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Social services in transition – towards a European social services information system

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Introduction

Social policies and social service delivery as well as social service finance systems in the European Union are undergoing far-reaching changes and are facing major challenges. To a large extent, these changes are triggered by demographic trends and subsequent increases and shifts in demands for personal social services of all kinds. Unfortunately, our understanding of these changes and their impact on social service systems in the EU and accession countries remains limited. There is no solid, comparative, systematic and comprehensive information base on demand and supply, capacity and output, standards and quality, user groups and providers. Such a system could assist the EU as well as individual member states in assessing, developing, implementing and monitoring adequate policies and measures to address the challenges and opportunities of the greater 'Europeanisation' of social service financing and delivery. It could contribute to an improvement in our theoretical and policy-relevant understanding of the role of social services as one cornerstone of national systems of social protection. It could play a role with regard to different systems of reporting, partly initiated by efforts of an improved co-ordination of policies amongst European Union member states (as e.g. in the framework of the open method of co-ordination), both at the European Union level ('The social situation in the European Union'; 'Joint Report on Social Inclusion') and on the national level. These new instruments of social reporting require a solid empirical base of comparable, systematic and current information, too.

Thus, developing an information system on social services in Europe is not only a matter of scholarly concern. It is indeed a matter of utmost practical importance for policymakers and other stakeholders. It would add significantly to the knowledge and expertise of three groups of 'users': the academic community interested in social policy issues, policy-makers of the European Union and in member states dealing with social policy and social services questions, and practitioners working in and for social service organisations, including users and their representatives. A European social services information system would constitute a clear European value added: for different communities and stakeholders, it would show what the potentials, challenges and opportunities are for social services in Europe. It would open up a research field for comparative policy analysis of great benefit to all member states. As a second contribution, the project would point to policy implications and suggest measures for the EU itself as well as for national governments and social service industry representatives. This would make possible a policy dialogue that today is still handicapped by incomplete information, imprecise concepts and ill-defined approaches.

In order to promote the idea of a European social services information system and to prepare a cross-country project, the Institute for Social Work and Social Education (ISS) in Frankfurt am Main, Germany, hosted a conference on December 18th and 19th 2000. The seminar was part of the activities of the Observatory for the Development of Social Services in Europe (cf. http://www.soziale-dienste-in-europa.de/), a project funded by the German Federal Ministry

for Family Affairs, Senior Citizens, Women and Youth. The present documentation contains the proceedings of this conference, where presentations on major current and future challenges as to demand for, supply and delivery of social services in a cross-country perspective with country reports on the Czech Republic, France, Germany, Italy, the Netherlands, Sweden and the United Kingdom were brought together.

The documentation contains all these country reports (cf. articles by Marie-Eve Noël, Astrid Pfenning and Thomas Bahle, Sergio Pasquinelli, Trudie Knijn, Kerstin Westergren and Thomas Gunnarson, and Martin Knapp). Unfortunately, the Czech project partner was not able to submit written contribution. They all give an overview on policies, institutions and the data situation in the field of social services, with a clear focus on the areas of childcare and long-term care for the elderly.

In order to provide a framework for comparative research and social reporting on social services and social work, the contributions by Jane Lewis, Trudie Knijn and Martin Knapp tackle some of the major challenges social services and the agencies delivering them are or will be facing across all European countries. Let's only mention the following issues: 1) shifts in the welfare mix, 2) the relationship between formal and informal/family care on the background of new patterns of household composition and female/mothers' labour market participation, 3) changing expectations as to service quality and user involvement, 4) the importance and role of personal social services as central element to realize social rights and to advance social citizenship, 5) marketization, managerialism, and demands for greater accountability, and 6) evolving legal stipulations at local, regional, national and the European Union level.

Helmut K. Anheier's basic article sketches out the conceptual and methodological groundwork for a European social services information system as well as its basic contours. The establishment of such a solid and up-to-date database would enable theoretical advancement and provide information for policymakers, scientists and other stakeholders. It is to focus on personal social services (in German known as *'personenbezogene soziale Dienstleistungen'*, in French called *'services de proximité'*), i.e. services that are provided by a third party to the benefit of a user or client. Social security payments and related financial assistance as well as education and health care are excluded from this perspective. Public, non-profit, for-profit organisations as well as individuals may deliver the service. In an initial phase, only a subset of the different fields of social work could be covered in greater detail. It is proposed to focus on two core fields, child day care and long-term care for the elderly and to start off with a limited range of countries. The social service information system is conceptualised as to comprise both quantitative data and indicators (such as employment, capacity, output, or costs of service delivery) – to be based on cross-country definitions and classifications – and qualitative information related to the organizational features of the national systems of social service provision as well as to central institutional regulations. Obstacles and challenges to be faced are due to the fact that concepts, definitions, legal treatment, delivery systems, types of providers, needs and demands as well as the political context vary widely across member states, as does data quality and availability.

This seminar documentation intends to promote the idea of building up such a cross-country information system on social services, underlining the need for such a system by sketching out both a basic concept and expectable benefits. The editor would welcome this documentation to give an impulse for the different stakeholders to join forces and resources to implement appropriate structures and networks.

The conference proceedings are published both under series *ISS-Referat*(Nr. 5/2002), edited by the Institute for Social Work and Social Education (ISS), and in the *Working Paper* series of the Observatory for the Development of Social Services in Europe (Helmut K. Anheier et al.: 'Social services in transition – towards a European social services information system', No. 8, Frankfurt am Main, May 2002).

Mathias Maucher, building on texts by Helmut K. Anheier

Prof. Dr. Helmut K. Anheier, London School of Economics and Political Science, London

Toward A European Social Services Information System

Abstract

Social policies and social service delivery and finance systems in the European Union are undergoing far-reaching changes and are facing major challenges. To a large extent, these changes are triggered by demographic trends and subsequent increases and shifts in demands for personal social services of all kinds. Unfortunately, our understanding of these changes and their impact on the type, range and quality of social services across the EU and the accession countries remains limited. Any improvement in our understanding requires a solid empirical base of comparable, systematic and current information. The conceptual and methodological development of such an information system on social services is the primary objective of the project presented here.

1 Background

As recently as ten years ago, policy-makers and scholars could work on the assumption that social and health policy were largely a matter of member states and national concerns (de Swan, 1992). Initially, and according to the Treaty of Rome, the EU had only a most limited competence in social affairs. This changed with the Treaties of Maastricht and Amsterdam, when EU competencies were somewhat expanded. Although the full implications of greater EU competencies in social affairs are long-term and are difficult to gauge at present, it seems likely that are at the beginning of a process of Europeanisation of social services and social security systems.

Within the framework set by the Maastricht and Amsterdam Treaties, social security, health care and social services will be organised according to the principle of subsidiarity. This means that the EU would gain only as much legal and political competence as needed, whereas member states would retain the highest level of policymaking capacity as possible. At the same time, however, this basic framework is being tested from various sides:

Subsidiarity. The subsidiarity framework is a largely formal principle, but lacks substantive content in terms of social policy objectives and directives. In other words, subsidiarity specifies how policies are implemented, not what the purpose of the policies are. Not surprisingly, therefore, the goals of European social policy continue to remain fragmentary and subject to developments in other policy fields that are more advanced in their objectives, in particular enterprise and competition policies. As a result, observers like Leibfried and Pierson (1999) point to a slow erosion of state sovereignty in the social policy field which de fact limits the capacity of member states to design and implement adequate measures at member state levels.

Amsterdam Treaty. Even though the European Commission had no central role in social policy until recently, Article 137 of the Amsterdam Treaty changed this in a significant way and allocated competency to the EU in a number of major fields. Moreover, the number of field explicitly exempted from EU policy competence has been reduced. In this context we find a clear example of what analysts like Scharpf (1994) identified as a general deficit in EU policy-making: the capacity of the EU in terms of policy formulation, making and implementation does not grow at the same rate and quality as that the capacity of member states is being reduced. As a result, there is a growing imbalance in legal competence, knowledge and expertise in social policy fields, carrying with it a great potential for unintended consequences and negative developments.

Deregulation. Next to direct measures, other EU activities have significant consequences for social policy. This is the case whenever the EU becomes active in policy fields that are linked to social services in the broadest sense. EU competition and deregulation policies, e.g., in the insurance industry, may have repercussions on the financing of social services and change the cost and revenue situation of provider organisations.

Related to this is the greater marketability of some social services, which attracts commercial providers, in addition to the more traditional organisations in the field, typically either nonprofit organisations or public (state) agencies. The introduction of long-term care insurance in Germany in 1995, for example, brought with it a substantial growth in the number of for-profit providers in a field that had traditionally been populated by charities and similar organisations.

Cross-border trade and mobility. At the same time, fuelled *inter alia* by the greater mobility of employers, employees and professionals and retirees alike, there is growing demand for cross-border provision of social services. Particularly in the aftermath of recent decisions by the European Court of Justice, e.g., Kohll (C-158/96), Decker (C-120/95), and Regione Lombardia (C-70/95), it is likely that the social security and social service systems of member countries will be come increasingly open. In this context, many critical questions arise in terms of competition among social service systems and the associated problems of social dumping and free riding, leaving aside the immense array of technical and administrate issues when it comes to eligibility, accountability, and financial coverage of what kind of services to what type of user.

2 The Problem

European social policy in the social service field is thus confronted with great challenges, which will become even more acute with the scheduled accession of countries from Central and Eastern Europe. Most likely, social policies at the EU level and in individual member states are likely to change in the coming years due to increased demand, marketisation, free flow of goods and services and other factors. Given these challenges, it would be necessary to develop effective and innovative policies, to test different policy scenarios, to explore the implications and effects of policy decisions on the quantity and quality of social services supplied etc. Unfortunately, any such attempt to develop a forward looking European social policy in the field of social services continues to be frustrated by the lack of information, or more precisely: the absence of an information system on demand and supply, capacity and output, standards and quality, user groups and providers.

Indeed, the paucity of systematic and comparable data in the field of social services is surprising, given the expected changes and the political sensitivities involved. Only a few attempts have been made in the past, most notably at the more general level the Luxembourg income studies (O'Higgins et al, 1990), the family policy database at the University of Mannheim (Bahle and Maucher, 1998), and some initial attempts at the European Centre for Welfare Research in Vienna. What is more, information is collected at national levels, with little regard for cross-border and EU-related aspects. Examples are the National Information System on Social Services in Italy, or the National Information Centre on Social Security, established in the Czech Republic with EU support. As a result social policy faces a double challenge. On the one hand, at the EU level, social policy remains formalistic, with no substantive vision of what a future European social policy should look like in terms of objectives and major policy parameters (equity issues etc). On the other hand, no information system is in place that could help the EU and member state, let alone other stakeholders, to develop medium to long-term policies and strategies.

The glaring deficit in comparative information on social services at the EU level is amplified by the fact that for member states, this area belongs to the least developed parts of national statistical systems. It is only a slight exaggeration to state that we know more about steel and wine production in Europe that we now about social services, even though the latter is in economic terms alone far more important than the former two combined! The continued underdevelopment of national social service statistics contributes to problems of comparability in concepts, data collection methods and preparation as well as reporting. Ultimately, this underdevelopment leads to a highly precarious situation for policymakers and other stakeholder; and the persistent lack of information will most likely reduce the policy options available to all parties involved, thereby increasing the likelihood that negative trends will be caught too late, and that policy measures "misfire."

Thus, developing an information system of social services in Europe is not only a matter of scholarly concern. It is indeed a matter of utmost practical importance for policymakers and other stakeholders. The purpose of the project proposed here is to develop the conceptual

and methodological groundwork for such an information system. Of course, any such attempt will face great obstacles and problems: concepts, definitions, legal treatment, delivery systems and the political context vary widely across member states, as does data quality and availability. For this purpose, the project will follow an incremental, step-wise approach that starts with the potential users of the system in building an methodological approach that aims at developing an overall architecture that reconciles different expectations and needs as well as data requirements and data availability. How, then, do we propose to approach this task?

3 The European Social Service Information System— ESSIS

3.1 Approach and Methodology

Every information system is based on assumptions about its purpose and uses that depend in large measure on the wider academic and political context in which the system is being developed and supposed to operate. The information system of social services is no exception. Its context is the Europeanisation of social security and social services systems. These 15 – and soon 19 – systems are still organised along national laws and structures in terms of financing and delivery. Together, these different systems create a highly complex policy field as they come into ever-closer contact with each other, and as EU competence in this area increases.

Central in this respect are questions of definition and coverage. Member states vary in their definition of social services and the extent to which definitions cover some types of services rather than others. Clearly, developing a common definition of social services is not something that can be imposed; rather, it needs to be developed as part of the work proposed here. The approach to develop a common definition through the systematic comparison of national definitions has proven success in related contexts, such as the Luxembourg Income Study (O'Higgins et al, 1990) or the Johns Hopkins Comparative Nonprofit Sector Project (Salamon and Anheier, 1997). More formally, the UN system of national accounts, ILO's system on social economic security and employment, and educational statistics by UNESCO, are examples that demonstrate that cross-national definitions are, at least in principle, possible.

Although a common definition of what constitutes social services will have to be developed as part of this project, it may be useful to focus on personal social services (German: "personenbezogene soziale Dienstleistung"; French: "*service de proximité*"), i.e., services that are provided by a third party to the benefit of a user or client. This would exclude social security payments and related financial assistance as well as education and most health care. Public, nonprofit, for-profit organisations as well as individuals may deliver the service. Typically, financing and delivering social services includes different organisations.

Once fully developed, the information system is intended cover the following types/groups:

- Children and youth
- Family services
- The elderly
- The disabled
- Drugs and alcoholism
- Long-term care
- Poverty

- Long-term unemployment
- AIDS
- Homelessness
- Immigrants and asylum-seekers

Of course, only a subset of these fields can be covered in full detail during the developmental phase of the information system, with others being added at some later stage once a prototype has been put in place. An initial list could include two core fields of social services:

- Child day care
- Long term care for the elderly;

and three other fields for additional consideration:

- Services for the disabled, including services provided by the disabled themselves
- Asylum seekers and immigration
- Homelessness

The decision about field selection is based on four criteria:

- Data availability
- European value-added
- Urgency of social problem associated with field, and
  - Manageability and extent of pre-existing contacts among relevant research organisations and national as well as EU agencies in the field.

3.2 Users

The information system would be of interest to a variety of users. It is likely that these groups see different uses for the system and bring different expectations and ideas to the project. It would be important to make sure that each group of stakeholders has a voice in the process of developing the information system. Thus, the approach taken here is to make sure that all stakeholders can adequately participate in its development and design. Specifically, the following groups stakeholders and users come to mind:

- Scientific community and social policy experts;
- EU institutions (European Commission, Economic and Social Council, Parliament);
- National governments (Ministries and specialised agencies);
- Statistical offices (national agencies, Eurostat);
- International organisations (ILO, OECD, WHO, Nordic Council etc);
- National peak and umbrella groups;
- Specific organisations and service providers (Caritas, UNIOPS etc);
- Interest organisations, professional organisations (social workers etc).

To make sure that all relevant groups are represented in the project, ESSIS will constitute a European Advisory Committee that guides the work through its various phases.

3.3 Characteristics of ESSIS

The proposed information system is to be more than a simple collection of tables. It would be designed and implemented as a comprehensive, and inter-connected data system with the following characteristics:

- Comparative across EU countries and over time;
- Modular in its ability to focus on particular aspects (e.g., organisations delivering services for children, elderly, the homeless) and areas (e.g., family services);
- Flexible in the sense that other fields and areas can be added at a later stage of development, i.e., the system will not be designed as a closed but as an open system.
- Variable in terms of the desired aggregation level and country selection (e.g., accession countries or regions like Southern Europe or Scandinavia as well as single countries and parts thereof);
- Integrated with other systems like the European System of Accounts and employment and population data (e.g., social security statistics like Eurostat's Social Protection in Europe, MISSOC, and Employment in Europe, health statistics, demographic statistics etc);
- Multidimensional by taking into account quantitative and qualitative information; next to more quantitative information like employment, capacity and output, or various costs and revenue items, the system would cover a broad range of social indicators and legal and other relevant background material.
- Policy-relevant to current political initiatives and scenarios;
- Long-term in focus as the full development of the system may take some time given the conceptual and methodological complexities involved; and
- Simple and user-friendly in its operations and applications by trying to reconcile the criteria of comprehensiveness and parsimony.

4 From Fuzzy Information to Systems: The Soft Systems Methodology

Recent development in information systems (Checkland, 1990; Avison and Fitzgerald, 1995) suggests approaching the design of systems not from the perspective of engineering and software design, but from the perspective of the potential users. Beginning with the users and their problems and expectations, the development of information systems becomes an interactive process that includes five core phases:

- Problem formulation
- Modelling
- Analysis
- System implementation, and
- Testing and revisions

In the following, we will only describe the first two phases (problem formulation and modelling) in some detail. We can only briefly deal with the subsequent phases as their precise content is contingent of the outcome of the former.

4.1 Problem Formulation

This step of the development process has one central aim: to get a basic understanding of the problem(s) the information system is to be designed to solve. This means that a series of fundamental questions have to be asked and addressed systematically: What is the range of issues and topics that are relevant for the system? Where are information deficit and what are their causes? What are the major problems diagnosed by different stakeholders? Why is the system needed and for what purposes? What are the items, variables and data the information systems should cover?

The purpose behind this exercise is to bring out four essential aspects of the problem formulation:

- What are core information needs?
- How do they differ among potential users?
- What are some of the basic relations and links among data items?
- What information sources exist?

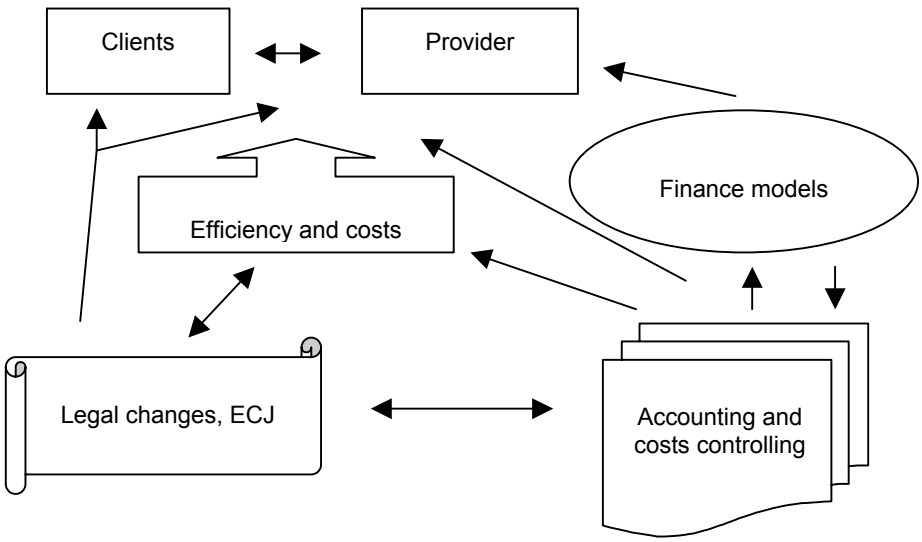
The aim is to develop a problem statement that can lead to a consistent and accepted information system over time. In dealing with the questions above, it is important to draw in systematically the expectations and user needs of all major stakeholders. The *rich picture approach* (Avison and Fitzgerald, 1995) is very useful is this respect. Rich pictures are a form of pictogramme or flow diagramme that conceptually show core relations among the various elements of the system.

For example, with the help of experts, potential users would to draw a picture of what they regard as their basic information needs in terms of data items, and how these, in turn, would relate to each other as well as to neighbouring systems or statistics. In other words, the rich picture approach aims to capture and make explicit the central objectives, purposes and structural components of the information system based on the needs and perspectives of potential users. As a result of this process, analysts will be able to identify core from peripheral aspects, establish system boundaries as well as links to other data systems (economic statistics, social security statistics etc).

In this context, it will be important to include a broad range of potential users and other stakeholders. Typically, the rich picture approach let's each user/stakeholder group develop its own "picture" separately at first. The analysts then contrast and compare the various pictures and suggest a common problem and design statement for the future information system that is then fed back to the users/stakeholders. This dialogue between designers and analysts of the system on the one hand, and the users and stakeholders on the other is an important not only for reasons of quality; it ultimately increases the acceptance and sense of ownership in the future system across a broad spectrum of users.

Figure 1 offers an illustration of a rich picture for some aspects of social services. Clearly, economic variables are at the centre of this hypothetical case, dealing largely with cost and efficiency consideration, financial models and accounting procedure in the context of legal changes such as the recent European Court decision mentioned above. Terms are not yet defined, and the overall picture approach may yield initial representations that can be either fuzzy, too simplistic or overly ambitious. Yet there is purpose behind these graphical representations: despite all imprecision, they allow all users/stakeholders to identify core system element, relations and boundaries.

Fig. 1 – Illustration of Simplified Rich Picture (hypothetical)



There are various ways in which the rich picture approach can be adopted to a particular task or topic. The first step is to select the range of users and stakeholder and include a list of experts for additional consultation. In a second step, it is useful to vary the way in which rich picture are developed: expert interviews, qualitative in-depth interviews, group-discussion, focus group sessions and the like. The key point is that the rich picture approach is designed and conducted in such as way as to invite input from a diverse group of potential users and other parties involved.

4.2 Root Definitions

Of course, the rich picture approach is only the first step in conceptualising the future information system of social services. The pictures are input for the first systematic and analytic step, which begins with the development of root definitions and classifications. For example, the definition of social services, which could be left somewhat open while drawing the rich pictures, must now be clearly defined and used. In other words, each element of the future system must be operationalised, categorised, classified and made part of an initial inventory of terms and their uses.

Root definitions aim at the better conceptualisation of the data and information problem the system is designed to serve. Typically, many terms are at a high level of abstraction and must be operationalised accordingly. As part of this effort of developing root definitions, each element identified in the rich pictures will be examined from six perspectives:

- Who? Actors (type of provider, client, funder etc)
- What? Action and transaction (activities like helping, financing, providing)
- For whom? Initiator (private organisation, public agency etc)
- How? Modality (transfer payment, professional service, voluntary service)
- Why? Reason (entitlement, demand, legal requirement)
- Context? Environment (health care reform, drug problem, new legal aspects)

The purpose of root definitions is to make sure that terms used in the system are consistent and non-contradictory. The operationalisation of root definitions is a central step in the development of the system for two reasons: first, many root definition are relational definitions in the sense that they refer to other terms either horizontally, i.e., on the same level of aggregation, or vertically, i.e., between levels of aggregation; second, because the system aims at comparability across member states, each root definition must be designed to operate at three levels:

- *Domestically* – the specific member country, i.e., it must relate to definitions and data systems in use nationally;
- *Cross-nationally* – other member countries and accession state, i.e., comparability across sites; and finally,
- *Longitudinal* – in a temporal terms across different points in time, as definitions may change over time due to legal and policy changes, technological developments.

Definition and classification are closely related tasks. In many instances, it will be necessary to develop detailed classification schemes in an attempt to categorise the attributes of core definitions, in particular qualitative ones. A classification system that could serve as a useful model is the *Classification System of Benefits, Services and Time Rights,* developed in the field of family policy by the *Mannheim Centre for European Social Research* (Bahle and Maucher, 1998). The classification system has five major groups (cash benefits, tax benefits, personal social services, benefits in kind, and time rights), which are subsequently refined into 16 groups and 45 subgroups, with additional refinements at the sub-subgroup level. The project will make full use of available classification systems and develop new ones as necessary.

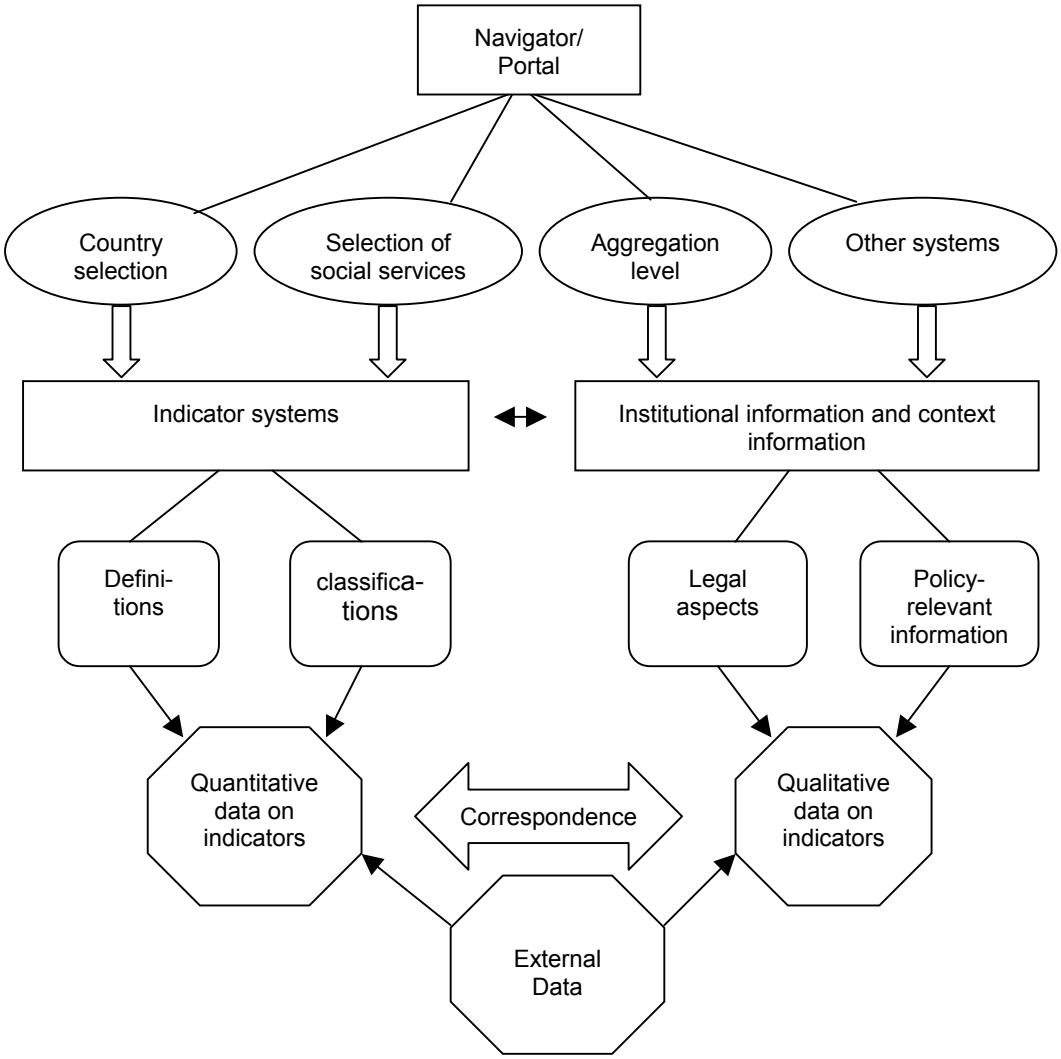
4.3 Conceptualisation

Once the elements of the information system have been subjected to the process of root definitions and classification, the next task is the full conceptualisation of the model. In terms of purpose, conceptualisation is very similar construction plans in architecture:

- It includes the major design features of the system: elements, definitions, and relations;
- It serves as the basic communication platform and means between users, programmers and analysts; and
- It functions as the basic map for the computerisation of the system.

A simplified and illustrative version of such a map is presented in Figure 2. The conceptual model, as the final product of the problem development phase spells out the major components and relations of the future information system. As such, it becomes the basic blueprint for the data structure and data requirements, including time series and external links to other data sources.

