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Social Protection Innovative Investment in Long-Term Care

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THE ROLE OF PUBLIC AND PRIVATE ACTORS IN DELIVERING AND RESOURCING LONG-TERM CARE SERVICES

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Executive Summary

This report develops a framework which describes (i) the key actors in the LTC system, and (ii) the key functions they fulfil and which define the way in which actors interact with each other. The proposed framework is then used to discuss how the nature of the interrelationship between actors might influence key policy objectives.

Public and private actors in LTC

The analysis differentiates between "individual actors" involved in the execution of care activities at the individual case-level, and "institutional" stakeholders involved in the policy development and regulation of the LTC system. A second important distinction that cuts across the discussion is between public and private actors.

Individual-level actors and care functions

The process leading to the provision of care involves six steps: case finding, needs assessment, care planning, service commissioning, care provision and review.

This case finding activity can involve a myriad of actors, ranging from self-referral from private individuals to referrals from health care professionals. It is crucial to the performance of the system, as it fulfils the function of gate-keeping, and is the process by which the care system "selects" cases to be supported.

Two broad models for needs assessment exist. In entitlement-based systems, needs assessments are typically based on "algorithmic" formulae on the basis of relatively simple indicators of LTC needs. In systems without legal entitlements to care, needs assessments rely more heavily on the judgements of care professionals. Whilst less transparent, these forms of assessments are more flexible in the range of needs that they consider.

Whereas in certain systems based on cash-payments, individuals do not get any support with the care planning and commissioning activities, in other systems these tasks are fulfilled on behalf of the service user by care managers. The personalisation agenda is empowering services users to decide which services they want to receive, and from which providers.

LTC provision

Formal caregivers have contracts specifying responsibilities, are paid and entitled to social rights and working regulations, and their care tasks are specified according to professional qualifications. The professional background and training of front-line workers can vary significantly across European countries. Many care systems are relying increasingly on migrant workforce to meet the rising demand for formal care services.

Formal caregivers are usually employed by provider organisations, which can vary in their size, the type of support they provide, and the sector of the economy they belong to. For profit providers often outperform the state sector in terms of costs, but no clear evidence exists regarding service quality.

Services in the community include support provided in an individual's own home and services provided outside of it, such as in daycare centres and social clubs. Institutional care is sometimes divided between residential care and nursing care, the latter catering for people with higher levels mental or physical disability.

Family and friends constituted the centre pillar supporting LTC systems across European countries, and are seen as the key to their long-term sustainability. They are not usually trained to provide care, and normally have no contracts regarding care responsibilities, are not paid, and perform a wide range of tasks including personal-care, help with instrumental activities of daily living and emotional support.

The boundaries before between informal and formal care provision have been diluted in some countries, leading gradually to the creation of a mixed workforce made up of informal family carers, migrant care workers, personal assistants and formal professional care staff.

Institutional actors and functions

Key regulatory and institutional activities shape the way in which individual functions are carried out. These are regulations concerning the funding of care, eligibility to services, market management, and quality assessment and monitoring.

Although both private and public options for funding LTC services exist, the state organises by far the main collective funding systems in LTC, and private voluntary insurance products fund a very small proportion of LTC expenditures. In most European countries, state funding arrangements do not cover the totality of care expenditures, and cash tot-ups (or additional informal care support) are required.

In many countries, administrative, funding and professional differences between the health care and social care systems have led to the emergence of 'cliff edges' in the eligibility to state support for very similar needs.

Cultural differences can lead to significant differences in the way informal care is taken into account when setting LTC eligibility criteria. Three models are discussed in the literature, depending on whether carers are treated as resources, co-workers or as co-users.

Market management responsibilities are particular crucial in systems in which it does not provide directly the majority of care services. Market management involves tasks such as purchasing care services on the state's behalf, assessing population needs, negotiating contracts with providers and performance monitoring.

Markets tend to be more efficient at allocating resources than hierarchies, but they are susceptible to information problems and they can introduce higher transaction costs than hierarchies.

Quality measures are required by purchasers of care (private or public) to aid them in their commissioning decisions and to contribute to the monitoring of aspects of performance, such as efficiency and effectiveness. However, quality indicators are difficult to define in the LTC area because of the "experience good" properties of social care. There is an increasing desire to involve more directly service users in the assessment of service quality, by reflecting and responding to their views of the quality of the services they use.

The most widespread LTC governance model in Europe gives responsibility for the delivery of care to municipalities (local authorities), but locates the decision-making (and partially funding) role in central government. This often leads to local variability in the patterns of LTC service provision which can cause concern among the public.

Actors, functions and social investment in LTC

Effective social investment requires that effective coordination of the activities of the different private and public LTC stakeholders is achieved, and that their objectives are aligned with social investment principles.

Improving care coordination

Service delivery fragmentation in the LTC area is particularly evident in the structural and financial barriers dividing agencies and providers of primary/secondary care and health/social care.

Different strategies have been proposed to improve care coordination between health and social care actors, including the integration of key functions; the creation of networks; joint working, and the integration of clinical processes. Financial incentives have also been introduced to align the objectives of health and social care actors. No reliable estimates of the economic impact of integrated care models exist, but there is growing evidence of the interrelationship in the performance of the two systems.

Improving value for money

Increased market shares by private (for profit and/or non-profit) LTC actors has been reported in many countries. Recent analyses have identified a link between market competition and reductions in the unit costs of care home services, but possibly at the expense of service quality.

The growth in the user choice and the personalisation of care can be portrayed as an extreme form of marketization, in which individual service users and/or their family "vote with their feet" by selecting their preferred support and provider. Overall, there is limited conclusive evidence about the consequences of user choice on the costs and outcomes of the LTC system.

Investing in cost-effective prevention

Given the need for a "life course" approach, promoting active ageing implies the coordination of policies across a number of areas of the welfare system, and during different stages of the life of individuals.

The identification of at-risk groups, and the implementation of cost-effective support models for them will require significant investment in innovation, in terms of the care arrangements and structures, and in terms of technological solutions for collecting and sharing information.

Conclusions

Ambitious social investment, and associated policy objectives such as promoting active ageing or effective coordination between health and social care services will require novel solutions which achieve effective collaboration and joint working across a wide number of public and private agents.

This report has highlighted the size of the task, by describing the number and characteristics of LTC actors and the many ways in which their interrelationship is structured depending on the nature of the regulatory framework.

However, the economic and outcome gains from successful active ageing policies and improvements in care models compatible with social investment principles should be high.

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Acronyms and Abbreviations

ADLs:	Activities of daily living
EU	European Union
ICT	Information and communication technology
IADLs	Instrumental activities of daily living
LTC	Long-term care
MoLGs	Ministry of Local Governments
NGO	Non-governmental organization
OECD	Organisation for Economic Cooperation and Development
PAOs	Public administration offices
SI	Social investment
SPRINT	Social protection investment in long-term care
WP	Work package

1 Introduction

This report addresses the objectives of deliverable D2.3 by describing the role of public and private actors in delivering and resourcing long-term care services. The paper contributes to setting out (together with the other WP2 deliverables) the key features of the long-term care (LTC) system, and to discuss how these features shape the potential for the application of social investment principles. Specifically, this paper develops a framework which describes (i) the key actors in the LTC system, and (ii) the key functions they fulfil and which define the way in which actors interact with each other. The proposed framework is then used to discuss how the nature of the interrelationship between actors might influence key policy objectives.

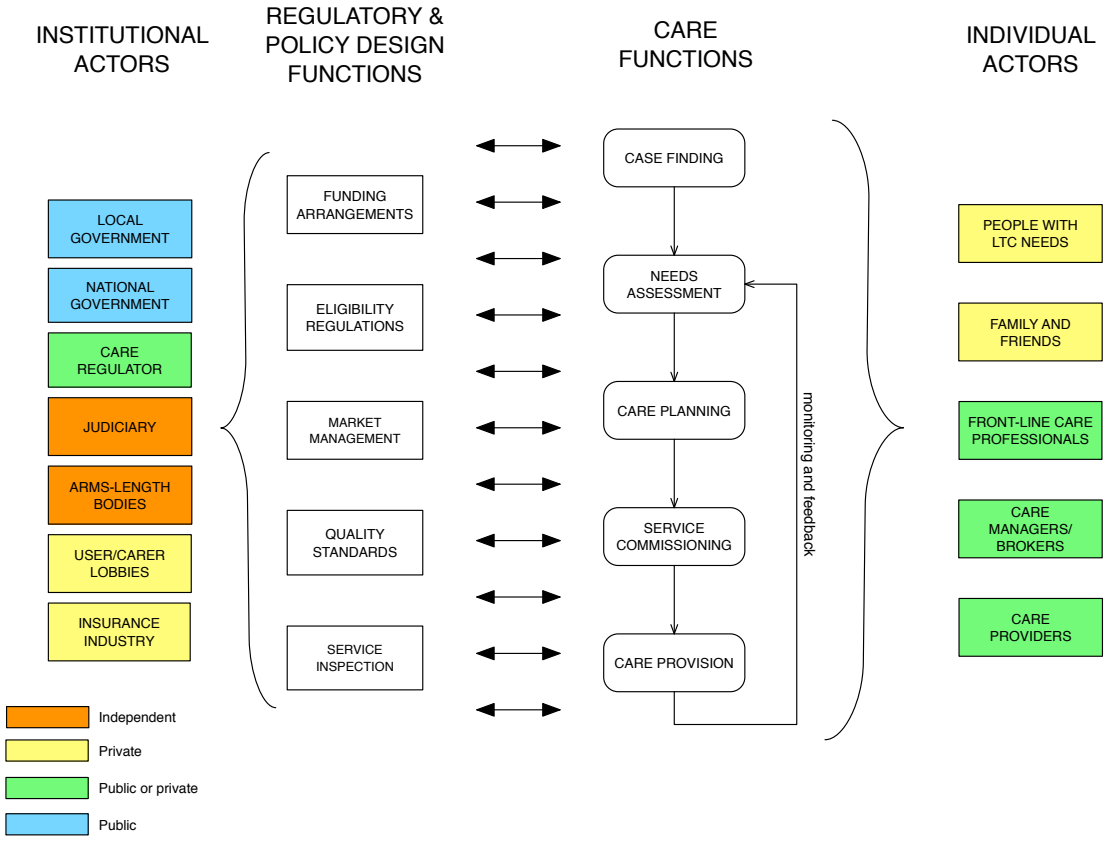
It could be argued that successful social investment requires (i) the identification of opportunities for change leading to cost-effective improvements in outcomes across society as a whole and (ii) the design of mechanisms which enable such opportunities to be realised, for instance by aligning the incentives of the different actors involved in the care system with the direction of the desired change, and then overcoming the barriers to change. The framework presented aims to support future SPRINT work to study the way in which opportunities for social investment could arise in the LTC sector, and to think through the design of appropriate incentives that reflect the nature of the interaction between LTC actors.

