CARE SERVICES IN EUROPE

by

Jane Lethbridge

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PSIRU, Business School, University of Greenwich, Park Row, London SE10 9LS, U.K.
Website: www.psiru.org *Email:* psiru@psiru.org *Tel*: +44-(0)208-331-9933 *Fax*: +44 (0)208-331-8665
Director: David Hall Researchers: Robin de la Motte, Jane Lethbridge, Emanuele Lobina, Steve Thomas, Violeta Corral

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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. More details of national policies are set out in Table 1.

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.

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 (see Tables Section 7).

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 (Section 7: Tables). 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](EPHA, 2004).

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. Major national companies involved in the care sector

During the last two decades, in many European countries, there has been an expansion in private and non-governmental provision of social care services. This is illustrated by the decrease in numbers of residential beds provided by the public sector, often as part of municipal services. It can also be seen through the increase in the number of private sector providers of home-care services. This has led to the "*emergence of a significant new economic sector*"[77] Whilst there are clearly identifiable moves from public to private and non-governmental provision, the patterns of ownership in the private sector are diffuse. In several European countries, large parts of national markets are dominated by a group of national companies whose ownership changes regularly. The rest of the private sector consists of many small and medium scale businesses providing residential and or home care. In most national social care markets, continual processes of merger and acquisition have been taking place in the last decade. The United Kingdom, France and the Nordic region will be considered below.

7.1. United Kingdom

In the UK, there has been a widespread transfer of care from the public sector to the private and non-profit sector. The number of local authority residential care beds fell from 54,610 beds in 1998 to 37,210 in 2002. [78] This has resulted in the expansion of the private residential and home care sector. [79] Local authorities now purchase more home care services from the private and non-profit sector than they deliver themselves.[80] There has also been an increase in the demand for home care following the NHS and Community Care Act (1990) (Community Care Direct Payment Act), which enable older people to purchase their care directly from services providers.

The social care market in the UK is dominated by a group of five companies. Private equity, venture capitalists and business groups involved in the service sector, are the main shareholders. These groups are interested in a good rate of return on their investments and change their shareholdings in these companies regularly. Apart from BUPA, these companies were set up in the 1980s and 1990s, following changes in community care legislation. They have had several changes of ownership. In 2004, three of these companies had significant changes in their shareholders.

Table 1: Five largest social care companies in the UK

Company	Shareholders	Beds	Workers	Turnover
BUPA Care services	Non-profit	17,631	6,950 (total health / care	£418m (2002)
Four Seasons Healthcare group	(2004)Alchemy venture capital group sold to Allianz Capital Partners (part of Allianz insurance group)	15,315		£105m
Southern Cross Healthcare Ltd	(2004) Blackstone Group	7,741	12,000	£104m (2003)
Craegmoor Group Ltd	(2001) Legal and General Ventures - subsequently syndicated a proportion of their interest to a number of other private equity investors including LDC (formerly Lloyds TSB Development Capital), CDP Capital, RBS Mezzanine and funds managed by JO Hambro	5,828	7,500	£158m (2003)
Westminster Healthcare Group	A public limited company until 1999 but since owned by financial institutions. Sold in 2004 by 3i to Barchester Healthcare Group. Now merged.	5,747	12,000 (post merger)	£142m (2002 – pre-merger)

Source: Laing and Buisson, Community Care Market News November 2003
www.westminsterhealthcare.co.uk; www.craegmoor.co.uk;
www.southerncrosshealthcare.co.uk; www.blackstone.com; www.bupa.com

Since its acquisition in 2002 by West Private Equity, Southern Cross Healthcare Services has been developing both residential services and home care (Clinovia Homecare). In 2004 Blackstone capital Partners IV, an affiliate of the Blackstone Group, bought the Southern Cross healthcare services from West Private Equity. The principal of the Blackstone Group said in a press release "The privately operated healthcare services market in the UK is undergoing significant change….Southern Cross intends to bolster its position in the private pay elderly care market and in specialist healthcare services through both organic growth and acquisitions."[81]

Westminister Healthcare was sold by 3i, a private equity investor to Barchester Healthcare Group in October 2004. Westminster Health had been a public company until 1999 but has since been owned by leading financial institutions and its management team. 3i a private equity and venture capital company led the £267m buy-out of Westminster in 2002. Barchester Healthcare was founded in 1993 and is a wholly owned subsidiary of Grove Ltd, a Jersey company. Management and staff own about 10% of the business. Barchester will have sales of £100m in 2004 and EDITDA in excess of £20m. The company has more than 4,000 staff, which is now merged with Westminster Healthcare to form a workforce of 12,000.

These companies provide care services for older people, homecare services, people with disabilities and in some cases childcare. Pollock (2004)[82] discusses the increasing size of nursing care homes. The larger the care home, the more profitable it will be because the larger companies have access to higher revenues and can generate economies of scale.[83] Residents may feel that the larger size of homes may contribute to a sense of institutionalization and decrease in the quality of care.[84] Many of these companies are also becoming involved in home care.

There have been some changes in the care home sector in the period since 1997 in the UK. Although the number of beds in the public sector has decreased, the private sector has also experienced some changes with the number of homes decreasing from 13,817 to 10, 899. This was partly a result of the introduction of the Care Standards Act 2000, which introduced new minimum standards for care homes.[85] Some small care homes were unable to meet the minimum standards and had to close. The growth of home care has also had an impact on the care home sector because it is considered a cheaper care option than care homes. Local authorities have increasingly commissioned home care.

Laing and Buisson, private health and social care sector analysts, in their review of the domiciliary (home care) market give some interesting insights into the industry.[86] The structure of the industry has recently been consolidating through a series of mergers and acquisitions although it remains very fragmented. Larger companies have bought smaller providers. Some of the reasons for consolidation include:

- Need for companies to spread overheads between head and regional offices
- More effective management of the market by local authority purchasers who increasingly want to purchase from a few providers
- Greater demands by social services for training, quality systems and administrative systems, which demand time and money - difficult for small providers
- Expected requirements of regulatory regimes
- Squeezing of prices and profit marking on local authority contracts
- Increasing difficulties in recruiting staff

This analysis is important because of what is implied about the influence of both local authority purchasers and systems of regulation. In 2003, home care companies were dependent on local authorities for 65% of their revenues. Any changes in how local authorities commission or new regulatory requirements were felt to influence the industry directly.