Fig. 2 – Schematic Representation of Conceptual Model



4.4 Modelling

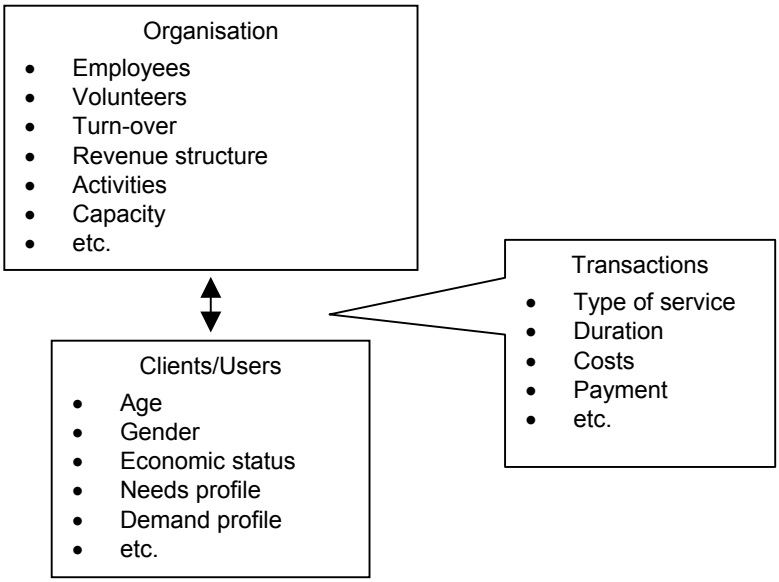
Based on the conceptual model, the modelling phase is the beginning of the actual information technological work needed to develop the system. This involves three major steps:

- Entity modelling
- Normalisation, and
- Flow diagrams

Entity modelling tries to develop systematic building blocks of the information system. With the root definition at hand, entity modelling identifies the relevant characteristics of each element and creates locations and their addresses in a system of inter-related tables (databases). Some of the most central entities are terms like “social services,” “provider,” “client” or “country.” These entities and their characteristics and relationships among each

other (transactions), form the core building blocks of the future system. Figure 3 offers a simplified illustration of the entity model for "provider organisation."

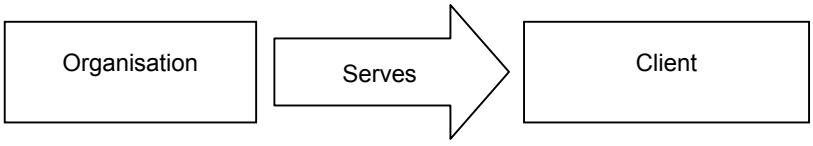
Fig. 3 – Example of Entity Modelling



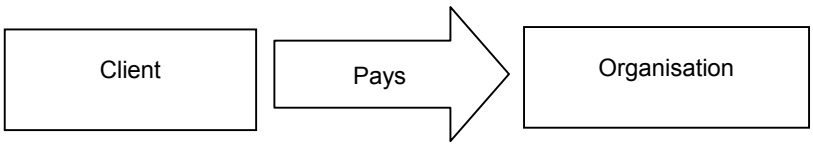
As Figure 3 shows, many of the terms used under the headings "organisation", "client/user" or "transactions" point to other entities, which will be part of the modelling phase as well. The end product of entity modelling, and the sum of relations identified as part of this effort, makes up the structure of the information system. In other words, for each element/entity in the system, three essential pieces of information are needed:

- Root definition and classification
- Characteristics and level of measurement; and
- Relations with other entities in terms of transactions.

Transactions and other relations among entities form the structure of the system in the sense that the root definition of one element is systematically linked to the root definition of another. This is illustrated in the following diagram:



Or:



For this rather meticulous and complex task, it is useful to develop computerised inventories of relations and dictionaries for root definitions. After this task has been completed,

normalisation is the next step. This involves a technical procedure that checks relations and definitions for consistency and logic across different aggregation levels. Finally, with the help of data flow diagrams, the relations along entities are implemented in computerised form.

5 Conclusion

In the field of European social service policy, the lack of solid, comparative, systematic and comprehensive information presents a major obstacle. Such as system could assist the EU as well as individual member states in assessing, developing, implementing and monitoring adequate policies and measures to address the challenges and opportunities of the greater "Europeanisation" of social service financing and delivery. What is the likely impact of increased cross-border trade in social services in terms of efficiency, effectiveness and equity? What are the policy implications of these developments, and what policy measures can be suggested to the EU and member states? Unfortunately, given current knowledge, we cannot address these questions in a serious and comparative way.

What is more, the efforts of social scientists in the field of comparative social policy are continuously frustrated by the lack of systematic and comparative information on social services (Clasen, 1999; European Commission, 1994; Alber, 1995; Deacon et al, 1995). What policy-makers and scholars need most urgently is an information system that would include data on basic aspects of social service systems in member states. Such a system would include information on supply and demand, cross-border transfers such as the import and export of services, financing models and financial flows, delivery systems and organisational providers, client profiles and other relevant quantitative and qualitative data on the full range of social services.

The systematic description and analysis of social services in a European context has barely begun. Of course, comparative research on social services in the various European countries has a long tradition, and has gathered momentum in recent years (e.g. Clasen, 1999; Evers and Svetlik, 1993; Leibfried and Pierson, 1995; Deacon et al, 1995). But little systematic work has been done cross-nationally at the European level in an empirical sense that goes beyond a relatively well defined type of service (day care) for beneficiary group (children, elderly etc). As a result, there is a growing hiatus between more abstract policy approaches and the detailed analysis of specific fields. The information system proposed here would help reduce this hiatus by filling some of the most glaring gaps in knowledge in the field, and boost research efforts well beyond the confines of this particular project.

The policy community in Brussels and the national levels are frequently faced with the great challenge of coming to terms with the very different national cultures, laws and policies in the social service field. While the Union has achieved some common policy terrain in other fields like agriculture, manufacturing or banking, it lacks such a platform when it comes to social services. The proposed project would help build this terrain by systematically creating a common language and approach in the field of social services. The fundamental research efforts that have to go into the conceptualisation and development of such an information system is the central objective of the project proposed here.

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Social Care Services: The Informal Sector

Abstract

The relationships between the state, the market and the family has been widely recognised as central to the understanding of modern welfare systems, even though for the most part typologies of welfare regimes have been constructed on the basis of the relationship between the market and the state with only passing reference to the family (and virtually none to the non-profit sector). However, increasing recognition of the rapid pace of family change during the last quarter of the twentieth century by both governments and academic commentators has drawn increased attention to the family as a driver of welfare state restructuring to rival globalisation.[1] This in turn makes it possible to insist on something that feminist approaches to social provision have long argued: that the issue of care, the bulk of which has always been provided by the family, is a central issue for modern welfare states (Daly and Lewis, 2000; Daly, 2000). These notes for discussion will comment first on family change, in terms of the demographics and the changing nature of the contributions of men and women to the family, and the implications of these for the informal provision of care. I will then review the social programmes that recognise care work, both in terms of the provision of cash and services. Finally I will examine trends in the mixed economy of care in European welfare states and the growth of in respect of social provision and their implications for social citizenship.

1 The Changing Context for Informal Care Work

In the main, it has always been assumed that the vast majority of the care needed by dependent people will be provided informally by 'the family', and in particular by women in the family. The male breadwinner model family, in which men earn and women take responsibility for housework and care work, described, with varying degrees of accuracy in different countries at different historical moments, the pattern of economic activity in the family. In western countries it also exercised considerable *prescriptive* power for much of the twentieth century. This meant that governments tended to *assume* that care would be provided by women in families and legislated accordingly. The basic programmes of social protection in western countries were in large measure built around the labour market and the male worker's relationship to paid work. Social insurance in particular operates via the labour market and has always privileged the full-time, usually white, male worker (Gordon, 1990). The post-war welfare settlements in Western European countries were forged between capital and labour, but also between men and women in the family, and were based firmly on the twin principles of full-time male employment and stable families. Both family change and the growing labour market participation of women, together with their increasing labour force attachment have therefore posed major challenges to the whole welfare settlement. How care is to be provided is a central challenge.

[1] Contrast for example Esping-Andersen (1990) with Esping-Andersen (1999, 2000).

The main dimensions of family change are well known. They include first, falling birth rates, particularly in Southern Europe, and rising proportions of frail older people. Thus while there are fewer children requiring care, there are many more older people needing help for an indeterminate length of time. It is also likely that what has been termed the 'low fertility equilibrium' (Esping-Andersen, 1999) is also related to changes in the nature of the contribution women are making to households in the form of their greater labour market participation and the lack of support for 'reconciling' work and family responsibilities in many countries, including those of Southern Europe.

Second, there are the well-known statistics of family breakdown and change: high and stable divorce rates in Northern Europe, more moderate rates in Continental Western Europe and low rates in the Southern countries (but rising rates of separation); and extraordinary rises in the proportion of live births outside marriage in the Northern countries, wide variations in the increase in the Continental Western European countries (high in France, low in (West) Germany), and wide variations in the Southern countries (Portugal had a higher rate than many Northern countries as early as 1960 and had a higher rate than Germany in 1995). Divorce and unmarried motherhood are routes into lone motherhood and the proportions of lone mother families have therefore increased. Cohabitation is the driver of much of the change, it is now sequel and alternative to marriage and has contributed to the increasing separation of marriage and parenthood that has marked the end of the twentieth century. Cohabiting relationships seem to be less stable (four times more so in the UK according to British Household Panel Survey data), which again contributes to the increasing numbers of lone mother families. Lone mothers experience particular problems in combining paid work and care work.

In regard to the changing contributions of men and women to the household, there has been considerable convergence in terms of women's entry to the labour market. All countries have seen an increase in female labour market participation and declines in male participation rates (largely accounted for by the early retirement of men 55 and over). Focusing on three European countries which have historically had strong male breadwinner model families, the dimensions of change become clearer. In the UK in 1975, 81% of men 16-64 were economically active and 62% of women. By 1996, this figure was 70% for both men and women. Married women were as likely to be employed as non-married women. In The Netherlands, the increase in female labour market participation has been more dramatic, from 29% of all adult women in 1975, to 44% in 1995; in Germany the rise has been from 46% in 1970 to 61% in 1998. However, the changes do not constitute a shift to a dual career model.

The vast majority of women work part-time in most European countries. In the UK the figure is 44%, and almost a quarter with children under 10 work 15 or fewer hours per week. In The Netherlands, 80% work part-time and 29% short part-time (between 12 and 19 hours a week). In Germany, 25% work under 20 hours. Large numbers work part-time in the Nordic countries too, 40% in Sweden, but long part-time and with pro-rata benefits.

Thus as Figure 1 shows, there are different forms of transitional dual-earner model families, where women work short part-time or long part-time. Model III, in which both men and women work part time does not exist, although it is officially promoted in The Netherlands under the 'Combination Scenario' (a relatively large number of Dutch men work part time – 17% - but these are mainly young or older and are thus unlikely to be sharing the care of children). These different patterns of male and female paid work will be accompanied by different welfare mixes in terms of care provision. The precise nature of these remain unknown and the Figure is speculative in this respect. Single earner families, which are more and more likely to consist of lone mothers and their children, face particularly stark choices in terms of balancing work and care, and are particularly responsive in terms of their labour market behaviour to the provision of affordable and accessible formal care services (Bradshaw et al., 1996).

Fig. 1 – Patterns of male and female paid work and arrangements for care

1. Male Breadwinner Model	
Male FT earner	Female FT carer
2. Dual Breadwinner Model (i)	
Male FT earner, Female short PT earner	Care supplied mainly by female earner and kin
3. Dual Breadwinner Model (ii)	
Male FT earner, Female long PT earner	Care supplied mainly by kin, and state/voluntary/market
4. Dual Breadwinner Model (iii)	
Male PT earner, Female PT earner	Care supplied by male and female earners
5. Dual Career	
Male FT earner, Female FT earner	Care supplied mainly by the market, and kin/state/voluntary sector
6. Single Earner (Lone Mother Family)	
Female earner FT or PT, or FT mother reliant on state benefits	Care supplied either by the mother or by the mother, kin and the state

Taken together, family change and labour market change have effectively eroded the male breadwinner family model on which the post-war settlement was largely based. Indeed, Hochschild (1995) has argued that it is now appropriate to talk of a 'crisis in care'. There has been an enormous amount of debate about the meaning of these changes, some (e.g. Giddens, 1992) view them optimistically as the 'democratisation' of personal life, others (e.g. Popenoe, 1993) see an essentially selfish individualism at work. Social capital theorists in particular have expressed concern about the fate of the traditional family, which they see as a crucial underpinning for the other social and economic structures of modern western

societies. Thus Amitai Etzioni (1993), for example, has talked about a ‘parenting deficit’. There is the whiff of nostalgia in this for the male breadwinner model family, but none has called for state intervention to put women back in the home as full-time carers. Indeed, most commentators, no matter whether they feel positive or negative about the changes, write as though full individualisation with full sexual and economic autonomy has arrived. However, the majority of families still have two parents and operate a one-and-a-half earner model. Norms and expectations have changed. It is now expected that women, lone mothers included, will enter the labour market, but on what basis, full-time or part-time, is not clear. This has major implications for the informal provision of care.

2 Social Programmes that Recognise Care Work

Most western countries have begun to recognise unpaid care work, but there are a variety of ways in which this has been done. Provision in the form of both cash and services is involved. The trend is towards more cash provision.

Ungerson (1997) identified five types of ***payments for care*** in respect of adult dependants:

- care allowances paid through social security and tax systems to carers;
- care allowances that constitute 'proper wages' for carers;
- direct payments to care users;
- symbolic payments to kin, neighbours and friends who care;
- 'paid volunteering' financed by voluntary organisations and local authorities to volunteer carers.

Ungerson points out that these means of recognising what has hitherto been unpaid work are eroding the boundary between paid and unpaid care work. Payments may be attached to the carer or to the person-cared-for. Care is a contested area, the interests of carer and person-cared-for are often not the same. Svenhuijsen (1998) has probed the motives for caring which may include a desire for control. The direction of money payments will inevitably affect power relations in the household. Broadly speaking, payments for care have developed from benefits for care recipients, to allowances for carers, to direct payments to care users. As Ungerson notes, this reflects a chronological shift in the politics of care and the politics of disability. Disabled people in the UK have been as vocal in claiming the right to benefits that they can use to buy the care of their choice (e.g. Oliver, 1990; Morris, 1993), as feminists have been in identifying care as unpaid work that requires recognition.

Care allowances are allocated according to eligibility rules. Carers must demonstrate a particular status in relation to the person-cared-for and the social security/tax system. These allowances recognise claims based on caring. To the extent that this is the case, such allowances are potentially radical. However, the eligibility criteria for the benefit may be linked to the receipt or non-receipt of other benefits by the person being cared for, which as Lister (1997) has pointed out, means that such a benefit is not an independent citizenship entitlement (see also Knijn and Kremer, 1997). In the Scandinavian countries, carers may become effectively employees of the state and are paid 'proper wages', which constitutes a version of the old feminist claim of 'wages for housework'.

Direct payments to care users may be routed in turn to neighbours or kin who provide the care, or to other, market-based care providers. The amount made available by such payments is usually relatively small, which means that the terms and conditions of those employed by the person needing care will be poor. Ethnic minority groups or even illegal immigrants may be employed in this kind of 'care economy'. This is the case in the UK, but in France the expansion of this form of provision for both child and elder care has been

accompanied by the requirement that these *emplois de proximité* are subject to full social protection in the form of social insurance entitlements and employment rights.

Symbolic payments are often made to friends, neighbours or kin by people who are in receipt of some form of disability benefit. These benefits were usually intended to cover the additional costs arising out of disability, but are often seen as a means of paying a small amount to helpers. Paid volunteering is probably unique to Britain and involves contracting caring labour from strangers to work in the family. However, they are paid only tiny, symbolic amounts.

There are fundamental problems in respect of the gender divisions of care when care is recognises via cash benefits of one form or another. As many have pointed out (e.g. Leira, 1998) payments for care represent a 'difference strategy'. They recognise carework as work performed by women. The problem is that in so doing, they may serve to perpetuate it as women's work. The workings of the German social care insurance scheme offer some additional evidence in this regard. Recipients of the care insurance benefits may claim services or take a cash payment. Apparently most take the latter and the payment is routed to the female carers who have hitherto been providing care on an unpaid basis. It is difficult to know whether this outcome should be seen positively as a step towards recognising unpaid care work, or in terms of a policy that serves to reinforce women's traditional role. Much of the debate around cash benefits more generally has focused on Esping-Andersen's (1990) idea of measuring how far paid workers are permitted to 'decommodify' their labour. Some feminist policy analysts have suggested that we should look instead at the extent to which policies permit women to escape 'compulsory altruism' by permitting them to 'defamilialise' their labour (McLaughlin and Glendinning, 1994; Daly, 2000).

The ***provision of services***, in contrast, provides paid employment for women, but also allows female carers to enter the labour market. Many policy analysts insist that it does not matter whether the state provides services or cash. Indeed, the latter may well be preferable for two reasons: first, it allows recipients to exercise choice in respect of services; and second, it makes it easier to allow the better-off to 'top-up' the benefits they receive. However, from a gender perspective the cash versus services debate is very different. The provision of accessible and affordable childcare is a crucial determinant of whether and how much women engage in paid work. Services for elderly people may also be crucial in this regard. If women are to have a genuine choice as to whether to give up paid work in order to care, there must be good quality care services. Women who do choose to care for a frail elderly person also rely on services to help them to do so.

The debate over cash versus services has become particularly strong in respect of childcare. Countries with strong state provision in both respects, such as France, have been veering towards 'cashing out care'. *Emplois de proximité* have been created in the childcare as well as the elder care sectors. Leira (1998) has summarised the heated debate that has been conducted in Norway as to how far childcare services should be replaced by a cash benefit. This would, its proponents argue, allow women to choose whether to stay at home with their

children or go out to work. Those against the proposal warn once more of the creation of an informal labour market for care work.

Most of the literature on social provision focuses on the relationship between paid labour and cash benefits. But it is just as possible to use care as a lens through which to view social provision. This immediately focuses attention on the relationships between unpaid work, paid work and social provision, and between cash benefits and social services, as well as on their gendered effects. Women's relationship to paid and unpaid work and hence to social provision is considerably more complicated than that of men. Thus, provision in relation to care may effectively support either women's traditional caring role, possibly to the extent of creating a 'caregiver parity' model (Fraser, 1994), or some form of dual-earner model. These choices further complicate debates on the nature of citizenship entitlements.

Modern welfare states have historically built provision round the citizen worker (classically in the form of social insurance programmes). Given their often marginal attachment to labour markets, women have usually been included as wives and, less often, as citizen mothers. It is possible to think about building a system of social protection that includes citizen carers by three methods:

- first, by creating a citizen income scheme;
- second, (as has been the case in Sweden and Denmark in the recent past), by treating all adults as citizen workers and then grafting on policies that compensate for caring work;
- third, by paying carers 'proper wages'.

The last of these operates only in some of the Scandinavian countries and is very expensive. Parental leave schemes have been a key plank in the second strategy. Despite their gender-neutral title, these have been taken mainly by women. In Sweden, male and female labour market participation rates are almost equal, but the labour market is one of the most highly sexually segregated and women's continued responsibility for care work (albeit within a framework of recognition and compensation) is in part responsible. The first system is untried. Whatever policies are proposed, they must address the issue of how care is shared as well as valuing it.

3 Comparative European Perspectives on Trends in the Mixed Economy of Care[2]

Care is at one and the same time a growing concern for welfare states and an ever more frequent object of social policy. Demographic and financial factors have acted as pressures increasing the demand for care, whereas social factors, in particular changing norms about family and kin responsibilities and the role of women, have contributed to a transformation of the conditions under which care has been traditionally organised. All of these together have acted to effectively decrease the supply of care at a time when the demand is rising. As a result, practically all European countries, apart from Ireland, are experiencing a crisis of care (Hochschild 1995). The origins of the associated pressures vary, not least because different welfare state models have incorporated care differently. There is no single or simple way to categorise welfare states but it is possible to identify certain tendencies around care in particular welfare states.

The Scandinavian states form a distinct group in this regard, tending to collectivise caring for both the elderly and children. More than half of all under school age children in the Scandinavian countries attend a publicly controlled day care service and every third elderly person is a recipient of either domiciliary or domestic help and care (Hanssen 1997: 110). The model of social service provision in this part of Europe was in the past if it is not any longer one of abundant, locally organised services which are available on a universal basis and funded out of general tax revenues. In these states the pressures around care arise mainly from shortages in public funds and to a lesser extent from disenchantment with a primarily public model of service provision. The Scandinavian countries are really the only countries to form something resembling a cluster in regard to care. At first glance the countries from the middle and south of Europe appear to be bunched together in favouring a 'privatisation' of caring. However this is a relatively large and diversified group of welfare states - embracing both the Bismarkian and Mediterranean welfare state models - and there is considerable variation among the constituent countries. A key aspect of this variation centres on the nature of 'privatisation'. In the Mediterranean countries care tends to be privatised to the family. With the exception of Italy, public services for the care of adults and children are limited and there is no developed market involvement in care-related services. In Germany the privatisation of care means something rather different. When undertaken outside the family, care is seen to be most appropriately a function of voluntary service providers. This means that there is a relatively large voluntary, quasi-statutory sector which, through public funding, provides a range of services related to caring for the elderly as well as for children. Then there is the case of France which makes a strong distinction between care for children and that for the elderly. Only the former is collectivised and the voluntary sector plays a minimal role. In all of these countries, the main source of pressure is the decreasing supply of family caring resources. A further type of approach to caring is to be

[2] This section is drawn from Daly and Lewis (1998) and Lewis (1998).

found in the welfare states of a Beveridgean provenance (Britain and Ireland). Like France these states make a relatively strong distinction between care for children and for adults. But unlike France the former tends to be constructed as a ‘state free zone’, whereas the latter is much more likely to be collectivised. In the present times, these welfare states experience pressure from both sides: family resources for caring are shrinking as are the resources (funds and commitment) available to and for public services.

Care is therefore a key element around which one can analyse welfare states. While it does not lead to any clear groupings or simplistic clusters, it is revelatory of how European welfare states vary from one another. In this regard it draws in such factors as the congruence between policy for the care of children and the elderly, the degree to which provision is privatised or collectivised, and the contribution of the different sectors.

4 Trends in the mixed economy of provision

One possible type of transformation is a change in the contribution and role of different sectors in the provision of care. In this regard, a number of changes are taking place simultaneously in the welfare states of Western Europe. One could analyse these in terms of the nature and content of the 'welfare mix'. It is certainly the case that the market is assuming or being granted a greater role than heretofore. A first significant implication of the growth of the market in the provision of care is that it is likely to herald a change in what constitutes care and the conditions under which it is carried out. This trend in regard to the 'marketisation' of care is complex and multi-faceted, involving changes in both the balance of the mixed economy of service provision and an increased faith in the application of market principles to the public sector. What is happening is considerably more complicated than simple cuts in the level of service provision. Nor does 'privatisation' adequately capture what is underway, although in many countries the balance of provision has shifted away from the state and towards the 'independent' (private and voluntary) sector.

Glennerster and Le Grand (1995) have insisted that the shift towards some form of 'marketisation' of services in so many EU countries cannot be explained simply by ideology and Right wing ideology in particular. While all forms of 'marketisation' have been strongest in the UK, there have been similar developments along the lines of the introduction of purchaser/provider splits and internal markets in many northern European countries, even in Norway, conspicuous within Europe for its lack of economic problems. Nevertheless, any temptation to see these trends in terms of convergence should be resisted. The meaning of reforms that look quite similar on paper can be quite different because of the context into which they are inserted and because the motivation behind them is often different. This in turn has important implications for who actually delivers care and under what conditions. The increase in private sector providers in Finland has been marked by the entry of small scale female entrepreneurs, usually exiting the public sector (Simonen and Kovalainen, 1998) for example, whereas in the UK large firms have played an increasingly important part in provision and have driven down the wages and terms and conditions of the predominantly female care workforce (Lewis and Glennerster, 1996). Writing from the German, corporatist and more consensual perspective, Evers (1993) has taken a much more positive view of the more pluralist provision of care, believing diversity of provision to be inevitable in a pluralist society.

'Marketisation' also has implications for care recipients. The application of market principles to public sector care services results in a more systematic targeting of those in need of services, which in turn means that some – whether elderly people with lower levels of dependency and risk, or children with unemployed parents – no longer qualify for assistance. In which case, it is the family-based carers who must pick up the slack. Moves towards a more mixed economy of care with more plural provision is justified largely in terms of providing greater individual choice for those in need of care, but it may also be prompting more 'compulsory altruism' on the part of family carers. Thus, ethical issues underlie contemporary welfare state restructuring. In particular, social care raises in an acute form

the question of what the 'limits to markets' might be. Contract has tended to assume 'the unencumbered self' (Sandel, 1996), existing outside relationships, which makes it inherently problematic in respect of care. Some philosophers of welfare (Wolfe, 1989; Anderson, 1993) seek to argue that the market and the family are structured by norms that express different ways of valuing people and things, and must therefore be kept separate. But this pushes us back towards the dichotomous treatment of public and private spheres, which is not possible if the manner in which welfare state restructuring is reconfiguring those boundaries is to be properly understood. The issue of coercion looms large in relation to the way in which 'marketisation' also elicits more family-based care. In addition, care-work is liable to be degraded in our society if it does not attract a monetary value, and yet also degraded if it does, because that monetary value is so small.

5 The implications for social citizenship

When the focus is on social care, it becomes clear that the changes which are being introduced in contemporary welfare states have the potential to alter the nature of social rights (social citizenship) quite substantially. In terms of service provision, social care has tended in most states to be a more residual service (compared to education and health) and has rarely amounted to citizenship-based entitlements. Where 'marketisation' is taking place, services have become more systematically targeted to those in most need, which has meant in practice a larger role for professional discretion in determining who receives service. Those with lower levels of dependency and risk or those with available family carers are less likely to qualify for provision. In respect of cash provision, whereas formerly payments for care to the extent that they existed were in the least generous tier of benefits, this is not necessarily so today. For the most part the new developments around care are being introduced as a middle tier, often a new middle tier, between the most generous (usually social insurance) and the meanest and most conditional benefits. The degree of exceptionalism and innovation in developments around caring is high in that they tend to break with the existing principles in practically every system where they have been introduced. For example, the introduction of a new tier of social insurance to cover care in Germany offers a flat-rate payment under very particular conditions concerning levels of need in contrast to the norm for German social insurance which is earnings-related and conditional on labour market participation. There are positive aspects to the development also though, not least the fact that it is an example of how social insurance can be used to cover risks which are not strictly employment-related. Overall it seems that as the retrenchment options in relation to the benefit system are difficult to engineer and tend to prove politically sensitive, welfare states are reserving their most innovative attempts for the domain of care which seems to be much more manipulable and porous.

In the debates about the crisis of the welfare state and its legitimacy, issues around care have been central. From the mid-1980s there has been a stampede to emphasise obligations (rather than rights), which translated into policy in the form of the direct enforcement of parental responsibilities and more indirect encouragement of responsibility for the care of elderly relatives. The obligation to engage in paid labour, which was, of course, essentially about the obligation of the individual to seek the means of economic independence rather than about obligation to the other, was also very much a feature of social security reform, as in the case of the French *Revenue Minimum d'Insertion* and, more robustly, in the British welfare-to-work proposals. The rediscovery of the importance of trust, commitment and obligation has not necessarily been conducive to promoting feminist (relational) notions of the ethic of care. Most strikingly, the desire to promote obligations within the family and with regard to employment have clashed in respect of lone mothers. Interestingly, in The Netherlands and the UK, where there was the most thoroughgoing recognition in terms of social policy of these women's care obligations, the obligation to seek paid employment in the absence of a male breadwinner has gained the upper hand in the late 1990s. These developments have been complicated and have thrown up strange alliances. The main purpose of introducing them here is to highlight the significance, and in many cases the

similarity, of discourses across nations. It is remarkable how much the attack on selfish individualism has been confined to women and to the private sphere, the extent to which this has been exacerbated by the restructuring of welfare state services during the 1990s, and the dangers inherent in this gendered public/private separation.

