Changing care policies in Europe

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CHANGING CARE POLICIES IN EUROPE....1

1. Executive Summary

There are several changes taking place in care services in Europe. Many national policy changes in financing and delivery of social care services have been triggered by the perceived view that the increasing size of the older population will cause an expansion in demand for social care services for older people. Although services are still funded by taxation in many countries, some countries have introduced new systems of long term care insurance and co-payments.

There has been a transfer of services from the public sector to the private and voluntary sectors although municipal and local state authorities remain responsible for commissioning and purchasing social care services. There has also been a decline in the number of care homes in many countries with a corresponding rise in home care services. The trend is for people to remain in their own homes for as long as possible. This is also contributing to the development of the "assisted living" concept where companies or public-private partnerships build residential developments, which also provide some care services.

A new type of funding provision involves the government giving money directly to service users so that they can purchase services to meet their own care needs individually. The impact of these arrangements on the care workforce is only just beginning to be understood. There are some indications that individually purchased care in some countries leads to increased insecurity for care workers in both employment and income. In a few countries it is leading to an increased professionalisation of care work. The impact of individual purchasing of care services will have to be monitored in future.

National care markets are dominated by a small group of large companies as well as many smaller companies running small scale care homes and homes care services. Markets are fragmented although some consolidation is taking place. To what extent this process of national consolidation will lead to regional consolidation is unclear. Multinational company presence in the social care sector is still relatively limited.

The development of childcare services is slightly different to social care services. Childcare provision is closely linked to employment policies, which are trying to expand the participation of women and single parents into the labour force. Government support for childcare is through direct service provision in some countries but through private and voluntary provision in others. The move towards integrating childcare services with education services in several countries is helping to improve the status of childcare workers.

Private provision of childcare services is done through small and medium sized companies mostly operating at regional or national levels. Multinational company activity in childcare is still relatively small.

In countries of Central and Eastern Europe, the development of a social care model of provision is relatively new. Much care for older people or people who are chronically ill, still takes place in institutions. There are often long waiting lists for the care homes that exist. In several countries, acute care beds are used for long term care for older people. These institutions are publicly owned and still publicly run. The beds are funded usually by state or local government funding.

There are also signs that a new social care system is being introduced in several countries that will be less controlled by the public sector. This is being driven partly by policy changes following health sector reform but also by a shortage of different types of social care for older people.

Multinational company presence in the social care sector is still relatively limited. This means that there are relatively few companies that operate in more than one country in Europe. The companies that are technically eligible for a European Works Council are: Attendo, Bridgepoint Capital, BUPA, Carema, Medidep and Orpea.

2. Introduction

In 1997, EPSU commissioned a report from the Public Sector Privatisation Research Unit (PSPRU) on the Care Sector, which provided an important analysis of developments in the care sector in Europe, including multinational expansion and sectoral employment data. Since 1997, there have been some changes in ownership of companies providing services for older people in residential settings. There have also been changes in social welfare policies in many European countries, which are influencing the development of private sector provision, particularly homecare services. Changes in policy towards employment and childcare are stimulating the expansion of private provision of childcare services in several countries. This paper presents changes in policy at national and European level and how they are influencing the development of national and European care markets.

Aims

- To analyse private sector participation in the social care sector including care for older people, homecare and childcare

Objectives

- To present an overview of the trends in the overall care sector including care provided for older people, homecare and childcare
- To outline national organisational and funding arrangements for social care in Europe
- To provide a European policy overview of the three sub-sectors
- To identify and outline major national companies involved in the care sector
- To profile key multinational companies active in the care for older people, homecare and childcare including data on numbers employed, subsidiaries and profits

2.1. Definitions used in this paper

There are several types of social care for older people in developed countries: care provided at home; in residential homes; and care provided in specific types of sheltered housing. Home care consists of different types of support, for example, cleaning, bathing, dressing of wounds, and shopping, that enable an older person to continue to live in their own home. Social care provided in residential homes is for older people who can no longer live alone and need some combination of nursing and social care. Increasingly new residential schemes are being built by private and in some cases public-private partnerships that provide accommodation for older people and access to centralised care support when needed. Social care workers may work in residential homes or provide care to older people at home or in sheltered housing schemes. They may be employed directly by the public sector, usually a local authority or municipality but increasingly they are employed, either directly or self-employed, by the private or non-profit sectors.

Childcare services are delivered through childcare centres, nursery schools, pre- and after-school centres and family households. In countries where there is a greater public sector or non-governmental provision, workers are directly employed in childcare centres, nursery schools and pre- and after-school centre. In countries, often where childcare is provided predominantly by the private sector, for example, the United Kingdom, many childcare workers are employed by the private sector. Childminders, babysitters and nannies are three major categories of child care workers that are employed directly by a household or family or are self-employed. They take care of children either in their own homes or those of their children. Baby sitters are paid on an hourly basis and do a range of activities. Nannies, are often full time, sometimes live with the family and provide a range of services from childcare to housework.

2.2. Methodologies

The material for this paper has been drawn from research reports on care and care workers. Academic databases have been used to identify published research. There have been several large research programmes in Europe, funded by the European Union, that have been examining both social care for older people and childcare. The results of these research programmes provide important new material that help to understand how care work is changing and how care workers are being affected.

Industry wide analyses, company annual reports and other company materials have been used to understand multinational company strategies. Reports from international and national agencies, policy documents and trade union surveys of working conditions have also been used to provide a global view of care policies. Other sources that have been consulted include national newspapers, trade union reports, and non-governmental research. The country profiles of the European Observatory on Health Systems and Policies have provided national analysis of social care arrangements. A study conducted by the European Foundation for the Study of Living and Working Conditions into the future of social public services in Europe also provided a series of national perspectives in relation to both workers and users of services (Appendix 1).

3. Trends in care provided for older people, homecare and childcare

There are several trends in care services identifiable in Europe. Countries in Western Europe have a longer history of using a social model of care but countries in Eastern and Central Europe are beginning to adopt this following health sector reform.

The perceived view that the increasing size of the older population will cause an expansion in demand for social care services for older people has triggered many national policy changes in financing and delivery of social care services. Although services are still funded by taxation in several countries, other countries have introduced new systems of insurance of long term care and co-payments.

There has been a transfer of services from the public sector to the private and voluntary sectors although municipal and local state authorities remain responsible for commissioning and purchasing social care services. There has also been a decline in the number of care homes in many countries with a corresponding rise in home care services. The trend is for people to remain in their own homes for as long as possible. This is also contributing to the development of the "assisted living" concept where companies or public-private partnerships build residential developments that also provide some care services.

A new type of funding provision involves the government giving money directly to service users so that they can purchase their own care needs individually. The impact of these arrangements on the care workforce is only just beginning to be understood but it can lead to employment and income insecurity for care workers.

National care markets are dominated by a small group of large companies with many smaller companies running small scale care homes and homes care services. Markets are still described as fragmented although some consolidation is taking place. To what extent this process of national consolidation will lead to regional consolidation is unclear. Multinational company presence in the social care sector is still relatively limited.

The development of childcare services is slightly different to social care services. Childcare provision is closely linked to employment policies, which are trying to expand the participation of women and single parents into the labour force. Government support for childcare is through direct service provision in some countries but through private and voluntary provision in others. The move towards integrating childcare services with education services in several countries is helping to improve the status of childcare workers.

Private provision of childcare services is done through small and medium sized companies mostly operating at regional or national levels. Multinational company activity in childcare is still relatively small.

These trends will be discussed in more detail in the following sections.

4. National organisational and funding arrangements for social care in Europe

In Western European countries, there have been extensive changes in the way in which social care is provided and funded over the last 20 years. Almost all countries have introduced new legislation to reform social care for older people as well as services for people with mental health problems and physical and learning disabilities.

The impact of these new systems of funding and financing of social care vary in different European countries according to the welfare state system already in place, although there are some common features that emerge in an analysis of social care in Western Europe. These are:

- Changing role of government in social care
- Increasing provision by the private sector even when funded by the public sector;
- Decreasing direct provision by municipal authorities;
- Benefits / payments for people to purchase their own social care services;
- Carers allowances;
- User fees;
- Regulation issues.

4.1. Changing role of government in social care

Government involvement in social care occurs in several forms: funding for care services, which are delivered directly to a person in their own home or in a residential home; payments to informal carers, known as a 'carer's allowance'; funding directly to people needing care, who can then purchase services from local social care agencies. The government role in the direct provision of social care is declining in many countries and the provision of social care services, even when funded by the public sector, is increasingly provided by the private and non-profit sector.

