

Chapter 2

Unity and Diversity of SSGIs in the European Union

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Abstract At the start of the 2000s, a new category of SGIs appeared in European debates: *social* services of general interest (SSGI). This is a new category that brings with it at least two new research questions: what services may be characterised as SSGIs and do they form a legal category to which one could apply a consistent body of rules? To address these questions, this paper, on the basis of the study ‘Mapping of the Public Services’ 2009–2010, discusses SSGI in the EU by considering the relationship between diversity and unity, in the context of the available empirical data, through four distinct ‘approaches’.

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2.1 Introduction

The study ‘Mapping of the Public Services in the EU and in the 27 Member States’,¹ was conducted between 2009 and 2010 on the whole range of SGIs in the 27 Member States of the EU. The study provides us with an analytical grid of the European public services and their evolution since the process of Europeanization began almost 30 years ago, an evolution marked by tensions and interactions between unity and diversity. In this Chapter, the data are used specifically to consider the SSGIs, their characteristics and the challenges they raise.

On the basis of the information gathered at the time of the study ‘Mapping of the Public Services’, this Chapter first addresses the problematic issues of the terms and concepts that can be attributed to, and that help to define, SSGIs (Sect. 2.2). The discussion then turns to a consideration of the unity–diversity ratio (Sect. 2.3) before analysing the empirical data that we collected in four geographically diverse ‘approaches’ (Sect. 2.4). The Chapter then draws to a conclusion with a consideration of the final research question regarding whether it is possible to define or establish a European general framework for all SSGI (Sect. 2.5).

2.2 European Union Norms and Problems of Definition

During the consultation exercise for the Green Paper on services of general interest in 2003,² the actors of the social sector (local public authorities, service providers, representatives of the users) expressed a growing legal insecurity with regard to the developing bodies of European legal norms to which they were subject, taking into account the specific nature of the social services provided. They stressed that they belonged to a ‘grey area’, that sat, in particular, between services clearly described as ‘economic’ and others that could be considered as ‘non-economic’. The distinction is important since the one and the other do not belong to the same body of the European rules. This was a lack of clarity that appeared to the actors of the social sector as prejudicial to the achievement of their missions.

In response, the Commission, in its White Paper of 2004,³ proposed ‘a systematic approach in order to identify and recognise the specific characteristics of social and health services of general interest and to clarify the framework in which they operate and can be modernised’. The White Paper led to several

¹ Bauby and Similie 2010.

² Commission, *Green Paper on Services of General Interest*, COM(2003) 270, 21 May 2003.

³ Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, White Paper of Services of General Interest*, COM(2004) 374, 12 May 2004.

Communications⁴ and studies⁵ whilst, at the same time, the Directive on services in the internal market⁶ excluded most of them from its field of application and the European Parliament asked for the development of a sectoral secondary law on several occasions.⁷

The description given by the Commission in its Communication of 2006 on the implementation of the Lisbon programme⁸ leaves unanswered the question of what we should understand by the term ‘social services’ in the European Union. In addition to health services, which are not covered by this Communication, they can be attached to the one of the two main categories:

- statutory and complementary social security schemes, organised in various ways (mutual or occupational organisations), covering the main risks of life, such as those linked to health, ageing, occupational accidents, unemployment, retirement and disability;
- other essential services provided directly to the person. These services that play a preventive and social cohesion role consist of customised assistance to facilitate social inclusion and safeguard fundamental rights. They comprise, first of all, assistance for persons faced by personal challenges or crises (such as debt, unemployment, drug addition or family breakdown). Second, they include activities to ensure that the persons concerned are able to completely reintegrate into society (rehabilitation, language training for immigrants) and, in particular, the labour market (occupational training and reintegration). These services complement and support the role of families in caring for the youngest and oldest members of society in particular. Third, these services include activities to integrate persons with long-term health or disability problems. Fourth, they also include social housing, providing housing for disadvantaged citizens or socially less advantaged groups. Certain services can obviously include all of these four dimensions. Then, the Communication specifies in a note that ‘education and training, although they are services of general interest with a

⁴ Commission, *Communication from the Commission, Implementing the Community Lisbon Programme: Social Services of General Interest in the European Union*, COM(2006)177, 26 April 2006; Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, Accompanying the Communication on ‘A Single Market for 21st Century Europe’, Services of General Interest, Including Social Services of General Interest: a New European Commitment*, COM(2007)725, 20 November 2007.

⁵ See in particular Hubner et al. 2008.

⁶ Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on Services in the Internal Market, *OJ* 2006 L 376.

⁷ *EP, Report on the Commission White Paper on Services of General Interest*, Rapporteur: Bernhard Rapkay, 2005/2101(INI), 14 September 2006; *EP, Report on Social Services of General Interest in the European Union*, Rapporteur: Joel Hasse-Ferreira, 2006/2134(INI) 6 March 2007; and *EP, Report on the Single Market Review: Tackling Barriers and Inefficiencies through Better Implementation and Enforcement*, Rapporteur: Jacques Toubon, 2007/2024(INI), 23 July 2007; *Conclusions of the Lisbon SSGI Forum of 17 September 2007*.

⁸ See COM(2006) 177.

clear social function, are not covered by this Communication' which leave open the question of knowing if they are SSGIs. We will return to this idea.

The Communication adds that:

although, under Community law, social services do not constitute a legally distinct category of service within services of general interest, the list above demonstrates their special role as pillars of the European society and economy, primarily as a result of their contribution to several essential values and objectives of the Community, such as achieving a high level of employment and social protection, a high level of human health protection, equality between men and women, and economic, social and territorial cohesion. Their value is also a function of the vital nature of the needs they are intended to cover, thus guaranteeing the application of fundamental rights such as the dignity and integrity of the person.

Consequently, the Communication advances a series of 'organisational characteristics' applying to SSGIs 'they operate on the basis of the solidarity principle,⁹ which is required, in particular by the non-selection of risks or the absence, on an individual basis, of equivalence between contributions and benefits; they are comprehensive and personalised integrating the response to differing needs in order to guarantee fundamental human rights and protect the most vulnerable; they are not for profit and in particular to address the most difficult situations and are often part of a historical legacy; they include the participation of voluntary workers, expression of citizenship capacity; they are strongly rooted in (local) cultural traditions; this often finds its expression in the proximity between the provider of the service and the beneficiary, enabling the taking into account of the specific needs of the latter; an asymmetric relationship between providers and beneficiaries that cannot be assimilated with a 'normal' supplier/consumer relationship and requires the participation of a financing third party'.

The Communication adds that social services constitute a booming sector and they are 'the subject of an intensive quest for quality and effectiveness'. It specifies that 'all the Member States have embarked upon modernisation of their social services to tackle the tensions between universality, quality and financial sustainability'.

Here, we consider if SSGI may constitute a specific legal category to which one could apply the same body of rules. Obviously, they all have social objectives as their outcomes and one could refer to the European concept of 'social cohesion' defined in Union primary law in the Single European Act of 1986. Yet, neither the Treaties nor the secondary law contain the expression 'social services of general interest'—nor do they give a definition of this as a subcategory of services of general interest.

With no distinct general European legislative framework applicable to SSGIs they are subject to the same legal regime as SGIs. As a consequence the distinction existing today in the primary law between SGEIs and NESGIs lead one to try to distinguish between economic and non-economic social services of general interest. The term SSGI cannot be reduced to a definition whereby 'non market services are [merely] equivalent to social services of general interest',¹⁰ the

⁹ See the European case law cited below.

