economic activity in the EU-15(*), 2000 and 2006 (in % of total employed per economic activity, age group 15 to 64)						
Services	2.0	3.0	1.9	4.4	0.7	3.8
of which						
Health and social work	1.6	2.6	1.4	3.4	0.4	2.9
Total economy	2.0	3.3	1.9	4.8	0.8	4.0
Share of employed recent immigrants(**) by economic activity in the EU-15(*), 2000 and 2006 (in % of total employed per economic activity, age group 15 to 64)						
Services	0.3	0.6	0.4	1.7	0.4	1.3
of which						
Health and social work	0.2	0.4	0.2	1.3	0.2	1.1
Total economy	0.3	0.6	0.3	1.8	0.5	1.3

(*) Does not include Italy and Ireland, for which no data by nationality were available in 2000 and 2006, respectively.
(**) Recent immigrants here defined as foreign nationals who have been resident five years or less in the receiving country.
(***) Differences in sum due to rounding.

Source: Own calculations using Eurostat LFS data.

Considering all those facts, there is a wide variety of working conditions and wage levels in health and social services, with not only high-quality, high-wage employment but also many workers on low wages and in unstable employment, as illustrated by the relatively high incidence of temporary contracts in most western European Member States.

The latter characteristics, together with higher health risks and difficulties in achieving a good work–life balance, lead to a low degree of job satisfaction([24]).

2.1.4. Conclusions

Health and social services have contributed strongly to job creation and structural change in the European Union, in particular to the increase in female employment and the employment of older workers. The sector has performed remarkably well in terms of employment creation at a time when other sectors are shrinking, as employment growth in social services has been strong both in periods of fast economic growth and in periods of slower growth. According to *Employment in Europe 2006*, female part-time employment in particular has contributed to about 60 % of total employment creation in recent years.

([24]) See Chapter 3 in *Employment in Europe 2007.*

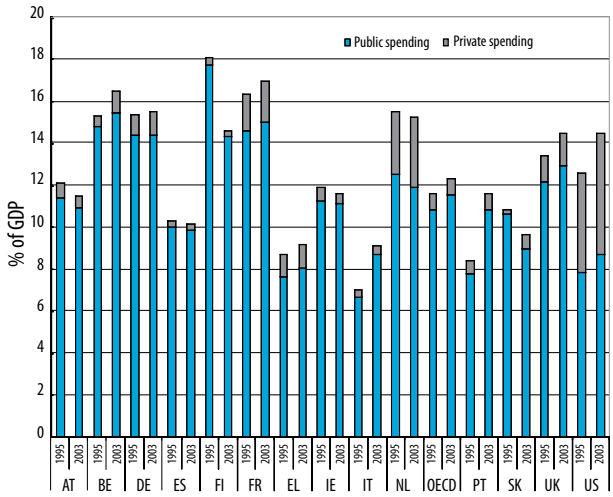
The further development of health and social services should help to achieve the goals of the Lisbon strategy as it is particularly relevant for increasing employment of women and older workers. Health and social services are relevant not only as a source of employment but also to facilitate labour market participation for those with care responsibilities — still mostly women([25]) — and for helping those who need to adjust to economic change.

But, as seen above, there are also a number of challenges to the continued growth of employment in social services. The fact that non-standard working hours are more frequent can lead to some work dissatisfaction.

Moreover, in contrast with the above-average educational levels and the higher share of non-standard working hours, gross hourly earnings are below average in those Member States for which data are available, which confirms that sectors with high female shares in employment are characterised by low wages.

Financial constraints might have contributed to keeping wage levels low in the sector, while the availability of part-time jobs might have attracted people looking for such arrangements. In recent years a rapid increase in migrants from non-EU countries might have also played a role. The possible consequence of these developments is that it will in future become more difficult to attract qualified employees, which could lead to staff shortages or reduce the quality of services, a frequently mentioned concern among policy analysts and stakeholders.

Figure 2.12: Public and private social protection spending, 1995 and 2003



Source: OECD.

2.2. Social expenditure

The economic significance of health and social services becomes evident when looking at the funds used to finance them. Indeed, social protection benefits in kind, public or private, which is the best estimate available for the resources devoted to health and social services, amounted in 2005 to around 9 % of the GDP of the EU-25. The present section describes trends in expenditure on health and social services. First, the respective roles of public and private social spending is analysed, then the composition of total social spending and the trends are examined. Finally, the relationship between social expenditure and employment in the health and social work sector is reviewed.

2.2.1. Public and private social expenditure

Social protection expenditure is used both to provide social security and health and social services and can be financed from both public and private sources. While information on private sources is limited, the OECD produces regular statistics that include an estimate of publicly and privately financed social expenditure. Not surprisingly, social protection spending is mostly financed from the public purse in the majority of Member States, but in some countries private social expenditure is relatively high, while at the same time there are signs that it is increasing in general.

In all the OECD member countries, privately financed social expenditure rose from 11.8 % to 13.2 % of total social expenditure between 1995 and 2003. In 2003, the share of private financing was highest in the Netherlands (27.1 %), the United Kingdom (24.7 %) and Finland (17.2 %). The exclusion of pensions, which account for the bulk of privately financed social expenditure, gives a better impression of the privately financed share of spending on social services.

Figure 2.12 shows a rise in the privately financed share from 6.1 % to 6.7 %, indicating a slight diversification in the financing of such services. Behind these numbers there are again significant national differences, with private financing of social spending higher in the Netherlands (21.6 %), Greece (12.4 %), France (11.6 %) and the United Kingdom (10.3 %), a fact that only in Greece seems to be explained by relatively low levels of public expenditure.

([25]) See chapter 3 in Employment in Europe 2004.

The rise in the share of private financing should, however, not be confused with how such services are provided (discussed in Chapter 3). Even in countries that rely fully on public sources for funding the provision of care or other social services, the provision might be organised as a mix between private market-oriented enterprises, non-profit organisations and a limited number of direct public institutions.

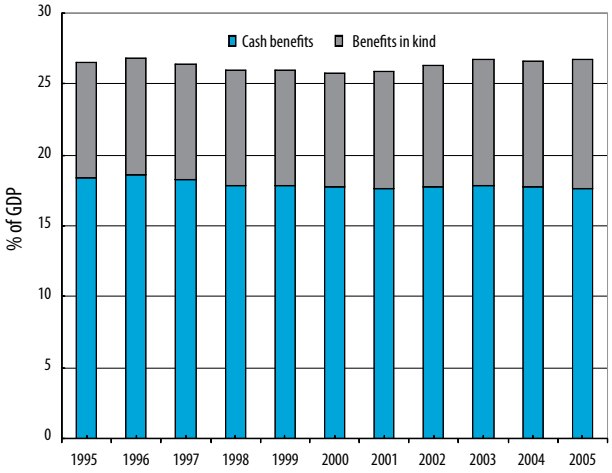
The rest of the analysis in this section will look at the distribution of social spending by functions as recorded in the Eurostat database 'European system of integrated social protection statistics' (ESSPROS)([26]).

2.2.2. Social expenditure by function: a shift from cash benefits to services

Expenditure on social protection can be disaggregated between cash benefits and benefits in kind. Among other things, it includes cash benefits such as pensions, maternity payments, unemployment benefits and social assistance and services such as childcare and care for the elderly and disabled. While only part of the spending on cash benefits is intended for the consumption of social services, practically all the spending on benefits in kind finances social services. Therefore, the rest of this section will refer interchangeably to benefits in kind and health and social services.

Figure 2.13 and Table 2.2 show that between 1995 and 2005 spending on social protection benefits in the EU-15 remained fairly stable on average, rising only by 0.2 p.p. from 26.5 % of GDP in 1995 to 26.7 % of GDP in 2005. This may be the result of Member States' efforts to contain growth in social expenditure as part of public expenditure control, but could also be due to the different cyclical positions and the decline in structural unemployment over the 1995–2005 period. In the EU-25, spending rose by 0.7 p.p., from 25.6 % of GDP in 2000 to 26.3 % of GDP in 2005. Taking a closer look at the individual Member States, we cannot identify any clearly defined trend, even though we observe rather strong increases in social spending in those Member States that had a fairly low point of departure such as Ireland, Greece and Malta.

Figure 2.13: Trend in social protection benefits for the EU-15, from 1995 to 2005



Source: Eurostat (ESSPROS social expenditure database)

Figure 2.13 and Table 2.2 also show a slight trend for cash benefits to be replaced by more spending on benefits in kind. While spending on cash benefits fell from 18.4 % of GDP in 1995 to 17.6 % of GDP in 2005, spending on health and social services rose from 8.1 % of GDP to 9.1 % of GDP in the EU-15 during the same period.

([26]) According to Eurostat, social protection encompasses all interventions by public or private bodies intended to relieve households and individuals of the burden of a defined set of risks or needs, provided that there is neither a simultaneous reciprocal arrangement nor an individual arrangement involved. The list of risks or needs that may give rise to social protection is, by convention, as follows: sickness/healthcare, disability, old age, survivors' pensions, family/children, unemployment, housing, and social exclusion not elsewhere classified. See *ESSPROS Manual The European system of integrated social protection statistics (ESSPROS) - 2008 edition.*

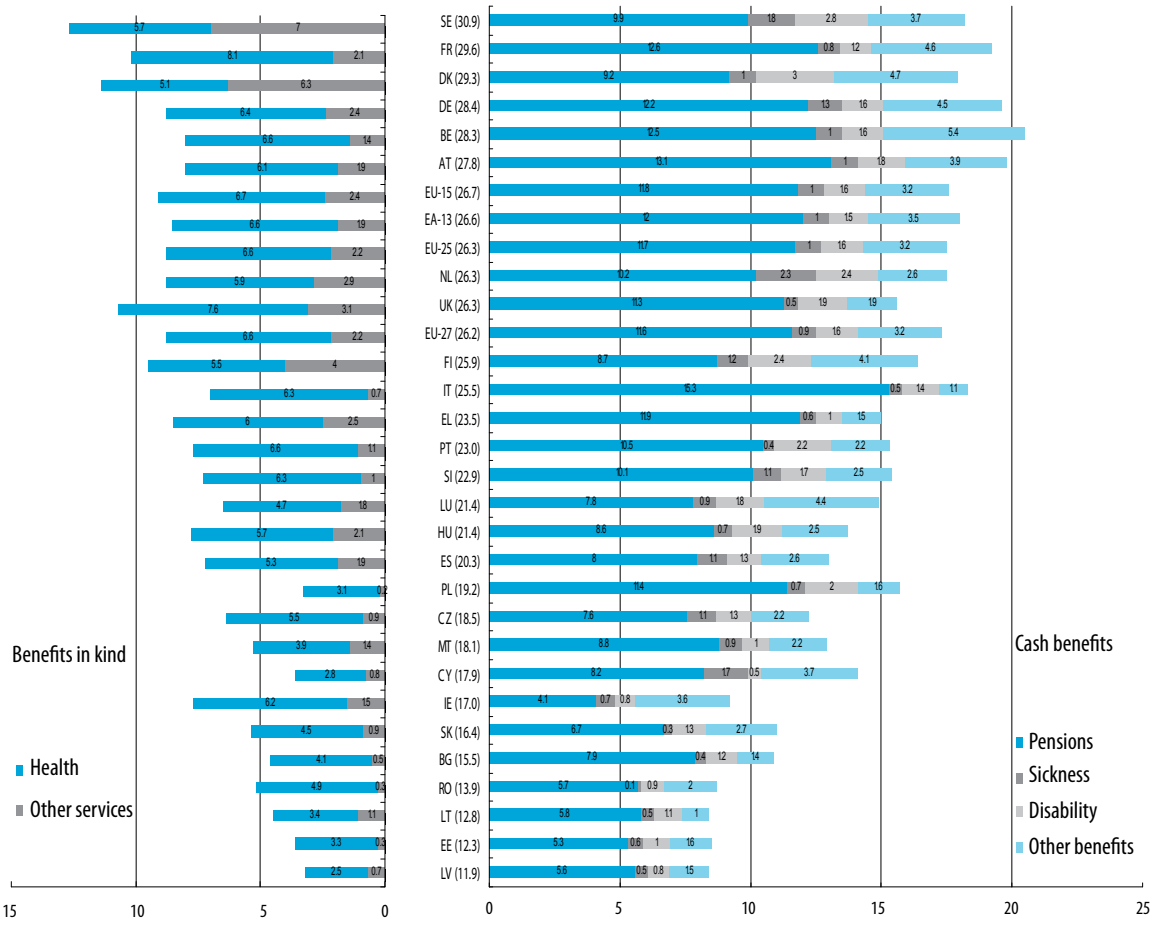
Table 2.2: Social protection benefits, as a % of GDP, in the EU-15 and EU-25

	EU-15			EU-25		
	1995	2005	Difference 1995–2005	2000	2005	Difference 2000–05
Social protection, total						
All functions	26.5	26.7	0.2	25.6	26.3	0.7
Cash benefits						
All functions	18.4	17.6	-0.8	17.6	17.4	-0.2
Sickness/healthcare	1.3	1.0	-0.3	1.1	1.0	-0.1
Pensions(*)	13.3	13.4	0.1	13.3	13.3	0.0
Family/children	1.5	1.5	0.0	1.5	1.5	0.0
Unemployment	2.1	1.5	-0.6	1.5	1.5	0.0
Benefits in kind						
All functions	8.1	9.1	1.0	8.0	8.9	0.9
Sickness/healthcare	6.0	6.7	0.7	5.9	6.6	0.7
Care for the elderly and disabled(**)	0.7	1.0	0.3	0.8	0.8	0.0
Family/children	0.6	0.6	0.0	0.5	0.6	0.1
Unemployment	0.1	0.1	0.0	0.1	0.1	0.0
Housing	0.6	0.6	0.0	0.5	0.6	0.1

(*) The figures presented here are the sum of all benefits in cash under the functions old age, survivors and disability in ESSPROS.
(**) This includes benefits in kind under old age, survivors' and disability functions.

Source: Eurostat, ESSPROS social expenditure database.

Figure 2.14: Expenditure on social protection benefits by broad social policy area, as a % of GDP, 2005

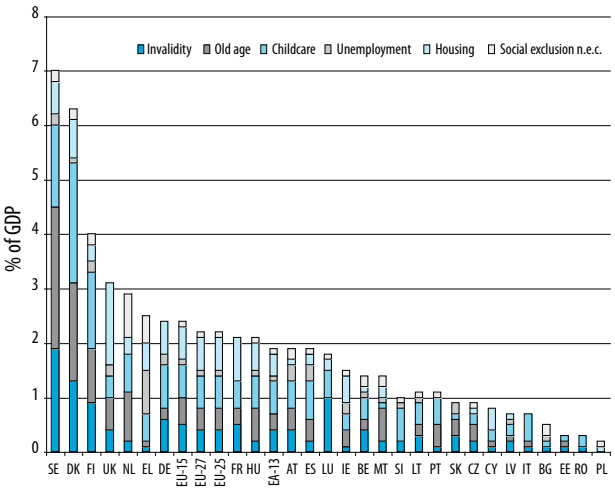


Source: Eurostat (ESSPROS).

As seen in Figure 2.14, total social spending on benefits in the EU-27 was 26.2 % of GDP in 2005. It ranged from about 12 % of GDP in Latvia and Estonia to about 30 % of GDP in Denmark, France and Sweden. Spending on social services, i.e. health services, care for the elderly and disabled, childcare, labour market services, social housing and social inclusion, is lower than spending on cash benefits in all Member States. Spending on benefits in kind was 8.9 % of GDP for the EU-27, ranging from around 3.5 % of GDP in Latvia, Poland, Estonia and Cyprus to about 10 %-12 % of GDP in Sweden, Denmark, the United Kingdom and France.

