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The Future of Social Services of General Interest

Minutes

On behalf of
European Commission
DG Employment, Social Affairs and Equal Opportunities

The future of Social Services of General Interest

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The Peer Review was hosted by the Belgian Federal Public Service for Social Security.

Welcome and introductory remarks

Welcoming the participants to Brussels on behalf of her Minister, **Isabel Moens** (Ministry of Social Affairs and Public Health, Belgium) emphasised that the issue of change in social and health services, within a changing Europe, is of major concern to Belgium. The debate on long-term care is a good case in point because these services are at a crossroads of concerns.

- It is a good example in the general debate on social services of general interest in relation with the evolution of the European jurisprudence and legislative environment (internal market, competitivity, public procurements) and their impact on the regulation capacity and autonomy of the MS in this area. They vary considerably from one EU Member State to another, but one of our main concerns should be the approach to be taken by the authorities in order to ensure that all citizens have access to affordable quality services. Will not such access be put at risk by the services directive if LTC services are not totally excluded from the scope of this directive? How could we face two different European legislations for LTC services and health services when everybody is asking for more integration of those services? How can we protect that access for the people who are dependent on these services if there are no regulations in this domain with an increasing participation of private enterprises? The European Commission did, she stated, set down the first markers for the protection of such individuals in its Communication of April 2006. This is an issue that needs further work.
- Account will also have to be taken of socio-economic aspects and demographic developments differing situations and approaches in the various Member States. How are we going to strike a balance between accessibility, quality and financial viability? How can we draw on good practice in each other's countries, so as to ensure that all our citizens have access to the services they need? A meeting such as this one, attended both by experts on this topic and by specialists on European affairs, provides a good opportunity to discuss all the hotter issues. This is, after all, a matter that directly affects the more fragile and dependent people within our societies.

Concetta Cultrera (European Commission, DG Employment, Social Affairs and Equal Opportunities) said this seminar was taking place at a particularly useful moment for the Commission. On 4 June, a conference would be held on the general topic of social services. It would be discussing the results of a Commission study on social services of general interest. A consultation exercise on social services, launched last year, has just been completed. Also, the results of a reflection group on legal affairs should assist in improving the quality of the discussion. The Commission has an ambitious plan, which aims to answer the questions raised by Isabel Moens. A new Commission Communication should be adopted by the end of 2007, allowing the Commission to clarify the challenges, of a legal nature, mentioned by the previous speaker. So for the Commission, this is an important time for clearing the way forward and establishing a clearer idea of the direction to be taken. The issue will

need to be discussed in greater depth with the Member States. At the present time, social services face many challenges – social change, for example in the structure of families, as well as issues related to the modernisation, the quantity and the quality of the services on offer. During 2006, the issues involved at the national level became very clear, as a result of the open method of coordination. So the issue of the care system is now on the table, and questions of legal protection, appropriate financing and quality will need to be tackled. She hoped the present seminar would be a rich source of concrete examples.

Long-term care has only recently become a separate social policy issue in a number of countries, **Manfred Huber** (Thematic Expert - European Centre for Social Welfare Policy and Research) pointed out in his introduction to the review. While the services concerned have long been important policy topics in themselves, the practice of grouping them under the heading of “long-term care” is fairly new, and the equivalent term in various languages does not necessarily cover exactly the same range of services. Increasingly, it applies to services for all age groups. Long-term care includes a complex array of services, ranging from care for people with severe disabilities, whether at home or in institutions, to personal assistance services such as respite care, day care and increasingly, very active programmes that support families. In the majority of EU countries, families still shoulder much of the burden of care. Enlarging the range of support services provided to families will certainly be a key factor in ensuring the future sustainability of social services. Care management should extend along the whole continuum of services, including rehabilitation. In some countries, there is a trend towards merging high-level and low-level care. In others, there may be an organisational split between them – for example, intensive care in nursing homes may come under the national health service, while home care may be the responsibility of the social services.

European-level legislation applicable to long-term care includes the rules on competition and state aid, the freedom to provide services, freedom of establishment, public procurement rules and the free movement of persons. Fundamental principles of the EU Treaty applicable to all services, of an economic or non-economic nature are equal treatment, non-discrimination, transparency and proportionality. To define a service as being in the general interest, in European terms, reference needs to be made to a public interest objective or mission. However, apart from a few rulings on health services, there is so far very little EU case law on long-term care. The current uncertainties stem more from an analogy with rulings on other sectors. One case on which there is an EU ruling concerns care homes. They were held to be an economic activity, but the ruling does also recognise that governments can act to restrict the running of private care homes mainly to the non-profit providers. A number of Member States have introduced various types of care allowance or personal budget which permit the care user to become a direct “purchaser”, so promoting consumer choice in this sector. The transferability of such allowances from one EU Member State to another, if the person concerned moves across an internal border, is a complex issue. For instance, recent rulings mean that the Austrian and German allowances are portable across the EU but the differently structured British allowances are not. For care users, such legal distinctions are difficult to understand.

These days, long-term care tends to be a mixed market, with both public providers – often municipal - and private ones, which may be either non-profit or commercial. This means that EU competition law will have to be respected. As long-term care is increasingly devolved to the local level, local government will also have to be aware of the implications of EU law. However, an eight-country survey recently conducted for the EU shows that both the degree of devolution, and the split between public, private non-profit and private for-profit providers vary greatly between Member States. These differences in the organisation of service provision imply considerable variations in access to the services by those who need them. Overall spending on care services also differs widely across

Europe, as does the proportion spent on each service. But in almost all countries, spending increased substantially between 1995 and 2004.

Quality assurance is an increasingly important issue in most countries' care services. There is a growing emphasis on "value for money". From a previously mainly regulatory approach, countries are now moving towards quality management. This shifts the responsibility more towards the care providers themselves, who are increasingly adopting the kind of quality management techniques found throughout industry. This has, he said, led to better outcomes and greater security for those in care. However, it has also made regulation more complex. More particularly, it has complicated the issue of defining what constitutes a mission of general interest.

Discussion

Complimenting Manfred Huber on the quality of the discussion paper produced for the review, **Anne-Sophie Parent** (AGE – the European Older People's Platform) reported that it had been circulated to AGE's member organisations. Some of them felt that a mention should be added concerning the role of new technology in helping to meet the needs of dependent people, and particularly in enabling them to live at home for longer. **Manfred Huber** agreed that this point should be included. As a good example of care at home, he recommended the scheme operating in West Lothian, Scotland. Recent research suggests that such schemes are cost-effective.

Patrick De Bucquois (Caritas Europe) welcomed the paper. He asked if promising models for investment in care can be identified at the European level. Or is practice still too diverse for that? **Manfred Huber** replied that there are huge variations in the level and quality of care. Before a European model can be envisaged, some member countries will first need to build up their care systems. An emerging trend across Europe is to give more choice to families, but it is too early to say whether this will form the core of a European care model. The biggest challenge is to activate the families.

The need to involve families was also emphasised by **Isabella Manichini** (Ministry of Social Solidarity, Italy). She asked about the basis for the discussion paper's analysis *(Fig. 4 of the discussion paper)* concerning the devolution of public authority competences for long-term care services in different countries. **Manfred Huber** said it is based on the main level at which the provision is organised and partially regulated.

Regarding *Table 7* of the discussion paper *(Estimated expenditure on long-term care and projections until 2050),* **Ri De Ridder** (INAMI/RIZIV, Belgium) asked if the big disparities between the different countries might not in part be due to problems of methodology. Could differences in definition mean that the figures are not really comparable? **Manfred Huber** agreed that there are considerable problems with the statistics. A European initiative is currently under way to harmonise them. For the moment, however, the figures are not wholly comparable, and should be regarded as just a snapshot.

Great efforts are currently being made to encourage people, and particularly women, to stay in paid employment for longer, **Anne-Sophie Parent** pointed out. What will be the effects on informal care of family members? Have these effects been taken into account in the projections? **Manfred Huber** replied that the projections in the table are not detailed enough to reflect that. However, other research conducted for the European Commission does look into the impact of those effects in four countries.