¹⁰ See, Gallo 2011, pp. 4–5.

reduction is too simplistic. As is the assertion of the Commission in 2006 according to which ‘almost all services offered in the social field can be considered ‘economic activities’ within the meaning of Articles 43 and 49 of the EC Treaty’.¹¹ The public authorities and the service providers in the field of SSGI recognise the constant evolution of the CJEU’s jurisprudence and, in particular, the evolution of the notion of ‘economic activity’ as a source of uncertainty: ‘[w]hilst the case law and Community legislation have endeavoured to reduce this uncertainty or clarify its impact, they cannot do away with it completely’.¹² In its communications,¹³ the Commission distinguishes *within* the category of social services, the fields of social protection (compulsory and complementary), access to employment, health, social housing, teaching, education and training. The list of activities is not exhaustive and some of the categories mentioned are questionable in the light of some national approaches to the qualification service provision as one of social service, especially services regarding education.¹⁴

These communications from the European Commission have appeared after several years of Union jurisprudence that has brought some clarification to the economic or non-economic nature of certain social services. According to the European jurisprudence, social services are regarded as being non-economic activities concerned with the management of compulsory insurance regimes that pursue an exclusively social goal, that function according to the principle of solidarity, or that offer insurance services independent of the contributions.¹⁵ For the CJEU, the criterion marking the non-economic character of the activity is not due to the status of the service provider, or the organisation,¹⁶ nor the nature of the

¹¹ See COM(2006)177, p. 7.

¹² Ibid.

¹³ COM(2006) 177; COM(2007) 725.

¹⁴ In the questionnaire of consultation addressed to Member States in 2004, the European Commission noted that ‘it is clear that some... fields go beyond “social protection” in the narrow sense. But nevertheless e.g. also education and training or access to placement services could form part of the social services (e.g. vocational training, training of handicapped persons) or have similarities to social protection...’.

¹⁵ CJEU, Case C-109/92 *Wirth* [1993] ECR I-6447; CJEU, Case C-355/00 *Freskot* [2003] ECR I-5287; CJEU, Case C-263/86 *Humbel* [1988] ECR 5365; CJEU, Case C-159/91 *Poucet et Pistre* [1993] ECR I-637; CJEU, Case C-218/00 *INAIL* [2002] ECR I-691, paras 43-48; CJEU, Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01 *AOK Bundesverband* [2004] ECR I-2493, paras 51-55.

¹⁶ CJEU, Case C-172/98 *Commission v. Belgium* [1999] ECR I-3999; CJEU, Case C-70/95 *Sodemare* [1997] ECR I-3395: ‘Articles 52 and 58 of the Treaty do not preclude a Member State from allowing only non-profit-making private operators to participate in the running of its social welfare system by concluding contracts which entitle them to be reimbursed by the public authorities for the costs of providing social welfare services of a health-care nature. As Community law stands at present, a Member State may, in the exercise of the powers it retains to organise its social security system, consider that attainment of the objectives pursued by a social welfare system which, being based on the principle of solidarity, is designed as a matter of priority to assist those in need, necessarily implies that the admission of private operators to that system as providers of social welfare services is to be made subject to the condition that they are non-profit-making.’

service.¹⁷ It has regarded as an economic activity those regimes of voluntary insurance that function according to the principle of capitalisation, even where they are provided by not-for-profit organisations.¹⁸ These organisations include medical departments within or without a hospital framework,¹⁹ emergency services and the transport of patients,²⁰ and the placement services carried out by public employment offices.²¹

It seems necessary, however, to position the uncertainty raised here because, on the one hand where a service is described as ‘non-economic’, it is clear that it ‘is not subject to the rules of the treaty relating to the internal market and competition’. However, if, on the other hand, the service is regarded as ‘economic’, it becomes subject to the norms of the internal market and competition only ‘in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them’ (Article 106 TFEU). Thus, rather than worrying about the division between economic and non-economic, the question should focus on the public authority responsible for the activity concerned that should have, as an requirement, an obligation to attempt to define clearly and precisely the ‘particular mission’ of the service that it entrusts to a service provider, and in what particular way that service may be obstructed ‘in law or in fact’ by the application of the rules of the internal market and competition.

In *BUPA*, the GC, relying on what is now Article 5(2) TEU (the principle of subsidiarity), confirms the Member States’ competence to determine the nature and scope of a SGEI mission in those areas of specific action that is not within the competence of the Union, or which are based on a shared competence.²² According to the Court:

the national authorities were entitled to take the view that certain services were in the general interest and must be provided by means of SGEI obligations when market forces were not sufficient to ensure that they would be provided that the national authorities were entitled to take the view that certain services were in the general interest and must be provided by means of SGEI obligations when market forces were not sufficient to ensure that they would be provided.²³

¹⁷ The fact that a provision falls within the field of social security or of health does not in itself lead to exclude the application of the Treaty rules. CJEU, Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473.

¹⁸ CJEU, Case C-244/94 *FFSA* [1995] ECR I-4013, paras 17-22; CJEU, Case C-67/96 *Albany* [1999] ECR I-5751, paras 80-87.

¹⁹ CJEU, Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473, para 53; CJEU, Joined Cases 286/82 and 26/83 *Luisi et Carbone* [1984] ECR 377, para 16; CJEU, Case C-159/90 *Society for the Protection of Unborn Children (IVG)* [1991] ECR I-4685, para 18; CJEU, Case C-368/98 *Abdon Vanbraekel* [2001] ECR I-5363, para 43; GC, Case T-167/04 *Asklepios Kliniken* [2007] ECR II-2379, paras 49-55.

²⁰ CJEU, Case C-475/99 *Glöckner* [2001] ECR I-8089, para 20.

²¹ CJEU, Case C-41/90 *Höffner* [1991] ECR I-1979, para 21.

²² GC, Case T-289/03 *BUPA* [2008] ECR II-917.

²³ *Ibid.* para 42.

The Court identifies that:

the health sector falls almost exclusively within the competence of the Member States. In this sector, the Community can engage, under Article 152(1) and (5) EC, only in actions which is not legally binding, while fully respecting the responsibilities of the Member States for the organisation and provision of health services and medical care. It follows that the determination of SGEI obligations in this context also falls primarily within the competence of the Member States.²⁴

Because of their precise nature, some EU norms impose on categories of SSGI a different legal regime. The Services Directive,²⁵ for example, provides for the exclusion from its field of application *NESGIs*; the services of *temporary work agencies*; *healthcare services* ‘whether or not they are provided via healthcare facilities, and regardless of the ways in which they are organised and financed at national level or whether they are public or private’²⁶; and *social services* ‘relating to social housing, childcare and support of families and persons permanently or temporarily in need which are provided by the State, by providers mandated by the State or by charities recognised as such by the State’.²⁷ In addition, in this context, *NESGIs* constitute a category *distinct* from that of social services and the *social* attribute is not attached to healthcare services. However, no definition of *social services* is to be found in the Directive.

The study ‘Mapping of the Public Services’ did not have as an objective a specific analysis of SSGI or of each category of social services identified in the EU Member States. Nor was it able to assimilate the effects of the financial and economic crisis that started to impact on this sector in 2008. However, the statistical categories used²⁸ allow for an estimation of the weighting to be applied to certain categories of social services, healthcare and education, in terms of the numbers of employees and contribution to GDP, in each Member State and at the European level.

Table 2.1 presents the data resulting from the Mapping study and shows, on the one hand, the percentage of persons employed and, on the other hand, the contribution to GDP (added values for the network sectors, expenditure for the other activities) for those sectors identified as Public Administration and social

²⁴ Ibid. para 167.

²⁵ Directive 2006/123/EC.