In the UK, the Community Care Act (1992) promoted subcontracting from local authorities to private providers by separating local authority purchasing and provider functions. Initially, this led to an expansion of the private social care residential sector and a transfer of provision from local authorities to private residential homes. Between 1997 and 2002, the percentage of beds in local authority staffed homes fell from 24% to 14%. The overall number of people in either local authority, private or non-profit staffed residential or nursing care home rose from 236,335 in 1997 to 259,490 in 2002. There has also been a transfer of home care services from local authority to private or non-profit sector. The number of contact hours of home care provided directly by local authorities has fallen by 30% between 1997 and 2002. Another trend in home care is that the number of households receiving home care has actually fallen between 1997 and 2002 although the number of contact hours that each household received has increased. This can be interpreted as a targeting of home care services to the most dependent. In Section 5.2 these changes will be discussed in relation to users of services.

In Sweden, full responsibility for long term nursing care was transferred from the county councils to municipalities in 1992. These reforms, known as the ADEL reforms, have led in a similar way to an expansion of private sector provision with the contracting out of long-term care facilities, home-care services, meal and transport services. The total number of nursing home beds has declined since 1992. In 1992, there were about 32,000 beds but following the ADEL reform these beds were transferred to the social care sector and the municipalities[1] with some transfer of beds from the public sector to the private and non-profit sectors. A Finnish trade union (KTV) survey in Sweden found that privatization has been introduced through competitive tendering, by turning public operations into joint-stock companies owned by local

authorities, and by use of the 'service voucher' model. This has also led to some contracting out of home care services to the private sector.[2]

The introduction of market principles to the public social care sector has resulted in many home care services becoming "*business units*", and having to compete with the private sector.[3] Care services in municipalities have also been redefined as "*care products*". Methods for "*measuring and securing the quality of care*" have been introduced which have been drawn from the private sector and the manufacturing sector.[4] This is illustrated by the case of Denmark, where the delivery of services has been influenced by changes in national policies for older people. Nursing home residents were given the right to choose which services they take up, so nursing homes were obliged to define the services that they provided and their cost.[5]

Changes in the healthcare sector have also led to national social care policy changes because of the mutual dependence of these sectors. The attempts to limit the number of older people in acute hospital beds in some countries, for example the United Kingdom and Sweden, has created a new category of 'intermediate' care which is often a mix of social and medical care for older people who have recently been in hospital. Both the UK and Sweden have placed the responsibility for providing these beds on municipal authorities. Since 2003, local authorities in England are penalised if they are unable to provide appropriate care and accommodation through the Community Care (Delayed Discharge) Act.[6] This has led to local authorities changing both the organization of social care and the way it is priced. They have become more dependent on service provision from profit and non-profit providers. It has also created new opportunities to charge for care services. In 1992/3, 72% of local authorities were charging for home care services. This proportion had increased to 94% by 2000.[7] The rate charged for home care service varies between local authorities. There is no standard national home care charge.

In Denmark, changes in the home help services have taken place since the late 1970s, characterised by the introduction of 24 hour care which involved both home help workers and home nurses.[8] As this arrangement became more established, home help workers moved from working from their own homes, to becoming part of a "*semi-autonomous group*" where a group of home help workers operated as a team, divided work up and sorted out problems themselves. The municipalities in charge of these teams presented this as a form of empowerment for home care workers. However, new national legislation, which was designed to eliminate the black market in domestic services, allocates subsidies for home service or housekeeping activities.[9] Private firms, with as few as two people, can register to receive these subsidies. Anyone can hire a home service firm to do cleaning or shopping. The person receiving a service pays an hourly rate and the government also pays the service provider. In this way, the government is effectively subsidizing the expansion of private sector involvement in the home care sector. The expansion of home care services is also related to the new systems where money is paid directly to service users so that they can purchase their own personal care services (see Section 5.2). The proposed Services Directive could potentially affect the expansion of home care services (see Section 6.1).

4.2. Decreasing direct provision by municipal authorities

Social care services have traditionally been delivered at local level often by municipal authorities. The introduction of the internal market and the contracting of services by municipalities are influencing the way in which services are organised and delivered.

In many countries, municipalities remain responsible for the commissioning and planning of social care services but have relinquished direct provision of services. In the Nordic countries (Sweden, Finland, Norway and Denmark) and the UK, Italy and Spain, municipalities remain responsible for social care services although the provision of care has been transferred to the private, non-profit sector in varying degrees. In several other countries, the local state, regional or county authorities still have responsibility for commissioning and purchasing but not for provision. Many of these arrangements reflect attempts by central government to place the responsibility for controlling expenditure to local level.

4.3. Cash payments to users to purchase own services

Many of these policy changes have emphasised consumer choice and the concept of the service user as a "purchaser". Older people and people with disabilities, in some countries, are being given cash benefits which means money from public funding to purchase the services that they require. Austria, Germany, France, Belgium, Spain, Greece, UK, Denmark and Finland have introduced these types of arrangements for people needing care. Norway, Sweden, Netherlands and Portugal do not have this provision.

There has been an expansion of home care in many countries where systems of social care funding have changed. With an increase in individually assessed care packages, there is a rising demand for care services delivered at home. In the UK, the Community Care Direct Payment Act has led to increased home care provision. To enable people to purchase their own social care services, the services had to be costed and priced, which contributed to the process of commodifying social care services.

At the same time there has also been an increase in medical care services, for example, cancer treatments and renal dialysis that can be delivered at home. Trained nurses and other specialised health workers deliver these services. Although they are not going to be considered in this paper, it is important to be aware of this parallel development of medical home care services for the private sector because it will affect the future of homecare services and the future of homecare workers. Increasingly skills will be needed to provide medical care, which will be delivered along with social care.

Homes care services are being purchased from care providers, who may be self-employed individual care workers, voluntary services that provide social care, or commercial care service providers. In countries where only the basic costs of care are provided by government, any extra costs have to be covered by the individual, leading to the introduction of user fees.

The availability of cash for care work can also stimulate the expansion of non-regulated, unskilled, untrained and undocumented labour. This new type of care worker, is often not covered by social rights and employment regulation. Ungerson (2003) [10] writing about the impact of carers allowances to families in Italy, found that of those who employed a care worker, all had employed workers without rights of residence who lived locally. Of the care workers interviewed, only one care worker had residence rights in Italy.

The payment of care subsidies has also facilitated the employment of undocumented foreign care workers in Austria to such an extent that agencies have been set up to organise it. [11] Migrant workers are recruited as temporary labour in Austria, by recruitment agencies operating in Hungary and Slovakia. Older people often employ two care workers, one to provide 24-hour care for 2 weeks and the second to provide similar 24-hour care for the following two weeks. The care workers live with the older person who they are caring for. This enables care workers to maintain work in one country as well as returning to their home countries regularly.

More positively, in some countries where older people can purchase services themselves; this has led to the creation of new professional categories, which is beginning to influence the status of care work. In Germany, where a new professional category of social care worker was created at the same time as care insurance was introduced, there has been an expansion of registered care workers.[12]

In some countries, a more structured and regulated care worker labour market develops when private and non-governmental agencies provide care services. Care users access these care providers through agencies. In France, Ungerson (2003) [13] found that care workers were engaged in "*multiple care relationships*," often visiting up to 13 clients a day. Many had a basic qualification, which had provided them with access to training and an ability to reflect on their work. This made them aware of the boundaries and some of the contradictions between the different tasks that they undertook. They were involved in a wide range of tasks, including cooking and shopping. The significance of these care workers being able to reflect on their work and what it means for their clients may be important for the future development as care work as an occupation. [14]

In Austria, where care allowances are paid directly to people needing care, a major voluntary organization, Caritas, has become involved as an employer of the care worker/giver who may be a relative. In this way,

the relative can access social security rights, holiday pay, and a contract of employment. In many cases it also raises the self-esteem of the care worker who had often moved from informal caring within the family to being paid for care work.

4.4. Carers

The rights of carers have often been recognised for the first time in new social care legislation, for example, the United Kingdom, Ireland, Germany. Many social care systems depend on unpaid carers in the family to provide different levels of care, from a few hours a week to full time care to older relatives. The majority of carers are women. In many Southern European countries the family has been assumed to provide care for older people. The increasing participation of women in the labour market is making this continued provision of family care more difficult.