Developments around caring demonstrate especially that welfare state change and transformation involves more than benefit retrenchment. In fact provisions around social care, especially cash transfers, represent a notable, and sometimes the only, case of programme expansion within contemporary welfare states. In addition, welfare states appear to be at their most innovative when it comes to introducing provisions for care. The fact that they often comprise a new 'middle tier' of benefits for example and some of the conditions attaching to the benefits (for example the investment of a particular type and duration of labour) suggest that some of the conventional categories of welfare state analysis may need to be revised. In addition, developments around caring demonstrate that welfare state transformation is more complex than is generally conceived and that state support may be in the process of taking a new form rather than being adequately characterised as being 'cut-back'. And above all care is central to the ideological debates about the contemporary relationship between individuals, families, markets and (welfare) states.

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Transformations in Social Services: Some Preliminary Statements With a Focus on the Netherlands

1 Introductory remarks

When searching for a framework to analyse current transformations in social services, two schematic representations of the relationship between actors and institutes might be of help (Knijn, 2000). The first scheme (Figure 1) represents the welfare mix of family, market and state and outlines all possible directions and shifts in responsibilities of the pillars of that triangle. This scheme however doesn't differentiate between providing and purchasing social services. Maybe two triangles are necessary; one to indicate shifts in purchasing, the other to measure shifts in providing social services. The current tendency to disconnect payments from discretion and control would justify a twofold representation (purchase and provision) of the welfare triangle. Another disadvantage of this triangle is that it is a better metaphor for liberal welfare states than for corporatist welfare states because it doesn't offer a space for the many voluntary or collectively based social services. They might be included in the centre of the triangle, since they overlap with all the three angles of the triangle. Firstly voluntary organisations are connected to the family because of their corporatist basis. Secondly, they are often (partly) purchased and controlled (quality and efficiency) by the state and thirdly they increasingly are obliged to work conform to market conditions.

The second framework (Figure 2) lacks the dynamic characters of the welfare mix triangle and is more focused on transformations inside the social services. It distinguishes different logics that govern social services at four levels; the position of receivers, the position of providers, the assumptions underlying the provision of services and the character of social control on the services. This framework proves to be very helpful in analysing what (mixture of) logic dominates specific social services or to analyse which actors are defending what kind of logic. The assumption is not that specific actors defend their own specific logic, in contrast, it is very interesting to see that sometimes governments plea for more market and more familial involvement while care recipients plea for more public services etc.

2 Trends in the Netherlands

1. First of all it is clear that in spite of the withdrawal or the restructuring of the welfare state pure marketisation hardly occurs in social services. Instead one speaks of a social investment state, new social contracts or, in the Netherlands, regulated competition. Secondly; while it might have been that in Britain the New Right was responsible for the marketisation of social services, in many other countries social-democrats are the driving force behind this tendency.
2. Transformations take place in the context of already fixed institutional relationships; path-dependency is a strong barrier in governments' intentions to reshape social services. That is why, parallel to an overall trend in privatisation and marketisation, effects not only vary from country to country but also from one social sector to another. I have illustrated this for two sectors in the Netherlands; home care and childcare (Knijn 1998). The first sector – home care – is based upon strong corporatist traditions, the second sector – childcare – is brand new and could therefore be build upon the new principles of the Dutch government, that is tripartite responsibility including the state, employers and parents / employees.
3. Managerialism, resulting from the strategy to decentralise responsibilities while at the same time social services have to work more conform market principles, occasions harsh conflicts between managers and professionals in almost all social services in the Netherlands. In the field of education, healthcare and home care and even law, professionals are loosing trust in politics because of the 'Tyranny of transformation' (Clarke and Newman, 1997) and the continuous monitoring of their work. Due to an economic boom this is one of the reasons why there is an enormous lack of personnel in all social services.
4. The position of clients is changing too; their evaluation of services is increasingly valued and a competition for clients (by exclusion as well as inclusion) is going on. The redefinition of core tasks or social services results in a redefinition of core markets of clients. This happens not only in the provision side of the social services, but also the purchasing side is influenced. For instance in discussions about whether general practitioners should be included in the basic health insurance, if only children of working parents should get entrance to childcare and if pupils who regularly don't come to school should be denied access.
5. Informal social help is increasingly included in formal social services and governed by formal rules. This seems to be unavoidable because of the stricter eligibility rules. Examples can be found in the personal budget system by which formerly informal home help will be paid and regulated in the near future and in the plea for regulating the relationship between children and their foster parents in order to support these parents in getting services for foster children at the same costs as they would have obtained them for their biological children. The favourite way of regulating these informal (paid) arrangements is by contract to avoid taxes, premiums and pensions.
6. There seems to be a general agreement among all spokesmen and politicians in the Netherlands that public services should be based upon demand-side instead of supply-side mechanisms. They prefer private responsibility (either by way of the market or the

community) or at least a mixture of responsibilities above state-provided and publicly financed care. This is in sharp contrast to the wish of the Dutch population that time after time shows a majority in favour of paying more taxes under the condition that public services of good quality are provided. Recently some question have been raised by some politicians concerning the privatising tendency because of bad experiences with the partly privatised railway and telephone companies. Nevertheless primary schools are now free to demand parental contributions, the new basic health insurance probably will be on a very low level in order to stimulate people to add a huge private premium for additional costs, and pensions have been decreased to a lower level etc.

Fig. 1

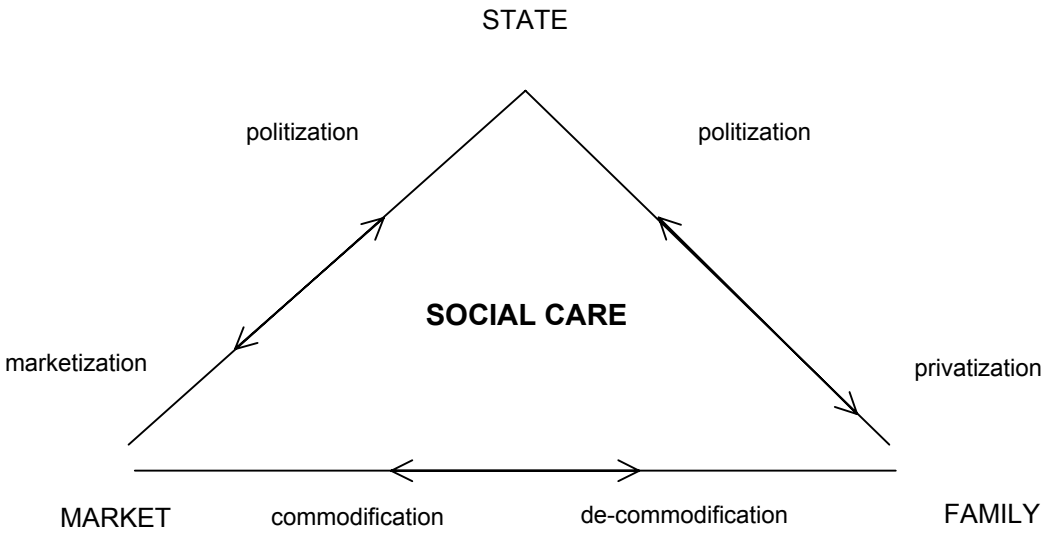

Fig. 2

	Care Recipients	Care Providers	Assumptions	Control
Bureaucratic Logic	citizens	public services	justice and fairness/equal treatment	supply side/ democratic control
Professional Logic	clients/patients	professionals/ experts	expertise/ personal treatment	professional ethics/ standards
Familial Logic	kin/significant others	(female) relatives/ volunteers	social bonds/ reciprocity/ moral claims	social and personal control
Market Logic	consumer/ customer	entrepreneurs	efficiency/ effectiveness/ profit	demand and supply/ managerialism

3 Issues under discussion in the Netherlands

3.1 Care for children

Childcare. Municipalities now have the main responsibility for developing childcare while parents (19%), companies (45%) and the state (33%) share the costs (1998). In 1990 the division was 34%, 11% and 53% (CBS: Statistiek Kindercentra 1990-1998). The Ministry of Social Affairs pays the costs for lone mothers' childcare since they got the obligation to work in 1996, but only for a very limited period; the discretion is given to the local social office. At the moment there still are long waiting lists, municipalities can hardly deal with their new responsibility and a law on basic provisions for childcare is under discussion in parliament. For sure there will be no right for parents to childcare; the government states that childcare should be part of collective agreements and will try to enforce all companies to arrange and pay childcare for their employees. Childcare therefore will be part of secondary labour conditions, which shall increase employees' dependence on their company. Critics also fear that this kind of regulation will disadvantage low-paid, flexible and temporary workers, that high-paid employees, for instance, will have to choose between a lease car and childcare and that the strict link between the job and childcare will not promote good quality childcare in general.

After school care. After school care is rather underdeveloped in the Netherlands, based upon voluntary work or flexible work contracts, often by mothers of school aged children. After school care is being developed now, limited governmental budgets are available, but it still has to start from scratch. In 1998 only 2,2 % of all school-aged children made use of after school care (CBS: Statistiek Kindercentra 1990-1998) No good facilities are available, only a few ideas about how to pay for it properly and there are hardly any ideas about its pedagogical quality. The Ministry of Social Affairs is supporting some experiments, and professionals from the Netherlands Institute for Care and Welfare (NIZW) are trying to collect and disseminate good practices from other countries.

Private childminders. Due to a lack of childcare and also because many Dutch families prefer a private solution there has been an enormous increase in the number of private childminders; in 1998 9% of all families with children under 15 make use of paid private childminders (SCP: Taakverdeling onder partners 1998). The majority of these are older women, who have already raised their own children and who now want 'something to do'. Also childminders from abroad are filling in the gaps, but this is still a minority. These women work on informal contracts, have no qualifications and no additional de-commodifying benefit, such as insurance, unemployment benefits or pensions. We can assume that within a few years the former housewives, now taking care for children of other families, will have disappeared. The question is if they will be replaced by good quality childcare or by immigrant women leaving their own families?

3.2 Care for the elderly

Home Care. This kind of care has a long history in corporatist and pillarised welfare organisations, in particular because of the huge increase of homes for the elderly in the 1960s (because of the lack of houses for young families). The tendency now is to let the elderly stay at home as long as possible, but this leads to enormous problems for home care, especially as the budgets were reduced instead of increased (SCP: AVO 1991-1999). Finally many protest and court cases resulted in getting this issue on to the political agenda and now new investments in home care can be expected. In the meantime home care is completely taylorised, resulting in high rates of burnout and exit of workers in the area.

Home care is paid by a collective insurance (AWBZ), but the government decides about the yearly budgets, having limited the budgets to such an extent that people in need of care started court cases to get the care they have paid for. The court decided that the insurance companies have the responsibility to deliver home care once people are diagnosed as needing it and that the government has to increase the yearly budgets to make this possible.

Elderly Homes. Substitution policies also influenced the composition of people living in these homes; now they only have people who can't stay at home any longer. This service is paid by the elderly themselves and in addition by the AWBZ. Cost efficiency prevails about good quality care and homes for the elderly also have to deal with huge shortages of personnel (SCP: AVO 1991-1999; VWS: Taskforce 2000a,b,c-2001a,b). There are major differences between homes for the elderly, depending on management, additional budgets etc. But elderly hardly have a choice for where they will go. New initiatives mainly concern quality management.

Nursery Homes. Many people fear these homes; it is the real final destination for the elderly who are hardly aware of the world around them. They lack every form of privacy (only a bed and a cupboard) have to share rooms with five other persons and the quality of care is not good. People working there don't have time for personal attention and to deal with the emotions of their patients. Recently it was decided that these homes have to be rebuilt in order to have rooms for no more than two people.

3.3 General conclusion

Care for the children is still in the main seen as a private responsibility; in childcare we see a shift from one private area (the family) to another (the market). In home care substitution has been the main tendency in the 1980s and 1990s but now it has lost its elasticity and new investments and new qualities probably will get a chance.

4 Available statistics

For the ESSIS project two national statistical institutes are of main importance:

CBS (Centraal Bureau voor Statistiek/Statistics Netherlands)

- They deliver every four years the 'Woning Behoefte Onderzoek' (WBO/ Housing Needs Survey) containing information of households, housing stocks, the quality of houses, prices etc. at a national level, differentiated by local and regional data. It is also the main source of information on household composition related to labour market participation and income.
- CBS also runs the Statistiek Kindercentra (Childcare Statistics), including kind of childcare services (childcare centres, corporation centres, after school care), types of childcare slots (public or privately paid by parents or corporations), use of childcare (fulltime or part-time) etc.

7. SCP (Sociaal en Cultureel Planbureau/Social and Cultural Planning Office)

- They deliver every four years the 'Aanvullend Voorzieningengebruik Onderzoek' (AVO/Additional Services Survey) containing information about the use of childcare, home care, intramural and extramural care, needs for care etc. among elderly, chronically ill etc.

Both the SCP and CBS have an official responsibility to collect the national statistics, to co-ordinate networks and to disseminate the data.

In addition there are several other sources of information on specific data; insurance companies, local and regional institutes have statistics that can be used for specific items or local and regional information.

For ESSIS also some other data sources are of interest:

SPVA (Sociale Positie en Voorzieningengebruik Allochtonen/Social position and use of services by ethnic minorities). This is done by ISEO (Institute for Social and Economic Research), containing information about the social position and services used by four groups of ethnic minorities, namely people from Suriname, the Antilles, Morocco and Turkey. However this database is rather contested, not more than 200 people from each of these minorities are included and the definition of 'ethnic minorities' is rather unspecific (including Dutch citizens from the former colonies as well as children born in the Netherlands from at least one parent born outside Europe, and partly based on self-definition).

OG (Onderzoek Gezinsvorming/Family Monitor) done by CBS including all kinds of data on families and households. Every two years the data are available and presented in co-operation with the Dutch Family Council. These data are also used for the European Family Monitor and will be improved by including both partners of the same household in the coming years.

NKPS (Netherlands Kinship Panel Study). A database that will be developed from 2001 on by the NIDI (Netherlands Institute for Demographic Research), Utrecht University, Tilburg University and the University of Amsterdam. This dataset will contain data about 10.000

Dutch people and their relatives (children, parents, brothers and sisters). The data will be available immediately for all researchers in the Netherlands and abroad.
VWS (Ministerie van Volksgezondheid, Welzijn en Sport). Its taskforce collects data about waiting lists in (health)care in 2000 and 2001.

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The Mixed Economy of Care: Critical Issues and Developments in England Since 1990[3]

1 Social care policy in England

The 1990s saw the most significant changes to the organisation of social care in the UK since the sweeping 'welfare state' legislation of the late 1940s. Quasi-markets were introduced (or stimulated, since arguably they already operated in limited form), provision was gradually separated from purchasing and the routes by which public funding subsidised the care of lower income individuals were altered. Care management arrangements were strongly encouraged – seen as the 'cornerstone' of successful community care. Further emphasis was put on community-based alternatives to residential care options.

Underpinning or running through many of these changes is a common theme: the development of what has become known as the *mixed economy of care* – the myriad arrangements for service provision, funding (and purchasing) and the interconnections between them. This paper describes this developing mixed economy, its effects and some of the major issues remaining to be resolved. The focus is primarily on arrangements for supporting older people (because they account for the largest share of state social care expenditure) and on England (because there are differences in policy emphasis across the UK, with some implications for service and funding configurations).[4]

The largest single legislative influence on modern day social care has been the 1990 *National Health Service and Community Care Act*. A great many of the organisational and practice features of social care to be found in England today were prompted or encouraged by the Act and its subsequent implementation guidance. The broad aims of the legislation were to promote independent living, user choice, innovation and cost-effectiveness. In pursuit of these aims, the Conservative government of John Major (taking forward the approach of his predecessor, Margaret Thatcher) sought to alter a number of balances:

- between central and local government funding responsibilities;
- between institutional and community-based care;

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[3] This paper is based on a presentation in Frankfurt, December 2000.

[4] Some of the detail in this paper comes from the Mixed Economy of Care Programme at PSSRU, conducted jointly with the Nuffield Institute for Health (Leeds University). This programme of research is currently undertaken jointly with Julien Forder, Brian Hardy, Jeremy Kendall, Tricia Ware and Tihana Matosevic. Some of the material in this paper is covered in more detail in two recent publications (Knapp et al., 2001a, 2001b).

- between supply-led, provider-dominated services and needs-led, purchaser-dominated services;
- between public sector and independent sector provision;
- and between National Health Service and local government responsibilities for strategic decision-making and funding.

Some changes were mandatory (such as the transfer of funding) and others left largely to local agencies (and contexts) to determine the extent, speed and priority (Wistow et al., 1994).

What has happened since Tony Blair's Labour government came to power? Although significant organisational developments are in train, in the broader scheme of things neither the Labour government's 1998 White Paper (its statement of policy intent) nor subsequent announcements or actions suggest strategic changes that will greatly alter the broad thrust of the 1990 legislation. There is no longer explicit ministerial preference for 'a flourishing independent sector', but neither is there a return to public sector dominance of service provision. As the Secretary of State for Health argued: 'It is no longer who provides the social care than matters. It is the quality of care that counts' (Milburn, 1999). The main intentions of the present government are to give greater priority to prevention and rehabilitation, and to strengthen and expand the shape of statutory regulation of services in the pursuit of better quality care. Some of the details - particularly on regulation and how quality standards are to be attained – have now been settled, notably on quality standards for residential and nursing home care. There is also a performance management framework (Department of Health, 1999) to structure the pursuit of quality and the monitoring of success. Continued emphasis is put on support for carers, with – among other things – the development of a National Strategy for Carers.

A potentially considerable influence on the structure of social care provision from outside the field has been the introduction, across the whole of local government, of the Best Value requirement: 'The duty of Best Value [is] to deliver services to clear standards covering both cost and quality, by the most effective, economic and efficient means available' (Department of Health, 1999, paragraph 1.5). Non-commercial as well as commercial considerations can play a part in deciding from which provider to purchase services. It seems likely that this will accelerate the rate at which local authorities run down their in-house provision in favour of independent sector services (Blackmore, 2000). Although the Labour government has stressed partnership arrangements between purchasers and providers, it has not done anything to arrest market development, although it is urging the maturation of commissioning arrangements (see also below).

Social care services thus continue to be provided through market-like arrangements, with central government's intended performance endpoints (quality and best value, which are obviously interlinked) perhaps now more explicitly stated. Partnership arrangements between commissioners and providers are emphasised, and also between commissioners in different agencies.

2 Charting the Mixed Economy

What, then, is meant by a 'mixed economy of care' and what does it look like in England today? A good starting point is to chart the mix of funding (purchasing) arrangements and the mix of providers and the governance arrangements which bring them together. Cross-classification of the main purchaser and provider types gives a simple representation of the inter-connections characterising social care in England today (Table 1). The funding and provider types in this matrix can now be explained.

Table 1 – Purchaser-provider connections and examples of governance arrangements

Purchasing or funding mode	*Provider sector*			
	Public	*Voluntary*	*Private*	*Informal*
Tax-based funding	Hierarchical structures; 'internal' quasi-markets	Public contracting-out, i.e. 'external' quasi-markets		Public support for carers; direct payments to users
Charitable funding		Foundation support for voluntary efforts	Trust funding to 'top up' care home fees	
Corporate funding		Support/subsidies to professionally orientated providers		Employers giving paid leave or other support to carers
Personal funding (for own use)	User charges for public services	Fee-for-service delivery by charities	Textbook market	
Personal funding (for others' use)	Voluntary contributions used within NHS	Formally organised volunteering in day care settings		Family, friends and neighbourhood contributions

2.1 Who provides social care?

A minimum requirement is to distinguish four main provider sectors - public, voluntary, private and informal - each with a distinct legal form (or set of forms), but each in fact comprising a number of organisational types driven by a mix of motivational forces. In other words, the fourfold classification is already quite a considerable simplification of reality. The 1990 Act brought many changes to the provider side of the mixed economy, especially in the balance *between* the sectors.

The *public sector* in England comprises local authorities, hospital and community health services, primary care services, the social security system and criminal justice agencies. Social services authorities - there are now 150 of them in England - were the main providers of care for older people and other client groups from the late 1940s until the early 1990s. After the 1990 Act they became the key players in the community care system, with coordinating responsibilities across the public sector and with 'enabling' responsibilities both within and outside it. The last two decades have seen the rapid waning of local authorities' direct service provision roles (despite the development of various quasi-public, not-for-profit agencies out of former in-house services) and the waxing of their commissioning functions.

Locally they should play strategic roles in shaping social care markets, although whether they proactively grasp this role is a moot point (see below).

Defining the *voluntary sector* is not straightforward, although here it is not necessary to get caught up in the complexities of identification or labelling (see Kendall and Knapp, 1994). In social care, the voluntary sector is essentially the collection of formal organisations - large and small - which are independent of government and which, although they may earn surpluses, are bound by a 'nondistribution constraint', that is they cannot distribute these surpluses to any owners or shareholders. Historically, the voluntary sector has played a variety of roles in social care, including provider of specialist services, supporter of marginalised population groups, innovator and advocate for change, and direct substitute for public provision (Kendall and Knapp, 1996, chapter 7). Most voluntary organizations in the social and health care fields in Britain have charitable status, conferring certain tax and reputation advantages.

The *private sector* is obviously constitutionally separate from government - a characteristic it shares with the voluntary sector - but it is not bound by any nondistribution constraint. Consequently, profits may be earned and distributed to owners, although a feature of many social care markets in the last few years has been very small profit margins. Private sector care provision for older people in the UK has long been dominated by small family businesses, many of them running a single residential or nursing home, and few with 'profit maximisation' as their primary aim (Kendall, 2001). They operate on a small surplus (mark-ups of only 8-11% on cost; Forder et al., 2000) but have the (potential) benefits of capital accumulation in the business. It is only in the last few years that the corporate sector has begun to acquire a bigger slice of this particular market.

The largest provider sector and undoubtedly the most important is the vast collection of *informal carers*, principally composed of individual family members and neighbours. A recent estimate suggests that there are now approximately 5.7 million carers in Great Britain - one in ten of the population - three-quarters of whom provide care to someone aged 65 and over (Rowlands, 1998). A small proportion of these carers provide highly intensive support and personal services to dependent older people, with nearly one million carers providing co-residential care (Pickard, 2000). Some carers are involved in mutual support groups, and thus - if we are seeking a categorisation of the provider side of the market - shade into the 'self help' limb of the voluntary sector if they organise formally (although many remain essentially *ad hoc*). The 1990 Act sought to provide more support for family and other carers, and encouraged local authorities to involve them more fully in decision making, and this policy theme has been taken up by the Labour government, notably with its 1999 National Strategy for Carers.

2.2 How is social care funded?

Again as a very minimum, five main routes of purchasing, funding or demand should be distinguished and these are organised vertically in the matrix in Table 1. However - and

again as with the qualificatory remark made about the four broad provider sectors - for more focussed discussions of policy and practice it would really be necessary to employ a finer categorisation.

Tax-based funding is coercive (citizens have no choice but to pay taxes) and collective (decisions on how the accumulated tax revenues are to be spent are collectively made or collectively delegated). The public sector acts as purchaser on behalf of citizens, mandated by democratic processes. This has been quantitatively the most important funding source for formal social care since the late 1940s. It may be routed directly to providers through central government (now very rare) or through local government as the in-house service provider or through the purchasing under contract of private and voluntary sector services. Increasingly over the next few years it will also be directed through quasi-independent public sector agencies such as primary care groups and trusts which might commission a range of social care services.

A second but much smaller source of funding is uncoerced or voluntary collective support - labelled as ***charitable funding*** in Table 1. Voluntary organisations (and occasionally other bodies) use voluntarily-donated funds to finance their own or other agencies' services. The choice as to what goods or services to purchase, and for whom, is controlled by the funding organisation and not (usually or directly) by individual donors. In recent years, voluntary organisations in social care have come to depend less on this source, and more on public (tax-based) funding under contract (Kendall and Almond, 1999).

Corporate funding of mainstream social care - that is purchasing by private-sector corporations or other businesses - is of very modest scale in the UK. Because Britain has had tax-based, universal health and social care systems, generally quite well resourced since the late 1940s the need for employer-funded private or social insurance payments has been limited. There are nevertheless corporately-supported services with perhaps a bearing on social care (such as workplace nurseries for children and occupational health provision for employees) and some companies (but not many) allow flexible leave arrangements for carers.

Personal funding of social care is of two main types: payment for goods or services consumed by the payer, with or without subsidies from social security or other transfer payments, and payments for goods and services to be used by someone else. Payments in these cases are made directly to suppliers and not to intermediary voluntary organisations (the latter being charitable funding in this schema). Payment for other people's services could be generalised to include formal volunteering, which can be a significant input to social care in the UK, as well as informal volunteering and family support (Davis Smith, 1998; Knapp et al., 1996; Pickard et al*.,* 2001). Private long-term care insurance is rare in the UK (Royal Commission, 1999).

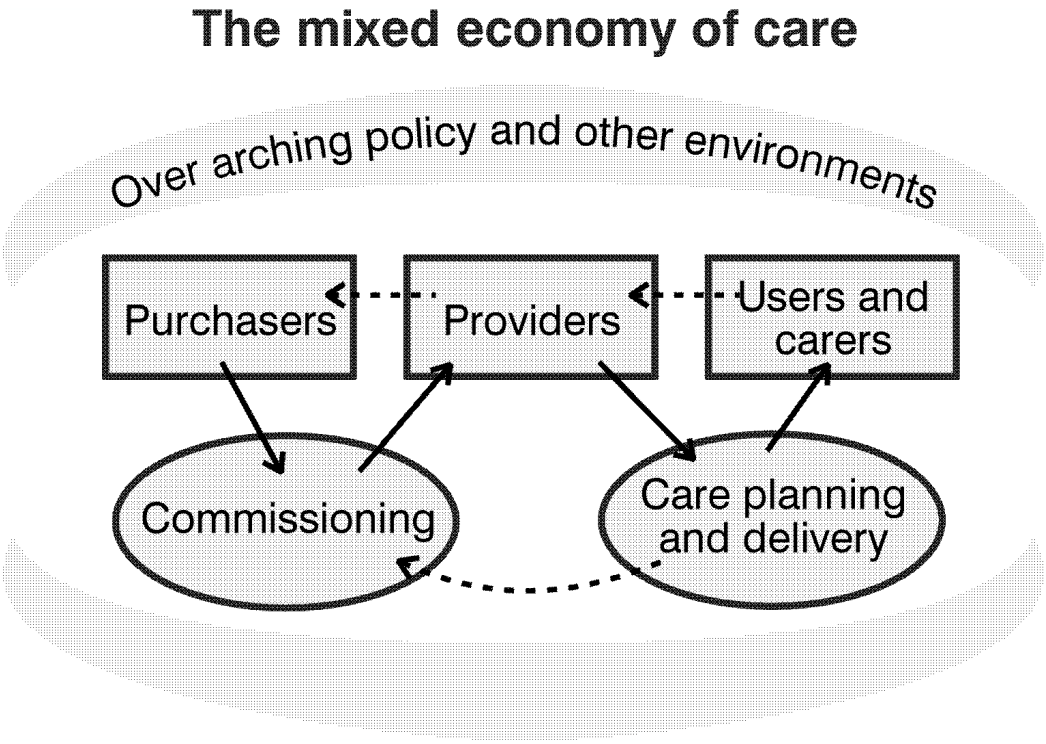
2.3 Governance

Purchasing and providing are the most readily identified and regularly discussed dimensions of a mixed economy, and their cross-classification produces the didactically appealing matrix representation of Table 1. It is the governance dimension which interconnects them. Governance arrangements fashion the transactions or interrelationships represented in the cells of the matrix and include all those institutions, rules, regulations and protocols that govern stakeholders in undertaking transactions. The concept therefore covers the bureaucratic or hierarchical structures in public organisations that directly fund their own in-house services, market-based exchange mechanisms (such as contracting-out), private exchange arrangements and state support for informal carers.