As identified in other SPRINT outputs, LTC arrangements vary significantly across European countries. The present deliverable does not aim to provide an exhaustive description of the interaction between public and private actors across all European LTC systems. Instead, it sets out an overarching model describing public and private LTC actors, and illustrates with national examples how the specification and functions of different actors can vary across systems, and how these have evolved through time. Given their related nature, the content of this report overlaps somewhat with the analysis in D2.4, which provides a detailed country-by-country analysis of LTC arrangements and resource levels. We nevertheless provide in Appendix 1 a summary of the main features of the LTC systems across countries in the SPRINT study. These descriptions were developed using local policy literature and local knowledge from SPRINT partners. Appendix 2, a case study of the role of social cooperatives in Italy, is included with this report because, although not focusing specifically on LTC, these models may be of interest for potential adaptation in an LTC context.

Because it aims to provide a foundation for further analyses, this deliverable is largely derivative in the range of evidence it uses. The framework builds on key references from the long-term care and social investment literatures. Its new contribution is to discuss the ways in which social investment opportunities might arise in the long-term care sector given the range of actors involved and the functions that such actors need to perform.

The rest of the report is organized as follows: Section 3 outlines the range of actors to be found in LTC systems, differentiating (among other things) between actors involved in the organisation and provision of care, and those involved in regulatory and other system-level activities. Section 4 then considers how differences in the specification of the roles and responsibilities of different actors might impinge in the system's performance. The chapter examines issues such as prevention, care coordination, and improvements in the system's efficiency.

Figure 1: Key actors and functions in the LTC system



2 Public and Private Actors in LTC

This section presents an overview of the central actors operating in LTC, with a focus on the countries represented in the SPRINT project.

Figure 1 underpins our analysis. It describes the range of actors or stakeholders involved in the design, regulation and implementation of LTC systems. It also lists the main functions fulfilled by

the different actors in the care system, to clarify the context within which interactions between them take place. Figure 1 differentiates between "individual actors", those involved in the execution of care activities at the individual case-level, and "institutional" stakeholders, those involved in the policy development and regulation of the LTC system. We use the terms 'actor' and 'stakeholder' interchangeably in this report.

A second important distinction that cuts across the discussion below is between public and private actors. Generally, public organizations are responsible for setting care policy, providing funding and defining the regulatory framework (which itself is described in more detail in WP3). In many cases, public organisations also provide services directly.

Private actors are normally involved in the delivery of services, but they can contribute to other functions of the care system, such as its funding through the offer of private LTC insurance products (deliverable D2.4 provides a fuller discussion of these issues), or through the funding of certain care services by the voluntary or non-profit sector.

The purpose of highlighting the functions undertaken by the different actors in the LTC system is not to describe how such functions are organised in different European countries (deliverable D2.4 covers a lot of this ground, and future deliverables D3.1 and 3.2 will provide further evidence). The aim is rather to define in general terms the range of functions undertaken by different actors to illustrate how they shape the nature of the interaction between actors and in turn the opportunities for cost-effective social investment in LTC.

2.1 Individual-level Actors and Care Functions

The process leading to the provision of care and support to people with long-term care needs generally involves the following six steps: case finding, needs assessment, care planning, service commissioning, care provision and review. These functions can be organised in many ways and executed by different "actors" (Davies, 1992).

2.1.1 Case finding

Case finding refers to the process(es) through which the potential need for LTC support is recognised and contact between the care system and the persons in need of support is initiated. This case finding activity can involve a myriad of actors, ranging from self-referral from private individuals (family and friends, and/or the dependent person herself) to referrals from health care professionals (e.g. GPs, nurses). Often, the first contact between potential service users and the care system is made through a telephone call, and professionals respond using agreed (and in some cases highly structured) protocols. Another case finding route would be referral from a

health care organisation or professional, or from a neighbour or community member concerned about the wellbeing of (say) an older person.

An efficient case finding process is crucial to the performance of the LTC. On the one hand, it fulfils the function of gate-keeping, thus helping to manage demand pressures on the care system. On the other hand, it represents the process by which the care system "selects" cases to be supported, including those that might benefit from preventative interventions. As the ageing of the population puts increasing pressure on public finances and LTC systems – in an effort to manage their limited resources – concentrate their resources on the neediest cases, an important debate is emerging about whether significant opportunities for early intervention are being consistently missed at the point of initial contact with services (Walker, 2002). Given that early intervention might involve a range of support services, it is important that actors in charge of case finding activities are aware of other components of the support system, such as availability of income support (welfare benefits), health care and housing support services.

2.1.2 Needs assessment

Once first contact is established and the person is noted as *likely* to meet existing eligibility criteria for LTC, a professional carries out an assessment of the needs of the individual, and depending on the care system also of the needs of family and friends with caring responsibilities.

The process used and the outcome of the needs assessment both vary from system to system, but it is worth distinguishing between two broad models. In private or social insurance systems in which entitlement to long-term care is defined as a right (as in Germany, France, Austria and Spain) the assessment of the care needs is typically based on "algorithmic" formulae which define needs thresholds on the basis of relatively simple indicators of LTC needs, such as limitations with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These algorithms determine simultaneously eligibility to care and the level of resources the person is entitled to. While these systems are transparent, as the rules for entitlement are more explicit, they are criticized for not taking into account all the subtle and often important characteristics of individuals in need. In particular, factors such as general frailty and the need for supervision, for instance, for people with cognitive impairments, are difficult to incorporate into formal algorithms of entitlement to support.

In pay-as-you-go, budget-constrained systems in which no entitlements to care are defined by law (such as England), assessment of eligibility relies more heavily on the perception and judgement of a care professional (often termed "care manager") who enjoys some discretion over actual service provision. Whilst less transparent, these forms of assessments are more flexible in the range of needs that they consider, and can often take into account areas of need which are not easily amenable to measurement and thus are difficult to reflect in algorithms, such as the quality of the relationship between the person with the care needs and their family and friends, or the suitability

of their housing environment. Overall, in these systems costs can be contained more easily by continuously updating eligibility rules in line with available budgets. However, these systems, given their reliance on the skills of case managers, have been criticized both for a lack of transparency in their allocation decisions and for not providing individuals with a clear description of their entitlements to care (Fernández et al., 2009).

2.1.3 Care planning and service commissioning

The type and amount of LTC support provided by the state to service users with the design of their care packages varies significantly from country to country. In a number of tax-based and social insurance-based systems, including those in Austria and the Czech Republic, eligible individuals are provided with cash benefits which can be used by consumers to purchase services that best meet their needs, but with minimal guidance from the state in terms of range of services available or their quality (Oesterle and Meichenitsch, 2008).

In countries such as the UK, Germany and Sweden, care managers are meant to interact with service users and their families in order to discuss different care options, and within the resources available, develop an agreed care plan which best suits the needs of the person. Hence, care management processes are meant to have a good understanding of the range of care services available locally, and "match resources to needs" by carrying out a holistic assessment of care needs and maximising flexibility in the commissioning of care services (Davies, 1992). Care managers are therefore meant to fulfil a dual role of representative of the individual in need of care and of the state, and to balance the need for budgetary restraint with the objective to maximise the user's wellbeing.

Whereas the implementation of care management arrangements has led to improvement in the targeting of resources in some countries (Davies et al., 2000), in recent years there have been calls for increased choice and empowerment of service users under the banner of the need to "personalise" care services (Lundsgaard, 2005).

The personalisation agenda has therefore led to the implementation of direct payment and personal budget schemes in a number of European countries. Such policies aim to shift the balance of power between private individuals and the professionals representing the state, on the assumption that by empowering users to make choices over their care, new services will emerge that – to a greater extent than has been the case so far – meet the needs and satisfy the preferences of service users and their families. Evaluations of these new personalised models, however, have indicated the need to support service users to operate as commissioners in the care market, by providing information and advice and care brokerage services. In the UK, as a result, "support organisations" have been set-up to help service users using direct payments with accountancy, advocacy and recruitment and employment tasks. These organisations are typically

from the voluntary and not-for-profit sectors, and often combine the support function with other activities, including the provision of some care services (Davey et al., 2007).

2.1.4 LTC service provision

Although the actual delivery of LTC services can be done by one single actor, typically it involves a complex network of public and private, for-profit and non-profit organizations and private individuals (Riedel and Kraus, 2016).

Front-line care workers

In its definition of LTC workforce, OCED include nurses providing long-term care at home or in LTC institutions (other than hospitals) and personal care workers (caregivers), including formal workers providing LTC services at home or in institutions (other than hospitals) and who are not qualified as nurses. Personal care workers at home or in institutions are defined as people providing routine personal care, such as bathing, dressing, or grooming, to elderly, convalescent, or disabled persons in their own homes or in institutions (other than hospitals) (Colombo et al., 2011).

Formal caregivers have contracts specifying care responsibilities, are paid and entitled to social rights and working regulations, care tasks are specified according to professional qualifications, and care workers have a time schedule and go 'off duty'. Depending on the national context, formal care can be provided mostly by trained, licensed and qualified professionals, employed directly by the state or by non-statutory care organisations. In Germany, for instance, all LTC caring activities in residential care homes are fulfilled by qualified nurses. In many other systems, however, the majority of front-line LTC workers are low-skilled (often with a lower professional status than other health care professionals) and the sector is frequently characterised by high staff turnover rates. In some countries such as Germany, this is leading to the introduction of reforms to enhance the career prospects of LTC workers.

The rapid increase in social care need and demand has led to shortages in the supply of front-line care workers in many European countries, and an increased reliance on migrant workforce. Hence, the direct (legal) employment of migrant care workers by private households prevails in most Mediterranean countries (with the exception of Portugal) and in Austria, while they make up a significant proportion of staff employed by formal service providers in Anglo-Saxon (United Kingdom) and continental care regimes (Germany).

Care providers

Most formal care workers in the LTC sector are employed by care provider organisations. These organisations can vary significantly in characteristics such as their size, the type of support they provide, and their sector of the economy they belong to.

As is discussed in greater detail in deliverable D2.4, European LTC systems vary in the relative presence of public, for-profit and non-profit (voluntary, charitable, third sector) providers. Changes in the sectoral balance have been very marked in some countries. Across all European countries, however, there are debates about the efficiency and equity consequences of 'commissioning' services from the different sectors (Kendall et al 2006).