²⁶ Ibid. Article 2(2)(f).

²⁷ Ibid. Article 2(2)(j).

²⁸ NACE rev. 1, Section L ‘Public Administration and Defence; Compulsory Social Security’, Section M ‘Education’ (primary, secondary, higher education, adult and other education), Section N ‘Health and Social Work’ (including veterinary activities). Section J ‘Financial Intermediation’ contains ‘66. Insurance and Pension Funding, Except Compulsory Social Security’.

Eurostat statistics on the social protection take into in the structure of expenditure of social protection benefits in kind (in goods or services) the healthcare expenditures (direct provision and reimbursement of in-patient and out-patient healthcare, including pharmaceutical products) and social services (Social services with accommodation, assistance with carrying out daily tasks, rehabilitation, child day care, vocational training, placement services and job search assistance, etc.).

Table 2.1 Source: mapping study

Countries	Persons employed by SGI providers (in % of the total number of employees)					Expenditures or added value by SGI sector (in % of GDP)				
	Public Adm	Education	Health	Total 3 sectors	Total SGI	Public Adm	Education	Health	Expenditures	Total SGI
	%	%	%	%	%	%	%	%	3 sectors	%
Austria	6.4	5.8	8.7	20.9	28.2	4.3	5.1	10.1	19.6	25.6
Belgium	9.9	8.8	12.4	31.1	40.0	3.6	5.6	10.3	19.4	24.9
Bulgaria	7.2	6.9	5.3	19.4	27.2	7.9	11.2	7.2	26.3	35.5
Cyprus	8.4	6.9	4.0	19.3	?	5.6	7.9	6.3	19.7	25.7
Czech Republic	6.8	6.0	6.8	19.6	27.0	6.6	7.6	6.9	21.1	29.5
Germany	7.8	5.8	11.4	25.0	31.8	4.2	4.3	10.6	19.1	24.7
Denmark	6.0	7.6	17.5	31.1	39.9	8.7	5.8	9.6	24.1	29.2
Estonia	6.0	9.1	5.8	20.9	25.9	6.6	7.6	5.1	19.3	27.0
Spain	6.2	5.6	6.0	17.8	22.7	5.0	4.7	8.4	18.1	22.8
Finland	5.6	6.9	15.0	27.5	35.1	9.1	5.3	8.2	22.5	27.7
France	9.6	7.1	12.2	28.9	37.4	5.1	5.0	11.0	21.2	27.0
Greece	8.6	7.4	5.1	21.1	?	4.8	?	9.5	?	18.5
Hungary	7.6	8.2	6.9	22.7	30.5	7.0	9.1	8.3	24.4	30.6
Ireland	5.1	6.6	10.0	21.7	26.2	5.1	4.0	7.1	16.2	19.1
Italy	6.3	6.9	6.8	20.0	25.2	5.2	4.6	9.0	18.8	23.5
Lithuania	5.1	8.8	7.1	21.0	27.4	5.9	9.0	6.2	21.1	27.3
Latvia	8.1	8.1	4.7	20.9	32.1	6.8	9.0	?	?	22.6
Luxembourg	5.4	4.7	7.7	17.8	26.6	3.1	3.0	7.3	13.4	18.7
Malta	9.4	8.1	7.6	25.1	?	5.6	?	?	?	?
Netherlands	6.5	6.4	15.4	28.3	39.6	7.2	5.1	9.7	22.0	27.9
Poland	6.3	7.8	6.0	20.1	25.7	6.0	9.1	6.2	21.3	27.9
Portugal	6.9	6.2	6.4	19.5	23.6	4.1	6.5	10.2	20.7	26.1

(continued)

Table 2.1 (continued)

Countries	Persons employed by SGI providers (in % of the total number of employees)					Expenditures or added value by SGI sector (in % of GDP)				
	Public Adm	Education	Health	Total 3 sectors	Total SGI	Public Adm	Education	Health	Expenditures	Total SGI
	%	%	%	%	%	%	%	%	3 sectors	%
Romania	5.4	4.4	4.1	13.9	181	6.4	?	4.5	10.9	16.6
Sweden	5.7	11.1	16.1	32.9	40.1	9.6	5.7	9.2	24.5	29.7
Slovenia	6.1	7.7	6.3	20.1	25.8	6.2	7.7	8.3	22.2	27.7
Slovakia	7.0	7.2	6.7	20.9	27.3	5.7	6.9	9.1	21.7	30.8
United Kingdom	7.0	7.2	6.7	20.9	33.7	11.8	4.7	8.5	25.0	32.1
Total EU	7.2	7.0	9.6	23.8	30.1	6.4	4.9	9.4	20.7	26.4

Source Mapping of the Public Services, 2010

security, Health and social services, and Education and that are regarded here as SSGI. The figures, mostly drawn from Eurostat analysis, are global and relate to the year 2006, the most recent datasets available at the time of the study. They do not specifically distinguish *social services* from within the whole spectrum of each statistical category, nor are social housing or complementary social security services included as they are not subject to data collection.²⁹ The data presented should be understood in terms of its comparative value, as between the Member States, given the uncertainty and incompleteness inherent in the source datasets. The Table does however show both the importance of SSGI in all EU Member States and a broad diversity between the Member States that reflects, for example, different levels of prosperity, social protection systems, unemployment rates and demographical trends.

SGIs represent more than 30 % of employment in the 27 Member States, with nearly 80 % of that accounted for in health and the social services (9.6 % of total employment) whilst public administration and education each account for more than 7 %. Five countries are clearly above the average: Sweden, Belgium, Denmark, the Netherlands (particularly in the health and social services sectors) and France. One finds the data somewhat different with regard to the national contribution to GDP, primarily because certain of the more recent Member States of Central and Eastern Europe the contribution of the education sector is particularly high (Bulgaria, Hungary, Poland, Lithuania and Latvia).

For a more detailed representation of the importance of the social services in the Member States, we can further consider the indicators of social protection and health. In 2006, Eurostat data,³⁰ indicates that the gross average expenditure on social protection in the EU 27 accounted for 26.9 % of GDP of which, 38.5 % was attributable to old age benefits, 28.1 % attributable to sickness benefits, 7.7 % attributable to family and child care benefits, 7.2 % attributable to disability benefit, 5.9 % attributable to survivors, 5.4 % attributable to unemployment benefit, 2.2 % attributable to housing benefit and 1.3 % attributable to social exclusion. In 2006:

- 7 Member States, France 31.1 %, Sweden 30.7 %, Belgium 30.1 %, Netherlands 29.3 %, Denmark 29.1 %, Germany 28.7 % and Austria 28.5 % devote more than 28.5 % of GDP expenditure on social protection.

²⁹ They are part of the Section J 'Financial Intermediation', subdivision 66 « Insurance and pension funding, except compulsory social security ».

³⁰ The European System of Integrated Social Protection Statistics (ESSPROS). Available at: http://epp.eurostat.ec.europa.eu/portal/page/portal/social_protection/introduction

Expenditure on social protection contain: social benefits, which consist of transfers, in cash or in kind, to households and individuals to relieve them of the burden of a defined set of risks or needs; administration costs, which represent the costs charged to the scheme for its management and administration; other expenditure, which consist of miscellaneous expenditure by social protection schemes.

- In contrast, 10 of the new 12 Member States from the 2004 and 2006 enlargements, together with Ireland, devote less than 20 % of GDP on social protection.