John Halloran (European Social Network) also congratulated Manfred Huber on the paper, which will be used extensively in the network. He quoted one of the paper's conclusions: "There is evidence that the quality of services is frequently not up to the expectation of users or of their families". While not disagreeing with that statement, he wondered how the evidence was gathered. **Manfred Huber** said the quality of care services is perceived differently by different people. In some countries, elderly people are happy if they are simply being taken care of. However, future generations will have higher expectations. There are some international collections of objective data on care quality, such as the incidence of pressure sores in nursing homes. The figures are not always strictly comparable, but they do point to big problems. Anecdotal evidence also comes from recurrent, well-publicised scandals. More systematic analysis is possible by examining death certificates and noting the number of deaths due to causes that could probably have been prevented. More subjective evidence comes from asking care receivers themselves for an evaluation. But these assessments have to be treated with caution. People in care will tend to say that they are happy with the services they receive. In some European countries, discussion of care quality is now based on verifiable criteria, such as the number of people who have to share rooms in a nursing home. A European comparison of the indicators used to measure care quality would be helpful.

Antoine Saint-Denis (European Commission, DG Employment, Social Affairs and Equal Opportunities) noted from Manfred Huber's PowerPoint presentation that the concept of "general interest" is unknown or unused in many countries. Is this just a matter of labelling, or might some EU countries take issue with the idea that long-term care is a service of general interest? **Manfred Huber** did not think that any country, once familiar with the term "general interest", would dispute that it is applicable to long-term care. However, it was clear from the responses to the questionnaires for the Peer Review that the concept of "general interest" is not clearly understood in some countries, even though they have a tradition of embedding long-term care within social services. This cultural factor could have legal implications when it comes to defining "general service missions" for providers or setting the rules for public procurement. In some countries, the contract with providers might be more implicit than explicit. This too could raise issues concerning the "general interest" framework.

Aino-Inkeri Hansson (Ministry of Social Affairs and Health, Finland) said that Finland puts a great deal of emphasis on health promotion and preventive medicine, as they are seen as the only way out of the demographic challenge that the country will be facing in the near future. She quoted another of the discussion paper's conclusions: "Services of prevention and rehabilitation that could contribute to preventing or postponing dependency and functional limitations that lead to the need for long-term care are still underdeveloped". Are there any European studies, or examples, of successful prevention and rehabilitation schemes? There are some good practice examples, **Manfred Huber** replied, of which a number are in Finland. However, a methodological framework for cross-country analysis is lacking. There has been some European-level research on this, but no real comparison of cost-effectiveness. This is a major gap in current knowledge.

First session: Legal issues and competition rules

Belgium

The 80+ age group is set to grow faster than any other segment of the Belgian population, **Ri De Ridder** reported. Services classified as long-term care for the elderly in Belgium are nursing home care, day-care centres, short-stay centres, residential or rest homes and rest and nursing homes. Most institutions are a mixture of these different types. There are currently around 125,000 beds available, with the possibility of adding about 10,000 more in the near future. In 2004, 5.1% of people

aged 60 years and older were in a residential home or a rest and nursing home. That represents an 11.6% increase over 1998. The running of the approximately 1,800 institutions in the country is quite evenly divided between local public authorities, the non-profit private sectors and the commercial sector. The care competences of the various levels of government, within Belgium's federal system, are not always clearly separated. So a coordinating group was established to develop a coherent policy for the elderly, which is set out in a cooperation protocol between all the competent authorities. In particular, the development of alternatives to the existing care institutions is being encouraged. The local element is important here, as most of these institutions developed either as local authority initiatives or as small local enterprises.

Funding for the care structures comes both from the health insurance and from the elderly people themselves. Residents' own contribution varies according to the services offered by each institution. The average charge is about €35 per day. Assistance is available, and there is no evidence that any section of the population is excluded from care for financial reasons. However, funding for new provision is limited and there are some problems with waiting lists.

Care receivers cannot be regarded as consumers, he emphasised. Long-term care is not a piece of merchandise. The Belgian view is that care is a social right. Given the European rulings on health care, he wished to state quite frankly that Belgium is very sensitive to the connection between the subsidiarity principle and the so-called autonomy of Member States. This relationship is not as clear as it sounds. European rules could pose problems for regulation of the care sector in Belgium, where no rest home can open without prior authorisation. Financing, requirements for the type of personnel to be employed, building norms, equality and the internal organisation of the institutions are all issues on which Belgium places clear restrictions on the operation of market forces and the mobility of services in the care sector. At the same time, the arrival of commercial operators from other countries is leading Belgium to wonder whether its own national legislation is capable of resisting such developments. Should not the EU framework be used in order to combat these trends and defend Belgium's national approach? But this also raises employment issues. Belgium still has an unemployment problem. It could experience an influx of care sector workers from the new EU Member States. Would such an open job market be the right policy for the new Member States themselves, who would see their trained, capable care workers draining away to, for example, Belgium? Should these flows of workers be discussed among the countries concerned? At the same time, Belgium has seen inflows of care home residents from France and the Netherlands. This also has an impact on the financing of the Belgian system and on waiting lists.

Up to now, Belgium has not encountered any specific problems with European law in this field, but it wants to know whether it will be allowed to continue with its own system or not.

Finland

The scope of social services is very broad in Finland, **Aino-Inkeri Hansson** explained. The municipalities are responsible for organising sufficient services, which they can either provide themselves or buy in. The financing is about 90% public, drawn from local and national taxation. Client fees account for the other 10%. Finnish local government is currently undergoing reorganisation. An unevenly distributed population means that some municipalities cover half a million people, while others have only a few hundred inhabitants. This obviously poses problems for care provision in some regions. Most long-term care and social services for the elderly are still provided by the municipalities themselves, but the private sector is growing very rapidly. A "third sector" consists partly of volunteers and partly of providers that are similar to private enterprises. It

receives public support through a slot machine association, which is likely to prove problematic in terms of EU competition rules. Social services for the elderly include home care, day services, housing services, institutional care and support for informal care, which is currently on the increase. The aim of Finland's policy is to promote the functional capacity and independence of the elderly, with the intention that as many older people as possible can continue to live in their own homes and environments. For this reason, considerable emphasis is placed on health promotion and preventive work. Long-term institutional care includes medical care, full board, hygiene and clothing services and services that promote social well-being.

Finnish legislation does not recognise the concept of social services of general interest, introduced by the EU. The meaning of that concept is unclear to most Finns. It is not yet known what practical impact it will have, when taken in conjunction with EU rules on the free movement of persons and services and on competition. Distinguishing between economic and non-economic services is difficult for Finns. The characteristics of social services of general interest are broadly and vaguely defined, she felt. They leave room for interpretation. In Finland, the social service system is politically defined, by parliament. The definition is based on the needs of the whole population, not on the characteristics of the services. That would be seen as a legalistic approach. She wanted to raise a provocative question for discussion: is it for the Court to decide whether a social service is of general interest or not? How much flexibility is possible with regard to the EU Treaty?

Better definitions are obviously needed, and objectives must be clarified. Analysis of the contradictions between national systems and EU legislation is also required and is being done. Similarly, there should be analysis of the jurisdictional space for deviation from the internal market rules and EU competition law. A political issue is the proper level of subsidiarity to be applied in this context. The need to maintain current welfare regimes in different parts of Europe is also a political matter. The principle of proportionality and its application should be examined. Finally, there is a need to determine the factors that should *not* be utilised in a competitive environment.

Discussion

Anne-Sophie Parent asked what percentage of residents in Belgian care institutions come from other countries. She was aware that this phenomenon has been creating waiting lists for Belgian care users. Some Belgian institutions favour French applicants because they tend to have a higher disposable income. She wondered how private for-profit providers can be prevented from discriminating in favour of potential residents who have higher financial resources and can therefore purchase more services outside the core package. As part of Finnish care is financed through a slot machine association, she wondered what would be the impact of the EU's intention to liberalise the market for lotteries. Also, how does Finland intend to ensure care for older people in its rapidly depopulating rural areas? **Ri De Ridder** replied that there are no precise statistics on the proportion of non-Belgians cared for in Belgian institutions. The lack of transparency on this, particularly in the private sector, is causing problems. But it is known that, for example in the Belgian province of Hainaut, the care structures are now used more by French people than by Belgians. This makes it difficult to plan care provision. Belgium does not want to stop people from other countries from taking up places in its care institutions, but it does need greater transparency. There ought to be European action on this. There is no particular evidence that the private for-profit providers are trying to cherry-pick the wealthier residents. However, the protocol between the Belgian regions does insist on a strict definition of what must be covered by the standard price and clear information on any supplementary charges. Again, it may be wondered whether this is compatible with the European legislation. **Aino-Inkeri Hansson** said that Finland very much hopes that it will be able to maintain its slot machine

association and its third sector, where the NGOs' voluntary work is now separated out from commercial services, in order to avoid breaches of the competition rules. The Finnish municipalities are now forming bigger entities, covering a population of at least 20,000 each, in order to ensure the continuation of services in the depopulated regions. New technology and mobile units are being used in an attempt to overcome the shortage of care staff in the rural areas.