There is three types of ownership in the home care industry: sole traders/partnerships, limited companies and public limited companies (plc) and voluntary/ charitable bodies. Between 1997 and 2000 the limited companies and publicly limited companies expanded from 36% to 41%, a sign of the consolidation process that is taking place. Voluntary/ charitable bodies decreased from 22% to 18%.

Laing and Buisson also provide a useful perspective on how the home care industry relates to nursing and residential care homes.[87] About a third of sole traders also have residential and nursing home businesses. However, many homes care agencies also developed from nursing agencies. There is considered to be much more synergy between home care and staff recruitment agencies than between home care and nursing homes. Care homes operate with a small number of permanent staff whereas home care requires a large pool of staff, many of whom work part time.

The majority of home care workers are women. A UKHCA survey[88] in 2000 found that 56% of workers were aged over 40, with 31% over 50. 22% of carers have other paid work especially care work in hospitals or care homes. 43% were currently looking after a relative or friend. A fifth of care workers had a qualification but were mostly under 30. 50% had received training recently but the workers with qualifications were most likely to have received training recently.[89]

7.2. France

In France, social care provision is also dominated by a group of 5 national companies, which provide short term care services. Companies have focused on the short stay market. [90]

Table 2: Five largest social care companies in France

Company	Shareholders	Beds	Turnover
ORPEA	Dr. Marian 33% Other founders 25% Investors 10%	6541	€192 million
Medica France	Bridgepoint 70% Executives 30%	6332	€210 million

MEDIDEP	ORPEA 29% Other shareholders 71%	4918	€250 million
Domus Vi	Yves Journel 68% Barclay Capital 24%	4499	€150 million
Serience	Batipar and Morgan Stanley Investment Fund 100%	3261	?

Source: Medidep Annual Report 2003

As in the UK social care market, there have been several changes of ownership in the last 2-3 years. Private equity and venture capital also play an important role as shareholders in the social care sector. ORPEA bought a 29 % share in MEDIDEP in 2003. Bridgepoint, a European private equity group, bought 70% of Medica France from Caisse de Depots, a Quebec fund manager for public and private pension funds. In 2003, Generale de Sante, a private healthcare company, sold 51% it shares in its care homes to DOMUS Vi which allowed the founder, Yves Journel, to regain control. [91]

Most follow-up care and rehabilitation beds are still attached to public sector hospitals in France. Non-profit providers dominate the home care market in France. However, since 2001, the large private companies delivering residential care have also set up subsidiaries that deliver home care by obtaining home hospitalization licences, for example, MEDIDEP and Medica France.[92] In the home care market, private companies dominate the market for sale and rental of hospital equipment in the home.

7.3. Nordic region

In Sweden in 1999, private providers provided 9% of public care for older people, although services are still publicly funded and the users pay fees, which are means tested.[93] The market for social care is dominated by four large companies, which are active in Norway, Sweden and Finland (They will be discussed in Section 8 Multinational companies). They hold 50% of the social care contracts in Nordic countries. Privately operated care is more common in urban centres than in rural areas, suggesting that delivering care to geographically scattered communities is not profitable. The municipalities that have privatized services, were more likely to be run by conservative political parties.[94]

7.4. Assisted living

The private sector is also becoming involved in social care indirectly through property investments. New housing schemes for older people, which focus on the concept of "assisted living" are being introduced in the UK, several Nordic countries, France, and Germany. They are usually set up by an alliance of property developers, investors, social care providers and sometimes a municipal authority. Each housing unit has a kitchen and bathroom but also shares some common facilities. They are often serviced by municipal home care services, which may be contracted out to private providers. These schemes are often built with public subsidy and residents have a tenancy agreement with rent calculated on a sliding scale. People have to be assessed by the municipality. Since the introduction of this legislation in 1997 in Denmark, there has been a decline in the number of nursing homes and an increase in assisted living schemes. [95]

Player and Pollock (2001) identify the growing links between property investment and care homes in the UK. In 2004, the UK Treasury published a consultation paper on the development real estate investment trusts, a concept well established in North America.[96] Companies provide capital for investment in the building of residential care centres for older people and often sub-contract the provision of social care to a local or subsidiary company. Primarily, the investment is considered a property investment, which is realised as part of a larger property investment portfolio. The development of REITs (Real Estate Investment Trusts) is also tax beneficial for investors.

There are indications that the social care market is considered a difficult market within which to make profits. However, an analysis of national social care markets suggests that companies consider there is potential for expansion because of the expanding older population in European countries. However, many companies are searching for a mix of services that will successfully generate profits. In this context, the

expansion of national care companies into different types and forms of care, whether for older people, adults with disabilities, adult with mental health problems, or childcare, needs to be monitored. In addition, the role of government funding and the changing national government policies towards the provision of intermediate and home care, will also influence the strategies of national care companies

7.5. Provision of services for childcare

The expansion of private provision of childcare in the UK has provided opportunities for several types of private company to move into the childcare market. Private equity and venture capital trusts are involved in investing in private childcare companies. Companies already providing social care for older people are buying childcare companies, for example, Four Seasons Healthcare Group, and BUPA.

In 2004, a UK company Kids Unlimited bought the UK arm of KinderCare, a US childcare company. This involved the purchase of two nurseries, with 100 and 134 places each. Kidsunlimited have 41 sites and capacity for 3,700 full time children.[97] Shortly after this acquisition, Kidsunlimited announced that it was to merge with Asquith Nurseries to form Nursery Years Group. This will be the largest provider of childcare with 17,300 children and 3,430 staff. The new company "*expects to participate actively in government schemes to help meet their states childcare and education targets*".[98] This is an example of how childcare companies also view part of their role in providing childcare for government funded schemes.