The UK introduced "attendance allowances" as payment for carers who previously would have provided unpaid, informal care. Jensen (2002) considered that the introduction of care allowance programmes was determined more by the aim of allowing older people to remain independent rather than the goals of valuing informal caring. [15] Ireland has also introduced a Carer's Allowance.

4.5. Financing

The underlying reason for many of the changes in social welfare policy in the last 15 years has been a perceived need to reduce the cost of public sector provision. In some countries, new systems of long term care insurance have been introduced as a way of covering the costs of care. In Germany, a Long-term Care Insurance Law was introduced in 1994, which introduced universal insurance to cover the costs of long-term care but not accommodation costs. Until 1994, six welfare organisations ran the majority of care homes but this has now dropped to 50% because of competition from the private sector. Following the new legislation introducing long term insurance, private companies were given subsidies to build new facilities but subsidies for non-governmental organizations were reduced.[16]

In the Netherlands the Exceptional Medical Expenses Act is a contribution financed health insurance system that supports the provision of home care, day care and nursing homes for older people and people with disabilities. This new funding arrangement has led to a growing professionalisation of care workers.

Some countries still retain a tax based system that covers all care expenses but this is becoming increasingly rare. Italy and Spain still have basic benefits funded by the state. Many countries have means tested benefits for either home and / or nursing home care. In France, the 2001 Personal Dependency Allowance is means tested and adjusted to the level of dependence of the individual. Long term care residential costs are also means tested. Other countries that use some form of means testing are the UK, which assesses on both income and assets, and Portugal.

Co-payments have also been introduced as a way of reducing public expenditure on social care. These can be seen in countries where home care has expanded, for example, Norway and Finland. Both Belgium and the Netherlands, which have social insurance schemes for social care, also have user fees. Germany's new insurance scheme for long-term care, also involves user fees because the insurance provision does not cover all ways in which care is delivered.

Funding arrangements often influence the development and prosperity of the private sector. The impact of policies may be felt in relation to systems of payment for long-term care or home care services. If services are 100% paid for by the public sector, whether or not they are provided by that sector, there is scope for the expansion of private sector provision but it will be increasingly dependent on government policy and regulation. Changes in UK regulation of residential homes in the 1990s and the setting up of minimum standards, particularly room size, had an immediate impact on the expansion of the residential sector. This resulted in the closure of many smaller companies.

4.6. Central and Eastern Europe

In countries of Central and Eastern Europe, the development of a social care model of provision is relatively new. Much care for older people or people who are chronically ill still takes place in institutions. There are often long waiting lists for the care homes that exist. In several countries, acute care beds are used for long term care for older people. These institutions are publicly owned and still publicly run. These beds are funded usually by state or local government funding.

There are also signs that a new social care system is being introduced in several countries that will be less controlled by the public sector. This is being driven partly by policy changes following health sector reform but also be a shortage of social care for ageing populations.

The policy changes that will underpin the expansion of social care are being introduced slowly. Estonia is working towards a reduced and restructured institutional care and an *"open care"* system. This involves decentralisation of provision to local administrations with the development of local networks of social services that encourage people to care for themselves. The market for local social services is still small and unevenly developed so that the private sector has little interest in becoming involved. Non-profit organisations that use volunteers are becoming the main providers of home based social care.[17]

In 2003, Ukraine introduced new legislation "*About social services*" which recommends funding from user fees and from state and local budgets as well a enterprises, charitable funds and individuals. This has yet to be implemented.

The lack of adequate social care provision is leading to the increased involvement of the non-governmental sector and to a certain extent the private sector. New social care services are mainly focused on home care provision although there is some small-scale institutional provision. In Hungary, 24% of social care services are provided by the non-governmental sector, the largest percentage in countries of Central and Eastern Europe so far. There has also been some NGO expansion in Poland, Lithuania, and Romania. Non-governmental agencies provide 14% of places in older people's homes in Lithuania. In Latvia several private clinics in Riga have started to set up geriatric wards. These are only available to those able to pay.

In the Czech Republic, long term care institutions were opened to public competition in 1997. At the same time there was an expansion of private home care agencies. In Croatia, private home care agencies have been set up. These are often owned by a nurse or physiotherapist and employ doctors, nurses, social workers and nursing auxiliaries, which suggests that a combination of primary health care and social care are being delivered.

The demand for social care services, whether in institutions or at home, is expanding in almost all countries of Central and Eastern Europe. This is already placed increasing pressure on existing services. At the moment, financing of existing institutions and other services is largely from state or local authority budgets, for example, Hungary, Slovenia, Romania, Poland, and Estonia.

Social care reforms generally follow health sector reforms but financing mechanisms are often linked, especially in relation to health insurance funding and the introduction of co-payments. In Slovakia, health insurance companies finance nursing and rehabilitation care. Community care is financed through a combination of co-payments and the state budget. In Lithuania, co-payments contribute 30% of the costs for older people's services. In Latvia, nursing home care is financed partly through co-payments with state and municipal funding.

4.7. Childcare

The sectors providing childcare vary from country and are influenced by the arrangements for financing and supporting childcare. In Nordic countries, there is a large public sector provision. Parents pay some

contribution to fees but this is dependent on income. In Spain there is an extensive private for profit provision where parents pay fees directly.

Table 1: Childcare provision and funding

Country	Childcare funding	Majority provision
Denmark	Publicly funded	Public sector
Sweden	Publicly funded	Public sector
Finland	Publicly funded	Public sector
Norway	Publicly funded	Public sector
United Kingdom	Public/private funding	Private sector
Hungary	Public funding	Public sector
France	Public funding	Public sector
Spain	Some public funding but mainly parental fees	Private sector

Source: Cameron et al, 2003; Rostgaard, 2003

Thirty one per cent of children aged under 3 in Sweden were cared for in full or part time non-relative care in regulated family day care homes and 26.6% were cared for in public day centres. Private day care has only started to expand since 1990 and is still relatively small. Both family care homes and day care homes are subsidised and regulated. Responsibility has been moved down to municipal levels. The rationale given was to respond more to regional needs although cost cutting was also involved. As a result some municipal contracts were privatised.[18]

In the UK, there is a large private childcare sector, which has been encouraged by government childcare policies. Between 1997 and 2002, the number of children in childcare services increased by 547,000. Most of this increase in provision was through the expansion of private sector provision, sometimes supported by new business start-ups in disadvantaged areas.[19] The Education Act (2002) also allows schools to set up childcare and out of school activities.

Services for children under school age have been another area of expansion. By 2003, 99% of three year olds were receiving early years education, with 88% in publicly funded places.[20] Although 88% were in publicly funded places, 57% of three year olds were in places provided by private and non-profit providers. There has also been an expansion of nursery place by private providers.

Childcare and pre-school care is increasingly being characterised as having both caring and educational components, which is also influencing whether childcare policy is considered as part of educational or welfare policy. During the last decade there have been examples of governments moving responsibility from welfare/health departments to education departments, for example, Sweden, England. These departmental changes have implications for how the services are organised and delivered and the way in which care workers are trained and paid.[21]

5. The impact of policy changes on workers and users of services

5.1. Care workers

The proportion of care workers as a percentage of the total workforce varies from country to country. Nordic countries have relatively high levels with Denmark (10%), Sweden (9%) and the Netherlands (7%). In the UK, care workers form 5% of the workforce with lower levels in Spain and Hungary (3%). The majority of care workers in any country are women, often 90%.[22] In the UK, women make up 90% of the care workforce, which is based mostly in the independent/private sector.

There is an increasing demand for all types of care workers. A growing number of workers are recruited from abroad because of a shortage of workers willing to work within the care sector. Only in Denmark, where there is a 'core' pedagogy worker, is there a growing interest in this type of care occupation. [23]

Gender plays an important role in defining care with the majority of care workers being women. Men are being encouraged to enter care work for both children and older people although the percentage of male care workers is still small in all countries. Denmark has the highest proportion (14%) of male child care workers but the majority of men work in out-of-schools services rather than services for children from 0-3 years. [24] In many countries, the majority of social care workers are aged over 40. This has implications for the provision of social care in the long term.