When considering the costs of service delivery, non-state, and particularly for-profit providers often outperform the state sector. In England a few years ago, for instance, the hourly cost of home care provided directly by (public sector) local authorities was more than 80% higher than the seemingly equivalent service provided by for-profit and non-profit bodies (Health and Social Care Information Centre, 2008). One concern, however, is that lower unit costs in the non-state sectors may be linked to inferior working conditions for front-line staff (poorer pensions, holiday entitlements and training opportunities; (Robinson and Banks, 2005), which could lead to higher staff turnover rates, in turn meaning poorer continuity of care and more frequent coordination failures in care. The inter-sector differential in unit costs has been found to be partially offset by increased transaction costs for the state because of the regulatory and commissioning frameworks needed.

The size of the care provider is particularly important with regards to the balance of power between LTC actors. At one extreme, single individuals can operate as care providers, for instance as personal assistants employed by direct payment users.

The locus of care is one of the most important policy issues in LTC, particularly whether services are provided 'in the community' or in institutions. Services in the community include support provided in an individual's own home (such as personal care, meals on wheels and sitting services) and services provided outside it, such as in day care centres and social clubs. Institutional care is sometimes divided between residential care and nursing care, the latter catering for people with higher levels of mental or physical disability.

New service models are being developed which attempt to merge features of the 'home' (domestic) environment whilst providing enhanced care levels. Hence, provision of sheltered accommodation, assisted living apartments and 'extra care' facilities has grown significantly in recent times in most countries. Although highly valued by users, these new services have tended to target people with low or moderate levels of need (Darton and Callaghan, 2009). The potential for using ICT solutions in the LTC system is also attracting significant policy interest across the EC, despite some disappointing results of early evaluations (Steventon et al., 2013; Henderson et al., 2014; Greve, 2016).

There is a high degree of substitutability between types of formal (and informal) services, and between support in the community and in institutions (Davies et al., 2000). In part, the potential for substitutability reflects the relatively low skills required to provide support with tasks such as bathing, dressing and feeding. This characteristic of much LTC might also limit the potential for efficiency improvements in the provision of support.

Informal carers in the LTC system

Most of the discussion so far has assumed that the activities associated with the design and provision of LTC support are fulfilled by care professionals. In contrast, family and friends constitute the central pillar supporting LTC systems across European countries, and are seen as the key to the longer-term sustainability of care systems.

The OECD defines informal (or family) carers as "individuals providing LTC services on a regular basis, often on an unpaid basis and without contract, for example spouses/partners, family members, as well as neighbours or friends" (Colombo et al., 2011).

Family members and friends are key frontline providers of LTC, and the time devoted to unpaid caring is often considerable. The supply of such support varies significantly across countries and cultures. The analyses of SHARE data[1] for the SPRINT project by Tinios and Georgiadis (2016) provide a useful comparative picture of the balance between formal and informal care in different European countries. They show that informal care is particularly pronounced in those countries where the state traditionally leaves a larger part of LTC provision to the family. Hence, the intensity of informal care amongst the very old is more than six times higher in Greece, Germany and Poland compared to Denmark. In southern and eastern European countries, the intensity of informal care is even higher, given that that co-residential personal care is more common in these countries and co-residential carers tend to provide more hours of informal care. Deliverable D2.4 describes variations in informal care provision across European countries.

Availability responds to a range of influences. Some countries are experiencing a reduction in the number of households shared across generations, with fewer older people living with their children and more marriages ending in divorce. This decrease in the rate of cohabitation is particularly important because co-resident carers are typically those providing the most intensive levels of long-term care support.

There are marked inter-country differences in social and cultural expectations about the role of family and community in supporting people in need (Eurobarometer, 2007). Whereas it is still the case in many Southern European countries, for example, that the family is expected to provide the bulk of the support required by older people with care needs, in recent times in many countries there has been a fall in the expressed and observed willingness to provide informal care. In contrast, the reduction in the life expectancy gap between men and women means that some countries are seeing increases in the levels of support provided by older males to their dependent spouses (Pickard et al., 2000).

Informal care is important because of its buffering effect on demand for formal services, thus reducing state expenditure. But it can have considerable knock-on effects on carers' opportunities in the labour market, and consequently for their ability to prepare themselves financially for their

[1] www.share-project.org

own old age (e.g. by contributing to a pension scheme). Moreover, very intensive levels of informal care have been linked to increased risks of health problems, including depression and high levels of stress (Molyneux et al., 2008).

Informal carers are not usually trained to provide care (although they may benefit from ad hoc training, and some carer-support interventions now being trialled do include elements of what could be seen as 'training' in basic care skills), and normally have no contracts regarding care responsibilities and are not paid (although they may have some reimbursement). Informal carers perform a wide range of tasks (also performed by formal carers) including personal care, help with instrumental activities of daily living and emotional support. Halfway between formal and informal care, a mixed offer of LTC services supported by cash-benefits provisions is widespread in some countries (Riedel et al., 2016).

Across Europe, but particularly in Southern European countries such as Italy, the boundaries between informal and formal care provision have been diluted, leading gradually to the creation of a mixed workforce made up of informal family carers, migrant care workers, personal assistants and formal professional care staff, operating with varying intensity in providing, delivering and sharing LTC services (Triantafillou et al., 2010).

2.2 Institutional Actors and Functions

The successful execution of the care functions outlined above by service users, families, care professionals and service providers constitutes the litmus test of the performance of the care system. However, most decisions taken at the individual case level are determined (or at least mediated) by a range of system-wide regulatory and other activities setting out arrangements for funding services, eligibility criteria for care, the oversight of care supply and care markets, and the definition of quality standards and service inspection procedures.

2.2.1 The role of different actors in funding LTC

In theory, a number of private solutions could be considered for the funding of LTC services. In practice, however, the state has taken the leading role in the organisation of collective funding arrangements across most European countries. Market failures mean that private funding solutions, through informal care or through unregulated markets, do not offer effective protection against the consequences of long-term dependency. Many dependent older people have no or only limited family support, and out-of-pocket payments for intensive support packages can be unaffordable for a large proportion of people.

Voluntary insurance against long-term care dependency also presents difficulties. Few people consider it an option because of low risk-perception, risk-neglect (low willingness to pay for

insurance coverage), moral hazard and adverse selection (see Johnson and Uccello, 2005; Finkelstein and McGarry, 2006; Gleckman, 2007; Brown and Finkelstein, 2008; Brown and Finkelstein, 2008). In addition, private insurers have found it difficult to calculate care costs associated with long-term dependency, and thus to price their products accurately. In Europe, only France and Germany have developed meaningful private insurance markets (and in the case of Germany, private insurance funds are required to offer the same benefits as the public system).[2]

Collective funding systems allow resources to be targeted on the most vulnerable groups in society, and have therefore been justified on equity grounds (Wanless et al., 2006). Indeed, funding arrangements do not just impact on 'who pays for what service' but also 'who gets what service', and therefore have potentially major implications for the distribution of burdens and benefits. In particular, the choice of revenue-raising mechanisms (direct or indirect taxation, earnings-related social insurance contributions, private insurance premiums, or user charges) will create different incentives, and imply different degrees of income redistribution. Higher user charges at the point of need, for instance, might deter both unnecessary and necessary consumption, and so can lead to unmet need.

Overall, state-organised funding arrangements in most European countries do not provide funding for all care needs or for all the population in need of support. As a result, other actors including private individuals (through in-kind informal support or out-of-pocket financial contributions) are required to contribute to the cost of care. Non-profit organizations can also fill gaps where public provision falls short in terms of quality or quantity or private market-type products are not affordable, and they may sponsor community-type experiments.

2.2.2 Eligibility regulations

The nature of the regulations defining eligibility to state support is one of the key elements influencing the interaction between individuals with LTC needs, their family and the state. As mentioned above, the nature of these regulations is often linked to the general approach of the welfare system. Social insurance-based models tend to use algorithmic rules for determining access to state support, which are seen to be more transparent but that can fail to consider needs which are difficult to quantify.

In many countries, administrative, funding and professional separations between the health care and social care systems have led to the emergence of 'cliff edges' in the eligibility to state support. In the UK, for instance, the extent of state funding for support with personal care tasks depends significantly on whether the origin of the needs is considered to be health-related, for instance

[2] See deliverable D2.4 for a fuller description of funding arrangements across European countries.

following a stroke, or whether it is related to a "social" problem, a term which includes dementia (Lewis, 2001).

Whether or not the availability of informal care is considered when assessing levels of state support can affect the equity, efficiency and sustainability of a care system, the key aspect being whether eligibility for support is reduced when informal (unpaid) carers provide support (as in England; the so-called 'carer-sighted' option) or whether informal care activity is ignored (as in Austria; 'carer-blind').

In fact, formal care systems can interact very differently with the informal care sector (Twigg, 1989; Twigg and Atkin, 1994). At one extreme, carers are perceived purely as resources, and entitlement to state support is denied to people with informal support. Under a second "model", formal services treat carers as co-workers, providing them with support and encouragement so that they can continue fulfilling their caring role. Dependent people with informal carers are still entitled to (reduced levels of) state support, with funding also made available for services aimed at reducing carer stress, such as respite care. In a more extreme form of this model, formal services aim to meet the needs of carers per se, hence treating carers as co-users of services. Finally, in models in which carers are superseded by formal services, the state aims to replace fully their caring activities.

Providing the same amount of formal care to someone with no informal support as to someone with equal needs but with significant family support might not be regarded as unequivocally fair. But neither might it be fair to leave carers to provide, unsupported, all the burden of looking after dependent older people.

2.2.3 Market management

Market management tasks involve the purchasing of care services on the state's behalf, but also include assessing population needs to determine likely future demand for care, determining which services could meet those needs, negotiating contracts with providers (and eventual contract termination), performance monitoring, and then reconsidering the consequences for strategic decision-making. Market management could also include overarching stewardship of particular (service-demarcated) markets, with the aim of counter-acting uncompetitive practices that could leave people with long-term care needs vulnerable to exploitation or at risk of low-quality care, and to ensure that major providers are not working to such fine business margins that they risk bankruptcy and the resultant potentially very serious disruption of care settings.

These activities are particularly important (and challenging) in systems in which the state does not provide directly the majority of care services, because of its reduced capacity to *directly* intervene and effect change in the supply of care services.

Many European countries have undergone significant organisational reform in recent years, and have introduced competition into hitherto public bureaucratic care systems, contracting out, the

adoption of 'hard' contracts with providers, and the use of fixed-price payment systems notably in the Netherlands, France, Australia and England (Propper, 1993; Knapp et al., 1994; Lyons, 1994; Roberts et al., 1998; Knapp et al., 2001; Schmid, 2003).