At the moment there are identifiable national markets for social care and childcare which each tend to be dominated by a few large national companies although they are also characterised by large numbers of small operators. Companies are increasingly involved in several dimensions of care: residential care for highly dependent older people, care for adults with psychiatric/ neurological conditions, home care, and residential accommodation sometimes with access to care facilities. In the UK, care companies are also becoming involved in child care. These are significant trends when examining the presence of multinational companies in the care sector. Cohen et al (2004) argue that nurseries and homes for older people (in the UK) have "*come to exemplify the liberal welfare regime's emphasis on private provision and market solutions, in which services are treated like any other private product for which there is a demand*". [99]

8. Key multinational companies active in the care for older people, homecare and childcare

The changing nature of social care provision and the increasing trend towards both privatization and commodification has presented some multinational companies with new opportunities. Demographic trends suggest a growing demand for care services for older people and companies have identified potential new markets, but this has not yet resulted in a major expansion by multinational companies into social care. Both childcare and social care work are labour intensive and as many companies have found in the last decade, do not always generate profits. This section will identify some of movements of multinational companies into social care, childcare and broader investments for services for older people.

8.1. Social care provision

A survey of the privatization of social care provision in Europe in 1997, commissioned by EPSU, as measured through the awarding of contracts listed in the European Union Tender Electronic Database (TED) database, identified five major multinational companies that had been awarded contracts for delivering social care in the United Kingdom, Nordic countries, and Germany. [100]Many of these companies were new to the social care sector. Multinational companies tended to concentrate on services in residential homes for children, older people and people with disabilities. The contracting out of homecare services was limited to domestic companies. The five companies identified in the 1997 survey were Bure (Sweden), ISS (Denmark), Marseille-Kliniken (Germany), Sodexho Partena Care (France) and Sun (United States).

As a way of demonstrating how multinational company presence in the social care sector has changed in the period since 1997, company developments will be examined since 1997. Most striking has been the process of divestment of services for older people within the last few years by four of the companies.

Table 3: Divestments of four multinational companies in Europe

Company	Date services sold	Company acquiring
Bure/Capio	2004	Attendo AB
Sodexho Partena Care	2001	Attendo AB
ISS	2002	Management buyout, partial sale of Finnish subsidiary to Medivire, 2004
Sun	1999	Ashbourne Homes

Source: www.capio.se; www.attendo.se; www.carepartner.se;

Bure Healthcare was set up by a Swedish investment company in 1994 and entered the markets for both acute and social care. By 1997, it had begun to move into the market for care of older people through a series of acquisitions. It had contracts to provide care to Swedish municipalities and county councils on a long term basis. In 2000, it became a publicly floated company and changed its name to Capio. It is now a major multinational company delivering acute care in Northern Europe and France. However, in 2004, it sold its older care services to Attendo, a Swedish company operating security, residential and care services for older people, in the Nordic Region. The Chairman of Capio attributed the sale to staffing problems and a lack of synergy with its other activities. [101]

Sodexho is a multi-service, global facilities management company. It purchased Partena Care AB, a company providing catering, cleaning, care and security services in Sweden and Norway in 1995. After restructuring, especially the security division, Sodexho sold Partena Care[102] to Attendo Care in 2001, the same company that bought Capio's older people's services.

ISS is a Danish company providing cleaning, catering and other facilities management services, a major competitor to Sodexho. It entered the care market through the acquisition of residential homes for older people. By 1997, it had started to provide home care in Sweden but by 2002, ISS care services were subject to a management buyout with ISS retaining 49% of the shares. The new company, Care Partner has been active in several Nordic countries but in 2004, it sold its Finnish CarePartner subsidiary to Medivire, a Finnish occupational health company, previously privatised by the Finnish government.[103]

By contrast, the German company, Marseille -Kliniken-AG illustrates the growing links between care provision and property interests. It runs retirement homes, rehabilitation homes and special geriatric hospitals mainly in Germany and expanded into the rehabilitation sector in 1996 by buying a company called KASANAG. It is now the largest provider of private nursing care and the third largest clinic operator in Germany. The company also operates the AMARITA franchise system set up in 2000 to provide nursing care. The company builds nursing homes and then sells the buildings. The strategy of the company is to reduce the stock of company owned beds and release resources through the sale of existing property and new buildings, e.g. AMARITA nursing homes. It aims to move from a ratio of 70% property owned and 30% rented to 30% owned and 70% rented. This is an example of a company trying to minimise investment risk. In nursing, it plans to acquire facilities from public providers, build new facilities and create a national presence [104]

SUN Healthcare is a United States healthcare company that in 1997 owned nursing homes in the United Kingdom. It was also entering the Australian healthcare market at the same time. In 1995, Sun was under investigation for fraud by the US federal government and at least one US state government. In Connecticut, the company was investigated for "*submitting false and misleading information on its 1993 and 1994 Medicaid cost reports*"[105] Patient complains about the standards of care in nursing homes were investigated by the US Federal government in 1997 and the company was banned from operating in California. By 1999, the company had filed for voluntary Chapter 11 protection and sold all its international operations. It emerged from Chapter 11 protection in 2001 and in 2002 a restructuring operation was approved. The company is still operating long term and nursing care facilities, therapeutic rehabilitation centres, homecare and medical staffing in the United States[106]It has not attempted to expand into international operations again.

The last seven years have seen continual changes of ownership in the multinational social care sector. Although the strongest trend is divestment, the expansion of Attendo in Sweden suggests that companies

with a combination of services including social care may be the most successful. The acquisition of a majority shareholding in Attendo by a major European private equity company, Bridgepoint Capital in February 2005, supports this view.[107] The case of Marseille-Klinken also shows that combining social care services and property interests is another strategy being pursued by companies.

8.2. Childcare provision

In many European countries, the public sector to still the main funder and provider of childcare. In Nordic countries the public sector both funds and provides childcare services. In Spain and the United Kingdom there is extensive private sector provision.