In terms of expenditure per capita purchasing power standard (PPS) the differences are more pronounced.³¹ Luxembourg is identified with the highest expenditure (13.458 PPS per capita), followed by the Netherlands and Sweden (around 9.000 PPS per capita). With the lowest levels of GDP attributed to social protection, Romania and Bulgaria had the lowest expenditure (respectively 1.277 PPS and 1294 PPS per capita), followed by the Baltic countries (all with less than 2.000 PPS per capita), more than three times less than the EU 27 average (6.349 PPS per capita).

Based on the 2006 data, an average of only 35.4 % of all benefits expenditure in the EU 27 represented social benefits paid in kind (goods and/or services). However, large differences exist between those Member States with less than 20 % of expenditure made in kind, for example Poland, and those Member States with more than 40 % of expenditure made in kind, for example, Ireland, Sweden, the United Kingdom and Denmark. In only three countries (Sweden, Denmark and Finland) the level of the social benefits paid in kind for healthcare was similar with those paid in kind for social services (assistance, rehabilitation, child day care, vocational training, placement services, etc.). In 2006, the lowest expenditure in kind for social services, other than for healthcare, is found in Poland, followed by Romania, Italy and Estonia.

With regard to health services, a recent study³² shows that in 2006, the countries best endowed with hospital beds had seven or eight beds for every 1,000 inhabitants (Germany, Austria, the Czech Republic, Hungary, Lithuania, Latvia and Finland), whereas the United Kingdom and the countries of the Southern Europe (i.e. Portugal, Spain, Italy and Greece) had low health facility levels per inhabitant and more marked regional differences (five hospital beds for every 1,000 inhabitants for the areas best equipped, two or three in other areas). However, the authors of the study suggest that the density of social infrastructure is not the best indicator of the provision for social services, since the satisfaction of the user is linked to the quality of the service provided.

Expenditure on social protection (as % of GDP) ^a								
Countries	EC 6 1962	EC 9 1973	EC 10 1981	EC 12 1986	EC 15 1995	EC 15 2000	EC 25 2004	EU 27 2006
Total EC/EU	15.3	19.8	24.4	24.2	27.1	26.2	27.2	26.9
Belgium	14.6	19.1	26.9	26.7	26.6	25.3	29.3	30.1

(continued)

³¹ Eurostat, Total expenditure on social protection per head of population. PPS. Available at: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tps00100>

³² DEAS, CIRIEC International, CSIL and PPMI, Study for the European Parliament, 2010.

(continued)

Expenditure on social protection (as % of GDP)^a

Countries	EC 6 1962	EC 9 1973	EC 10 1981	EC 12 1986	EC 15 1995	EC 15 2000	EC 25 2004	EU 27 2006
Germany ^b	16.5	22.2	26.3	25.5	27.8	28.5	29.8	28.7
France	15.4	18.5	25.2	27.0	29.0	28.3	31.3	31.1
Italy	13.4	19.3	20.1	21.3	23.9	24.3	26	26.6
Luxembourg	14.9	16.9	27.6	22.4	22.9	20.2	22.2	20.4
Netherlands	13.2	22.9	29.9	30.2	29.2	25.7	28.3	29.3
Denmark		21.8	28.3	25.2	31.3	28.0	30.7	29.1
Ireland		15.3	20.7	22.5	18.1	13.4	18.2	18.2
United Kingdom		16.6	22.7	22.9	26.9	25.8	25.9	26.4
Greece			13.9	18.5	21.5	25.5	23.5	24.2
Spain				18.2	21.4	19.6	20.7	20.9
Portugal				13.0	18.5	20.2	24.7	25.4
Austria					28.7	27.9	29.3	28.5
Finland					30.9	24.4	26.6	26.7
Sweden					35.0	31.7	32	30.7
Cyprus							18.1	18.4
Czech Republic							19.3	18.7
Estonia							13	12.4
Hungary							20.8	22.3
Lithuania							13.3	13.2
Latvia							12.9	12.2
Malta							18.6	18.1
Poland							20.1	19.2
Slovenia							23.4	22.8
Slovakia							17.2	15.9
Bulgaria								15
Romania								14

^a Eurostat, cf. Bento et al. 2003; for 2004 and 2006, Puglia 2009.^b Up to September 1990: West-Germany, since 3 October 1990: Germany

2.3 Diversity and Unity of SSGI in the European Union

The ‘Mapping’ study showed that the use of Union concepts, in particular the term SSGI (and even less the categories of NESSGI and SSGEI), are not integrated into the law of the Member States, nor are they common in the national vocabulary. In some countries, some of the European concepts (in particular SGI, SGEI or public service obligations) may have entered into the national legislation through EU law but still play a very minor role compared to national ones (for example, in Finland, France, Ireland, Portugal, Romania). In others, there also seems no generally agreed translation available of European terms (for example, in the case of Slovakia or Hungary).

We should not confuse the category *social services*, such as it exists in the Member States, with that of ‘social services of general interest’, nor should we equate all ‘social services’ with the provision of a public service mission. Few Member States seem to lack a particular conceptual category for social services, the term ‘public service’ being the term of reference for services having a social nature (for example, in Slovenia). In many Member States, the term ‘social services’ is applied at the legislative level and/or in practice but often without any specific legal conceptualisation or definition. Across the Member States several terms are used: for example, in Cyprus, ‘services of social welfare’ applies to services fulfilling goals of social cohesion or the more general concept of social protection, related to the notion of the Welfare State; in France, the terms ‘social services’ and ‘socio-medical services’ are used in the legislation; in Greece, the terms ‘social care’ and ‘social welfare’ are both often used; in Hungary the term ‘social public services’ is sometimes understood to refer only to ‘other essential services provided directly to the person’ and ‘human public services’.

The expression ‘social services’ may appear to have a uniform presence in the terminology of the Member States but the national interpretation and definition of the expression carries different meanings:

- in Finnish legislation ‘social services’ relates to all social actions other than the allocation of subsidies³³;
- in the Italian legal order, there was no distinction between industrial or commercial services and social services until the end of the 1980s when the notion of social services became defined in terms of any action corresponding to the constitutional aims of physical and mental welfare development of the population, or to activities concerning the supply of services—free or with fee—that help to satisfy specific needs and difficulties of life, excepting those provisions guaranteed through the welfare and health systems, and by the administration of justice (Article 128 of D.Lgs. n° 112/1998). According to the Law on Social Services as it now stands, ‘Social services shall be the services aimed at providing assistance to a person (family) who, by reason of his age, disability, social problems, partially or completely lacks, has not acquired or has lost the abilities or possibilities to independently care for his private (family) life and to participate in society’;
- Lithuanian Law defines two kinds of social services: (1) social services of general interest (*Visuotinės svarbos socialinės paslaugos*—literal translation) (information, counselling, mediation and representation, social and cultural services, organisation of transportation, organisation of catering, provision of necessary clothes and footwear as well as other services) and (2) special social services (social attendance and social care). Special social services are provided when social services of general interest are insufficient to provide for an individual to meet the care needs of his family or to participate in society;

³³ Article 17 of the Law No.1982/710.

- in Latvia, social services are generally defined by the Law on Social Services and Social Assistance (approved on 31 October 2002) as services of social care, social rehabilitation, professional rehabilitation and social work;
- in the Czech Republic, social services are defined as ‘An activity providing support to socially disadvantaged people in social integration and protection against social exclusion with the aim of enabling them to integrate into regular life of society and use its systems in a way which is normal for other people (e.g. housing, schooling, healthcare, employment services, etc.). Social services is a public service’.³⁴

According to the various interpretations applied in the Member States, the definition of ‘social services’ appears very diverse. In some countries, for example in Lithuania, services such as counselling, mediation and representation, farming services are considered within the framework of social services. In the UK ‘social services’ are limited to care for the elderly, the disabled and vulnerable children. They do not include social housing or education or health, all considered as SSGI in European terminology. According to the German definition, educational and training measures are not social services as the State’s educational mandate is not directly derived from the principle of the social welfare state, but from the State’s supervision of the school system and of the institutional guarantee applicable to institutes of higher education (Article 7 and 5 of the Basic Law).