Migrant labour, which is often insecure in terms of visa or residency status, is becoming a growing part of the care labour force. Migrant women are increasingly providing care services in childcare and care of older people as part of a global transfer of female labour from low to higher income countries. Debates about the gendered welfare state and crisis of care have not addressed the role of migrant women in the provision of care services. [25] [26] As an example of how care companies are recruiting migrant workers, in 2004, Bupa Care Homes said it hoped to recruit 50 carers from Poland, and was seeking staff from the Czech Republic, Estonia and Lithuania, which were about to become EU members. [27]

A recent report 'Forced Labour and Migration to the UK'[28] examined the residential care sector as one of four sectors (construction, agriculture/horticulture and contract cleaning) in which there are highly exploitative labour conditions, including forced labour. Care work in the UK is described as involving "*many different kinds of work – including nursing, laundry services, catering and cleaning – and is conducted under many different types of contractual relationships*". The sector is becoming consolidated but there are still many small operators. The report argues that "*The relationships between the large and small operators, and their different degrees of market power vis-a vis the buyers of goods and services, helps explain the range of labour conditions*". The full cost of operating a good quality care home is between £75 and £85 higher than average fees paid by local authorities. [29] Only larger care home owners can operate profitably.

Income/ pay

Both the social care and childcare sector are characterised by low pay in many countries but there are some variations between countries. Care workers in Denmark and Sweden have higher pay and status than in other countries in Europe. However, a trade union survey found that in Sweden after privatisation, wages for women in caring, nursing, cleaning and food preparation have either remained unchanged or declined. Pensions, holiday pay and other benefits also declined or become more restricted following privatisation. [30]

In other countries, where allowances are paid directly to informal carers, middle-aged women are able to enter the labour force by joining a social security scheme. However the extent of their incorporation into the labour force is often limited to being part of a small sub-section of the labour market characterised by insecurity and low pay. [31]

The recruitment of migrant labour can also result in a form of exploitation in relation to skilled labour, which devalues the skills of migrant workers who have trained as nurses abroad. In the UK *"both private homes and NHS trusts may obtain work permits to employ nurses, but nurses who have received their training abroad are usually subject to a probationary period to "upgrade" on the job, during which they are paid as care assistants*". Once they have completed this adaptation, which usually takes 3-6 months they can register with the Nursing and Midwifery Council, have to right to practice as nurses and be paid on the nursing pay scale. The employer is responsible for declaring that the nurses have completed their "adaptation" but "*there is a financial incentive for the home to delay registration, continuing to pay on a lower scale"*. Nurses have often borrowed money to travel to the UK and being paid at a lower rate restricts their ability to repay the loan. [32]

Employers of childcare workers, such as babysitters and nannies, do not always pay statutory contributions. Workers in residential care homes for older people and home care workers, where there is a high turnover of workers, have temporary or part time jobs, and have limited entitlements to other benefits. Migrant workers working in social care are not always integrated into the social security system. The lack of formal integration into the social security system will affect the long-term income of these workers. Even if part time or temporary workers are paid the same hourly rates as permanent staff, they are often not eligible for the same holidays, sick pay or pensions. This also has important implications for the long-term income of the women workers. [33]

Terms and conditions of employment

Contracts within the sector are often short term and part time for social care and childcare workers. Those working within the public sector are likely to have contracts ensuring more stability. For example, both social care and child care workers in Denmark or Sweden, have better terms and conditions of employment. In the UK, there is a trend towards casual work in the care sector to ensure 24 hour, 7 day a week cover, especially among large providers.
"*Care assistants rank as one of the lowest paid jobs in the UK…Living-in is a solution to the 24 hour-demands of care work, and live-in care workers are particularly prone to working excessive hours*" This makes care workers vulnerable to owners of care homes, dependent on them for accommodation, telephone and other facilities. [34]

The availability of cash for care work can also stimulate the expansion of non-regulated, unskilled, untrained and undocumented labour. This new type of care worker, is often not covered by social rights and employment regulation. Ungerson (2003) writing about the impact of carers allowances to families in Italy, found that of those who employed a care worker, all had employed workers without rights of residence who lived locally. Of the care workers interviewed, only one care worker had residence rights in Italy. [35]

In Austria, where care allowances are also paid directly to people needing care, a major voluntary organization, Caritas, has become involved, as an employer of the care worker/giver. In this way, the relative can access social security rights, holiday pay, and a contract of employment. In many cases it also raises the self-esteem of the care worker who had often moved from informal caring within the family to being paid for care work.

The payment of care subsidies to care workers has facilitated the employment of undocumented foreign care workers in Austria to such an extent that agencies have been set up to organise it. [36] Migrant workers are recruited as temporary labour by recruitment agencies operating in Hungary and Slovakia. Older people often employ two care workers, one to provide 24-hour care for 2 weeks and the second to provide similar 24-hour care for the following two weeks. The migrant care workers live with the older person who they are caring for. This enables care workers to maintain work in one country as well as returning to their home countries regularly.

Childcare workers in publicly run childcare centres are often more secure in their jobs than those providing childcare as self employed or through private companies. Lack of employment security is most often found in child care workers operating from their own homes or the homes of the children they care for.

Hours of work

Childcare and social care workers work long hours. In many countries, where care workers operate in private homes, there is a lack of supervised health and safety standards, with much lifting involved in the care of older people and increasingly young children. There is increased pressure to complete tasks quickly with resulting health and safety risks. Care work is considered to be mentally and physically stressful.

A Labour Force Survey in the UK found that 10% of social care workers, which includes social and probation workers, had a work limiting disability, which is above average for women workers. [37] In addition, 7% of child care workers had a work limiting disability.

Care work as a career

The impact of social welfare policy changes, particularly the introduction of direct payments made to those needing care is affecting the organization and status of care workers. There are some significant variations from country to country in Europe. [38] These can be seen in terms of how care work is developing as a career. Perceptions of care work as a worthwhile career can also develop from a more micro-level in seeing how workers are able to influence their daily work and achieve satisfaction with work tasks.

In countries where older people can purchase services themselves, the creation of new professional categories is beginning to influence the status of care work. In Germany, where a new professional category of social care worker was created at the same time as care insurance was introduced, there has been an expansion of registered care workers. [39] In the Netherlands, a similar process is taking place.

In some countries, a more structured and regulated care worker labour market develops when private and non-governmental agencies provide care services. Care users access these care providers through agencies. In France, Ungerson (2003) found that care workers were engaged in "*multiple care relationships,*" often visiting up to 13 clients a day. Many had a basic qualification, which had provided them with access to training and an ability to reflect on their work. [40]

A study of workplace privatization in Sweden, where private companies now run care homes, shows inconsistent findings in relation to how care workers are able to influence their work. Sometimes privatization has improved the workplace atmosphere, in others it has increased insecurities and anxieties among workers. In some cases privatization has shortened the decision making process and introduced a simpler management structure. Workers often then feel that they have more power to influence their own work and to act on their own initiative. [41]

In Denmark, changes in the home help services have taken place since the late 1970s, characterised by the introduction of 24 hour care which involved both home help workers and home nurses. [42] As this arrangement became more established, home help workers moved from working from their own homes, to becoming part of a "*semi-autonomous group*" where a group of home help workers operated as a team, divided work up and sorted out problems themselves. The municipalities in charge of these teams presented this as a form of empowerment for home care workers. The introduction of the internal market and the contracting of services by municipalities are also influencing the way in which home help services are organised and delivered.

Different occupational models for childcare and out-of-school care influence to what extent there is a defined career. The type of training needed to enter the sector and the provision for in-service training and maintaining skills also influences the perceptions of childcare work as a career. [43] In childcare in Europe, the move towards integrating childcare with out-of-school care and schools is leading to increased professionalization of the workforce. However, Cohen et al (2004) argue that in countries where there is large private sector provision in the childcare sector the scope to transform childcare workers into a professional group is limited because of the resources and investment needed to achieve this. [44]

Training

Training for the care of older people is less extensive than for child care workers in many countries. In most countries, care workers for older people have limited training. In some European countries there are moves towards increased training of social care workers as a way of upgrading the work and so improving recruitment and retention. This training is often less accessible for migrant workers. In UK, training for social care is based on competency training and this type of training is expanding although the rapid turnover of the social care workforce means that take-up is often limited. In France, there is a more formal system of training and many social care workers now have a qualification. [45]

Childcare workers often have a higher initial level of training than care workers working with older people although sometimes this only involved two years of training after the age of 16 or 18. A three-year training at higher education level is becoming the norm for child care and early years workers in Nordic countries.

The core 'early childhood' worker in Spain also has this level of training. In other countries, training for child care workers is at a lower level.

