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TECHNICAL BRIEF

SOCIAL CARE SYSTEMS IN EUROPE



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The working paper is printed in this form to communicate the result of an analytical work with the objective of generating further discussions on the issue.

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Executive summary

1. Social care in Europe – *the provision of support to meet needs arising from vulnerability, illness, or disability* – is facing demographic and social changes. Though characterised by a variety of organizations, all European social care systems are under financial constraints and going through policy and organizational changes. This has led to a professionalization of care services providers and to the emergence of innovative ways of financing within the social care sector.

2. The Council of Europe Development Bank (CEB), has been investing in the social care sector for the past 30 years, these changes represent an opportunity not only to upgrade, adapt and develop social care infrastructure, but also to support policy developments and organization in terms of staff training and improved quality of care services.

3. This note provides an overview of the institutional setting of the social care system, as well as its challenges and opportunities in a sample of eight European countries, which together, illustrate the different care models in the region: Albania, Belgium, Croatia, France, Italy, Poland, Spain, and Sweden. Specific attention is given to the demand for care, the ongoing decentralization and deinstitutionalization process and the increasing role of new, non-state service providers.

4. Some of the possible areas for the CEB to explore for further collaboration with its member states include:

   - ✓ Supporting the process of deinstitutionalization by providing funding for new or adapted infrastructure aimed at community-based services. With growing pressure for formal care, combined with the need to develop care services in the communities where users live, more European countries will likely seek to develop, adapt and upgrade their social care infrastructure.
   - ✓ Supporting investment in human capital to develop existing and new social care training programmes, as well as changes in skills and skill-mix development.
   - ✓ Providing technical assistance to improve the planning of social care services (such as conducting needs-assessments for care services and mapping and registering social care providers), support the development of investment initiatives in the social sector (such as targeted investment funds), as well as the improvement of quality of social care provision, and the accreditation and quality-assurance of social care services.
   - ✓ Supporting the development of social enterprises as new potential borrowers, including large private care service suppliers, cooperatives, NGOs, and social enterprises.
   - ✓ Exploring new funding mechanisms, such as Social Impact Bonds (SIBs) to develop preventative care services, as well as for supporting innovative services.

5. While awareness to invest in social care is growing across the continent, the CEB as the social development bank in Europe is well positioned to develop further its role in the social care sector.

1. Why Do We Care in Europe?

Social care - *the provision of support to meet needs arising from vulnerability, illness, or disability* - plays a vital role in advancing social inclusion: it ensures that those who are not fully capable of self-care maintain the best possible quality of life, with the highest possible degree of independence and human dignity.

There are a variety of social care systems in Europe, shaped by the heritage of different welfare states (Scandinavian, Continental or Bismarck, Anglo-Saxon, Mediterranean and Communist). Regardless of their differences, all these social care systems are facing similar mounting pressures resulting from societal and demographic transformations, government policy and fiscal constraints.

Demographic and social changes are occurring at a pace that poses significant challenges to social care budgets. An ageing population with higher life expectancy, coupled with declining fertility rates as well as changes in female employment and family patterns, have boosted the demand for care services while shrinking the pool of informal caregivers.

Policy has also changed the supply and organization of social care systems. Social inclusion of vulnerable populations of all ages, including children without adequate parental care, the elderly, the mentally and physically disabled, the homeless and migrants, has gained increased attention from European policy makers. The European Union's strategy, "Europe 2020", sets the ambitious goal of lifting at least 20 million people out of poverty and social exclusion and more recently, the Gothenburg declaration proclaimed the European Pillar of Social Rights for delivering new and more effective rights for citizens.[1] Similarly, many national governments have set more comprehensive social care strategies, aiming to increase the amount of care services provided, as well as to better address the diversity of eligible populations.

Due to economic and societal reasons, many European countries have shifted, or are in the process of transitioning, from a centralized social care model, relying primarily on residential institutions, to a decentralized community-based model, thus allowing for individuals to stay in their home or within their community. This process of replacing long-stay residential institutions with less isolated community-based services, also known as deinstitutionalization, is likely to generate additional costs, at least in the short and medium-terms, as new adapted infrastructure will need to be built.

In terms of organization of social care system, European governments are moving towards a more integrated social services delivery: one-stop shop for different services and different beneficiaries, potentially allowing for economies of scope by avoiding duplication of services. External service providers, non-for profit organizations, social enterprises, cooperatives, and private companies are increasingly cooperating with local and central administrations in the delivery of social care services.

Since 1997, the Council of Europe Development Bank (CEB) has been investing in the social care sector, primarily in the improvement of social care infrastructure. The growing demand for formal care in the CEB's member countries, combined with the need to develop care services closer to the users, and the diversification of actors providing social care services, offer new investment perspectives in this area. The Bank could explore new opportunities to develop, adapt and upgrade non-residential social care infrastructures, train social care personnel and provide technical assistance to governments to improve the planning, accreditation and quality-assurance of care services.

This note provides a brief overview of the major transformations in the organization of social care in Europe today, the challenges providers face to satisfy the increased and diversified needs of vulnerable populations, and investment opportunities to improve the availability and quality of social care services. It also provides a snapshot of the institutional setting of the social care system, as well as its challenges and opportunities in a sample of eight European countries, which together, illustrate the different care models in the region: Albania, Belgium, Croatia, France, Italy, Poland, Spain, and Sweden (Annex 1). Rising demand for care, ongoing decentralization and deinstitutionalization and the increasing role of new, non-state service providers offer a new spectrum of investment opportunities and potential borrowers in the social care sector for CEB.

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[1] EU Social Summit, 17 November 2017: Chapter III on *Social protection and inclusion* builds upon Principle 17 *Inclusion of people with disabilities* and Principle 18 *Long-term care*

2. Social Care in Europe: A plurality of models

Social care in Europe varies from country to country, depending on the degree of the centralization of planning and funding, sources of funding (e.g. via general taxation, obligatory social security, voluntary private insurance or out-of-pocket payments), the share of public funds in total supply, the availability of community-based alternatives to residential or family care, and the types of providers.

Across Europe, there are wide variations in the degree to which affordable formal services have been developed or are made available as a result of country specific welfare systems. Some European states rely mostly on informal care (provided by family members and friends), some guarantee universal access to public social care delivered by public agencies or outsourced to private providers, while others rely on external providers (for-profit and non-for-profit organizations) to fulfil the care needs of their vulnerable populations.