A closer look at the specific benefits in kind shows that social spending on health services ranged from 2.5 % of GDP in Latvia to 8.1 % of GDP in France. Other services ranged from as low as 0.2 % in Poland to over 7 % of GDP in Sweden. Social spending on health services accounts for a larger share of social spending than all other social services put together in all Member States but Sweden and Denmark, where spending on other services is higher, especially as care for the elderly and disabled has a large weight in social spending (4.5 % of GDP in Sweden and 3.1 % of GDP in Denmark). The same pattern can be observed with childcare, where Denmark and Sweden spend 2.2 % of GDP and 1.5 % of GDP, respectively, while some Member States spend almost nothing. The United Kingdom (1.5 %), France (0.8 %) and Denmark (0.7 %) have the highest spending on social housing services, while the Netherlands (0.8 %), Greece (0.5 %) and Denmark (0.3 %) spend most on services to combat social exclusion. The breakdown of benefits in kind apart from health and sickness care can be seen in Figure 2.15.

Figure 2.15: Social protection benefits in kind (excluding healthcare), 2005



Source: Eurostat (ESSPROS).

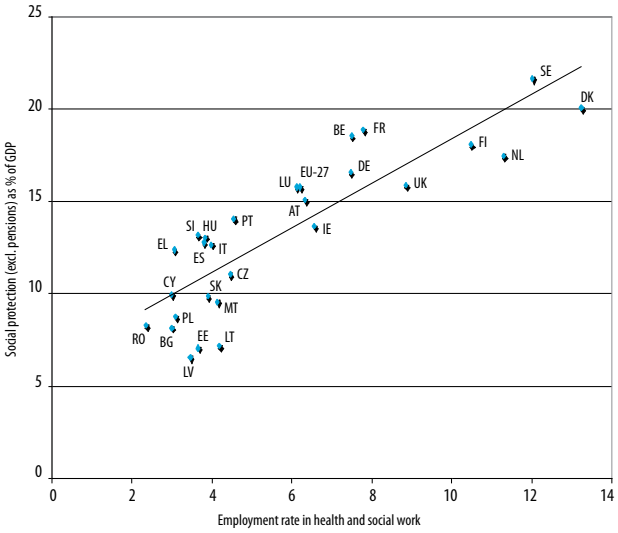
Health thus remains the single biggest item of expenditure, but other social services seem to be on the increase. Overall, cash benefits still account for most social protection expenditure, but expenditure on services is gaining in weight. Nevertheless, there is still scope for a further shift towards a more proactive approach, notably in childcare.

2.2.3. The relationship between employment and social protection benefits

Finally, we can analyse employment in health and social services in relation to social protection benefits by plotting the employment rate in the health and social work sector against social protection expenditure excluding pension expenditure. This gives a fairly informative picture (see Figure 2.16).

As expected, there is a strong correlation between the two indicators. Member States with a high expenditure-to-GDP ratio also have a high employment rate in the health and social work sector and vice versa. The main explanation for this fact is the relatively large weight of wages and salaries in spending on benefits in kind. Salaries can make up to 80 % of total expenditure in sectors such as long-term care, disability care or childcare. As noted in the 2006 communication, these sectors focus on services for individuals delivered by people and are therefore employment-driven.

Figure 2.16: Employment in health and social work vs social protection benefits (excluding pensions), 2005



Source: Eurostat (LFS and ESSPROS).

In Figure 2.16, we can again clearly differentiate between three groups of Member States. In the first group, we find Denmark, Finland, the Netherlands and Sweden, where the employment rate in the health and social work services is higher than 10 % and social protection expenditure higher than 15 % of GDP. The employment rate is highest in Denmark (13.7 %), whereas social protection expenditure is highest in Sweden (21.7 % of GDP). A second group is near the EU average: in Belgium, Germany, Ireland, France, Luxembourg, Austria and the United Kingdom, the employment rate ranges between 6.1 % in Luxembourg and 8.8 % in the United Kingdom, while social protection expenditure ranges from 13.7 % of GDP in Ireland to 18.9 % of GDP in France. In the third group, we find all the Mediterranean and the east European Member States, with the employment rate varying from 2.3 % in Romania to 4.5 % in Portugal, while expenditure can be as low as 3.4 % of GDP in Latvia, or as high as 14.1 % of GDP in Portugal.

Moreover, while both the health sector and the social work sector are quite labour-intensive, it appears that the gains in terms of employment are higher in those Member States that spend relatively more on social services than on health services. This can be seen by looking at the relation between health and social expenditures in Figure 2.14 in the countries above and below the line in Figure 2.16. Countries below the line spend relatively more on social services than on health and have higher employment in the sector. For example, Sweden has a higher benefits expenditure-to-GDP ratio, but the employment rate is somewhat lower than in Denmark, where expenditure on social services is higher. The same observation can be made comparing France with the United Kingdom and Germany with the Netherlands, with France and Germany spending relatively less on social services and

somewhat more on health services than the United Kingdom and the Netherlands, respectively.

This seems due to the fact that the social work sector almost only needs employed persons to produce the services, i.e. take care of the old, the children, or the unemployed, while there is a wide use of high technology in the health sector that increase productivity.

2.2.4. Conclusions

All in all, the analysis shows that the financial resources devoted to health and social services are largely public, although the small private component is increasing. Over the last 10 years, Member States seem to have slowly shifted funds from cash benefits to benefits in kind, allowing for the growth of health and social services. Nonetheless, there seems to be scope for a further shift towards a more proactive approach, notably on childcare. While the largest expenditure item is healthcare, we see the strongest increases in care for the elderly and disabled. Finally, because social services are very labour-intensive, there is a high correlation between social expenditure and employment in the sector.

Of course, the strong dependency of these services on public funds makes them particularly vulnerable to the development of public finances in general and the pressures coming from the ageing of the EU population, as demonstrated by the long-term projections carried out by the EPC and the European Commission([27]). It might be the case that the high dependency on public funds might have led to some of the tensions noted in following chapters between the desire of service providers for long-term stability and short-term financial constraints. Such constraints may also explain some of the observations made regarding employment characteristics, notably the trends in earnings. These tensions will increase with the ageing of the EU population and might also lead to further pressures on wages and impact on the quality of the services offered. If, on the other hand, Member States pay attention to the quality of services, the need for well-trained and motivated personnel will increase, leading to further increases in the financial resources required.

One way to reconcile these needs is to strengthen inclusive labour markets and anticipatory policies such as prevention and rehabilitation. This could reduce the need for income replacement benefits for people of working age and moderate the growth in the numbers of those requiring long-term care, as illustrated in the ageing working group projections. At the same time, this calls for a strategy of proactive social policies which allows for further refocusing of public expenditure and increased efficiency([28]). Chapter 3 will show how these pressures have emerged in specific sectors and how policies have responded.

([27]) Economic Policy Committee and European Commission (2006), 'The impact of ageing on public expenditure: projections for the EU-25 Member States on pensions, healthcare, long-term care, education and unemployment transfers (2004-50)', *European Economy*, Special Report No 1/2006.

([28]) In this regard, the introduction of information and communications technologies (ICTs), for example in the area of e-health, might result in productivity improvements.

3. Trends in long-term care, labour market services for disadvantaged persons and childcare

The present chapter looks at three sectors: long-term care, labour market services for disadvantaged persons and childcare. Ongoing socioeconomic changes, such as ageing, globalisation, gender equality and changes in family structures have a strong impact on these sectors, which are also particularly illustrative of health and social services' contribution to employment growth in the EU. This chapter analyses the role played by these services in European societies, presents an overview of service provision and expenditure and describes the forms that the modernisation process can take in these three sectors.

The chapter is based mainly on the results of the 2008 SHSGI study([29]), which drew in turn on in-depth country studies from eight Member States (the Czech Republic, France, Germany, Italy, the Netherlands, Poland, Sweden and the United Kingdom). More specifically, the part on long-term care is based on an analysis of the service provision in these eight Member States, the part on labour market integration compares the Czech Republic, Germany, Poland, Sweden and the United Kingdom, and the part on childcare builds on an analysis of the service provision in the Czech Republic, France, Germany, Italy, the Netherlands and Poland([30]).

At the same time, the present chapter draws on various other studies and analyses prepared or commissioned by the Commission services, such as, for instance, the EU report on long-term care in the European Union([31]) or the *Employment in Europe* reports([32]).

3.1. Long-term care

The definition of long-term care, the services and benefits provided as well as the population coverage vary between the Member States.

The OECD has defined long-term care as 'a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living([33]) over an extended period of time'([34]). Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with instrumental activities of daily living([35]). In the 2008 SHSGI study, long-term care services encompass three broad groups: (i) services for elderly persons with severe functional limitations who receive care in institutions; (ii) services for persons with moderate to severe functional limitations who receive care in the community, often as a mix of informal and formal care; (iii) social services to support care in the community, such as respite care, day care, and counselling and the like for care recipients, their families and other volunteers. In the present BR, long-term care refers to services both in an institutional and in a community setting.

Long-term care operates at the boundaries between health and social care and is usually provided to persons with physical or mental handicaps, the frail elderly and particular groups that need support in conducting their daily life activities. Different levels of organisation and different divisions of responsibility (public–private) as well as differences in the demarcation of the boundary between the medical component and the social care component result in great variation in long-term care services, their organisation and their role within the social protection systems of the Member States([36]).

Long-term care systems have undergone major changes during the past decade in terms of their financing, planning, provision of services and quality developments. The expected, and observed, increase in demand for long-term care services represents a policy challenge for many Member States, as the current supply is considered to be insufficient and inadequate in terms of meeting current and especially future needs.

The great diversity that exists in the organisation, financing and provision of long-term care services across

([29]) The SHSGI study 2008 analyses not only long-term care, labour market services for disadvantaged persons and childcare, but also social integration and re-integration and social housing. The Commission is currently analysing the results on the study related to the last two sectors and will decide on follow-up activities, including as part of the open method of coordination on social protection and social inclusion.

([30]) We refer to the SHSGI study 2008 for detailed references and sources.

([31]) EU report: 'Long-term care in the European Union', April 2008, available at: http://ec.europa.eu/employment_social/spsi/docs/social_protection/ltc_final_2504_en.pdf. This report reviews the 2006 national reports in relation to long-term care. It analyses the main challenges Member States face and their strategies to tackle these challenges in the light of the agreed common objectives within the open method of coordination.

([32]) *Employment in Europe* is the main tool used by Employment, Social Affairs and Equal Opportunities DG to analyse employment performance and labour market developments in the European Union and in the acceding and candidate countries. It provides the basic analytical and statistical background to underpin the *Joint employment report* as well as other instruments key to the European employment strategy. The report has been produced annually since 1989, with electronic copies available since 1998. For the last few years, the report has been entirely written by the Employment Analysis Unit of Employment, Social Affairs and Equal Opportunities DG in close collaboration with Eurostat, and is published in the autumn. See: http://ec.europa.eu/employment_social/employment_analysis/employ_en.htm

([33]) 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 a chair, moving around, using the toilet, and controlling bladder and bowel functions.

([34]) *Long-term care for older people*, OECD, 2005.

([35]) Instrumental activities of daily living are activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

([36]) EU report: 'Long-term care in the European Union', April 2008, pp. 2-3.

Member States translates into different responses and strategies to address this policy challenge. This influences several aspects of long-term care provision: the degree of accessibility of long-term care services and their financing, the role of informal carers and the degree of support received, the quality of the care provided and the long-term sustainability of the resources dedicated to the sector. Additionally, better integration of, or cooperation between, health and social services remains an important challenge in most Member States.

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

Member States are currently at different stages in developing comprehensive policies for the provision of care to persons in need of long-term care. As with childcare, this sector of social services very much relies on the participation of private households, which still provide the bulk of care in all Member States. Often, these households also have to shoulder a large financial burden in cases where out-of-pocket payments and co-payments for formal care services are required.

Demand for long-term care on average is expected to increase. According to Eurostat's 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 Member States. By 2050, the number of very old people will have almost tripled. In Italy, the share of persons aged 65 and over was 16 % of the total population in 1995, and grew to 19 % in 2005, compared with EU-15 and EU-25 averages of 15 % and 17 %, respectively. Italy (19 %), Germany (19 %) and Greece (18 %) were the Member States with the highest old-age-dependency ratios 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 will rise to 30 % in both the EU-15 and EU-25 and to 35 % in Italy.

Demographic ageing and societal changes, as such, do not necessarily translate into an increased demand for long-term care services. It is the increases in life expectancy and the incidence of disability and dependency that drive increases in demand for long-term care. Increased longevity will spur future demand for long-term care services in both the formal and informal setting. Increased longevity has and will bring about additional demands in terms of rehabilitation, prevention of ill-health in old-age, adequate living conditions for the elderly population (social assistance and pensions) and various policies aimed at enhancing participation in societal activities and empowerment schemes. Population ageing results in an increasing share of old and very old people in the population, leading to new patterns of morbidity and mortality, such as an increase in (often multiple and reinforcing) degenerative and chronic diseases. Demographic ageing, coupled with fertility rates below replacement level and a prevalence of chronic disease in the older age groups, can serve as a proxy of the future demand for long-term care. A higher prevalence of chronic diseases and dependency patterns in old age does not mean that long-term care is a concern solely for the elderly population despite their predominance among long-term care recipients([37]). Steeply increasing age-dependency ratios will negatively affect the fiscal stance by increasing spending needs and reducing the expected amount of contributions from the working-age population.

Older people, however, not only live longer lives: there is also evidence from at least some Member States that people stay healthy longer and that the onset of severe disability is more and more delayed. The most important element in addressing the future needs for long-term care services (both formal and informal) is the degree of additional life-years spent in good health or the health status of the elderly population. Indeed, since demographic developments point to the increased longevity of the population, a serious challenge, or opportunity, in terms of public health is the prevention of ill-health in old age, i.e. delaying the onset of disability or dependence. Demographic developments increase the pressure on long-term care systems to provide more and better curative medical care but also more rehabilitative, nursing and social care([38]).

One ought to remain cautious in any analysis of future demand and possible cost-containment measures with regard to long-term care provision and financing, since the evidence concerning this trend is currently mixed. As a recent OECD analysis quoted in the 2008 SHSGI 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'. 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 and hence the costs of publicly provided long-term care services. These uncertainties together with the uncertainties related to future life-expectancy estimations make long-term care projections rather difficult.

Demographic ageing and societal changes impact on both the provision and supply of long-term care services. Long-term care services are provided both on a formal, accredited basis and on an informal basis. Informal care has traditionally been undertaken predominantly by women. Societal changes such as the increased participation of women in the labour market mean that there is, and will be, less time available for

([37]) EU report: 'Long-term care in the European Union', April 2008, pp. 5-6.

([38]) EU report: 'Long-term care in the European Union', April 2008, p. 8.

women to take on such care responsibilities. Additionally, considering the life-expectancy gap between men and women (on average women live longer) and the identified trend in the evolution of family structures (dissolution and break-up), it can be argued that women in the older ages will need some form of care (formal and/or informal) since, in view of the prevalence of dependency and disability in older ages, this could not be provided on an informal basis by family members. This issue will be addressed later when analysing the general drive to improve support mechanisms for informal carers and increase the provision of formal care in a community setting.

Together with the concerns about the impact of demographic trends and societal changes, the need for better adapting long-term care to users' needs is at the top of social policy agendas. These come in addition to other important concerns, such as staff shortages and improving staff qualifications, although these seem to be more pressing issues for Member States where the public supply of services and their funding are already advanced. In particular, the current staff shortages 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 by concerns regarding pay levels, high staff turnover and difficult working conditions.