In the UK, Cameron et al, 2004 found that at least half of all child care staff in the UK did not have specialist training for the job. These include child minders, many childcare staff in private nurseries, some play-workers and nannies. In the Nordic countries the situation is different. In Denmark, the status of professional childcare is high, and training and job prospects are good. There are also a higher proportion of men working in the sector. Even family day carers, although not required to have a qualification, over 75% of them have a childminder certificate or have received 50-100 hours mandatory training from municipal employers. [46]

In many European countries funding for in-service training is often decentralized to municipalities, for example Sweden, Finland, Netherlands, and Italy. In Denmark and Belgium funding for in-service training is decentralised to schools. In the United States there is a requirement at state level that childcare centre workers spend a certain number of hours per year in in-service training. Opportunities for further training in childcare are available in Spain, Denmark and Hungary. [47]

Trade union membership

With the majority of care workers part time and low paid, unionization is limited in many countries because care home owners often do not recognise trade unions and also make it difficult for workers to have contacts with trade unions. Care workers employed in domestic settings also find it more difficult to organise themselves into trade unions because they are scattered and do not have the opportunity to meet other home care workers. The growing use of migrant labour in Europe and North America also makes unionization difficult because workers with insecure residency are often afraid to access trade union support.

A Finnish trade union survey of Swedish privatization found that participation in trade union activity has also become more difficult.[48] In some companies, employees have lost the right to criticise their workplaces. In the UK, in a survey in 1997, two-thirds of care homes surveyed did not have any trade union members and did not recognise trade unions for bargaining purposes. [49]

In Sweden, trade unions have played a significant role in integrating the childcare workforce through integrating their own trade unions and so strengthening their bargaining power. [50] This will also contribute to further developments in the childcare profession.

Some of the changes in social care policies have directly affected the security of many social care and homecare workers. The prospects for improvements in the childcare workforce, appear to be better because of the links between care and education for children. In social care, there is not the same force for change, even through new categories of social care workers are developing in some countries as a result of older people being able to purchase their own care. More widely, social care in residential and home settings is poorly paid and undervalued. Workers often have little training and the level of unionisation is low.

5.2. Users of services

Considering how the changes in financing, organization and delivery of services have affected both access to services and the quality of services, needs to seen in the context of how social welfare policies have developed in the twentieth century in Europe. In most countries there are significant differences in the ways in which childcare and care for older people have evolved as public services. Childcare has developed in response to the growing participation of women in the labour force although the levels of public and private provision different from country to country. The recognition of childcare as a social right is becoming widely accepted in Europe.

Care of older people often has its origins in laws designed to relieve poverty and provide social assistance. [51] Defining and maintaining older people's rights to good quality social care has been a much greater struggle. The introduction of cash payments and cash transfers is considered one of the few recent examples of the

expansion of welfare state programmes.[52] The attitude of societies towards older people is a significant barrier to improving services. The effect of commercialization of social care has often not led to improved services. Some research is beginning to show that access is often restricted for some groups.[53]

Ungerson (2003) argues that the new financing arrangements that enable individuals to pay for their own care, are creating a new context for care but the impact on the nature of the care relationship has still to emerge.

The increased targeting of programmes has an effect on the distribution of care. Increased targeting of services to those with high levels of need also leads to those who have lower levels of dependency and need (especially older people) receiving fewer or even no services. The income level of an older people often determines whether additional services are paid for or whether family members take on some caring tasks.

Studies examining changes in the provision of home based services to older people in Sweden have found that since 1990, there has been a decline in the number of people receiving services, often focused on the most frail, older people. The impact of a decline in the number of beds for older people in the healthcare sector has led to more frail older people being looked after by municipal services at home. Resources are then limited to personal and home nursing care rather than municipal provision of services for shopping, cleaning, laundry and walks. [54] The needs assessment process necessary to make an individual eligible for care has been implemented more strictly resulting in people with minor needs being excluded from access to social care. This results in family members being drawn in as care providers or for those on higher incomes, paid carers. Szebehely (2004) found that changes in home help arrangements in Sweden resulted in an increase in informal care by frail older people with lower education levels, and an increase in private care by frail older people with higher education levels.

Lewinter (2004) examined the changes in levels of provision of home care in Denmark to older people over 67 and found the percentage of people on low levels of care (< 2 hours a week) and the highest levels of care had increased whereas these on intermediate levels (2-8 hours a week) had decreased.[55] Trydegard, Thorslund (2001) also found that there was a wide range of variation of the level of home care available at municipal level.[56]

There are signs in England that a similar process is taking place as seen through trends in the provision of home care services. Although the number of contact hours provided by home care services increased by 14% between 1997 and 2003, the number of households receiving services decreased by 23%.[57] Moreover, the proportion of households receiving home care involving 6 or more visits and over 5 contact hours increased from 28% to 41% but the proportion of households receiving home care and only one visit of 2 hours or less in duration decreased from 27% in 1997 to 17% in 2002. During the same period the number of hours of home care provided by the private sector increased from 42% to 64%.

As Sweden has moved toward assisted housing, this is seen administratively, as a type of housing, rather than care, and so older people have to pay rent and charges for different services which are means tested.

Ungerson (2003) found that the payment of kin to do tasks that were previously seen as part of "unpaid work" could lead to changes in family and household relations. Where a care worker is a resident member of the family, payments will contribute to the family income but if the care worker is non-resident, commodified kin relations are more likely. In Italy, the payment for care was often used to subsidize a low income by continuing to use family and relatives to provide informal care.

In the UK there have been several trends in service provision that have directly affected users of services. With the Community Care Act of 1990 and the introduction of standards for care homes, the costs of meeting national care standards for residential homes led to both local authorities and private providers closing residential care homes with a decline in provision. By 2003, 88% of residential care had been transferred to the private sector and 66% of local authority funded home care was provided by the private sector in the UK.[58]

The quality of care in residential homes is variable. There have been many newspaper reports about individual cases in BUPA care homes where residents have received poor quality care. [59] The Manchester Evening News reported that a care home inspection had found poor quality living conditions for residents.

> *"The Bedford Residential Nursing Care Home in Leigh needed to make major improvements in 29 out of 34 categories, according to a report by the National Care Standards Commission. In one of the BUPA-run home's buildings corridor carpets were soaked in so much urine that they were "sticking to the inspector's shoes." The NCSC report warned: "This is not only a cleanliness issue but increases the risk of cross-infection." The home, which charges up to £473 a week, had 26 areas where improvement was required by law and the report made 12 further recommendations that would bring it up to required standards"*[60]

There is a growing focus on home care, which provides support for people to remain in their own homes, or to live in sheltered housing provision. Care is provided in these facilities through home care agencies. Several home care agencies, both public and private, may provide care to residents in these sheltered housing facilities as well as to users in their own homes.

Home care services show varying levels of quality. A recent survey of social workers in the UK (Centre for Public Services, 2004) found that they felt unable to commission suitable packages of care for service users because they had to use agencies that they were not happy with or were constrained by budget restrictions.[61] The increase in the number of social care providers has led to more fragmented services rather than 'joined-up' service provision.

The impact of cost cutting and making social care workers do more tasks in a limited period of time has an effect on the quality of care delivered. Land (2003) gives an example of how savings on insurance may mean that a social care worker is no longer covered by an agency's insurance to take a client in a wheelchair to shops or the park.[62] This directly affects the quality of the older person's life.

The Social Services Inspectorate in the UK compared a local authority service with that provided by the private sector. It concluded that although there was evidence of good services, they also heard about "*domiciliary care, which was not providing good quality service. This was almost always in relation to independent agencies. We heard about high staff turnover, unreliability, poor training and failure to stay the full time*"[63] (Social Services Inspectorate SSI quoted in Land, 2003). This shows how the socio-economic security of social care workers, in relation to pay and training have a direct influence on the quality of services delivered.

Changes in the way in which social care is financed is having an impact on how users access care and the quality of care. In Sweden and Denmark, the targeting of care towards frail older people is resulting in less dependent older people losing access to public social care services. This affects low and high income groups differently. High income groups can purchase their own care services but low income groups have to draw on care from informal carers. Care payments have affected family relationships in both positive and negative ways.

In the UK, there are early signs that an increase over the last three years in the number of places for people with learning disabilities in institutions run by the private sector has increased by 50% to over 1000 places. Private sector providers are arguing through the publication of a book entitled 21st Century Asylums, that institutional care is more appropriate for people with learning disabilities and mental health problems. [64] Annual charges are likely to range from £180,000 to £230,000 for each patient. Commissioners of services find it easier to commission a place in a private hospital than to set up a "*complex multiservice support network in the community*". This trend needs to be seen in the context of the long term prospects for community care for older people and whether higher costs of intensive home care will lead to a return to institutional provision.