Social Care in Europe can be broadly categorized into the following five models (Munday, 2003):

- **The Scandinavian model**: characterizes the social care system in Denmark, Finland, Norway and Sweden. This model relies on the principle of universalism, with services for vulnerable groups readily available and paid for from taxes. Local governments play a central role in the planning, financing and delivery of social care, and in previous years, NGOs and for-profit organizations contributed only marginally to the system. This model has been often considered as an example to follow, given the broad range, accessibility and quantity of community-based services. However, over the past two decades it has witnessed an important transformation, with increased outsourcing of services to private (and often for-profit) providers, and a more limited supply of public home-based care services. This trend is analyzed in more detail in the country profile of Sweden.
- **The Continental, or subsidiarity model**: features the social care system of Austria, Germany, the Netherlands, and to a lesser extent, Belgium and France. In this model, social care services are largely provided by NGOs, and financed by the state or local authorities. Families are also responsible for the care of their members.
- **The Anglo-Saxon or means-tested model**: describes the social care system of the United Kingdom and Ireland. In this system, care users are expected to pay for services if they can afford them. Local councils can also provide financial assistance for social care on a means-tested basis – that is, for individuals with insufficient income to pay for their care. For-profit service providers and NGOs play an important role in the system.
- **The Mediterranean, or family care model:** it is mostly prevalent in Cyprus, Italy, Greece, Malta, Portugal, Spain and Turkey. This model relies on family caregivers, while wealthier people tend to use private services. In Italy, however, the state plays a more prevalent role in the financing and delivery of social care services as compared to other Mediterranean countries.
- **The transition countries model:** Some common features in transition countries of Central and Eastern Europe include high reliance on civil society and increasing partnerships between government and NGOs to provide care services, ongoing deinstitutionalization and decentralization, and the participation of international organizations in the funding and development of the social care system. Reliance on family caregivers is also important in areas where social infrastructure is not available or where care services are of poor quality.

3. Common challenges to address in the future

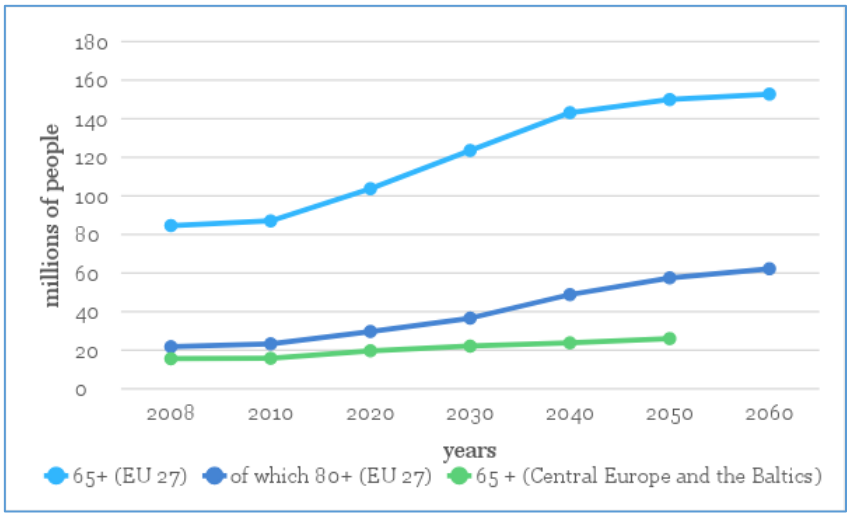
Regardless of the model of social care, all European states are witnessing similar demographic and societal transformations that bring about common challenges in the planning, organization, delivery and financing of formal social care in future years.

3.1. A growing demand for care

People tend to live longer, and the baby-boomers[2] are starting to join the ranks of the elderly. In 2014, the share of the European population, aged 65 or over, reached 18.5 percent of the total population, and it is projected to increase to around 30 percent by 2080 (Eurostat, 2015).

The number of Europeans over 80 years old, who are more likely to suffer from physical or mental disability leading to dependency, is expected to triple between 2008 and 2060 (Figure 1).

Figure 1: Total population aged 65+ and 80 + in Europe; 2008-2060



Source: G. Lanzieri (2011). For Central Europe and the Baltics, World Bank Data (2017)

In Belgium, France, Italy, Spain and Sweden the share of population, aged 80 years and over, will double by 2080 and triple in Croatia and Poland. In Albania, projections suggest the population over 80 will increase by a factor of four by 2050 (Table 1).

Table 1: Share of population over 80 years old, current and projected (8 countries in this study)

	Proportion of the population over 80 in 2014 (%)	Projected proportion of the population over 80 in 2080 (%)
Albania	2.2	9.6
Belgium	5.3	10.6
Croatia	4.5	13.2
France	5.7	11.1
Italy	6.4	13.3
Poland	3.9	14.9
Spain	5.7	10.8
Sweden	5.2	10.7

Source: Eurostat, 2015. For Albania, values refer to years 2014 and 2050, World Bank Data, 2017.

Population ageing and improvements in life expectancy are being compounded by an increase in the prevalence of chronic diseases and lower fertility rates. The former is important because it can limit people's autonomy in their daily activities, while the latter reduces future availability of adult children to care for their dependent elderly parents (European Commission, 2015).

[2] 1960 is taken as the representative year for the baby boom. (see, G. Lanzieri, 2011)

It is also more common for older people to live alone, and women, who traditionally provided care for their dependent family members, are increasingly more likely to enter the labour market. For all of these factors, it is expected that the demand for formal care increases in the coming years.

In addition to the ageing of population, increase in demand of social care will come from other vulnerable populations. High child poverty in some European countries, more unaccompanied minors seeking asylum and increasing numbers of severely disabled children living longer are factors that can potentially increase the demand for social care services in future years. Table 2 shows that since 2010 more than one in five children under six is at risk of poverty and social exclusion in Belgium, Croatia, France, Italy, Poland and Spain, and in some countries (Italy and Sweden) the percentage of children at risk of poverty in 2016 was higher than in 2010.

Table 2: Percentage of children aged 0-6 at risk of poverty and social exclusion (2010-2016)

Country/Year	2010	2011	2012	2013	2014	2015	2016
European Union (28 countries)	25.8	25.4	25.8	25.7	25.8	24.8	23.7
Belgium	25.2	25.4	22.0	20.8	22.0	21.1	20.5
Croatia	23.0	31.8	34.1	28.1	23.6	22.6	21.6
France	23.2	21.5	20.8	19.3	21,2	20.4	19.7
Italy	28.6	28.4	31,1	28.2	29.4	29.6	29.4
Poland	28.6	26.8	25.6	27.1	25.0	22.8	20.3
Spain	28.6	27.4	27.4	28.2	32.1	29.0	27.8
Sweden	14.1	17.3	15.2	16.4	16.9	20.6	19.5

Source: Eurostat People at risk of poverty or social exclusion by age and sex, 2017

According to the World Health Organisation (WHO), some potential risk factors for parental neglect and abuse include young or single parenthood, parental unemployment, and substance abuse (WHO, 2013).

Table 3 below shows that in all countries considered in the study, except for Belgium, the number of single adults with children has increased over the past six years.

Table 3: Single adults with children (change 2010-2016)

Country	Change in the number of single adults with children 2010-2016 (%)
European Union (28 countries)	+6.92
Belgium	-6.90
Croatia	+10.33
France	+20.95
Italy	+22.48
Poland	+14.39
Spain	+52.94
Sweden	+12.27

Source: Eurostat, Household composition statistics, 2017

In addition to this, the number of minor asylum applicants in the EU in 2016, has been rising since 2013. In 2016, there were 63 300 unaccompanied minors seeking asylum in EU member states, a value five times higher than the yearly average for the period 2008-2013, although lower than in 2015 (Eurostat, 2017).