BUPA is a UK based non-profit company that was set up in 1947 in the United Kingdom (UK), to provide health insurance and healthcare services for privately insured patients. However since 1996, in the UK, it has expanded extensively into residential care homes and since 2000 into nursery services where public sector provision is limited or has been reduced. Care services for older people and children contribute almost half of sales in their health and social care services sector [108] It recently announced that the company has won a new contract to run out-of-school clubs for school age children in the UK.

There have been recent movements of US childcare companies into the UK market, for example, the UK arm of the US company Kindercare was acquired by Kidsunlimited, a UK childcare company in 2003. With the continued expansion of the private childcare market in the UK, the opportunities for US multinational companies will grow.

8.3. Broader investments

There are signs that both national and multinational companies are beginning to explore the feasibility of providing a range of services connected with ageing and social care. As mentioned in relation to national markets, the clearest model is the "assisted living concept" which draws a range of services, including social care, security systems, into a residential complex. Social care will be provided but may not be the dominant activity. This is a model, which has been developed in North America but is also being tested in the Nordic region and the UK.

In the Nordic region, the concept of "assisted care" for a company focuses as much on the investment in property than on the direct provision of social care. This trend may also be supported by changes in the way in which social care services for older people are paid for, moving towards a clearer breakdown of what services cost and older people being able to pay for specific services directly. This approach can be illustrated by the activities that Attendo Care, a Swedish multinational company, provides in three divisions. One division provides products and systems that "*improve the efficiency of providing care to older people and people with disabilities*", for example, care phones or response systems. A second division helps to develop monitoring centres that become the focus of the organization of care and support. A third division provides more conventional forms of social care: nursing homes; sheltered housing; homecare. This division also provides what it describes as "over the counter" care packages to local authorities or individuals [109] At the moment, the social care division is the most profitable division which may be because of the size of its acquisitions in the last four years.

Conclusion

The liberalization of social care, as seen through the introduction of an internal market for public social care services, the contracting out and privatization of many social care services, has led to the expansion of the private social care sector in many countries. However, multinational companies have not yet expanded significantly into these national social care markets. Expansion has been slow and often short term. The interest that private equity and venture capital investors have in both social care and childcare suggest that short term investments are successful with some expectations that both markets are likely to expand in the future.

9. European Works Councils company eligibility

9.1. European Works Councils and EU legislation

The European Works Councils (EWC) Directive, which was initially adopted in 1994,[110] 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,[111]or groups of companies[112], with

- at least 1000[113] employees across the member states,[114] *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.

9.2. 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

9.3. 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	

9.4. 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

9.5. Companies with EWCs or EWC eligible

9.5.1. 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. [115] Bridgepoint Capital Group also acquired a holding in the French care company Medica in 2003.

9.5.2. 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*".[116]

9.5.3. 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.

9.5.4. 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

9.5.5. 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. [117]

9.5.6. 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)

9.5.7. 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.[118]

9.6. NON EWC eligible companies

Companies that are not yet eligible for EWC are grouped by country. The company details expand some of the points made in Company overview (Section 3).

9.6.1. FRANCE - Company name DOMUS VI

Domus Vi,
47, rue Hallé
75014 Paris
Website: http://www.domusvi.com/AccueilDomusvi.htm

Company outline and strategy
Domus VI was formed after Generale de Sante sold its care homes through a management buyout in 2003, supported by Barclays Management Capital.[119] Ascaide Domus Viviendi is a company providing home care in France. It specialised in care of older people and is the fourth largest operator with 4, 632 beds and operates 57 homes for older people and agencies for home care services.

9.6.2. FRANCE – Company name MEDICA FRANCE

Website: www.medica-france.fr

Strategy and activities
Medica France runs 86 elderly care homes and intermediate care centres with 7000 beds. It is the second largest private social care provider in France in relation to the number of beds. Sales for 2003 were €210 million. Bridgepoint, a European private equity investor bought 70% of its shares in 2003.[120]

As well as developing 5-6 new care homes with 500 beds it also wants to acquire small and medium sized care groups in France and in Europe. This is a sign that along with Orpea and Medidep, it is hoping to expand into Europe.

9.6.3. GERMANY Company name MARSEILLE-KLINIKEN

Owner
Marseille Kliniken
Sportallee 1
D-22335 Hamburg, Germany
Phone: 49 40 5 14 59 0
Fax: 49 40 5 14 59 709
www.marseille-kliniken.de

Employees: 4,122

Company activities and strategy
Marseille -Kliniken-AG, founded in 1984 by Theo and Ulrich Marseille, runs retirement homes, rehabilitation homes and special geriatric hospitals mainly in Germany with expansion since 1992 into eastern Germany. The Marseille family owns five percent of the shares. Of the remaining shares, 50% are individually owned and 50% institutionally owned.

It expanded into the rehabilitation sector in 1996 by buying KASANAG and its subsidiary companies and is now the largest provider of private nursing care and the third largest clinic operator in Germany. The company also operates the AMARITA franchise system set up in 2000 to provide nursing care. The company builds nursing homes and then sells the buildings. The company plans to fund future growth through the sale of its own properties and sale of AMARITA nursing homes. It aims to move from 70% property owned and 30% rented to 30% owned and 70% rented. This is another example of a healthcare company selling properties to release capital.