According to a survey conducted on the definition of terms such as ‘social services of general interest’ in some EU Member States, ‘it became first of all clear that a concrete definition of the term “social services of general interest” does not seem to exist in most Member States and local territories. Moreover, the term appears to be rarely used. Public and private actors often simply speak of “social services”’.³⁵

The categorisation of beneficiaries also varies between the Member States. According to the Swedish law, a person is not entitled to social assistance if he/she is able to meet his/her own needs or get them met through other means and a series of conditions exist for the financial assistance. There is a tension between universal coverage and the definition of specific categories of beneficiaries. Thus, in the social housing sector, whilst the European Commission considers it is only addressed to ‘disadvantaged citizens or socially less advantaged groups’, some Member States (such as the Netherlands or France) promoted a more general approach (in France, to ensure social mix/*mixité sociale*). Each national construction has a distinctive approach anchored in its own history, tradition, social and political power struggles, institutions (centralisation or de-centralisation, separation of powers, etc.).

At the same time, all the European countries give considerable attention to social services in the same fields and/or sectors. They all recognise the social rights of each inhabitant, set up social protection systems, establish institutions and

³⁴ Ministry of Labour and Social Affairs, Standards for Quality in Social Services, 2002, p. 23. Available at: <http://www.mpsv.cz/files/clanky/2057/standards.pdf>.

³⁵ REVES 2009, p. 2.

public services or services of general interest to guarantee the respect of these rights. The references in the European Treaties to services of general interest as ‘common values of the European Union’, or to the ‘social market economy’ find here their full meaning. Even if each Member State has, in its history, built its own ‘social model’, there is also a ‘European social model’, which is characterised by solidarity and socialisation, the collective assumption of responsibility within the fields essential for life. Thus, as the European Commission underlines,³⁶ that although social services are organised very differently in the Member States, certain general aspects of a modernisation process can be seen:

- the introduction of benchmarking methods, quality assurance and the involvement of users in administration,
- decentralisation of the organisation of these services to local or regional level,
- the outsourcing of public sector tasks to the private sector, with the public authorities becoming regulators, guardians of regulated competition and effective organisation at national, local or regional level,
- the development of public–private partnerships and use of other forms of funding to complement public funding.

This general modernisation process is introducing a more competitive environment that takes into account the special needs of each person and creates a favourable climate for a ‘social economy’, marked by a recognition of the importance of non-for-profit providers, but also confronted with the requirement to embrace the effectiveness and transparency of private sector provision.

As underlined in EU case law (*Poucet and Pistre* and *Kattner Stahlbau*), ‘EU law does not detract from the powers of the Member States to organize their social security systems’. In a judgment of 1987, concerning the effect of the social objectives of the Treaty (now, in substance, Article 3 TEU) the Court appreciates that:

the promotion of an accelerated raising of the standard of living, in particular, as one of the aims which inspired the creation of the European Economic Community and which, owing to its general terms and its systematic dependence on the establishment of the common market and progressive approximation of economic policies, cannot impose legal obligations on Member States or confer rights on individuals.³⁷

The Court, in this case made reference to the ‘objectives of social policy laid down in Article 117 [EEC]’ that were ‘in the nature of a programme’.³⁸

Article 118 of the Treaty of Rome in 1957 provided the historical platform whereby, ‘without prejudice to the other provisions of this Treaty and in conformity with its general objectives, the Commission shall have the task of promoting close co-operation between Member States in the social field, particularly in matters relating to: employment; labour law and working conditions; basic and advanced

³⁶ COM(2006) 177.

³⁷ CJEU, Case 126/86, *Fernando Zaera v. Institut Nacional de la Seguridad Social and Tesorería General de la Seguridad Social* [1987] ECR 3697, para 11.

³⁸ *Ibid.* para 14.

vocational training; social security; prevention of occupational accident, and diseases; occupational hygiene; the right of association, and collective bargaining between employers and workers'. It was a platform that allowed for a developing co-ordination of national social security systems within the Union since the 1970s³⁹ and the adoption of national social security measures necessary to facilitate freedom of movement for workers to ensure that social security benefits are not lost when workers move from one Member State to another.

The aim of achieving a high level of social protection and healthcare become a policy initiative with the Treaty of Maastricht 1993⁴⁰ and, with the Treaty of Amsterdam an objective of the Union.⁴¹ The Treaty of Amsterdam also refers explicitly to the European Social Charter of 1961 and the Charter of Fundamental Social Rights of Workers of 1989. The Treaty of Nice amended the Social Chapter of the EC Treaty by adding 'the modernisation of social protection systems' to the list of areas where the Council may adopt measures designed to encourage cooperation between Member States.

With ongoing reform, the Lisbon European Council of March 2000 endowed the EU with the open method of coordination (OMC) to fulfil, common objectives agreed by all Member States, including, in the area of social protection, an objective that has become established as one of the pillars of the Lisbon Strategy. According to the European Council, 'the European social model, characterised in particular by systems that offer a high level of social protection, by the importance of the social dialogue and by services of general interest covering activities vital for social cohesion, is today based, beyond the diversity of the Member States' social systems, on a common core of values'.⁴²

According to the Lisbon Treaty, in force since 1 December 2009, the EU:

shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity between generations and protection of the rights of the child.⁴³

Whilst the shared competences between the Union and the Member States applies to the social policy,⁴⁴ the Union has competence to ensure coordination of

³⁹ Council Regulation No. 1408/71 of 14 June 1971 on the Application of Social Security Schemes to Employed Persons, to Self-Employed Persons and to Members of their Families Moving within the Community, *OJ* 1971 L 149/2 and Council Regulations No. 574/72 of 21 March 1972 Laying Down the Procedure for Implementing Regulation No. 1408/71 on the Application of Social Security Schemes to Employed Persons, to Self-Employed Persons and to Their Families Moving within the Community, *OJ* 1972 L 74/1.

⁴⁰ The Protocol on Social Policy and Article 136 EC [now Article 151 TFEU] stating for the objective of a 'proper social protection'.

⁴¹ According to Article 2 EC, one of the Community's tasks is to promote 'a high level ... of social protection'.

⁴² Council, Presidency Conclusions, Nice European Council 7-9 December 2000, SN 400/00, Annex I European Social Agenda.

⁴³ Article 3(3) TEU.

⁴⁴ Article 4(2)(b) TFEU.

the employment policies of the Member States⁴⁵ and with regard to the protection and improvement of human health the ‘Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States’.⁴⁶ Also, the Treaty requires that:

in defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.⁴⁷

According to Article 151 TFEU the:

Union and the Member States, having in mind fundamental social rights...shall have as their objectives...proper social protection...and the combating of exclusion...To this end the Union and the Member States shall implement measures which take account of the diverse forms of national practices, in particular in the field of contractual relations, and the need to maintain the competitiveness of the Union’s economy. They believe that such a development will ensue not only from the functioning of the internal market, which will favour the harmonisation of social systems...