It is important to note that these figures (child poverty, single parenthood, and the number of minor asylum-seekers) illustrate the prevalence of some of the driving factors behind the placement of children into care. However, they do not provide an estimate of the current demand for care, nor a projection of future demand.

Other than economic downturns and family patterns that can increase children's vulnerability, the number of people with disabilities is expected to increase due to medical developments promoting higher survival rates and increased life expectancy (UNICEF, 2013). For instance, a study concluded that under different scenarios, the number of adults with learning disabilities in England is likely to witness a sustained increase between 2009 and 2026, a trend that can result in higher demand for formal care services (Emerson and Hatton, 2008).

3.2. High pressure on public budgets to meet demand for social care

Long-Term Care (LTC) is one of the different types of social care services available for vulnerable populations in Europe.[3] However, the ageing of the population is a major demographic driver for an increased demand for social care in the future. For this reason, LTC is used as an example to illustrate the current and projected public expenditure in social care. Table 2 shows current (as of 2013) and projected (2060) public expenditure as percentage of GDP, under two different scenarios:

- Base Case scenario (Column 2): This scenario shows the projected expenditures in 2060 under the assumption that the elderly dependent population grows in size, but the proportion of the population who receives either informal care, formal care at home or institutional care is kept constant. In other words, it isolates the impact of the demographic changes, under the hypothesis that there is no change in the formal coverage of LTC.
- Shift to formal care scenario (Column 4): this scenario shows projected expenditures in 2060 under the hypothesis that there is growing pressure to increase public finance and provision of formal LTC services, which replaces or supports informal care. In particular, this scenario examines the budgetary impact of a progressive shift into the formal in-kind sector of 1 percent per year of the dependent population who has so far received only informal care or cash benefits.

Table 4: Current and projected public expenditures in LTC 2013-2060 (7 countries in this study)

	Public expenditures on LTC in 2013 (% of GDP)[4]	Projected expenditures on LTC in 2060, Base case scenario (% of GDP)[5]	Base case scenario increase from 2013 (%)	Projected expenditures on LTC in 2060 if shift to formal public care[6] (% of GDP)	Shift to formal care scenario increase from 2013 (%)
Albania	N/A	N/A	N/A	N/A	N/A
Belgium	2.1	3.9	83	4.1	95
Croatia	0.4	0.5	28	1.0	125
France	2.0	2.9	47	3.6	80
Italy	1.8	2.8	58	3.4	90
Poland	0.8	1.8	127	2.9	264
Spain	1.0	2.6	159	2.8	186
Sweden	3.6	5.5	51	6.6	82

Source: European Commission, 2015

As Table 4 illustrates, LTC public expenditure is expected to increase in the seven countries for which data is available assuming there are no changes in LTC formal coverage (ranging from a 28 percent increase in Croatia and up to 159 percent in Spain). The increase in public expenditure in LTC is even steeper for all seven countries under the hypothesis that public finance and provision of formal LTC

[3] Long-term care (LTC) is a variety of social care services that aims to meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods. This type of care service is predominantly used by the elderly.
[4] European Commission, The 2015 Ageing Report, 2015, Table I.3.4, p. 155
[5] Ibid, Table I.3.4, p. 155
[6] Ibid, Table II.3.7 p. 157

services progressively replace informal care, ranging from an 80 percent increase in France, to 264 percent in Poland.

Policy choices are also affecting public expenditure for social care. Most people prefer to live in their homes or in their communities. European countries have been increasingly shifting from institutional care, in institutions and hospitals, to home-based settings; albeit slowly in some cases, such as in Albania and Croatia (Albania's Ministry of Social Welfare and Youth, 2016; Croatia's Ministry of Social Policy and Youth, 2016).

This process of deinstitutionalization generates additional costs for countries that are currently in the transition phase. During this transition, the state needs to run both the institutional and the community-based services as residents make the move to the community. In addition to this, there are costs related to the improvement of existing infrastructures, and the building of new community centres in areas where infrastructure is lacking. Finally, introducing a wider array of community based services that did not previously exist may require additional funding to support the operational costs of public and private providers.

Deinstitutionalization and the diversification of community-care services also have an impact on public budgets in more mature social care systems. In Sweden for example, the increased variety of disability care and childcare services set in national guidelines, added to the reduction of the number of beds in the health care systems, have further strained local budgets (Szebehely et al. 2012). As a result, municipalities have become more restrictive in approving publicly-financed home help services, which has led to more help by informal caregivers (Anell et al., 2012).

3.3. Re-organization of the sector and rise of new actors

The development of the Social and Solidarity Economy (SSE) is a promising perspective to expand the supply of social care services under strained public budgets. The SSE encompasses a broad range of organizations (cooperatives, NGOs, social enterprises) which provide goods and services for the market and use their profits primarily to achieve social objectives. In many countries, such as Italy, France, and the United Kingdom, social enterprises are already playing an increasing part in meeting the growing need for social care services.

However encouraging, the rise of these new actors adds more complexity to the planning, delivery and monitoring of social care services, and requires specific regulations for the SSE sector.

Several European countries have passed specific acts to promote and regulate the development of the sector. Table 5 summarizes some of the most recent developments in national regulation of the SSE sector, in the period ranging from 2011 to 2016 (CIRIEC International, 2016).

Table 5: Developments in national regulations of the SSE sector (2011 to 2016)

Croatia	Plan	Strategy for the Development of Social Entrepreneurship in the Republic of Croatia for the period of 2015 – 2020 (April, 2015)
France	Law	Loi n° 2014-856 du 31 juillet 2014 relative à l'économie sociale et solidaire (National Law on Social and Solidarity Economy)
Italy	Law	Law n. 106 – 6 June on Third Sector Reform (2016)
	Law	New bill on social enterprises and new law on regulation of the third sector (2017)
Poland	Draft Law	Draft law Social economy (2012)
	Plan	Plan Krajowy Programme Rozwoju Ekonomii Społecznej (National Programme of Social Economy Development) adopted by the Ministry of Labour and Social Policy in 2014
Spain	Law	Ley 5/2011, de 29 de marzo, de Economía Social (2011) (National Law on the Social Economy)
	Plan	Spain National Programme to foster the social economy and POISES - Operational Programme for social inclusion and the social economy - ESF 2014-2020.
Sweden	Plan	Sweden Multiannual programme to support work integration social enterprises, by the Department of Labour jointly with the Department of Enterprise.

Source: CIRIEC International, 2016

3.4. Coordination between central and local governments and incomplete deinstitutionalization

Social care supply generally involves different levels of government (central and local), sources of funding (central, local, and out-of-pocket payments) as well as service providers (municipalities, private companies, NGOs). This complexity poses coordination challenges for the planning, financing and delivery of care services.