2.4 Commissioning in the mixed economy

Governance is manifested most clearly through the commissioning arrangements that are put in place in a mixed economy (Wistow et al., 1996). The centrality of commissioning can be seen from the framework in Figure 1, which offers a stylised representation of the mixed economy as two processes connecting three sets of stakeholders (Wistow and Knapp, 1998).

Fig. – 1



Commissioning has been widely discussed in social care, and of course in the UK public policy arena more generally. At its most basic it is the primary link between purchasers and providers. The tasks of commissioning extend beyond the 'mere' procurement of services to include:

- the clarification of organisational mission as it relates to purchasing and provision,
- the definition of need,
- the identification and assessment of need,
- the clarification of the services necessary to meet those needs (i.e. service specification),
- the negotiation of contracts with providers to deliver those services,
- the monitoring of contracts, and especially of performance,
- the re-negotiation, termination or extension of contracts.

A variety of commissioning 'styles' is being used. For example, some local authorities are building long-term and some only short-term relations. Some commissioning links look quite robust and some look more 'cosy'. These styles are overlaid on to a set of commissioning *options*, ranging from the broad choice of hierarchy versus market as the principal means by which services are organised and delivered, through finer details such as contract type and mode of reimbursement, to more general (and longer-term) concerns about the balance between adversarial and obligational purchaser-provider relations. The most important such commissioning options in social care in England today would thus relate to:

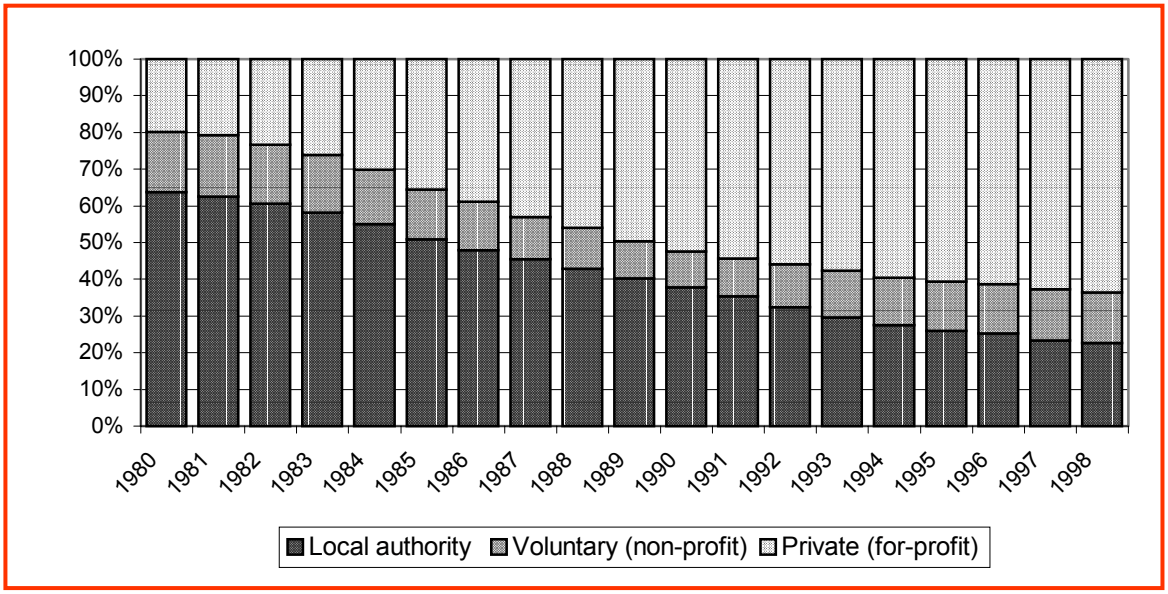
- market or hierarchical (bureaucratic) forms of allocation;
- in-house or contracted-out (external) provision;
- open tendering for contracts or limitations via an accreditation or preferred provider system;
- contact form (such as block, spot or cost-and-volume - defined and discussed below);
- reimbursement arrangements, particularly whether payment levels can vary retrospectively in response to unforeseen events; and
- the balance between adversarial and obligational approaches to purchaser-provider relations.

The choices made along each of these commissioning dimensions will clearly have considerable implications for market shape, functioning and performance. These choices will thus also potentially have consequences for market success or failure by affecting the distribution of relevant information, the allocation of risk, the nature of incentives and relationships, and the level of competition. There is insufficient space in this chapter to discuss each of these commissioning options in detail (but see Wistow et al., 1996, for some discussion). Contract type and mode of reimbursement are touched on later in this paper, and the first and last dimensions in the above list are considered in the final section of questions for the future.

3 Residential care trends

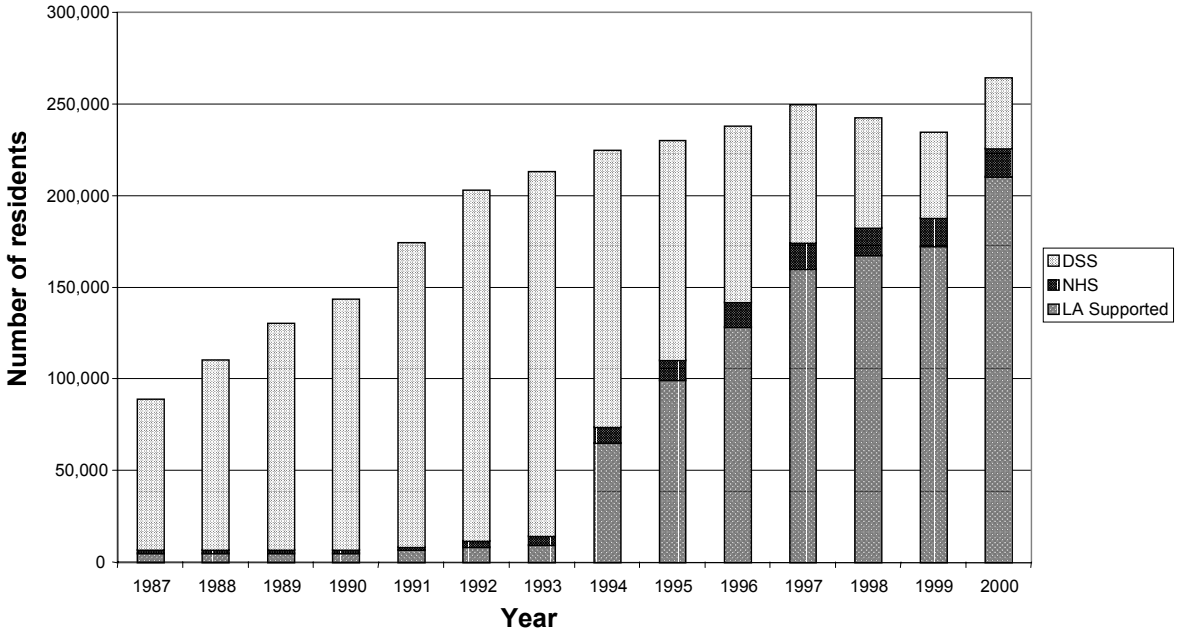
The market for residential care and nursing home services has been transformed over the last two decades. As can be seen from Figure 2, the balance of provision - the market share - has shifted dramatically away from the public sector towards the independent sectors, and particularly to the private (for-profit) sector. Part of this re-balancing has been achieved by local authorities selling or transferring their own in-house provision off to independent sector providers. However, the greater influence has been the willingness and ability of private sector providers to expand their operations or to enter what was a quite rapidly growing and financially attractive market. The voluntary sector has retained that fairly constant market share, whilst the public sector has obviously declined considerable in relative scale.

Fig. 2 – Market shares for residential care provision



A second important trend in residential and nursing home care relates to the funding balance. Prior to the 1990 Act, or more specifically prior to its full implementation in April 1993, many older people were able to enter residential or nursing home care and have their fees paid by the state, provided their income or wealth levels were sufficiently low. Funding was therefore means-tested, but strangely was not needs-related. In other words, anyone wishing to enter such a facility, and finding a facility willing to admit them, could do so. This is why the market was described as 'financially attractive' in the previous paragraph. The 1990 Act transferred the funding that previously came from the Department of Social Security to local authority social services departments, thus giving much more control to the state over the admission of (publicly-funded) people into residential care. Hereafter public sector funding for residents in such facilities was not only means-tested but also needs-related. Figure 3 shows how the balance of funding has changed in the last few years. Over the course of this period the proportion of residents who are entirely self-funded has remained fairly constant.

Fig. 3 – Source of funding for publicly-funded people in residential care



Source: DSS figures provided by DSS. NHS and local authority figure: Laing & Buisson 2000.

Within the overall totals shown in Figure 2 there have also been a number of important changes. As noted earlier, much of the growth of the private sector during the 1970s and 1980s was achieved by the entry into the market of small businesses, often a married couple running a single facility with family support and a number of part-time staff. Those homes were able to survive on relatively modest profit margins all the time that funding from the social security ministry was predictable and secure. Once the funding route changed, and particularly once a needs requirement was formalised, many of these small facilities found themselves in some financial difficulty. The quality of care that was offered in some facilities was poor (although generally these are not particularly bad providers, and they are often popular with residents), and their small scale meant that they did not achieve economies of scale. There was little scope for short-term cross-subsidisation from other, more profitable activities. These small homes were therefore unable to compete on price with some of the other, larger providers in the market.

In fact, corporate providers were almost completely absent from this market until a few years ago, but today they account for a significant proportion of residential care provision and especially of nursing home care. In 1997, for example, organisations operating three or more homes accounted for 26% of all private sector provision (Laing & Buisson, 1998). By early 2000, 18 large companies were together running 1360 homes, or roughly 22% of all private sector UK provision.

Looking across the full span of providers, generally rather few of them express or demonstrate behaviour consistent with profit maximisation as the dominant motivation for being in this line of business. In other words, although they are in the private sector, their motives for being in this market and for their behaviour are more mixed, with many providers

expressing a complex mix of empathetic, professional and autonomy-oriented motives, as well as the need to earn an adequate revenue stream (Kendall, 2001). Further analysis of data in one of the recent PSSRU studies suggested that providers who prioritised income or profit had higher price-cost mark-ups (Forder et al., 2000a). It is clearly important to have a good understanding of the business, professional and personal motivations of providers in seeking to manage a social care market in the best interests of vulnerable individuals and populations. It is also an integral part of efficient commissioning.

4 Domiciliary care trends

One of the important emphases of the 1990 Act was to encourage more older people to remain in their own homes with good-quality supportive care, thus delaying or removing completely the need for admission to residential or nursing home accommodation. This policy emphasis has had some demonstrable influence over the subsequent years and has allowed the proportion of people in congregate care settings to decline. One way in which this has been achieved has been to target available domiciliary care services on a smaller proportion of the older population. Although the overall size of this market has grown - that is, although the number of home care hours has increased quite substantially (for example there was a 52% increase in contact hours between 1992 and 1998; Department of Health Community Care Statistics) - the number of people receiving the services actually fell (for example by 17% between 1994 and 1998). Obviously the average number of hours per user grew: the intensity of provision increased from 3.2 to 5.8 hours per week between 1992 and 1998, and has subsequently increased even further. At the same time there was an extension of provision in order to offer more weekend and evening services, and generally greater responsiveness to the needs and preferences of individual service users.

There are no national statistics on the overall volume of domiciliary care provision in England, but there are data on that provision which is funded by local authority social services departments. The independent sectors' shares of this publicly-funded domiciliary care market have grown hugely in just a few years. For example, in 1992 the private and voluntary sectors delivered 2% of all home care hours funded by local authorities, but by 1998 that market share had increased to 46%, and exceeded 50% for the first time ever in the following year. Intensity of provision is higher in the independent sectors (8.1 hours) than in the public sector (5.2 hours) Department of Health, 2000).

Domiciliary care provision is thus increasingly dominated by the independent sectors, with private providers easily out-numbering their voluntary sector counterparts. It is a young market, with many of today's providers quite new to this line of business (Matosevic et al., 2001). As with residential care providers there is no simple way to characterise the motivations of domiciliary care agencies: a complex mix of intrinsic and extrinsic motivations is at play (Kendall et al., 2001). As with residential care, profit margins are modest (around 10% over cost), leaving providers with little scope to absorb further price squeezes without compromising quality and service standards (Forder et al., 2001).

5 Contract arrangements

There are many questions to be addressed in designing contracts between purchasers and providers: Should they be long-term or short-term? Should they be block or spot? Should they employ fixed-price or cost-plus reimbursement schedules? Do they allow for contingencies? These interlinked specification issues have implications for provider performance, for purchasers' abilities to secure good-quality services at affordable prices, for present and future market shape, and for providers' willingness and ability to invest in human and physical capital (staff training or care arrangements), with associated (potential) benefits for users.

One central choice in contract specification is the degree of flexibility, particularly with regard to prices. Whilst a pre-determined price has the advantage of predictability to the purchaser, the provider may experience cost changes that leave their net revenue (their profits if they are in the commercial sector) uncertain. Moreover, pre-determined prices are not responsive to the individual needs of users. Providers may thus not have the incentive to tailor the services they supply to specific individual circumstances. Flexible, spot-determined or contingency-sensitive prices shift some of the risk back to the purchasers, and offer greater incentives to providers to respond to the changing circumstances of care. They also have the potential more quickly to transmit information on the state of the market.

Contracts can take up a lot of administrative time to negotiate, agree and monitor. Both purchasers and providers might therefore incur substantial transaction costs as a commissioning agency seeks to move from an overall budget to a set of services on the ground, and in turn to the achievement of user outcomes. Of course, these transaction costs do not only arise with market-like allocation mechanisms: hierarchical systems heavily burdened by the 'dead hand of bureaucracy' also have potentially high transaction costs, though perhaps less readily observed.

If commissioning links between budget holders and service providers (even within the same organisation) can be based more on trust rather than on adversarial relations, there will be greater potential for reducing these transaction costs. Trust cannot be created overnight, but can clearly be destroyed very quickly, which might be seen to make it quite a fragile basis for a relationship.

Experience in social care to date with the different types of contract has been mixed. In the residential and nursing home markets, spot contracts tend to dominate, whilst for day care block contracts are much more frequently used. In the domiciliary care market there are few block contracts, but perhaps equal numbers of spot and cost-and-volume contracts. Certainly there has been some movement in recent years towards giving providers greater security in their local markets, something which domiciliary care providers have commented positively upon (Ware et al., 2001). Across the broad spectrum of social care, one of the difficulties that many providers currently face is an unsure future revenue stream, and there are arguments

that commissioners should be seeking to use more block or cost-and-volume contracts in order to share more equally the market risk between purchasers and providers.

6 Questions for the future

There are a number of questions that need to be addressed in order to understand the potential for the developing mixed economy of social care to achieve good outcomes for older people at an affordable societal cost.

One very fundamental question relates to the appropriateness of market forms of allocation in this particular area. Social care services are *personal* services, delivered to people who are usually vulnerable and frail, and in circumstances which give users few opportunities to exercise much choice or to move to another provider should services prove to be unacceptably poor. Consequently, social care markets have not only economic characteristics, but also political, societal and personal features which policy makers need to take into account. One possibility that deserves serious consideration, of course, is whether these very characteristics of social care mean that markets are a *more* appropriate way to organise provision than are traditional hierarchies or bureaucracies. Which ever broad strategic approach is taken, no simple market-like or bureaucratic arrangement is going to be sufficient to achieve society's aims in this challenging policy area.

A second question often asked when looking at any new market is whether the transaction costs - the costs of actually operating the system - are unnecessarily (i.e. wastefully) high. The very nature of social care and its users means that commissioners need to set in place effective procedures for ensuring that good quality care is delivered. This either requires careful and perhaps time-consuming specification at the time that contracts are agreed and/or regular monitoring of the quality of care achieved and the actual quality of life improvements for users. Clearly without (some of) these transaction costs there would be considerable risk of poor quality care. Moreover, we must not be fooled into thinking that transaction costs only arise with markets; hierarchical or bureaucratic procedures are famous for their often high levels of X-inefficiency. What is clearly needed is a way to reduce the unnecessary transaction costs in any system, and one possibility that is being actively sought in the UK in both health and social care markets is to rely more on obligational than adversarial forms of relationship, with contract transactions underpinned more by trust than by heavy monitoring or resorts to litigation.

This leads to the related question of whether commissioning arrangements can 'mature'. The commissioning tasks given to local authorities in the 1990 Act were almost completely new, especially in social care contexts. On the provider side of the market, the much more formalised relations with purchasers also represented new experiences and challenges. It was perhaps almost inevitable that both purchasers and providers should develop somewhat formalised ways in order to cope with these completely new contexts and expectations. Over time, however, and particularly as experience with agencies on the other side of the 'contract table' develops, there ought to be considerable scope for substituting collaborative for adversarial relationships. Trust has been seen as one of the best ways to economise on transaction costs, but it must be well-placed. Mature commissioning arrangements would be based on a suitable combination of trust, robust negotiation and fair competition.

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Health and social services for early childhood and the elderly: the French case

1 Introduction

The health and social services available to families, the elderly, the disabled and those excluded from society constitute a complex system from the point of view of benefits granted, services available, financing bodies and methods of financing, not to mention the heterogeneousness of beneficiaries. Benefits may include hygiene care, personal assistance (meals on wheels, transport, etc.), and the improvement and maintenance of accommodation, etc.

They may involve services in kind or financial aid, which may be used as the user wishes. Service providers may be public, private or depend on the local community. Beneficiaries of services may have a direct financial link with the person(s) who provide(s) the service (nurse, home help, etc.) or they may themselves be employers in a mutual agreement. On the contrary, they may benefit from services without having to manage their relationship with these services themselves. There are many financing bodies: the State, regional authorities, the ‘‘*Départements*’’, health insurance offices, mutual benefit insurance companies, private insurance and charity organisations. The methods of financing are themselves extremely varied: the financing of services to people, exemptions from social security contributions, tax deductions: legislation and regulations proliferate which result in the existence of many decision-makers.

The complexity of this system is the fruit of a positive development, which is reflected by the expansion of welfare since 1945, based on a large number of initiatives. Movements of associations for helping families, the elderly and the disabled, generally voluntary during the start-up period, were at the origin of the setting up of the different services. Progressively the State, local authorities and health insurance offices have taken over and perpetuated the system. The 1960’s saw the development of a whole range of policies for the elderly following the work of the Commission chaired by Pierre Laroque in 1962. In the 1980’s and 1990’s the focus has been on policies for fighting against social exclusion with the creation of a guaranteed minimum income in 1988.

This complexity can be explained by the way in which health and social services have grown: whilst asserting the need for global care for people, services have been set up by successive

strata: a new service, a new category of social workers and new regulations which are added to those existing without revising the systems5. Institutional turmoil, which has characterised the history of social ministries6 since 1948, and the decentralisation policy constitute a second explanation for the complexity of the health and social services production system.

Government action in the field of health and social services is structured according to four main lines:

Home care, as long as possible for the elderly and disabled in order to satisfy the personal wishes of these populations, to anticipate the increasing severity of the handicap and ageing and to avoid very cumbersome forms of accommodation. The economic argument that leads the community to prefer home care to institutionalisation is no longer currently used, although policies were based on this for a long time.

Enable women to work in good conditions for themselves and their children. The female labour participation rate for women between 25 and 54 increased from 50% in 1970 to approximately 80% in 1990. This lead to the development of different forms of child-care and financial assistance for families.

Reintegrate socially excluded people by offering them jobs in social economics.

Support the creation of family jobs, or so-called proximity jobs through a system of public assistance, mainly exemptions (or reductions) from social security contributions or tax exemptions.

It is worth noting that re-integration and family job creation policies have often gone hand in hand. Public grants have encouraged the occupation of family jobs people who find themselves in a situation of re-integration, which has posed a problem for specialised organisations which want to increase the qualification of these jobs.

On the whole, all of these policies have had unquestionable effects on employment but we are still a long way from satisfactorily covering all needs. However, the new personalised autonomy allowance (APA: *allocation personnalisée d'autonomie*) should especially improve the situation of elderly people by enabling the financing and therefore the development of the services required.

The precise analysis of services for young children and elderly people presented below incontestably comes up against the question of data collection.

The multiplicity and diversity of social services regulators, purchasers and providers, the multiplicity of administration offices concerned, the multiplicity of public authority and

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[5] See Hespel Thierry report: ''Summary of the findings and proposals of the mission on personal assistance services'', 1998, mimeographed document.

[6] Bernard Friot: "Social ministries and their central departments from 1946 to 1992", *Revue française des affaires sociales* (1), pp. 140-171, 1996.

administration levels concerned, the diversity of service providers (associations, private not-for-profit institutions, private for-profit organisations, public agencies) have an immediate consequence: a fragmented statistical production the reliability of which can be questioned.

The absence of required legal registration data system represents a major difficulty for those who wish to carry out a well-researched analysis of the situation. The Department of Research, Investigation, Assessment and Statistics (DREES) at the Ministry of Employment and Solidarity however produces good quality data on some social benefits and on certain target populations from the surveys it carries out. However, no exhaustive overall vision of French health and social services is available to date.

The multiplicity of social occupations, the absence of a national register of these occupations and the massive intervention of non-professional helpers, caring for elderly people in particular, are structural obstacles in the collection of precise data on service providers.

The modification of work settings (less institutional facilities and more and more small services), the development of new intervention areas also complicate the collection of statistics.

The CNIS (*French National Council for Statistical Information*) carries out important co-ordination work between the providers and users of public statistics. The statistical knowledge of social services is one of its medium-term objectives.

We will successively analyse services aimed at young children and services aimed at the elderly.

2 Social Services for Children and Youth

2.1 Young Child Care

In 1998, 4,350,000 children were under 6 years old and 2,112,000 children under 3. The care services available are as follows:

2.1.1 Collective services:

- Childcare centres (crèches) with a capacity of 138,400 places. They are run by the municipality or associations. Financing is provided by the local authorities and social security offices (family allowance) and firms.
- Co-ordinated child minders (family crèches) with a capacity of 60,900 places.
- Flexible day care centre (halte-garderie) with a capacity of 68,100 places.

Capacity in childcare centres has strongly increased following agreements between local authorities and social security ("*contrat crèches*" in 1982 and "*contrat enfance*" in 1988).

2.1.2 Home services:

- Registered child minders (caring in their own homes)
- Domestic employee
- Non-registered staff (family members, neighbours, nannies…)
- Children under three are cared for in the following structures:

Fig. 1 – Method of care for children under 3 years old

Care system	%
At home by parents	49
At child minder's home	15
In child care centres (crèches)	9
At home by nurse	2
Non registered staff	25

Children between 3 and 6 years old are usually accepted at nursery schools.

Public expenditure on assistance for minding young children in 1998 was 19 billion Francs in the strict sense of the term, i.e. by adding the financial assistance granted for child minding [AFEAMA: assistance for the employment of a child minder by families, AGED: home child minding allowance], expenditure by family allowance offices and local authorities for different nurseries and minding institutions and the assistance given to families to reduce child minding costs outside the home.

A wider assessment of this public expenditure including the APE (allowance for parents having children under three, when one or both parents reduce their working hours), amounts to 31.9 billion Francs.

2.2 Child Protection

The child protection policy is defined on a national level and delegated to the child welfare service (*Aide Sociale à l'Enfance*). Since 1983 (Decentralisation law), implementation of policy has been decentralised to local authorities (*Départements*).

2.2.1 Children under child protection

Forms of child protection differ according to whether the children are removed from their families or protected within them.

Removed from their families. In 1998: 144,000 children or young people (under 21)

- 80% following a juridical decision
- 20% on request of family or young persons themselves
- 49% in foster homes
- 37% in child protection centres ("maison d'enfants à caractère familial")
- 14% others (sheltered housing, ordinary flats…)

4,193 children in state care ("*pupille de l'Etat*"), including 1,056 on the way to adoption.

Protected within their families

- Family worker: 15,000 to 20,000 families
- Educative actions: 130,000 actions
- Financial help: 400,000 to 450,000 families

2.2.2 Specific actions targeted at young people in difficulties:

There is a whole series of Specific actions targeted at young people in difficulties: Teams specialised in preventive actions in the context of urban policy
Assistance funds for young people (local authorities + state): allowance for young people after reaching their majority (under 21)
Information and guidance desk for young people

The recent development of social services for children[7] is marked by three factors:

- A constant increase in spending
- A raise in entries to institutional care following a juridical decision

[7] Statistical documents N° 310, SESI, August 1998, DREES Studies and Results N° 46, January 2000.

- In the long run:
    - The number of children assisted outside their family decreases
    - The number of children under educative action increases

The case of sexually abused children has taken on a particular importance over the last few months[8]. Significant efforts have been made to better identify children at risk and provide a more rapid and more direct response to these distressing situations.

The "Observatoire de l'enfance en danger" (Observatory for childhood at risk) computes statistics on the basis of cases of abused and at risk children reported to local authorities (Département). These statistics are published by the national agency for decentralised social actions (ODAS).

Fig. 2 – Abused children and children at risk[9]

	1994	1998
Abused children	17,000	19,000
Children at risk	41,000	64,000
Total	58,000	83,000

Prevention and care for abused childhood lead to promoting "well-treatment", a global approach for children and family welfare, for balance of rights and duties of each members of the family.

A general interest public group formed by the State, the *Départements* and associations has set up a special telephone number (119) for these abused children. In 1998 it received 1.9 million calls, i.e. 5,200 calls per day. Permanently listening to these children in difficulty gives rise to advice and enables the most serious cases to be referred to the department of social services.

[8] Report to Parliament in pursuance of the law of 10-7-89, a permanent inter-ministerial group for abused children, September 2000.

[9] The figures do not include the most serious cases which are directly reported to judges by hospitals, police and "gendarmerie" forces.

3 Health and Social Services for the Elderly

The health and social services given to the elderly are currently being overhauled for legislative, political and economic reasons.

The legal framework which supported the organisation of these services is undergoing a complete transformation.

- The personalised autonomy allowance (APA) was voted by Parliament and is currently being implemented. After years of parliamentary debates, the production of many reports by specialists, the successive introduction of an experimental dependency allowance (PED: *prestation expérimentale dépendance* and a specific dependency allowance (PSD: *prestation spécifique dépendance*), the authorities have finally taken a stand for a more general system following on from previous benefits. A total expenditure of 23 billion is planned at full development with a maximum benefit of 7,000 francs for the most dependent. It is a universal and personalised right but the amount of the benefit is adjusted according to the elderly person's income. A medical and social assessment of needs precedes the attribution of the benefit.
- The medical and social institution tariff reform has also been voted. It will lead to the distinction of three rates for medical care, accommodation and dependency. It obliges medical and social institutions to sign an agreement with the Social Security and the ''*Département*'' in order to promote quality in institutions. This tariff reform is accompanied by a medicalisation plan for institutions.
- Its application will facilitate to take into account the seriousness of dependency of the population cared for in defining the budgets needed and in allocating the necessary resources to the institutions which was not the case until now.
- Finally, the law of 1975 on medical and social institutions which defined the legal framework of all medical and social activities is currently being revised.