In the period 1999-2003 there have been changes in the composition of the workforce, which is made up of 2,105 employees in nursing, 790 employees in rehabilitation and 1,227 employees in services. In both nursing and rehabilitation, there has been a slight decrease in housekeeping staff.[121]

9.6.4. UNITED KINGDOM – Company name FOUR SEASONS HEALTH CARE

Four Seasons Health Care Limited
Emerson Court, Alderley Road
Wilmslow, Cheshire
SK9 1NX
Tel: 01625 417800
Fax: 01625 417827
Website: www.fshc.co.uk

Employees: 19,000

Strategy and activities

The Four Seasons Health Care group consists of Four Seasons Health Care Limited, one of the largest independent providers of care services in the United Kingdom, and Principal Healthcare Finance Holdings (Guernsey) Ltd. Until July 2004, it was owned by Alchemy Partners, a private equity group but was then sold to Allianz Capital Partners for €1.15 billion. Allianz Capital Partners are hoping to launch Four Season Heath care as a public company - "In a few years' time, we will consider an IPO for Four Seasons Health Care."[122]

Four Seasons Health Care Limited operates 300 Care Homes and several Specialised Care Centres in England, Scotland, Northern Ireland and Isle of Man. It cares for 15,000 people. As well as care homes for older people, the company also provides respite care, rehabilitation, intermediate care, terminal and palliative care as well as care for younger persons suffering from chronic conditions. It also runs three nurseries – two in Scotland and one in the south coast of England. Four Seasons's Health Care also operated four retirement villages (2 in the Isle of Man, 1 in Scotland and 1 in Northern Ireland). [123]

In Scotland it also runs nursing services which provide day care, night care, sleepovers, bathing/showering, tuck-in, respite care, domestic duties. It charges the following prices per hour:

	Registered General Nurse/ registered Mental Nurse	EN	Care Assistant (Care Home/Hospital	Care Assistant (Community)
Weekdays	£16.00	£13.10	£8.40	£8.00
Nights	£18.35	£14.70	£9.80	£8.50
Weekends	£20.50	£17.60	£10.60	£8.75
Public Holidays	£32.00	£26.20	£16.80	£15.95

CARE ASSISTANT (Community)
Sleepover(Mon-Fri) 5.05
Sleepover(Sat-Sun) 5.65
Sleepover Public Holiday 10.75
Single hour(Mon-Fri) 10.10
Single hour(Sat-Sun) 11.35
Single Hour Public Holiday 19.75[124]

This gives an indication of how caring services are broken down into a series of tasks, which can be priced. The company provides nurses and carers to care homes, hospitals, NHS/Social Work community teams and industry. These are the prices that will be charged to the purchaser. They are not the hourly rates paid to the care workers.

9.6.5. UNITED KINGDOM – Company name CRAEGMOOR GROUP Ltd

Craegmoor Healthcare Co. Ltd.
Craegmoor House
Perdiswell Park
Worcester
WR3 7NW
Tel: 01905 459 800
Fax: 01905 459 801

Website: www.craegmoor.co.uk

Number of employees: 7,500

Strategy and activities

The Craegmoor Group was set up in 1994. It is the largest providers of specialist care in the UK with 300 care homes. It has three operating businesses: care homes; secure services and supported living. Secure services cover low, medium and high secure accommodation, rehabilitation units and independent hospitals for people with "complex mental health needs". Supported services cover supported accommodation and rehabilitation for people with specialist needs with a view to reintegrating them into the community.

The company has a turnover of £160 million. On 27 July 2001 funds managed by Legal & General Ventures Limited purchased a majority shareholding in the Group and has subsequently syndicated a proportion of their interest to a number of other private equity investors including LDC (formerly Lloyds TSB Development Capital), CDP Capital, RBS Mezzanine and funds managed by J O Hambro.[125]

9.6.6. UNITED KINGDOM – Company name SOUTHERN CROSS HEALTHCARE Ltd

Southern Cross Healthcare Group
Enterprise House
Valley Street North
Darlington DL1 1GY
Website: www.schealthcare.co.uk

Total number of employees: 12,000

Strategy and activities
Southern Cross Healthcare is the fourth largest provider of long term care beds in the United Kingdom, operating over 150 care homes with 8,000+ beds. The company has grown rapidly since 1997 through a series of acquisitions and new developments. In August 2002, the management backed by West Private Equity and Healthcare Investments Limited, acquired Southern Cross through a management buy-out. In September 2004, management and Blackstone Capital Partners completed a secondary buy-out of the business from West Private Equity and Healthcare Investments Limited. Southern Cross provides a range of services including services for older people, rehabilitation, physical and learning disabilities and intermediate care (care for people who have been in hospital care but are unable to return home). Since its acquisition in 2002 by West Private Equity, Southern Cross Healthcare Services has been developing both residential services and home care (Clinovia Homecare). [126]

9.6.7. UNITED KINGDOM – Company name WESTMINSTER HEALTH CARE

Westminster Health Care (Central Office)
Westminster House
Randalls Way
Leatherhead,
Surrey KT22 7TZ
Tel : 01372 860300
Fax : 01372 860333
Email : info@whc.co.uk
www.whc.co.uk

Employees: 12,000

Strategy and activities
Westminster Health Care manages 89 care homes and provides care for older people, including intermediate and respite care and care for adults with neurological conditions, for young adults with mental health problems and facilities for sheltered or assisted living. Westminster Health Care was a public company until 1999, and has since been owned by leading financial institutions and its management team. It was bought by Barchester Healthcare Group in 2004.

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11. Tables

11.1. Analysis of social care policy and funding by country – Nordic region

Country	Key legislation	Eligibility/ basic principles	Cash Benefits	Contribution by user
Norway	Municipal Health Services Act 19 November 1982 Social Services Act 13 December 1991 National Insurance Act 28 February 1997 Chapter 6	Universal Scheme Municipal responsibility All residents No age conditions Need for long term assistance and care	No cash benefits	Cost sharing charges for home care but varies according to municipality Long term nursing care – pays 75% income above €715 and up to basic amount of NOK? €6,774 85% of any exceeding income up to full cost of a nursing home place Property and capital assets left untouched
Denmark	Social Services Benefits Act 6 August 198 (law on social services amended)	Universal All residents No age conditions – the law also provides for the care of children No qualifying period	Cash benefit can be granted instead of home care so that disabled person her/himself can provide care aids, assistance and accompanying service	None
Sweden	1992 Transfer of nursing care services from County Councils to Municipalities Social Services Act January 2002	Universal security scheme Persons in need of care and assistance All residents	No cash benefits	Assistance is means tests according to Social Services Act
Finland	National Pensions Act 8 June 1956 including pensioners' car allowance	Universal security scheme Disabled people have a subjective right under the Services and Assistance for the Disabled Act	Pensions's allowance €51/month Increased rate €128.93/month Special rate €257.94?month Child disability	Personal participation in public longterm care (+ 3 months) is income related. Fee may be no more than 80% of person's net monthly income.

