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IMPROVING SERVICES
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ALTERNATIVES TO PUBLIC PROCUREMENT IN SOCIAL CARE

2019

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Executive Summary

Social services are the key component of the welfare state in Europe, albeit their development trajectories, coverage and legal status still vary considerably across countries. Although they have progressively gained a stronger foothold in national legislations and social policy agendas, their status remains weaker compared to health or education services. Moreover, due to the austerity measures brought about by the 2008 financial crisis, they have been subject to cuts and reorganisation.

The restructuring of welfare states that started in the late 1980s has profoundly affected the governance of social services in Europe. There have been changes in the 'vertical' division of responsibility among different government levels, as well as in the 'horizontal' division of responsibility among the main actors (service providers, state, family, community). There have been changes in the way social services are financed, organised and provided, with the introduction of 'market mechanisms' in the management of services and in the selection of providers. The financial crisis of 2008 has added further stress on the capability and/or willingness of welfare states to support social services, albeit with different intensities and outcomes, depending on countries and their welfare state traditions and trajectories (Martinelli et al., 2017).

Since its adoption in 2006, the UN Convention on the Rights of Persons with Disabilities together with the recent European Pillar of Social Rights, call for a paradigm shift in the way in which care and support services are provided, a shift towards homecare and community-based services, enabling the full inclusion of all (European Association of Service providers for Persons with Disabilities (EASPD) et al., 2016).

In this context, not only investment levels are important but also funding models become a key issue to ensure the transition towards quality, person-centred, inclusive and community-based services. Four main funding models have dominated the scene across Europe in the last decade: public procurement; reserved markets; user-centred models and private investment.The present study describes and analyses in detail the four models and provides examples of implemented models across Europe.

The limitations of public procurement and the problems created in some contexts where social and care services are procured through competitive tendering are described in detail. In addition, alternative models to public procurement in the funding of social care, especially for people with disabilities have also been identified and studied.

Reserved contracts can be considered as the "classical"/traditional model for social service provision across Europe. They allow for stable and long-term cooperation between public authorities and service providers, which in most cases are not-for-profit. An interesting example of reserved contracts has been found in the region of Salzburg (Austria). In the region of Twente, in The Netherlands, the study has identified a specific type of reserved contract, the so-called "open-house models", which work as an admission system in which care providers can get contracted if they meet the requirements set by the public authorities.

Most of the alternative models identified in the study fall within the area of user-centred models and take the form of personal budgets. Sweden, The Netherlands, UK (England and Scotland), and the region of Flanders in Belgium, amongst others, have established personal budget systems in their legislation. When implemented well, personal budgets allow users to try new ways to meet their social care needs, give them more choice and control over the care they receive and give them the opportunity to achieve the outcomes they want from their care. Personal budgets are seen as a way to empower persons with disabilities to have more freedom, citizenship and access to their human rights, in line with the UN Convention on the Rights of Persons with Disabilities. Despite some drawbacks highlighted in the study, personal budgets may be seen as the future model for the funding of social care services, especially for people with disabilities.

In the area of private investment, public-private partnerships (most of them under the form of project financing) and Social Impact Bonds are some examples of private investment models that can help public authorities meet their social policy objectives.

Finally, some important elements a funding model of service provision for people with disabilities should look to ensure have been identified. Funding models should guarantee a high level of quality and be person-centred; continuous over time; equal and accessible; efficient; competitive and optimised; open to innovation; integrated and transparent. They should be implemented together with professionalisation and sensibility plans for civil servants (or for the persons in charge of its implementation) who need specific training on the rights and needs of persons with disabilities.

Introduction

Social services are a key component of the welfare state in Europe, albeit their development trajectories, coverage and legal status still vary considerably among countries. The way social services are provided and made available to people bears significantly on social and territorial cohesion, on the gender balance and, ultimately, on the wealth of any society.

While much is discussed and written about social policy and welfare systems, social services are somewhat neglected. Although they have progressively gained a stronger foothold in national legislations and social policy agendas, their status remains weaker compared to health or education services. Moreover, because of the austerity measures brought about by the 2008 financial crisis, they have been the primary object of cuts and reorganisation. And yet, from a social capital and social investment perspective social services should get much more attention. Cuts in the social service systems have very severe consequences on older people and people with disabilities, as well as on households – women – with small children or living in poverty.

The restructuring of welfare states that started in the late 1980s throughout Europe has profoundly affected the governance of social services, possibly more than other welfare provisions. There have been changes in the ' vertical' division of responsibility among different government levels, as well as in the ' horizontal' division of responsibility among service providers – the state, the family, the market and the community. There have been changes in the way social services are financed, organised and provided, with the introduction of 'market mechanisms' in the management of services and in the selection of providers.