Generally, the entire legal and statutory environment of health and social services has been reconsidered over the last two years, although the specific consequences of these transformations are not yet apparent.

Another important factor must be noted. The law on the reduction of working hours (35 hour week) is particularly difficult to implement in the health and social sector. The organisation of work is seriously questioned by the introduction of the 35-hour week, in particular because there are many part-time jobs. Negotiations are currently at a difficult stage. The subsequent shortage of nurses poses serious problems to health and social institutions and services, and they are only partly solved by calling on foreign labour.

We shall successively examine accommodation for the elderly and the organisation of home care.

3.1 Residential care for the elderly

There are two main categories of accommodation for the elderly.

Retirement and nursing-home. There are many different providers: public institution or private not-for-profit institutions or private for-profit institutions.

There are three sources of financing:

- Accommodation is paid by residents or by social assistance - income criteria;
- Health care is paid by national health insurance fund, between 20 Francs and 164 Francs, by day and person;
- Disability is paid by the residents or subsidised by a specific benefit (APA) – income and incapacity level criteria.

Fig. 3 – Accommodation for the elderly:

	Number of institutions	Capacity (Beds)
Without medical care sector	4,528	202,974
With medical care sector – medical care (*included*)	4,709	374,536 149,244

Long-term care hospital is not taken into account.

Sheltered housing. 62,762 elderly persons living in 903 facilities.

3.2 Home services for the elderly

Home nursing-care. Home nursing-care is provided by health and social services. 1,627 services are caring for 62,984 elderly. The home workers are visiting elderly at home, they are providing personal health care, help for the elementary activities of daily living. The elderly are more than 60 years old, or dependent following medical prescription.

Social Security is financing that kind of services (200 Francs maximum by day for a very dependent people).

Home help (housework). Association or community centres for social services are providing support and help for everyday life tasks. Two cash benefits can be allocated. Legal allocation may be paid by local authorities (*Département*). The *Département* fixes the number of hours and the fee rate.

Extra legal allocation may be paid by old age insurance funds. Each fund fixes the number of hours and the fee rate. There is a large variety of situations.

Home workers. They are employed directly by the elderly or by an association. In some cases, they can be workers from local authorities. Their task consists in supplying additional home help for a continuous attendance by day or by night. Financing is assured by the elderly or by the old age insurance fund.

Beyond the legal transformations of personal assistance, several structural reforms are underway. They should significantly modify the production of social services. Four main lines can be distinguished:

- Negotiation between CNAVTS (National Retirement Insurance for Salaried Workers), the Ministry of Budget, DSS (Social Security Head Office), DGAS (Social Help Head Office) to modify the home help financing system. Introduction of “quality criteria”.
- Creation of CLIC (information and co-ordination local centres).
- Reform of services of home nursing care (extended competence).
- Improvement of the formation of home workers.

In addition, a whole series of specific measures have been implemented.

- Creation of an institute of ageing.
- Reform of the placement in foster home.
- Plan of leave for family care.
- Propositions to fight against ill-treatment of elderly people.
- Plan for people suffering from Alzheimer’s disease.

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Structures of Social Services in Germany

Summary

The article describes structures of social services in Germany. Social services are regulated under social assistance law, under the law on child and youth welfare and under the law on long-term care. Social services comprise heterogeneous measures and serve different target groups in diverse life situations. The focus of social services in Germany is on child and youth welfare, and care for the elderly. Issues in social services comprise co-ordination of social services, the effects of marketability, and quality in social services. Quantitative data are best developed in the field of child and youth welfare, whereas quantitative data on social services under social assistance law remain poor. Data on long-term care services will improve considerably, since a new care statistics has been created by the federal statistical office.

1 Introduction

The field of social services in Germany is complex. When studying social services an initial observation is one of institutional fragmentation and a heterogeneous character of individual services which serve different groups in diverse life situations through a variety of means. Social services comprise such different provisions like meals-on-wheals, residential care for the elderly, child day-care services, sheltered workshops for the disabled, or counselling for debtors. Moreover, we find a variety of actors on the scene: the state, regional bodies, and municipalities, social insurance funds, welfare organisations, interest groups, private firms, families, etc. This paper aims at describing the structure of social services in Germany by depicting the main areas and actors from an institutional perspective. A further section addresses present issues in social services, and the last section gives an overview on available national data.

2 Regulation of social services

In Germany we will find no coherent framework or logic guiding social service provision. Organisation, financing, and delivery systems differ between bodies and target groups. There is a broad range of services available, addressing a variety of needs. But there are some common characteristics of German society that shape the character of social services:

- the dominance of the family as the genuine provider of services;
- political federalism and local self-government;
- the priority of welfare organisations in service provision

The family in social service provision. From an empirical perspective the family may be said to be the most important actor in social services, delivering the bulk of care work. From a more normative point of view, in Germany as well as in many other European, above all Southern European countries, there has been and still is a widespread assumption that the family is the genuine provider of care services, that public social services should supplement family services, and support the family in fulfilling its tasks, but not substitute family tasks. This general assumption has consequences for the types and extent of public intervention in social service provision.

Political federalism and local self-government. Germany is composed of 16 states with autonomous governments, deep rooted historical and political experiences, and cultural traditions. The federal states' traditions result in differences in social services provision and implementation - differences in types of services offered, coverage, priorities, etc.. Very often the federal states are responsible for the implementation of social services, for example child day-care services, resulting in considerable regional diversity in supply. Local self government has a long tradition in Germany too, and is laid down in the German constitution, giving municipalities considerable freedom in priority-setting as well as in the organisation of tasks assigned to them (*Organisationsfreiheit*, *Personalhoheit*). Thus, we may expect diversity in local service infrastructures and local policy priorities.

The priority of welfare organisations in service provision. In Germany there is a strongly institutionalised third sector in social service provision. We find here six big national welfare organisations with religious, humanitarian, and ideological orientations that are heavily involved in social service provision. According to the principle of subsidiarity laid down in German social law, these welfare organisations have priority over public service provision. The welfare organisations cover an intermediary position between public and private social service provision, offering services on a voluntary basis with a non-profit orientation and commitment to the public good. There has long since been a debate on the German 'welfare corporatism', revolving around the welfare organisations' independence, legitimacy, and political power as well as their economic dependence on state subsidies (see below).

2.1 Legal framework of social services

The most important laws regulating social services in Germany are the 'Federal Law on Social Assistance (BSHG)' which regulates the provision of cash benefits and services to

persons in difficult social circumstances, the 'Law on Child and Youth Welfare' (*Kinder- und Jugendhilfegesetz*, KJHG), regulating child and youth protection, including child day-care services and services for children at risk, the *Pflege-Versicherungsgesetz* (PflegeVG) related to the German long-term care insurance, and the *Heimgesetz* (HeimG) regulating clients' rights in residential care.

2.2 Services under social assistance law

Cash benefits and services provided under social assistance law aim at enabling individuals to 'live in dignity' ('*menschenwürdige Lebensführung'*). As a rule social assistance is provided to persons in need who have no income or property of their own and no close relatives to support them. Social assistance comprises cash benefits ('subsistence help') as well as supplementary social services providing 'help in particular life situations' (*Hilfe in besonderen Lebenslagen*). Social services under social assistance law address a broad range of needs and target groups, like families, women, unemployed, ill persons, persons in need of long-term care, drug addicts, mentally handicapped, homeless, etc. Cash benefits and services provided under the social assistance scheme are not, however, designed to address general demands, but do respond to individual emergencies. Assessments of individual needs have to take the whole living circumstances into account.

Cash benefits under social assistance law (*Hilfe zum Lebensunterhalt*) are means-tested measures and comprise of a general subsistence allowance, supplements for special risks (like disability, pregnancy, invalidity, etc.), and additional subsidies (i.e. subsidies for heating costs). Social assistance is provided by local (municipalities and districts, *Landkreise*) or regional authorities (*überörtliche Sozialhilfeträger*, either autonomous regional bodies (*Landeswohlfahrtsverbände* or *Landschaftsverbände)* or federal authorities). Regional bodies may delegate tasks under social assistance to local authorities.

Expenditure for social assistance amounted to 50 billion DM in 1998. A considerable share was spent on subsistence allowances (*Hilfen zum Lebensunterhalt*, 22 billion). Another 23 billion were spent on in-kind benefits and services (*Waren und Dienstleistungen)*. Unfortunately, the figures do not allow for a more exact estimate of expenditure on services. One can say, however, that the service dimension under social assistance is not very well developed. The focus of provisions under social assistance law is on cash benefits and counselling. Only services for families – poor families, and families with many children – and services for people in difficult life situations – prisoners, homeless, and persons with behavioural disturbances – are comparatively well developed. Synopsis 1 presents an overview on the target groups and measures provided under social assistance and other law.

Synopsis 1 – Target groups and services provided, Germany

Target groups	*Types of intervention*	*Measures*	*Major bodies of law*
Children and youth	– Youth education	– Day-care services for children (Kinderkrippen, Kindergärten, Kinderhorte, Tagespflege) – youth centres youth holidays, youth camps	Child and Youth Welfare Law (KJHG)
	– Youth social work	– Social and employment-related measures for young people at risk, with educational deficits, and children of immigrants	
	– Child and youth protection measures	– (Temporary) placement of children in child protection centres or foster families (Inobhutnahme, vorläufige Unterbringung)	
Persons in need of long-term care	– Assistance to live a life in dignity	– Home care, residential care, respite care, short-time care, apartments, meals-on-wheels, hauswirtsch. Dienste	Law on Long-Term Care Insurance (PflegeVG); Social Assistance Law (BSHG)
Asylum seekers		– In-kind benefits	Law on Benefits for Asylum Seekers (Asylbewerberleistungsg,)
Families	– Family aid – Counselling in family matters – Family education	– Measures supporting poor families and families with many children – Counselling in matters like marriage, pregnancy, divorce, education of children – Family education centres – Holiday schemes for families	Social Assistance Law (BSHG)
Women	– Help for battered women	– Counselling offices – Women's refuges (Frauenhäuser)	Social Assistance Law (BSHG)
Senior citizens	– Integration in community life	– Counselling – Leisure activities – Services like meals-on-wheels, apartments, etc.	Social Assistance Law (BSHG)
Workers	– Employment-related social work	– Social work at the workplace – Integration of disabled workers – Measures for workers approaching retirement	
Unemployed	– Unemployed youth (Jugendberufshilfe) – General assistance to work (Hilfen zur Arbeit)	– Measures addressed at integrating unemployed youth in work life – Support and training for long-term unemployed, unemployment centres	Social Assistance Law (BSHG)
Ill persons	– Preventive health care – Medical aid for the needy	– General medical service (öffentlicher Gesundheitsdienst) – Home-care services	Social Assistance Law (BSHG)
Drug addicts		– Counselling, therapy, – In-patient care	Social Assistance Law (BSHG)
Disabled persons	– Assistance to integration in social life	– Counselling for disabled workers – Sheltered workshops – Residential homes, apartments	Social Assistance Law (BSHG); Law for severely disabled (Schwerbehinderteng.)
People in difficult life conditions	– Prisoners – Homeless – People with behavioural disturbances	– Services for prisoners, including youth court aid (Jugendgerichtshilfe, Bewährungshilfe) – Accommodation for homeless (Wohnungslosenhilfe, Nichtsesshaftenhilfe) – Services for people with behavioural disturbances	Social Assistance Law (BSHG) Law on Jugend-gerichtshilfe
Immigrants, resettled Germans (Spätaussiedler)		– Counselling – Language courses – Assistance in finding accommodation	Social Assistance Law (BSHG)
Tenants, debtors, consumers		– Counselling services	Social Assistance Law (BSHG)

Source: Bäcker et al. 2000; own summary.

2.3 Services under the 'Law on Child and Youth Welfare' (KJHG)

The second major area for social services is social services to children and youth under the 'Law on Child and Youth Welfare' (KJHG). Services for children and youth comprise of three kinds of services. The first is educational services addressed at all children. Child day-care services are subsumed here as well as education measures outside school, like holiday schemes, etc. The second field of activity is youth social work directed at children with social disabilities or from disturbed backgrounds. Third, child and youth protection measures are included here. These aim at crisis intervention, i.e. providing help for youth and their families in crisis situations, as well as providing temporary placement of children in care facilities or in foster families if the family situation constitutes a risk for the child's welfare.

The Law on Child and Youth Welfare was last reformed in 1990 reflecting a debate that had started already in the 1960s. The debate revolved around the respective responsibilities of state and families regarding the welfare of children and youth, as well as the division of labour between public and non-public providers (*öffentliche Träger* and *freie Träger*) in the field of child and youth welfare. In addition, the 1990 reform reflects the public debate around the reconciliation of paid employment and family tasks, for the first time recognising the supply of child day-care services as a public task. The reformed KJHG gives child and youth assistance a new orientation, with a focus on prevention and co-operation with clients (children, youth, and families) in service provision. The rights to public control and intervention – that had been far-reaching in the older law – have been considerably curtailed.

Expenditure for child and youth welfare amounted to 33,25 billion DM in 1998 (Table 1), with day-care services for children forming the main expenditure category (55.9%), followed by youth protection measures (24%). Youth education follows third but plays a subordinate role in quantitative terms (7.3%).

Table 1 – Expenditure for children and youth by function, 1998

Expenditure	%
Day-care services for children	55.9
Youth protection	24.0
Youth education	7.3
Integration of mentally disabled children and youth	1.1
Further (youth social work, staffs' further education)	1.9
Other (personnel of youth administration)	9.8
Total expenditure	*100.0*
in billion DM	33.25

Source: Statistisches Bundesamt, 1998, Fachserie 13, R. 6.4, pp. 7, 10.

2.4 Child day-care services

Child day-care services form quantitatively the most important part of child and youth services. There are four main types of institutions in Germany: crèches for under-threes, kindergartens for 3–6 year olds, all-day centres and after-school facilities for children six years and older (see Table 2). Crèches for children below three are rare (1.8% of all facilities in 1994), due to a wide-spread assumption that very young children are best cared for at home. Kindergartens for children between 3 and 6 years are the most common facilities today. They are usually aimed at socialising rather than addressing the needs of working parents. Until very recently the bulk of kindergartens had provided part-time places. Since 1999 a place guarantee has become fully effective, and all children between 3 and 6 are entitled to a place in a kindergarten. All-day kindergartens (with a share of 10.1% in 1994) and after-school facilities (7.8% of all facilities) have traditionally been limited to children in need. Due to an – although reluctant – recognition of working parents' needs these institutions are slowly expanding.

Table 2 – Day-care services for children by type of institution and provider, Germany 1994

Type of institution	Total		By type of provider (%)	
	N	%	Public providers	Non-public providers
Crèches, ages 0–3 years (*Kinderkrippen*)	856	1.8	46.3	53.7
Kindergartens, ages 3–6 (*Kindergärten*)	29,757	63.8	26.1	63.9
After-school facilities, ages 7 and older (*Kinderhorte*)	3,657	7.8	70.8	29.2
Day centres, ages 3–6 *(Tageseinr., alterseinheitl. Gruppen*)	4,702	10.1	72.0	28.0
Day centres with age-integrated groups, all ages (*Tageseinrichtungen, alters-gemischte Gruppen*)	4,675	10.0	64.4	25.6
Day centres with age-integrated and homogeneous groups	2,976	6.4	66.9	33.1
Total	**46,623**	**100.0**	**47**	**53**

Source: Statistisches Bundesamt. Fachserie 13. Reihe 6.3.1, p. 7

The provision and coverage rates of publicly funded day-care services for children vary greatly across the *Bundesländer* and even across municipalities. The legal framework is set up by the federal government, but the states and the local authorities are responsible for the implementation and financing of day-care for children. Consequently, we find considerable regional diversity in service supply. Table 3 shows day-care coverage rates by age groups. The table shows a west-east divide in child day-care supply, the 'new states' (*neue Bundesländer)* offering a broad range of services and high coverage rates for all age groups. The situation in the new states is shaped, however, by a closing-down of numerous facilities that existed in the former GDR to allow for a reconciliation of paid and unpaid care, as well

as taking over of the remaining facilities by public and, more hesitantly, non profit providers. Above all the extremely low fertility rates in the new states contributes to the favourable aggregate picture of coverage in child day care services. Coverage of kindergarten places, the traditional form of child day care in Germany, is more homogeneous across all German states, whereas there are considerable regional disparities in coverage rates for under-threes and school-age children.

It is interesting to note that coverage rates in day-care services in the old states have traditionally been related to the spread of the big churches, reflecting the involvement of the churches, above all the Catholic church, in matters of education. Among the old states, there is a divide along religious lines: in the predominantly protestant states coverage rates are lowest, whereas in the catholic and religiously mixed states, coverage rates are on or above average.

Table 3 – Coverage rates in child day care by age groups, 1994[a]
(places in day-care facilities as % of respective age group)

	Crèches	Day-care centres (incl. kindergartens)		After-school facilities		
	<3	3–<6	3–<6.5	6–<8	6–<10	6–<12
			Old states			
Baden-Württemberg	1.2	107.9	92.4	5.5	2.8	1.9
Bayern	1.0	88.0	75.5	9.3	4.8	3.3
Berlin (West)	19.1	60.0	51.4	52.6	27.3	18.5
Bremen	6.4	76.3	65.6	31.6	16.4	11.1
Hamburg	11.9	59.3	50.9	40.6	21.2	14.5
Hessen	2.1	91.3	78.2	14.0	7.2	4.9
Niedersachsen	1.5	74.8	64.1	5.8	3.0	2.0
Nordrhein-Westfalen	1.5	73.5	63.0	7.4	3.9	2.6
Rheinland-Pfalz	0.9	105.8	90.4	5.5	2.8	1.9
Saarland	1.7	97.6	83.6	4.3	2.2	1.5
Schleswig-Holstein	1.4	75.7	64.9	8.1	4.2	2.9
Total	*2.2*	*85.3*	*73.0*	*9.9*	*5.1*	*3.5*
			New states			
Berlin (East)	54.5	118.3	97.6	44.2	22.2	14.9
Brandenburg	54.1	118.4	97.3	132.8	65.6	43.2
Mecklenb.-Vorpommern	39.0	108.5	89.1	91.3	45.3	30.1
Sachsen	32.8	118.5	97.9	106.6	52.9	34.9
Sachsen-Anhalt	43.0	11.6	92.0	1.5	0.7	0.5
Thüringen	36.4	123.9	101.9	3.2	1.6	1.0
Total	*41.3*	*116.8*	*96.2*	*68.7*	*34.1*	*22.6*
			Federal Republic of Germany			
Total	***6.3***	***90.7***	***77.2***	***22.8***	*11.7*	*7.9*

[a] Data on child day care are collected quarterly. Unfortunately the 1998 data are not yet available. It is expected, however, that coverage rates for day-care centres have improved, as in 1996 a place guarantee for children between 3 and 6 years came into effect.

Source: Beher 1997: 336.

The welfare organisations' legal priority in provision of day-care services clearly shows up in the data. In 1994, 53% of German child-care institutions were run by these organisations, and 47% by local authorities (see Table 2). The table shows a focus of the welfare organisations provision of kindergartens, whereas crèches, all-day centres and after-school facilities are more often provided by local authorities. In the new states public providers dominate in all forms of child day care (not shown in the table). The welfare organisations only hesitantly gain ground there. Church membership is rare in the new states and a religiously-based service infrastructure is practically non-existent since activities of the churches were limited during the GDR regime.

Local authorities, parents, and welfare organisations contribute to the costs of child day-care services. Child-day care services belong to local authorities' statutory tasks, and they have to cover the bulk of the costs. The religiously based welfare organisations contribute to the running costs of institutions, but the amount – which traditionally used to be around one third – is diminishing. Parents' fees contribute modestly to the running costs, between 15 and 25%. Social assistance covers fees for children in need.

Current issues in child day-care include improvements in services for very young and school-age children. Since the place guarantee of day care for children between 3 and 6 years has been accomplished, the focus has shifted to another major problem area which is irregular school hours and the difficulty for parents of school children in combining paid employment and family tasks. In this respect, co-ordination between the education system and the system of day-care services in after-school care has become an issue. After school-care is a neglected field in Germany. Primary schools are half-day schools under the responsibility of the German states' ministries for education. Some states have started to offer after-school care under education law; others offer after-school services under the child-and-youth-welfare law. So far there is no national or co-ordinated initiative at improving after-school care.

It should also be mentioned here that the integration and co-education of disabled children in day-care services and primary schools has become an issue in recent years. The same is true for children of migrants. Germany is a country of immigration with high shares of migrant workers and their families. Measures for the integration of migrants' children and disabled children include extra staff and reduced group sizes.

2.5 Services under long-term care insurance

The third major area for social services in Germany is long-term care. The delivery system for long-term care has undergone tremendous changes during the last 30 years, responding to a constantly growing demand. The expansion has been foremost in the category of nursing homes (*Altenpflegeheime*). Home-care services have expanded as well, reflecting a shift in priorities from residential care to home-based care.

Before the mid-1990s costs for residential care in old-age and nursing homes had to be covered by clients themselves, or, in many cases, by the social assistance scheme. Home-care services were covered by health insurance, with a very limited coverage. Financial pressures and growing needs have led to the introduction of a long-term care insurance as part of social insurance in 1995. Insurance covers all persons insured against sickness in statutory public (90%) or voluntary private (9%) insurance, together about 99% of the population. Long-term care insurance is co-financed by employers' and employees' contributions. Pensioners have to contribute also.

The need for long-term care is assessed by the medical services of health insurance funds; persons at risk are grouped into one of three levels of need, with differing levels of benefits.

Level I allows for in-kind benefits of up to 800 DM or 400 DM if the payment for care is opted for. Level II is up to 1800 DM for in-kind benefits or 800 DM for the payment for care; level III is up to 2800 DM or 1800 DM respectively. The budget for services under the long-term care insurance is dependent upon the numbers of insured persons and the rate of contributions by employers and employees. At present contribution are fixed at 1.7% of gross earnings.

Benefits under the long-term care insurance give priority to home- and family-based care, supported through cash benefits and/or supplementary social services. Residential care is provided if there are no alternatives. In the case of home-based care a payment for care is available, or the person in need of care may opt for the services of a home-care service. The payment for care may be used to pay for a care person, which is usually the spouse, or the children, or step-children (the daughter or step-daughter). Table 4 shows the distribution of long-term care recipients by type of care. Most persons in need of care continue to live at home (72%), only 28% are in residential care.[10] In the case of home-based care the payment for care – that usually serves as a compensation for the care work by close relatives – is clearly preferred; only very rarely the in-kind benefit alone – i.e. services by private home-care services – is chosen.

Table 4 – Recipients of long-term care by type of care, Germany 1998

Type of provision	N	%
In-kind benefit only (*Pflegesachleistung*)	134,240	7.5
Payment for care only (*Pflegegeld*)	963,130	53.8
Combination of in-kind benefit and payment for care (*Kombinationsleistung*)	178,239	10.0
Day care*	6,320	0.4
Respite care (*Verhinderungspflege*)*	3,408	0.2
Temporary care (*Kurzzeitpflege*)	6,230	0.3
Total recipients of home care	*1,291,575*	*72.2*
Residential care	445,991	24.9
Residential care in homes for the disabled*	51,262	2.9
Total residential care	*497,253*	*27.8*
Total long-term care	**1,788,828**	**100.0**

* Recipients may receive this service in addition to other services.

Source: Eisen & Mager, 2000: 230.

[10] Persons with less care needs are cared for at home more often than persons with higher care need. But even among persons with most intense care need (level III) the rate of home-based care is still 57%.

The costs of residential care are also covered by the long-term care insurance funds. The care facilities regularly negotiate caring rates with the insurance funds and the social assistance funds, up to a maximum defined by law. In case of residential care the caring rates do not, however, cover the costs of accommodation and living. As a consequence, recipients usually have to contribute considerably to the costs of residential care. In the case of recipients with very low incomes/pensions, social assistance covers these costs.

Expenditure for long-term care amounted to 30,7 billion DM in 1998 from the long-term care insurance and 5,8 billion DM from assistance to care (*Hilfe zur Pflege*) under the social assistance scheme. Before the introduction of the long-term care insurance, social assistance was the main instrument offering assistance to persons in need of long-term care. The introduction of the long-term care insurance has relieved the social assistance budget. Since 1994 expenditures for 'assistance to care' have been continuously diminishing. Expenditures amounted to 13,9 billion DM in 1994, and went down to 5,8 billion DM in 1998. The numbers of recipients of 'assistance to care' diminished by 47% between 1994 and 1997, from 476,000 to 251,000.

Among current issues in care for the elderly, co-ordination in social services is often mentioned. Due to the variety of provisions available and a variety of providers, and on the other hand, limited capacities of the persons in need, there is a growing need for institutionalised care management at the field level, i.e. assessments of individual needs and arrangement of individual care packages.

A second issue in care for the elderly is marketability. In contrast to child day-care services, there is a considerable - and growing - share of private care facilities and private home-care services in the field of long-term care. The consequences of private involvement in care services is an important issue in Germany these days. The long-term care insurance has opened up the care market for private involvement. Only slowly are the consequences for the supply in long-term care recognized but little is known about the direction of change. Empirically, we observe a retreat of public providers from welfare provision and a stagnation of the welfare organisations' share. But are we witnessing a general change in the welfare mix in Germany in long-term care, a shift towards the free market, or will private provision in the long run only cover market niches? Moreover, what will be the consequences for the welfare organisations of a growing competition with for-profit provision? Questions like these have started to be systematically addressed and are topics of several research projects initiated by the Federal Ministry of Employment and Social Affairs.

3 Actors in social services

The profile of actors involved in social service provision in Germany is complex. To start with, we suggest to distinguish two types of actors that are part of the public, professional social service delivery system:

Public actors include

- local actors, i.e. local authorities (Städte and Gemeinden) and districts ((Land)kreise);
- regional actors: the German states (Bundesländer) and regional bodies (Regionalverbände);
- social insurance and social assistance funds.

Non-public actors comprise

- the locally active welfare organisations, their regional branches and national peak organizations (*Spitzenverbände*);
- private providers, including individuals, small firms, and large companies.

There is a third group of actors that are usually not part of the public delivery system in the narrow sense, but play an important role in social services in various ways, as alternative providers, or supplementary actors. These other actors include social networks, self-help groups, and volunteers in social services. In the following the different types of actors are presented in more detail.

3.1 Public actors in social service provision

Local authorities bear the main responsibility for the provision of social services. There is a general responsibility regarding social services deriving from local autonomy. Local autonomy as well as local authorities' responsibility for citizens' welfare are laid down in the German constitution. According to the principle of subsidiarity local authorities have to co-operate with the welfare organisations in the provision of services. Local authorities' statutory tasks (*Pflichtaufgaben*) in social services are laid down in social assistance law (*Bundessozialhilfegesetz*), and child and youth welfare law (*Kinder- und Jugendhilfegesetz*). Tasks encompass a broad range of social services for children, youth, families, elderly as well as services for persons in difficult life circumstances like prisoners, homeless, and long-term unemployed (see Synopsis 1 for a general overview).