PSIRU, Business School, University of Greenwich, Park Row, London SE10 9LS, U.K.
Website: www.psiru.org *Email:* psiru@psiru.org *Tel*: +44-(0)208-331-9933 *Fax*: +44 (0)208-331-8665
Director: David Hall Researchers: Robin de la Motte, Jane Lethbridge, Emanuele Lobina, Steve Thomas, Violeta Corral

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	Social Welfare Act 17 September 1982 including support for informal care Primary health Care Act 28 January 1972	All residents No qualifying period People in constant and regular need of assistance or care (at least once a week	Allowance and disability allowances (3 different rates)	Minimum of €80 left for personal use.

11.2. Analysis of social care policy and funding by country - Continental Europe

Country	Key legislation	Eligibility	Cash benefits	Contribution by user
Austria	Cash benefits – Federal Long term care benefits Act No.110/1993; with amendments and 9 similarly phrased Long-term care benefit Acts of the Lander Benefits in kind : Agreements between the Federal Government and the Lander on joint measures for people in need of care	Cash benefits: Tax financed Long term care benefit System of the Federal Government and the Lander Benefits in kind: provision of social services by public and private providers Cash benefits and benefits in kind: all residents Benefit by birth (except 2 Land age 3) Benefits in kind No age conditions Only qualifying period for inpatient care if move residence Cash benefits – no qualifying period	Long term care benefit (monthly) Seven categories €145.40 – €1,531.50	Share for the use of benefits in kind. This share is to be paid for long term care benefit and for further income. The rest will be borne by the state.
Germany	Statutory long term care insurance 1994 Federal Social Assistance Act	Compulsory social insurance scheme financed by contributions in accordance with compulsory affiliate and sickness limits. Social assistance is tax financed Statutory long term care insurance :people in need of care who as a result of physical, emotional or mental disease or handicap, permanent and regularly need substantial long-term assistance Social assistance – in principle same as for long term care insurance – also provision to people needing care for less than 6 months – if outpatient or day care is in-acceptable	Instead of residential benefits in kind, patient can receive care benefits for monthly amount of: Categ 1 €205. categ 2 €410 and categ 3 €665 Social assistance – same care benefits as under longterm care assistance	Statutory long term care insurance – covers nursing home care but not accommodation costs Social assistance – according to income and assets

PSIRU, Business School, University of Greenwich, Park Row, London SE10 9LS, U.K.
Website: www.psiru.org *Email:* psiru@psiru.org *Tel*: +44-(0)208-331-9933 *Fax*: +44 (0)208-331-8665
Director: David Hall Researchers: Robin de la Motte, Jane Lethbridge, Emanuele Lobina, Steve Thomas, Violeta Corral

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		Almost whole population is insured Social assistance is for people who are not insured or for insured people who receive benefits **because of limits of long-term care insurance** No age conditions Statutory long-term care insurance - 5 year qualifying period Social assistance – none		
France	Supplement for permanent assistance of a 3rd party. Compensatory allowance for assistance by a 3rd party (Law-94-43 of 14 January 1994 2001 Personal Dependency Allowance	Supplement for permanent assistance of a third party - Less than 65 years Compulsory social insurance scheme – special supplement Compulsory allowance for assistance by 3rd party – between 16 and 60 years Allowance for loss of autonomy – from age 60 People requiring regular aid of a 3rd party in order to accomplish daily tasks No qualifying period	Supplement for permanent assistance of 3rd party – supplement of 40% to add to various pensions with a monthly amount of at least €945.87 Compensatory allowance for assistance by a 3rd party – amount is fixed according to resources and can reach €1,166.77	Allowance for loss of autonomy – means related contribution to long term care costs
Belgium	No specific legislation on long term care however certain benefits are provided in particular corresponding legislation on sickness and invalidity insurance and on guaranteeing sufficient resources. Some benefits foreseen at local and regional levels	Sickness and invalidity insurance- compulsory social insurance scheme for employees Beneficiaries of sickness and invalidity insurance Guaranteeing sufficient resources – social assistance scheme financed by State budget A person who is not able to perform basic activities of daily life. Aid is provided according to an individual appreciation of each case	Cash benefit can be granted instead of home care so that disabled person can provide for care aids, assistance and accompanying services	No share borne by insurance
Netherlands	General Exceptional Medical Expenses	Contribution financed health insurance system for medical risks not covered by compulsory or private health	No cash benefits	Cost sharing in residential care in an institution from age 18. Two kinds of

	Act (1967)	insurance Long term hospitalised people, elderly people, disabled people and mentally disabled people with chronic problems All residents No age conditions No qualifying period		cost sharing: 1) high contribution income related with a max of €1,700/month 2) low contribution – income related with max €685.40/month And a fixed contribution only applicable in care of short stay in an institution for mentally handicapped or for home care. The amount is €11.80/hour with a max of €528.20 per four weeks