For example, in more mature social care systems, such as Sweden, medical treatment is financed by county councils, while nursing and rehabilitation is financed by the municipalities. The distinction between these two services is not always straightforward and requires coordination. Since 2010, the municipalities and the county councils draft an individual care plan where they describe the care services and treatment that patient require and the authority responsible for each type of care (Fukushima, et al., 2010).

In transition countries, where decentralization and deinstitutionalization is still ongoing, these challenges are more pervasive. For example in Albania, local governments were ill-equipped, in terms both of financial and human resources, to plan, outsource and run social care services. Regional councils, who had the mandate to plan the network of social care services, were not able to conduct thorough needs assessment processes and identify care needs proactively, mainly due to a lack of financial resources. Staff in municipal councils, who are responsible for public procurement of private social care providers, have limited capacity to develop technical terms of reference and judge on the quality of tenders (Hoxha et al., 2013).

As a result, formal care supply is deficient, and is still mostly financed at the central level. Care services are patchy, with 90 percent of social care services provided in urban areas and community-based services are underdeveloped (Jorgoni et al., 2014). There are many underserved vulnerable populations, including migrants, street children, disabled children, adolescents leaving care and victims of trafficking.

3.5. Scarce human resources

Social and health services are labour-intensive, and have contributed to the creation of new jobs in Europe, particularly for women and older workers. In 2013, they employed about 11 percent of the total European workforce, and created 1.3 million new jobs between 2009 and 2013 (European Commission, 2014).

However, across all European countries, there are dramatic shortages of qualified staff in the sector, which may further accentuate as demand for care increases. For example, a 2012 WHO survey of the Swedish health and social care systems showed that municipalities were experiencing difficulties in recruiting qualified care professionals (e.g. nurses) at a time when the number of patients with more complex medical and caring needs was rising (Anell et al., 2012).

Wage levels have declined, working conditions are very demanding, and part time or short-term contracts are very common. Furthermore, there are insufficient quality training opportunities, both prior to entering the caregiver profession or as continuous career development. The WHO highlights that in Europe, central and local authorities often have deficient training capacities in geriatrics and gerontology, both at the central and local level. Another example is Albania, where the majority of teaching staff in special schools for disabled children does not have the appropriate degree (Save the Children, 2016).

This results in high turnover and frequent staff shortages. In recent years, the sector has increasingly employed foreign workers coming from non-EU countries, yet it is unclear whether the influx of migrant workers will suffice to meet the growing demand for care.

Unless there is an improvement in working conditions, the sector is likely to find it increasingly difficult to attract qualified workers, which could in turn accentuate staff shortages and deteriorate the quality of care.

Social enterprises can also contribute to improving caregivers working conditions. For example in the United Kingdom, some social care enterprises are employee-owned, which means that part of the profits is shared with workers, and the rest re-invested in the service.

3.6. Incomplete measurement of quality of social care services and providers

In many European countries, the registry and accreditation of service providers, as well as the continuous quality-assurance of social care services is not sufficiently developed.

For example, a 2008 UNDP report highlights that in Croatia, where NGOs and private providers play a prominent role in the supply of social care services, there was no comprehensive national registry or inventory of non-state service providers.[7] In addition to this, although in the Croatian Welfare Act defined quality standards for social services (Social Welfare Act, 2013) alternative care service providers were not systematically monitored, and monitoring data was not always used to improve the quality of services (SOS Children's Villages, 2012).

Even in European countries with a long-standing tradition of comprehensive supply of social care services, such as Sweden, there has been little measurement of the quality and cost-efficiency relative to the high level of spending and human resource commitment of these services (OECD, 2013). The concern about the quality of care services in Sweden has received renewed attention, after a series of media investigations uncovered alarming shortfalls among several private care companies (The Swedish Institute, 2012).

4. The Council of Europe Development Bank: Over two decades investing in Social Care

Since 1997, the CEB has been investing in several projects and programmes that can be recognized as spending in the social care sector. Often labelled Health, Education, Housing or Energy Efficiency, these projects give little visibility to their social care specificity even though it is their primary feature. Table 6 provides examples of the CEB's most recent experience, by type of borrower.

These projects represent good examples of what the CEB does and what it could develop in the future. Indeed, such schemes allow for easier access to the targeted vulnerable populations. A programme such as the one contracted with the BPCE[8] (France) builds upon the expertise that this bank has acquired around health and social care and in the social economy. In Belgium, Belfius Public and Social Banking is a leader in reaching out to small and medium organizations of the social sector.

However, these programmes have been financing mainly infrastructure and more could be done also to support human capital development, through trainings with a view to adapt to new skills requirements for social care.

Moreover, in countries where local authorities have direct responsibility in the financing of infrastructure, programmes articulated around social care could be set up, involving other institutions which have established relationships with private and non-for profit institutions offering social care services in the countries. For example Erste Bank from Austria has knowledge of social banking in central European countries, and CaixaBank has established relationships with several foundations in Spain. Similarly, a certain number of national or pan-European organizations active as social care providers, social care foundations or social care advocacy groups well established in their field of competence, could facilitate identification of opportunities.

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7 There are some initiatives to map social care services at the municipal level. For example, the city of Zagreb produced this guide: http://www1.zagreb.hr/vodics/index.html

8 Banques Populaires Caisses d'Épargne

Table 6: Examples of projects financed by the CEB

Year of approval	Country	Description	CEB Loan Amount (million EURO)
Central authorities (Ministry of Finance)			
2006	Romania	Social centres for vulnerable children and families	10
1998	Lithuania	Community health centres	10.8
Regional authorities			
2015	Slovak Republic	Regional infrastructure Trnava: renovation and extension of daily and weekly stations for the disabled	49.5
2009	Poland	Modernizing and extending the existing network of Social Aid Centres, such as nurseries, care centres for children and elderly people, including medicalized units	47.3
2008	Slovenia	Municipal investments in favour of the elderly	30
2005	Denmark	Special housing for the elderly	100
Commercial banks			
2017	Belgium	**Belfius Bank** Financing renovation and expansion of retiring and nursing homes, as well as long term care, among other things	200
2016	France	**Crédit coopératif** Financing infrastructure for vulnerable populations	100
2014	France	**BPCE (Banques populaires Caisses d'Epargne)** Financing the renovation, expansion and improvement of care centers for dependent populations (incl. public, private and non-profit institutions, homes for the elderly, centres for the disabled, and day-care centres)	150
2012	France	**Crédit agricole** Funds distributed to associations, foundations, religious institutions, social enterprises and municipalities working in health, social care, social housing, education, environment and sport	100
2009	Portugal	**Caixa Geral de Depositos** Funds to finalize the construction of a clinic providing therapy for drug addicts and acquiring a system for central heating	50
2006	Finland	**Pohjola Bank** The building of a new rented house. Special apartments are for mentally handicapped youngsters	100

5. The way forward

While awareness to invest in social care is growing across the continent, the CEB as the social development bank in Europe is well positioned to develop further its role in the social care sector.