In response to these challenges, most Member States have initiated reforms to long-term care systems, often with a special focus on quality assurance, improvement and accreditation initiatives. In some cases, this goes hand in hand with expanding the scope of available social services while keeping in mind their accessibility and, at the same time, the resources available. Concerns regarding quality improvement often include the expansion of support schemes for informal and formal carers such as respite care and their inclusion in social security schemes.

3.1.2. Overview of service provision

The structure and the organisation of the different long-term care schemes vary between the Member States, reflecting more the organisational features of each system rather than population structure and demographic developments. The variations reflect the differing national approaches to familial solidarity (occurrence of informal care and support for carers) as well as identifiable disparities between the demand for and the provision of publicly funded long-term care services([39]).

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

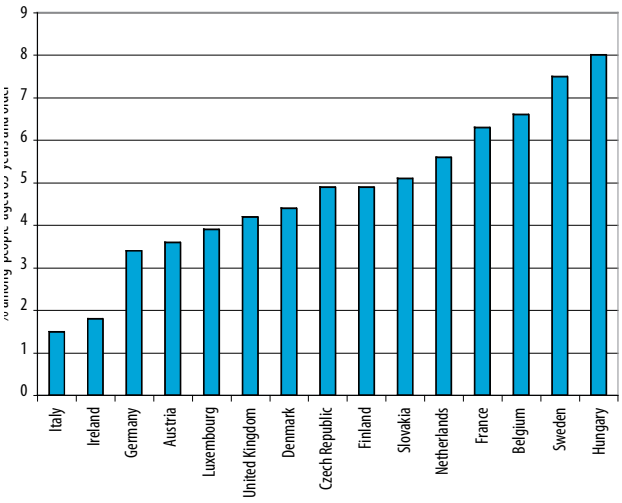
In some cases, the devolution of responsibilities for organising long-term care to local level has resulted in differences in the way care assessment is implemented and in differences in the generosity of services, often depending on the allocation and size of local budgets.

Moreover, there is now considerable competition among different types of suppliers of long-term care in many Member States, which has in some instances helped to drive the agenda of internal and external quality assurance and increased reporting to the public. While public providers are still dominant in the Czech Republic and in Sweden (with shares of 80 % and 70 % of the supply, respectively), they account for only 10 % in the United Kingdom and 5 % in Germany. Midway between these extremes, they represent 42 % in France and 30 % in Italy. Non-profit providers represent 80 % of the supply in the Netherlands, approximately 50 % in France, Germany and Italy, 15 % in the Czech Republic and 10 % in both Sweden and the United Kingdom. In the latter, for-profit providers have a share of 80 % of the supply. As for other Member States, with the exception of Germany (approximately 50 %), the share of for-profit providers is very low (20 % in Sweden, Italy and the Netherlands, 7 % in France and 5 % in the Czech Republic).

The numbers of dependent older people who 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 offered and the type of institutions that are behind the aggregate numbers of Figure 3.1 below are not the same in the different Member States. 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 Member States. With the exception of Sweden, the average number of persons per room in a nursing home typically ranges from 1.4 in Germany or the United Kingdom to 2 in the Netherlands or more in other Member States.

([39]) EU report: 'Long-term care in the European Union', April 2008, p. 15.

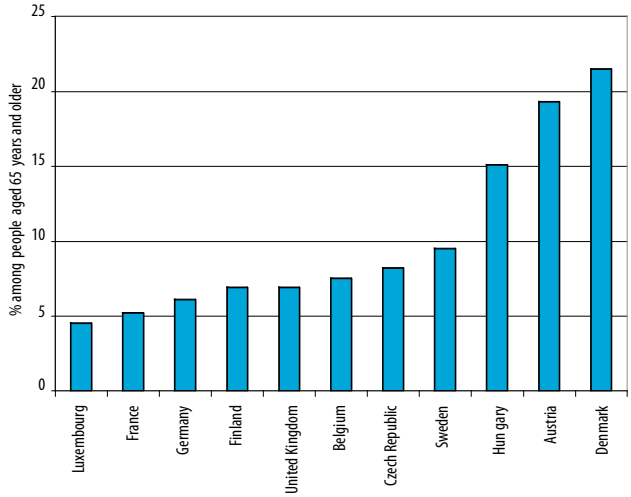
Figure 3.1: Long-term care recipients in institutions, 2004



Source: OECD (2006 health data).

The reasons why some Member States 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 Member States, such as Italy and Ireland, and public policy has only recently become more active in complementing family care with more publicly available care alternatives. For other Member States, there is a combination of a continuing family tradition in providing 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. care allowances in Austria and Germany).

Figure 3.2: Long-term care recipients in the community (including people receiving care allowances), 2004



Source: OECD (2006 health data).

Home-care services are in many cases less developed than care provided in institutions. Moreover, as shown in Figure 3.2, there is a great disparity between Member States in the share of older people who receive care in a community setting([40]). However, this comparison is more difficult than in the case of care in institutions due to national differences. In Austria, for example, the large number of care recipients includes many people who receive relatively modest monthly payments, whereas the entitlement conditions (combination of functional restrictions and minimum number of hours of care needed) in Germany result in fewer people getting over the threshold for entitlement to care allowances or, alternatively, professional home-care services.

The boundary between 'institution' and 'home' is increasingly getting blurred as public long-term care programmes have aimed to create 'home-like' environments for persons who need long-term care. In Denmark, for example, many nursing-home places have been converted to service apartments served by the same providers also active in home care. These cases could now show up in the statistics either under 'institution' or under 'home'. One ought to remain cautious when assessing the statistics on long-term care provision by settings. It is difficult to measure the exact degree and coverage of long-term care provision. Difficulties in measurement stem from varying definitions of what constitutes long-term care, what schemes are included under the long-term care concept, and the length of stay. Some Member States favour longer lengths of stay in institutions than others.

In any event, as appears from the EU report on long-term care in the European Union, Member States are firmly focused on enhancing tailor-made home and community care services and are moving away from institutional care. This does not mean that institutional care provision is to be dismantled. Rather, institutional care must be maintained for those with severe disabilities and conditions for whom home care is not the most appropriate alternative([41]).

There is also a general trend towards care coordination, which is seen as crucial in enabling a high level of quality and efficient use of resources in the provision of long-term care services in an institutional or community setting, thus ensuring an adequate continuum of care irrespective of the different levels of long-term care provision (local, regional, national) and organisation. Some Member States focus on the provision of a medical care continuum, whereas others discharge patients from institutional care faster while emphasising the rehabilitative or preventive follow–up

([40]) ICT for 'ambient assisted living' is a way to allow for independence and continuity of care at home. For this purpose, the Commission proposed a decision on the establishment of the joint programme for research in ambient assisted living (COM(2007) 0329 final) that will be adopted in June by Parliament and the Council.

([41]) EU report: 'Long-term care in the European Union', April 2008, p. 13.

of care. Indeed, coordination problems at the interface between medical, social services and informal care can result in negative outcomes for users and an inefficient use of resources([42]).

Community care, home care, residential care and day care are labour-intensive sectors with staff costs accounting for the majority of the overall costs in these settings. Labour supply in these settings is a major preoccupation for Member States, particularly considering the labour shortages in medical, nursing and social care. In the community care setting, the problem of insufficient and inadequately trained staff is exacerbated by the fact that the bulk of the care provided in that setting tends to be carried out by family or informal caregivers.

As informal care will continue to play an important role and given the strong focus on home provision, there is a recognised need to develop structures that support informal caregivers. Policy proposals for informal care include: information, training, counselling, respite care (allowing caregivers time off), financial aid to informal carers, tax credits and exemptions, allowing informal caregivers to reconcile care provision and paid employment (in particular through work leave to care for relatives and consideration of care periods as part of the contribution period for pension purposes), formalising their status and including them in social insurance schemes([43]).

Staff shortages in the long-term care sector in both the institutional and home settings, coupled with demographic developments and changing family structures, will most likely result in an increased demand for formal care-giving in both settings. The quality of the workforce inevitably influences the quality of the long-term care services provided. In addition to adequate qualifications and constant training, Member States have had to devise ways to support and sometimes formalise the working conditions of informal caregivers([44]).

3.1.3. Overview of expenditure

Total expenditure on long-term care in the EU-15 ranges from below 0.2% of GDP to around 1.8% of GDP. About half of all EU Member States for which data are available have an overall public spending of 0.7% of GDP or more (see Table 3.1 and Figure 3.3 below).

([42]) EU report: 'Long-term care in the European Union', April 2008, p. 26.

([43]) EU report: 'Long-term care in the European Union', April 2008, pp. 31-32.

([44]) EU report: 'Long-term care in the European Union', April 2008, pp. 31-32.

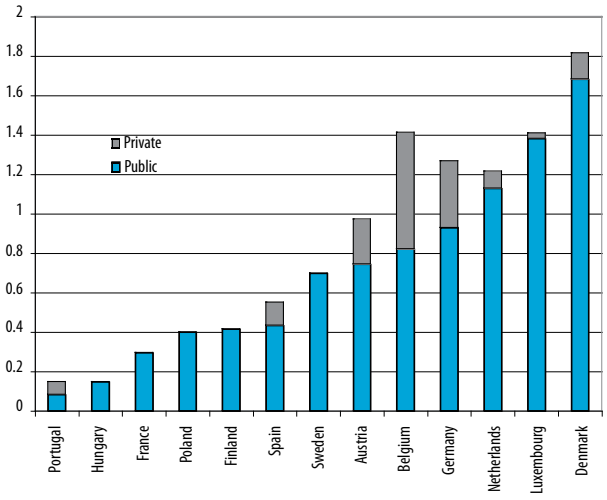
Table 3.1: Estimated expenditure on long-term care and projections up to 2050

	AWG Reference scenario (ECFIN)			OECD estimates		2050 Projection			
Country	2004	2050	Change (2004–50)	2004 (health data 06) (*)	2005 (**)	Cost pressure	Change (2004–50)	Cost containment	Change (2004–50)
BE	0.9	1.9	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
EL	n.a.	n.a.	n.a.	n.a.	0.2	2.8	2.6	2	1.8
IE	0.6	1.2	0.6	n.a.	0.7	4.6	3.9	3.2	2.5
ES	0.5	0.7	0.2	0.4	0.2	2.6	2.4	1.9	1.7
FR	0.3	0.5	0.2	0.3	1.1	2.8	1.7	2	0.9
IT	1.5	2.2	0.7	n.a.	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	0.5	0.9	0.4	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
EU-15	0.9	1.6	0.7	0.7	1.3	3.5	2.2	2.6	1.3
CY	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

CZ	0.3	0.7	0.4	0.1	0.4	2	1.6	1.3	0.9
EE	0.3	0.6	0.3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
HU	0.6	1.2	0.6	0.2	0.3	2.4	2.1	1	0.7
LT	0.5	0.9	0.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
LV	0.4	0.7	0.3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
MT	0.9	1.1	0.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
PL	0.1	0.2	0.1	0.4	0.5	3.7	3.2	1.8	1.3
SK	0.7	1.3	0.6	n.a.	0.3	2.6	2.3	1.5	1.2
SI	0.9	2.1	1.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
EU-25	0.9	1.6	0.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: ECFIN (2006), OECD (2006), OECD (2006 health data).

Figure 3.3: Expenditure on long-term care (as a % of GDP), 2003/2004



Source: OECD (2006 health data).

In all EU Member States, private households take on part or all of the burden of care, either by providing the majority of care hours that people needing long-term care receive or by making substantial contributions to the financing of long-term care, in the form of co-payments to publicly provided care or as out-of-pocket spending on care for which no or only very little public coverage (reimbursement or exemption) 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 (see Figure 3.3 above).

As many pensioner households in all Member States do not have the financial means to afford 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 Member States where long-term care provision is currently low, e.g. Portugal or Spain.

Although home-care or community services are less expensive than acute care in an institutional setting, the resources allocated to the home-care sector vary between Member States. In the majority of Member States, publicly funded institutional care still accounts for more than half of the long-term care expenditure. Despite the fact that most Member States wish to expand community and home care, either for financial reasons or in order to provide patient-centred services, the share of home care as a component of public spending on long-term care varies. In the Member States with the least developed long-term care systems, the share of public spending on home care as a proportion of total long-term care expenditure is minimal. Other Member States have made significant steps towards increasing public spending on home and/or community care. The schemes included in the definition of long-term care and the legal status of long-term care providers will also affect the degree of comparability between the various schemes and their levels of expenditure([45]).

In the coming decades, public long-term care expenditure is expected to increase steeply. This growth will be determined by several factors in addition to demographic ageing: (i) the availability of informal care by family, friends, and the voluntary sector; (ii) public pressure to put public long-term care programmes in place, where these are currently rudimentary, and to enhance them where long-term care provision is already developed; (iii) the cost of improving the quality of care in both the community and institutional settings; (iv) cost pressures arising from staff shortages; (v) trends in the incidence and prevalence of dependency and disability, which are currently uncertain, and, finally, (vi) trends in the living conditions of older people, such as income levels, means available for meeting their long-term care needs, and changing family structures, which can often lead to the isolation of elderly people. Changing family structures and the degree of development of long-term care provision influence the availability of formal and informal carers, which must be taken into consideration in addressing the quality of life of long-term care recipients in a community setting.

([45]) EU report: 'Long-term care in the European Union', April 2008, p. 15.

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 in the EU-15 may almost double from currently around 1% of GDP to almost 2% of GDP, according to recent OECD projections, and increase by two thirds according to the AWG reference scenario of the EPC (see Table 3.1 above).

To interpret these projections correctly, it is important to keep in mind that they are mainly driven by estimates of: (i) the future numbers of elderly persons (population projections); (ii) the future numbers of dependent elderly persons (prevalence rates and projections of dependency); (iii) the balance between formal and informal care; (iv) the balance between home and institutional care within formal care provision, and (v) the unit costs of care. One needs to remain cautious in the interpretation of these projections as gathering data in order to set baseline expenditure levels has proved very difficult([46]).

3.1.4. Modernisation trends in long-term care

From the analysis in the 2008 SHSGI study it appears that modernisation within the field of long-term care is mainly driven by socioeconomic transformations that affect both the needs for care and the financing needs.

- **Demographic changes:** As seen above, this is one of the main issues that most Member States are facing and is of particular importance for Member States with care provision based on contributory or social insurance systems.

- **Changes in the needs for care:** Twenty years ago, institutions and services mainly addressed people experiencing social difficulties (insufficient resources or absence of a family environment). With the increase in the number of dependent people, the level of dependence and the poly-pathologies of the elderly, long-term care services are increasingly called upon to provide more professional and often more medical services to a broader and more differentiated segment of the population. This trend will also impact on the skills required to provide these services.

- **Increased need for combining formal and informal care:** The ageing of the population is also taking place in a social context where the structure and the role of the family have evolved in most of the Member States. This has an impact on traditional informal care provided by family members and volunteers to the elderly and people with disabilities or illnesses. As seen above, in many Member States, ensuring a better combination between formal and informal care is a topical issue and several have developed specific schemes to support informal carers and have even included them under social security schemes.

- **User orientation — from public to private provision of services:** As will be further analysed in Chapter 4, the increased focus on user empowerment is accompanied in most Member States by the introduction of market-based regulatory mechanisms and the increased involvement of the private sector in service provision. Personal budgets, supplemented by professional case management, as is the case in Germany, the Netherlands and the United Kingdom (England), increasingly appear to be a way of empowering users. The development of ICT applications for health and social care can, in most cases, allow for a better adaptation of service provision to users' needs.

- **Integration of health and social services:** In most Member States, the separation of health and social care leads to difficulties in coordinating care packages for dependent people. Some measures have recently been introduced to promote the integration of health and social care services. In the United Kingdom, for example, local authorities are now obliged under the Community Care Act 2003 to reimburse NHS hospital trusts if a patient cannot be discharged from hospital because there are no alternative long-term care services in place. Initiatives have also been taken to promote the development of intermediate care. In the Netherlands, this trend has led to a wave of mergers between different types of service providers.