11.3. Analysis of social care policy and funding by country – UK and Ireland

Country	Legislation	Eligibility	Cash benefits	User contribution
United Kingdom	Social Security Contributions and Benefits Act 1982 1990 Health and Community Care Act Direct Payments Act	Non-contributory, state financed system providing cash benefits and benefits in kind for elderly or disabled people and their carers All residents with an unrestricted right to remain in the UK	Attendance Allowance – people aged 65+ who have personal care needs during the day and/or night because of physical or mental disability – person must have met the disability condition for at least 6 months prior to making claim Disability Living Allowance – people under 65 who have personal care and/or mobility needs because of illness or disability. Can be paid after 65 if the care/mobility needs continue. Must have had condition for 3 months before making claim and expect condition to continue for at least 6 months. 3 rates for care needs. Carers' allowance €61/week - payable to person not earning more than €109/week (after allowable expenses) who is providing at least 35 hours care a week to another person who is in receipt of certain benefits – for carers over 16	If a disabled person is receiving care or other services from the local authority, reasonable charges may be made for that care or those services depending on ability to pay
Ireland	Social welfare (consolidation) Act, 1993, as amended: Constant Attendance allowance, Carer's benefit, carer's allowance Health Act, 1970:	Carer's Benefit and Constant Attendance Allowance: Compulsory Social insurance scheme for all employees with flat rate benefits.	Carer's Benefit: for a single care recipient €149.70/week Several cared recipients: €224.60 Constant Attendance Allowance €149.70 Carer's Allowance Max amounts –single cared recipient €139.60 For several cared recipients €209/4 Domiciliary Care Allowance max rate €179.80 per child with	Carer's Benefit, Constant Attendance Allowance, Carer's Allowance, Domiciliary Care Allowance and Home Care – no costs borne by beneficiary Nursing Home Subvention – the excess cost of nursing home care – amount varies.

	Domiciliary Care Allowance, Home Care Health (Nursing Homes)Act 1990; Nursing Home Subvention	Carer's allowance: tax financed scheme for all carers with means tested flat rate benefits Domiciliary Care Allowance: Tax financed scheme for all carers of a child with a severe disability. Home Care and Nursing Home Subvention: tax financed services for all inhabitants	disability	

11.4. Analysis of social care and funding by country – Southern Europe

Country	Legislation	Eligibility/ basic principles	Cash benefits	Contribution by user
Spain	Legislative Royal decrees no.1/94 of 20 June 1994 in which amended version the Social Security General act is approved	Social insurance system Compulsory insurance systems for all employees. Benefits depend on contributions. Certain total incapacity for any job pensioners. No age conditions Guaranteeing sufficient resources System for all residents. Tax financed. Non-contributory invalidity pension with a supplement of 50% to persons between 18-65 years with a degree of disability of chronic disease equal or over 75% and who need the help of a 3rd person to carry out essential daily tasks. These people must have been legally resident in Spain for at least 5 years, 2 of which much be immediately prior to	Social insurance systems – minimum pensions €617 /month and with a dependent spouse €727 Maximum pension €2,086 /month Guaranteeing sufficient resources Non-contributory invalidity pensioners in need of help from another person to perform daily activities receive the pension with 50% supplement in 2004 it amounts to €5,802 /year paid in 14 monthly instalments	No share borne by the beneficiary

		the benefit claim. Being a recipient of a non-contributory invalidity pension		
Portugal	Social insurance Statutory Order 209-A/2000 of 30.11.200, Statutory Order 265/99 of 14.7.1999 Guaranteeing sufficient resources Stat.order 309-A/2000 of 20.11.2000 Social action Government decree 407/98 of 18.6.1998	Social insurance – public compulsory insurance scheme. Recipients of invalidity, old age and survivors pensions; recipients of family benefits Guaranteeing sufficient resources – non-contributory case benefits Recipients of invalidity, old age and survivors pensions; recipients of family benefits Social action – benefits in kind provided by the integrated social action measures and health care benefits Persons in need of temporary or permanent, light or severe care for physical, mental or social reasons People needing the assistance by a 3rd party to perform the activities of daily life No age conditions No qualifying period	No cash benefits	Social insurance – no participation Guaranteeing sufficient resources – no participation Social action – depends on own income or the family income
Italy	Law No 104 of 5 February 1992 Art.33 Law No.53 of 8 March 2000	Benefits that can be considered as dependency benefits under both the social security and social welfare system Social insurance in case of disability – allowance granted in case of disability to pensioners who need help of a 3rd party to move around or who require permanent assistance to carry out basic tasks Recipients of a disability pension Payment of a minimum contribution to the INPS for 5 years Guaranteeing sufficient resources : nonactive handicapped people not able to carry out basic tasks	Social insurance in case of disability – monthly assistance allowance Guaranteeing sufficient resources €200/month Regional programmes – different application according to regions - generally cash benefits according to need	Benefits are funded entirely by the State

		Very old people who require domestic assistance (in kind) or who wish to be cared for at home – non active handicapped people – very old people No age conditions		
Greece	Old age and invalidity – no special legislation Law No 1140/10981(revised version) JL 68A/20.3.81 provides for some benefits Guaranteeing sufficient resources The statutory orders NO.162/73 (measures for the protection of the elderly and chronically ill) and No.57/73 (measures for the protection of persons with little financial means) provide for some benefits. Further measures are provided for by a number of ministerial orders	Old age and invalidity – insurance scheme Persons affiliated to social insurance schemes – no age conditions – 4,050 days of insurance Guaranteeing sufficient resources – social welfare scheme – elderly persons in need of care – permanent residents – no qualifying period No age conditions	Old age invalidity the amount of disability benefit is increased by 50% in the case of total disability Guaranteeing sufficient resources Disabled persons can profit from 7 basic from an amount of 192 to 490 and 3 comple-mentary benefits from an amount if 58 to 131	With the exception of certain cases there is as a rule by participation borne by the insured

11.5. Country analysis of care provision – Nordic region

Country	Type of provision Home care	Temporary residential care	Nursing home care	Responsibility for provision
Norway	Practical assistance and/or care at home according to need, carried out by municipal home services assistants or nurses Some private provision	Short term stays in nursing homes offered as relief for family of patients cared for at home Capacity shortages in many municipalities	Provided in municipal nursing homes Waiting lists due to limited capacity Some contracting out to private sector	Municipalities
Denmark	Personal hygiene, domestic help. Assistance to a person to maintain her/his capabilities	These benefits can be granted as a relief to the care givers of disabled or dying persons	Homes or special apartments for disabled or elderly people	Municipalities
Sweden	In municipalities benefits in kind are provided for home care services	Special housing provided according to need of care	Special housing provided according to need of care	Municipalities
Finland	Municipalities provide home nursing home services, and services for disabled (transport services, personal assistant, house alteration) Support for informal care	Muncipalities provide special housing according to need of care	Provided by municipalities according to need	Municipalities