Some of the challenges described in this note are related to exogenous factors (demography, epidemiology, institutional set-ups and legal frameworks), while others are more operational and could be addressed by the CEB. This section highlights possible areas that the CEB could explore for further collaboration with the country governments and institutions.

- ✓ **Decentralization and deinstitutionalization**: The process of deinstitutionalization does not imply that all social care services will be provided outside of institutions, and that social care infrastructure will no longer be needed. In fact, the process of deinstitutionalization requires new or adapted infrastructure to provide community-based services. With growing pressure for formal care, combined with the need to develop care services closer to the users (in their communities), more European countries will likely seek to develop, adapt and upgrade their social care infrastructure. Therefore, the CEB's support could continue to focus on:
  - The improvement of existing infrastructure (for example, infrastructure that is in a deteriorated state and that could be renovated),
  - The adaptation of residential institutions for an alternative use (for example, large children's homes can be converted into apartments for young, single mothers and their children),
  - The adaptation to quality standards (such as improving access for the disabled, and improving energy efficiency).
  - The building of new community centres in areas where infrastructure is lacking.

- ✓ **Human resource development**: CEB could support governments (at central and decentralized level) to invest in human capital and develop the workforce in the social care sector by providing financial support to:
  - Expand access to existing social care training programmes
  - Develop new training programmes to respond to specific care needs
  - Support changes in skills and skill-mix development
- ✓ **Government planning, monitoring and delivery of social care services**: In some countries, the CEB could also provide technical assistance to improve the planning of social care services (such as conducting needs-assessments for care services and mapping and registering social care providers), support the development of investment initiatives in the social sector (such as targeted investment funds), as well as the improvement of quality of social care provision, and the accreditation and quality-assurance of social care services.

- ✓ **Diversified mix of social care providers and funding mechanisms**: As mentioned above, in many countries, social enterprises are already playing a part in meeting the growing need for social care services. This offers the CEB a variety of new potential borrowers, including large private care service suppliers, cooperatives, NGOs, and social enterprises.

- ✓ **New funding mechanisms**: Social Impact Bonds have recently become part of the public services landscape in Europe and internationally. SIBs are a pay-for-results contract, where the government commissioner partners with social investors to fund interventions that seek to tackle a social problem. The social investors cover the upfront costs necessary to set up the interventions implemented by service providers, and the government pays a return on investment if pre-defined outcomes are reached. A recent study found that social care is an important growing field for SIBs, with six existing bonds that address foster care, foster care avoidance, adoption, and support for vulnerable single mothers, and services for the elderly (OECD, 2016). This funding mechanism can be particularly relevant to develop preventative care services, as well as for supporting innovative new services. The Dutch, Finnish or Swedish experiences could be examples to follow.

References

Albania's Ministry of Social Welfare and Youth (2016), *The National Strategy for Social Protection 2015 – 2020*

Anell A., A. Glenngård, and S. Merkur (2012), *Sweden: Health system review*, Health Systems in Transition, 14(5):1–159

CIRIEC International (2016), *Recent evolutions of the Social Economy in the European Union*, Accessed December 3, 2017 http://www.ciriec.ulg.ac.be/wp-content/uploads/2017/10/RecentEvolutionsSEinEU_Study2017.pdf

Croatia's Ministry of Social Policy and Youth (2016), *National Social Report 2016 Republic of Croatia*, Zagreb

Croatia's Social Welfare Act (2013), *Official gazette 157/2013, Accessed August 1, 2017* http://www.mvep.hr/files/file/dokumenti/prevodenje/zakoni/zakon-o-socijalnoj-skrbi-nn-157-13-eng.pdf

Deboosere P., and P. Fiszman (2001), *About Persistent Socio-Spatial Inequalities in Health: The Belgian Example*, Université des Sciences et Technologies de Lille

Emerson E. and C. Hatton (2008), *Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England*, CeDR Research Report 2008:6

European Commission (2015), *The 2015 Ageing Report, Economic and budgetary projections for the 28 EU Member States (2013-2060)*, Accessed August 1, 2017. http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/ee3_en.pdf

European Commission (2014), *Health and social services from an employment and economic perspective,* Quarterly Review, Supplement December 2014

Eurostat (2017), *Household composition statistics*, Accessed November 15, 2017 http://ec.europa.eu/eurostat/statistics-explained/index.php/Household_composition_statistics

Eurostat (2017), *News release 80/2017: Asylum applicants considered to be unaccompanied minors,* Accessed November 15, 2017 http://www.europeanmigrationlaw.eu/documents/Asylum%20applicants%20considered%20to%20be%20unaccompanied%20minors.pdf

Eurostat (2015), *News release 166/2015: International Day of Older Person*, Accessed August 15, 2017 http://ec.europa.eu/eurostat/documents/2995521/7012459/3-29092015-AP-EN.pdf

Eurostat (2017), *People at risk of poverty or social exclusion by age and sex*, Accessed November 15, 2017 http://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion

Fukushima N., J. Adami and M. Palme (2010), *The Long-Term Care System for The Elderly in Sweden*, Enepri Research Report No. 89

Hoxha A., E. Jorgoni, S. Ymeri, E. Kulluri, V. Vjero and P. Stubbs (2013), *Social Care Services at the Regional Scale: Analysis and Recommendation*, Institute of Contemporary Studies as part of the Social Care Reform Programme, supported by UNICEF and the Swiss Development Cooperation

Jorgoni E., P. Stubbs and S. Ymeri (2014), *Rescaling Social Care Services, Proposing Responsibilities and Functions for Local Government Units*, Institute of Contemporary Studies as part of the Social Care Reform Programme, supported by UNICEF and Embassy of Switzerland

Lanzieri G. (2011), *The greying of the baby boomers: A century-long view of ageing in European populations, Population and social conditions Statistics in focus*. Accessed August 2, 2017 http://ec.europa.eu/eurostat/documents/3433488/5578868/KS-SF-11-023-EN.PDF/882b8b1e-998b-454e-a574-bb15cc64b653

Munday B. (2003), *European social services: A map of characteristics and trends,* Council of Europe

OECD (2016), *Social Impact Bonds: State of Play & Lessons Learnt,* Working Paper. Accessed November 15, 2017. https://www.oecd.org/cfe/leed/SIBs-State-Play-Lessons-Final.pdf

OECD (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing

Osservatorio nazionale sulla salute nelle regione italiane (2017) *La condizione delle persone con disabilità in Italia* http://www.quotidianosanita.it/allegati/allegato4880055.pdf

Save the Children (2016), *Albania Country Spotlight*, 2016. Accessed July 20, 2017 https://campaigns.savethechildren.net/sites/campaigns.savethechildren.net/files/Albania_Proof_Fonal.pdf