- **Decentralisation:** as will be further analysed in Chapter 4, there is a trend towards transferring more responsibility to local levels in the organisation of social services, with different results depending on the national context (increased weight of community care versus institutionalised care, decreasing level of welfare state provision, etc.).

The table below shows the main drivers in each of the Member States analysed in the 2008 SHSGI study.

([46]) EU Report: 'Long-term care in the European Union', April 2008, pp. 9-11.

Table 3.2: Drivers of modernisation in long-term care

Type of driving force	Member State							
	CZ	DE	FR	IT	NL	PL	SE	*UK*
Demographic change	2	1	2	1	1	1	1	3
Stronger concern to take into account user interests and user choices	2	2	2	2			1	2
Budgetary constraints on public authorities and/or social insurance agencies	3	2	1	4	1	1	2	1
More weight for participatory processes	3	3	2		1		3	3
Evolving concerns/demands (e.g. support for 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 a stronger focus on accountability, efficiency, effectiveness and the control of these factors)	3	4	2				2	2
Organisational restructuring (e.g. in the 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
NB: Rating from 1 (very important) to 5 (not at all important)		1	2	3	4	5		

Source: 2008 SHSGI study — results from the questionnaire for in-depth country-studies, p. 245.

3.2. Labour market services for disadvantaged people([47])

Persons with disabilities([48]) who are inactive and unemployed and those with other disadvantages, e.g. with a low education or in long-term unemployment with little work experience, are the main target groups of the labour market services offered under national labour market public policies.

Since its start in the late 1990s, the European employment strategy([49]) has placed a particular emphasis on the integration of disadvantaged persons into the labour market. In addition, the Commission launched an initiative in 2006 for the active social and economic inclusion of people furthest from the labour market([50]). The strategy proposed is based on three integrated pillars: adequate income support, access to inclusive labour market and quality social services. For labour market integration to be sustainable, disadvantaged people first need to be supported with sufficient resources and personalised

([47]) The present section only takes into consideration the providers of services that offer 'work integration' services in a stable and continuous way for a large category of beneficiaries, and not those which concentrate on particular sub-categories of specifically disadvantaged people, such as former prisoners, drug addicts or severe mentally disabled, or those which concentrate on particular types of professional training, such as the construction sector. Thus, the report analyses providers that offer various support and assistance services with the aim of permanently reintegrating disadvantaged persons back into the labour market.

([48]) For more information on the situation of people with disabilities in the European Union see the communication 'Situation of disabled people in the European Union: the European Action Plan 20082009', COM/2007/738 of 26.11.2007 in http://ec.europa.eu/employment_social/index/com_2007_738_en.pdf and its related annexes in http://ec.europa.eu/employment_social/index/sec_2007_1548_en.pdf.

([49]) On the European employment strategy see website (http://ec.europa.eu/employment_social/employment_strategy/guidelines_en.htm).

([50]) COM(2006) 44 final of 8.2.2006 and COM(2007) 620 final of 17.10.2007. See: http://ec.europa.eu/employment_social/spsi/active_inclusion_en.htm

employment and social services, to enhance their social participation and employability.

Persons with a long-standing health problem or persons with disabilities are considered as a group at high risk of being excluded from the labour market. 78 % of the 'very severely' disabled and 49 % of the 'severely' disabled persons of working age in the EU were inactive in 2002, as against 27 % for the non-disabled. However, the employment rate of persons with moderate or mild disabilities is comparable to that of the general population. The reasons behind low participation rates among the 'very severely' and 'severely' disabled in most Member States are their lower employability, benefit traps (i.e. risks of losing benefits on starting work) and the reluctance of employers to recruit disabled workers. Given the demographic phenomenon of a shrinking labour force in the future and given the EU agenda of promoting higher economic growth, competitiveness and social cohesion, it is crucial to implement active inclusion policies for people with disabilities, especially to provide better access to services and programmes to help them to get a job in the open labour market or in sheltered workshops.

3.2.1. The role of labour market services

The main purpose of labour market services for disadvantaged persons([51]) is to integrate them into the regular labour market by enhancing their employability. This goal is mainly achieved by creating job opportunities and by providing training in sheltered conditions and experience with on-the-job training, in order to improve the social and professional abilities of disadvantaged persons and to increase their skill levels and opportunities so that they are able to find jobs in the regular labour market.

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

([51]) 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 but who would like to enter the labour market and are disadvantaged in some way.

3.2.2. Overview of service provision

In most cases, the regulation, financing and delivery of labour market services are responsibilities shared between national, regional and local authorities. The framework legislation is often formulated at national level, while detailed regulations and the delivery of services are frequently delegated to regional and local levels. However, as with long-term care services, the devolution of responsibilities for organising labour market services to local level has resulted in differences in the way the services are provided, due to differences in the local budgets available.

Ensuring the provision of labour market integration services for disadvantaged persons is obviously a complex task. The competent public authorities remain responsible for the process of work integration as a whole at their respective levels, but service provision can be in the hands of numerous actors and combine various types of resources.

Public employment services remain the most important labour market institution. They deliver personalised and tailor-made services to disadvantaged people, by understanding and knowing their needs. They play a crucial role, as they have (i) the ability to provide services to all disadvantaged people; (ii) the advantage of proximity to job seekers through full geographic coverage of the country; (iii) a life-long perspective, as they offer a large number of training facilities; (iv) a comprehensive view of labour market needs; (v) the capacity to implement mainstream approaches and to implement strategies, policies and measures defined by government; (vi) the capacity to network at local level as they have the ability to involve all stakeholders at local level (e.g. in large cities) and to create partnerships to improve the efficiency of action, allowing a more rapid and effective approach to unemployed and inactive persons.

Among the Member States studied in the in-depth analysis (the Czech Republic, Germany, Poland, Sweden and the United Kingdom), the United Kingdom has 60 % of its service provision in the hands of public entities, while the remaining 40 % is divided equally between for-profit and non-profit providers. In the other four Member States, public institutions take up a larger share (in excess of 80 %).

The new partnership models and modes of provision that are currently developing include the participation of several types of providers and stakeholders. The chain of intervening actors and the synergies generated in the reintegration process thus now matter more than the individual input of each provider. However, the coexistence of providers with different ways of working may entail difficulties. Thus, the forms of governance in place and the coordination of the public, private for-profit and not-for-profit actors intervening in the process are key factors.

Finally, the participation and motivation of the beneficiaries in the management or organisation of their reintegration process is a particular challenge, with a view to enhancing their self-confidence and their own capacity to reintegrate within the regular labour market. Given the characteristics of the beneficiaries, this participation is often quite difficult to achieve. The degree to which it is achieved is an important indicator of the quality of the services provided.

3.2.3. Overview of expenditure

In 2006, total public expenditure on all labour market policies was 1.9 % of GDP in the EU-27. However, this figure hides considerable differences across Member States with respect to the level of expenditure and its distribution between the services of public employment agencies, active labour market policy measures and passive labour market income support policies. For instance, in five EU Member States, the share of GDP spent on labour market policies was more than 2.5 % or more: Denmark (4.34 %), Germany (2.97 %), Belgium (2.9 %), the Netherlands (2.68 %), and Finland (2.54 %). In contrast, many Member States spent less than 0.5 % of GDP, notably Estonia (0.15 %), Lithuania (0.39 %), Romania (0.43 %), Greece (0.47 %) and the Czech Republic (0.49 %) (See Table 3.3).

Table 3.3: Public expenditure on labour market policy, by category, as a % of GDP, 2006

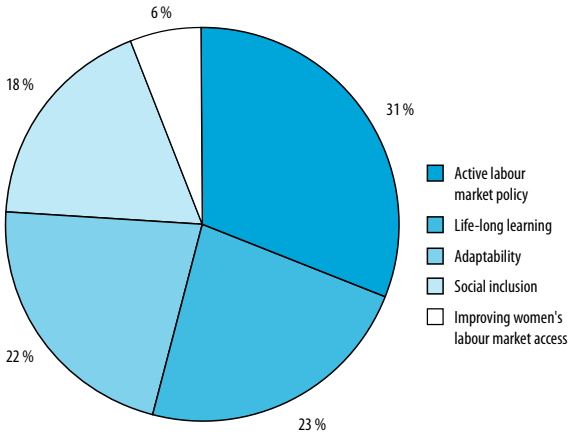
	Labour market services (1)	Training (2)	Job rotation and job sharing (3)	Employment incentives (4)	Supported employment and rehabilitation (5)	Direct job creation (6)	Start-up incentives (7)	Total LMP measures (2–7)	Total LMP supports (8–9)	Total LMP (1–9)
EU-27	0.22	0.21	0.00	0.12	0.06	0.07	0.04	0.51	1.20	1.92
EU-15	0.22	0.22	0.00	0.13	0.06	0.08	0.04	0.53	1.25	2.00
Belgium	0.20	0.20	-	0.21	0.12	0.35	0.00	0.89	1.81	2.90
Bulgaria	0.06	0.05	-	0.05	0.01	0.29	0.01	0.39	0.18	0.63
Czech Republic	0.13	0.01	-	0.03	0.05	0.03	0.00	0.13	0.23	0.49
Denmark	0.16	0.54	-	0.47	0.51	0.00	-	1.52	2.66	4.34
Germany	0.27	0.34	0.00	0.06	0.01	0.09	0.12	0.61	2.09	2.97
Estonia	0.02	0.04	-	0.00	0.00	-	0.00	0.05	0.08	0.15
Ireland	0.24	0.21	-	0.03	0.01	0.21	-	0.46	0.86	1.57
Greece	0.01	0.04	-	0.02	-	-	0.00	0.06	0.40	0.47
Spain	0.10	0.15	0.01	0.32	0.02	0.06	0.08	0.63	1.43	2.16
France	0.24	0.29	-	0.12	0.07	0.19	0.01	0.68	1.39	2.32
Italy	0.03	0.22	0.00	0.18	-	0.01	0.04	0.45	0.79	1.27
Cyprus	:	0.01	-	0.04	:	-	0.01	:	0.66	:
Latvia	0.07	0.10	-	0.05	0.01	0.01	-	0.17	0.30	0.54
Lithuania	0.09	0.07	0.00	0.06	0.00	0.05	0.00	0.18	0.13	0.39
Luxembourg	0.06	0.12	-	0.20	0.01	0.06	0.00	0.39	0.59	1.04
Hungary	0.09	0.06	-	0.08	-	0.05	0.00	0.19	0.36	0.64
Malta	:	:	-	-	-	0.00	-	-	-	-
Netherlands	0.47	0.13	-	0.13	0.49	-	-	0.75	1.47	2.68
Austria	0.18	0.40	0.00	0.06	0.04	0.04	0.01	0.54	1.39	2.11
Poland	0.09	0.10	-	0.05	0.16	0.02	0.04	0.36	0.71	1.16
Portugal	0.13	0.25	0.00	0.13	0.04	0.03	0.00	0.45	1.27	1.84
Romania	0.04	0.02	-	0.05	-	0.03	0.00	0.11	0.28	0.43
Slovenia	0.10	0.06	-	0.03	-	0.07	0.02	0.18	0.39	0.66
Slovakia	0.17	0.01	-	0.02	0.01	0.05	0.04	0.14	0.34	0.65
Finland	0.13	0.37	0.05	0.10	0.10	0.09	0.02	0.72	1.69	2.54
Sweden	0.19	0.33	0.06	0.51	0.20	-	0.03	1.13	0.96	2.28
United Kingdom	0.37	0.02	-	0.01	0.01	0.00	-	0.05	0.19	0.60
Norway	0.12	0.26	-	0.02	0.13	0.06	0.00	0.47	0.50	1.08
NB: Denmark (2004), Greece (2005)										

Source: Eurostat (labour market policy database (labour market policy intervention, 2006)).

The European Employment Strategy and the OECD Job Strategy recommend redirecting spending towards active labour market policies, mainly because these measures specifically target labour market reintegration for disadvantaged groups. However, according to the 2008 SHSGI study, Member States have not made any significant progress over the past decade in shifting resources from passive to active measures. In fact, in the majority of the Member States, spending on active measures is less than one half of the amount spent on passive labour market income support policies. The Netherlands, Sweden and Denmark stand out as those Member States that spent a relatively higher proportion on active measures.

The European Social Fund (ESF) and the European Regional Development Fund (ERDF) have also invested substantially in active labour market policies across the European Union. In the 2000–06 period, as shown by Figure 3.4 below, around 30 % of total ESF funding, amounting to some EUR 19 billion, was devoted to this policy field. In the same period nearly EUR 291 million were spent via the ERDF under the same heading. In addition, some EUR 4 billion were spent on specific measures to improve women's access to the labour market via the ESF and EUR 84 million via the ERDF. Member States made use of ESF and ERDF funding to a different extent. By way of example, while the share of active labour market policies in national ESF spending amounted to 47 % in Slovakia, 40 % in Spain, and 37 % in Latvia, some Member States devoted less then 10 % of their ESF budget to this area (Belgium: 2 %, Ireland and Malta: 6 %, Portugal: 8 %).

Figure 3.4: Breakdown of the European Social Fund (out of a total ESF budget of EUR 70 billion), 2000–06



Source: European Commission.

In 2004, out of the total expenditure on active labour market policies in the EU-25, 17.8 % specifically targeted the integration of persons with disabilities([52]). Other major categories of expenditure were training (40.4 %), direct job creation (16.3 %) and employment incentives (18.5 %).

Expenditure on active labour market policies can take the form of direct transfers to individuals, employers or service providers, and there are considerable differences within the EU in this respect. For example, more than two thirds of expenditure in the Netherlands and the United Kingdom are direct transfers to service providers, whereas over two thirds of expenditure in Italy, Latvia, Hungary, Bulgaria and Romania are transfers to employers. In Ireland and Finland, a high proportion of all expenditure on active labour market policies comprises direct transfers to individuals (65.2 % and 49.2 %, respectively).

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, received some assistance to work in 2002. In the EU-15, the assistance provided most often involved the kind of work to be performed (37 %), support and understanding from 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 %).

Compared with training programmes, spending on employment incentives and public employment services is associated with significantly better outcomes. The evidence suggests that job-search assistance programmes in general, and activation policies in particular, feature highly among the more cost-effective active labour market policy measures in terms of helping the unemployed to find a job and keep it([53]).

3.2.4. Modernisation trends in labour market services for disadvantaged people

The modernisation process of labour market services is strongly encouraged by the European employment strategy([54]).

From the analysis developed in the 2008 SHSGI study, it appears that developments in this area are influenced by more general trends characterising labour market policies. These include a stronger focus on the quality of human resources and continuous learning, and on the development of active labour market policies addressing specific target groups (long-term unemployed, unqualified youth, etc.).

([52]) This includes expenditure on regular and sheltered employment and other rehabilitation and training programmes.

([53]) *Employment in Europe* report 2006, p. 162.

([54]) On the European employment strategy see website (http://ec.europa.eu/employment_social/employment_strategy/guidelines_en.htm).

In this policy context, according to the 2008 SHSGI study, the modernisation of labour market services is characterised by the following features:

- **Welfare 'contractualism'**, under which the beneficiary of a service/allowance also has certain obligations and responsibilities. This trend has translated for example into policies that make rights to benefits conditional upon the beneficiary following specific work integration programmes. The 'new deal' programme put in place in the United Kingdom in 1997 is an example of such an active labour market policy.

- **Rescaling** of provision modes, with, in general, local authorities being given greater room for manoeuvre in the choice of services and their implementation. In certain Member States, however, some 'recentralisation' has taken place. In Sweden, for example, in 2005 a new integrated government agency replaced the 21 regional social insurance offices, which became regional branches.