While some countries (such as Denmark and Finland) still retain high levels of public hierarchical organisation in long-term care, we now see a substantial use of market-like arrangements supplanting the traditional public model. Other countries, particularly the US, have a much longer modern history of market arrangements, most notably in the nursing home sector. Regardless of the starting point, a key LTC policy goal is to strike the right balance between markets, hierarchies and networks. Key questions include the degree to which provision should be separated from commissioning, where non-public sector providers are in competition; how transactions between providers and public sector commissioners should be organised; the sort of contracts to use; and whether the use of non-profit rather than for-profit providers should be promoted.

Although markets tend to be more efficient at allocating resources than hierarchies, for example, markets are susceptible to information problems when services are complex, as they often are in LTC (Milgrom and Roberts, 1992). Also, formal contracting in LTC markets often introduces higher transaction costs than hierarchies (Williamson, 1986; Forder et al., 2005).

A key consideration for the state when designing market management structures is provider motivation. Indeed, given the information asymmetries and difficulties in performance monitoring, the delivery of services by providers who are solely motivated by financial reward could lead to poor welfare outcomes for service users, and could even expose them to unacceptable levels of risk. In fact, research examining the intrinsic motivations of residential care providers in England suggested that the majority, regardless of sector, are not primarily motivated by pecuniary rewards (Matosevic et al., 2007). Classifying non-state providers on the basis of expressed motivations into three broad groups (‘empathisers’, ‘ professionals’, and ‘income prioritisers’), Kendall et al. (2003) found that most had primarily empathic motives, while the second largest group were ‘professionals ’, motivated primarily by ‘mercantile’ considerations linked to a desire for autonomy and control over one’s business. Clearly, commissioning structures and arrangements need to respond to provider motivations, and build especially on their empathetic and mercantile aspects.

2.2.4 Quality standards and inspection

Quality measures are required by purchasers of care (private or public) to aid them in their commissioning decisions and to contribute to the monitoring of aspects of performance, such as efficiency and effectiveness.

Measuring and assessing service quality in the social care sector, however, presents distinct challenges. The ‘experience good’ properties of social care, for instance, and the large influence played by subjective judgements about the quality of personal relationships and of process-related

service characteristics make it difficult to develop indicators of service quality (Malley and Fernández, 2010).

In part prompted by the marketization and personalisation agendas, there is an increasing desire to involve more directly service users in the assessment of service quality, by reflecting and responding to their views of the quality of the services they use. A number of strategies are being tried to collect the views of service users, such as the use of "trip advisor" type rating systems, and the use of user experience surveys (Rodrigues et al., 2014; Trigg, 2014).

Overall, users of social care services have tended to perceive service quality in terms of either aspects of 'quality of care' (accessibility, accountability, attitudes of staff, continuity of care) or of 'quality of life', for instance the extent to which services help improve users' health and physical functioning, and how well they meet basic physical needs with activities of daily living (Osborne, 1992; Reed, 2007).

Where provision is organised within a tutelary model (as in Belgium's home care sector), there are close and longstanding relationships between public administration and providers. Such systems do not tend to develop a system of benchmarking, and performance assessment focuses on inputs or intermediate outputs (such as provision of particular services or staff-user ratios) rather than user outcomes per se. Providers have "an obligation to means" rather than "an obligation to results"; i.e., to be accredited they must comply with input-related standards.

Marketisation, in contrast, creates a clear rationale for particular forms of performance assessment. Where there are unfetttered markets or quasi-markets, relationships are likely to be of a shorter duration, more business-like and based less on trust. Purchasers lack mechanisms of direct control, and some form of oversight is necessary to gather data about providers' operations for the purposes of quality assurance and accountability for public expenditure. In countries where the logic of markets exists, and in the context of the growing role of independent home care providers, the collection and use of service performance-related evidence could be critical in order to guarantee the efficient functioning of the care market by helping to address problems of incomplete and asymmetric information, and monopoly-like provider power. In these systems, responsibility for the measurement of quality, the setting of minimum standards and the inspection of care providers often sits with a quasi-independent regulator.

Important questions remain, however, about the success of such regulatory efforts. First, to what extent performance assessment frameworks, in particular those based on highly standardised measurement processes, can fully capture the complex array of factors contributing to good quality and good service performance in the home care sector. Second, how the different approaches to performance assessment support informed choice and improve the efficiency of the market. Due to these difficulties and to the different degrees of marketisation of long-term care systems between countries, we see that performance is not always measured by looking at outcomes. Process and structural quality indicators are still commonly used in the SPRINT countries, even if they provide a limited picture of the performance of the whole system.

It is also worth noting that the inspection and data collection activity involved in the assessment of service quality can be very resource-intensive. As a result, inspection regulators often target inspections on those providers at highest risk of failure. These systems require a degree of trust between service providers and regulators, for instance when submitting self-evaluation reports or other information required by the inspection activity.

2.2.5 Local and central government in LTC

The most widespread LTC governance model in Europe gives responsibility for the delivery of care to municipalities (local authorities), but locates the decision-making (and partially funding) role in central government. In some cases, for example Italy, there is an intermediate – regional – level with coordination and control powers. Three-tier responsibilities exist in some cases (e.g. in Spain) which can lead to problems of lack of coordination and/or overlap between central, regional and/or municipal levels.

Decentralization of delivery responsibility (and funding) to local authorities is quite widespread, even if with different levels of decision-making and funding autonomy. Often, the decentralisation of LTC functions to the local level is accompanied by an increase in the flexibility of decisions regarding eligibility to care and care models, the implicit assumption being that local decision-makers have a better understanding of local societal preferences, and how to best use local resources to meet local care needs. As a result, however, localised care systems are often characterised by significant geographical heterogeneity in the patterns of LTC support (see for instance Davey et al. (2006) and Fernandez and Forder (2015)). In the context of social investment, localism might be associated with increased opportunities for cost-effective investment, but at the cost of increased geographical inequalities.

Local variations in patterns of care provision have been subject to public criticism. In England and Sweden, for instance, the term “postcode lottery” is often used to describe a situation where entitlement to support simply differs according to where an individual lives. The question is the extent to which such variability can be justified on the grounds of local accountability and responsiveness to local preferences and constraints, or whether it bears witness to significant variations in performance and territorial inequity (Boyne et al., 2001; Powell and Boyne, 2001).

Some European countries (e.g. Sweden, Finland) have or are in the process of reorganising local responsibilities. These reorganisations are aiming to consolidate responsibilities on larger public authorities, in the hope that efficiency improvements and some reductions in local heterogeneity will be achieved.

3 Actors, Functions and Social Investment in LTC

The EC defines Social Investment (SI) as "policies designed to strengthen people's skills and capacities and support them to participate fully in employment and social life"[3]. Building on this definition, the SPRINT project has defined SI in LTC as "welfare expenditure and policies that generate equitable access to care to meet the needs of ageing populations, improve quality of care and quality of life, increase capacities to participate in society and the economy, and promote sustainable and efficient resource allocation".

Public management literature highlights the importance of recognising the presence of different interests in strategic decision-making, and that balancing the goals of different actors in a cooperative way can lead to improved overall performance. The underlying idea is that each actor's interests can be better satisfied through the achievement of a "common good" that goes beyond their specific interests, but that they are happy to embrace (Borgonovi, 1984; Mintzberg, 1996; Hughes, 1998).

Following the analysis in Section 3, it is therefore essential for social investment goals to be achieved to coordinate effectively the efforts of the different private and public LTC stakeholders, and to align their objectives with social investment principles (Charbit, 2011).

In this section, we aim to highlight some important policy areas in which the relationship between LTC actors is particularly significant for fulfilling the social investment aspirations. The analysis focusses on the areas of care coordination, efficiency improvements, and prevention. This analysis will be extended by future SPRINT deliverables, and particularly by D3.1 and D3.2, that will explore the way in which legal frameworks affect performance in the LTC sector.

3.1 Improving Care Coordination

Successful LTC policies are based on well-functioning networks and networking cooperation has often been identified as a key mechanism for enhancing public performance (Robins et al., 2011). Policy networks, to be effective, need their participants to share a common background and to be able to manage innovation and to face new challenges within a context of continuous change. An important ingredient for successful cooperation is a shared sense of "community" across policy agents (Powell et al., 1996), and the development of relationships based on trust (Siverbo, 2004). The concept of "collaborative advantage" can be used to study the interrelations and the

[3] http://ec.europa.eu/social/main.jsp?catId=1044, accessed 31 October 2016.

interdependences between the actors involved in policy areas such as LTC – including public and private, central and local actors, etc.

As reported in Berry et al. (2004), networking was first identified and assessed for policy management and governance in rural development and regional councils (Gage, 1984); later, the literature identified networking as a method of management to incorporate the horizontal and vertical relationships necessary to deliver intergovernmental programs effectively (Gage and Mandell, 1990; Agranoff, 1986). By the late 1980s, academics focused on intergovernmental management (Agranoff, 1986), taking into consideration the success of federal policy implementation (Peterson et al., 1986), and defining typologies and characteristics of networks (Gage and Mandell, 1990). By the mid-1990s, network research had become an integrated part of public administration studies and health care management. Following movements "hollowing out" and "reinventing" the state, the focus of scholars, especially in the US, shifted to cover the importance of networks in managing delivery systems for public services (Agranoff and McGuire, 1998; O'Toole, 1997; Provan and Milward, 2001). While this concept does not focus primarily on LTC, it does seem, given the diversity of actors and the differences between financing and delivery arrangements, to be a relevant concept.

Service delivery fragmentation in the LTC area is particularly evident in the structural and financial barriers dividing agencies and providers of primary/secondary care and health/social care; providers having distinct organizational and professional cultures and with differences in terms of governance and accountability (Glasby et al., 2006). There are particular concerns regarding the negative effect on the health care system of shortages in social care services, which it is argued result in avoidable admissions to, and unnecessarily long stays in inpatient beds, in particular for older people. Integrated care should, it follows, achieve gains in health outcomes, enhancing patient care experience and cost reduction (Berwick et al., 2008).

Different strategies have been proposed to improve care coordination between health and social care actors. The main forms of integration, according to Delnoij et al. (2002), are functional: integration of key support functions and activities, for example financial management, strategic planning and human resource management; organizational, for example creation of networks and contracting; professional – joint working, group practices, strategic alliances of health-care professionals; and clinical – integration of the different components of clinical processes, with coordination of care services for individual health-care service users. The benefit of integrated LTC approaches is not limited to improved health but includes short and long-term cost savings because reduced healthcare utilization, reduced carer burden, increased labour productivity, and other effects.

The use of case management processes has been seen as important in reducing fragmentation in care planning and delivery: they can serve as a link between service users and the services these individuals need but of which they often are unaware. They can guide potential patients to cost-effective ways of meeting their long-term care needs, and their skills can potentially also help in

addressing the issue of cost containment in long-term care (Davidson et al., 1991; Massie, 1993; 1996).