All such changes were aimed at reducing public expenditures, while at the same time democratising governance, improving the quality of services and increasing the satisfaction of users. In the last few years, the intensification of old and new social risks, together with the financial crisis of 2008, have added further stress on the capability and/or willingness of welfare states to support social services, albeit with different intensities and outcomes, depending on countries and their welfare state traditions and trajectories (Martinelli et al., 2017). Last but not least, the UN Convention on the Rights of Persons with Disabilities (UN CRPD) -ratified by the EU and all Member States- together with the European Pillar of Social Rights, call for a paradigm shift in the way in which many care and support services are provided, a shift towards homecare and community-based services, enabling the full inclusion

of all (European Association of Service providers for Persons with Disabilities (EASPD) et al., 2016).

In this context, not only investment levels are important but also funding models become a key issue to ensure the transition towards quality, person-centred, inclusive and community-based services. Funding models are not neutral instruments, on the contrary, they affect the way social care and support services are developed. They bear on the ability of social service providers to develop better quality, more community-based services. It is therefore important to analyse the prevailing funding models that exist in the EU, their strengths and weaknesses, and to identify the challenges for social service providers to reach their goals of better service provision.

The current report on "Alternatives to Public Procurement in Social Care" is structured in 5 sections:

- Section 1, on the state of play on the Funding of Social Care and Support across Europe;
- Section 2, on perspectives on the use of public procurement in social care;
- Section 3, on the main alternative to public procurement in the funding of social care, especially for persons with disabilities;
- Section 4 will present the summary and conclusions and
- Section 5 will list the main bibiliographical references used.

The list of the persons interviewed is presented at the beginning of the document in the Acknowledgements section and the template used for the interviews is in Annex

State of play on the Funding of Social Care and Support across Europe

The contents of this section are based on and complement the work carried out by EASPD in the report: "How to fund quality care and support services: 7 key elements". The following paragraphs look into the different funding models of social care and support services, providing examples from different EU countries.

Four main funding models have dominated the scene across Europe in the last decade:

1. Public Procurement.
2. Reserved markets.
3. User-centred models.

4. Private investment.

It should be taken into account that there are differences between these models across the EU countries. At the same time, a Public Authority can use different models for funding different types of care and support services.

1. Public Procurement

Public Procurement is the way through which public authorities purchase goods, works and services, including the provision of social care and support services. This model has grown in influence the last decade as public authorities have looked at ways to better manage more limited budgets, as well as due to the influence of EU legislation in this field (Association of Service providers for Persons with Disabilities (EASPD), 2019a).

Local and regional authorities in different parts of Europe increasingly use competitive tendering of care provisions. Outsourcing of publicly funded care services to for-profit and non-profit providers through competitive tenders has led to a decrease of the share of direct 'in-house' provision by local authorities and this tendency has given for-profit organisations a stronger position. As a result of outsourcing, for-profit services are growing rapidly in several countries in Europe. The new situation has also challenged non-profit organisations. Their non-profit provisions have traditionally supplemented public provisions in a number of countries – or even formed the bulk of services in many countries – but now they have to compete against for-profit providers, which has led to a reduction in differences between the for-profit and non-profit sectors. Non-profit social care providers have also been the first to be pro-active in filling in unmet social needs on the ground, even before they are sometimes recognised by public authorities. They also bring many benefits which for-profit providers are unable to provide; yet this is generally not taken into account in competitive public procurement procedures. These advantages include:

- anchored in the community (and funding therefore redistributed into the local economy via wages, etc);
- work with a strong group of local volunteers; have long-term commitment to social inclusion;
- re-invest the surplus/profit into local social action;
- are social innovative.

As a result of the increasing use of competitive tendering, for-profit service providers are growing rapidly in several EU countries and this situation has posed