SOS Childrens' Villages (2012), *A Snapshot of Alternative Care Arrangements in Croatia*. Accessed August 15, 2017 https://www.sos-childrensvillages.org/getmedia/aebb94ad-5ad8-4b94-adaa-6fed22e74063/Alt-Care-Croatia-EN.pdf?ext=.pdf

Szebehely, M., and G. Trydegard (2012), *Home care for older people in Sweden: a universal model in transition, Health and Social Care in the Community*, 20(3), 300–309

The Swedish Institute (2012), *Facts about Sweden disability Policy*, Updated June 2012. Accessed August 1, 2017 https://sweden.se/society/swedens-disability-policy/

UNICEF (2013), *Children and Young People with Disabilities Fact Sheet*. Accessed November 20, 2017 https://www.unicef.org/disabilities/files/Factsheet_A5__Web_NEW.pdf

World Bank Database (2017), *Population Estimates and Projections*, Accessed November 15, 2017 https://data.worldbank.org/data-catalog/population-projection-tables

World Health Organization (2013), European report on preventing child maltreatment. Accessed November 20, 2017 http://www.euro.who.int/data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf

Annex 1 - Social Care Systems at a glance in eight countries

ALBANIA: Social Care at a Glance

Institutional setting

Ministry of Social Welfare and Youth (MSWY) develops policies and standards for delivery of social care services and finances public care services.

Since 2016, the Regional level (counties/Qark) maintains a coordinating role to prepare the regional social plan coherently with the social plan of the local authorities.

Local Level (municipality/commune): With the 2016 law, planning, management and delivery of social care became an exclusive function of the municipalities.

Municipalities, in cooperation with the MSWY, shall create and administer a social fund for financial support to the local government units, to improve the standards and administering capacities of existing services of social care, to create new services and to develop social policies.

Social care delivery and source of funding

According to the law on Social care services, funding is provided by the state and the local government units' budgets. Less than 5% of total government spending on social protection is earmarked for social care services, with most of it going to finance benefits for income support (*Ndihma ekonomike*) and disability benefit (*PAK*).

The state funding for social services is transferred from the MSWY to the local authorities at the beginning of each year.

Public spending in social care services is low, and most social care services are provided by civil society organizations and private institutions funded on a voluntary basis or by development partners.

The general cost for the implementation of the National Strategy for Social Protection 2015 – 2020, is evaluated at approximately €6.2 million. The MSWY covers approximately 62% of the cost of this strategy; donor funds (World Bank, UNICEF and UNDP) cover approximately 22%, and the remaining gap is being discussed with donors.

Key challenges

Unachieved decentralization process: most local governments do not have the capacity to finance residential care services and rely on the state budget and donor funding to establish new community-based services.

Limited technical capacity of local authorities to prepare contracts for private social care providers (lack of a public services procurement law).

Uneven coverage: 90% of social care services are provided in urban areas.

Under supply of community-based services, such as for returning migrants, youth, street children, orphans, support for domestic violence.

Over-reliance on cash services. Spending on social care services at the local level in 2014 was less than 3 percent of total spending on cash benefits (social assistance and disability entitlements).

Opportunities

Priorities of the National Strategy for Social Protection (NSSP) 2015-2020 include: increase by 10% the number of beneficiaries from community services; establish an integrated system of social care services at the local government units; train the workforce.

The government identified a financial gap of around €965 thousands in the NSSP, and a gap of around €3.6 million in the 2016-2020 Action Plan on Persons with Disabilities. Funding for both strategies is currently being negotiated with donors.

Areas for further investment: new infrastructure, funding non-state operators (NGOs, social enterprises), improve social care network, reorganizing community and residential services, and training healthcare staff on community-based approaches.
New public procurement modalities have been prepared by national government, which include civil society service providers.

BELGIUM: Social Care at a Glance

Institutional setting

The Ministry of Social Affairs, together with the National Institute for Health and Disability Insurance, are responsible for the overall long term care (LTC) budget, planning, setting fees and levels of public intervention, and certification and quality control of residential care services.

Regions are also responsible for the regulation, certification, monitoring and quality control of residential care services.

The Flemish community has set up a separate scheme for LTC insurance, partly financed by a general contribution from the adult population.

Local Level (municipality) organizes home care services. Public Welfare Centres (CPAS) are based in each municipality.

Social care delivery and source of funding

Public Welfare Centres (CPAS) are the main social care services providers for several populations (elderly, youngsters, drug addicts, homeless, and people with disability). CPAS are financed by regions and municipalities, and the bigger ones partially through cash generating activities (retirement homes, hospitals etc.).

The Ministry of Social Affairs finances social care services through the Federal Public Service Social Integration.

Key challenges

Strong socio-spatial inequalities of health and social care remain in Belgium: the regions, the cities and the most economically disadvantaged districts are those where the state of health is the weakest. An important part of the population considered to be in poor health is clearly distributed amongst the municipalities of the former Walloon industrial axis and the province of Hainaut.

The informal care model is still predominant for the elderly because of cost and time spent.

The quality of care services suffers from the lack of qualified staff.

Opportunities

Mental health treatment needs are expected to rise, as in the rest of Europe. Continuously adapting to the new needs and demands of modern social care is one of the biggest policy challenges according to the Ministry of Health. Similarly, autism and dementia are now part of nationwide strategic initiatives, including modernisation of facilities and training of staff.

The Ministry of Social Affairs is also promoting innovative, cross-cutting, flexible, cutting-edge projects. For instance, trans-border initiatives between Belgium and France tend to bring forward complementarity in the provision of services and availability of resources. New types of providers, such as cooperatives, are often looking for financial support.

CROATIA: Social Care at a Glance

Institutional setting

The Ministry of Demographics, Family, Youth and Social Policy (MDFYSP) selects providers at the regional and local level; verifies compliance of providers with the minimum requirements for the provision of social care services and runs the registry of social welfare institutions.

The Agency for Quality and Accreditation in Health Care and Social Welfare is responsible for the accreditation of social welfare institutions.

The regional self-government units (counties) prepare the Plan for Social Welfare (through the County Social Welfare Council) which describes the availability of services in the county, and outlines specific objectives for the development of institutional and non-institutional social services, with particular emphasis on services for groups at greater risk of social exclusion. Based on this Plan, the MDFYSP organizes public tenders to select social care services providers. Counties establish and fund public institutions offering social care to the elderly, and the homeless.

Municipalities and towns, also establish public social care homes, deliver homeless care services, and can co-finance (together with MDFYSP) home-help services.

Social care delivery and source of funding

Public Social care services are delivered by Social care centres (also translated as Centres for social welfare) and social care homes.

- **Social care centres**: first point of contact for beneficiaries of social care services. They conduct needs assessment, provide information on social care services, preventive counselling, family mediation services, as well as foster parent and adoptive parent education.
- **Social care homes** offer specialized services for populations in need of social care. They typically provide institutional care, but are now providing various non-institutional care services.
- There is an important (although still underdeveloped) network of private providers.