Patrick De Bucquois noted that the concept of public services of general interest is well understood in Belgium, but less so in Finland. He wondered whether this is really just a matter of perception, or whether it reflects real, functional differences in the two countries' systems. Recently, he had heard a Swedish speaker express concern about the future of Sweden's traditional "social economy" non-profit service providers, in view of the new public procurement rules which tend to work in favour of multinational enterprises. Is there a similar problem in Finland? **Aino-Inkeri Hansson** agreed that, due to the homogeneous Nordic welfare state model, Nordic countries have more problems with the "general interest" label than does Belgium, where the structures are more varied. Finland's third sector has indeed been facing some problems similar to those experienced by Sweden's social economy providers, but on a smaller scale so far.

Muriel Rabau (Belgian permanent representation to the EU) noted that the concept of "social services of general interest" is not found as such in Belgian legislation. But in Belgium this concept is used, in a European context, in an attempt to save its system from the potential threats posed by the evolution of internal market and the competition rules. It is not certain that this solution is the right one, but for the moment it is the one that Belgium is working on. In her presentation, Aino-Inkeri Hansson had called for the clarification of definitions and objectives. Does she want this to take place independently of the debate on social services of general interest, or within the framework of that debate? **Aino-Inkeri Hansson** said it needs to be done on both levels. Nationally, Finland is already engaged in this clarification and analysis. But of course, it also needs to happen at the EU level.

Concetta Cultrera noted that it is the choice of EU Member States to introduce market logics in the way public services are provided. One consequence of this choice is the application of the certain EU rules (in particular, competition and internal market rules). This was very apparent in both the Belgian and the Finnish presentations. The role of Court is due to the fact that we are living in a law-based society. The Court's rulings are responses to changes that are taking place. At the present stage of the process of clarifying EU rules, the important thing is to look at concrete problems – for example, the problem that the competition rules might pose for the financing of the Finnish third sector, or the perceived conflict between those rules and the Belgian authorisation system. These things should be discussed, so that we can see how much room for manoeuvre is left within the EU rules. Those rules should be seen not as a danger but as an opportunity. There are instruments which should be explored, such as Article 86(2) of the Treaty. **Anne-Sophie Parent** emphasised that all of AGE's member organisations, in every country, are very attached to the subsidiarity principle. The organisation of services to people should be left at the level which is closest to them, and over which they have control. Great anxiety is being caused by the creation of all kinds of rules at the EU level, without knowing what impact they will have on everyday life. Making rules first and mitigating their effects later is not the right approach. The impact of the lotteries liberalisation on the financing of Finnish care services is a case in point. One DG within the Commission was unaware of a discussion within another DG which was going to have a huge impact on a totally separate issue. **Ri De Ridder** added that a European Court of Justice ruling had clearly stated that hospital care is an economic activity and that hospitals are enterprises. So it is very clear that the provision of long-term care is to be seen in that light. While he was not saying that EU legislation is a threat, there is currently a great deal of uncertainty. If all social services are regarded as economic activities, then it is not at all sure that Belgium's regulatory system will be compatible with EU law. Belgium does not want to be ruled

by case law, but by democratic choices – made, if possible, at the European level – which will guarantee that the Belgian authorities' competences will be maintained. **Muriel Rabau** pointed out that some, but by no means all, social services have been placed outside the scope of the services directive. Those not covered by the directive include services to persons in need. She would like to think that long-term care will be regarded as a service to people in need, but she feared that the DG Internal Market will not see things that way. Some social services will be covered by the directive and others will be outside it, even though in some countries all those services are integrated. Those covered by the directive will be put under anti-regulatory pressure. This is one of the dangers facing long-term care.

Second session: Financing of services

Luxembourg

In Luxembourg, the term "long-term care" covers services to children and working age adults, as well as to older people, explained **Raymond Wagener** (Ministry of Social Security, Luxembourg). This means that there is a lot of interaction with other policy areas, such as education and employment. 1974 was an important year for the financing of long-term care. Before that date, such care was mostly privately financed or provided by religious charities. From 1974 to 1986, a reform of social security and pensions led to increased co-financing by the State, through agreements with the NGOs, and to the introduction of health care insurance. There was also increased public investment in nursing homes, under the Ministry of Health, and in homes for older people, under the Ministry of the Family. During this period, the Ministry of the Family organised regional monopolies, formed by the municipalities, to provide care at home. In 1998, long-term care insurance was introduced for all those covered by the health care insurance. One of its aims is to help people to stay in their own homes if possible. It is not means-tested and is available to dependent persons of all ages. There are no co-payments, but the coverage has a threshold of 3.5 hours of assistance per week. For people on lower incomes who require help below that threshold, means-tested State subsidies are also available. Extra payments such as "hotel costs" in nursing homes are not covered by the insurance. The "hotel costs" are high in Luxembourg, and this could explain why some Luxemburgers go into Belgian care homes.

There are also investment subsidies to assist the construction of nursing homes and homes for older people. After 1998, ministerial responsibility for these services was unified under the Ministry of the Family. Responsibility for health care financing rests with the Ministry of Social Security.

In Luxembourg, the insurance for long-term care and health care is handled by a public financing monopoly. It is a compulsory insurance scheme, with no opt-outs and therefore no opportunity for skimming off good risks. The contribution rates and benefits apply for all. There is a free choice of care providers, and no distinction is made between publicly owned and privately owned providers. However, different types of provider (for example, long-term care institutions as opposed to long-term care networks) are remunerated in different ways. The public health care and long-term care insurance covers 96.3% of residents. Almost all the others are covered by employer-based insurance. People now contribute 1.4% of their income to the scheme (before 2007, it was 1%). For reasons of competitiveness, it was not possible to increase the wage bill by introducing employer contributions, so unlike the pension funds and the health care insurance, the "social contribution" to long-term care insurance comes from the insured person alone. The 1.4% is payable on all income,

including capital, and there is no ceiling. But no contribution is due on one-quarter of the minimum social wage. The contributions are not tax-deductible. 45% of the expenditure comes from the State budget. The State's share will be renegotiated in 2009, when it is likely to go down to 40%.

Lithuania

In the period when Lithuania was part of the Soviet Union, before 1990, care services were provided in residential institutions only, recalled **Daiva Buividaite** (Ministry of Social Security and Labour, Lithuania). Almost all of these institutions were under the Ministry of Social Security and Labour. The years 1991-2000 saw a quantitative leap in the development of social services. New types of care, such as day care, were brought in, and institutions with varying affiliations opened. In 2006, there were some 87,000 social care recipients (elderly and disabled adults). The number of people receiving care at home or in institutions has doubled over the past five years. Day care has shown particularly strong growth. In 2003, day care centres were attended by 21,500 people. The figure for 2006 was 64,200. Expenditure on social care for the elderly and disabled adults in 2005 was Lt 300m (about €90m), of which some Lt 200m was for the disabled and Lt 100m for the elderly.

Social services are financed by the State budget, the municipal budgets, EU structural funds, foreign foundations, charities and users' own payments for services. The State allocates the biggest share of the funds. The share of municipalities' budgets spent on social services ranges from 0.1% to 7%. The Concept of Social Services Provision Reform for 2003-2010 puts the emphasis on improving quality of provision through the following principles and measures: accessibility and affordability of services that meet people's needs; determining priority social groups of people and matching the available financial and human resources; increasing the competitiveness of social service providers; involving users in the social service provision process; and the implementation of a social service purchase model in order to create a social service market mechanism, regulated through equal requirements placed on all providers.

The new Law on Social Services, approved in 2006, changed the basis on which social services are paid for. They are to be financed from municipal budgets, which will receive targeted subsidies from the State budget. From 2007 onwards, the social care of persons with a severe disability will be funded entirely from these targeted State contributions to municipal budgets. A level playing field for competition within the social services market is to be created. Charges will be varied according to the type of services provided and the individual's capacity to pay. The charge to be paid for daytime care in day care centres or at home may not exceed 20% of the income of a person living alone or in a family whose income does not exceed three times the State-supported income level (about Lt 600 per person). For a person living in a family with incomes above that level, the daytime care charge may not exceed 50% of the person's income. Charges for short-term or respite care may not exceed 80% of the person's income. For long-term care, charges may not exceed 80% of a person's income where the value of the person's property is below a threshold established by the local municipality. The poorest people will be able to receive social services free of charge. Those who can afford it will either be required to pay the greater part of the cost of municipal services or will be advised to use private services. It is hoped that these reforms will improve access to social care and lead to the more effective use of State funding. Municipalities will be encouraged to develop alternatives to institutional care. Help is also to be provided to those who care for people with disabilities within the family but who wish to participate in the labour market.