a challenge to non-profit organisations. An example of this situation is Finland. In Finland, the national procurement legislation is very strict on the competitive neutrality between the for-profit and the non-profit providers. Thus, non-profit service providers have to resemble their for-profit counterparts to be successful in competitive bids. They have to compete in terms of service prices to win the bid because the system of direct award is not common in Finland. Thus, there is no longer room for developing innovative services typically piloted and run by non-profits (Martinelli et al., 2017, p. 229). In addition, the progressive "marketization"[1] of social services in the country is witnessing the concentration of the care markets in a few large, private, for-profit companies (as highlighted in several studies (Martinelli et al., 2017, p. 231)) and this has many implications. First, international companies become powerful political actors, capable of influencing the development and planning of care systems. Their lobbying power is on a very different level compared to small and often local companies or associations providing services. Secondly, international companies are quite efficient in tax avoidance (OECD (2015)) and national non-governmental organisations have assessed the amount of tax revenues lost due to aggressive tax planning by multinational companies. Finnwatch estimated that in Finland alone the state loses between 430 and 1400 million in tax revenues annually (Martinelli et al., 2017, p. 231). The share of this annual loss due to care companies is not known but is significant. Thirdly, as private companies provide more and more publicly funded services, a larger share of people work now in the private sector.

Also in Finland, a Citizens' Initiative with the objective to get the scope of the procurement law restricted was launched in December 2017. Although the change in the procurement law has been rejected by Parliament on March 2018, the key messages remain.

Finnish citizens' initiative to amend the Law on Public Procurement[2]

The purpose of the Citizens' Initiative was to amend the Law on Public Procurement and Concessions (1397/2016) to exclude the provision of services for the essential care and support of persons with disabilities in residential and everyday life. The key message of the citizens' initiative is that competitive tendering is not a viable way of providing vital, life-long services for people with disabilities. According to the initiators, services provided to disabled people through public procurement and thus competitive tendering have often proved to be

[1] Marketisation refers to the growing presence of private for-profit providers and the increasing influence of market ideas, logics and mechanisms within public service delivery. From the point of view of the Nordic model, marketisation is now the major rationality shaping and framing public sector service provision (Martinelli et al., 2017, p. 220))

[2] Translations from articles in Finnish: Signatures collected for "NOT FOR SALE"- The citizens' initiative. Disability organizations thank Parliament: Competition for lifelong and essential services for people with disabilities can now be stopped (3/9/2018) and Termination of competitive tendering for assistance and support for persons with disabilities. The Economic Committee.

inadequate to the needs of service users. Customers feel that they have not been properly consulted in the design of services and the preparation of tenders. The initiators of the Citizens' Initiative are of the opinion that the purchase of services is priced at the expense of quality and that the services purchased do not meet the needs of the users. The explanatory memorandum of the initiative emphasizes that persons with disabilities should have the right to choose their place of residence and that, as a result of the tendering procedure, they have no participation or legal remedy in their own affairs. In addition, the initiative highlights staff exchanges as a result of the re-tendering of already competitive services, which may have fatal consequences or residents' mental health and performance.

The Committee on Social Affairs and Health considers the problems raised by the initiative and the expert opinions received by the Committee on the procurement of services for persons with disabilities to be serious. The initiative shows that services procured through competitive tendering are a poor way of organizing services for people with disabilities or other long-term care or support services. The Committee considers it particularly problematic that persons with disabilities are not sufficiently involved in the decision-making process, that the continuity of services is not guaranteed and that users of the service do not have sufficient legal remedies to appeal. The committee's expert consultations have highlighted the negative effects of competitive tendering on the well-being and health of people with disabilities. For people with disabilities and their families, the situation has been unsustainable.

The problems caused by the tendering of housing services have also been highlighted by the Ombudsman for Equality in his Annual Report to Parliament (C 6/2018 vp). According to the Commissioner, the competitive tendering of housing services and the resulting uncertainty about the permanence and ability of service providers pose a significant risk to the equality, self determination and individual freedom of the disabled person.

The EU Procurement Directive, which underlies national procurement law, requires in particular that the UN Convention on the Rights of Persons with Disabilities (CRPD) be respected and that the principles of transparency and equality be respected. According to Article 108 of the Procurement Act, in addition to specific legislation on social and health services, account must be taken of factors relating to quality, continuity, accessibility, affordability, accessibility and coverage, as well as the specific needs and consultation of those using social and health services. In the case of long-term care and customer relationships, the duration and other conditions of the contracts must be defined in such a way that they do not lead to unreasonable or inappropriate consequences for the users of the service. However, the Committee notes that current competitive practices do not always meet the requirements of the UN Convention on the Rights of Persons with Disabilities and national legislation. In

addition, the procurement procedure does not provide adequate redress for users of disability services, which is not fully in line with the spirit of the UN Convention on the Rights of Persons with Disabilities, whose mantra is that nothing should be done about persons with disabilities without them.