Ongoing Treaty revisions have gradually extending Union competencies with regard to social services. Article 48 TFEU provides for the European Parliament and the Council, acting in accordance with the ordinary legislative procedure, to adopt measures in the field of social security as are necessary to provide freedom of movement for workers. On a broader front, measures concerning social security or social protection may be adopted in reinforcement of the right of Union *citizens* to the free movement provisions.⁴⁸ A dividing line in this evolving framework of shared competence is however highlighted in Article 153 TFEU, where, with a reference to the objectives of the social policy set out in Article 151 TFEU provides that ‘the Union shall support and complement the activities of the Member States in...social security and social protection of workers’.⁴⁹ However, the Treaty further provides that ‘the provisions...shall not affect the right of Member States to define the fundamental principles of *their* social security systems and must not significantly affect the financial equilibrium thereof, shall not prevent any Member State from maintaining or introducing more stringent protective measures compatible with the Treaties’.⁵⁰

With the coming into force of the Treaty of Lisbon, the Charter of Fundamental Rights of the EU gained the same legal status as the Treaties. Amongst the provisions of the Charter, there is explicit recognition of Union citizens’ entitlement to national ‘social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case

⁴⁵ Article 5(3) TFEU.

⁴⁶ Article 6(a) TFEU.

⁴⁷ Article 9 TFEU.

⁴⁸ Article 21(3) TFEU.

⁴⁹ Article 153(1)(c) TFEU.

⁵⁰ Article 153(4) TFEU [emphasis added].

of loss of employment...[entitlement] to social security benefits and social advantages...[and, in] order to combat social exclusion and poverty... the right to social and housing assistance so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Union law and national laws and practices.⁵¹ In Article 35 of the Charter, the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices is recognised, together with an undertaking that a:

high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities'. For citizens with disabilities, the Charter also endorses, in Article 26, a Union recognition and respect for 'the right of persons with disabilities to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community.

2.4 Geography and the Four Approaches

Empirical work undertaken within the last few years,⁵² as in the study 'Mapping of the Public Services', show that social services in the Member States have experienced important changes in relation to demographical trends, to new requirements for adaptation to meet the needs of individuals, and in relation to quality expectations: all within a changing context marked by an increasing role for local authorities and private initiatives.

The conceptual construct of social services in the Union is understood or applied in different ways in the different Member States. According to their institutional structures, welfare traditions or stakeholders awareness, there is a variable definition of SSGI within different institutional settings between the Member States, and on the sub national levels, within which social service provision is operating.⁵³

There is no attempt here to establish an EU typology of SSGI by gathering them into large categories of 'models' from the 27 Member States. If 'national models' of reference for social services could be admitted, it is clear that 25 years of committed reforms have now largely destabilised former references and make current models more complex. The combination of reciprocal national influences and the process of Europeanization (bringing with it the phenomenon of hybridization) is current and explains the lack of previously understood paradigms. What this Chapter does offer is a brief analysis of four, essentially geographical,

⁵¹ Article 34 CFR (Social security and social assistance).

⁵² See in particular Hubner et al. 2010; DEAS, CIRIEC International, CSIL and PPMI, Study for the European Parliament, 2010; REVES 2010.

⁵³ Hubner et al. 2010.

approaches for the organisation of social services, on the basis of some particularly significant examples.

2.4.1 Northern Europe and Local Socialisations

Social services, in their development and form constitute an important and specific part of the Swedish Welfare State.⁵⁴ The conception and the importance attached to social services are probably the most distinctive elements of the Swedish model. They are largely universal (according to the needs, independent of resources) and are strongly subsidised, in order to guarantee the same access and the same quality of services to the entire population. Compared to other countries, Sweden is also characterised by the fact that expenditure in the field of social protection remains more largely directed towards such services.

In Sweden, the Constitution mentions that the State is responsible for the well being of its citizens. Local administration has a long tradition in Sweden and it is responsible for a significant proportion of public services. The principle of local self-government is one of the fundamental principles of the Swedish democratic system and forms the basis of activities undertaken by municipalities.⁵⁵ Social service provision is primarily the responsibility of the local authorities and encompasses financial allowances or material support for people who need special assistance, for vulnerable groups and care services for elderly (social and healthcare) and for the disabled. The mandatory tasks of municipalities in the social fields include, in particular, child-care, schools, elderly care,⁵⁶ and long-term healthcare. The county councils are responsible for providing healthcare (hospitals), dental services and mental healthcare. There are no hierarchical conflicts of power between the counties and the communes,⁵⁷ as each one holds responsibility for different, specific, activities. In 2005, about 54.1 % of the local public sector budget was apportioned to health and social services.⁵⁸

Municipalities and county councils are free to decide the legal forms in which services may be organised (direct management, municipal companies, private

⁵⁴ A 'service State' as opposed to 'transfer states' that offer mainly cash benefits. Compared to France, for example, in 1990, about one-third of social spending in Sweden were devoted to services contrary to a bit more of a ninth only in France (Gøsta Esping-Andersen, *op.cit.*, p. 85).

⁵⁵ Madell 2009.

⁵⁶ A new provision of the Social Services Act, in force since 1 January 2011, stipulates the 'dignified life within elderly care' (*Värdigt liv i äldreomsorgen*) to be provided by social services, to guarantee an appropriate response according to the needs and requirements of every individual and by taking into consideration the various cultural, ethical and other particular conditions associated with the person's identity.

⁵⁷ The size of the municipalities is very different (from 2.800 to 740.000 inhabitants, on average 15.000 inhabitants).

⁵⁸ Hoorens 2008, p. 671.

entrepreneurs under contract, co-operative companies, associations and individuals). Where, since the early 1990s, municipalities have been turning to the private sector for the provision of some services, social services are still mainly provided by the public sector. Some provision exists today through the contracting out of service provision to several providers in order to introduce user choice (without the privatisation of the services' funding). Whether provided by public or private operators, municipalities and county councils are considered to be the responsible authorities. Financing is based on the principle of solidarity such that services are provided free or at a limited cost for individual, to ensure equal access and equal standards for all inhabitants. Health and medical care services are mainly provided by the public sector and mainly publicly funded.

A new law (Act on System of Choice in the Public Sector 2008:962⁵⁹), entering into force on 1 January 2009, reinforces the system of choice and competition in health and social services. It applies when a public authority opens up some activities to competitive contracting (obligatory for primary care conducted by county councils but voluntary for municipalities; it also concerns the National Public Employment Service). With such an approach to procurement, the municipality sets a fixed level of quality and price and thus operators are encouraged to compete based on the highest quality instead of the lowest price. The funding system continues to be tax-based but the financing flows to the provider chosen by the user. With regard to some labour-market activities (e.g. for immigrants), the system of choice is mandatory since 1 May 2010. The system of choice is supervised by the National Competition Authority.⁶⁰

The Swedish welfare system also provides for the right to decent housing for all citizens as a policy choice to stimulate integration and avoid segregation. In 2006, some 22 % of all households in Sweden were provided by either municipally owned, non-for-profit housing companies, or by private housing companies.

Voluntary organisations (charitable, church organisations etc.), play only a minor role in Swedish social services provision.

2.4.2 *Federal and Regionalised States*

In Germany, SSGIs are the responsibility of the *Länder*, but are operated to a large degree by local authorities and by independent welfare organisations (in particular charitable organisations).⁶¹

⁵⁹ Available at: <http://www.notisum.se/rnp/sls/lag/20080962.htm>

⁶⁰ The list of service contracts also includes rail and water transport services, investigation and security services, education and vocational education services, etc. Available at: http://www.kkv.se/upload/Filer/ENG/Publications/System_of_Choice.pdf.

⁶¹ At the origins of the formal recognition of the role of these organisations in the provision of social services, according to the 'subsidiarity principle' the state should get engaged in these services only if the families and the 'charitable' organisations fail.