AGE

Anne-Sophie Parent's presentation was based mainly on questions sent in by the AGE network's member organisations across Europe. Overall, she reported, there is great anxiety about the financing of services for the dependent, even in countries where those finances are currently well organised. Needs are evolving very rapidly, due both to the ageing of the population and to higher expectations. Unfortunately, the financing seems to be evolving in the opposite direction. There are more and more expectations and less and less resources. Everywhere, AGE's members note a tendency to re-individualise dependency risks, whereas fifty years ago, the movement had been towards a pooling or mutualisation of these risks. Also, the threshold for entitlement to services or support is being pushed upwards, leaving more and more care needs to be met by families or the individuals themselves. In Germany, this is creating huge problems in particular for women, who live longer and have lower resources, yet may not be at the level where they qualify for means-tested support. There is a growing expectation that new technologies will help in the search for cheaper solutions. But cheaper for whom? Will the savings be passed on to the users as well as the funders? And what will be the implications for the quality of services to elderly persons? In most Member States, testimony from families shows that they are having more and more difficulty in coping with the extra cost of a dependent person. In some countries middle-aged people are having to use their pension capital to cover the care costs for their elderly parents. This means that the next generation of elderly people will have had no opportunity to build up adequate savings for their old age. Homes are also being remortgaged to cover care costs, and the full implications of this have not yet been assessed. All of this means that some older people do not request the care that they need, because they are afraid that their house will be mortgaged. This is, for example, the case in the UK, where an increasing number of social services are no longer fully covered by the National Health Service, and therefore have to be paid for by the individual.

There is a growing market for private insurance to cover dependency needs. Will this not create a risk of discrimination between wealthier and poorer people, but also on health grounds, as there is no legislation to prevent insurance companies from discriminating on the basis of health conditions? The arrival of multinational care companies in some Member States also has implications for the public sector. Increased provision of long-term care in a Member State produces increased demand for publicly funded health care. More research is needed on the potential impact of this.

In countries where care is municipally funded, there is an increased risk for the localities with a rapidly ageing population. In such cases, what is the impact of moving the responsibility for financing from the federal or national level to the lower level? In the Netherlands, part of the responsibility for financing has recently been transferred to the local level. This has led to inequality of provision between different areas, which Dutch AGE's members find unacceptable.

All AGE members emphasised that citizens and families need more information. The rules are not always well understood. The lack of coordination between the different systems and services that people are entitled to means that many of these services are not taken up. But of course, if the take-up rate increases, the financing will have to follow. AGE members stress the fundamental principles of equal access and quality services. The term "services of general interest" should be better defined, as should people's entitlements, even though these will obviously evolve over time.

Discussion

Florence Lianos (Ministry of Employment, Social Cohesion and Housing / Ministry of Health and Solidarity, France) asked for more details of the dependency insurance introduced in Luxembourg in 1998, as France and a number of other countries have been looking at similar schemes. In particular, where is the line drawn between what is covered by the health insurance and what is covered by the dependency insurance? **Raymond Wagener** replied that the population covered by the health insurance and by the dependency insurance is the same, but the contributions are calculated differently. For the health insurance, there is an employer contribution, calculated as a percentage of the total wage bill. For the dependency insurance, there is no employer contribution. The dependency insurance is intended to cover everyday activities – nutrition, hygiene, mobility etc. So there is really no overlap with the coverage of the health insurance, except perhaps regarding some items of equipment, such as wheelchairs. But here too, there is a difference. The dependency insurance would not cover a sudden, short-term need for a wheelchair – for example, after an accident – whereas the health insurance would. It is very similar to the German dependency insurance, and it covers all age groups, which can pose problems for the assessment of needs.

John Halloran asked if the Luxembourg scheme also covers the provision of residential care. Does the funding cover a certain minimum level? Would any personal top-up contribution be required from a user who chose a private provider or a different kind of provision? Or are charges regulated to ensure that they are fully covered by the insurance? And in Lithuania, as users are charged in line with their income, where does the rest of the cost of care come from? Are there different levels of cost, according to different levels of service? Is competition on the basis of the quality provided at a fixed price, or are price variations permitted? **Raymond Wagener** said that Luxembourg had at first wanted to introduce competition between different networks, but this proved rather difficult. One of the conditions imposed was that any network that wished to take part must be in a position to offer the whole range of services. Networks are not allowed to get funding from the dependency insurance and then pick and choose the services that they will provide. The services must also be on offer nationwide, including in the rural areas. These conditions are part of the contract. The prices are set administratively, and cannot be exceeded. Institutional care services are included in the insurance, but not the charges for the room, although there are separate means-tested grants for these in case of need. Questions are being asked about why room charges are so high in Luxembourg. It may well be that some kind of cross-financing is going on. **Daiva Buividaite** explained that Lithuanian law does not permit the charge for social services to exceed the actual cost of those services. Also, municipalities have the right to exempt people from payment in case of need. As the level of Lithuanian pensions is low, many older people are unable to pay the charges. The part of the costs not covered by individual contributions is covered by the municipal budgets or State subsidies.

Isabella Manichini asked if in Lithuania, the term “social services” includes health care provision. **Daiva Buividaite** replied that the problem is to integrate those two profiles. Nursing care, for example, is covered by health insurance and is not within the responsibilities of the social security ministry.

Volker Berger (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany) said that the option of financing dependency insurance through a percentage levy on a person’s total income had been examined in Germany, but had been rejected as too bureaucratic. How did it work in practice in Luxembourg? Do workers have to declare their total income to their employers, so that the correct deductions can be made at source? **Raymond Wagener** replied that a normal declaration of income is made by the individual to the authorities, up to a ceiling of seven times the value of the wage. If total income exceeds seven times the wage, a separate declaration of the additional income

has to be made, but this is not always easy to check. The capital income figure is passed on separately by the tax administration, one year late.

Muriel Rabau wanted to return to some of the questions raised by Anne-Sophie Parent, notably concerning the devolution of financing to the local level. This does indeed raise problems for equality of access. The question of differentiated subsidies to non-profit and for-profit providers also needed to be discussed. **Isabella Manichini** agreed that major problems of governance are involved. How can devolution to the lowest level, desirable in itself, be reconciled with the maintenance of high standards and equality of access? This is a broad issue facing Italy and other decentralised countries, also in terms of the allocation of resources. It would merit wider debate at some stage. **Anne-Sophie Parent** asked if private dependency insurance is a growing market in the various participants' countries, and if the directive on financial services is likely to accelerate the trend. Again, she asked if guidelines or principles are being developed to prevent discrimination by insurance companies. At a time when legislation is being brought in against age discrimination in employment, there appears to be no corresponding legislation against age discrimination in insurance. **John Halloran** stressed the need for the highest possible minimum standards of care for frail and vulnerable people. There is indeed a market created by people who want more than the State could provide, although that State provision should in any case be at a good level. People are now consumers, more than they used to be, in all aspects of their lives. They would want some element of choice for themselves or an elderly relative which may fall outside the normal public provision. So one of the dilemmas for the future will be how far to respect choice. How will people's wish to fund additional care for themselves and their families fit in with the wider public provision of services? Will it be possible to avoid a two-tier or three-tier service? Does choice lead to discrimination, or is it a desirable reflection of people's growing aspirations? We perhaps need to develop more sophisticated financial incentives, so as to ensure that some people are not left behind. The future financing of long-term care is a major issue which requires debate in all Member States. **Patrick De Bucquois** said the debate had shown the high degree of interlinking in the provision of different social services. Also, the issue of insurance is clearly linked to the protection of fundamental rights. In answer to the consultation by the European Commission, Caritas had emphasised that social services are not just personal services. They are the implementation of social protection schemes. We have to make sure that internal market duties do not endanger those schemes. As regards geographical equity, all systems have schemes under which a central budget is devoted to the municipalities. There is a responsibility to ensure that the criteria for the distribution of that budget correctly match the social situation in the various municipalities. This is not always the case.