As childcare is the focus of increased policy initiatives, there has been an expansion of childcare facilities in many countries which is resulting in greater access to care. However, in countries such as the United

Kingdom, where the private sector is the main provider of childcare services, there are issues about how standards are maintained and complaints about services are dealt with.

A study, commissioned by the European Foundation for the Study of Living and Working Conditions, concluded that future public social services needed to be user orientated with both users and workers participating in the organisation and planning of services. Quality initiatives need to be flexible and take account of local needs. Quality requirements, rather than cost criteria should lead the development of services. Services need to be integrated. Partnerships between service providers, funders, user groups and social partners need to underpin service delivery. Services need to invest in the participation and training of care workers. Equal opportunities between women and men need to recognised so that women's role as carers and as workers are valued and their needs met.[65]

6. A European policy overview

6.1. Social care policy in Europe - European Union

The direct influence of the European Union (EU) on social care and childcare might be considered to have been more limited because of the absence of specific EU level policy on both older people and children. Although there have been some attempts by the EU to influence social care policy for both children and older people these have taken the form of recommendations or advice rather than binding legislation. These include *Recommendations on ChildCare* (92/241/EEC) adopted by the Council in 31 March 1992, which points out that lack of childcare limits women's participation in the labour force but does not provide further obligations for Member states to meet any minimum requirements [66]

As part of the EU Employment strategy, each member state has to develop its own employment strategy to incorporate many groups that are not currently part of the labour force[67] (EU, 1997). The provision of childcare has been recognised as an important factor in getting women back into the labour force. Single mothers with children have been a target group in many countries, for example, the New Deal Programme in the United Kingdom.

The "*Green Book on European Social Policy*" (1993) encouraged Member States to share responsibility for social policy implementation with voluntary organizations, social partners and local authorities. The EU has commissioned research looking at the role of carers and the prospects for care of older people.

In 2001,the first EU Communication on "*The future of Health care and care for the elderly ; guaranteeing accessibility, quality and financial viability*"[68] was published. This argues that with increasing life expectancy and an increasing percentage of older people, the demand on health services for treatment for age related illnesses would increase. However, the type of care required is a mix of medical and social care. If this trend continues and also considering the changes in family arrangements and the increasing role of women in the labour force, new measures will be required to meet this demand for care. Human resources are seen as a key issue because the need to recruit care workers would come at a time when the number of people in work is either stabilising or falling. Medical technology is a second issue which will bring new products and treatments but high spending. A third issue is the growing demand for healthcare and patient involvement in healthcare systems.

The Communication identified three long-term objectives:

- Accessibility - recognising the links between social inequality and health status, the need to improve coordination between health and social services, and expand provision to disadvantaged groups;
- Quality - how to measure in different national systems;
- Financial viability – seen as requiring the regulation of demand through increased tax contributions or co-payments and user fees with the regulation of supply of social services through introduction of competition within internal markets.

The questionnaire on Health and Long term Care for the Elderly – issued by the Social Protection Committee – aimed to gather information on the way in which these three objectives (accessibility, quality and financial viability) can be delivered in health and long term care for the elderly in Member states. This was described as "*mechanisms for accessing the effectiveness of delivery and the main challenges to their provision and planned policy responses to these challenges*". Member States responses were analysed and presented in a Joint report (March 2003).[69] [70]

The Joint report (Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions) places an emphasis on the financial viability and introduction of cost control mechanisms. These will include measures to shift costs to consumers; price and volume controls on both supply and demand; and reforms to encourage the efficient use of resources

In 2004, the Commission released the Communication (COM(2004) 304 final) - *Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies* using the "*open method of coordination*"(21/04/2004). [71] This recommends "*universal coverage must be based on solidarity, according to the structure of each system, benefiting in particular those on low incomes and those whose stare of health requires intensive, long or expensive care*". It also acknowledges that there are problems in accessing services for certain groups due to inequalities in the distribution of facilities. Recruitment and retention problems of staff also contribute to inequalities of provision.

The report calls for a "*Global strategy for health care systems*" which in a first communication would a) propose "*common objectives for the development and modernisation of health care provision and funding, which would allow Member States to define their own national strategy and benefit from the experiences and practice of the other Member States*". This would complement three other areas of social protection: pensions, inclusion and "Making Work Pay".

A second communication follows up the "*High level process of reflection*" and presents a set of proposals .. "*Providing for the mainstreaming of the objective of providing a high level of human health protection*" in Community policies. Social cohesion is reinforced by access to quality care. Providing employment is considered a goal but specifically, improving the quality of jobs so that people do not take early retirement. "*Improving the productivity and effectiveness of care providers will also be a key element in the sustainable development of this sector*". E- health will contribute to "*informing, preventing and improving care provision and the lifelong training of health care professionals*".

The impact of technological progress has made it more difficult to promoting high quality care because its impact is uncertain in the context of an ageing society. Technological progress may make systems more effective, increase life expectancy and increase costs as well as resulting in rising demand for care from an educated population. In order to address these uncertainties there will be a need to audit the spending of resources on health and long term care and adopt preventive strategies to improve wellbeing and the effective management of care. This will be achieved through:

- promoting evidence based practices and treatments
- making strategies gender sensitive to meet the needs of women and men
- increased training for health workers
- through health and safety
- allocation of resources according to need
- promote governance and defining rights of patients and facilities

The third principle, financial sustainability of care, is seen as dependent on "*healthy and sustainable budgetary systems*". Financial sustainability is considered to be dependent on a number of instruments: reimbursement rates, prices and volumes of treatments to control products or prescriptions; fixed budgets in the hospital sector; and "***giving more responsibility for the management of resources to people working in the sector and financial backers".*** This range of financial instruments indicates that whilst recognising the

importance of universal coverage, financial arrangements are dominated by an acceptance of limiting public sector spending and the continuing adoption of user fees. The need to give more responsibility to people working in the sector and financial backers also suggests that private finance investors will be given opportunities to influence the future development of the sector. This Communication is currently being discussed by Member states and an updated report will be made available in spring 2005.

The overall role of the European Union in social care policy has been limited and is similar to the situation in healthcare, where the principle of subsidiarity allows national governments to develop their own social care policies. However, in a similar way to healthcare, internal market legislation is beginning to influence the social care sector. This can be seen firstly in a judgement made in relation to a challenge made under national competition law, by the BetterCare Group (a private social and residential care company) operating in Northern Ireland, about the contract price set by the North and West Belfast Health Services Trust. The North and West Belfast Health Services Trust was also a direct provider of social and residential care services. Although the Office of Fair Trading rejected this complaint arguing that the North and West Belfast Health Services Trust provision of social services was not an economic activity, the case went to appeal at a tribunal of the UK Competition Commission, which found in favour of BetterCare.[72]

The implications of this ruling are still being felt. Land (2003) gives an account of how the ruling led the North and West Belfast Health Services Trust to sell off its residential and social care services.[73] The longer term implications of a judgement made by a national Competition Commission could be significant for the future of public sector services.

The European Union was expected to have even more influence on the social care sector through the new draft Services Directive (June 2004) *Services in the internal market COM(2004)* which recommended that "*personal social services*" are considered a Service of General Economic Interest (SGI) and so subject to competition law rather than a Service of General Interest (SGI) which would not be subject to competition. One of the most important implications of this classification is that a service provider operating within the EU would be subject to the laws of its country of origin and not of the host country where the service is actually provided. In relation to the posting of workers, Member State governments would have limited scope to influence the labour standards of workers who are employed in their country by a company from another country. The proposal was for the government of the country of origin of the company to try and influence labour standards and legislation because "*a provider must, as a general rule, only be subject to the law of the country within which it is established*". This would limit the power of governments to take action against undocumented migrant workers if they are recruited by an agency based in another EU country. This would have had implications for the recruitment of health and social care workers, their working conditions and the quality of services provided [74]

Following extensive campaigning and lobbying from a wide range of organisations, institutions and governments the Directive was abandoned in its present form. In February 2005, the Commission President Barroso announced that "*As the Directive was written, it would not have been successful…This is the reason why the Commission has unanimously accepted to make changes*"[75].

A number of developments mean that the issue of whether social care services should be classified as a Service of General Interest has not been resolved. The Altmark judgement by the European Court of Justice (ECJ) has resulted in the decision "*to exclude Government support for services, such as public transport, from the term "state aid" and therefore from the tendering requirement*". This is also significant for social care services. Local authorities that are providers of social care services will not be expected to tender these services.