There is local and regional diversity regarding the administrative organisation of social services due to local authorities' legal autonomy in matters of organisation and personnel (*Organisationsfreiheit* and *Personalhoheit)*. We will, however, find in most municipalities a department for social services and a youth department. In addition, local authorities provide a so-called ‚General Social Service (*Allgemeiner Sozialer Dienst*, ASD). The General Social Service is usually decentralized and organized as district field work, with district offices and field workers (*aufsuchende Sozialarbeit*). The main field of activity is the welfare of families and youth; older people, chronically ill, and handicapped persons are further clients. The

general social service addresses individual or family emergencies and offers the necessary support, be it through own services, or, more often, co-operation with other social services. Clearing, case management, and co-ordination of assistance are important functions of general social work. The general social service makes use of all available techniques of social work, like individual assistance, group work, district work, as well as social-therapeutic measures. The ASD co-operates with many other institutions in social services, like social, youth and health departments, the welfare organisations, schools and kindergartens.

Besides the general social service there may be special offices offering individual services – according to special local demands, or when expert knowledge is required. There may be, for example, offices for drug addicts, family aid, resettled Germans, asylum seekers, or offices for youth court aid (*Jugendgerichtshilfe*). In some cases – where local demand for individual services is low, or where local budgets are insufficient – local authorities do co-operate in the provision of social services, forming associations (*Zweckverbände*) to provide individual services.

Besides local authorities, regional bodies (*überörtliche Träger*) play an important role in the supply of social services covering regional demands. Regional bodies provide, for example, specialized in-patient institutions and residential care, like clinics for drug addicts, or homes for the disabled. The tasks of the regional bodies are, like the tasks of local authorities, specified in federal social assistance law (BSHG) and in child and youth welfare law (KJHG).

Besides local authorities the social insurance funds are to be mentioned here as public actors in service provision. Although their main field of activity is financing of health and social services, some funds provide a limited range of social services, for example counselling services for persons in need of long-term care or persons seeking employment.

3.2 Non-public actors in social services

When describing non-public actors in service provision in Germany, we have to mention first and foremost the welfare organisations that are organized in 6 national head associations (*Spitzenverbände*) and form the core of a strongly institutionalised third sector in social service provision. These welfare organisations are the religiously-based organisations of the *Caritas* and the *Diakonie* as the organisations of the Catholic and the Protestant Churches, a workers' welfare organisation (*Arbeiterwohlfahrt*) is linked to the Social Democratic Party, the *Paritätischer Wohlfahrtsverband*, an explicitly non-denominational provider, the German Red Cross (*Rotes Kreuz*) with a humanitarian orientation, and a Jewish welfare organisation (*Zentralwohlfahrtsstelle der Juden in Deutschland*) providing services for the members of the Jewish communities.

The welfare organisations' roots date back to the second half of the 19th century when local associations of religious and charitable intention, to support the needy, first emerged. These different religious and ideologically motivated associations gradually started to organize trans-locally. The incorporation of the welfare associations in German social policy dates

back to the beginning 20th century. During the Weimar Republic (Catholic) political elites supported the formation of head associations, to ensure the influence of Catholicism in the social sector and relieve the state from social tasks. The diverse welfare organisations, on the other hand, attempted at stabilizing their position and securing their influence on societies development. The head organisations, above all the religiously-based ones, were incorporated step by step into social policy. In 1922 the organisations formed an umbrella organisation, the *Deutsche Liga der Freien Wohlfahrtspflege*. The division of labour between state and welfare organisations was fixed according to the principle of subsidiarity, adopted from Catholic teaching, that up to the present secures the priority position of the welfare organisations in social service provision. After the Second World War the corporatist lines of German social policy were restored. The welfare organisations' position was even strengthened by a 1967 rule of the Federal Constitutional Court (*Bundesverfassungsgericht*) that confirmed the traditional division of labour between welfare organisations as providers of social services and local authorities principal responsibilities in ensuring the supply of social services.

The welfare organisations today are heavily involved in social services in Germany in different ways. They are by law involved in national decision-making and law-making processes and have to be consulted in government decision-making in all issues touching the social services. Moreover, they are heavily engaged in service provision. Another important characteristic is the lobby activities of the 6 head organisations that are organised as the *'Bundesarbeitsgemeinschaft der freien Wohlfahrtspflege'* and act as advocates for individual organisations active on the local level.

The welfare organisations' employment in 1996 amounted to more than 1,1 employees (Table 5). The denominational organisations Caritas and Diakonie are outstanding here, with together more than 860,000 employees. The welfare organisations' activities concentrate in the fields of health care, child and youth welfare, and services for the disabled (Table 6).

In 1996 the six top organisations ran 91,000 of the facilities with more than 3,2 million places/beds. 52% of child all day-care facilities, 62% of all residential facilities for disabled and in long-term care, and more than 40% of all hospitals were run by them. Their services are heavily publicly subsidized, with more than 80% of the budget for social services coming from public finances, including social insurance funds.

The welfare organisations' growing significance as employers and providers of services, backed by an institutionalised subsidiarity and their broad involvement in political decision-making on the local, federal, and national level has led to considerable criticism. Criticism revolves around their claimed 'intermediary position' between state and for-profit sector. Critics have pointed to

- their quasi-public status with a high dependency on state support and state funding;
- their tendency to represent solely their own interests and their failure to integrate innovative and alternative approaches;
- their failure to properly represent their clients' needs and interests;

- the erosion of the organisations' value bases due to general secularisation processes in society;
- processes of professionalism, centralisation, and bureaucratisation of social work that discourage voluntary involvement.

Table 5 – Employees in the welfare organisations

Organisation	Numbers of employees[a] in 1995
Caritas (Catholic organisation)	463,161
Diakonisches Werk (Protestant organisation)	399,621
Arbeiterwohlfahrt (workers' welfare organisation)	69,330
Deutsches Rotes Kreuz (German Red Cross)[b]	42,438
Deutscher Paritätischer Wohlfahrtsverband (non-denominational organisation)	149,554
Zentralwohlfahrtsstelle der Juden in Deutschland (Jewish welfare organisation)	1,000
Total	**1,125,104**

[a] Voluntary work not included.
[b] Employees in social services only.

Source: Boessenecker 1998: 43.

Table 6 – Fields of activity of the welfare organisations

Organisation	Numbers of employees[a] in 1996
Health care	367,697
Children and youth	242,585
Families	50,171
Elderly	229,401
Disabled	151,085
Further social services	61,301
Further education	12,893
Total	***1,124,133***

[a] Voluntary work not included.

Source: Boessenecker 1998: 44.

3.3 For-profit providers of social services

For-profit provision in social services is not new in Germany. There have traditionally been private facilities addressing needs of better-off users demanding high-quality services. What is new in service provision in Germany is a rapid growth of private involvement in home-care

services and care facilities that have traditionally been dominated by public and non-profit providers. We find small businesses in home-care services as well as companies in residential care operating on a regional and even national level. The quantitative significance of private involvement in service provision is hard to assess, however, since the validity of available data is questionable. According to different data sources the share of private facilities in residential care lies between 10% and 30%. The data situation in home care is even worse. Little is known but the fact is that there is rapid growth in private home-care service, stimulated by the introduction of the long-term care insurance. The data situation will soon improve, however, since a new national care statistics, the *Pflegestatistik*, has only recently been introduced. Data under the new care statistics were first collected in 1998 and will be published in 2001.

3.4 Other actors in social services

Social services are not exclusively provided by professionals, within a highly institutionalised framework. The bulk of services is provided in the private sphere, by the family, and social networks. Moreover, we will find an informal sector for social services in Germany, represented by self-help groups, and volunteers.

The family. As mentioned before, the family remains the most important actor in social services: It is the first resort in cases of social need, since it is naturally responsible for the well-being of its members, including provision of care services to vulnerable members. Moreover, the family may be said to be the last instance for complex individual needs too, that are not or may not be served by public delivery systems.

Social networks as providers. Besides the family, social networks are candidates for the provision of social services too. Social networks, comprised of neighbours, friends, and colleagues, are usually based on reciprocity and are valuable sources for spontaneous support in daily activities. In social services, we will surely find neighbours sharing in child-care tasks. Very seldom, however, do we find that neighbours and friends take over comprehensive responsibilities for continuous, long term care of elderly persons in need.

Volunteers. It is a well-known fact that the German welfare organisations increasingly do have difficulties in recruiting volunteers (Beher et al. 2000). A study on the third sector in Germany in the mid-1990s, for example, has pointed to the dualism of a professional system of service provision organized at the national level that is mainly constituted by the welfare organisations and a sphere shaped by voluntary work and citizen participation in small, loosely organized units at the local level (Anheier et al. 1997). The two spheres seemingly develop independently and in parallel. Two developments have contributed to this situation: One is a movement to alternative forms of citizen participation, including self-help groups and alternative forms of political participation in the 1970s and 1980s that has been described as a counter-movement to the centralising tendencies of an ‘authoritarian state’ and its agents, including the welfare organisations. A more recent development of the 1980s and 1990s is towards new forms of social participation in short-time citizen projects that are increasingly being preferred to traditional forms of participation in highly institutionalised corporate structures. Both developments do contribute to a segregation of the two realms of social participation.

4 Current issues in social service provision in Germany

4.1 Co-ordination in social services

A characteristic of social service provision in Germany is its diversity. There is not one logic or framework guiding social service provision. Instead we find a heterogeneous mix of services, providers, and agencies, often acting in parallel and addressing the same target groups. An institutional fragmentation of social services is often stated. Seen from the perspective of its users the institutional fragmentation of social services may result in problems of access to services, and – in cases of complex needs – in problems of ensuring an adequate mix of services best covering individual needs. Users of social services have often criticised a lack in transparency of service supply, and the necessity to address several offices in individual cases. In the UK and the US the concept of case management has been developed addressing questions of co-ordination of social services at the field or user level. Case management is addressed at identifying individual needs and providing individual 'care packages' of single services best serving individual needs.

Whereas in the UK, for example, case management is described as a 'corner-stone' of community care policies, in Germany, case management has not systematically been institutionalised. The field workers under the general social services that usually co-operate with several agencies in working with families or individuals in difficult life situations come closest to this idea. There is, however, a deficit in case management functions in long-term care for the elderly. So far, persons in need with their often limited capacities, or the care taking persons who may be under considerable stress, are left alone to find the adequate services and providers, with the consequence that an adequate care package is often not ensured. The welfare organisations sometimes do offer counselling services and visit clients upon request, and some local authorities have installed counselling officers, but there is no institutionalised assessment of needs and co-ordination of the necessary services.

Seen from the supply side, co-ordination in social services is crucial to ensure an adequate local service infrastructure, avoiding over or under-supply of services and ensuring co-operation of agencies and institutions. The laws on social services do only very generally address the issue of co-ordination. Under social assistance law local authorities are made responsible 'to provide an adequate stock of services' to persons in emergencies. In the law on the long-term care insurance, adequate supply, co-ordination of single services, and co-operation of providers are formulated as general policy goals without implementing a specific responsibility. In practice we will find numerous committees and round tables in all fields of social services, bringing together the agencies from the supply side. Some local authorities employ consultants offering counselling and expertise and initiating co-operation among providers. But, again, efforts at co-ordination are voluntary, not institutionalised.

The chances for a co-ordination of services are best in the fields of general social assistance and child and youth welfare, where local authorities have traditionally operated in close co-operation with non-profit organisations. On the other hand, co-ordination of services has

become more difficult and less likely in the field of long-term care with its provider mix and growing competition between providers. Here the market is more and more becoming the main regulatory mechanism.

4.2 Marketability of social services

Marketability is a key issue when discussing changes and trends in social service delivery. Market orientation seems to be a trans-national development. In many European countries we observe trends of more 'market-like' provision of social services. Marketability of social service delivery in Germany is discussed from two perspectives: one is the implementation of measures improving the efficiency and effectiveness in public and non-profit actors' performance. The second aspect of marketability relates to the growing shares of private bodies delivering social services under a for-profit orientation.

Marketability in the first sense has for long been an important issue in Germany on the part of the welfare organisations that have been more and more under pressure to modernize their organisations and improve their performance – due to restrictions in social budgets and cost containment policies of public financing bodies. The welfare organisations have reacted and are more or less successfully implementing planning and management techniques, and budgeting and controlling elements. The implementation of elements of business administration poses considerable problems for these organisations since these rationales partially run counter to the organisations' traditional rationales as disinterested actors offering comprehensive services solely oriented at the clients. Market orientation has long been regarded as a foreign element in the welfare organisations' performance, and causes considerable tensions within organisations, between management goals, nurses' and social workers' performance, and clients' needs. In splitting up the complex process of social care, defining and standardizing caring activities and fixing duration and prices of single activities, the implementation of the social care insurance has accelerated the trend to market orientation and aggravated inner-organisational conflicts.

The second aspect of market orientation relates to the growing numbers of for-profit providers in social services. In many European countries we find today for-profit providers in the field of old-age care offering home-care services or residential care for the elderly. Private provision seems less common in the field of child day care (the UK being the most notable exception here). In Germany we find a considerable and growing share of private care facilities and private home-care services operating in the field of care for the elderly, whereas in child day-care services private provision is practically non-existent. In care for the elderly, public providers have been heavily on the retreat; the share of the welfare organisations has remained quite stable during the past 20 years. Traditionally, there has been a limited, but continuous involvement of private providers in residential care, with a growing tendency since the 1990s. The average share of private providers is estimated between 10% and 30% (according to different data sources). The share of public providers is between 10% and 20%, and the welfare organisations' share around 60% of residential care facilities (Bundeministerium für Familie, Senioren, Frauen und Jugend, 2000, own

calculations). Home-care services for the elderly have traditionally been supplied by 'community nurses' (*Gemeindeschwestern*) employed by the churches. After the erosion of the system of community nurses, the welfare organisations have continuously increased their share since the 1970s. Today, we will find a variety of providers: non-profit organisations as well as private providers – including small firms as well as regionally operating companies – in the field of home-care services for the elderly. In implementing the social care insurance, the German government has partly departed from the traditional social policy of subsidiarity in an important field.

4.3 Quality in social services

In analysing quality aspects of social services in Germany, distinctions are made between characteristics of service infrastructures, characteristics of social service performance, and evaluations of outcomes. Characteristics of service infrastructures (*Strukturqualität*) are often laid down in law including, for example, regulations on numbers of clients per room or square metres per child, staff ratios, staff education, coverage rates, etc. Quality standards are often subject to debates, a 'lowering of standards' being regularly suggested as a means of cost containment by social services financing bodies. In the German debate on the place guarantee for *kindergarten* children, for example, many municipalities – without success – suggested increasing group size or place-sharing to be able to offer additional kindergarten places on limited costs. On the part of providers, the welfare organisations have traditionally acted as advocates for improvements in quality standards for the clients best needs.

Another area of quality in social services is the performance in social services (*Prozessqualität*). Performance indicators show how the delivery of care by individual facilities varies, i.e. existence of a general concept of care, individual care concepts for clients, staff schedules, documentation of care, information and involvement of clients and other care persons like parents or other relatives, etc. The field of care performance has recently become a focus of attention for policy-makers in long-term care in Germany. In residential care the law on residential institutions (*Heimgesetz*) has in 2000 been reformed providing improved measures for the protection of clients in residential homes. In the field of home-care services comparable legal measures for the protection of clients are at present under discussion.

Since the introduction of the long-term care insurance, social insurance funds are responsible for securing the quality and efficiency of care and care facilities are obliged to participate in quality development. As a consequence representatives of insurance funds and care facilities have signed an agreement on principles of quality, quality assessment, and quality control (*Gemeinsame Grundsätze und Maßstäbe der Selbstverwaltung zur Qualität und Qualitätssicherung einschließlich des Verfahrens zur Durchführung von Qualitätsprüfungen*) pertaining to residential facilities, home-care services, and temporary care, and encompassing both characteristics of service infrastructures as well as performance standards. Present initiatives of the insurance funds addressing the quality of care include the development of a system of care advisors (*Pflegebeauftragte*) for individual

care facilities, advisors (*Vertrauenspersonen*) for clients of home-care services, and service hot lines for all insured persons. In addition, quality control measures are developed. Medical services or other experts may on behalf of insurance funds pay visits to individual care facilities and assess care performance and outcomes. Sanctions include cancellations of care contracts.

5 A note on the data situation

Since there is no coherent system of social service provision in Germany, the major challenge for a social service database is to map service infrastructures by target groups and integrate the various sources of information provided by the different organisations: statistical offices, national, and federal government, the welfare organisations, insurance funds, private bodies, etc.

The comprehensiveness and reliability of data differs considerably according to the fields of social services: The statistics is best developed and documented for the field of child and youth welfare. Data on day-care services, employed staff, and expenditure data are available on national as well as at federal levels. Another well-developed statistics includes national and regional data on youth social work and youth education, where information on types of measures, employed staff, and expenditure are available.

Compared to childcare services, statistics on care services for the elderly has so far remained poor. There are crude time-series data available, collected by federal governments, and published by the Ministry of Family Affairs, on types and numbers/places of homes for the elderly, with a distinction between public institutions, institutions provided by the welfare organisations, and private facilities. The statistics is, however, not very well documented, and its reliability is questionable. A database developed by the long term care insurance funds provides basic data on approved long-term care facilities and home-care services, including numbers of institutions and places in long-term care, staff numbers, as well as information on the distribution of caring charges.

The data situation on long-term care will, however, soon improve considerably. As a consequence of the introduction of the long-term care insurance, the national statistical office has developed a statistics on facilities and home-care services for the elderly, giving information on numbers and types of facilities, places/clients by type, types of providers, number and profile of employed staff, caring rates as well as basic information on clients, i.e. age, sex, and type of care.

In addition to national statistics on child and youth welfare and care for the elderly, some of the federal states collect their own statistics in the field of child and youth welfare as well as care for the elderly for the purpose of social planning. The statistics vary, however, in comprehensiveness, periodicity, and reliability. Moreover, these statistics are not harmonized and rarely comparable.

Another source of information on social services is by the welfare organisations themselves. The welfare organisations' umbrella organisation (Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege e.V.) documents the member organisations' activities quarterly. The statistics includes basic information (on type of facility, places/beds, number of staff) on the whole range of provision, including hospitals, child and youth welfare, family services, care facilities for the elderly, help for the disabled, and help for people in difficult circumstances.

Compared to services for children, youth, and the elderly, services for the disabled are less developed. There are crude statistics available on persons with disabilities, by type of disability, and type of rehabilitation measure, distinguishing between health-related, employment-related and social rehabilitation measures. The statistics deal mainly with cash benefits to clients, however. Data on facilities and social rehabilitation measures are not available from the national statistics.

There is a range of services offered by numerous volunteers in self-help groups, projects and initiatives. These groups are usually not members of the welfare organisations and they rarely show up in the statistics since they are usually active at the local level only, although they often make up important elements of local service infrastructures.

Summarizing, these examples may suffice to show that for an information system on social services, a variety of data sources of varying comprehensiveness and reliability and built for very different purposes have to be considered. One may say that German national and regional statistics cover services for children, youth, and elderly well, whereas other segments of social services especially services being provided under social assistance law, such as services for the disabled, family services, and help for people in poor social circumstances, tend to be underrepresented in national statistics.

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Social Services And Social Information Systems In Italy: Outline And Trends

Summary

This paper first of all outlines the major dimensions and historical trends of the Italian welfare system, with particular attention to the role and the dimensions of the third sector. National data is provided by the first national census of non-profit organisations which was recently completed. The article then illustrates current availability of information concerning social services, both at the national and at regional levels, basically characterised by fragmentation and a low degree of comparability. Different approaches in the organisation of informative systems are discussed. Some of the challenges facing the set up of the new national information system on social services, promoted by law n° 328/2000, are finally outlined.

1 Introduction

This paper is organised in two parts: in the first part the major dimensions and historical trends of the Italian welfare system are summarised; particular attention is given to the recent reform law n° 328 approved in the year 2000; also, the role and dimensions of the third sector are profiled, given its importance within the delivery of personal social services. In the second part, the focus will be on the state of the art of the social services information system(s), both at the national and at regional levels.

To speak of social services is to refer to a wide variety of actions in the field of social needs. The task of discussing this point, fully clarifying different meanings and making distinctions, goes beyond the purpose of these pages. Nevertheless it might be useful to shortly explain the terminology here used, making at least two distinctions:

Social services may concern *specific projects*[11] (which usually have a given time span and are often conducted on an experimental basis) or *routine activities* (with more stable, consolidated history, a more heavily bureaucratised apparatus and so on). I will refer mostly to this latter type of services.

Social care which includes the provision of *money transfers to individuals* (under the form of social pensions, care allowances and so on) and *direct personal social services* delivered by social workers. I will mostly refer to this latter type of social care.

[11] For example, there is a wide set of social projects promoted by law n° 285/98 pertaining the youths. Such projects are having a relevant impact from a number of points of view, though still hardly to quantify nationally.

2 The welfare background

In a traditionally catholic-dominated welfare system, Italy witnessed a remarkable development – during the last twenty years – in those different public and private organisations delivering social services. While religiously inspired institutions still play today a large part in the Italian welfare society, traditional catholic values have lost their hegemony. Secularisation of voluntary agencies concerned with social welfare services has gone together with increasing heterogeneity of organisational identities and behaviours.

From the time Italy became a unified state in 1861, up till the beginning of the 1920s, social intervention by the state was of very modest proportions. During this time social services were the almost exclusive domain of the Catholic Church, whose charitable structure was based on a dense network of national and local institutions of a philanthropic nature.

Such a network was mostly made by Opere Pie, now called IPAB (*Istituzioni Pubbliche di Assistenza e Beneficienza*), that is institutes run by church-affiliated organisations, and by private education: this was the majority of the nonprofit sector, taken as a whole, until the end of nineteenth century. After then - with the famous Crispi's Act of 1890, which was as a matter of fact an annexation made by the state of many social organisations and/or institutions affiliated to the church - and especially after World War II, a strong process of secularisation took place, together with the transformation of the state from a "liberal" model toward a welfare-oriented one.

Today the Italian version of welfare state seems to be quite close, at least in principle, to the systems of the other EU countries, especially when compared to the conditions of the preceding decades. The sixties and seventies were really the two decades in which the welfare state made its decisive jump, both in quantitative and qualitative terms. From the former point of view, we can see that the monetary expenditure for welfare purposes almost doubled between 1960 and the mid-eighties. In 1998 social protection expenditures, as defined by Eurostat, have reached 25.2% of GNP[12], the most part of which (16.2%) is spent on pensions (the highest proportion on EU countries).

During the seventies important reforms acts were approved: decentralising most social welfare functions and services from the state to Regions and Municipalities in 1977 (with decree n°616), establishing the national health service in 1978 (law n° 833), closing the psychiatric institutions the same year (law n° 190), just to name the most important. Despite these efforts appearing to build a more just and universalistic welfare state, it remains characterised by "clientelism" and "particularism" (Paci 1984; Ascoli 1987).

During the sixties and seventies the Italian welfare system grew with three main characteristics:

[12] According to Eurostat the mean percentage in EU is 27,6%.

Fragmentation based on municipality provision and (sometimes) regional planning;
Absence of statutory universal rights for social services and provision upon discretion;
Differentiation between the North (more developed in terms of social services and community care provisions) and the South.

For a long time, the great ambiguity of Italian policy making has concerned the conflict between centralisation and decentralisation. Local authorities have various devolved responsibilities, including the implementation of personal social services, but they are heavily dependent, financially and otherwise, on regional and central governments. The result has been a fragmented policy, dominated by a public finance often used for political interests. Against the background of a prolonged financial crisis, further uncertainties have appeared, because the necessity to cut public expenditure goes against the major political parties' interests in maintaining popular consensus and avoiding unpopular decisions.

As a general consideration we can say that most of the attention to develop a welfare system was concentrated on the development of a public apparatus, which has today assumed large proportions, literally devouring huge amounts of money. A major role is covered by non-profit institutions. Private hospitals and nursing homes were the first institutions to have been funded by the state[13].

In the year 2000 law n° 328 was finally approved, being the most important comprehensive legislation on social services. It gives an overall, national framework to social services and aims toward the building of "an integrated system of social services and activities", through the participation of State, regional and municipal institutions, and of third sector actors (Ranci Ortigosa 2000). This law states for the first time and in clear terms the roles and functions of these different actors, adopting "the method of planning activities, of operating through projects, of evaluating their quality and impact" (art. 3). It regulates relationship within the different actors, giving special emphasis to the power of the twenty Regions, especially in planning services and allocating funds. It also provides new regulation on the relationship between public and nonprofit agencies, the so called welfare mix, which has developed greatly in recent years.

New legislation has to deal with the great geographic differences existing in Italy. The basic unit of Italian local government – the *Comune* or municipality – is by far the most important supplier of social services. There are more than 8,000 *Comuni* and they differ greatly in size, political orientation, level of service provision. In particular, there are growing differences between the North, where services are comparable to northern European standards, and the South, where the basic services are often not existing or very scarce. This can be clearly seen in Table 1, which shows that social services in the South still needs consistent

[13] In 1973, with *provvedimento di classificazione* religious hospitals had the chance to decide whether or not to become fully funded by the state, thus becoming really Quangos. Today, only one fifth of all religious-managed hospitals' beds belong to such quangonized organisations.

development. The only type of services which are more widespread in the South is residential care.

Table 1 – Municipalities with over 20,000 residents which provide social services (percentages), 1997.

Services delivered:	Geographical aggregation				**Italy**
	North-west	North-east	Centre	South	
Kindergartens	95.6	83.6	78.4	63.4	77.6
Home care for the elderly	97.1	98.2	90.2	79.4	89.4
Residential care for the elderly	59.4	58.2	54.9	62.6	60.4
Day care centre for the elderly	72.3	54.5	64.7	49.6	58.7
Tele-assistance	65.4	83.6	29.4	13.7	40.9
Economic assistance	85.5	87.3	58.8	42.7	63.7
Day care for the disabled	76.6	63.6	60.8	24.4	49.8

Source: ISTAT, *Rapporto ISTAT 1999*, 2000.

A mention has to be made on the developing structure of social needs in Italy. In fact, changing demographics are bringing severe consequences for the social services system. Italy is one of the fastest ageing countries in the EU, with a large number of elderly people - in 2000 it was almost 11 million, which is 18% of the population -, and one of the lowest fertility rates in the world. Italy is the first country (in 1996) in which people aged over 65 have become more numerous than people under 15. 38% of Italian families have at least one individual over-65 years old living with them, and one fourth of all elderly people lives alone (for a total of 2.6 million). All this produces growing pressures on community care services, in a country where home care for the elderly involves no more of 5% of total target population, and in which less than 4% live in nursing homes, against EU mean percentages which are substantially higher. Many observers consider as inadequate such levels of coverage, a situation which is going to be exacerbated in the short- and especially long-term, given the ageing process of population. The ageing Italian society has also recently known heavy immigration flows, especially from North Africa and Eastern Europe. In a country where immigration was almost non-existing until the eighties, in the year 2001 immigrants have reached 2.5% of total population (which totals 57.8 million).

3 The Nonprofit sector: a profile

Nonprofit organisations play a large part in the delivery of social services. In 1997 Legislative Decree n° 460 has established a new normative profile: ONLUS, i.e. *Organizzazioni non lucrative di utilità sociale*, being nonprofit organisations with a social purpose. Registration in regional registers allows access to public funding and the benefit of some fiscal reduction in private donations.

The first national census of nonprofit organisations, completed by ISTAT, the Italian Statistical Office, in 2001, gives for the first time a comprehensive picture of the Italian nonprofit sector[14].