Competitive tendering may also have negative effects on the staff and on their working conditions. The European Platform for Rehabilitation (EPR), in a brief note of March 2018 "EPR input to the revision of the EC Guide to socially sustainable public procurement" (European Platform for Rehabilitation, 2018), stated that " (...) Some EPR members report that pressure on prices of services from procurement procedures negatively impact working conditions, and some lose out on contracts because they have decent working conditions and are therefore more expensive than competitors. Pressure on wages also impacts the ability of the sector to fill vacancies or meet rising demands. To ensure a win-win of high quality services and quality jobs, (...) it should be shown how contracting authorities can take into account "the organisation, qualification and experience of staff assigned to performing the contract, where the quality of the staff employed can significantly impact the level of performance of the contract" in the award criteria, if an authority chooses the best price-quality ratio to award the contract. Social services are person-intensive and staff interaction with the service users is a key element of the job, so the quality of the staff would clearly affect the level of performance of the contract".

On the issue of the importance of the staff in social service provision, EASPD has just published the report "Staff Matters: from care worker to enabler of change" (Association of Service providers for Persons with Disabilities (EASPD), 2019b) . In spite of the fact that social service provision is one of Europe's biggest job creators with over 10,9 million professionals across the European Union and with over 2 million new jobs created in the last decade alone, professionals in social care and support are facing many challenges, such as lack of recognition of their impact, frequent underfunding of services resulting in poor salaries and unattractive working conditions, insufficient training opportunities, inadequate career paths and an overly strong focus on management and bureaucracy. In addition, in many services, the crucial enabling role of the support worker has still to replace the out-dated idea of 'caring' under a medical model of care. For Service Providers, this has led to significant staff shortages and difficulties linked to recruitment and retention, in particular of qualified staff. All this has a detrimental impact on the transition to person-centred and community-based forms of care and support which cannot be underestimated. The UN Convention on the Rights of Persons with Disabilities calls for person with disabilities to be enabled to take control of their own

lives to the greatest extent possible. Consequently, social care and support work is increasingly about co-operation with local communities and engaging more and more with local stakeholders. As a result, there is a strong need for an up-skilled workforce with a more diverse skill-set and who have a better understanding of these new needs and insight into the changing modus operandi of all these various stakeholders. It also means providing the services in different settings and circumstances; for instance, more in more in people's own homes, in businesses or in schools. Last but not least, the growing use of technology in social care and support will also impact the way social care and support is provided and therefore also impact on the day-to-day work of social care and support professionals. To effectively respond to these developments, a pro-active approach – focused on adequate training in social care education and continuous professional development- is required to ensure that all professionals in social care are able to provide such services in the right environment. Since problems of staff shortages have become the norm, improving recruitment and retention in social service provision must become a priority for policy-makers, providers and users alike, especially at a time when demand for social services is increasing (and will continue to increase in the foreseeable future). It must also be ensured that the sector is adequately resourced by public funding, as well as implemented through the right funding models which place workforce development and the implementation of the UN CRPD at their heart of their social investment strategies.

Tendering procedures can take a socially responsible approach to contracting social services. An interesting example cited in the EPR brief note is about Estonia.

In Estonia, from 2010 to 2014 in the framework of a European Social Fund project, providers of services to persons with disabilities and other disadvantaged persons implemented the European Voluntary Quality Framework for social services in their organisations - private, semi-public and public entities alike. One outcome of the project is that meeting the requirements of the Framework, together with financial considerations, has become one of the criteria for the funding of social services by public authorities in Estonia. The Framework was implemented through the EQUASS[3] Assurance tool, and saw an increase in the level of quality, efficiency of service governance, promotion of users' rights and their enhanced participation. This practice, which has earned the Ministry and the partner organisations multiple awards, can be replicated through public procurement.

[3] EQUASS is an initiative of EPR, launched in 2003, that enhances the social sector by engaging social service providers in continuous improvement, learning and development. EQUASS aims to guarantee service users high quality services. The sector-specific quality framework provides a comprehensive approach to quality management, features a rights-based approach and is a recognised tool for implementing the European Voluntary Quality Framework for Social Services. www.equass.be

In Spain, regulations on public procurement are basically governed by the Law on Public Sector Contracts of 8 November 2017. This law includes specific regulations for certain service contracts of a social, health or educational nature (basically additional provision 47). In any case, thanks to the initiative of the social sector in Spain and the various institutions and organizations that represent it, important social criteria are provided for in public procurement throughout the general scope of the Law (requirement of compliance with social standards, award criteria, execution conditions, reservations of contracts, preference criteria in the event of a tie, etc.) that especially favor persons with disabilities and the social sector as a whole.