There are continuing discussions about the possibility of a Framework Directive for Services of General Interest. Some of the issues emerging in these discussions can be seen in the outcomes of a conference held in June 2004 "*Social Services of General Interest in the European Union – Assessing their Specificities, Potential and Needs*" [76] which outlined a number of issues that need to be considered in the context of social services as Services of General Interest (SGI). This conference brought together the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, the Platform of European Social NGOS

and the Observatory for the Development of Social Services in Europe with the support of the European Commission. It can be seen to reflect many of the concerns felt by a range of stakeholders involved in the future development of social services.

The conference felt that the *"modernisation"* policies introduced to social services have been based on the assumed need to cut costs. Future modernisation of social services needs to take a wider view of how to meet the needs of people for social care services, rather than view change only in relation to budgetary reductions. The definition and measurement of quality of services remains a difficult issue to address. Specific questions about which stakeholders should do this, how and at what level need further discussion. The language of Services of General Economic Interest (SGEI) and economic performance indicators is not appropriate for social services. Social services may need a legal recognition to give them a clearer identity, which would include *"appropriate modulated application of market and competition rules, according to user needs and quality of services"*. There are unresolved tensions between local, regional, national and EU levels of society in relation to social services. Continued participation of stakeholders to inform the development of the EC *"Communication on social and health services in the European Union"* is still needed.

7. European Works Councils company eligibility

7.1. European Works Councils and EU legislation

The European Works Councils (EWC) Directive, which was initially adopted in 1994,[77] aims to improve the right of workers to information and consultation, in trans-national companies. It requires transnational companies to establish information and consultation agreements covering their entire European workforce, if they have not already done so. The content of these agreements is largely left to negotiation between management and employee representatives, but minimum requirements where management refuses to negotiate include the requirement of annual reports to the EWC on the company's business prospects, and the right to be informed about exceptional circumstances affecting employees' interests, such as closure or collective redundancy.

The EWC directive applies to companies,[78] or groups of companies[79], with

- at least 1000[80] employees across the member states,[81] *and*
- at least 150 employees in each of two or more distinct member states.

These employment criteria represent a lower bound – *companies meeting them are obliged to establish an EWC*, but companies which do not meet them may nonetheless choose to establish one voluntarily. In a number of instances companies have chosen to do so, whether it be for purposes of labour relations, prestige (to demonstrate Europe-wide coverage), or (in the case of UK during its opt out) in the expectation of the future introduction of a legal obligation.

7.2. EWC Eligible

Companies with activities that include social care, in more than one European country

Company	European presence	Number of workers
Attendo	Sweden, Norway, Denmark,	3,000
BUPA Care Homes	UK, (Spain, Ireland)	6,950
Carema	Sweden, Norway, Finland	4,500
ISS Care Partner	Sweden, Norway, Denmark	

Medidep	France, Belgium	4,000
Orpea	France, Italy	5,700

7.3. Non-EWC eligible

Company	Number of workers
Craegmoor Group Ltd	7,500
Four Seasons Healthcare	19,000
Southern Cross Healthcare Ltd	12,000
Westminster Healthcare/Barchester Health Care group	12,000 (post merger)
Domus VI	
Medica France	

7.4. Significant acquisitions and sales of subsidiaries

Company	Buying	Selling	Year
Attendo	Sodexho Partena Care (2001) Capio Elderly Care (2004)	-	2001 2004
BUPA	-	Sold homecare services subsidiaries except Strand Nursing Services	2001/2
Capio	-	Sold elderly services	2004
Generale de Sante	-	Sold care services to DOMUS-VI	2003
ISS	-	Sold 51% shares in ISS ISS and EQT III fund (EQT) have agreed to form a joint venture taking over ISS Health Care and ISS CarePartner AB.	2002 2005
Sodexho Partena Care	-	Sold to Attendo	2001

7.5. Companies with EWCs or EWC eligible

7.5.1. Company name ATTENDO

Attendo Senior Care AB
Arstaangsvagen 1A
117 43 Stockholm
Tel: +46 8 775 7700

Fax: +46 8 744 1050
www.attendo.se
www.telelarmcare.se
www.attendo.co.uk

Total number of employees: 3,000

Company activities and strategy

Business area	Activities	Countries	Sales (SEK)	Workers
Attendo systems	Markets products and systems (care phones, internal systems, response systems, activity validation systems, technical service and accessories) that improve the efficiency of providing care to older people/people with disabilities	Nordic countries, Iceland, Germany, Austria, Spain, Switzerland, UK	383m	230
Attendo response	Developing standards of services that go beyond dealing with emergencies and receiving alarm calls i.e. developing monitoring centres which can become the focus of organisation of care and support	Denmark, Sweden, Holland, UK, and France	112m	
Attendo care	Nursing homes (for people needed high degree of supervision), sheltered housing, domiciliary care, special services and "over the counter" where the company operates units and sells the services "over the counter" to local authorities or private individuals	Denmark and Sweden	964.6m	2,000+
Total sales			1,444m	
Gross profit			300.5m	

The company employs 3,000 people. Its main shareholders are Saki AB, an investment company; Melker Schorling (also on Scandia Board); and Lars Forberg (through family and company). The company's aim is to be Europe's leading supplier of care services and products. It bought Capio's elderly care services in 2004 and this has made it the largest social care provider in the Nordic region. In February 2005,the British private equity funds management company Bridgepoint Europe II, belonging to British Bridgepoint Capital Group Limited, has bought a majority holding in the Swedish care services provider Attendo AB. [82] Bridgepoint Capital Group also acquired a holding in the French care company Medica in 2003.

7.5.2. Company name – Bridgepoint Capital

Bridgepoint Capital Ltd
101 Finsbury Pavement
London EC2A 1EJ
Tel: +44 (0)20 7374 3500
www.bridgepointcapital.com

EWC: NO – ELIGIBLE?

Strategy and activities

Bridgepoint is a leading provider of private equity with a 25-year history of investing in businesses for long-term capital growth. Bridgepoint invests in companies through management, arranging and leading buy-outs or providing further financial resources to help companies grow. Independently owned, Bridgepoint Capital has raised over €5 billion from leading third party institutional investors. It also sells businesses, so returning €2.5billion to investors since 2000. Investors include US state pension funds and institutional investors in Europe and the Middle East.

It currently has a portfolio of five companies in the healthcare sector:

Company	Activities	Type of deal	Deal size (m)	Date	Revenues
Alliance Medical **www.alliancemedical.co.uk**	Private operator of diagnostic imaging equipment (UK)	Management buyout	€178	2001	€63m
Attendo **www.attendo.se**	Operator of care homes for older people (Sweden)	Management buyout	£245	2005	£275m
Match Group **www.match.co.uk**	Staffing provider to the healthcare sector (UK)	Management buyout	€117	1999	€240m
Medica **www.medica-france.com**	Operator of care homes for older people (France)	Management buyout	€330	2003	€207
Robinia Care Group **www.robinia.co.uk**	Provider of specialist residential care for young people and adults with learning disabilities (UK)	Independent buyout	€49	2003	€36

Announcing its acquisition of Attendo AB, Bridgepoint Capital said that it "*intends to be an active owner, using its extensive industry knowledge and capital resources to offer the necessary support to management and the business*".[83]

7.5.3. Company name BUPA

BUPA
BUPA House
Bloomsbury Way
London WC1A 2BA
www.bupa.com

EWC: NO – ELIGIBLE

Total number of employees: 9,120 (Europe)

Regional breakdown (Europe)

Country	Number of employees
UK	6,950
Ireland	170
Spain	2,000
Total	9.120

Major European subsidiaries

Company	Ownership	Country	Contact	Website	Employees
Sanitas – Spain	100%	Spain	c/via Augusta 13-15, 28042 Madrid Tel: + 902 10 24 00	www.sanitas.es	2,000
BUPA Ireland	100%	Ireland	12 Fitzwilliam Street, Dublin 2 Tel: (01)662 7662 Fax: (01)662 7672	www.bupa.ir	170
BUPA Hospitals Ltd	100%	UK	Bloomsbury Way, London WC1	www.bupa.com	6,950
BUPA UK Insurance	100%	UK		www.bupa.com	
BUPA Care Services Ltd	100%	UK		www.bupa.com	
BUPA Childcare Services Ltd	100%	UK		www.bupa.com	
Strand Nurses Bureau Ltd	100%	UK		www.bupa.com	

Company outline and strategy

Care services have been BUPA's largest area of expansion since the mid 1990s. BUPA Care Services consist of the three subsidiaries: BUPA Nursing Homes ltd, BUPA Care Services ltd and Care First Group plc. BUPA runs 223 care homes, 54 sheltered retired homes and in 1999 cared for 26,000 people in residential care or through home care services. BUPA has also expanded into nursing, other care services and childcare. It sold off many of its homecare services in 2001/2 but retained Strand Nursing Bureau, a nurse recruitment agency, which has moved into home care.