Financial incentives have also been introduced in an attempt to align the objectives of health and social care actors. Inspired by the Swedish experience, cross-charging was introduced in England in 2004, a system whereby the social care system compensates the acute health sector for delays in hospital discharges linked to a lack of social care support (Andersson, 2000). In general, financial integration strategies between health and social care agencies have been found not to reduce costs overall, but possibly to improve care outcomes by facilitating the identification of unmet needs (Mason et al., 2014).

While reliable estimates of the economic impact of integrated care models do not exist (Nolte and Pitchforth, 2014), there is growing evidence of the interrelationship in the performance of the two systems (Fernandez and Forder, 2008; Forder, 2009). Further research is needed, but the existing evidence suggests a significant degree of substitutability between health and social care. Improved coordination and integration of care is therefore universally considered a key goal across European LTC systems.

Whilst better evidence based is developed, increased efforts should be made to identify transferable lessons and examples of good practice that will support better outcomes (Nolte and Pitchforth, 2014). How these strategies can have an impact on measurement of social investment will be considered in WP4 and WP5 within the SPRINT project.

3.2 Improving Value for Money

3.2.1 The marketization of care

Public administration has been likened to a supermarket delivering a wide variety of public services, disciplined by market competition (Olsen, 1988). In this sense, the contracting of service delivery to non-governmental organizations is a relevant issue, especially for LTC policies. National and local governments are institutions different from the private firms, particularly in terms of the legitimate political authority (as opposed to market authority) that characterizes governments (Boyne, 1998). For this reason, it is very relevant how political and market competition interact in the selection of the form of service delivery.

There are many models of public service delivery. Increased market shares by private (for profit and/or non-profit) actors has been reported in many countries, especially in LTC (see deliverable D2.4 for a detailed discussion). How much and for which services governments should contract out provision is debated in academia and amongst policy makers and care practitioners (Longo and Barbieri, 2013). As indicated above, some studies suggest that privatization of public services can at least in some cases improve the quality of the services (Cooper, 2003; Savas, 2000).

And it should be noted that decentralization and privatization of public service delivery in itself cannot be considered as an isolated driver of efficiency, and other strategies should also be considered (Westendorff, 2002). It has been argued, for instance, that governments might improve efficiency and quality of public service delivery while employing autonomous and specialized public agencies, delegating the delivery to another organization, or pooling the activity of complementary public organizations (Barlow and Röber, 1996; Fernandez, 2007; Ferri and Graddy, 1991; Goldsmith and Eggers, 2004; Hood, 1991; Kettl, 1993; Langfield-Smith and Smith, 2003; Verschuere and Barbieri, 2009).

In the LTC area, recent UK analyses have identified a link between market competition and reductions in the unit costs of care home services, but possibly at the expense of service quality (Forder and Allan, 2014). In any case, the process of marketization of the care system implies a reduction in the state's capacity to assess and influence directly the quality of the services provided, and therefore often accompanied by an increase in regulatory activity, including the setting up of clear quality standards and service inspection processes (Malley and Fernández, 2010; Armstrong, 2013).

The precise configuration of the commissioning process, the roles played in it by different actors, and the range of services and providers that might be contracted from will have significant implications on the impact of competition on the range, quality and costs of care services. Across Europe, the UK has spearheaded the introduction of markets in the long-term care system. Introduced in the 1990s by a conservative administration, successive governments have not sought to reverse these changes, although increasing emphasis has been placed in collaboration rather than competition. As a result, over 90% of services are provided by the non-statutory sector in England at present. These changes have shifted the roles of agents in the care system, with local authorities taking an enabling role, with the aim to shape local markets so as to "guide" the development of the supply of high quality services in sufficient quantities to meet future increases in demand.

Public-private mix in the provision of long-term care services is managed in different ways through Europe. The German market for long-term care services is dominated by private providers in both institutional and home-based care settings (Riedel and Kraus, 2011). In Scandinavian welfare systems, public provision is predominant. In all the other countries, 30% or more of the market, at least for formal home-based care, is held by private providers. The larger private presence is usually in home-based care rather than in institutional care. This is true in particular for new EU member states. Surprisingly, in Hungary while most legal entities providing home nursing care are private, most providers of home care are public (Tarki, 2009).

3.2.2 Personalising care

Public service delivery is shaped, but also enabled, by citizens' empowerment and social partnerships. Interdependent public and private actors need to cooperate, persuade, bargain, and build trust (Barbieri and Salvatore, 2010). Public administration is organized on the basis of authority but also as competition and cooperation (Olsen, 2005).

In many ways, the drive towards user choice and the personalisation of care can be characterised as an extreme form of marketization, in which individual service users and/or their family can "vote with their feet" by choosing (in theory at least) the type of support and the provider that meets their needs best, within available resources.

Choice has been hypothesised to help in addressing quality aspects that are difficult to quantify but easy to experience for users, such as the personal interaction between care recipients and caregivers (Lundsgaard, 2005). Many European LTC systems offer free provider choice in both institutional care and home-based care. In Italy, free provider choice is limited mainly to home-based care. Only in Finland are care recipients not free to choose their provider (Riedel and Kraus, 2011).

Again, there is still little conclusive evidence about the consequences of user choice on the costs and outcomes of LTC services. An evaluation of the implementation of personal budgets in England found, however, that whereas some improvements in social care quality of life could be observed amongst personal budget holders, the shift of commissioning responsibilities from state actors to private individuals placed a significant burden on care users, and that this could increase anxiety levels, in particular among older people (Glendinning et al., 2009; Glendinning et al., 2011; Netten et al., 2011).

3.3 Investing in Cost-effective Prevention

The European Commission underlines that social investment, innovation, efficiency are important principles that should underpin a new approach towards LTC in Europe (Fransen, 2014). A variety of initiatives are being promoted with the aim of reducing the need for care in different countries, dependent on the institutional context in each country: active and healthy ageing, improving the capacity for independent living, successful rehabilitation as early as possible, and the use of ICT in a drive for higher productivity. More generally, given the long-term nature of the needs of people supported by LTC systems, improvements in the design of care packages could influence significantly the outcomes and costs of the LTC system (Davies et al., 2000).

The EC has identified the following key components for promoting active ageing:

- identifying and targeting resources on the specific causes of dependency

- adopting a "life course" approach
- identifying those within the older age group who are most at risk, designing "personalised action plans" to promote the most effective form of prevention
- implementing innovative organisational approaches and technical solutions targeting frail older people for evidence-based interventions in order to reach a more efficient use of resources, skills and technology, and improve the health and quality of life of older people and caregivers
- developing and deploying ICT effectively
- exploring new ways to promote active and healthy ageing with age friendly environments
- running pilots to analyse integrated approaches to age-friendly urban design, housing, transport health and social services, age-friendly workplaces, ICT and smart environments (EU, 2014).

Active ageing implies "the process of optimizing opportunities for health, participation and security in order to enhance quality of life" (WHO, 2002: 12). It allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, providing them with adequate protection, security and care. The term "active" refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Through successful active ageing, older people who retire from work, are ill or live with disabilities can remain active contributors with their families, peers, work associates and neighbours. In essence, active ageing initiatives aim to extend healthy life expectancy and quality of life.

Given the need for a "life course" approach, promoting active ageing implies the coordination of policies across a number of areas of the welfare system, and during different stages of the life of individuals. In addition, the identification of at risk groups, and the implementation of cost-effective support models for them will require significant investment in innovation, both in terms of the care arrangements and structures, and in terms of technological solutions for collecting and sharing information and for improving the cost-effectiveness of care models available. As is illustrated in the case of Italy in Appendix 2, such innovation can be rooted in innovative practices derived from social finance and the experience of social enterprises.

The development of technological solutions is attracting significant interest (the potential of ICT solutions will be further discussed in WP4). The use of telecare and telehealth, which offer a range of solutions for remote monitoring of individuals' health, has increased significantly since the early 2000s in many countries, and as a result is becoming more affordable and cost-effective (Millican et al., 2011). Internet tools may help older people to be in contact with family and friends who do not live nearby and provide vital social contacts, especially for those with physical disabilities.

Smart homes can respond to a variety of needs, especially through assistive technology[4]. Co-housing (clustered housing groups of a variety of formats) is not innovative *per se* (the first experiments started in the 1960s) but it represents a growing phenomenon, linked to the increased role of the non-governmental organizations and social experiments in community care and social participation.

4 Conclusions

Social investment, in Hemerijck's words (2015), involves a significant change in the core elements of the policymaking process, moving from a focus on "repairing" the damage caused by events to a focus on preparing individuals and families to address life chances and deal with disruptive events, and preventing some of the negative effects they can cause. This implies focusing on the creation of capacities, shifting policy analysis from an exclusive focus on present costs to a focus on current and future impacts; addressing social risks within life-course dynamics, and in doing so overcoming the divide between carers and recipients; and fostering more efficient work policies.

Stakeholder engagement is a complex process cutting across territorial and institutional organizational layers: managing this complexity should be a priority for public decision makers.

Some of the most ambitious policy objectives, such as promoting active ageing or effective coordination between health and social care services will require novel solutions which achieve effective collaboration and joint working across a wide number of public and private agents. The present deliverable has highlighted the size of the task, by describing the number and characteristics of LTC actors, their functions within the care system, and the many ways in which their interrelationship is structured depending on the nature of the regulatory framework.

However, the economic and outcome gains from successful active ageing policies and improvements in care models compatible with social investment principles are potentially high.

[4] Assistive technology can be defined as "any device or system that allows an individual to perform a task he would otherwise be unable to do or increases the ease and safety when performing a task" (McCreadie and Tinker, 2005: 92)

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6 Annex 1: Key Roles of Long-term Care Actors in SPRINT Partner Countries

In Belgium, LTC delivery is by a range of services organized at the federal, regional and municipal levels. LTC services are provided mostly as part of the federal public compulsory health insurance system financed by social security contributions and general taxes. Informal care is provided mainly within the family (Willemé, 2010). Day care and short stay centres provide care services for elderly dependent persons who still live at home but (temporarily) lack adequate informal care. Formal and informal care coexists even if the latter is provided mainly by relatives. Informal care is also predominant in cases requiring intensive levels of care. Recent state reforms designing important transfers of competences in health and long-term care from the federal to the federated level have been decided and are progressively being implemented (EU, Belgium Social Reporting, 2015).