Table 2 – Number of nonprofit organisations, by legal status and sector of operation, 1999

	Legal status						
Sector of activity:	Legally recognized association	Foundation	Legally un-recognized association	Committee	Social cooperative	Other	Total
Culture, sport and recreation	37,102	827	97,444	2,327	476	1,557	139,733
Education and research	2,620	707	5,667	202	135	2,206	11,537
Health services	5,338	167	3,483	64	362	262	9,676
Social assistance	6,557	768	8,056	321	2,396	1,136	19,234
Environment	1,274	15	1,738	155	66	29	3,277
Economic development and social cohesion	963	82	2,281	204	692	116	4,338
Advocacy and lobbying	1,582	21	4,948	171	–	120	6,842
Philanthropy and volunteering promotion	380	147	635	59	–	25	1,246
International co-operation	420	36	847	90	10	30	1,433
Religion	1,250	207	3,090	117	–	2,138	6,802
Labour union	3,605	–	11,850	75	–	104	15,634
Other	222	31	707	48	514	138	1,660
TOTAL	61,313	3,008	140,746	3,833	4,651	7,861	221,412

Source: ISTAT, First national census of nonprofit organisations, 2001.

At the end of 1999 a total of 122,412 nonprofit organisations were operating in Italy, employing about 630,000 paid workers (first three columns in table 3), a significant figure for the national economy, given the fact that 532,000 are employees with permanent contracts and only 97,486 temporary employees or employees temporarily seconded/replaced by

[14] Definition and classification of nonprofit organisations have been made following the 1993 UN national accountability definition and the International classification of nonprofit organisations (ICNPO) developed by the Johns Hopkins University Comparative Nonprofit Sector Project (http://www.jhu.edu/~cnp).

others (see table 3). Over half (53%) of Italian nonprofit organisations are located in the North. Although more than half of all organisations, and 11% of the total non-profit workforce, fall into the sports, culture and recreation category, in the operational field of concern, i.e. social services, the largest single group of employees is involved in social assistance (this category covers 26,6% of paid work force and includes 8,6% of total organisations), followed by the health sector and education (see table 3).

Table 3 – Number and type of staff involved in nonprofit organisations, by sector of operation, 1999

	Type of staff					
Sector of activity:	Employees with permanent contracts	Personnel temporarily seconded/replaced by others	Temporary employees	Volunteers	Religious	Non-violent military objectors
Culture, sport and recreation	43,658	2,298	25,312	1,668,363	7,618	4,732
Education and research	100,782	958	17,151	113,602	14,706	860
Health services	121,389	1,650	5,768	318,894	4,715	4,948
Social assistance	146,911	2,968	15,749	491,737	21,752	10,906
Environment	2,264	37	620	85,274	28	1,059
Economic development and social cohesion	26,832	379	4,279	34,305	385	1,940
Advocacy and lobbying	10,175	1,540	1,723	208,347	862	685
Philanthropy and volunteering promotion	476	149	329	45,940	170	199
International co-operation	908	154	597	34,230	1,241	293
Religion	22,379	110	1,002	143,155	44,143	1,432
Labour union	45,425	6,884	6,966	65,616	45	550
Other	10,727	419	444	11,722	383	184
TOTAL	531,926	17,546	79,940	3,221,185	96,048	27,788

Source: ISTAT, First national census of nonprofit organisations, 2001.

Nonprofit employees in Italy account for a total of 3% of the national employed labour force, a smaller percentage in comparison with the mean of the EU countries (Salamon, Anheier 1998). Among the plentiful information available it is perhaps interesting to highlight that the majority of nonprofit agencies (87%) rely on private resources for the most or exclusive part, only 13% benefiting from public money. This is quite surprising for organisations which have been increasingly considered as dependent on public funds, and will certainly need further investigation. Furthermore, the size of organisations is in mean terms relatively small: 55% of them have a budget which is lower than 15,000 Euro per annum.

The wide variety of organisations involved in the delivery of social services can be separated into three broad categories.

Residential care, that is nursing homes, mostly religiously inspired or affiliated. This was the main way to provide social services up until the seventies. They consist of centres for the elderly, the disabled, and the young.

A consistent though decreasing part of such homes are made of IPAB (see § 2). The foundation of most of such organisations dates back to more than a century ago as IPAB. They could be regarded as Quangos (or "Quasi-autonomous non-governmental organisations"), bodies which are unelected and unaccountable[15]. They are under special controls from local authorities; but as a matter of fact they have a high degree of autonomy from statutory agencies and benefit of independent decisional powers.

The most recent ISTAT data counted 5,400 residential homes, 21.4% of which are run by IPAB, 57.5% by other private (mostly nonprofit) institutions and only 18.1% are directly managed by public authorities. The number of IPAB is decreasing: during the last twenty-five years by a third. This is due to the conversion of many services into day-care centres. In contrast to this, the number of other private organisations has increased, because in 1989 ISTAT included types of organisations not previously considered under this new category. Finally, homes managed by public local authorities (municipalities) have gone through a period of growth (they have grown from less than 10% in 1969 to their current 18%).

Some regional data substantially confirms such a picture: residential homes for long-term institutionalisation of the frail elderly in Lombardy number 482, 60% of which are IPAB, 26% are other types of private organisations and 14% are managed by public bodies. In *Veneto*, homes for the elderly number more than three hundred: IPAB are 53%, other private centres 32%, while 15% are public. Data are not very different as far as other types of clients cared for, like handicapped or minors are concerned (Facchini 2001).

Such data, which reveal the weight of the third sector within residential services, has been relatively steady in the last twenty years, differentiating itself from other European countries, such as Great Britain, where public units' share has dropped to 22% of total residential care, compared with 63% in 1970 (Knapp *et al.* 2000).

Community care. This wide organisational area consists both of professionalized agencies, having several contracts with local authorities (municipalities), and of groups made up of volunteers. This latter form is called *volontariato*, which has been widely studied in Italy (Ascoli 1999). Such informal organisations were the "new phenomenon" during the 1980s. They grew in number and developed new cultural patterns. Born of the turbulent social movements of the 1970s, these new organisations are at least supplementing church-based ideas of charity with a new altruism based on secular concepts of social justice (Pasquinelli 1992). Law n° 266/1991 regulates the activities of volunteer groups and their relationships with local authorities. Clients served are mostly elderly people and handicapped, although

[15] Cf. e.g. URL http://www.cabinet-office.gov.uk/central/1997/consult/quchap1.htm for a definition given by the British government.

such groups play an important role also in activities in favour of drug addicts, minors at risk and families with relationship problems.

The most recent research shows at least 15,000 acting volunteer groups, mostly operating in health/social services, with a total of 3.2 million volunteers involved at different levels (see table 3): two thirds of such groups were founded after 1981 according to a recent national survey (Presidenza del Consiglio dei Ministri, 2000).

Trends toward the growth of community care volunteering have begun to slow down since the mid-nineties and a new phase has emerged since then, in which some groups ceased while others have gone through deep changes. Such changes usually go towards internal professionalisation, creating a new entrepreneurial class within community care agencies, which emphasise their secularised and more market- oriented structure. In fact, until the mid-seventies only residential homes employed a substantial number of professional workers. Today community care has strongly evolved in this direction, too.

As an example, in the field of services for the handicapped, one can see the rapid increase of the Milan branch of ANFFAS (National Association of Sub-normal Adults and Youths), which in 1982 had about 30 employees, to reach over 170 in 1999; *Don Gnocchi*, an institute based in Milan but acting nationally, strongly committed in community care, is another good example, with a staff which has doubled in the same period, reaching more than 800 paid professionals. The number of clients served has increased proportionally. It is important to say that all these changes were only possible due to an increase in public funding.

Advocacy and self-help organisations have also grown over the last fifteen years. These usually are single-issue groups, especially engaged in fields such as handicaps and different pathologies, aids-affected, and drug-addictions. Widespread consumer advocacy activities are also carried out.

Little research has been conducted on this topic, but it is clear that different organisational "generations" exist. If we look for example at handicapped, we see that earlier organisations, as in other countries, were founded for the blind and deaf (before World War II), and today receive strong public support. More recently grass-roots organisations have grown (though with a very moderate degree of professionalisation). For example, *Comitato per la Difesa dei Consumatori* (Consumers' Defence Committee), founded in the mid-seventies, now has 280,000 members and has become a stable counterpart of many public bodies.

The pressure these organisations exert is often a potent force in local policy-making processes. Evidence shows that these kind of organisations give voice to wide popular dissatisfaction with traditional representative organisations (political parties and trade unions).

4 Social services information system: the national level

The building of information systems on the social services gained attention in Italy during the eighties. As a result of such an interest what we have today is a situation characterised by quite fragmented and uncoordinated regional or more local information systems, focused on the "supply side" of social services. These systems are different in the purposes (specific functions) they attain, the types of service they cover and the degree of investigation they allow.

Notwithstanding the attempt (actually aborted) made at the beginning of the nineties by the Ministry of the Interior to build a social information system through the so called Comit-Sinsa, Italy lacks a national information system on social services focused on the supply side, that is on the delivery of social services (with reference to the demand side, ISTAT provides a wide range of data).

With reference to the supply side the situation is still critical. The lack of national information system has given way to a number of regional experiences. It is nevertheless extremely complex even to compare the data gathered at the local level. This is due to two main reasons: one consists of the heterogeneous range of services provided; the other consists of the different criteria used to gather the information.

This situation is going to provide several obstacles for the setting up of a national information system, the necessity of which, for these very reasons, is becoming increasingly stronger. In other words, it is exactly to overcome current fragmentation that it seems worth to set up a national information system on social services in Italy.

Basically speaking, four types of information are collected at the national level:

a) data on *residential care* (for the elderly, for the youths), such as on the number of existing, authorised nursing homes and of "beds/places" in the different regions, the number and type of clients, and so on; this is now being completed by ISTAT for the year 1999;

b) data on *social services carried out by municipalities*, which includes information on the number and type of services, number and type of clients served, amount of expenditures. ISTAT has recently completed an experimental survey for the year 1997 and has plans to extend it;

c) data on *pensions and allowances* in favour of specific groups of people (the elderly, the disabled, poor families) are being collected by INPS, which is the National Social Insurance Institute. Italy has a quite complex system of allowances in favour of the disadvantaged. Information collected includes the number of total beneficiaries and economic flows sustained, with breakdowns by regions;

d) data on *specific projects* promoted and funded on the basis of national laws, most notably law no. 285/87, which deals with innovative social services combating child and juvenile social exclusion, involving a great number of public and non-profit agencies. To remain on this example, there is a National Observatory on such legislation which collects information provided by Regions on an annual basis.

Recent reform law on social assistance n° 328 (approved in November 2000) states that a national information system on social services has to be set up (a technical committee has just been appointed). The system should be based on the implementation, exploitation and co-ordination of the different experiences carried on at regional levels to date. It applies to different target groups (elderly, youths, disabled, etc.), different types of services (residential care, home care, day care) and should also make links between the supply and the demand side.

The technical committee will face several tasks, which can be summarised as follows: to define a mission and operational strategy for the whole system, avoiding the risk of creating a national information system and many regional ones, but integrating and managing compatibility among different levels; to identify the boundaries of the system itself, addressing several aspects and trade-offs (supply/demand, personal services/care allowances, public/private); to give uniformity to, and consolidate a terminology; to set up the architecture of the system, such as the data collection and elaboration procedures and to define who does what (State, Regions, Municipalities).

As a consequence of law n° 328/2000, a new National Plan of Social Services 2001-2003 has been approved. This assigns to the new social services information system the following tasks:

a) to verify, in each Region, the adoption of a basic provision of services (*livelli essenziali dei servizi e delle prestazioni*, art. 22), which have to be identified at national and regional levels;

b) to evaluate specific measures which have been recently introduced, in particular *Reddito minimo di inserimento*, that is the Minimum Income policy accompanied by social insertion measures (following the French experience of the *Revenu minimum d'insertion*);

c) to analyse the quality of services, their degree of adequacy in meeting social needs, also using a set of indicators which will have to be stated in specific citizens charters.

5 Social services information system: the regional level

In absence of a national, comprehensive information system, many regions have implemented their own systems, with the result of having different information with a very low degree of comparability. These regional experiences, however, have mixed objectives and limited scopes, from the geographical and sector points of view. Several regions have built up computerised records about the supply side of social services (*Regione Emilia Romagna, Regione Lombardia, Regione Piemonte, Provincia Autonoma di Bolzano* among others). Here are some examples:

- SISA, developed by Regione Emilia Romagna: it regards home care and day social services;
- SIS, developed by Regione Lombardia: focuses on handicapped, minor and elderly persons;
- CISIS-SISA, multi-regional information system, developed by Regione Piemonte; it focuses on services for children and teenagers;
- SIPSA, developed by Provincia Autonoma di Bolzano: it focuses on all intervention fields: family, children, minors, elderly, handicaps, psychic disease, immigrants, economic interventions.

Basically speaking we can trace two underlying purposes in these experiences:

1. On one hand we have information systems that basically are reporting systems on how activities are carried out by each unit, (how many clients, how many employees…) and on how money is spent. This type of information systems has the main function of supporting the decision-making process on the allocation of economic resources, year after year. Typical data collected (with limited detail) by each unit which delivers services concerns:
    - budget information
    - number and types of staff involved
    - number and types of client served
2. On the other hand we have systems with a broader and more ambitious, "encyclopaedic" approach, aiming not only to support decision-making but also to evaluate services' performance and quality. These try to give a wider picture of activities and try to evaluate the supply side of social responsibilities. Typical data collected (with rich detail) concerns:
    - organisational structure of each unit
    - number and characteristics of employees
    - number and characteristics of clients served
    - type of activities carried out
    - financial flows

These two approaches may be seen as the two poles of a *continuum*. Many experiences are now moving towards one or the other. Both approaches have positive and negative aspects. These deal with the kind of information they reach, the economic and organisational costs they have, their capability to support the policy process, and their reliability, among others. Pure reporting systems are more up to date and less costly, but do not help in evaluating the performance of services, as the information collected is insufficient. Furthermore, their limited information on clients does not allow to make any link between the demand and supply sides. Multi-dimensional information (encyclopaedic) systems are more costly, consuming more organisational resources, are complex and take longer to build, and paradoxically the Italian experience shows that information collected within this approach is often under-utilised.

On our way towards a national system, the distance between these two approaches will have to be reduced together with the setting up of national standards for a comparable set of information. The need to evaluate the performance of social services gets stronger in order to give answers to questions regarding the attainment of quality standards and clients' satisfaction. Also, the need to take policy decisions which are evidence-based gets stronger. This requires stricter accountability systems enabling a pragmatic discussion on which efforts are worth pursuing.

6 Concluding remarks

The setting up of an integrated information system on social services will be a difficult task. At the same time, the way towards a national information system seems to be very interesting in this period of transition for the Italian social service system. Three basic questions *inter alia* have to be addressed, and this can also be of interest from a European point of view, as such questions cross national borders. I will pose them in interrogative terms:

To report or to evaluate? (i.e.: which assumptions do we undertake?) The national system has to identify its mission, directing its architecture towards one or the other of the alternatives outlined in § 5.?. Experience tells us that information systems with just a reporting function (which is generally related to the function of allocating resources) present several limitations in terms of supporting more generally the social policy process. To develop the *evaluative* side of informative systems (analysis on how services perform) has to go with the task of rendering them more compatible from an economic and organisational point of view. It is a big, but fascinating, challenge.

How to collect data? The architecture of the system is a crucial point to get good quality data. Such data will have to be collected at a local level, so there is a relationship, an "information balance" between central and local government which has to be studied. In this respect, Italians do not have a good track record in the collection of data and this is particularly true within social services: poor quality data and delays in their collection are very frequent in regional experiences and suggest to pay particular attention to how the different actors involved are motivated in the process, and which kind of input/output they are interested in. The idea to link information systems with the allocating of funds process may have important advantages, as the regional experiences tell us, but is also exposed to the risk of information distortions.

What do we mean by…? In different Regions the same services are referred to in different ways. There are sometimes problems in "speaking the same language" and the need for uniformity still exists. To define the who, the what and the how of a national information system it will be necessary to use one terminology, as a pre-requisite to collect comparable data.

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Social Services in Sweden

1 Social services in Sweden

1.1 Responsibilities of local authorities

Social services performed by local authorities, i.e. the municipalities, play a key role in Swedish welfare policy. The overall aims for all operations within social services can be found in Section 1 of the Swedish Social Services Act (*socialtjänstlagen*) (SoL). This states that social services are to be aimed at liberating and developing the innate resources of individuals and groups while also taking into consideration the responsibility of the individual for his or her own social situation and that of others. Meeting the *individual* rather than general needs of socially and financially weak groups makes social service interventions an important complement to the general financial support systems. Social services also meets the service and care needs of larger groups, particularly with respect to care of older people and disabled people.

1.2 Social services' areas of activity

Social services in Sweden given by the municipalities comprise two main areas; *individual and family care* and *nursing and care of older people and disabled people*. Since 1997 child care has been the responsibility of the school system and is no longer part of social services. Municipal refugee reception work spans several areas of activity and is integrated into the work of social services.

1.2.1 Individual and family care

The aim of social services' individual and family care service is to support, help and protect vulnerable groups in society by various means. This includes individually targeted interventions for children, families, alcohol and drug misusers and individuals with psychosocial problems who need advice, support and motivation, care, treatment, financial assistance (social security benefits) and financial advice, family counselling and family law services.

Individual and family care also includes certain interventions which may be carried out without the consent of the individual, i.e. compulsory. Such action is backed by the Care of Young Persons (Special Provisions) Act (*lagen med särskilda bestämmelser om vård av unga*) (LVU) and the Care of Abusers (Special Provisions) Act (*lagen om vård av missbrukare i vissa fall*) (LVM).

There is also a responsibility to take part in social planning, preventive work and general interventions for various groups, as well as being responsible for emergency social work provision.

1.2.2 Nursing and care of older people and disabled people

Municipal nursing and care of older people and disabled people is regulated by the Social Services Act (SoL), the Health and Medical Services Act (*hälso- och sjukvårdslagen*) (HSL) and the Act Concerning Support and Service for Persons with Certain Functional Impairments (*lagen om stöd och service till vissa funktionshindrade*) (LSS).

According to SoL, municipalities must set up special forms of accommodation for the service and care of older persons in need of particular support. These special forms of accommodation for service and care include those previously known as old people's homes, service flats for older people, sheltered housing (supervised shared residential accommodation) and the nursing homes which were transferred to local authority control from the county councils in conjunction with the reforms in the care of the elderly, "*Ädelreformen*" of 1992. Municipalities must also set up special forms of accommodation – homes with special services – for people who for physical, mental or other reasons "encounter serious difficulties in their everyday lives" and who therefore need such housing.

The municipalities are responsible for health care (excluding medical treatment) and for simple technical aids in special forms of accommodation and daytime activities. The municipalities can also, on agreement with the relevant county council, take over responsibility for home nursing in a person's ordinary accommodation. At the beginning of 1999 just over half of the municipalities nationwide had taken over responsibility for home nursing. A significant proportion of care in the final stages of life, care of those with dementia and after-care and rehabilitation is also in the hands of the municipalities.

1.3 Social services under constant reform

Several major reforms of local authority-run social services and other related activities were carried out during the 1990s. These have resulted in new areas of responsibility for municipalities, as well as placing increased responsibility on the citizens who live or stay in the municipality.

Certain changes made in 1998 to the Entitlement to Assistance section (Section 6) of the Social Services Act are particularly central, concerning as they do the *right* to assistance. A "*national norm"* was created for a number of items to be covered by social assistance, and *individual assessment* of a number of additional expenses, previously part of the National Board of Health and Welfare standard, was introduced. The target level for what is to be considered reasonable housing costs has been lowered. Housing benefit is now decided locally in relation to what a person on a low income can normally afford in that area. Finally,

the opportunity to lodge an administrative appeal regarding certain types of assistance was removed.

A new section (Section 7a) sets out requirements that measures within social services are to be of high quality and that personnel with suitable training and experience are to be available. The quality of the activities must be systematically and continuously developed and assured.

A new provision was also introduced on support for those caring for a close relative who has a long-term illness or is old or disabled. This means that relief is offered to a caring relative by either a professional carer, who would take over for a limited time in the client´s own home, or by a trip outside the home for the client. This adds to the financial support to the caring relative already existing in the form that he/she could be employed by the municipality in certain cases.

1.4 The scope of social services

Every year a large number of people of various ages and with various needs receive help through social services. The intervention which affects most people (almost 8% of the population in 1998) is social assistance. Home help services and special accommodation also covers many people, see table 1.

Table 1 – Number of people in the population covered by particular social serviceinterventions as of 1 November 1998.

Intervention	People
Social assistance[1)]	692 000
Home help in ordinary accommodation[2)]	126 000
Special accommodation[3)]	119 000
Services to persons with functional impairments[4)]	51 000
Care of adult misusers of drugs or alcohol	20 000
Care of children and young people[5)]	16 000

[1)] Some time during 1998.

[2)] People aged 65+.

[3)] Accommodation for old/disabled linked with various types of services (such as help with dressing, cleaning, cooking, shopping and medical care given by nurses) for which an extra amount has to be paid.

[4)] Act concerning Support and Service for Certain Persons with Functional Impairments (LSS).

[5)] Includes both residential and foster care (the latter in so-called family homes).

1.4.1 Social services cost SEK 107 billion in 1998

Social services' costs increased considerably during the 1990s. The primary reason is that the municipalities were given wider responsibility and more duties in the care of older people and disabled people. The municipalities' total costs for social services in 1998 amounted to

around SEK 107 billion, 5% up on the previous year. Nationally the cost was equivalent to SEK 12 100 per inhabitant per year.

Just over three quarters of the costs, SEK 83 billion, went on *nursing and care of older people and disabled people*, an increase of around 5.5% on 1997. These costs are to a certain extent (less than 10%) financed by charges. These include the charges which clients pay for nursing and care plus rent for special accommodation. Costs per *inhabitant* for activities in 1998 amounted to SEK 9 400, see table 2.

Table 2 – Cost of social services, education and child care inthe municipalities, 1998. Total and per inhabitant.

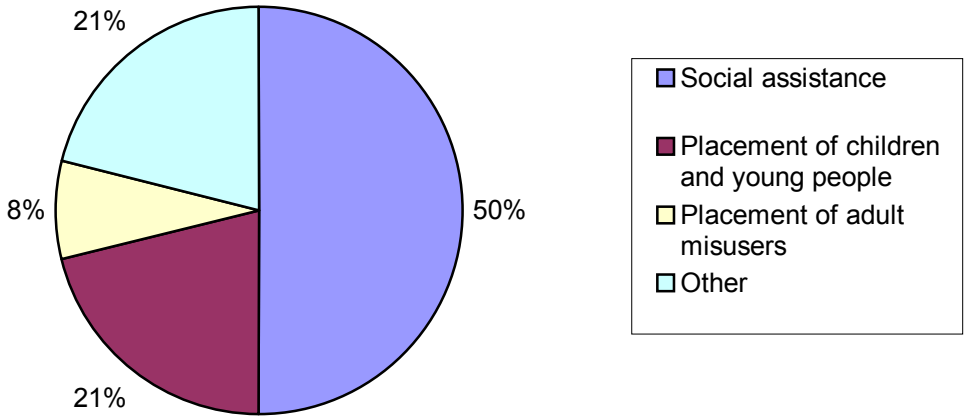
Intervention	Total SEK million	Per inhabitant SEK
Individual and family care	24 060	2 700
of which social assistance	*12 029*	*1 400*
Care of older people and disabled people	83 338	9 400
Social services total	**107 399**	**12 100**
Education[1)]	87 791	9 900
Child care	39 543	4 500

[1)] Covers compulsory school, approximately for the ages 6/7-16, and the high school level (in Swedish "gymnasieskola"), approximately for the ages 17-19/20).

The cost of *individual and family care* for 1998 stood at SEK 24 billion, 3% more than the previous year. This figure includes social assistance for refugees and introduction benefit paid to refugees in conjunction with drawing up an “integration plan”. These costs are covered to a large degree by state grants to the municipality.

Social assistance constituted half the costs of the individual and family care service for 1998, see diagram 1. The majority of the entry “Other” is taken up by non-residential interventions for children and young people and out-patient interventions for adult misusers of alcohol and drugs.

Diagram 1. Allocation of costs in individual and family care, 1998. Percentage



1.4.2 Cost development 1995 – 1998

The cost of care of older people and disabled people has increased at relatively the same rate as individual and family care during the latter part of the 1990s, as shown in table 3 which shows costs at current prices.

Table 3 – Cost[1)] of care of older people anddisabled people and individual and family care,1995 – 1998. SEK billion.

Year	Costs, SEK billion	
	Older and disabled people	Individuals and families[2)]
1995	68	20
1996	77	22
1997	79	23
1998	83	24

[1)] Current prices.

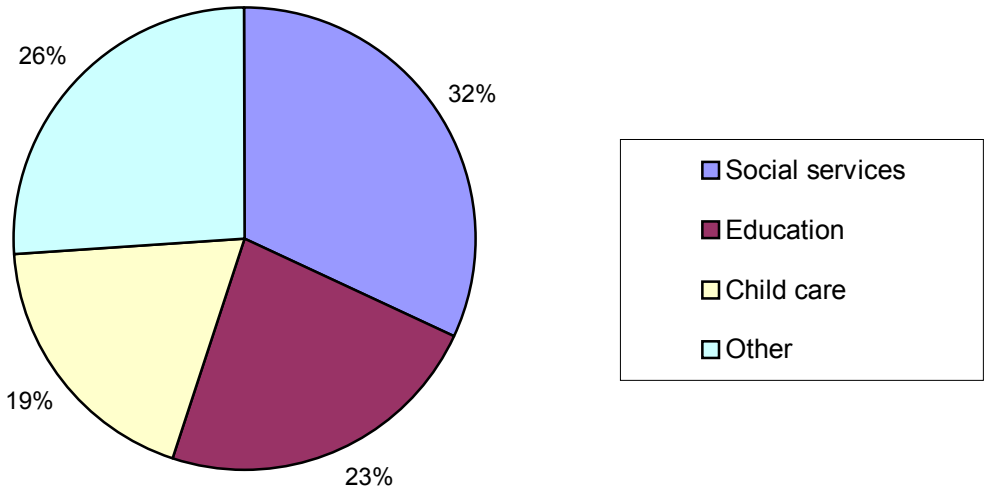
[2)] Excl. social security benefits and expenditure on integration benefit for refugees.

1.4.3 One third of municipal staff work in social services

In terms of staff, social services is the largest sector in the municipalities with a total of 188 000 full-time equivalent employees in 1998, equivalent to 22 full-time employees per

1 000 inhabitants in the municipalities. The vast majority, over 90%, worked in care of older people and disabled people. The rest were involved in individual and family care.

Diagram 2. Proportion of full-time equivalent employees in various local authority areas of activity, 1998. Percentage



Staff in social services are predominantly women across all the staff groups. In 1998 nine out of ten staff were women. However, a comparison with 1997 shows that the proportion of men increased by 5% against an increase of 1% for women.

1.4.4 Care sector sees increase in private sector employees

The number of employees, both *public (municipal and district authorities)* and *private (for-profit organisations, intermediary organisations, voluntary organisations and self-help groups)*, in sectors which come under the banner of social services increased by over 10% in the period 1995 – 1998, from a total of 175 000 employees to almost 200 000. In 1998 the vast majority were working in the public sector, see table 4. The largest *relative* increase was seen in activities under private management. For example between 1995 and 1998 the number of private sector employees in “care and service for residents in their own homes” increased by a huge 146%.

Table 4 – Number of employees in certain sectors of social services, by body responsible. 1995 and 1998.