The public social care centres are funded by the central government and by regional self-government.

Regional self-government units and the City of Zagreb finance the public homes for the elderly and infirm, as well as services for the homeless. However it is important to note that the homes for the elderly primarily depend on beneficiary self-financing, regardless of the type of ownership.

The national government, the European institutions and other agencies are providing financial support to Croatia's deinstitutionalization process.

Key challenges

Insufficient community-based social care services: The major challenge in Croatia is developing the network of community-based social services.

Need to develop specific care services for the populations affected by the war: Besides the insufficient supply of care services for vulnerable populations such as the elderly and disabled, Croatia needs to develop specific care services for war veterans and victims, including psychosocial care.

Supply of existing community-based services is geographically uneven, not well coordinated and relies on short-term funding.

Need to develop new skills: The competences of personnel in the social care sector remain inadequate, especially in the areas of social policy reforms implementation and monitoring.

Opportunities

The deinstitutionalization is not finalizedd yet and implies upgrading of facilities, transfer of properties and construction of new, better quality institutions

A 2008 UNDP mapping of non-state providers of social care in the community, showed that NGOs offering community-based services were concentrated in the City of Zagreb, and the counties of Split Dalmatia, Osijek-Baranja and Primorje-Gorski Kotar. Most of these NGOs were financed through short-term projects, casting doubt on their long-term sustainability.

Training of staff, change of skill mix and strengthening of competences.

FRANCE: Social Care at a Glance

Institutional setting

The Ministry for Health and Social Affairs (Ministère des Solidarités et de la Santé) is in charge of general planning of social care, supervision of social care centres, and training of health and social care professionals. It also defines health and social care benefit tariffs and supervises health insurance institutions.

Regional level: Since 2010, regions are in charge of organizing and managing health and social care services in their territory.
Regional health agencies (ARS) coordinate prevention, care and support. -They adapt national social care strategies to their specific characteristics (geographies, populations) and develop the regional social care strategy (schémas régionaux d'organisation médico-sociale -SROMS).

Social care services are organized at the municipal level, under the supervision of the Regional Health Agency.

Municipalities organize day (ambulatory) care centres, out-patient clinics, and residential centres such as institutions for housing for dependent elderly people (EHPAD) and institutions for the disabled.

Social care delivery and source of funding

The Caisse Nationale de Solidarité pour l'Autonomie (CNSA) finances services for the elderly. Social Security finances services for the disabled and children.

Departments and communes, also known as *collectivités territoriales* co-finance social care services.

Key challenges

The main issue is the financing of the social care: beyond the cost and sustainability of the system, it is very expensive for the beneficiaries and weakens certain models such as the EPHAD. In most cases, the quality of social care services is correlated.

The challenges of taking charge of a broader spectrum of people (frail, isolated, etc.) and of adapting to the increase of the elderly are very important Latest figures show that by 2020 more than 2.37 million elderly people will become dependent or 7.8% of those aged 60 or over.

The issue of resolving territorial inequalities is also significant, between urban and rural areas.

Opportunities

An agreement on sustainable development was signed on May 5th, 2017 between the state and the federations of the health, social and medico-social sectors, making these a pillar of the SSE in France.

The National Health Strategy (SNS) includes social care and aims at supporting new structures and tools that are transversal, multifactor and connected. It also incorporates the development of new structures for addicted people and specifically for young people and teenagers. Moreover, it wishes to develop new structures in the French overseas territories because of their characteristics and their natural risks and against tropical diseases, reduce territorial inequalities and bringing specific funding.

Moreover, cross-border initiatives between France and its neighbors can benefit from European funds and blending from other agencies

The quality of social services and training of qualified staff are also priorities.

Finally, the Paralympic Games in 2024 are seen as an opportunity to better invest in social infrastructure aimed at people with disabilities.

ITALY: Social Care at a Glance

Institutional setting

The Ministry of Social Services develops policies, and standards for the delivery of social care services. It defines a national statutory benefits package to be offered to all residents in every region – the "essential levels of care" *(livelli essenziali di assistenza*).

It is also in charge of social support for people with dementia/elderly dependent people, sickness maternity, unemployment, and family benefits and guaranteeing sufficient resources.

The Italian National Health Service (Servizio Sanitario Nazionale,SSN) plans and manages, through local health units (aziende sanitarie locali), home health-care services – the so-called 'integrated domiciliary care' (by the assistenza domiciliare integrata, ADI).

The National Institute of Social Security: provides cash benefits (indennità di accompagnamento) to disabled persons, independent of their financial situation.

Regions regulate social care delivery.

Municipalities usually manage state funds for social care services, or entrust these funds directly to the Local Health Authorities.
They manage personal social care services, both domestic and personal care tasks provided at home (by the servizi di assistenza domiciliare, SAD) and institutional social care.

Social care delivery and source of funding

National and local taxes are the main funding sources of social care.

Public home care services for elderly, disabled and low-income people are financed by local municipalities (although there is cost-sharing).

Financial support and vouchers for both home care and residential facilities (including disability support) for elderly vary considerably across regions and municipalities. Paying for long-term care and residential or semi-residential services where health care and rehabilitation are provided is based on cost-sharing between the patient and his/her municipality with important variations across regions and even municipalities.

Key challenges

Due to the decentralization and regionalization of social care in Italy, there are several issues:

- decentralization has led to inequalities in service provision between the North and other regions;
- unfinished distribution of responsibilities between the State and the regions and their respective contribution to the financing of the system.

Of the 4.5 million people with disabilities, more than 2 million are in particularly severe conditions and of these 888,000 live in the South, 806,000 in the North and 461 000 in Central regions. Inclusion of people with disabilities in terms of help and education and access to the workplace is still acute and family care most prominent: intergenerational family support is stronger in Italy than in the rest of Europe.

Finally, only one in ten seniors (one of the countries in the world where there are the most elderly) is said to be autonomous in personal care, mainly due to high cost and pricing of care.

Opportunities

A new bill on social enterprises and law on regulation of the third sector was introduced in 2017.

Social care services (home care) are still very much subject to the informal economy. Day (ambulatory) care centres for the elderly or the disabled to relieve families in their daily lives are offering alternatives and may be expanded.

The provision of social care services is small and scattered. It includes many private actors and associations looking for financing. Investment needs in the southern part of the country are high.

Structures for education or access to school for disabled people are lacking.

POLAND: Social Care at a Glance

Institutional setting

The Ministry of Labour and Social Policy sets the strategy of social assistance, develops legal regulation in the field of social assistance, defines standards of services provided by social assistance organizational and analyzes the effectiveness of the measures taken.

Provinces (voivodships) supervise the quality and standards of services provided by social assistance organizational units in districts and municipalities. They authorize public and private social care providers (e.g. social assistance homes for seniors, for serious chronic conditions, for chronic mental disorders, for cognitive impairment and for people with physical disabilities) and cooperate with providers and organizers of social assistance (for example NGOs).