Isabel Moens said that the Belgian region of Flanders, which has the devolved responsibility for dependency care, had experimented with opening it up to the market. One result that had been noted was a tendency to select risks. For instance, private insurers tend to go for employer-based group schemes, rather than insuring individuals, because company employees are younger and less at risk of dependency than is the population as a whole. Also, a number of private insurers who were initially interested in the Flemish dependency care market are now starting to withdraw from it altogether, because they feel that the administrative burden is too high and the profits are too low. Commercial operators have a quite different mentality to that of other operators in this field, and great care should be taken in future over any opening up of this market.

Ri De Ridder asked what constitutes a social service. It is difficult to arrive at a definition on the basis of characteristics alone, because there are all kinds of gradations in the way these services are organised. The most fruitful approach is perhaps to consider them in terms of social protection, taking the citizens themselves and their rights as the point of departure. Dependency care is one of those rights. If access to social services were declared to be a fundamental social right, this would resolve

many of the uncertainties surrounding the "general interest" status. **Anne-Sophie Parent** said that AGE's Dutch members had raised precisely this issue. It used to be the case that Dutch cardiac patients could take a taxi to their medical appointments and get the fare reimbursed. Now, the eligibility threshold for that reimbursement has been raised so high that anyone who is capable of walking more than five metres is expected to take the bus. Of course, some continue to take taxis – but only those who can afford to pay. So a definition of the citizen's social rights and entitlements is certainly needed. It should be flexible enough to take account of the rapid evolution in this field, but it should make it clear that full and equal access to care is a basic right. That is not the case at present.

Patrick De Bucquois said the question of the freedom to choose one's service providers had been discussed at length a few weeks previously at a meeting of the European Social Platform, which brings together social NGOs at the European level. It had been difficult to reach a consensus on this issue. Freedom to choose across a range of providers was not regarded as a fundamental right by many of the social NGOs. Rather, it was a matter to be decided in accordance with national traditions, in line with the subsidiarity principle. The important thing is that the users should be treated in their own language and in line with their cultural, philosophical or religious expectations. In some countries, that may mean a choice of providers. In others, it may not.

Third session: Quality of services

France

In France, as is often the case in the social field, the rules are quite numerous and complex, stated **Florence Lianos.** They are frequently the result of historical processes involving many actors. So her overview of the French system would, of necessity, include some simplifications. As everywhere, the proportion of elderly people within the French population is continually growing. Five million people in France are aged 75 or over, and there are one million people in a situation of dependency. In particular, the incidence of Alzheimer's disease has been increasing rapidly. Service provision, particularly to the elderly, is becoming more and more diversified, with strong growth in the private sector. There are some 10,000 medical or medico-social establishments taking care of elderly people. They provide 661,000 places, of which 221,000 are in the public sector. The rest is split between non-profit and for-profit private establishments. There are also residential homes that constitute a kind of halfway house between standard accommodation and medical care. Other intermediate solutions include day centres, temporary accommodation centres and what is known as "hospitalisation at home". The idea is to provide a continuum catering for all needs.

The wish in France is to impose the same rules right across this very diverse sector. Quality and equality of treatment are the main guiding principles. All the partners are very sensitive to the question of equal treatment. In 1999, the French Council of State declared that "the general interest has, for more than 200 years now, been at the heart of French political and legal thinking, as the ultimate goal of public action". Achieving that goal across all the different services is, of course, difficult. But all French politicians know exactly what is meant by "general interest". For elderly people, the aim is to maintain their links with their general environment. This is reflected in a very strong policy of keeping them in their own homes for as long as possible. Home help services, home care services and a range of home improvement grants help to achieve that. The personalised autonomy allowance helps to pay for other measures that maintain a person's independence. On the residential care side, great emphasis has been placed in recent years on the quality of care. This

issue is recognised by all the actors involved, including the emerging private companies. Sadly, ill-treatment of old people in residential care still sometimes occurs, whether through neglect or assault, and this must be dealt with. There is also a drive to promote innovation, notably in the medical and socio-medical establishments, which are encouraged to open up to the surrounding environment. Cooperation agreements and "bridges" between these establishments and other organisations are one way of achieving this.

The legislation, too, applies to both the public and private sectors. The 1975 law on medical and medico-social institutions ushered in a sort of post-modern period in French society by setting rules, which still apply, for the creation of establishments on the basis of an evaluation of needs. Priorities are established through planning, and operators can then launch projects only after receiving administrative authorisations. There is a whole series of such authorisations for the creation, management and alteration of an establishment. The sector is tightly regulated, but this has never caused problems vis-a-vis the European rules, as the same regulations apply to all. Laws dating from 1982 devolve considerable powers to the *département* level (the General Councils – the intermediate level between national and municipal government). They have taken on more and more of the responsibility for services to elderly people and people with disabilities. In 1990, the law on the monitoring of commercial establishments was adopted, aimed at bringing in regulations that would protect the interests of their residents. Notably, all commercial establishments are obliged to draw up contracts with their residents, including clauses on entry and resiliation, the services provided and the price for those services, and invoicing procedures in case of hospitalisation. Accommodation prices can be set freely by the for-profit sector. However, the State regulates the subsequent development of those prices. Each year, the Ministry of Finance issues a decree laying down the maximum permitted increase in accommodation charges. A law of 1997 embodied improvements to the contracts. After extensive consultations, another law clarified the rather complicated tarification structure. Three tariffs are involved, covering the very high cost of a place in a retirement home. The accommodation tariff is, normally, charged to the person concerned. For needy cases, it is covered by social assistance granted by the General Council of the *département* concerned. The dependency tariff is paid by the General Council. The care tariff is paid by the health insurance. These three tariffs apply in each establishment, of whatever type. Retirement homes are very expensive in France. The average accommodation charge is €1,800, whereas the average pension is €1,500. So this does pose problems for many people – and there are wide regional variations in charges.

As far as quality is concerned, all these laws aim to achieve five objectives: overall quality; equity throughout France, notably as regards charges (identified as a priority for reflection by the incoming Minister); the organisation of care (the linkage between the different elements of the care continuum); staff training (a major issue at a time when staff are in short supply); and the modernisation of establishments (many of which are quite old and no longer comply with current norms). Quality assurance tools include tripartite agreements between the State, the General Council and the establishment concerned. These concern tariffs but also quality benchmarking. Establishments are required to have both an internal assessment every five years and an assessment by an external body every seven years. These are on the basis of benchmarks set by specialists and validated by a central body, the National Evaluation Agency. Apart from these institutional tools, other measures help residents and their families to gain an insight into the establishment concerned. These include the establishment's own workplan, the contracts already mentioned, councillors who liaise with families, and mediators who can serve as go-betweens for a resident, the family and the establishment in case of need. Legal penalties apply if norms are not respected. Although not very severe, these penalties do help to guarantee quality. The prevention of ill-treatment, both in residential care and at home, is receiving particular attention at present.

For France, this really is a case of establishing a service of general interest and social utility. The for-profit private sector certainly has its place within that service. It is subject to strict, binding standards, which are for the most part accepted by the operators. It is then up to them to calculate whether the norms outweigh the profits. But many private operators are entering the retirement home market, particularly in areas where property prices and the residents' incomes make it worth their while. The State, meanwhile, is present throughout the sector.

Italy

Italy is currently preparing new legislation on the minimum level of dependency care, **Isabella Manichini** reported. The aim is to establish a system at the national level that will give all citizens the same rights of access to information and services, at a time when Italy has seen the development of quite different welfare systems at the regional level. Integration between the health and care profiles is well advanced, and services are well targeted on elderly people in a state of dependency, as well as their families, within that integrated approach. An exception is the South of Italy, where a full range of services is often not available. This raises an important point: to have freedom of choice, you first need something to choose from. So services have to be developed in those areas where they are still lacking. Hence Italy's two linked priorities:

- To determine a general system of social rights, which is the constitutional duty of the central government. Work on this has been proceeding over the past five years, but a recognised system of rights is not yet in place.
- To develop the system of services. For people in need of support, the basis for this must be integration between welfare and health care services.

The current lack of territorial uniformity leads to real discrimination in terms of access to care services. The lack of care services continues to contribute to low employment rates, especially among women and especially in the South, where women's participation in the labour market does not exceed 30%.

Innovative approaches to the care of dependent elderly people are being adopted in some areas, especially Tuscany, where a "health society" has been created – a type of independent agency based on integration of the two profiles. It works with non-profit organisations and defines the criteria for them to become service providers. However, the problem is that the various regions continue to work without a common set of criteria. In 2001, a decree was issued in which the essential level of services was defined. It also made provision for home care and health care services for the elderly, but without any real integration with the social aspects. The management of interventions and services in the two sectors is conducted at two different levels. The health system is in charge of the regional level, while the care services operate at the municipal level.