According to Article 28 of the Basic Law, for protecting the autonomy of local authorities, the municipalities have the right to determine the organisation and financing of services. Municipalities, cities and rural districts are active in the field of child and youth assistance, basic security for unemployed persons, social assistance and assistance for elderly, disabled persons and persons at risk, hospitals, long-term care facilities and kinder gardens. Hospital health services are typically the responsibility of local administrations but regional specialised university hospitals also exist.

The charitable activity (in particular of the Churches and their charitable associations) is constitutionally protected (Article 4 and Article 140 of the Basic Law, Article 137 of the Weimar Constitution [WRV]) and is concerned with a broad spectrum of social services: health, long-term care, family, youth, elderly care, children and disabled persons. Unlike the Scandinavian model, in Germany, the not-for-profit sector has traditionally played a dominant role in the provision of social services where the responsibility of the local authorities has been less comprehensive.⁶²

New Public Management reforms have seen an increase in the number of private operators in the field of social services where, particularly in the hospital sector, the provision of supply from the public sector has been reduced. A significant number of hospitals are owned by churches or belong to non-profit organisations although, in the context of budget deficits, sectoral restructuring policies, in particular of financing systems, has seen the privatisation of a growing number of hitherto public hospitals. Private companies have also begun to enter the health market and there is a trend for public hospitals to be taken over by private companies. Childcare services and elderly care fall under the voluntary competency of municipalities and are mostly provided for by public institutions although the private sector provision of elderly care is increasing. In social housing, partnership between private companies and charity organisation plays an important role.

The Bismarkian social insurance system, originating in Germany at the end of the nineteenth century, provided for health insurance and obligatory retirement, it established a system of welfare for workers having low incomes that were primarily financed through employers' and employees social security contributions. The main principles of the Bismarkian system of horizontal redistribution and benefits both dependent on and related to past contributions or earnings have since been incorporated in several European countries. Nevertheless, in comparison with the universalistic egalitarian ideals that later come to define the United Kingdom's Beveridge plan or the Scandinavian model, the early architects of Bismarkian social policy were 'authoritarian, étatist, and corporativistic'.⁶³ Today the welfare states that had their origins based on the Bismarkian model seem to retain more of a social insurance orientation than the Scandinavian countries. On the other hand, the provision of social services through private non-for-profit actors is a particular important feature of the actual German system.

⁶² Wollmann and Marcou 2010.

⁶³ Esping-Andersen 1996, p. 66.

2.4.3 Centralised and Unitary States

France represents the typical example of a centralised unitary state in which social services were traditionally defined by the State with reference to the basic principles of solidarity and equality even if their management was often decentralised, in particular, to the departmental level of administration (since the Revolution of 1789–1799 France has been divided in 100 departments). Responsibility for public services was traditionally assumed by the State or local communities whilst some sectors, such as water, gas, social and health services,⁶⁴ and local transport, have seen a modernisation of service provision throughout the twentieth century that has entailed a broader recognition of the involvement of private sector service providers and a diversification of delegation procedures, whilst preserving the essential role of public actors.

The large fields of social policy are compulsory social security (basic and complementary), complementary social protection (optional), health and medico-social actions, social housing and a series of personal services (for children, disabled people, elderly people, people in need, etc.). The system of ‘national solidarity’ was developed as a general regime for health and social security. In the field of social security, it was only in 1988 that the ‘Minimum Revenue for Inclusion’ (RMI, *Revenu Minimum d’Insertion*) was introduced; until then the ‘excluded’ people were not covered, the general social security schemes being restricted to an employment-based coverage that reflected the traditional role of the family and of the voluntary and local initiatives in the social protection. The RMI was subject to frequent reform and procedural change. On 1 June 2009 a new instrument came into force, the revenue for active solidarity (RSA, *revenu de solidarité active*), which combines the approach of the old RMI, granted to unemployed people, with a welfare benefit designed to support those on low incomes (RSA ‘activity’). Recently, new proposals have been launched by the political majority concerning, in particular, the role and funding of the RSA role that are questioning the obligation placed on RSA recipients to realise between five and ten working hours of social service per week.

In France, the process of decentralisation (of the Central state towards the territorial collectivities—Regions, Departments, Communes) launched at the beginning of the 1980s had important implications in the field of social and medico-social welfare provision. In particular Law n° 2004–809 of 13 August 2004, relating to local freedoms and responsibilities,⁶⁵ which reinforced the role of the departments with regard to social welfare. Now, the competences of the State for the organisation and the provision of the social and medico-social actions

⁶⁴ The French doctrine and jurisprudence do not distinguish the category of social public services because traditionally they were organised according to administrative law procedures. Nowadays, the terms ‘social services/*services sociaux*’ and ‘socio-medical services/*services sociaux-médicaux*’ are used in the French legislation. See Bauby 2011a, b, p. 114.

⁶⁵ Available at <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000804607&dateTexte>

(allowances to disabled adults, social rehabilitation and lodging centres) and the design of the national housing policy are shared in, particular with the departments, as regards the organisation of infant maternal protection, some social security benefits; and the financing, assistance and rental of housing equipment. The regions are concerned in particular with the provision of hospital public services, the high schools' infrastructure and the financing of actions concerning housing and habitat. The communes have responsibility for children's infrastructure services (cribs buildings and recreation centres), and optional social services that embrace, the financing, infrastructure and assistance for housing.

If decentralisation was aimed at improving the provision of social services by organising it on a level closer to the users it also increased the financial burden for local communities which, as a consequence of State debt and in the context of the current broader economic crisis, have led to important problems for financing. On 20 April 2011, set within the framework of a conflict between the general councils (departmental level) and the State with regard to compensation for the transfer of competence, the Council of State began legal proceedings in the Constitutional Council concerning, as a priority, the constitutional questions relating to the financing of the principal welfare benefits of solidarity.

To some extent, French decentralisation of social services responsibilities has consisted of entrusting local communities with the management of the social aspects of the great economic and societal welfare transfers related to European integration and globalisation, whereas the Central State preserved for itself the main powers of orientation and macro-economic control.⁶⁶ Private operators play an important role in the provision of social services whilst, at the same time, not-for-profit associations provide a whole series of social services to the user in a public/private hybrid of service provision (in health, elderly homes, etc.). Particularly, in the field of health, the public institutions together with private or not-for-profit associations established under the law of 1 July 1901 on associations as mutual organisations or foundations take part in the delivery of hospital public services.⁶⁷ Private commercial establishments (associations, foundations, companies) also offer healthcare services. In 2008, public hospitals represented 64,5 % of the total number of beds.⁶⁸ The healthcare institutions are in general financed by the social security budget, refunding the cost of care of patients on the basis of the principle of the free choice of the establishment by the patient. A new law reforming the regional healthcare system and hospital organisation in relation to patient care came into effect in July 2009.⁶⁹ The four parts of this new law concern

⁶⁶ See Bauby 1998.

⁶⁷ In France, hospital services accounted in 2006 for almost half of the health expenditure in France.

⁶⁸ Direction de la recherche, des études, de l'évaluation et des statistiques (DREES), *Le panorama des établissements de santé. Édition 2010*, 2011.