11.6. Country analysis of care provision - Continental Europe

Country	Type of provision	Temporary residential	Nursing	Responsibilities

	Home care	Care	Home care	
Austria	Provision of social services by public and private providers Outpatient services: Home help, qualified care giver, visiting services, organised neighbourhood help, mobile therapeutic services, family help, lending of nursing aids and appliances, laundry services, cleaning services, repair service, transport services, personal assistant	Provision of temporary residential care in care facilities e.g. day centres	Provision of inpatient care in care facilities e.g. nursing homes	Federal and Lander
Germany	Statutory long term care insurance: Monthly benefits in kind (provided by care centres or individuals) for the value of Category 1 up to €384.Category 2 €921, Category 3 €1,423 in cases particular hardship €1,918 cash benefits and benefits in kind may be combined Social assistance – benefits up to the amount of need	Statutory long term care insurance: Monthly benefits in kind for care in day and night centres in addition to residential care for a value of Category 1 €384, Category 2 €921 and Categ 3 €1,432 Social assistance – benefits up to amount of need	Statutory longterm care insurance: Care, medical treatment and social support expenses fully paid - a monthly benefit in kind for a max €1,432. At present there are 3 dependence categories: Categ 1 €1,023, Categ 2 €1,279 and Categ 3 €1,432. also €1,688 in case of hardship Social assistance – all costs as required for care and lodging for people not covered by long term care insurance For the insured – costs as required for board and lodging as well as investment costs for care facilities	Federal government/ Lander
France	Allowance for loss of autonomy – benefit varies according to long term care needs and person's resources	No specific provisions	Allowance for loss of autonomy – benefit varies according to long term care needs and person's resources	
Belgium	Sickness and invalidity insurance – measures of home care – measures provided according to degree of physical need for long term care in	In concerned regulation there are no benefits in kind in case of temporary residential care	Sickness and invalidity insurance (daily amounts) Rest and nursing homes – allowances for care and assistance of a person in need of care to perform basic activity of daily life provided by insurance	

	accordance with specific scale			
Netherlands	Home care included the necessary nursing, care, guidance and counselling required by the insured individual at home in connection with illness, recovery, disability, old age, death or psychosocial problem. It also includes the loan of nursing equipment for a max period 26 weeks	Day care in a nursing home is available to those with physical or mental disorders for which all the necessary care is not available in their own environment	Nursing home care and care in a home for the physically disabled included medical help and treatment, care and nursing provided by the home and the associated rehabilitation, physiotherapy and occupational therapy	

11.7. Country analysis of care provision – UK and Ireland

Country	Home care	Temporary residential care	Nursing home care	Responsibility for provision
United Kingdom	Local authorities provide funding for home care, meals on wheels, special aids and equipment, adaptations to the home and attendance at day centres Some means testing	None	Local authorities can arrange admission to a care home. In general the local authority pays for the accommodation and personal care costs unless the person can afford to pay for part or all of the cost. All direct costs of care from a registered nurse are paid for by the NHS	Local authorities
Ireland	Carer's allowance: free travel, telephone rental allowance, electricity allowance and TV licence Home care: public health nursing, home help and meals on wheels services, physiotherapy, occupational therapy and chiropody services, hospital service including	Day care centres providing services e.g. midday meal, bath, physiotherapy, occupational therapy, chiropody, laundry and hairdressing services	People who have very limited means may receive free nursing home care in a state owned nursing home	

	assessment and rehabilitation respite care			

11.8. Country analysis of care provision – Southern Europe

Country	Type of provision Home care	Temporary residential Care	Nursing Home care	Responsibilities
Austria	Provision of social services by public and private providers Outpatient services: Home help, qualified care giver, visiting services, organised neighbourhood help, mobile therapeutic services, family help, lending of nursing aids and appliances, laundry services, cleaning services, repair service, transport services, personal assistant	Provision of temporary residential care in care facilities e.g. day centres	Provision of inpatient care in care facilities e.g. nursing homes	Federal and Lander
Germany	Statutory long term care insurance: Monthly benefits in kind (provided by care centres or individuals) for the value of Category 1 up to €384.Category 2 €921, Category 3 €1,423 in cases particular hardship €1,918 cash benefits and benefits in kind may be combined Social assistance – benefits up to the amount of need	Statutory long term care insurance: Monthly benefits in kind for care in day and night centres in addition to residential care for a value of Category 1 €384, Category 2 €921 and Categ 3 €1,432 Social assistance – benefits up to amount of need	Statutory longterm care insurance: Care, medical treatment and social support expenses fully paid - a monthly benefit in kind for a max €1,432. At present there are 3 dependence categories: Categ 1 €1,023, Categ 2 €1,279 and Categ 3 €1,432. also €1,688 in case of hardship Social assistance – all costs as required for care and lodging for people not covered by long term care insurance For the insured – costs as required for board and lodging as well as investment costs for care facilities	Federal government/ Lander
France	Allowance for loss of autonomy – benefit varies	No specific provisions	Allowance for loss of autonomy – benefit varies according to long term care needs	

	according to long term care needs and person's resources		and person's resources	
Belgium	Sickness and invalidity insurance – measures of home care – measures provided according to degree of physical need for long term care in accordance with specific scale	In concerned regulation there are no benefits in kind in case of temporary residential care	Sickness and invalidity insurance (daily amounts) Rest and nursing homes – allowances for care and assistance of a person in need of care to perform basic activity of daily life provided by insurance	
Netherlands	Home care included the necessary nursing, care, guidance and counselling required by the insured individual at home in connection with illness, recovery, disability, old age, death or psychosocial problem. It also includes the loan of nursing equipment for a max period 26 weeks	Day care in a nursing home is available to those with physical or mental disorders for which all the necessary care is not available in their own environment	Nursing home care and care in a home for the physically disabled included medical help and treatment, care and nursing provided by the home and the associated rehabilitation, physiotherapy and occupational therapy	

12. Appendix A: Recommendations

The research carried out 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
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