Financially, the essential health care levels define the proportion of the expenses covered by the health care system. Generally, this is 50% in the case of hospitals or residential structures, with the rest coming from the municipalities and the users. The level of co-payment by users will therefore vary according to the financial resources of the municipality concerned. These differ greatly. A law reforming the distribution of responsibilities between central, regional and local government has been adopted. It applies the subsidiarity principle. The government has the responsibility for determining the essential level of assistance. The regions have the competence to allocate resources and define the main objectives of the programme. The local level has the responsibility for delivering the services. This legislation recognises the important role of the non-profit sector, both for consultation

purposes and as providers. It lays down criteria for the accreditation of non-profit organisations for the supply of services. It also highlights the importance of integrating the health and care aspects. Over the past five years, the regions and the municipalities, with government support, have tried to reach an agreement on tackling the disparity between these two aspects. In some regions, this works very well.

Typically, the municipalities provide services to users and their families, but also vouchers which can be spent on services of the user's choice. In 2005, almost 1.6 million people received national-level financial support, of whom 70% were elderly.

60% of the services in Italy are provided by non-profit organisations. This is a major, rapidly growing sector within the Italian economy. Specific laws govern the organisation of these social cooperatives. Here too, regional disparities exist. The non-profit sector is stronger in the North than in the South. The law providing for accreditation of non-profit providers is seen as an important step towards delivering a high-quality service. In general, free market rules are not applied to this sector, and most Italians do not think that they should be. Accreditation is also present in the health sector, as a preliminary requirement for setting up a contractual economic relationship between the providers and their association and the national health services agencies. Accreditation criteria proposed for the health aspects include the adoption of agreed auditing tools and gathering information on users, as one of the means of measuring how the standards are applied.

The development of quality standards is stronger in the health sector, as some €100bn are devoted annually to the health system. Obviously, it is easier for the government to negotiate an agreement with the regions on the use of these resources and the essential level of health care to be provided. For the social aspects, an essential level has not been defined, and so it is more difficult to tell the regions what quality standards they should apply. The national social fund pays for only 10-20% of services at the local level.

Some projects are being implemented to guarantee quality in the health sector. A classification of services and products, together with the computerisation of home care, is being carried out by the governments and the regions. Work is also being done on the measurement of outcomes, on the criteria for accreditation and authorisation. Fair access by elderly people to advanced medical technologies is being promoted, in order to combat ageism. Medical research into ageing is another priority field. The new agreement between the government and the regions on health care emphasises the development of home-based services, based on an assessment of the situation of the patient and his/her family. Sharing of the cost benefits is negotiated with the patient and the family.

New legislation, which was likely to be ready a few weeks after the seminar, will define dependency. A person will be assessed on the basis of the new classification of functional disability issued by the World Health Organisation in 2001. The legislation will also enshrine the right to integrated information and to a personalised programme of intervention. This programme will clearly set out the social and health services to be provided for the person and the family. It may also include allowances and other financial interventions where appropriate.

Poland

Both the health care system and the social assistance system are involved in the provision of long-term care in Poland, explained **Ewa Chylek** (Ministry of Labour and Social Policy, Poland). The health system provides some forms of institutional care, whereas the social assistance ensures also a wide range of home-based services. Institutional long-term care is provided mainly in establishments run by the local communities. There are also day care centres providing specialised services. A last resort is the social assistance houses, which provide accommodation and services for persons needing permanent care.

Quality standards are determined by the law governing social services in general (Law on Social Assistance). Quality control is the responsibility of the *woiwod* (regional-level government). The goals and quality standards defined in the legislation apply to the social assistance houses, day care and specialised services for mentally ill people. One type of social assistance house is specially designed for elderly people. A regulation applying the Law on Social Assistance lays down general rules – for example, that the houses should provide care tailored to people's needs. It also sets out very detailed requirements on matters ranging from meals and building specifications to care and support services. In addition to these nationally regulated services, local authorities have fairly broad scope for making additional provision on their own initiative. There is currently a debate in Poland about how to ensure that services provided by NGOs and private operators, come up to the same standards as the public ones. Since 2004, these other providers must also apply the legal rules if they are involved in long-term care for elderly people.

The *woiwod* has the responsibility for supervising the social assistance provided by local government, added **Anna Prekurat** (Ministry of Labour and Social Policy, Poland). It also oversees 24-hour care in social assistance homes and private homes for elderly people, as well as authorising and registering such homes and institutions. By checking the registers, citizens can see if an institution meets the required standards. In cases of non-compliance, the *woiwod* can report the institution to the administrative court or can impose penalties. Private or commercial entities that provide 24-hour care without authorisation are also subject to penalties. These are imposed administratively, with a right of appeal to the Minister responsible for social affairs. The providers covered by the legislation since 2004 have until 2010 to come up to standard. Some State subsidies are available for renovating buildings and for new construction. In many regions, there is a lack of qualified inspectors. Another problem on the horizon is where to accommodate the residents of the homes that may have to be closed in 2010 if they fail to come up to standard.

Caritas Europa

Caritas Europa is a network of 48 national Caritas member organisations working in 44 European countries, **Patrick De Bucquois** stated. It focuses its activities on policy issues related to poverty and social inequality, migration and asylum within all countries of Europe, emergency humanitarian assistance, and international development and world peace. While some Caritas member organisations have no activities in health and long-term care within Europe, most are involved in advocacy and voluntary work on issues of social cohesion and social inclusion, which also includes care structures for the elderly. A smaller group, especially in Germany, Belgium and Luxembourg, are active providers of care services. In Belgium, about 30% of institutional care services are provided by Caritas members.

Quality within social services is becoming more and more of a priority for some European-level NGO networks, which are now meeting regularly on this issue. Quality is a risky issue to deal with. The endless debates on the "quality of life" show that it can be a very subjective term. Nonetheless, it is a key issue within any service. He did not agree that availability should be ensured first and quality later. The two must be tackled together, along with accessibility, affordability, transparency and efficiency. A concern for quality is particularly important in the social economy, where good on-the-job training must be provided for staff.

At the Commission, DG MARKT (Internal Market and Services) has, he said, circulated a discussion paper on "Emphasising quality in the internal market for services". This acknowledges the importance of trust in commercial relations and proposes to implement third-party verification systems. This is a very important issue. One of the responsibilities of the public sector is to provide certification and verification. Quality standards cannot be left up to corporate social responsibility alone. This is even more true for personal social services, where trust and user participation are key to the provision process. There is sometimes a tendency to regard care users as consumers, and this is not entirely false, but they are much more than that. They are also co-producers within the care process. Without their participation, there cannot be any positive outcome. Building on the users' own capacities is a critical aspect of quality.

On services of general interest, there is no agreement within the European Social Platform that rules need to be enforced at the European level. But at least there should be some overarching principles, applicable throughout the EU – not only for social services of general interest but for *all* services of general interest. For example, transport services are of general interest. They help to guarantee the right of access to other services, as the example of the Dutch taxis had shown. Also, social and health services have very much the same characteristics. This also needs to be recognised within the European approach.

He identified a number of quality principles:

- Enforcement of fundamental rights. Certainly, needs must be fulfilled, but rights must not be overlooked.
- The existence of non-formal complaint procedures, such as an ombudsman.
- Social dialogue. Workers and their trade unions within these services must have a say.
- User participation - for example, through residents' councils in retirement homes.
- Stakeholder involvement (including by families and neighbourhoods).
- Continuity (24/7 service) and sustainability (the closure of a home can be a highly distressing, even fatal, experience for its residents). Continuity is one of the basic principles of public service.
- Good working conditions, with sufficient staff numbers and qualifications.
- Limits to profit-making behaviour – by law or through the institution's statutes.
- Limits on advertising by care services.
- Limits to the "marketability" of the providers. They should not be quoted on the stock market.
- Monitoring on ethical issues.
- Respect for cultural, spiritual and religious convictions.
- Safety – as regards living conditions, architectural standards, staff training and the environment.

The central issue at the EU level, he suggested, is how to ensure public responsibility in the field of social and health care while recognising the growing role of private standards organisations, such as

ISO or EQRM. These have their part to play. But the last word on standards must remain with the public authorities.