- **Targeting:** the policy rationale behind targeting is that long-term unemployment is a major cause of social exclusion. This trend has, for example, led to the development of policies targeting unemployment in deprived neighbourhoods.

- **Partnership with the third sector:** this trend in labour market services leads to the development of partnerships with organisations in civil society.

The table below shows the main drivers in each of the Member States analysed in the 2008 SHSGI study.

Table 3.4: Drivers of modernisation in labour-market services for disadvantaged people

Type of driving force	Member State				
	CZ	DE	PL	SE	UK
Budgetary constraints on public authorities and/or social insurance agencies	4	3	1	2	1
Stronger concern to take 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 a stronger focus on accountability, efficiency, effectiveness and the control of these factors)	4	3		2	1
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 the form of integrated services)	4	3		3	2
EU legal and political context	2	4	2	4	3
Evolving concerns/demands (e.g. support for family/informal carers, integrated approaches)	3	4		3	4
Demographic change	5	5		3	3
NB: Rating from 1 (Very important) to 5 (Not at all important)	1	2	3	4	5

Source: 2008 SHSGI study — results from the questionnaire for in-depth country-studies, p. 248.

3.3. Childcare

Childcare services have in recent years experienced rapid growth in many Member States, a trend that is mainly due to the increased labour market participation of women. This is 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 Member States in Eastern Europe, where the overall supply of childcare services declined during their transition towards a market economy. The main reasons for this development were the financial difficulties of local governments and a decrease in the demand for childcare services due to very low birth rates and high unemployment. In addition, the shrinking of supply was due to the extension of the parental leave to three years in the Czech Republic and to the privatisation of enterprises in Poland, whereas before the transition employers were relatively active in the organisation of childcare.

Hand in hand with the overall growth, recent years have been characterised in many Member States — in particular in the EU-15 — by diversification in the supply of childcare services, regarding the types of providers, the type of financing and the way these services are regulated.

3.3.1. The role of childcare services

Childcare services play a crucial role for a number of policy targets. Quality childcare can foster the healthy and sound development as well as the socialisation and education of children, and help parents to reconcile work and family life. They also help to strengthen social cohesion and inclusion, to promote gender equality, to raise female labour market participation([55]) and to improve quality and productivity at work. Thus, access to childcare services is essential for the well-being of children, for their families and for the community as well as for a productive and growing economy.

While the policy debate on childcare has mainly focused on facilitating the participation of women in the labour market([56]), in recent public discussion childcare seems to have shifted from being considered as an instrument of labour market policy towards being perceived as a goal in itself, playing an important role in the development of children and adding value to childcare at home. Furthermore, improving social cohesion and integrating children from disadvantaged socioeconomic backgrounds are gaining importance as issues across Europe.

Ensuring suitable childcare services is high up on the social agenda of the European Council and the European Commission and represents a policy priority in practically all Member States.

In order to remove disincentives to female labour force participation, the Barcelona European Council agreed on the goals of providing, by 2010, childcare 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. In practice, the level of childcare services differs considerably in the EU-25, but in most Member States it is below the Barcelona targets, notably for children below 3 years of age.

The increased attention given to childcare in policy debates has also been reflected in the evolution of the scope of the European Social Fund (ESF) and the European Regional Development Fund (ERDF). In the 2000–06 period, actions relating to childcare were in principle implemented only as accompanying measures, i.e. could be supported where necessary to ensure the successful implementation of main ESF actions (e.g. in the case of training for women, childcare can be financed to allow mothers to participate in such training)([57]). For the 2007–13 period, however, facilitating access to childcare is recognised as a key element in increasing labour market participation and can be supported 'in its own right'([58]). In the agreed operational programmes over EUR 555 million have been earmarked for spending on childcare infrastructure.

3.3.2. Overview of service provision

The underdevelopment of childcare services for children up to 3 years old — with the exception of the Nordic Member States, the Netherlands and France — is related to traditional views of childcare: a huge part of care responsibilities for small children is still left to the families. Crèches and nurseries are found mainly in urban areas, and are a last resort for working parents. Denmark, Sweden and the Netherlands are the Member States with the highest proportions of children in the 0–3 age group receiving formal childcare (40 % or more), followed by Finland and France (30 % or more)([59]). Much lower proportions are observed in the southern and central European Member States. In Italy and Germany, the public supply of early childcare services has traditionally been very low, while in the Czech Republic and in Poland the low rates are also a consequence of the transition process, as mentioned above.

([55]) Childcare services can be seen as a very effective labour market policy instrument as they not only facilitate the participation of women in the labour market but also offer job opportunities mainly for women.

([56]) 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, thus reflecting the view of childcare as a labour market instrument.

([57]) See Regulation (EC) No 1784/1999 of the European Parliament and of the Council on the European Social Fund, Article 3(2)(b)(i).

([58]) Article 3(1)(b)(ii) of Regulation (EC) No 1081/2006 explicitly mentions 'measures to reconcile work and private life, such as facilitating access to child-care and care for dependent persons'.

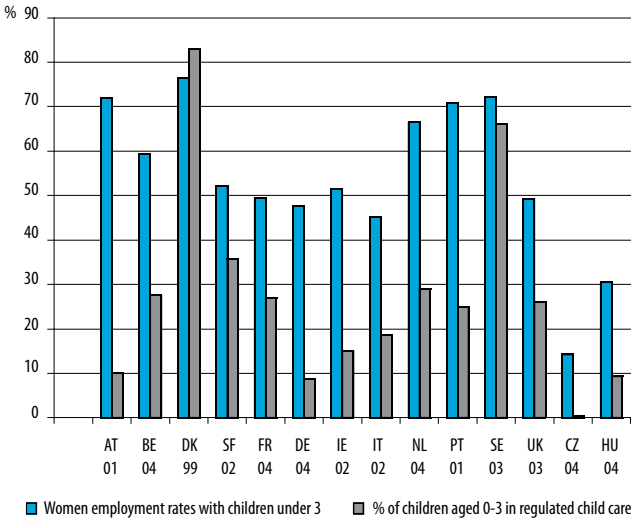
([59]) Eurostat EU-SILC (2005).

In contrast, there is almost universal access to kindergarten or pre-school for the 3–5 age group, following a clear educational approach. Coverage is 90% or more in several Member States and service availability is also more uniform across Member States.

Care provision for school-aged children (6 to 11 years) is still in the development stage in most EU Member States. Adequate care levels for this age group are provided in the northern Member States (40% or more in Denmark and Sweden), in the southern countries (35% or more in Italy and Spain) and to some extent in the new Member States (20% or more in the Czech Republic and Poland). As with formal services for pre-school children, central European Member States also lag behind for this service category.

There is a clear positive correlation between the enrolment rate of children in the 0–3 age group and the employment rate for women with children in the 0–3 age group. As the employment rate is higher than the enrolment rate in many Member States, one can assume that the gap is being filled by informal care and/or women working part-time. Although part of this may be due to voluntary decisions, it also indicates that there is a 'hidden' demand for childcare resources among working mothers (see Figure 3.4).

Figure 3.5: Employment rates for mothers with children under 3 years old and access rates for children under 3 years old to licensed early childhood education and care services



Source: OECD (Starting Strong II, p. 245).

Due to the increasing participation of women in the labour market and the wide spread of part-time work and irregular working times, not only the 'quantitative' availability of childcare facilities is relevant, but also the extension and flexibility of opening hours, which have major implications for working parents. Roughly speaking, crèches provide for full-day care throughout the year, whereas kindergartens and pre-schools partly follow a half-day system. A problem with after-school care centres, which usually cover at least office hours, is that they frequently close during holidays. In many Member States, however, replacement childcare facilities provide services during the holiday season. In general, there is a trend to extend the opening hours of childcare facilities.

In all the Member States analysed in depth in the 2008 SHSGI study, childcare services are largely regulated at central level. In recent years, however, many Member States have delegated responsibilities in the field of childcare from national government to the regions and municipalities. The latter are also responsible for planning and assessing the demand for childcare services.

The provision of childcare across Europe takes a variety of forms. 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 and mandatory school age, a broad system of kindergartens or pre-schools is usually 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, very common in many Member States.

In order to encourage the creation and diversification of services and to limit public expenditure, there is a trend toward the delegation of public services to the private sector. In many Member States, the provision of childcare services is already, in principle, open to private providers (e.g. third-sector organisations, commercial providers, enterprise-based services, user cooperatives, and the like).

These providers are usually subject to an accreditation process. Quality requirements frequently have to be met (pedagogical approach, capacity to reach set targets such as number of children, opening hours, care ratios, budget, etc.). If these conditions are met and the services receive a positive evaluation from the authorities, investment subsidies can be granted for their creation. Often these start-up contributions are granted on the basis of bids in response to an open call for tenders by the municipalities.

Usually, private providers also have access to public support for their current costs if they meet some specific criteria and requirements.

In addition, there are also demand-side measures in the form of tax deductions for private enterprises paying crèche fees for their employees or building or renovating company

crèches. In France, for example, for-profit enterprises have been able since 2004 to 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.

Italy and Poland provide special income tax or value-added tax rates for non-governmental organisations active in the field of childcare.

Moreover, public–private partnerships to provide childcare services are facilitated in a number of cases, although there has not been much advanced public–private cooperation in the field. The only exception is Germany, with its long-standing cooperation between public authorities and non-profit organisations in the childcare sector. Although public–private partnerships are encouraged in France through the possibility of non-profit or for-profit organisations participating in the *contrat-enfance* (childcare contract), so far very few of them have been signed. In Italy, public–private agreements with non-profit organisations play a role in parenthood support initiatives. In the Czech Republic, there has not been any advanced public–private cooperation in the childcare sector. In Poland, there are some examples of cooperation between municipalities and non-governmental organisations for kindergarten education in rural areas.

Notwithstanding the trend toward the emergence of new types of providers, public authorities, especially regions and municipalities, still remain the predominant providers of childcare. One of the exceptions is Germany, where — in accordance with the principle of subsidiarity — the current legislation stipulates that public providers (the *Länder*, municipalities) can step in only if the supply by independent providers is inadequate. Generally, the share of both non-profit and for-profit private providers is growing in all Member States.

The 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 remain indispensable in future.

The growing 'marketisation' of the sector has led to the problem of organising and coordinating the different providers in order to harmonise strategies in accordance with education and labour market requirements, demographic trends as well as interest and demand on the part of citizens. Thus, new planning and coordination mechanisms that take into account the new interactions between various levels of public authorities, the for-profit sector, non-profit organisations and civil society have emerged in practically all Member States. The new coordination tools can be seen as examples of innovative practices in terms of their regulatory design.

In terms of employment, there is a general tendency towards an increase in the number of jobs in childcare services, following the overall growth in service supply. In some EU-15 Member States, this has even led to a shortage of professionals in childcare services due to the growing demand for childcare places. In France, in particular, the employment of childminders and specialised educators for young children has increased. Again, exceptions to this trend can be seen in a number of east European Member States, among them the Czech Republic and Poland, where, as noted above, there has been a decline in childcare services.

The educational levels of staff and the qualifications required in the childcare sector vary. On the whole, the childcare workforce is not highly trained. People caring for children below school age have usually completed secondary vocational schooling but do not normally have an academic education. However, in many Member States, progress is being made in redeveloping the curriculum to introduce a higher competence-based profile. Thus, younger educators are becoming more qualified and increasingly have university degrees. As with childcare for school-aged children, many jobs are teaching posts or similar positions in after-school programmes.

In many Member States the average pay of trained staff in childcare facilities is significantly below the salaries of primary teachers. A huge number of community or voluntary providers are unable to offer higher remuneration due to financial restrictions. In most cases, workers in public facilities are better paid than those in private facilities. Unless childminders operate in a market with high demand, incomes in this field are also very low. Where out-of-school childcare is mainly provided by teachers, the pay is usually higher.

One problem in attracting adequately trained staff to the sector might be the relatively high proportion of part-time and short-term jobs. This holds especially true for out-of-school care provision and for Member States with a pre-school system on a half-day basis (e.g. Germany).

In almost all Member States, the share of female employees is very high (close to 100 %) in the childcare sector. This is the case in Germany (96 %), France (97 %), Italy and the Czech Republic (both close to 100 %) in services for children below 6 years of age. In the Netherlands, the share is 75 % in primary education as a whole but higher for services for children aged 4-6.

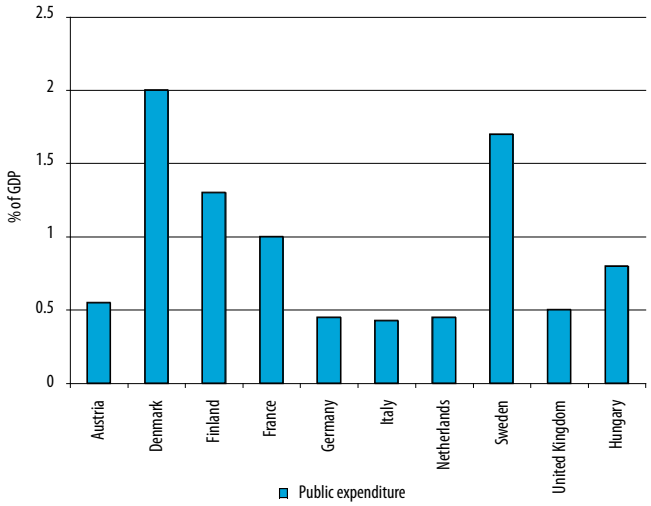
3.3.3. Overview of expenditure

Overall, public expenditure covers from about 66 % to 90 % of total childcare costs in Europe. As shown in Figure 3.5, public expenditure on early childhood services (0–6 years) ranges from 2 % of GDP in Denmark to about 0.4 % in Italy. In France,

expenditure is 1% of GDP, whereas in Germany and the Netherlands it is only slightly higher than in Italy. However, a number of Member States with comparatively low public expenditure (among them Germany and the Netherlands) have in recent years significantly increased their spending levels. In Italy, due to severe budget constraints, expenditure has been characterised by stop-and-go, rather than steady growth.

As a rule, regions and municipalities are responsible for financing childcare, but these services also receive subsidies from the central budget.

Figure 3.6: Public expenditure on early childhood education and care services (0–6 years), as a % of GDP



Source: OECD (Starting Strong II, p. 246).

As regards ESF resources, it is estimated that around EUR 2.4 billion will finance actions to support women in the 2007–13 period with the aim of improving access to employment, sustainable participation in employment and the reconciliation of work and private life, for example by facilitating access to childcare and care for dependent persons. In addition, in their operational programmes, Member States plan to spend some EUR 555 million from the European Regional Development Fund on childcare infrastructure.

Another source of financing is parents' co-payments. However, childcare should be affordable in order to provide more incentives for its utilisation and to improve parental choice. In general, parents' contributions are dependent on their incomes. Fees for private services are usually higher than fees for childcare services in the public sector. In general, parents contribute less than a third to childcare costs in Europe. In several Member States, e.g. France (from 2 years), Italy and the Czech Republic (from 3 years) and the Netherlands (from 4 years), pre-schools and kindergartens are free.

OECD research referred to in the 2008 SHSGI study 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% or more of the total family budget. Consequently, additional tax payments and the loss of social assistance or other benefits combined with even limited out-of-pocket expenses on childcare can leave parents making the transition from inactivity to labour market participation with less disposable income than if they were to stay at home([60]).

The OECD research suggests that only sustained public funding and investment in policy, services and management can secure both the affordability and quality of services in the future.

3.3.4. Modernisation trends in childcare services

In most EU Member States, the main driving forces behind the modernisation of childcare services are the changes in family structures (fewer children per family, a growing proportion of single parents, etc.), the increasing participation of women in the labour market, more flexible labour market requirements and the resulting increasing demand for these services.

As seen above, low birth rates and a wider orientation towards the early socialisation of children are other factors influencing childcare policies.