In Denmark[5], the state has the main responsibility for the overall regulations concerning the delivery of long-term care services, whereas it is the local municipality which decides the level, based on an assessment of needs. Private actors may play a role in the delivery of care and many private companies deliver cleaning services in private homes, whereas personal care is still mainly delivered by public sector employees. The municipalities offer accommodation in facilities that are suitable for long-term residence for persons who, due to significant and permanent physical or mental impairment, need extensive help for ordinary everyday functions and/or care, and where it is not possible to cover these needs in other ways. Compared to other countries, informal caregivers in Denmark play a relatively smaller role in the caring system. The municipalities now have to offer rehabilitation to elderly people in need of home care (EU, Danish Social Reporting, 2015).

In Finland[6], the 342 local municipalities are responsible for the organization of health care and social services, including long-term care. Municipalities can arrange the services by themselves, together with other municipalities, or by purchasing care from private providers. Round-the-clock residential long-term care for older people is mainly provided in the inpatient departments of health centres, in nursing homes and in serviced homes, also called sheltered housing units. The majority of nursing homes and health centres are owned by municipalities, but there are also a number of private serviced housing units and homes provided by NGOs[7]. The government's policy

[5] For further information about the Danish case see also: Greve (2016), Ministry of Social Welfare-Ministry of Health and Prevention (2008) and Schultz (2014).

[6] For further information about the Finnish case see also: Anttonen and Karsio (2016), Ministry of Social Affairs and Health, Finland (2001) and Johansson (2010).

[7] Around 50 per cent of service housing units with 24-hour assistance are private in Finland at the time of writing.

aims at replacing institutional care with support in the clients' own homes and or in a homely environment, such as sheltered housing units with 24-hour assistance. Karsio and Anttonen (2013) have shown that marketization has strongly influenced service provision in the Finnish municipalities and most particularly the services for to older adults.

In Germany[8], the role of insurance is very saliant: about 90% of the population is insured in the public social insurance system, with the remainder having cover through heavily regulated private insurance funds. These private insurance companies have to offer the same benefits as the public system. The introduction in 1995 of the long-term care insurance was associated with an increase in the number of nurses and professional caregivers for older people, especially in the ambulatory sector. An efficient care market operates for the supply of care services by private providers. Some of these have a link to the churches (e.g. Caritas, Diakonie); others are profit-making private enterprises of different sizes. Most of them work at local or regional level only, but there are plans for some enterprises to extend their activities to the national level. Residential care is mostly provided by the same institutions. In addition, some residences are run by municipalities; they follow the same rules as the private institutions. NGOs sometimes support persons in areas that are not covered by insurance (for example with companionship services and social activities). The latest reform of the LTC aims at more integration and better coordination among long-term care, medical and social assistance. A significantly reduced level of benefit in cash can be chosen instead of support in kind. A large number of beneficiaries opt for the cash benefit, whichb is normally used to compensate informal carers for the support they provide. Self-help groups and volunteers make an important contribution towards caring for people needing help. Since the insurance system covers only some 50% to 60% of the costs for professional or residential care, care within the family is very frequent.

Greece[9] suffers from poor service quality and low levels of coverage by the public long-term care system for older people. Private sector services have developed significantly since the 1980s, while the role of the voluntary sector remains limited. Care for the elderly in special care units is provided by the public sector, non-profit organizations and private institutions, the majority of which are concentrated in urban areas. There are significant limitations in the range of services available, as well as in the intensity of public support allocated. A limited number of public residential care homes for older people operate under the supervision of the Ministry of Health and Social Solidarity, providing shelter, food, psychological support, counselling and medical care. There are also private for-profit homes for but the quality of the services they offer is very low (Economou, 2010).

[8] For further information about the German case see also: Federal Ministry of Labour and Social Affairs (2015), Schultz (2010) and Fosti and Notarticola (2014).

[9] For further information about the Greek case see also: Ministry of Labour, Social Security and Welfare (2012), OECD (2016) and Vaiou and Siatitsa (2013).

In Hungary, long-term care services are provided by both the health care and the social care systems. These two separate systems have their own legislation, financing mechanisms and services (Czibere and Gal, 2010), however both of them have been administered by the Ministry of Human Capacities since 2010, resulting in slight improvements in the coordination of the two systems. Health care services are primarily financed by the National Health Insurance Fund[10]. The social care system is managed at a local level. The local governments assume primary responsibly for organizing and delivering social care, which includes home care, day care and residential care, under the framework set out by the central government. The main providers of basic social services (home care, day care, etc.) are the local governments while the role of other actors (e.g. churches) is secondary. Residential care institutions are maintained by a wider range of social actors, including central government, local government, churches, the NGOs and corporations (Hungarian Central Statistical Office, 2014 Yearbook of Welfare Statistics, 2014). Social care is mainly financed by a combination of central government, local government and out-of-pocket contributions (OECD, 2011). Non-governmental providers have a limited role in the care system, although NGOs providing public services are entitled to the same amount of funding from the central budget (through contracting with local authorities) as the local government providers. Care centres maintained by churches receive additional financial support (Czibere and Gal, 2010). Private insurance schemes are poorly developed. The bulk of LTC care is provided by households or the informal market. Recently, new providers, in particular charities, have entered the picture; public administration has become more decentralized; much of the previously informal activity has become formal; and unmet need has fallen. Instead of focusing on cooperation and coordination with alternative providers such as households, the system focuses on funding institutions rather than tasks (Czibere and Gal, 2010).

Long-term care provision in Italy[11] involves multiple public and private (for profit and non-profit) stakeholders, with different and often overlapping roles, which are defined in legislation. The state sets out the main directives on health and assistance, checks the uniformity of treatment, distributes resources from the National Fund for Social Policy and delivers cash benefits to elderly and disabled people. Regions mainly carry out coordination and control activities on social interventions with particular reference to health and social care with high health integration (Law 328/2000); define criteria for the authorization and accreditation of service providers; calculate users charges; determine the payments that municipalities are required to transfer to accredited subjects and distribute service vouchers for LTC facilities. This is not a direct operational role, which is exercised by municipalities. Municipalities are responsible for planning, designing and implementing local social services systems. Municipalities are therefore the main actors in the implementation of public assistance to disabled people. Most LTC providers come from the non-

[10] The coordinating and financing agencies of the health care system are under reorganisation based on a new governmental decree No. 386/2016 on health insurance bodies effective from 1 January, 2017.

[11] For further information about the Italian case see also: Fosti and Notarticola (2014).

profit sector or are individual carers. Residential or semi-residential facilities (Residenze Sanitarie Assistenziali – RSA) and community nursing homes (case protette) are the usual institutional settings for elderly and disabled people, including those with mental health conditions. In Italy, rather than one national LTC system there are many regional systems. The supply of social services is insufficient to meet the population's needs and is extremely diverse across Italian regions (Tediosi and Gabriele, 2010).

LTC for the elderly in Lithuania[12] is provided within the national health care and social services system. Non-governmental organisations together with informal private ones also constitute an important part of LTC provision for elderly people. From 1998 to 2000, a process of decentralization took place among social care institutions and the health care system (Marcinkowska, 2010a). All the institutions that had been subordinated to ministries were transferred to territorial self-governments. The major responsibilities now fall to local government (municipality or county). The Ministry of Health is responsible for health care system policy. The main administrative institutions for social services provided by the social security sector are the Ministry of Social Security and Labour, the Department of Supervision of Social Services under the Ministry of Social Security and Labour, and the municipalities. Municipalities provide general (without permanent assistance by specialists) and special (social attendance and social care) social services for elderly people. There were 48 nursing hospitals (providing nursing care, medical rehabilitation, follow-up treatment, palliative care and sanatorium treatment) in Lithuania (out of 134 hospitals in total) in 2014 (Lithuanian Ministry of Health, 2015: 47). Recently, LTC institutions have been established by private sector and community initiatives, although competition in the social services market remains at a low level. LTC provision by the informal sector (family members, neighbours and friends) supplies the most significant part of the support for elderly and disabled people in Lithuania. It is still very often considered in Lithuanian society that primary responsibility for the care of elderly rests with family. The main critique of the long-term care system in Lithuania is its division between the health care system and social services system, and the weak integration of these two providers of care services.

In Poland[13], after health care system reforms in the late 1990s, the "long-term care" concept has been adopted within the health care sector, even though a LTC system as such does not really exist. There are care and nursing facilities providing residential long-term care as well as long-term care nurses providing home care. Internal medicine departments of the hospitals often play, to some extent, the role of residential long-term care institutions for the elderly. The main actors in terms of care provision are first the family, and then public institutions. Private providers as well as NGOs play residual roles. In the private sector, a large part of LTC provision comes from

[12] For further information about the Lithuanian case see also: European Commission (2015), Government of Lithuania (2014), Marcinkowska (2010b), Ministry of Social Security and Labour (2014), National Audit Office of Lithuania (2015), Poskute (forthcoming), Republic of Lithuania (2006), Štreimikiene and Štreimikis (2013).

[13] For further information about the Polish case see also: Golinowska (2010) and Golinowska et al. (2014).

informal but paid carers (often migrants). A particular challenge in the long-term care system is the division of responsibilities among the Ministry of Health, the Ministry of Labour and Social Policy, territorial self-governments and others, and the lack of cooperation between them (Czepulis-Rutkowska, 2014). Care services are usually provided at the local level. The local social assistance centre can delegate the provision of the services to authorized organisations or via public tenders, which private providers can bid for. Private care homes can operate in the care market, or be funded by public money. Publicly owned residential care homes are established and managed by local government (usually the "powiats"). Independent residential care providers are established by the Catholic church, religious and other associations, foundations, and private individuals. More than 80% of LTC is provided within the family, a phenomenon due to the culturally strong family ties.

State provision of community care services in Portugal is limited but includes long-term care, day centres and social services. Long-term care has not generally been part of the public health agenda and delivery has mainly been provided by family and by Misericórdias (independent charitable organizations). Formal social care, personal care and domestic aid is mostly provided by non-profit and for-profit private organisations. Local government involvement has been marginal. The number of for-profit actors in the market is increasing but the main providers so far have been the Private Non-profit Institutions of Social Solidarity, subsidized by the state. Residential care provided in each region by the public sector, funded by the Ministry of Labour and Social Solidarity, is often of poor quality and lacks sufficient resources. To expand services, a new private/public mix centred on public subsidies of non-profit institutions was built up in the late 1980s. The state is facilitating vocational training opportunities in areas such as domiciliary care and informal provision of services as part of a job-creation scheme, although these forms of care are still very poorly developed (Joël et al., 2010). One critical issue is the state's ability and will to evaluate and control non-profit organizations (Santana, 2010). One of the main differences between Portugal and other southern and southwest European countries is the high degree of organization and power of the non-profit sector through strong and powerful peak organizations that participate actively in policy-making (Santana et al., 2014). The last decade has seen an improvement of the quality and quantity of services of integrated care delivered, partly due to the launch of the National Network of Long-Term Integrated Care (Governo de Portugal, 2015).