⁶⁹ Loi No. 2009-879 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. Available at: <http://legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000020879475&categorieLien=id>.

hospitals, improving access to healthcare, prevention of ill health and the regional organisation of the healthcare system. The new established regional health agencies—*Agences régionales de santé*—are concerned with all regional healthcare services, including medical care, medical and social welfare and prevention. This law also consecrates the category of ‘private health establishments of general interest’ (*établissements de santé privés d'intérêt collectif*), private establishments with no commercial purpose that participate to health public service such as defined by law.⁷⁰

Many services which are not dealt with by public authorities or the market concerning that section of the population at risk, in serious social difficulty or at with the loss of their independence (disabled persons, elderly, homeless, etc.) are provided for by social and medico-social structures mainly managed by not-for-profit organisations (Code of the social action and families), including volunteers. The private commercial operators are particularly active in the urban and suburban areas. These services are financed by public authorities and the social security offices and/or by contributions, donations, legacies or directly by users.

In the area of low-cost social housing, a ‘service of general interest’ defined by Article L411-2 of the Code of construction and habitat has as its objective the construction, acquisition, modernisation, attribution, management and transfer of rental residences at rents appropriate for people whose incomes are below the level at which they could afford the maximum rental ceilings fixed by the administrative authority for rental residences. The legal framework extends to people with intermediate income providing for access to property where their income is lower than the fixed maximum rental ceilings, and to the management or acquisition of property for resale in joint ownership or under a plan of protection.

2.4.4 Central and East European Countries

During the totalitarian regime in the countries of the Central and Eastern Europe the State was conceived of as the sole instrument required to meet the needs of the population by directly organising the production and distribution of services. As in other areas, social policy was statist and hierarchical. Political ideology did not acknowledge unemployment or social problems such as poverty or homelessness. Basic social services for childcare, the disabled, elderly people, and health was subject to state provision.

After 1990, these countries were faced with new challenges of unemployment, developing social inequality and poverty, economic down turn and change, financial deficit and new demographical trends. The available data shows that these new Member States are among the lowest spenders on social protection. Amongst these

⁷⁰ See in particular the public service mission defined by Article L6112-1 of *Code de la santé publique*.

new Eastern Member States, in 2006, Slovenia spent the most on social protection but still less than the EU 27 average. Furthermore, in the context of the decentralisation process' developed in these countries after 1990, local expenditures on social protection remain much less important than in other EU Member States (between 13.3 % of GDP in Lithuania, 13.1 in Romania and 3.2 in Slovakia). However, with the exception of Slovakia, the share of the local public sector expenditure on social protection in these new Member States is somewhat higher than in some of the EU southern countries: Portugal (2.3 % of GDP), Luxembourg (4.0 % of GDP), Italy (4.6 % of GDP), and Greece (5.5 % of GDP).⁷¹

Slovenia, as one of the smallest Member States of the EU, and a country that from the end of the World War II until June 1991 formed part of the Federal Republic of Yugoslavia. In its recent history as an independent state Slovenia has undergone a complex transition, from a socialist to a market economy, from a regional to a national service economy and, since 2004 membership of the EU. The actual unitary state is based, at territorial level, on a dispersed state administration (districts—*upravna enota*) and on a decentralised level of local administration that exercises its competences and responsibilities on the basis of the principle of local self-government. The process of establishing a regional level, as a second level of local administration, was initiated by the constitutional revision of 2006. According to the Constitution, 'Slovenia is a state governed by the rule of law and a social state' where its citizens have the right to social security (including a pension), to healthcare under conditions provided by law and the obligation of the state to create opportunities for citizens to obtain proper housing. It also guarantees rights of protection and work-training for disabled persons, and special protection and care for children.

The Slovenian legal system uses the concept of public service (*javna služba*) whilst the term 'social public service' (*socialna javna služba*) is also sometimes used. Provision of services, for example, in the areas of education, health and social care, and social insurance are considered as non-commercial public services typically organised through not-for-profit organisations. They are provided either by public institutions or by way of concessions. There is no established list of activities that define the category of public services but most services are statutory. A list of all SGI providers is prepared each year by the Slovenian Ministry of Finance.

There is a shared competence in the field of social services between the state and the local administration. The state in particular is responsible for adult disabled services, for the special protection of children, and for the institutional care for elderly. Local communities competence extends to the field of care for the elderly at home, primary healthcare, and primary and secondary education. Where the compulsory education service has budgetary funding, the home care services for elderly services are, in the main, paid for by users or may be partly subsidised by the local community on the basis of the solidarity principle.

⁷¹ Hoorens 2008.

In the field of social housing the Slovenian approach has established either not-for-profit rental housing (for lower and middle income earners) or subsidised rents. A special public fund has also been established for the construction and maintenance of housing that is supplemented by municipal funds and commercial bank credits. Not-for-profit rental housing is usually provided by municipalities and other private organisations which are required to allocate a large majority of their profits to the acquisition of not-for-profit rental housing.

In the field of healthcare, health services are performed as public services under equal conditions by public health institutes and private entities on the basis of concessions. Some health services can only be performed as public services. Concessions may be granted, for example, for primary healthcare. All health services which are qualified as public services either provided by public or private operators are publicly funded.

2.5 What European Framework for SSGI?

A request for a sectoral secondary law for all SSGI has been expressed. But, if one includes, as the Commission suggests, all of those services that embrace health, social protection, social housing, education and training, as well as personal services within a single class, it is difficult to see how the request for secondary legislation could be satisfied: both unity and diversity exist within and across so many of the areas of European social services that it would appear difficult to apply common rules. Even the concept of a SSGI framework directive seems challenging, especially as there is no clear European competence in the majority of these fields. However, such a conclusion does not address the uncertainties which the actors in the social services feel. It would undoubtedly be preferable to seek answers for each category listed, starting with personal social services which share a common fundamental characteristic that rests on the personal relationship between a provider and a recipient. These services cannot thus be ‘normalized’ with service contracts similar to those that apply to telephone services or electricity supply. Nor are personal social services sufficiently definite or precise to draft specifications with regard to mandates or invitations to tender. It should be recognised that personalisation is at the heart of service provision, even if it is considered that these services can be qualified as ‘economic’ it is necessary to explicitly exclude them from the provisions of Article 106 TFEU: they cannot be subject to the common competition law of the internal market, because that would obstruct the achievement of their particular mission.

For the other fields of SSGI—health services, social protection, social housing, education and training—it is on a case-by-case basis and in a pragmatic way that it is necessary to specify the particular missions they are charged with and to adapt the European rules to these outcomes.

More generally, taking into account all the national and sectoral diversities, a framework directive could not be clearer than the Protocol No. 26 on services of

general interest. In any case, there can be no majority within the Council or the European Parliament, given the three opposing positions currently present:

- a) those who argue for subsidiarity and who do not want more powers ceded to the EU and to the Commission;
- b) those who think that market will solve everything (market oriented); and
- c) and those who think that we should have only sectoral approaches.

Following the works of the third Forum on SSGI⁷² which took place on October 26–27, 2010 in Brussels, the Belgian presidency of the Council of the EU addressed 15 recommendations to the European Parliament, the Council and the Commission of which some were repeated by the Council in its Conclusions.⁷³ The Council invites the Member States and the Commission ‘to clearly identify European policies and measures having an indirect but significant impact on social services of general interest’; the Commission to clarify ‘the concept of affecting trade between Member States in the field of the application of the rules on state aids to social services of general interest of economic nature’. According to the Council, the SSGI ‘play a preventive and socially cohesive role, which is addressed to all women, men and children and which is based on the idea of universality, and have aims which are reflected in the ways these services are organised, delivered and financed’.

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⁷² Available at: http://www.socialsecurity.fgov.be/eu/fr/agenda/26-27_10_10.asp.

⁷³ Council, Council Conclusions Services of General Interest: at the heart of the European Social Model 8 December 2010, 17566, SOC 828.

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