Finally, the search for greater flexibility and for innovation, as well as budgetary reasons, are prompting increasing recourse to the private sector for the provision of services.

The development of public childcare is also influenced by the culture and traditions of the different Member States and by the perception they have of the division of responsibility between family and public policies.

Table 3.5. shows the main drivers in each of the Member States analysed in the 2008 SHSGI study.

([60]) The inactivity trap facing jobless households with children is referred to in the SPC report on child poverty 2008, which indicates that the share of those households in the overall population has not changed since the start of the decade, despite the growing overall participation of men and women in employment.

Table 3.5: Drivers of modernisation in childcare services

Type of driving force	Member State					
	CZ	DE	FR	IT	NL	PL
Evolving concerns/demands (e.g. support for family/informal carers, integrated approach, etc.)	3	2	1	1		
Demographic change	2	1	4	3		1
Budgetary constraints on public authorities and/or social insurance agencies	4	3	2	4		1
Stronger concern to take into account user interests and user choices	3	2	4	3	2	
Organisational restructuring (e.g. in the form of integrated services)	3	2	3	5	2	
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 a stronger focus on accountability, efficiency, effectiveness and the control of these factors)	4	4	2			
NB: Rating from 1 (Very important) to 5 (Not at all important)		1	2	3	4	5

Source: 2008 SHSGI study — results from the questionnaire for in-depth country studies, p. 253.

In the Member States analysed in the 2008 SHSGI study, there is generally an imbalance between supply and demand, which leaves part of the demand unsatisfied, in particular for children below the age of 3. The ongoing modernisation process aims to improve the childcare offered in both quantitative and qualitative terms. Increasing parents' freedom of choice and improving their access to childcare services are part of these strategies. The development of childcare services is also viewed as helping to provide disadvantaged children with better conditions and to create equal chances for the future.

These trends crystallise as two main strategies aiming to increase the supply of childcare services: (i) diversification in the forms of childcare and (ii) development of new forms of delegation and financial support.

3.3.4.1. Diversified forms of childcare

The coordination and cooperation between different forms of childcare is more and more seen as a way to increase the level of supply, as illustrated by the following examples.

- Collective services such as crèches which are able to provide both regular care (on a full-time basis) and occasional care for children who usually depend on other services (for example in France).
- Enterprise-based or -financed services as a way of supporting employees with childcare responsibilities (for example in Italy).
- Integration of childminders and family crèches within the existing mix of services (for example in France and Germany). However, the level of regulation of these activities might differ from one Member State to another.
- Introduction of (partly compulsory) pre-schools, in order to better integrate children requiring special care or children who otherwise would not be reached by formal childcare. This issue is being debated in several Member States. In the Netherlands, for example, pre-school arrangements are already on the rise, while Poland introduced pre-school preparation in 2004 for six-year-olds in order to create equal educational opportunities for children from different environments.
- A series of innovative practices can also be observed, which target disadvantaged groups and aim to improve the accessibility of childcare services (buses providing itinerant collective childcare, cooperation between local authorities and NGOs to provide pre-school education in rural areas where no childcare is available, etc.).

In this context, there is also an increased focus on the involvement of parents. In several Member States, committees or councils of parents have been established and are involved in childcare policies, even if their rights and roles can vary.

3.3.4.2. New forms of delegation and financial support

A shift towards the delegation of public services to the private sector can be observed in many Member States. The objective is to stimulate the creation of new services, to improve the accessibility of these services and to lower public costs.

In several Member States, more competition has been introduced in the provision of childcare services, with the intention of increasing parents' freedom of choice and improving their position as customers. The reasoning behind this move is that the combination of informed consumers and competing providers is likely to have a positive impact on the quality of services, while at the same time reduce public costs.

In Ireland, the United Kingdom and the Netherlands, for example, subsidies to parents, such as cash benefits, vouchers or tax reductions, are used more frequently compared with supply-side subsidies paid directly to service providers. The 'free choice' objective is also at the core of a recent reform of the funding system in France, which promotes childminders through vouchers and tax credits.

Both profit and non-profit private providers are involved in this process, but their relative importance and the segments in which they operate vary across different Member States.

3.3.4.3. Outcomes of the modernisation process

The modernisation trends identified above are leading to an increase in the supply of childcare services. This is a positive development both for children of working parents, who need to reconcile work and family, and for children with a disadvantaged background, for whom early socialisation is an asset.

At the present stage, however, a considerable part of the demand remains unsatisfied and the goal of 'free choice' is still far from being reached.

While the strategies identified above are likely to improve this situation, they are also creating new risks and challenges. The diversification in the available forms of childcare can make quality control procedures more difficult to implement. Childminders or 'family crèches' are not always subject to the same level of regulation in the different Member States. Moreover, parents are not always ready or prepared to take on the role of supervisors of quality. Finally, private childcare services, even if partially financed by public resources, are often more expensive than public services, which might limit the access of families with low incomes to these services.

The OECD research quoted in the 2008 SHSGI study suggests that, while the benefits of increased supply and choice that result from the increased role played by private providers cannot be ignored, the affordability and quality of childcare services can only be secured by sustained public funding and investment in policy, services and management.

4. Modernisation and the quest for good governance

As set out in Chapter 3 of the present BR, SSGIs are undergoing change in response to evolving needs and socioeconomic challenges. These changes have had an impact on the public provision and financing of these services. Member States have therefore embarked upon the modernisation of their social services to react to these needs and challenges while ensuring financial sustainability. In the context of the present report, the concept of 'modernisation' is used to cover the wide range of reforms that have taken place in the social field over the last 20 years.

Diversity of modernisation processes

Based on the analysis carried out in the 2008 SHSGI study, Chapter 3 gives a flavour of the different forms that modernisation processes can take in the various sectors concerned.

These processes are influenced by the inner logic of each policy field and by socioeconomic factors that have an impact on certain SSGIs more than others: for example: (i) the ageing of the population is the main challenge that long-term care services currently have to face; (ii) labour market services have to adapt to the requirements of the labour market and to changes in labour market policy orientations; and (iii) the development of childcare services is a response to new needs linked to gender equality and to changes in the role of families.

Moreover, depending on the political, historical and cultural context of each Member State, these processes have started out from different levels of government, and a variety of structural changes in the organisation, management, regulation and governance of social services can be observed across the EU.

The diversity of the existing national institutional frameworks for the provision of SSGIs is an important explanatory factor for the variety of modernisation processes that can be observed at national level. The following aspects influence the forms taken by national modernisation processes:

- the distribution of responsibilities for the organisation, regulation, provision, financing and evaluation of social services at national, regional and local levels;

- the main design parameters of social protection systems;

- the entitlement conditions for specific benefits — these conditions are sometimes clearly defined in the applicable legal framework while in other situations, particularly for means-tested benefits, local authorities enjoy some discretion, e.g. with regard to the form these benefits can take (benefits in kind, in cash, personal SSGIs, etc.);

- the different types of providers (public, private for-profit or not-for-profit);

- the different financing modes and sources of funding (shares of taxes, social insurance contributions, user fees, donations, own financial resources of providers, etc.),

- the extent of user participation in social service provision and evaluation, and

- the implementation of consumer protection mechanisms.

Some common trends

In spite of this diversity, some common trends regarding the organisation, management and governance of social services can be identified and are presented in this chapter.

Modernisation is a response to the main social and economic challenges EU societies are facing (ageing, gender equality, social integration, labour market flexibility and efficiency, etc). The necessity to adapt to changing needs, which cannot be dissociated from the search for quality improvement, efficiency and cost containment, is amongst the most important drivers of modernisation. In a context where the services needed are becoming more sophisticated and complex, the need to develop a stronger user orientation, to increase user empowerment and to promote access to social rights also play a role in this process.

The tables depicting the drivers of modernisation for long-term care, employment services and childcare, presented in Chapter 3([61]), show that for these three sectors the main drivers are the combination of demographic or societal changes and financial constraints. In second place come drivers relating to new forms of organisation, a new role for public and private providers and participatory approaches (reflecting in fact the process of modernisation itself). Concerns relating to the EU legal and political context come only in a third position.

These drivers play a role at different levels of the delivery system. They influence the organisation and management of these services, but also impact on the regulatory mechanisms and forms of governance that apply to them. Modernisation processes are therefore examined at two different levels in the following sections: the level of organisation and management, on the one hand, and the level of governance and regulation, on the other. The examples provided in the following sections generally come from the 2008 SHSGI study. They often refer to relatively recent experiences or pilot projects that have not yet been evaluated, in particular with regard to their mid- or long-term effects.

The present chapter builds on the findings of two consultation exercises (preceding and following upon the 2006 communication) and relies in particular on the 2008 SHSGI study.

([61]) See pages 36, 40 and 41 above.

4.1. Modernisation in SSGI organisation and management

Modernisation strategies within the field of SSGIs are part of a broader trend of modernisation in the public sector over the last 20 years. Traditionally public sector management used to focus 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.

Basically four orientations, each aiming to increase the efficiency and effectiveness of service provision, characterise the organisational and managerial reforms of social services in the Member States: performance management, user orientation, integration of services and rescaling of governance levels.

4.1.1. Performance management

A key feature of the reforms has been the increased measurement of performance. The main steps in measuring performance consist in (i) developing a consensus on missions, goals and objectives, (ii) implementing performance measurement systems including performance indicators, and (iii) using performance information as a basis for decision-making.

Three types of performance measurement tools are usually used in order to assess the performance of social services: performance indicators, benchmarking and outcome assessment.

- **Performance indicators:** the implementation of performance indicators in the social sector can be challenging, in particular because it is often difficult to link input (resources used to deliver social services), activities and outputs ('package' of services that may require a bundle of activities) to outcomes (the impact of the outputs on the needs to be addressed).

> In England, the Commission for Social Care Inspection (CSCI) uses a star rating to assess the service performed by local councils. Performance indicators form a key part of the star ratings. They provide a view of how local councils are serving their residents with respect to social services and highlight the progress local councils are making in improving services and meeting national objectives. It is still too early to make a final and comprehensive assessment of how this framework works in practice.
>
> *Source:* 2008 SHSGI study, pp. 210–211.

- **Benchmarking:** benchmarking can be defined as a means to find and implement best practices. It can apply at different levels. It can concern the processes and activities used to transform inputs into outputs, be used to compare different organisational performance or to specify performance norms or standards to be achieved.

- **Outcome assessment:** in this case, the assessment is not limited to the process by which inputs are converted into outputs but concerns the outcome of the public action. It requires appropriate evaluation instruments and is not a straightforward exercise. The value and objectives of the policies pursued, as well as the nature of the information collected to assess policies, can give rise to heated controversy.

The introduction of performance measurement tools within the field of social services constitutes an improvement in measuring efficiency and not only inputs, processes and compliance. However, this approach is not without risk, as assessing effectiveness can be methodologically and politically challenging. There is, for example, a risk of focusing too much on outputs, especially if performance is measured in quantitative terms (e.g. cases completed), at the expense of outcomes (e.g. satisfied users), with the consequence that the service at issue does not address sufficiently those who are most in need. For example, if the priority of a given public employment service is to reduce long-term unemployment, a performance indicator focusing on the number of unemployed persons in general who found a job over a one-year period would not properly assess the achievement of this priority if it does not take into account (i) the specific difficulties encountered in finding jobs for the long-term unemployed and (ii) the extent to which these persons stay on the labour market for a sufficiently long period of time. Moreover, performance measurement tools could lead to 'cream-skimming', in other words selecting and addressing 'easy cases' in order to improve the performance to be measured, and ultimately not, or not sufficiently, addressing the users who could be most in need.

4.1.2. User orientation and access to social rights

Getting the users of social services more involved in the delivery process is one of the general trends of modernisation across the EU. The objective is to enhance quality and efficiency, notably by establishing a direct feedback between users and providers. A further aim is to increase users' autonomy and their capacity to participate in society. This explains why modernisation strategies that aim to promote access to social rights also endeavour to increase user orientation and empowerment.

4.1.2.1. User orientation

There are different models of user involvement, which depend on whether the user is seen as a citizen with rights ('welfarist approach'), a consumer with choices and exit possibilities ('consumerist' approach) or a co-producer who influences service provision ('participationist' approach). In

practice, the strategies chosen are generally a mix of these different models.

The table below shows the main elements characterising each of these three models:

Table 4.1: 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: 2008 SHSGI study, p. 213.

Legislation imposing obligations on service providers with the aim of reinforcing users' rights (e.g. obligation to provide information, obligation to involve users in the management of the structure, etc.) generally corresponds to the 'welfarist' logic. For example, this is the case in France in the field of residential care. Legislation sometimes mixes the 'welfarist' and the 'consumerist' approaches (in the field of passengers' rights for example).

Direct payment schemes, providing users with an individual budget enabling them to choose among different options, are an example of a 'consumerist' approach. This possibility exists in several Member States, notably in the UK (England), in the Czech Republic, in the Netherlands, in Austria and in Germany, particularly in the field of long-term care.

Examples of a 'participationist' approach can be found where the users are directly involved in the management of a service, for example through participation in meetings or committees, to which a budget is sometimes allocated, etc. This is for example the case for public childcare facilities in Italy, where parents are playing an increasingly important role.

Even if these user models are based on different principles, they all assume that the user is informed and autonomous. However, this is not always the case in the social field, where beneficiaries often do not have the necessary information (on their needs, the providers, the possible choices, the level of quality, etc.) to make informed choices. Support mechanisms are therefore needed to make user orientation effective. This is the case for example in the UK, where volunteers assist users in managing direct payment schemes.

4.1.2.2. Access to social rights

Concrete access to social services strongly depends on the architecture of social provision: the applicable legal framework and the status of the rights to services, but also the resources allocated, the process and procedures for realising rights (e.g. how the service is financed and delivered, enforcement mechanisms, etc.) and the ability of users to claim their rights.

Strategies aiming to improve access to social rights often try to reinforce user orientation (for example by reducing 'organisational barriers' to social rights due to fragmentation, compartmentalisation and difficulties in cooperation between agencies and between different geographical levels of administration) and 'user empowerment' (by providing them with support and assistance to claim their rights).

4.1.3. Integration of services

Service integration means the coordinated delivery of a range of services to beneficiaries. It is usually implemented through 'integrated gateways to services' and through 'service platforms' that make access to services more user-friendly.

An example of service integration is the integration of legal and social consultancy for persons in excessive debt with placement services and with general social assistance and support services. In several Member States, health and social services are also integrated with services for drug addicts.

Another example can be found in long-term care, where the shift towards providing integrated care for the elderly is an important modernising trend. Historically, health and social services have been organised by different institutional actors, provided by different professionals and even fragmented into specialised services. However, the integration of health and social services is a complex process where professional histories and practices as well as cultural contexts often differ. Examples of service integration in the field of long-term care

can be found in Italy, where the use of integrated (social and health) home-care vouchers has recently been introduced in Lombardy. The debate is also ongoing in the Netherlands, where several mergers have taken place between home-care and institutional care providers.

Labour market policies are another field where the integration of services, benefits and agencies is on the agenda. This is notably the case in Germany where, as a result of recent reforms, unemployment assistance and social assistance have been combined.

In many areas of social policies, the integration of social services is a powerful tool for increasing the effectiveness of social services and avoiding the undesirable side-effects of social schemes. However, it requires sufficient resources to be allocated to coordination and need-assessment tasks.

4.1.4. Decentralisation

The overall tendency in the Member States has been to move towards decentralising responsibility for social policy from the central state to sub-national authorities. The idea that local authorities have a better knowledge of their citizens' local needs than central authorities, the increasing demands for regional autonomy and the search for cost-effectiveness and efficiency are among the many reasons for initiating these reforms. However, decentralisation should be accompanied by the allocation of sufficient budgetary resources as otherwise the differences in economic resources among regions could have a negative impact on service provision([62]).