The long-term care system in the United Kingdom[14] is characterized as a "safety-net" type of system where public funds support those with very severe needs who are unable to meet the costs of their care (Fernández et al., 2009). Formal services are provided by a range of agencies including local authority social services, community health services and independent (for- and non-profit) sector residential care homes, nursing homes, home care and day-care services. Central government is responsible for overall policy on health and social services. Local authorities

[14] For further information about the UK case see also: National Audit Office (2014), Hancock et al. (2013), Technology Strategy Board (2013), OECD (2013).

determine eligibility within a national set of minimum eligibility criteria: very large local variations in care provision exist, and services provided can be very different depending on the place of residence. Means-testing rules are nationally set. State-funded social care support accounts for approximately half of the total residential care use. Almost all community and residential care is provided by the private and voluntary sector. Residential or nursing care is provided in homes specifically for that purpose (Steele and Cylus, 2012). As health and social services are a devolved function within the UK, the central government role is located in the English, Scottish, Welsh and Northern Irish governments. This means that policies may differ among the four constituent countries of the UK. The long-term care system in England relies heavily on informal or unpaid care provided by family, friends or neighbours. Most home care is provided by home care agencies, the majority of which (90%) are private. The last ten years have seen major changes in home care in England. There has been a substantial decrease in local authority direct provision, accompanied by a major expansion of private sector provision (Fernandez et al., 2013).

7 Annex II: Case Study of the Role of Social Cooperatives and Social Enterprises in Italy

The Italian LTC system suffers from fragmentation of services, reductions in available public funds, poor quality of many public and private services, and inter-regional heterogeneity of service delivery. Here we focus on the role of social cooperation in Italy and the key function played by social cooperatives and third sector organizations more generally, in complementing, and sometimes substituting the private and public supply of LTC services.

The debate about social cooperation in Italy is well advanced, probably more so than in other European countries. Italian cooperatives have developed successful managerial and operative practices that should be studied and possibly replicated in other institutional settings, in order to test the efficacy of the distinctive way the third sector contributes to LTC in this country. The picture in terms of social cooperation is not homogeneous and not without many problems. However, we focus here on how it represents a possibility of addressing some of the problems faced by the LTC sector, in which the public offer has declined in terms of financial resources and service quality, and the private supply has not been able to deliver services to cover the needs of most of the population, in particular the poorest and frailest citizens.

It would be naive to present social cooperation as the solution to all the problems: the point is that it can offer viable innovation for the LTC sector, in particular if policymakers consider the actors operating in this sector as “social enterprises”, able to produce efficient managerial practices and governance mechanisms, develop high quality services and the promote integrative instruments of social inclusion and participation directed towards ambitious goals in promoting active ageing.

If we consider these actors as “enterprises” capable of operating on the market, with all their peculiarities and limitations, it is necessary to design innovative financial tools to fund them and innovative schemes of participation of the LTC stakeholders in the management of these actors. Stakeholder engagement, empowerment of local areas, coordination with the private sector, development of innovative data collection and analysis tools, definition of appropriate methodologies of needs assessment are among the main topics to be addressed if a serious investment is to be made in this sector.

Social innovation is not “something else” than the public offer, the marketization of the service delivery or the creation of insurance-type mechanisms of care funding: they are all facets of the same articulated governance setting in which LTC system will evolve in coming years. When designing policies of integrated care in LTC it would be a mistake not to consider social innovation, social enterprises and the financial tools developed to fund this sector. The closeness of these organizations to localities, their capability to interpret the needs of the elderly and of those taking care of them and their capacity to involve these stakeholders in the decision-making and

management process should be enhanced. The Italian case presents many interesting features to analyse in order to foster a cross-national investigation pattern at the European level.

7.1 LTC in Italy

The welfare system in Italy is characterized by a number of specific features deriving from historical reasons – the prominent role of churches and foundations, the poorly developed system of social care albeit with large regional variations) and from cultural patterns in the role of family and civil society. Changes during the last forty years have weakened the role of the public sector in many areas including LTC due to increasing privatization in the health and social service sectors. As a reaction to this trend, innovative measures and structures have been created by civil society. Of these, we discuss here the extension of cooperative enterprises to social service areas (social cooperatives) and a new form of enterprise culture and management, the social enterprises. They have innovated the enterprise culture and management form and introduced new value and criteria in the definition of social c apital, social investment and economic-social sustainability.

In Italy, the social economy emerged in the 1970s and consolidated its presence in the social, economic and entrepreneurial system through the following decades. Social companies addressed shortages in the supply of social services in both the Italian public and the private sector. Compared with other (profit) economic initiatives, social economy actors in Italy have to balance their economic activity with the social aim of providing services across a wide population, in particular with regard to the needs of vulnerable groups (European Commission, 2013). The social economy is fully integrated into the country's welfare system, providing a range of important services of general interest. From 1990 onward, a series of legislative interventions expressly recognised the concept of public benefit organisations, establishing the legal framework to support social economy activities (e.g. through the provision of tax benefits and other advantages) and regulating the institutional forms of the different categories of provider in the social economy. The Italian social economy is substantially different from those in other EU member states, and continues to play an important role in the Italian welfare system. Social economy organisations are particularly well suited to create social incentives and social capital development, as well as to link economic and social policies at different levels of governance (e.g. national, regional, local). In addition, the social economy in Italy is an important source of entrepreneurship and jobs in areas where traditional "investor driven" enterprise structures may not always be viable, because of low profit rates and high labour intensity.

7.2 Consortiums of Social Cooperatives in Italy

Consortiums of social co-operatives can address the issue of the typically small size of these enterprises while keeping their synergistic force.

The consortium is a second level organization bringing together a number of cooperatives comprising at least 70% of the overall structure (law 381/91). There are now approximately 200 consortiums, and their rate of growth coincides with that of social cooperatives. However large numbers of social cooperatives remain outside these forms of cooperation: about two-thirds of the total in southern Italy and about a third in the north.

The advantages of a consortium governance form can be summarized as follows:

- An integrated structure, not otherwise available, for supporting new cooperatives;
- Economies of scale through participation in the consortium, which avoid the need to increase the size of the enterprise, which would change its structure and participatory form;
- A recognized identity of the member cooperatives;
- A structure that can take initiatives without affecting democratic principles;
- The ability to offer low-cost loans through special agreements with banks;
- Brokerage business with municipalities to make possible large contracts with the participation of several members;
- A democratic forum for promoting the interests of cooperatives;
- Assistance to the members of the consortium to increase their influence in the planning and organization of contracts for social services.

7.3 The Role of Networks

Participation in consortiums and networks is not just a cultural or ideological choice, but has specific implications on the organizational level. The choice of joining a consortium is consistent with the “strawberry fields” pattern, invoked by various authors, which encourages small horizontally-connected groups, a form that combine the advantages of a small business with better specialization and strong measures to support innovation in the social economy. The networks act as a support to achieve efficiency in each organization and obtain the support of people and organizations not necessarily connected inside the same social cooperative.

In addition, networks are an absolute necessity when the production of goods and services is based on the convergence of inputs provided by different actors, as in the case of territorial development projects, and multipurpose activity, as in the case of complex services. Finally, the network is a useful tool in monitoring and evaluating activities and “finished products” which are often carried out by external actors and not only through their work alone, but also by public or private entities that may contribute to financing or co-funding.

The network allows for functions to be outsourced or co-administered with others in the network, as in the case of training, often outsourced, or as in the case of *Solidarete*, established in 2008 with the participation of the Consortium CGM, CTM and FOCSIV, incorporating collaboration processes between different networks.

Networks and consortiums of cooperatives are not only support structures providing services to members and promoting their internal cooperation, but also local business networks with their own autonomy of action and management. These organizational forms have also been applied in other areas such as social economy GAS (fair trade groups), fair trade, voluntary organizations, and others. Similar structures exist in other European countries such as France, for example ACEPP (*Association des Enfants Parents Collectives Professionals*) which brings together more than 1000 local initiatives throughout France related to parenting.

7.4 Social Cooperation and Migration

For several years social cooperation actors have begun to question their role in the analysis and management of migration flows. One objective which has been highlighted from the start is establishing a process which engages the destination communities but also has a degree of reciprocity with the countries of origin.

The management of migration flows promoted by the Italian social cooperation therefore aims to take account of the needs that exist in Italy, especially in terms of lack of personnel, the generation gap, and skills that generate these flows in the contexts of origin. In addition, questions have been raised about how to develop social and economic capital in the countries of origin, with the goal to open two fronts of action, “here” and “there”, and to improve the opportunities of movement and socio-working both in the place of arrival and in the contexts of origin.

Promoting the development of cooperation in the social contexts of origin has pursued the goal of maintaining consistency with the principles and standards achieved in Italy: to ensure the sustainability of initiatives it is necessary to create a balance between social factors and entrepreneurship and between business life and the communities. Another important aspect to consider is the issue of networks: it should be a priority to strengthen the structures offering support to individual companies. In Italy, in the reality of social cooperation, it is the consortium which provides this support. In other countries, as in Poland, there are different structures but with similar purposes.

7.5 CGM Strategy for Social Co-development: An Example

The international activities of CGM are inspired by the principle of co-development and connecting communities and people, translated into social practices of organization of coexistence. These two principles are opposed to those of competition and rivalry witnessed in some aspects of globalization. A capacity and commitment to developing partnerships applied in the most sensitive and vulnerable sectors is needed.

This commitment has to start from the assessment of needs and by the questions posed by people and communities. These questions arise in the daily management of social cooperatives designed as a new form of enterprise, the social enterprise.

This is why such projects up to now have always arisen from specific issues. In the case of the "Poland Project" (which is described below in more detail), the issue is the insufficient number of nurses in Italy, the difficulty for foreign nurses of enrolling in the professional register (IPASVI) and the resulting existence of a "B-side" market of the nurses who provide services in private facilities where registration is not a requirement. People with very specialized or advanced skills end up in less skilled jobs such as those of family caregivers and may find it hard to return and use these skills in the countries of origin that face a shortage of staff. For the caregivers, the problem derives from the fact that there is a transnational system of mediation between supply and demand, while theoretically this is the only way to gain access to our labour market. This creates a double disadvantage: for older people who need to find care on a market where there is no warranty, and for caregivers who also lack protection and experience risks associated with illegal labour.

Solutions to these issues are likely to involve moving beyond planning and implementation based on sectoral mechanisms and simplified supply and demand, to a more complex system of evaluation that shares the cost-benefit accounting across the whole community and the enterprises that constitute the institutional context.