7.5.4. Company name CAREMA

Kungsgaten 70 3tr
SE 111 22 Stockholm
Tel: +46 8 617 3900
Fax: +46 8 617 3980
www.carema.se

Total number of employees 4,500

Company outline and strategy

Carema is a Swedish company founded in 1996 and provides specialist care, primary care, care of older people, psychiatry, care of people with disabilities, and staffing. The company specialised in integrated care. It is active in Norway, Sweden and Finland.

There are three business areas in the Healthcare Business Unit

- Primary care runs 20 healthcare centres in Sweden
- Specialist care runs specialist healthcare in local hospitals, elective surgery and rehabilitation under the name of Carema Specialist Healthcare.
- Recruitment which runs the Rent a Doctor, rent a nurse, and care team brands.

All business units work on behalf of local councils. Councils pay for 100% of primary care services. Councils account for 90% of the recruitment business unit's revenue with the rest coming from private companies. It also has a very limited income from private health insurance and people who fund their own treatment.

The Nursing Business Unit provides support, services and care to people with physical and psychological problems (Care and Psychiatry). Also part of the Nursing Business Unit is elderly care. It is the biggest player in Sweden and provides care to 4,500 people in 40 centres. The company operates under contract, under its own management and other customer systems. The business unit is paid for its services by municipalities. This represents 70% of its turnover. The Nursing Business Unit is active in Norway, Sweden and Finland.

Major investors in Carema are Orkla, Ovriga, Jarla Investeringar AB, and the Saven family.

	2003	**2002**	**2001**
Revenues	2,356.3SEK	2,474.8Sek	2, 123.6
Results before and goodwill	71.9 SEK	16.5 SEK	-22.5 SEK

Source: Carema Annual Report 2003

7.5.5. Company name ISS CARE PARTNER SVERIGE AB

Box 42071
SE-126 13 Stockholm
Tel: 08 6816000
www.carepartner.se

Total number of employees: 4000

ISS Care Partner Sverige AB was formed after ISS sold 51% of its shares in its elderly services. It has been active in Sweden, Norway and Finland. In 2004, it sold its Finnish Care Partner subsidiary to Medivire, part of the Medivire Group. It was involved in homecare services, housing services and play school arrangements in day centres in Finland, a sign that social care for older people is being combined with childcare. The Medivire Group, a well as providing occupational health services, also provides housing services, home care and personal security phones. This also shows how social care services are being combined with personal security systems for older people.

In February 2005, ISS announced that it was setting up a joint venture with the EQT III fund to take over the activities of ISS Health Care, fully owned by ISS. The joint venture will also take over 100% of CarePartner AB, which is 49% owned by ISS and 51% owned by management. ISS takes over the 51% of CarePartner AB from management prior to the sale of the combined activities to the joint venture. This deal will be

subject to the agreement of the anti-trust authorities (ISS Press release 1 February 2005). The EQT investment group was founded in 1994, by Investor AB, Scandinavia's largest industrial holding group. It is part of the Wallenberg group. [84]

7.5.6. Company name MEDIDEP

31 boulevard de La Tour Maubourg
75007 Paris
FRANCE
Tel: 33 1 45 50 31 21
Fax: 33 1 45 50 39 99
http://www.medidep.com/

MEDIDEP
152 avenue de Malakoff
75116 PARIS
Mail : infodoc@medidep.com

Total number of employees: 4,000

Breakdown of employees (full time equivalent employees) 2003

	Managers	Technicians	Employees	Total
EHPAD	102	451	1628	2183
Clinics	163	391	956	1509
Home support	34	86	81	201
Medidep holding company	12	0	10	22
Total	312	928	2675	3914

Source: Medidep Annual Report 2003: 36

Company outline and strategy
Founded in 1992, Medidep expanded between 1998 and 2002 by acquiring 142 homes. It has also acquired 3 homes in Belgium. By 2004, 94 centres were in operation with 50,000 people.

In 2003, with the retirement of the founder, Pierre Austruy, there was a change in ownership. ORPEA, another leading French care company, became a major shareholder (29%) with Fidelity Investments owning 5% of shares.

There are three main business areas:

- Clinics providing rehabilitation, psychiatric care,
- EHPAD (establissements d'hebergement pour personnes agees dependante)
- Homecare. 17 homecare networks

The Medidep Group signed the CCU (Convention Collective Unique – single collective labour agreement) on 18 April 2002, which was initially applicable to clinics but after 10 december 2002 agreement, is not applicable to EHPAD establishments. Medidep favours a remuneration policy based on "performance bonuses linked top meeting qualitative and quantitative goals fixed at the beginning of the year".(Annual Report 2003, p.39)

Medidep has set up FORMADEP, a training centre to provide training programmes for Medidep employees. The company gives three reasons for focusing on training: "the shortage of nursing staff; the constantly changing technical nature of care services; draining nature of certain tasks and the psychological proximity to people at the end of their lives"(Medidep Annual Report, 2003:p.38)

7.5.7. Company name ORPEA

Groupe ORPEA
1-3, rue Bellini
92806 PUTEAUX Cedex
France
Tél.: 01 47 75 78 07
www.orpea.com

Employees: 5,700

Strategy and activities
Orpea is the largest private sector provider of social care in France. It has 106 homes or clinics with 10,017 beds. It recently bought a care home in Italy (Ancona) and is negotiating a further acquisition in Piedmont.[85]

8. Appendix A: Recommendations

The research carried out by the European Foundation for the Study of Living and Working Conditions on the development of quality social public services across each of the EU Member States suggests that the following can contribute to quality outcomes:

- **User**-oriented services and the active promotion of user involvement and empowerment;
- The participation of users and staff in **quality** systems and organisational development;
- Quality systems that are **flexible**, adaptable and relevant to local needs;
- Quality initiatives that take into account the **differential needs** or abilities of users;
- Quality frameworks that allow for organisational flexibility in order to respond to different needs and contexts;
- Quality that leads the organisation, rather than being subordinated to cost criteria;
- Performance targets and evaluation should allow for qualitative as well as quantitative feedback;
- Adequate time and resources for implementing user-oriented systems of quality;
- Coordinated and **integrated service delivery mechanisms** that meet needs in multifaceted ways;
- Continuity of services and funding;
- **Partnerships** of service providers, funding agencies, interest groups and social partners;
- A culture of **innovation** within service organisations that responds flexibly to needs and requirements;
- Effective systems of **evaluation** with feedback mechanisms;
- **Highly qualified staff** who are able to respond to user needs and develop organisational changes to reflect these;
- Services that invest in the **training and participation of workers** along with user participation and empowerment;
- **Equal opportunities** between women and men so that women's roles as carers and/or women's care or employment needs are not neglected.

European Foundation for the Study of Living and Working Conditions
Study of public social services in Europe
http://www.eurofound.eu.int/living/socpub_cstudies/quality.htm#1

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[78] The requirements apply to "undertakings", a term which may include partnerships or other forms of organisation as well as companies. *http://www.dti.gov.uk/er/consultation/ewcover2.htm*

[79] A group of companies (undertakings) includes a controlling company and any companies it controls ("exerts a dominant influence over"), whether by virtue of ownership, financial participation or the governing rules of the controlled company.

[80] Based on the average number of employees, including part-time employees, employed during the previous two years calculated according to national legislation and/or practice. *http://europa.eu.int/comm/employment_social/soc-dial/labour/directive9445/9445euen.htm*

[81] "Member states" means the member states of the European Union, but for the purposes of the EWC Directive includes since 1996 the rest of the European Economic Area (Norway, Liechtenstein and Iceland). The UK opted out of the EWC directive until December 1997. From 1995 to 2003 the EU had 15 members (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Sweden, UK), with 10 more countries expected to join in 2004.

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[84] http://www.eqt.se/

[85] Regis Mayer, Senioractu.com, 14 October 2004