In most Member States, however, a number of social policy instruments remain, 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 designing a multi-level governance system for 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 centralised budgetary control.

([62]) See also, on this point, the report of the European Parliament on SSGIs in the EU, A6-0057/2007, recital 16.

4.2. Changing forms of regulation and governance of SSGIs

This section examines the changes characterising the regulation and governance of social services and discusses three major developments in greater detail: the increased role of market-based regulation, the introduction of new forms of public–private partnership, and the development of new governance practices.

4.2.1. The increased role of market-based regulation

Two main regulatory mechanisms can be identified in the area of social services: (i) public programming regulation and (ii) market-based regulation. One of the major trends that can be observed is the shift from public programming regulation to market-based regulation. The latter usually requires the use of corrective mechanisms to tackle market failures.

4.2.1.1. Public programming regulation versus market-based regulation

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 process standards. It generally involves contracts between the public authority and the service provider and often encompasses the financing of any deficit, if need be.

> The French regulatory system in the field of long-term care is an example of public programming. It entails a procedure of authorisation and approval, together with a budgeting procedure based on the principle of reimbursement by the public authorities.
>
> *Source:* 2008 SHSGI study, pp. 225–226.

Under the **market-based regulation** approach, public authorities allow for more competition. This can include both competition *for* the market, whereby potential service providers compete for contracts awarded by public authorities and competition on the market, which allows users to choose between different providers (either profit-making firms or non-profit organisations). Under this approach, consumers and producers enjoy a greater degree of freedom and, in many situations, the user becomes a direct customer. By enhancing competition, public authorities aim at creating incentives, which incite service providers to reduce costs through efficiency gains and to innovate. However, public authorities often continue to play an important role in orienting demand, influencing price definition and guaranteeing quality, as well as in financing the provision of services. Cash allowances, integrated budgets, vouchers, etc. are among the tools used by public authorities to support the purchase of services and empower the users of these services.

4.2.1.2. The shift towards market-based regulation

The expansion of market-based regulation, and the consequent reduction in the scope of public-programming regulatory mechanisms, is one of the main trends that can be observed.

In the field of long-term care, market-based regulation has been introduced notably in the UK, France (home-help services), the Czech Republic and Poland (as a result of the de-institutionalisation of public care services) and in 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, for example, the Czech Republic, Germany, the UK and Sweden. However, no statistics reflecting their relative importance with respect to other forms of regulation and social service provision are available.

Market-based regulation may be exemplified by the British regulatory framework in 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 healthcare or social care. Health services are funded by central government from tax revenues. Social care services are funded by local authorities with revenue generated from local taxes (known as council tax) and user charges in addition to central government grants.

Since the early 1990s there has been a shift in the balance of service provision for the elderly from largely publicly provided care to services predominantly provided by the independent sector. Similarly, residential care has increasingly been provided by the independent sector. The commissioning of services involves decisions about the types of services required to meet local needs, decisions on the service and sector balance in order to ensure the supply of the services required and decisions on the quality assurance aspects of care provision. There has been an increasing focus on the significant role played by partnerships 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 the integrated commissioning of health and social care has been a major element of the policy agenda aimed at improving the coordination of care packages for dependent people. This drive has been accompanied by an increasing emphasis on the delivery of individualised care.

Source: 2008 SHSGI study, pp. 232–233.

4.2.1.3. Market-based instruments and corrective methods

In the field of social services, public authorities use different types of instruments to enhance competition while at the same time achieving policy objectives such as guaranteeing the desired level of service quality and continuity or service accessibility and affordability.

In this area, the efficiency of market mechanisms is limited by the fact that many of these services do not constitute a conventional market and depend on public funding. Moreover, these markets are characterised by information asymmetries, i.e. the fact that in general the provider has more information about the nature and quality of the service than the beneficiary. This situation leads to market failures, which is all the more true for social services addressing vulnerable persons who are generally not in a position to make informed choices. In such cases, the relationship between the provider and the beneficiary can in general not be equated with a commercial supplier/consumer relationship.

In order to achieve certain public objectives, public regulation is therefore often needed (hence the reference to 'quasi-markets', where competition is introduced but where certain conditions are put in place to ensure that public policy objectives are met, in particular through regulation).

Market regulation can take different forms, from price control to licensing or authorisation schemes ensuring that the desired level of quality is met and that the services are accessible. Certain requirements, for example quality requirements, can also be imposed on providers by public authorities in the course of public procurement procedures or as a condition to obtain a grant.

Compliance with the conditions imposed by public authorities through various instruments is generally a condition for obtaining public funds.

On the financing side, more specifically, different instruments are used to increase the affordability of social services, such as those below.

- **Grants** directly given to service providers;

- **Tax reductions**, which aim to reduce the final price paid by the user and may benefit either the service provider or the user;

- **Vouchers**, which are subsidies granting limited purchasing power to an individual to choose among a restricted set of services. Vouchers are an interesting example as this instrument combines the two objectives pursued by quasi-markets in the social field. By increasing the possibilities for beneficiaries to choose between different providers, they contribute to enhancing competition on the market. By

reducing the price paid by the user, they make the service at issue more affordable.

Other corrective methods, e.g. case management and individual needs assessment, have been developed to address market failures stemming from the asymmetry of information between users and providers.

- **Case managers** act as coordinators to help users obtain home and community care services, thereby bridging the gap between users and service providers. Additionally, the case manager provides links to other resources and services to assure that users' needs are met.

- **Individual needs assessment** provides comprehensive and integrated evaluations covering the physical, social, psychological, and environmental needs of the beneficiary. By identifying the presence of met and unmet needs, these procedures help prioritise plans for care provision and define an individual's care package.

4.2.2. The introduction of new forms of public–private partnership

As a result of these modernisation processes, the State has become less a direct provider of SSGIs but is playing an increasing role as regulator/guarantor.

The delegation of tasks to private providers requires comprehensive framework regulations that can range from technical specifications to quality standards and also cover the financing of services and how infrastructure and investment costs are shared between public authorities and providers. It also leads to new forms of partnership between public authorities and private organisations.

Public–private partnerships (PPPs) are a specific form of partnership and cooperation between public authorities and private entities. They involve the co-financing and sharing of risks and responsibilities. They can be complex settings that institutionalise collaborative arrangements between private (profit-making firms and non-profit organisations) and public sector organisations.

The consultation process did not provide evidence of any widespread usage of public–private partnerships in the field of SSGIs. The national reports of the Member States examined in the 2008 SHSGI study also show that PPPs, involving the sharing of financing and of responsibilities and risks, are at this stage not very common and do not play a significant role in modernising social services. Social services generally do not constitute a conventional market and few private actors are therefore willing to invest money and to take risks in activities that are mainly publicly funded and where the profitability is non-existent or minimal.

Some Member States (including Ireland, Spain, Austria and Poland) have expressed their intention to make increasing use of PPP-type models in the future. Even so, PPP models seem to be more relevant for specific sectors and limited tasks. This is particularly the case for the social housing sector, where PPP models concern essentially the construction of housing and not the operation of social housing or related services. As most authors and experts agree, PPPs are only likely to be used or needed where there is very large capital expenditure involved, and not for the operation of a service.

4.2.3. The development of new governance practices

Modernisation entails a changing role for public authorities from hierarchical intervention to network steering and partnership with multiple stakeholders. It also entails new forms of user participation, civic involvement and dialogue with civil society. Such negotiated social governance embraces a diverse range of actors: social partners, local authority representatives, social entrepreneurs and other NGOs as well as community-based groups, voluntary organisations and self-help initiatives.

Consequently, new forms of governance are needed in order to promote cooperative and strategic partnerships between a variety of actors, to enhance horizontal coordination 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 coordination.

In **France**, new forms of local governance can be observed in the field of childcare, where more emphasis is put on the role of public authorities in terms of coordination and governance. For example, at municipal level, 'childcare coordinators' have been put in place in order to facilitate the implementation of the '*contrats-enfance*' (childcare contracts) and to support the development of a common childcare culture at local level. They mainly work with non-profit organisations participating in the '*contrat-enfance*'. Locally, these institutional tools are implemented in different ways, leading to forms of governance that vary greatly from one place to another.

In **Italy**, special rules and arrangements have been introduced in order to support civil society initiatives within the field of childcare. The Region of Lombardy, for example, has recognised a new legal category, i.e. 'associations of social solidarity' and self-help associations of families (referred to as the 'fourth sector'), for which part of the regional funding is generally reserved.

Source: 2008 SHSGI study, pp. 238–239.

4.3. Consequences of national modernisation processes in terms of applicable Community law

As highlighted in the previous sections of this chapter, Member States have embarked upon modernising SSGIs in order to meet evolving needs and societal challenges. Even if these modernisation processes can take different forms and start from different levels, they are often characterised by increased decentralisation of the organisation of social services to local or regional levels, by the outsourcing of some services to the private sector and by the development of new forms of partnerships.

Modernisation processes have lead to a situation in which the State is less than before a direct provider of the service but is playing an increasing role as regulator/guarantor, while remaining an essential source of financing. Such a situation is relatively new and unfamiliar for most stakeholders (regional and local authorities, service providers and beneficiaries) in most Member States. Moreover, as a consequence of these changes, a growing proportion of social services in the European Union now fall under the Community rules on competition and the internal market, insofar as they can be considered economic activities. As a result, national authorities, at central, regional and local level, increasingly have to apply these rules when defining, organising and providing SSGIs.

The broad consultation process launched by the Commission following the 2006 Communication, and mentioned in the introduction to this BR, has revealed a lack of familiarity with and understanding of the correct application of Community rules among public authorities and service providers. This lack of familiarity and understanding is notably due to the fact that local authorities and small and non-profit providers — which play an important role in the social sector — have limited resources to dedicate to the necessary learning process.

A careful analysis of the questions raised during the consultation process has confirmed that, at this stage, the difficulties experienced in the application of Community rules are not caused by the rules themselves but rather by the fact that these rules are not well known and applied by public authorities and service providers.

It is important to recall that the interaction between Community rules and the organisation, provision and financing of SSGIs is relatively recent([63]), the opening-up of SSGIs markets to private actors is relatively new and the case-law is limited.

In particular, when existing legislations and provisions are considered, notably by those who have to apply them, as being 'problematic' or difficult to apply in the light of the nature of SSGIs, it is most often because the rules are misunderstood and/or not well applied. The following examples illustrate this point.

- *Various stakeholders seem to believe that Community rules impose on public authorities an obligation to outsource the provision of SSGIs and to apply public procurement rules. The application of competition rules is also often understood as implying that several operators should compete for the provision of the service concerned. These perceptions create fears that a 'market-oriented' approach would put at risk the objectives pursued by services that are generally driven by the principle of solidarity.*

This is however not the case: public authorities have full discretion to decide whether to provide the service directly or entrust it to a third party. In addition, the fact that competition rules apply to social services which are deemed to be economic activities does not mean that public authorities have to privatise service providers, to ensure that several service providers are present in the market or to abolish existing special or exclusive rights that are necessary and proportionate for the provision of the service.

- *Stakeholders in the social field often argue that the application of public procurement rules leads to a situation where the cheapest offer must be chosen to the detriment of the quality of the service.*

This interpretation of the rules is not correct. The underlying objective of public procurement is to obtain the best value for taxpayers' money. This however does not translate into an obligation to choose the cheapest option. The applicable rules enable public authorities to use criteria focused on quality and to incorporate their social considerations in tender procedures, in order to select the most suitable provider.

- *In the field of State aid, there is an obligation to ensure that the public service compensation which is paid by a public authority to a service provider entrusted with a mission of general interest does not overcompensate the costs incurred by this service provider. This obligation has often been interpreted as a requirement to provide in advance detailed calculation where it is often impossible to know all the details of costs when an operator starts providing an SSGI.*

In fact the State aid rules do not impose such kind of obligation. They only ask to determine in advance on which basis the compensation will be calculated, but not its exact amount, and to ensure that no overcompensation will be paid in the end.

([63]) While the 2008 SHSGI study highlights the uncertainty concerning the application of Community rules and its impact on the provision of SSGIs, the authors stress that 'in general it proved difficult to find supportive evidence when documenting the impact and consequences of the application of EU rules' (see the overview of Chapter 13, p. 262).

4.3.1. The strategy put in place by the Commission to provide practical guidance

The Commission considers that the appropriate response to the questions and queries from stakeholders active in the field of SSGIs is therefore not to change the applicable rules but to provide more practical guidance and support aimed at ensuring that these rules are correctly understood and applied and that the possibilities they offer are fully exploited. The Commission sets out its commitment in the communication 'Services of general interest, including social services of general interest: a new European commitment'([64]) presented in November 2007.

The communication acknowledged the difficulties experienced by public authorities and service providers active in the social field in understanding and applying Community rules and launched a strategy to provide stakeholders with the necessary guidance.

Two staff working documents([65]) dealing respectively with State aid and public procurement rules accompanied the Communication. These two documents bring concrete answers to the most frequently asked questions and are particularly relevant for the social field. Section 4.5 gives an overview of the answers already given in these two documents to concrete questions raised by stakeholders.

In order to ensure that concrete guidance is given on new questions raised in this field by citizens, public authorities and service providers, the Commission has created an **'interactive information service' (IIS)**.

Questions can be sent to the Commission by filling out a specific mail form *(http://ec.europa.eu/services_general_interest/registration/form_en.html)*

This service has been operational since the end of January 2008. Even if it is too early to evaluate the system, the results so far are positive as they show that the IIS is responding to a concrete demand to help stakeholders develop a good understanding of the application of Community rules to SSGI.

Most of the questions received so far fall within the scope of the IIS. Key themes raised include the interpretation of concepts such as 'general interest', 'economic' activities, 'act of entrustment' and 'overcompensation'. The interaction between public procurement, concessions and state aid rules and the scope and obligations deriving from the principle of transparency have also been raised. The most relevant and interesting questions will regularly enrich the two staff working documents which are available on the website.

4.3.2. The follow-up by the Social Protection Committee (SPC)

In January 2008, the SPC([66]) decided to reactivate an informal working group on SSGIs that had been involved in the consultation process initiated by the 2006 communication. The working group on SSGI is not an institutionalized group, but an informal working group gathering the experts of those Member States willing to participate. It works under a concrete mandate given by the SPC.

The SPC mandated the working group to contribute to the work undertaken by the Commission and, notably, to analyse the answers provided in the two staff working documents, to identify more examples derived from the SSGI sector and to review whether further questions or problems arise.

The working group held a first exchange of views at the beginning of March 2008, which provided an occasion to clarify doubts and misunderstandings raised by stakeholders and to enhance the mutual understanding between the Member States and the Commission services.

In the field of State aid, the debate showed that the application of the 54 SGEI package([67]) still raises various questions. The working group will look further into Member States' use of possibilities for financing SSGI both under the SGEI package and the de minimis Commission Regulation([68]), which is applicable to all economic activities. On public procurement rules, the debate focused on public public cooperation, the interaction between public procurement and State aid rules and the notions of 54 contract for pecuniary interest' and of 54 cross-border interest' . The relevance of institutionalised public private partnerships (IPPP) in the social sector, the national legal frameworks and practices concerning public public cooperation in the area of SSGIs and the potential interest for limiting through national legislation the provision of SSGIs only to non-profit operators appeared to be issues meriting further analysis.

([64]) This communication, which is systematically referred to in the present BR as the 2007 communication, is quoted in footnote 15 above.

([65]) Frequently asked questions concerning the application of the public procurement and state aid rules, SEC(2007)1514 and SEC(2007)1516 of 20 November 2007.

([66]) The role and tasks of the SPC are explained in the introduction to this BR.