Sector	Body responsible	1995	1998	Change %
Care and service for residents in special accommodation	Total	87 800	101 500	16
	of which private	5 600	8 800	57
Care and service for residents in their own homes	Total	45 000	51 400	14
	of which private	3 200	7 900	146
Special interventions for the mentally-handicapped, etc. in sheltered housing	Total	29 500	31 300	6
	of which private	1 900	2 100	11
Care and treatment in homes for care or residence, children/young people and adult misusers	Total	12 700	12 600	-1
	of which private	2 700	3 500	30

1.5 Alternative operational forms

Alternative operational forms in social services have become more common. However, the municipalities are still responsible for supplying services, which are financed through public funding. However, the activity or service may be carried out by others. The increase in alternative operational forms was greatest in the first part of the 1990s, but the proportion of clients cared for in alternative forms continued to increase between 1995 and 1997 in areas such as care of older people. Table 5 shows the proportion of users in certain activities run in alternative operational forms in 1997.

Table 5 – Proportion of clients cared for in alternative operational forms, i.e. other than run by the municipality. 1997. Percentage.

Activity	Proportion of clients %
Care of older people and disabled people	
Home help/nursing in ordinary accommodation	4
Nursing/care in special accommodation	11
Individual and family care	
Care of drug misusers, of which	44
– in structured non-residential care	*32*
– in sheltered housing	*23*
– in voluntary institutional care	*68*

The number of people receiving home help/nursing in ordinary accommodation or in their own homes has fallen over a number of years. This has led to the municipalities turning to the private sector to a lesser extent. Alternative operational forms in individual and family care principally concern care of those with an alcohol or drug problem and placements of children and young people in care. Almost a quarter of activities are run in alternative forms. In care of those with an alcohol or drug problem the proportion of interventions carried out under private management was estimated at just over 40%. Alternative operational forms are most common in institutional care. Just over two thirds of institutional care for children and young people is under private management.

1.5.1 Competition tested in social services

During the 1990s new needs, target groups and requirements placed on municipalities, as well as financial restraints, have resulted in attempts to find new ways of working. This has been particularly true for social services. One way of finding new solutions is to adapt the activity to market conditions and introduce various forms of purchasing/sales systems. This has meant financial responsibility being decentralised and becoming capable of being monitored within the various activities of the municipality, but also that certain areas, traditionally run by the municipality, have been opened up to competition. This has increasingly brought productivity and efficiency to the fore.

1.6 Co-operation and joint responsibility

Many problems and needs of social services' clients cannot be solved without close co-operation with the other local authority bodies or authorities involved, such as the child care sector, schools, the national insurance office, the employment service, the health service or the prison and probation service. This is necessary to find practically viable solutions for individual clients or for groups of people with specific needs. This is also the case for overall

aims such as ensuring that the activities of social services work efficiently with the available resources.

1.6.1 Major input from relatives

Many older people and people with long-term illnesses are cared for by a relative or close friend. This may involve everything from social support, supervision and practical help with housework to extensive help with personal care and in certain cases tasks of a nursing nature. The care work carried out by relatives is often overlooked and carries a responsibility which is often lonely and both physically and mentally demanding. When it comes to those in most need of help, relatives account for double the help given by the public care system.

1.6.2 Voluntary organisations increasingly significant

Input from the voluntary sector is playing an increasingly important role as the need for interventions increases, the public sector is decentralised and finances are limited. Pressure has increased on the voluntary sector and on “the civil society” to take on more responsibility for social issues. The voluntary sector can offer alternatives and complements to and replacements for public sector social services. This applies in both social services and health care and takes in everything from befriending and support initiatives to more comprehensive care and treatment activities.

2 Child care in Sweden

2.1 Legislation on child care

According to the Education Act, municipalities are obliged to provide child care in the form of pre-school activity and school child care for children aged between 1 and 12 to the extent required for parents to be able to work or study or if the child is in need of this activity.

The municipalities have a special responsibility for children in need of special support for their development. These children are to be offered a place at a pre-school or leisure-time centre unless their needs can be met in some other way.

Quality requirements are also detailed in the act. They describe the conditions that are to exist in order to meet children's needs for care and good educational activity. Requirements are made regarding group composition and size, the premises and staff. The act also stipulates that the municipalities can provide grants for private pre-school activity and school child care provided that the activity meets the requirements made in the act for quality and if the fees are not unreasonably high.

The provisions on childcare were included in the Social Services Act until 1997 but were transferred on 1 January 1998 to the Education Act. At the same time, the new type of schooling *the pre-school class* was introduced. The municipalities' earlier obligation to offer all children pre-school for at least 525 hours from the autumn term in the year of the child's sixth birthday was replaced by an obligation to provide a place in a pre-school class.

2.2 Organisation

The concept *child care* does not appear in the Education Act but is usually used as a general term for pre-school activity, activities which in turn include a number of activities.

Pre-school activity is intended for children who do not attend school and is carried out in the form of *pre-school*, *family day-care home* and *open pre-school*.

- The *pre-school* provides educational group activity for the children enrolled whose parents are working or studying or if the child is in need of the activity. Opening hours vary depending on the parents' working hours.
- In the *family day-care home,* a family childminder looks after children that are enrolled, usually in their own home, while their parents are working or studying. The opening hours are adapted to the parents' working hours.
- The *open pre-school* is intended for parents at home with their children. Together with the staff, parents are given an opportunity to develop educational group activity for children. The children are not enrolled. At many places, the family day-care homes have access to the activity of the open pre-school.

School child care is intended for children who attend school and is carried out in the form of *leisure-time centre*, *family day-care home* and *open leisure-time activity*.

- The *leisure-time centre* is an educational group activity during the school-free part of the day and year for schoolchildren up to twelve years of age. It can be carried out as a completely independent activity but is often integrated with school to a varying extent.
- The *family day-care home* also receives schoolchildren (see above).
- *Open leisure-time activity* is an alternative to activity that requires enrolment primarily for children aged between 10 and 12. It also serves as a complement for the schoolchildren who are in the family day-care homes. The children are not enrolled.

2.3 Expansion

Child care has been expanded very rapidly in Sweden. Between 1970 and 1997, the number of children in day-care homes, leisure-time centres and family day-care homes – activities offering full-day care – increased from just over 71 000 to 723 000, more than a tenfold increase. This can be compared to the fact that the number of children in the age of 1-5 years in Sweden actually decreased during the same period; from 589 000 to 552 000. Expansion was particularly great during the 1990s. In 1995, the municipalities' responsibility for child care was increased by an obligation being placed on them to provide a place to the children who needed it. Together with the high birth rate, the amendment to the law led to a record number of new child care places being created between 1994 and 1996.

During the last few years, the number of children has fallen slightly. The number of places substantially covers demand and falling birth rates have started to have an effect. In 1999, a total of 720 100 children were enrolled in some form of child care.

Table 6 – The number of children enrolled in different types of child care in Sweden and the proportion of enrolled as a percentage of all children in the population, 15 October, 1999[1)]

	Enrolled children, per age-group				Enrolled children, prop. of all in resp. age-group			
Activity Principal organiser	No. 1-5 yrs	No. 6-9 yrs	No. 10-12 yrs or older	Total 1-12 yrs	% 1-5 yrs	% 6-9 yrs	% 10-12 yrs or older	% 1-12 yrs
Child care, total	368 968	326 815	24 292	720 075	74.9	66.0	7.0	53.9
municipal	320 003	304 778	22 141	646 922	65.0	61.5	6.4	48.4
private	48 965	22 037	2 151	73 153	9.9	4.5	0.6	5.5
of which								
Pre-school activity	367 715	4 259	.	371 974	74.6	0.9	.	27.8
municipal	318 917	3 102	.	322 019	64.7	0.6	.	24.1
private	48 798	1 157	.	49 955	9.9	0.2	.	3.7
of which								
School child care	1 253	322 556	24 292	348 101	0.3	65.1	7.0	26.0
municipal	1 086	301 676	22 141	324 903	0.2	60.9	6.4	24.3
private	167	20 880	2 151	23 198	0.0	4.2	0.6	1.7
Pre-school activity:								
Pre-school	314 363	4 259	.	318 622	63.8	0.9	.	23.8
Family day-care home	53 352	.	.	53 352	10.8	.	.	.
School child care:								
Leisure-time centre	1 253	307 879	23 036	332 168	0.3	62.2	6.6	24.9
Family day-care home	.	14 677	1 256	15 933	.	3.0	0.4	1.2

[1)] Due to non-enrolment data for open pre-school and open leisure-time activity cannot be made available.

2.4 Pre-school activity

A total of 372 000 children were enrolled in some form of pre-school activity in 1999 (all children in the pre-school and children aged up to five years old in family day-care homes). This can be compared with 399 200 enrolled children in 1998. This reduction is mainly due to falling birth rates, but also because six-year-olds leave pre-school to attend pre-school class instead. The number of 1–5 year olds in the population fell from 519 600 to 493 000 children or by five per cent between 1998 and 1999. At the same time, the number of six-year-olds enrolled in pre-school dropped from almost 18 000 to just under 4 000.

The reduction in the number of children enrolled in pre-school activity is not corresponded to by any reduction in the proportion of children enrolled. This has instead increased in each age group. The proportion of children aged between 1 and 5 enrolled in pre-schools and family day-care homes increased from 73 to 75 per cent between 1998 and 1999. The proportion of those enrolled is higher among older children than younger. For instance, in 1999 about 84 to 85 per cent of all 4 and 5 year olds were enrolled in pre-school activity and over 40 per cent of all one-year-olds.

Pre-school is the predominant form of pre-school activity. In October 1999 there were 318 900 children enrolled in municipal-financed pre-school, compared with 337 900 the year before. Despite the number of enrolled children having fallen, the proportion of children enrolled has increased. In all, 64 per cent of all children aged between 1 and 5 in pre-school in 1999 compared with 61 per cent in 1998. The proportion of children enrolled has increased in all age groups (1–5 years). In 1999, 36 per cent of all one-year olds attended pre-school, 64 and 68 per cent respectively of two and three year olds and 73 and 74 per cent of all four and five year olds.

The number of pre-school children in *family day-care homes* peaked at the end of the 1980s and has thereafter fallen practically every year. In 1994, 86 800 children aged between 1 and 5 were enrolled compared with 53 400 in 1999. Between 1998 and 1999, the number of children enrolled decreased by almost 8 000 or by 13 per cent. The proportion of 1-5 year olds in family day-care homes of all children in the age group was 11 per cent in 1999, a reduction since 1998 of one percentage point. The reduction was about equally large in all age groups. Among all one-year-olds, 7 per cent were enrolled in family day-care homes in 1999. The corresponding proportion of children aged from two to five was between 11 and 12 per cent.

The number of *open pre-schools* decreased throughout the 1990s. At the beginning of the decade, there were over 1 600 open pre-schools, in October 1999 just over half this number (869). Between 1998 and 1999 alone, the number fell by six per cent. Opening hours vary. In 1999, 384 were open for over 16 hours a week. Since the children are not enrolled, no information is available on the number of children taking part.

2.5 School child care

In all, 348 100 children were enrolled in some form of school child care in 1999 (all children in leisure-time centres and 6–12-year-olds in family day-care homes). This is an increase since 1998 when the number was 321 700. The proportion of enrolled 6–9-year olds has increased from 60 to 65 per cent of the age group between the two years, while the proportion of 10-12 year olds enrolled has remained unchanged (7%).

Leisure-time centres is the type of child care that has increased most during the 1990s. In 1999, there were 332 200 enrolled in leisure-time centres, an increase of 10 per cent since 1998 and more than three times as many as in 1990. This increase has been particularly large in recent years. This is mainly related to the fact that more and more six-year-olds attend leisure-time centres. In 1994, 22 per cent of six-year-olds were enrolled compared with 68 per cent in 1999. However, the proportion of children enrolled has increased in other age groups as well. For instance, the proportion of eight-year-olds in leisure-time centres increased from 46 to 64 per cent between the two years.

The number of school children attending *family day-care homes* reached a peak at the end of the 1980s and has thereafter continuously declined. In 1998, there were 20 700 children

aged between 6 and 12 in family day-care homes and in 1999, the number had fallen to 15 900 enrolled children. The majority are aged between 6 and 9.

According to the Education Act, school child care for children aged between 10 and 12 can also be organised in the form of *open leisure-time activity*. This is an alternative to activity requiring enrolment (i.e. leisure-time centres and family day-care homes) for children in this age group. In 1999, 60 municipalities in Sweden (21 per cent) had open leisure-time activity. In all, there were 405 departments and three-quarters of these were open for more than 16 hours/week. According to the National Agency for Education's parent survey in autumn 1999,

approximately 5 per cent of 10–12-year-olds took part in this activity.

The year's information on open leisure-time activities is the first collected about the activity through national statistics. Data has been previously collected in various follow-up studies. For instance, the National Agency for Education showed in 1998 that only a quarter of the municipalities had open activity intended for 10–12-year-olds. According to the National Board of Health and Welfare, the corresponding proportion was 30 per cent in 1996. According to the follow-ups, the authorities had not surveyed the need for open activity to any great degree in 1998 or in 1996.

2.6 Privately-run activity

Privately-run child care has become more common in the 1990s. Altogether, there were 73 200 children in private pre-schools, family day-care homes and leisure-time centres in 1999, compared with 61 300 children in 1998. It was above all pre-schools that were under private management. In 1999, 15 per cent of the children enrolled in pre-school attended a private pre-school, compared with 13 per cent in 1998. Almost half of these children (45%) attended a parental co-operative. About seven per cent of the leisure-time centre children attended a private (for-profit) leisure-time centre (a provision based on subcontracts with the municipalities) and five per cent of the children a family day-care home. In both cases, this was an increase of two percentage points since 1998.

Private child care is most common in metropolitan areas and suburban municipalities. 73 of Sweden's 289 municipalities had no private pre-schools at all in 1999.

2.7 Mother tongue support

In 1999, 39 700 children aged between 1–5 years who were enrolled in pre-school and family day-care homes had a different mother tongue than Swedish. Of these only 13 per cent received mother tongue support. This is a reduction since the previous year when the proportion was 15 per cent. Compared with 1990, it is a very large reduction. In that year, 57 per cent of children with another mother tongue than Swedish received additional tuition in their mother tongue at pre-school.

2.8 Staff

In 1999, there were 102 500 supervisors and employees working with children at pre-schools and leisure-time centres and just under 12 500 family childminders. Altogether this is a reduction compared with the previous year of three per cent. There were 985 employees in the open pre-schools in 1999, which is the first year that information about the number of employees has been recorded.

The number of employees calculated as annual, full-time equivalent, employees was 59 300 in 1999 in pre-school and 18 700 in leisure-time centres. This can be compared with the previous year when there were 59 900 annual employees in pre-school and 19 000 in leisure-time centres.

One of the strategies for making savings used by the municipalities has been to reduce staffing numbers. The number of children per annual employee has increased throughout the 1990s. At the pre-school, however, the number of children per annual employee has reduced slightly during the past year, from 5.6 children per annual employee in 1998 to 5.4 in 1999. Since 1990, when there were 4.4 children per annual employee at day-care homes, the number of children per annual employee has increased by 25 per cent.

There has been a large reduction concerning the staff at leisure-time centres in the last decade. In 1999, there were on average 17.8 children per annual employee compared with 15.5 children the previous year. Since 1990, the number of children per annual employee has more than doubled (8.3 children 1990).

2.9 Expenditure

Gross expenditure by the municipalities on child care as a whole totalled SEK 39.7 billion, which is as much as in 1998 in fixed prices. Pre-school accounts for two-thirds of the expenditure (SEK 26.1 billion), leisure-time centres for just over a fifth (SEK 8.5 billion) and family day-care home for an eighth (SEK 4.6 billion). The open activities – open pre-school and open leisure-time activity for 10–12-year-olds – account together for one per cent of the total expenditure (SEK 0.4 billion).

2.10 Charges

An increased proportion of the gross expenditure on child care is financed by parental charges. In 1999, approximately 18 per cent of the costs for municipal child care were met by parental charges. In the early 1990s, this proportion was around 10 per cent. The extent of charge financing is highest at the leisure-time centres. Parental charges there account for 24 per cent of the gross expenditure, compared with 16 per cent at pre-school.

3 The Social Care of the Elderly in Sweden

3.1 Legislation on the care and nursing of older people

3.1.1 The Social Services Act

Under the Social Services Act (SoL) the municipalities are obliged to provide service, help and care for older people. Home-help services, daytime activities or other similar social services are to assist the individual to live at home and have contact with other people. The municipality is to set up special forms of accommodation for service and nursing of older people in need of special support. These forms of accommodation include service flats, old people's homes, sheltered housing (supervised, shared residential accommodation) and nursing homes. The municipalities are to plan their interventions for older people hand in hand with the county councils, and other bodies and organisations in the community.

3.1.2 The Health and Medical Services Act

The municipalities' responsibility for health care and medical services is regulated in the Health and Medical Services Act (HSL). The municipalities and county councils have a mutual responsibility for rehabilitation and providing technical aid, and for ensuring the availability of staff to provide good care. The municipalities must also appoint a medically responsible nurse and co-ordinate care interventions with the county councils, community organisations and private bodies.

3.2 Organisation of care for older people

Care and nursing of older people is largely determined by the individual municipality on the basis of framework legislation such as SoL and HSL and current financial and policy instruments. Political responsibility for care of older people in the municipalities is currently run by committees, which go under a wide range of titles.

The major change in care of older people came in 1992, when the municipalities gained total responsibility for long-term service and care of older and disabled people. The purpose of the reform was to create responsibilities and better organisational and financial conditions for realising the goals for care of older people laid down by the Swedish Parliament. The reform passed responsibility for running health and nursing care in the special forms of accommodation and in daytime activities to the municipalities. The municipalities also gained responsibility for providing simple technical aid. Each municipality is to have a medically responsible nurse. Local authority-run health and nursing care is to be headed by social welfare committees or equivalent.

Responsibility for health care and medical services can be expanded to cover home nursing if the municipality and the county council so agree. In 2000 just over half of Sweden's municipalities had taken over responsibility for home nursing. With the help of state grants

special forms of accommodation have been expanded in municipalities, including sheltered housing.

Another major change in the way care of older people is organised is that divided administration is becoming increasingly common. Here the exercising of authority – e.g. *investigating and assessing needs for assistance* – is distinguished from the responsibility for *implementing the decisions* – e.g. helping older people with cleaning and washing. In 1999 over half of the country's social services departments had implemented this change. Another clear trend in the 1990s is that care of older people has become open to competitive tender. The purpose is partly to reduce the costs of care of older people and partly to be able to offer alternatives to the care provided by the municipalities.

3.3 Social service interventions for older people

3.3.1 Home-help service

The home-help service (under the Social Services Act) facilitates the day to day life of older people in their own homes, enabling them to stay in their own homes. Examples of services provided include cleaning and washing, help with shopping, visiting the post office and bank and preparing meals. Personal care can cover help with eating and drinking, getting dressed and moving, personal hygiene and breaking social isolation.

More than 125 000 old-age pensioners (65+) living in ordinary accommodation were granted home-help service on 1 October 2000. They constitute 8% of that age group in Sweden. Some 70% of those who were granted home-help service were women.

More than 7% of the elderly who received home-help service got it from a private (for-profit) care provider.

In Table 1 the figures per 1 000 are relatively low for those in the highest age groups. This is because many people aged 80+ live in nursing homes, old people's homes, sheltered housing or other special accommodation.

Table 7 – Number of people living in ordinary accommodationwho were granted home-help service on 1 October 2000.

Age	Men	Women	Total	Per 1 000
65-74	7 058	10 418	17 476	24
75-79	7 310	14 468	21 778	64
80-84	9 669	23 596	33 265	134
85-89	8 419	24 324	32 743	234
90+	4 611	15 451	20 062	308
Total	**37 067**	**88 257**	**125 324**	**82**

Women received home-help service to a greater extent than men in the year 2000, both in absolute and relative terms. This applied in all age groups over 65. The explanation is primarily that there are considerably more women in the higher age groups and that they tend to be more likely than men to be living alone in ordinary accommodation.

3.3.2 Help hours are allocated to those in the greatest need

Fewer and fewer people have received home-help service under the framework of social services in the 1990s and interventions have increasingly been concentrated on the oldest of all and those in most need of help.

Reduced care provision for older people both in absolute and relative terms is due to an increasing problem in financing activities. Municipalities are now testing various strategies for managing the situation, including making needs-testing more stringent. This means that the need for help must be more pronounced than before to obtain home-help service.

The reduction in home-help service appears to have taken place without alternatives to public sector services having been developed to take their place. People are increasingly being recommended to buy services on the market or to manage without help of the society. The consequence may be relatives having to take an increased responsibility. Studies which have attempted to shed light on the consequences of a reduction in help interventions have so far not indicated any major groups of older people who are faring badly.

The need for personal care and supervision has increased among those receiving home-help service. This means, for example, that an increased percentage of those receiving the service are suffering from dementia, which in turn makes the work of home-help staff more physically and mentally demanding. The gradual shift towards more and more health care interventions in the home brings with it a corresponding demand for increased nursing skills.

3.3.3 Special forms of accommodation

About 121 000 old age pensioners lived permanently in *special forms of accommodation* on 1 October 2000, i.e. service flats, old people's homes, sheltered housing and nursing homes. This figure corresponds to 8% of the population in the age group 65 + years. Women

accounted for 70% of these residents. The proportion of women in such accommodation increases with age. This is partly because women live longer than men.

Table 8 – Number of people living in special forms of accommodation on 1 October 2000.

Age	Men	Women	Total	Per 1 000
65-74	5 123	5 747	10 870	15
75-79	6 346	10 372	16 718	49
80-84	8 934	19 346	28 280	114
85-89	9 277	25 524	34 801	249
90+	6 590	24 046	30 636	470
Total	**36 270**	**85 035**	**121 305**	**79**

The statistics for 2000 also show that private care providers managed the housing for more than 11% of the elderly who lived permanently in special housing.

3.4 Home-nursing and short-term care

Almost 45 000 people aged 65+ received medical care ("home-nursing") in their own homes performed by some half the number of municipalities at some point in 2000. This corresponded to 3% of this age group in the population.

On 1 October 2000 approximately 9 800 people were in short-term care. Here short-term care refers to needs-tested support in the form of temporary accommodation combined with treatment, rehabilitation and care to provide a respite for the normal carer/relative and as short-term in-patient care.

3.5 Daytime activities

Daytime activities are needs-tested support in the form of treatment and rehabilitation during the day for people e.g. with senile dementia, mental disability or those otherwise with a need for treatment and rehabilitation.

Daytime activities take many different forms. All municipalities have day centres, often in the same building as service flats or other forms of accommodation for older people. Activities often involve simple occupations and socialising. The scope of the content of daytime activities is vast, covering everything from “meeting points” where anyone can attend to a form of specialised care and treatment which takes place in the daytime and is part of a rehabilitation programme.

Around 15 000 people aged 65+ received needs-tested daytime activities on 1 October 2000. Most of these were living in ordinary accommodation. At average there were 8 visits at day-centres per person during October 2000.

3.6 Interventions by relatives and close friends

It is difficult to calculate the scope of the work carried out by relatives. Social services statistics only report those relatives who are employed by the municipality and the number of people who receive payment for looking after a relative. The work of relatives is often hidden, without financial compensation or support from the home-help service or primary care. The extent of help given by relatives to older people living at home is likely more than double that of that given by society. In most cases the carer is a husband/wife. Friends and relatives outside the household mostly give help of a practical nature, e.g. shopping and washing, while the municipality tends to be responsible for personal care, e.g. dressing and undressing and using the WC.

3.6.1 Relatives and friends employed by the municipality

Of those older and functionally disabled people who on 31 December 1997 had been granted social home-help service and/or were receiving home-nursing, 3 300 people (or 2%) received help from friends or relatives who were employed by the municipality as a care assistant or equivalent.

3.6.2 Grants to relatives and close friends

On 1 November 1998 about 6 400 people aged 65+ received financial compensation from the municipality in the form of grants to pay a relative/close friend for help in the home.

3.7 Staff

In November 1998 approximately 250 000 people were employed by the municipalities to care for older people and disabled people, see table 3. Over half, 51%, of the staff worked part-time and 23% full time. The remainder, just over 25%, were casual staff employed by the hour.

Table 9 – Employees and full-time equivalent workers employed in the care of older people and disabled people, November 1998. Rounded figures.

Staff category	Employees	of which part-time	Full-time equivalent workers
Care supervisors	8 200	6 500	7 600
Nursing assistants, orderlies, care assistants	147 300	26 900	97 100
Enrolled nurses, auxiliary nurses	57 500	14 600	42 100
Registered nurses	11 600	3 800	8 400
Other care and nursing	25 500	5 900	17 300
Total	**250 100**	**57 600**	**172 600**

The statistics *do not* include staff employed in private businesses from which the municipalities buy services for the care of older people and disabled people.

The number of full-time equivalent staff in local authority-run care of older people and disabled people has increased only marginally, barely 1% in the period 1995 – 1998.

3.8 Costs

The municipalities' costs for care and nursing of older people in 1998 are estimated to amount to just over SEK 60 billion according to information in the summarised local authority accounts, see table 4. The largest item is care and nursing in *special accommodation*, over SEK 43 billion. Care and nursing in *ordinary accommodation* cost SEK 15 billion. Added to this are the costs of preventive work. This item, which also includes work for disabled people amounted to over SEK 2 billion in 1998.

In total the cost of care and nursing of older people in 1998 accounted for around 56% of total social services spending.

The cost of care and nursing of older people and disabled people in 1998 was around SEK 82.6 billion. Care of older people accounted for approximately 73% of this figure.

Table 10 – Costs to the municipality of care and nursing of older people by area, 1998. SEK million.

Area	SEK million
Care and nursing under SoL and HSL	
in ordinary accommodation	15 029
in special accommodation 43 376	43 376
Preventive work 1)	2 114
Total	60 519

[1]) A certain amount of the costs refers to activities for disabled people.

3.8.1 Charges and fee scales imposed by the municipality

For older people in *ordinary accommodation* most municipalities apply a system where the charge varies according to both income and the scope of the intervention. In 1997 little more than one in ten municipalities had a fee scale which only depended on the intervention.

For older people in *special accommodation* on the other hand it was most common for charges to be set according to income, irrespective of care needs. This may be because older people in special accommodation are judged to have more similar care needs. Currently those in special accommodation now pay separate charges for accommodation, meals, services and nursing in just over half of Sweden's municipalities. A combination of intervention and income-related charges were applied in a third of the municipalities.

The majority of municipalities used a fee scale for *home-help services* based on levels of care. In most cases the charge increased in line with the extent of the care given. Almost a fifth based charges both on hours of care and the level of care. Very few municipalities based charges solely on the number of hours of care given.

3.9 Development of care for older people

In the 1990s care for older people in Sweden has undergone major changes. This trend is characterised partly by a *gradually reduced level of service* and partly by a strong focus primarily on *helping the oldest of all and those most in need of help.* This in turn has meant that interventions of a nursing nature are taking on an increasingly dominant role in the care of older people.

Increased charges are also becoming more common, partly as a form of funding but also as a way of reducing demand for services provided by the municipality. Some people are actively referred to the private market to have their needs for service met.

The 1990s also saw *responsibility for care of older people shifted*. Responsibility has moved from society to the individual, from the county council to the municipality, from central level to local level.

New providers of care and nursing for older people have also come into being and others have had to increase their interventions compared with previously. This concerns private carers, relatives and volunteers. The older person's own home has become an arena for increasingly wide-ranging care and nursing.

A major task for the municipalities and society as a whole is *meeting the need for staff* for local authority-run care and nursing of older people. The increase in the oldest of all in the population brings with it a considerable need to recruit new staff.

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