7.5.1 CGM project examples

Examples of projects that deal with elements of development and co-development operated by CGM and consortiums are:

- development of the activities of social services and employment in Colombia
- development of social enterprises in Brazil
- co-development in Peru of twinning business
- enhancement of health personnel and attendant care between Italy and Poland.

This last project, funded by the Foundation Unicredit in 2007, took place between Italy and Poland and its objectives and activities were divided into two lines of action:

1) Professional training and employment of immigrant women in the fields of nursing and assistance to families in Italy.

2) Strengthening of the social economy in Poland and creation of partnerships between Polish and Italian social enterprises.

7.5.2 Training and recruitment

Regarding the first component, the project started with the selection, in Poland, of the nursing staff. The identification of areas and people took place through, among others, local associations and cooperatives.

Poland has well-developed cooperatives providing health services, but they do not have a sufficient market. These organizations were asked to identify staff with professional experience, but also a culture of cooperation. These nurses were offered (in the country of origin) language training, and technical and specialized training that allowed them to enrol as nurses in Italy. They have since been employed by Italian facilities.

The national consortium of social cooperatives in Italy – CGM – has a network of cooperatives across the country and many of these have RSAs (Health Elderly Residences) and other facilities to which the nurses were allocated, with a structured reception. While still in their country of origin they were provided with key information about the situations into which they would be moving.

In Italy, the beneficiaries of the project were supported by careful social mentoring, training and acceptance that has taken measures to solve practical and logistical problems including housing. Among the operators of the facilities in Italy which the nurses joined, awareness was raised and support provided so that they were able to accommodate the new arrivals.

In Poland, 96 nurses and 14 ASAs were selected and trained to join the Italian network (from 2007 up to mid-2009) The nurses involved in the project were included in the RSA (senior citizens health residences), RSD (nursing homes for people with physical or mental disabilities), community psychiatric accommodation, community AIDS patients, and facilities for drug misusers and "mentally mixed community". About 10% of the nurses were placed in rehabilitative institutions of excellence such as the Don Gnocchi Institute and the San Camillo Hospital in Rome.

The second component of the project's work was with family caregivers through the "Crafts" desks managed by CGM in three regions, Lombardy, Emilia Romagna and Piedmont, provided by local consortiums operating within the CGM network. These desks offered the following activities: guidance interviews and skills assessment; access to the database for matching demand and supply of labour; cultural mediation and training for care work; family support for the management practices of residence and employment contracts with the family assistant; training for employment in the family; use of temporary employment contracts; and support to the family in case of the assistant being ill or absent for another reason.

This system selected and placed 420 caregivers, in households in the three regions covered by the experiment and in the areas covered by the network of cooperatives.

7.5.3 Transnational social cooperatives: twinning

A second objective was to facilitate the movement of personnel and social health nursing through an encouraging convergence between the labour markets in which the staff worked, the two poles of the migration process. The project therefore aimed to strengthen in Poland the sector of social cooperation in social and health services and to build twinning social cooperatives, Italian and Polish.

As for the goal of the development of networks and social economy in Poland, the work began with an analysis of the social cooperation sector in the country. Immediately it became clear that a convergence between Italian and Polish social cooperation was difficult because of the institutional, legal and social practices in the two countries. In Poland, the law on social cooperation is borrowed from Italian law but applies only to type B cooperatives, those that pursue work integration of disadvantaged people. A different law regulates the type A social care cooperatives, those dealing with interventions and social services. This represented a problem for the project, which aimed to build their own networks, both in Poland and at the transnational level, including type A social cooperatives, in order to facilitate the movement of personal social health workers.

Lobbying on legislation was undertaken to bring home the importance of legislation on the issue of social cooperation in the health and care sector. One positive effect of this work is that, thanks to the project, a parliamentary debate began in Poland and although discussions are not completed, a law now recognizes and regulates type A social cooperatives. At the same time a regulation was approved which lowered from 80% to 50% the number of job placements for disadvantaged people required by law and this made local social enterprises more sustainable.

Secondly, again in order to strengthen the local social cooperatives, seminars and exchanges were set up between managers of Polish and Italian cooperatives. Italian staff travelled to Poland to carry out educational activities on topics such as business planning, the structure of qualifications and so on.

A third activity involved policymakers and operators of cooperatives and employment agencies in Poland learning about the experiences of Italian social cooperation initiatives and the integrated system of social services. The Italian situation is a good practice at European level and therefore for countries which have recently joined the EU these practices have an even more important value in terms of strategic orientation.

At the conclusion of this work a twinning initiative was arranged between Italian and Polish social enterprises aimed at facilitating the exchange of knowledge and experiences on enterprise

development issues. In particular, the focus was on the production of services for the elderly and children: in Poland there is strong demand for services, which is assuming even more relevance due to the pressure exerted by migration and the ageing population. The work also revealed the strong interest in Poland for the establishment of integrated social protection mechanisms, and for stronger coordination between different policy areas and services.

This project made evident that in the future it will be necessary to strengthen financial instruments for the development of the social contexts of origin (for example through the creation of binational mixed RSA). Creating long chains in which convergence of labour markets promoted on both sides of the migration process is a tool of fundamental importance to creating a migration "choice": adapted to the needs of the labour market, allowing integration into society and the professional market from the moment of arrival in Italy, but also providing additional choices than the possible return, permanently or temporarily, in the context of origin.

In the short term, it is also important to strengthen the twinning business networks "here" and "there": this allows people to make an appropriate professional choice, maintains security guarantees and promotes a closer exchange system. There is also the opportunity to build innovative tools for the management of transnational welfare. For operators of social cooperation this may for example result in the construction of European cooperatives: namely the creation of joint ventures of companies working in two or more territories, managed by a bi-national or multi-national management. This integration of policies, operational tools and people is one of the results that this project opens up as interesting prospects for future action. The network between local authorities is particularly necessary to facilitate the process of developing new standards and processes of decentralization.

7.5.4 Traditional lending and mutual credit

In Italy, traditional lending and mutual credit constitute accrued debt instruments.

1. Traditional credit

Traditional credit involves loans, promoted by traditional financial institutions, created to support both long-term and short-term financial needs of organizations of the so-called third sector. The interest rates and loan conditions change widely from case to case[15].

[15] *Case examples:*

BANCA PROSSIMA – PAN is a non-profit consortium that aims to set up more nurseries and childcare facilities throughout the country, providing services to children and families with a level of quality controlled and guaranteed by the Pan system. The Pan Consortium was born from the union of the three largest networks of non-profit enterprises – CGM Gruppo Cooperativo (Gino Mattarelli), Con. Opera – Cdo social works by Compagnia delle Opere and Consortium DROM by Legacoop – Banca Intesa San Paolo – Federazione Italiana Scuole Materne. Banca Prossima, in particular, offers its affiliates financial solutions in order to suit their main banking needs.

Results: so far, more than 400 kindergartens have been affiliated and €6.6 million funding provided.

2. Mutual credit

Loans disbursed in the form of debt through mutual loan funds, funded both by the 3% payment of the annual profits by the member cooperatives and the collection of savings through the shareholder loan and other loans from non-profit financial institutions. The resources collected are used to finance the development needs of the associated cooperatives[16].

3. Grant or loan based social bond, crowdfunded lending and peer-to-peer lending

These are debt instruments, in the early stages of development in Italy, although in different stages of maturity in international markets.

Grant or loan based social bonds

With these terms, we refer to debentures, issued recently by some social-vocation Italian banks. They offer subscribers a market (or lower than market) return and establish the withdrawal by the issuer to a default quota of its margin (and/or the revocation by the subscriber to a part of the return). The funding from the bond is used to provide money, by way of donation and / or financing, under competitive terms, to support high social impact projects or investments.

Crowdfunded lending

This is a form of loan issued through an online platform: on the one side retail investors (natural or legal) allocate sums of money (with interest or interest-free) for social value projects (with the possible guarantee of capital return from a bank); on the other side non-profit organizations get funding at sustainable rates.

UBI BANCA – JEREMIE FUND ESF: This initiative includes the provision of loans by UBI – Banca Popolare di Bergamo to individuals who contribute, through granted financial resources, to capitalize the cooperative of which they are partners. The loan is paid in an equivalent form using the funds of the Bank and the Fund Jeremie ESF. Results: more than 3,000 loans have been granted by UBI Banca Popolare di Bergamo to cooperative members, amounting to more than €6 million, with the involvement of 190 cooperatives.

[16] *Examples:*

BCC – BUONA IMPRESA!

Started in 2012, it is an integrated project supported by Credito Cooperativo Italiano for Italians aged 35 or under starting or developing their own businesses, including cooperatives and non-profit organizations. The goal is to facilitate access to credit by providing mentoring services and providing tools to guide the design, verification and presentation of their business plan (a dedicated website and app). A special feature of the project is the partnership anchored on the local bodies who take charge of the services of support and coaching. Results: 2,530 youth enterprises were financed under the "Buona Impresa" project in 2013, 1,020 of them start-ups, to a total amount of €64 million.

BCC – DAL BENE CONFISCATO AL BENE COMUNE

The project "From confiscated property to the common good" operated by Credito Cooperativo Italiano has been developed in collaboration with the anti-mafia association Libera. It supports entrepreneurial organisers whose target is the management of social-oriented assets confiscated from organized crime, not only through access to credit (by the local BCC), but also with a series of support activities (grants, free tutoring) in collaboration with local organizations and associations.

Peer-to-peer loan

A method of debt financing that allows individuals to borrow and lend money without the need for professional financial institutions as intermediaries. The loan is issued online using different platforms and tools for the financial monitoring.

7.5.5 The actors

The social impact investment market is characterized by a wide set of operators involved in the offer of instruments. These include banks, banking foundations, insurance intermediaries, pension funds, and social cooperatives. To investigate the potential market impact in the short and medium term, the volume and source of "social" finance have to quantified. They can be characterized by:

• origin (how to find resources, as in the case of mutual and cooperative finance);

• target (because funds are directed to the operators of the social economy).

Currently, in Italy, a wide range of traditional intermediaries work in this area, mobilizing about €175 billion euro to non-profit organizations, social enterprises and small and medium-sized enterprises, according to the proportions described below.

In particular, about 300 commercial banks offer loans to non-profits and social enterprises, to a total volume of around €30 billion, while 380 Italian cooperative banks have a business volume of around €130 billion (which are distributed among households, SMEs and non-profit organizations not included in the above calculation). Cooperative societies run three mutual funds for the promotion of cooperation that amount to a total of €1 billion, and other loan mutual funds, to a total of €14 billion. Only part of the funds – approximately €51 billion – is allocated to the social economy (non-profit organizations, cooperatives and social enterprises).

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