([67]) In particular, this package encompasses Commission Decision 2005/842/EC of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest, OJ L 312 29.11.2005 and the Commission Framework for State aid in the form of public service compensation, OJ C 297 29.11.2005. This package is often referred to as the 'Altmark' or 'Monti-Kroes' package.

([68]) Commission Regulation No 1998/2006 of 15 December 2006 on the application of articles 87 and 88 of the Treaty to de minimis aid, OJ L 379/5 28.12.2006.

In June 2008, the SPC will send a questionnaire to Member States and stakeholders to gather their views in particular on the issues identified by the working group as meriting further analysis.

The results of the working group, including analysis of and responses to the questionnaire, will be reflected in a final report from the SPC to the EPSCO Council of December 2008.

4.4. Answers already brought to concrete questions raised by stakeholders

The present section sets out the most frequent and relevant questions identified in the context of the consultation and refers to the answers and guidance provided by the Commission inter alia in the two staff working documents.

4.4.1. Scope of Community rules

The fact that an activity or a service is considered to be "economic"([69]) triggers the application of competition and internal market rules([70]). Some SSGIs have been considered non-economic activities([71]). During the consultation process, public authorities as well as service providers underlined their uncertainty in relation to the definition of "undertaking"([72]), of "services"([73]) and of "economic activity"' in the field of SSGIs. In view of the local nature of many SSGIs, the interpretation of the criteria of 'affectation of trade' under competition rules and the boundaries of the scope of internal market rules have also raised questions.

General clarifications of these concepts are presented in Section 2.1 of the 2007 Communication. Moreover, the staff working document on State aid gives concrete examples of activities that have been considered as non-economic (see reply to question 2.4), or not affecting trade between Member States (see replies to questions 2.9 and 2.10). The staff working document on public procurement also gives indications of what could be considered as low-value contracts which have no relevance to the internal market (see reply to question 2.3).

The staff working document on State aid also recalls that even when an activity is considered economic, thereby subject to competition rules, this does not mean that public authorities have (i) to ensure that a multiplicity of operators operate on the market, (ii) to privatise public entities nor (iii) to abolish existing special or exclusive rights that are necessary and proportionate for the provision of the service (see reply to question 2.11).

([69]) Competition rules only apply to economic activities, namely the provision of 'goods or services' on a market by 'undertakings' . Internal market rules only apply to 'services' within the meaning of the Treaty, namely services corresponding to an economic activity.

([70]) However, public procurement rules do not apply to contracts that do not have a potential for cross-border interest. Competition rules do not apply if there is no impact on trade between Member States.

([71]) For example, statutory social security schemes resting on the principle of national solidarity do not constitute economic activities. See for example Joined Cases C-159/91 and C-160/91, Poucet and Pistre, [1993], ECR I-637.

([72]) According to well established case-law, an undertaking is an entity engaged in an 'economic activity', i.e. the provision of goods or services on a given market (see e.g. case C-41/90, Höfner and Elser, [1991], ECR I-1979).

([73]) Only services that are normally subject to remuneration and thus correspond to an economic activity are regarded as 'services' within the meaning of the Treaty.

4.4.2. Provision of SSGIs

Direct provision

Community rules concerning the choice of the provider, i.e. public procurement rules, do not apply when public authorities provide the service directly or through an internal provider (this is referred to as an 'in-house provider' situation)([74]). Most of the questions raised in this context ask whether public authorities can decide to provide SSGIs themselves or if they are constrained by Community rules to externalise service provision. More specific questions concern the scope and limits of the 'in-house provider' exception.

The staff working document on public procurement clarifies that a public authority has full discretion to decide whether it provides services itself or entrust them to a third party (see reply to question 1.1). It also provides explanations regarding the "in-house" provider concept (see replies to questions 1.2, 2.9 and 2.10). The recently adopted communication on institutionalised public private partnerships (PPPs) contributes to this clarification exercise by specifying the practical ways of carrying out a tender procedure to entrust services to a public private entity.

Externalised provision

A series of questions arise where Member States decide to externalise the provision of SSGIs.

(a) Limits to market regulation

Member States that decide to outsource the provision of an SSGI might choose to regulate the market in order to ensure that certain objectives of general interest, for example social objectives, are met.

During the consultation process, some stakeholders expressed concerns that the application of Articles 43 and 49 of the EC Treaty on the freedom to establish and the freedom to provide services and the application of the proposed Services Directive([75]), that was being negotiated at the time of the consultation, could call into question national measures regulating the provision of SSGIs (e.g. rules requiring approvals or authorisations built with the aim of protecting users, ensuring quality and access, and distributing supply over the entire national territory).

The questions raised in this context have generally speaking been related to the interpretation of the concepts used by the ECJ in its case-law on the basis of Article 43 and 49 and to the scope of the proposed Services Directive in the SSGI field([76]).

The 2007 Communication recalls that measures intended to regulate markets, such as authorisation requirements, are perfectly possible to the extent that they are justified by public interest objectives and proportionate to the objectives pursued. Concerning the Services Directive, the services of the Commission issued in 2007 a *Handbook on implementation of the Services Directive*([77]) which aims to provide guidance to Member States in the implementation process. The services of the Commission are also providing support to Member States in the ongoing screening process.

(b) Need to specify the scope and the nature of the service

Even if State aid rules and public procurement rules pursue different objectives and establish distinct legal frameworks, they both entail the necessity to specify the scope and the nature of the service to be provided. Under State aid rules, a clear **act of entrustment** is required when a public authority assigns to a provider a public service obligation to be compensated with public funding. Similar obligations to specify the scope and nature of the service exist under public procurement rules, where the characteristics of the service must generally be described in the **technical specifications**.

In these two areas, stakeholders expressed their concerns as to how to comply with the obligations related to the act of entrustment or the drafting of technical specifications and as to whether these obligations are adapted to the specificities of SSGIs. This was translated into more specific questions, such as follows.

- *How can the requirement for an "act of entrustment" from public authorities to SSGI providers be reconciled with the **autonomy** and the freedom of initiative of such providers that various Member States recognise and respect, according to their constitutional/legal framework? Such question relates to the fact that, historically, in some Member States, these service providers have themselves taken the initiative to develop the services in question well before public authorities became involved in social policy.*

The 2007 Communication recalls that in order to provide legal certainty and transparency, it is important that public authorities assign missions of general interest to service providers through acts of entrustment. It notes that in the area of social services, Member States seem sometimes less aware than in other sectors of the implications of Article 86(2)

([74]) However, public procurement rules may apply in cases where a public authority needs to buy goods or services required for it to provide a given SSGI itself, regardless of whether the SSGI corresponds to an economic activity or not, as in this case the public authority concludes a contract for pecuniary interest.

([75]) The Services Directive was adopted in 2006. Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in the internal market, OJ L 376/36 27.12.2006.

([76]) See feedback report, Section 4.3.

([77]) http://ec.europa.eu/internal_market/services/docs/services-dir/guides/handbook_en.pdf

of the EC Treaty which allows for the reconciliation between missions of general interest and Community rules by providing that the latter only apply insofar as they do not obstruct the performance of these missions.

On the specific aspect of the autonomy of service providers, the staff working document on State aid gives examples which show that the requirement for an 'act of entrustment' is fully compatible with the autonomy and freedom of initiative enjoyed by many providers in the social field (see reply to question 5.6).

- *How to draft an **act of entrustment** concerning services that have to be (i) seen in terms of an integrated approach; (ii) personalised to the specific needs of individual users and (iii) adapted in the process of delivery to changing situations in terms of care intensity, user profiles and number of users?*

On these aspects too, the staff working document on State aid provides clarifications. It shows that the acts of entrustment can take different forms depending on the nature of the service and of the entrusting body (see reply to question 5.2) and do not have to define each specific activity concerned in the provision of the service (see reply to question 5.3). It also explains that the concept of "act of entrustment" is fully compatible with an integrated approach (see reply to question 5.4) and is adapted to changing situations (see reply to question 5.5).

- *How to draft detailed **specifications** for a public procurement procedure concerning SSGIs? In this regard, public authorities and service providers have stressed the risk that: (i) tenders focus only on prices ignoring other criteria such as long term sustainability and continuity(78); (ii) services are segmented, whereas ensuring a "continuum" of service is of particular importance in the area of SSGIs (which means that an integrated approach to the different needs of the recipient is often needed in this sector and also, for example, that short-term contracts could be particularly detrimental in a sector where a personal relationship often has to be established between the recipient and the service provider).*

As recalled earlier in the present report, the underlying objective of public procurement is to obtain the best value for taxpayers' money, which does not translate into an obligation to choose the cheapest option. The staff working document on public procurement specifies that the applicable rules provide a wide range of possibilities to set up specifications and allow public authorities to use quality focused criteria and take into account the social dimension of the required service in order to select the most suitable provider (see replies to question 2.2). Moreover, Community rules do not impose on public authorities to conclude short-term contracts.

- *How to avoid creating too heavy a **burden** be avoided for small, locally based, non-profit providers which often employ voluntary workers? These service providers are very active in this sector and are generally considered to be well equipped to deal with situations that have a strong local dimension. This is notably because these organisations generally have a strong cultural and ethical focus on supporting the disadvantaged. Similar issues were raised by stakeholders as regards the selection of service providers and the financing of SSGIs.*

On this aspect in particular, both staff working documents provide useful information on how the existing rules aim at limiting administrative burden, which is particularly relevant in the SSGI field.

The staff working document on State aid first recalls that when the conditions for the application of the de minimis Commission regulation are met, a public authority can provide financial support up to EUR 200 000 over a three-year period without having to notify the Commission about related funding (see replies to questions 2.7 and 2.8).

For all other cases, the aid will be considered compatible and even exempted from notification if the conditions of the Commission decision of 28 November 2005 are met. The decision exempts from notification annual compensation of less than EUR 30 million for beneficiaries with an annual turnover of less than EUR 100 million. For hospitals and social housing, the exemption of notification is valid irrespective of any threshold.

For larger amounts of compensation a notification is possible and the related aid can be considered compatible by the Commission on the basis of the SGEI Framework. The objective of the decision and of the SGEI package in general is precisely to provide greater certainty for financing SGEI.

The staff working document on public procurement explains the legal framework applicable if a public authority decides to externalise the provision of SSGIs. It points out the wide range of possibilities provided for by the Public Procurement Directive 2004/18/EC(79), and in particular the possibility to define quality criteria. It recalls that only a few provisions of the Directive apply to social services, which means that in this field, public authorities already benefit from a larger margin of discretion compared with other sectors (see in particular replies to questions 2.1 and 2.3).

(78) See feedback report, Section 4.1 on the difficulties in drafting detailed specifications and a reference to the fact that 'the risk of public tender focusing on prices' has often been mentioned.

(79) Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts (OJ L 134, 30.4.2004, pp. 114-240).

(c) Selection of the service provider

The application of European public procurement rules seems a particular source of concern for stakeholders in the field of SSGIs. There is considerable misunderstanding of the applicable framework. Here also, general concerns were translated into more specific questions that the staff working document on public procurement has clarified, detailed below.

- *What is the exact scope of the principle of transparency, which applies even when the thresholds set in the Directive 2004/18 EC are not met?*

This aspect is dealt with in the replies to questions 2.1 and 2.4, which provide clarifications regarding the applicable framework, notably on the distinction between a public service contract and a service concession and on the obligations deriving from the principles of transparency and non-discrimination.

- *How to reconcile public procurement procedures, which are perceived as limiting the number of providers selected, with the preservation of a sufficient degree of* ***freedom of choice*** *for SSGI users([80])?*

This aspect is dealt with in the reply to question 2.5, which specifies that public procurement procedures do not aim at limiting the number of service providers selected.

- *Is it allowed to introduce as a criterion for the selection of a service provider its familiarity with the* ***local context****, this aspect often being essential for the successful provision of an SSGI? In light of the importance of the non-profit sector in the field of SSGIs, is it allowed to limit the selection only to non-profit service providers?*

The staff working document makes a series of clarifications on possible selection and award criteria which are particularly relevant in the social field, such as requirements related to the local context (see reply to question 2.6) or the non-profit nature of a service provider (see reply to question 2.7).

- *Do public authorities still have the possibility to negotiate with service providers during the selection process? This is particularly important for SSGIs as public authorities are not always in a position to define very precisely their requirements at the beginning of the process. Discussion with potential service providers is therefore sometimes necessary to help public authorities to define these requirements.*

This aspect is dealt with in the reply to question 2.8, which explains that negotiation remain possible insofar as the operators selected to participate in a negotiated procedure are treated equally.

- *To what extent do public procurement rules apply to* ***inter-municipal cooperation****? This cooperation could take different shapes, e.g. one municipality buying a service from another; two municipalities organising together a call for tender or creating a new entity for the provision of an SSGI, etc.*

The reply to question 2.9 describes different possible types of cooperation between public authorities.

- *To what extent do public procurement rules apply to public private partnerships?*

This aspect is dealt with in the reply to question 2.10. Moreover, a communication on institutionalised public private partnerships was adopted on 5 February 2008 ([81]).

4.4.3. Financing of SSGIs

Most SSGIs are highly dependent on public funding. The criteria used to assess the compatibility of public service compensation (PSC) with Community rules are defined in the "SGEI package". These criteria, in particular the necessity for the State to clearly define the mission it entrusts and to ensure that no overcompensation is paid, have been the subject of various questions from stakeholders in the social field, such as the following.

- *The parameters for cost compensation, which have to be established ex ante to limit the risk of overcompensation, were perceived as being not flexible enough to take into account the specificities of SSGIs. This was interpreted by various stakeholders in the social field as an obligation to provide in advance a detailed calculation of these costs while in this sector unpredictable changes in care intensity, in the number and profiles of users and in the level of revenues often lead to a high degree of cost unpredictability(82) and to the risk of ex post deficit.*

The staff working document on State aid clarifies that the applicable rules do not impose any obligation to provide in advance a detailed calculation of all the costs but simply to determine the basis for the calculation of the future compensation, so as to ensure a minimum of transparency (e.g., it might be sufficient to specify that the costs will be compensated on the basis of a price per day based on an estimation of the number of potential users). Clarifications on these aspects have been brought in Section 6 of the staff working document on State aid (see in particular replies to questions 6.1 and 6.2). More generally, Section 6 of the document answers a series of questions on compensation

([80]) See Section 4.1 of the feedback report.

([81]) C(2007) 6661.

([82]) See Section 4.4 of the feedback report.

issues (see for instance reply to question 6.7 for the meaning of 'reasonable profit').

- *Some stakeholders have also asked whether the definition of the parameters for cost compensation requires a comparison between different operators and a judgement on their efficiency.*

The staff working document clarifies that the application of State aid rules does not involve any judgement on the efficiency of a service provider or a comparison between service providers. If there is an act of entrustment, if the parameters for cost compensation have been clearly defined and if there is no overcompensation, all costs incurred by the service provider for the provision of the SSGI can be compensated (see replies to questions 6.10 and 6.11).

- *Some stakeholders pointed out that, with the exception of social housing and hospitals, aids exceeding the thresholds defined in Article 2(a) of the SGEI decision have to go through the process of prior notification to the Commission, which is perceived as burdensome.*

In this regard, one should note that Member States have not yet reported on the implementation of the SGEI decision, which already provides a very favourable framework for public service compensations. There is no evidence that the thresholds provided for in the decision are not adequate for the needs of certain sectors. The submission by the Member States of the reports on the implementation of the SGEI decision by the end of 2008 is an occasion for Member States to provide more information on their experience in implementing the package and on possible problems they have encountered.

European Commission

Biennal report on social services of general interest

Luxembourg: Office for Official Publications of the European Communities

2008 – 59 pp. — 21 × 29.7 cm

ISBN 978-92-79-09111-7
DOI 10.2767/39904

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ISBN 978-92-79-09111-7