European Social Network

John Halloran said the European Social Network's members are directors and other stakeholders contracting social care and public health in 23 countries. Social and health care vary widely across Europe, and so therefore do the responsibilities of ESN's members. Some provide all or most local social services for older people. Others contract most of the local services. There are many variations in between. Asked about the topics tackled by this seminar, many ESN members emphasised the need to respect economic and cultural differences. The subsidiarity principle is important here. Most felt that some competition between different sectors in a local environment can be positive. This does not mean completely free competition. Regulation is, of course, needed. Some of the quality issues raised by ESN members were:

- Who is responsible for quality? Where is quality monitoring located? How independent is it?
- How can a balance be struck between choice and equity?
- How can we finance *sustainable* quality?
- Who are we accountable to?
- How are we going to face the shortage of qualified staff?
- The needs of dependent people are increasingly complex. People are coming into residential and nursing homes with a variety of needs: mental health problems, Alzheimer's and other disabilities. How are the services to meet those needs going to be developed in future?
- What is to be the relationship between services for older people and social inclusion and social cohesion? How can contact with the wider world be maintained both for the people in care and for the service?

The following are what users appear to want:

- They need clear information, support and advocacy, in order to make decisions about their own lives. Many people in the later years of their lives do need independent help with taking important decisions.
- People need to feel valued and respected, whatever the system.
- Most people want to stay at home for as long as possible. Efforts to provide supportive social and health care are important here, and their boundaries can be pushed further, using new technology.
- People want access to quality, joined-up services. Health, social services, transport and housing services must be talking to each other.
- People do not want to lose their identity. They want to be cared for locally, where they were brought up and where their family lives.

ESN members feel that a number of principles and questions are important in relation to care:

- We must communicate a vision. We must express values and a commitment to the services that we are developing.
- If we talk about a social market or a social economy, how is that going to be managed? How are we going to ensure the right number of places, the right quality, the right degree of choice and the maintenance of equity?

- We need to consult users, carers and other stakeholders. Services should be reevaluated in consultation with them. This has been done too little so far.
- Clear quality standards must be developed, with impartial inspection and audit. The providers of a public service should not audit that same service.
- Some degree of transparency about quality standards is needed. The public should be able to access the reports and to be informed about the quality of the service being provided.
- Quality standards should promote learning and development, and this should be a continuous process. In some countries, comparative tables have been developed. This may or may not be an option that others wish to pursue. However, some degree of comparison at the European, national and local level may be useful in learning from each other's experiences.
- Service providers need to push the boundaries. Services should not just have written quality standards, they should be driven by quality. All members of staff should be aware that quality is the principle on which service is provided. Quality should be celebrated.
- Training must be continuous, as there is often high staff turnover in the care sector.
- There should be some degree of compatibility between monitoring of social services and monitoring of care services. In some countries, the inspection process now runs across the different disciplines, and this would seem to offer some benefits.
- Providers must inform, respect and listen to users, carers and other stakeholders.
- Diversity and inclusion in local communities should be promoted. The way that services are provided should take account of changes in the composition of society and of the family.
- The quality of the relationship between the users and the carers is quite fundamental.

At the macro level, the planning of service provision must also be part of the local corporate planning process. For example, in many areas of Europe, the cost of land has become prohibitive. Where are we going to locate future care services for old people? If new care institutions are built in some areas, they will be prohibitively expensive. Service planning will involve trade-offs between economic and social benefits in communities. It must be part of the regeneration process. Ensuring sustainable services also entails dialogue with all the stakeholders, including the commercial sector.

Over the next few months and years, the ESN would like to make its own contribution to this debate. In July 2007, it will be organising a seminar on long-term care, in cooperation with the European Commission and the OECD. It is hoped that a working group can be set up in early 2008 to address the issues in greater depth.

Discussion

Françoise Navez (Centre on the Social Economy, University of Liège, Belgium) asked if the new Italian law now in preparation takes account of Commission Communications on the various relevant rulings of the Court of Justice. She also asked for more details of the Caritas proposal on a minimum level of social rights. Would this take account of the European notions of the general interest and of subsidiarity? And where would the definition come from? From the interested NGOs? From the European Parliament? **Isabella Manichini** did not think that the Italian law will make specific reference to the European aspects, as it will be more general in scope. It is mainly aimed at providing a new fund for long-term care, as well as setting the criteria for the transfer of funds to the regions and municipalities and for assessing people's long-term needs. The definition of services is more of a local matter. However, there may be further decrees on this, and these may have to take account of the questions raised. Italians are not very aware of the current European discussion on the definition of services of general interest. However, efforts are now under way to draw it to the attention of

stakeholders and the judiciary. On the minimum level of social rights, **Patrick De Bucquois** emphasised that he was no specialist in EU law. However, he noted that Article 86(2) of the Treaty on services of general interest is frequently misunderstood. Often, it is interpreted as simply permitting exceptions to the laws on free competition, whereas in fact it authorises exceptions to the whole of Community law, including the internal market. This fact is not sufficiently utilised. In addition, there is the case law built up by the Court of Justice concerning "overriding reasons of general interest". That is a much broader concept, which leaves scope for developing something. Also, the European constitution as drafted would have put this matter on a more indisputable footing. So, in the negotiations now under way, we have a responsibility to ensure that a clear-cut legal basis is provided for this kind of initiative. On the political side, he felt that the Commission is bound to be rather touchy on this issue, because the Member States have somewhat diverging views. If the services directive had one merit, it was that it woke people up. They are now aware that things are no longer as they used to be. So the question now is not so much whether we want a framework directive or not, but whether it will be coherent. At present, there are efforts to develop a directive in the field of health care. That would be quite logical, if it is just about patient mobility, as Court decisions make it necessary to establish rules about that. But if it brings in all kinds of bits and pieces that have little to do with the core issue, it will be incoherent and will probably work to the detriment of the users. Either we will have a framework agreement first and then sectoral agreements, or else it will be the other way round, but in either case they must be coherent and they must be based on principles held in common. That is why the European Social Platform as a whole – and not only Caritas – wants to move not just towards European standards but also towards European principles. That is wholly achievable. **Alain Coheur** (International Association of Mutualities) said the statement just made by Patrick De Bucquois was very important. It is virtually impossible to arrive at a definition of social services of general interest, because they are too diverse. That is why there must be common principles, shared by the public authorities but also the NGOs and non-profit providers. It should be possible to get such principles accepted by all Member States, because their social services pursue the same aims. Similarly, the values shared by the public and private sectors are sufficiently broadbased to be taken up at the European level and identified as the common principles underlying all social services of general interest.

Concetta Cultrera felt that, with the reference made by the previous speaker to the role of art. 86.2, the discussion is headed in the right direction. The Commission absolutely intends to respond to concrete legal concerns and Article 86(2) should be used as a building-block. It does indeed apply to the EU Treaty rulese, and not just to the rules on competition, and at the same time the case law gives clear room for manoeuvre. The Commission's plans for a Communication at the end of 2007 are very much headed in bringing more legal clarity. Guidelines might be one way forward, and this is why concrete examples are the most useful thing that the present meeting can contribute. Article 16 gives room for manoeuvre and if one day, we could have a few lines added to this article, as intended by the Intergovernmental Conference of 2004, that would provide a clear signal to everyone that the EU is committed to protecting social services of general interest.

Abuse of the elderly is an important issue for AGE members, **Anne-Sophie Parent** said. AGE organised a seminar on this issue in 2006, to which it invited Commissioner Špidla. It also organised an inter-group meeting at the European Parliament. Following that, Commissioner Špidla in particular decided to address the issue. A Communication about it will be issued in early 2008. The Commission will also organise a conference to look at the longer-term perspectives and, in particular, to analyse whether quality standards can help to prevent abuse. She asked if the Commission will be using the results of a current survey of service providers in institutions and at home, to assess whether there is a need to develop quality standards, and whether it will also be using the outcome of a Eurobarometer study, due out soon, on citizen expectations regarding dependency needs.

Concetta Cultrera replied that the 2007 Communication should indeed touch upon quality issues. The Commission is thinking about launching an initiative, which will of course take account of the studies already under way. The objective is not to define common standards, but rather to move towards common ways of assessing quality. Work on this is in progress, and more will be made known within the next few months.

Muriel Rabau suggested that the widespread wish for quality standards in long-term care is in itself an indication that these services cannot just be left up to the competitiveness rules and the internal market. This is about people - about people who have become dependent or frail. So perhaps any definitions should point to the protection of the person as well as social protection. **Françoise Navez** added that the new directives on public markets also need to take account of the social services in general, in order to ensure that all the rules applicable to this sector remain consistent. **Isabella Manichini** supported Muriel Rabau's view. Social services have a specific profile. Market rules may help to promote quality, but clearly, social services cannot be focussed on economics. They must be centred on people. **John Halloran** agreed that these services require particular sensitivity, but he felt that they can learn from the commercial sector. The public sector can sometimes be patronising and old-fashioned, and the lack of any stimulus from outside has not always been beneficial. So he welcomed greater openness, as a means of improving standards for everybody. The commercial sector is sensitive in its own way – if it doesn't respond to users' needs, it doesn't make money.