Through counties or districts (Poviat) centres for family support, Poviats prepare social assistance resources assessment based on an analysis of local demographic and social situation, participate in the development and management of LTC facilities.

Social care delivery and source of funding

Poviats and municipalities provide the majority of social care services.

Central government provides grants to self-governments for the maintenance of care homes. Self-governments (Poviats and municipalities) co-finance LTC.

Poviats decide payment for patients living in a public residential care home.

Together with municipalities and communes, Poviats decide and pay cash benefits and the costs for residence in social security homes, participate in the management of LTC facilities and develop LTC infrastructure.

They also organize training of social care personnel and keep a register of social care service providers.

Key challenges

The country currently lacks a coordinated national level strategy on the transition to community-based care. The 2011 Act on Family Support and the System of Foster Care forbids the institutionalization of children under the age of ten. In practice, however, due to the insufficient number of foster families, children may still end up in institutional care.

Opportunities

Following the European trend to deinstitutionalize its social care system and moving towards a community based model of care has meant promoting the participation, activation and independence of otherwise vulnerable people receiving care. This process requires social investment in quality and sustainable community-based services.
EU Structural Funds present an opportunity to set-up projects aiming at making the transition to person-centred community services a reality.

Pilot initiatives in the cities of Gdansk and Lublin have successfully aimed at developing community-based services for people with disabilities, those with mental health problems and older people.

SPAIN: Social Care at a Glance

Institutional setting

The Ministry of Health, Social Care and Equality defines the social care policy.

The Institute for Elderly and Social Services (*Instituto de Mayores y Servicios sociales IMSERSO*) manages and monitors invalidity and retirement pensions, and cash benefits. It drafts basic legislation to assess the degree of disability, drafts social service plans at the state level in the areas of the elderly and dependent persons manages relations with foreign and international organizations and technical assistance in matters within its field of action. It establishes and manages specialized care centres.

The Territorial Council of the System for Autonomy and Care for Dependency and the Advisory Committee gathers representatives from the Autonomous Communities, the State General Administration and the Local Entities. It sets the standard for the evaluation of dependency, defines the criteria for determining the level of protection of the services, as well as the conditions and amount of financial benefits, defines the measures for guaranteeing the quality of the system, and sets common criteria for accrediting the social care centres.

Autonomous Regions and Cities of Ceuta and Melilla are responsible for the provision of benefits and social care services. They can also outsource social care services to non-state providers.

At local level (municipalities), Social Services Centres (*Centros de Servicio Social*) are public community centres that offer primary attention, with the exception of the provision of alternative accommodation that is realized from the centres of reception and shelters. They refer social care beneficiaries to other care providers, whether public providers or other non-governmental providers).

Social care delivery and source of funding

The National government and the Autonomous regions co-finance public social care services.

Public funding of long-term and social care services has been limited; traditionally there has been a reliance on family members to provide informal unpaid care. The ageing of the population, coupled with changing family structures, have raised the issue of long-term care up the policy agenda. A new law, guaranteeing the right to long-term care services, funded through taxes but subject to means testing has now come into effect. While increasing public coverage for long-term care services, this new legislation raises challenges in respect of coordination and delivery of services within and across the seventeen Autonomous Communities that are responsible for the provision of social care services

Key challenges

The high level of decentralization implies that identification of social care investment and expenses plans are being dealt with by Local Revenues Authorities according to local specific needs and fiscal capacity. Needs are uneven between Communities. Social care policies vary between regions (e.g. Basque Country and Navarre).

Opportunities

Beyond supporting non-professional care givers and residential care, coexisting with a high prevalence of non-use of social services by severely disabled persons, focus is made on promoting the integration of "informal" actors into the overall social care / long term care system. Support in training the necessary workforce in social care is thus needed.

Inter-sectoral and trans-border co-operation aiming to create structures related to health and social care to benefit from synergies can bring a significant added value in the rationalisation of services.

Intra-European migration (from the UK) is boosting the private nursing home sector.

SWEDEN: Social Care at a Glance

Institutional setting

The Ministry for Health and Social affairs is responsible for legislation, and general planning of social care services (for example, sets the maximum out-of-pocket fee care providers can ask from patients).

The National Board of Health and Welfare is responsible for supervision, follow-up and evaluation of health and social care services. It sets standards for social care services, and develops quality indicators, policies and guidelines for municipalities and county councils.

The Health and Social Care Inspectorate (IVO) is a government agency responsible for supervising health care, and social care services. It examines applications for permits for private social care service providers, and is responsible for the registers linked to these providers.

County councils are responsible for health care (finance around 80 per cent of health-care expenditure). They are responsible for providing home health services, but can transfer this responsibility to the municipalities if agreed.

Municipalities conduct social care needs assessments and planning, and fund and provide most social care services for persons of all ages and in need of care. Social care services include residential and home-based care, as well as support to informal caregivers. Even if they are free to outsource some of their services, municipalities remain the main responsible entity for the overall supply and quality of social care in their territory.

Social care delivery and source of funding

Social care services are delivered directly by municipalities or by private providers commissioned by municipalities (private companies, cooperatives).

The National Board of Institutional Care (SiS): is an independent agency that delivers compulsory care for young people with psychosocial problems and for adults with substance abuse. SiS is funded in part by central government and partly from the municipalities, and is inspected by a range of bodies including the Health and Social Care Inspectorate, the Swedish Schools Inspectorate and the Parliamentary Ombudsmen.

In recent years, the private sector has become increasingly important, as a result of the market policies introduced by the government, including a costumer-choice model (where beneficiaries of social care are free to decide which provider to use, from the public or private sector), as well tax-deductions on the private expenditures on personal care. In 2011, private providers supplied services for 18.6 percent of all elderly people getting home help.

The private sector in the elderly care market is highly concentrated: only two corporations own half of the private eldercare market.

Social care services are mainly financed by local taxes, levied by municipalities. Co-payments from beneficiaries are low by international standards, income-dependent and limited by national regulation.

Key challenges

Since the recession of the early 1990s, municipalities have been facing mounting pressure on their social care budgets. The increased variety of disability care and childcare services set in national guidelines, added to the reduction of the number of beds in the health care systems have further strained local budgets. As a result, municipalities have become more restrictive in approving publicly-financed home help services which has led to more help by informal caregivers.

Recent media investigations have uncovered alarming shortfalls among several private care companies. There has been little measurements of quality outcomes and value for money relative to the large level of spending and human resource commitment on elderly care services.

Opportunities

In Sweden, government priorities for the coming years include furthering the pay-for-performance policy, which consists in providing financial incentives to municipalities to improve the quality of their services, and investing in caregivers' education and training.

It might be also interesting to explore financing gaps for private providers.

Social care staff: Municipalities experience difficulties in recruiting qualified care professionals (e.g. nurses) at a time where the number of older people is rising, as well as the number of patients with more complex medical and caring needs. This might deteriorate the quality of services provided. Human resources development is thus needed.



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