Marie Keirle (Ministry of Employment, Social Cohesion and Housing / Ministry of Health and Solidarity, France) recalled that many contributions had also pointed to the other side of the equation – the people who work in social services. In the concern to find a definition of social services of general interest, this other aspect should not be overlooked. The employment policy implications, the need for training and the looming threat of staff shortages all need to be taken into account, notably in policies on the free movement of persons.

Listening to the day's discussions, **Antoine Saint-Denis** had felt that the meaning of the word "competition" was not always clear. There can be various types of competition. The presentations had shown the existence of strong public regulation but, in most cases, this coexists with certain forms of competition. Vouchers, for instance, permit freedom of choice up to a certain point. So this is not a case of "monopoly versus competition". Fortunately, stimulation and regulation are not mutually exclusive. **Alain Coheur** agreed that much can be learnt from the commercial sector, but it is important that everybody should play to the same rules. At the moment, it seems as if everybody is to be forced to use the commercial sector's rules. The Court of Justice decisions imply that it is not your status that matters but what you do. But that is completely false. A non-profit status will automatically influence the way in which an organisation behaves on the market. Its objectives will not be the same. Why should the rules of the market necessarily be right and other rules, which in some cases have been in place for many years, necessarily be wrong? Non-profit organisations often respond faster to emerging needs than do commercial organisations, which need to see the prospect of a sold profit base before they become interested. **Patrick De Bucquois** advocated a level playing field for all service providers. He had long pressed for a European statute for non-profit organisations, but the present Commission had withdrawn that proposal, for reasons on which he did not wish to expand. However, this does indicate an unwillingness to ensure that level playing field. This is a ground for concern.

Ewa Chylek said that a basic rule for long-term services should be empowerment of the users. That is written into the Polish regulations. She also agreed that ensuring a high enough ratio of qualified staff to unqualified staff is of crucial concern.

Anne-Sophie Parent said that AGE's members see a definite need for EU action to protect the consumers of long-term care. In most cases, these are captive consumers whose freedom of choice is purely theoretical. In emergency situations, most people accept whatever vacancy is available in a nursing home. There is also an urgent need to clarify the rules, so that all sectors play according to the same ones.

Concluding remarks

Drawing together the main points emerging from the seminar, **Manfred Huber** noted that:

- Long-term care services have evolved. In many cases, they now comprise a broader range of services, which have become more complex in response to the expectations and needs of populations.
- This expansion has its price. Some Member States have already substantially increased the public funding of long-term care, and others have plans to do so.
- Long-term care is clearly embedded in the national context, notably national traditions of solidarity and personal services.
- Modernisation of care is driven primarily by the quest for value for money. But the requirement for financial sustainability is balanced by the acceptance that quality should be, and in some cases must be, improved.
- Care is subject to increasingly complex rules, as regards both accreditation and quality assurance. The present mix of public and private markets has also contributed to this complexity. This raises the issue of how these markets are organised. To what extent should there be free competition, and should competition be on quality or on price? These are very complex regulatory questions when it comes, for example, to public procurement.
- One modernisation trend in many countries is that more consumer choice is granted, but this has a number of implications. Again, attitudes to choice are embedded in national views and cultures.
- With the increasing range of services comes a trend towards greater coordination between health and social services. This also reflects a more holistic view, in which the needs of the person concerned become the central focus, and various services cooperate to meet those needs. At the European level, this calls for coherence between policies on health and on social care.
- The financing of long-term care is, in most cases, a co-responsibility of public and private funds - for example through partial coverage ("hotel costs" in residential homes or hospitals may be separated out from the cost of medical care) of through substantial cost-sharing. In such cases, the "private" costs are often run up with the same provider which also receives public funds for other aspects of the care. This raises the issue of cross-subsidisation, which may need to be regulated at the national and supranational level.
- Possible new modes of financing include "reverse mortgages", in which most of a person's life savings may be spent on the cost of care in old age. Given the current pension reforms, it may be asked whether people will in future still have the savings needed to finance their care.
- Licensing systems have now become commonplace in countries that are at various stages of developing long-term care as a coherent policy. But in some cases, major ongoing investments are needed before the licensing requirements can be met.
- The long-term care sector is increasingly subject to international influences. The availability of comparative and comparable European statistics would be useful in this regard.

- For the quality control of services, the methods initially developed in the commercial sector – ISO and other quality management standards - are now spreading. So a challenge already exists at the national and local levels: how to regulate quality standards so as to ensure a level playing field within social services. This also applies for Europe as a whole.
- The empowerment of users is one important aspect of quality, and may also call for non-formal quality mechanisms such as an ombudsman or a residents' council.
- The cross-border hiring of care workers who are from new Member States or even further afield, often without work permits, is partially fostered by systems that promote choice in long-term care – such as voucher schemes or personal care budgets. These elements of choice can also promote cross-border movement of care users. For example, people have been moving into Belgian care homes from surrounding countries, where they have received personal budgets for care. This is causing some concern in the countries receiving these cross-border care users.
- Large international companies are now entering the long-term care market in some Member States. Through economies of scale, they may be achieving competitive advantages in public tendering vis-a-vis smaller local providers.
- Services for persons in need are excluded from the services directive. Where will the borderline between "in need" and "not in need" be drawn in the case of long-term care, which covers a long continuum of services? Will the operations of each provider need to be separated out into several different activities for regulatory purposes? What meaning is to be given to the phrase "services of general interest" when applied to long-term care and social services in general?

On behalf of the Belgian hosts, **Ri De Ridder** thanked the peer reviewers for presenting their systems. One message that he would take home from the seminar is that, even though there may be differences between national systems, the issues facing long-term care are very similar. So there is common ground for discussion. During the seminar, there had been some emphasis on the need to get back to local, tailor-made long-term care. This is to some extent in contradiction to the fact that more people will, in future, be using long-term care services in places other than those in which they contributed, through social insurance or taxes, to the financing of these services. Greater mobility means that people will not necessarily be growing old in the place where they worked. This raises the need for European action on making the link between the place where the contributions are paid and the place where the care is ultimately given. At the European level, the discussion on how to regulate services of general interest should not be concluded too hastily. The seminar discussions had strengthened his view that present assumptions about the characteristics of such services will not produce greater clarity. He suggested two possible ways forward, which might be complementary. One is to look at the needs to be covered by services. Services of general interest in the field of long-term care could be defined as each service identified by at least one Member State as needing to be organised by a public authority in the first instance, even it is actually provided as a regulated private service or a public-private mix. However, this does not resolve issues such as the regulatory approach to informal care, prevention and other aspects. These need to be discussed at the European level. The other way is to look at the issue in terms of social risk. If there is a risk that long-term care cannot be financed by many people on their own, then the insurance should be provided by the public authorities. Coordination of rights is another issue that should be tackled at the European level, at a time when more and more people will be taking up services in a place other than the one in which they paid their contributions. On the issue of quality standards, a benchmarking exercise at the European level, with commonly agreed indicators, could be useful. A deepening of common objectives is also needed, perhaps through a "soft" approach rather than legislation. This would be a way of putting long-term care on the European political agenda, rather than simply waiting for rulings by the Court of Justice. Belgium would be willing to contribute to such a policy-based approach.

For the Commission, **Concetta Cultrera** thanked the hosts and the participants for a lively and enriching debate. Ensuring more legal certainty on this issue is very much part of the present work of the Commission. Subsidiarity is, of course, the cornerstone of the legal context in which the Commission is acting. It is very important to ensure coherence of the various initiatives that Commission is currently undertaking A high value is also placed on open dialogue with Member States and all stakeholders. The conference of 4 June would be an opportunity for this. The discussion on finance and resource problems at a time of greater and more sophisticated demands on the social services raised important issues concerning the transfer of resources and competences to the local authorities. She cited a European Parliament resolution which referred to the need for Member States to ensure that the transfer of competences is accompanied by the transfer of resources. She repeated that in the Communication now being prepared for the last part of 2007, an initiative on quality will be announced. This will not aim to define quality standards or criteria, but agreed ways of evaluating the quality of social services. It will build on existing initiatives and will support exchanges of good practice among stakeholders and Member States. The Parliament and the Portuguese presidency would be organising a forum on these issues in September 2007.