Alternative ways of tendering are emerging following the 2016 EU public procurement rules that open up new options without hampering competition and transparency. Alliancing is a novel way of contracting for social services. Alliances are used in England and the model is also being tested in Scotland. It is still procurement but it is a more collaborative option. The legislation allows for this model through competitive dialogue and innovation partnerships[4] procedures. Alliance contracts have generated interest as a possible tool that commissioners can use to drive collaboration (Spalburg & Hutchinson, 2015). Alliance contracting started as a delivery framework for large multidisciplinary projects (especially for building huge infrastructures), focusing on a co-operative process which aims to promote openness, trust, risk and responsibility sharing, innovation, high performance and the alignment of commercial interests between parties who aim to deliver a project in a collaborative and constructive way. In 2014, the National Health Service (NHS) in England started to considering Alliances for their health and social care services contracts. The King's Fund (Addicott, 2014), one of the most important independent think tank in England working to improve health and care services in the country, emphasises that one of the most important characteristics of Alliances is that 'Commissioners and providers are legally bound together to deliver the specific contracted service, and to share risk and responsibility for meeting the agreed outcomes. As such, they should be incentivised to innovate and identify efficiencies across the system, rather than solely within their organisation' (Portes, 2017). In an alliance contract model, a set of providers enters into a single arrangement with a commissioner to deliver services. The commissioner(s) and all providers within the alliance share risk and responsibility for meeting the agreed outcomes. All organisations within the alliance are equal partners and they rely on internal governance arrangements to manage their relationships and delivery of care. The intention of this approach is that integration and collaboration are formalised through the contract, as commissioners and providers within the alliance are legally bound together to deliver the

[4] This allows public authorities to call for tenders to solve a specific problem without pre-empting the solution, encouraging tenderers to come up with innovative solutions in alliance with the authority.

specific contracted service. As such, they should be incentivised to innovate and identify efficiencies across the system, rather than solely within their organisation (Addicott, 2014). The basis is "what is best for a person" and it aims to get people to collaborate rather than to compete. An interesting example is the Integrated Personalised Support Alliance (IPSA) in the UK, an initiative which helps people with long-term mental health issues to live more independently in the community. The Integrated Personalised Support Alliance brings together four providers: a mental health trust, adult social care and two charitable organisations. They have worked together to provide a seamless service for those with severe and enduring mental illness. The common aim is to maximize people's independence, participation and enable them to recover and stay well. The service went live in April 2015. The alliance has been very successful for achieving its objectives of improving people's lives, reducing the need for residential placements and meeting the financial challenges (Integrated Personalised Support Alliance (IPSA), 2016).

2. Reserved markets

By reserved markets, EASPD means a system where public authorities can reserve access to specific public markets for organisations responding to certain characteristics (for instance, not-for-profit entities). Organised differently across Europe, this is a common model for the funding of not-for-profit social services (Association of Service providers for Persons with Disabilities (EASPD), 2019a). Reserved Markets exist both within and outside of the scope of the EU Public Procurement directive.

The EU Public Procurement Directive (2014) does not oblige member states to foresee the possibility to reserve contracts in their legislation, but it is recommendable to do so. The Directive provides the opportunity to reserve contracts for non-profit organisations and social economy enterprises for a limited period of time (Article 77 – reserved contracts for certain services). In this way it is possible to value the provision of social and health services by non-profit organisations and social economy enterprises, which in some member states is a long tradition and a feature of the welfare system. The EU Directive also recommends member states to include the provision on on reserved contracts (article 20) in national legislation: contracting authorities should then restrict some tendering procedures to sheltered workshops and economic operators whose main aim is work integration of persons with disabilities and disadvantaged persons (Social Platform, 2015).

In Salszburg (Austria), reserved contracts are currently used to fund housing and work related services (for persons with learning disability, high support needs - "unable to work"), early childhood intervention, therapies, kindergarten. Positive aspects of reserved contracts can be summarized as: (i) high planning reliability for service provider; (ii) high level of continuity for

service users, staff, commercial partners (e.g. companies, banks); and (iii) a certain level of quality is guaranteed. In theory, reserved markets can also come with negative aspects such as: (i) limited choices and flexibility for persons with disability (types of service, limited number of providers…); (ii) limited comparability, transparency of costs and efficiency of structures; (iii) less choice and control than with personal budgets and personal assistance.

In Spain it is a quite common practice to reserve calls for the provision of goods or services to certain organisations.The EU Directive/2014/24 was transposed in the Spanish system with Law 9/2017. The Law on Public Sector Contracts of 8 November 2017 refers to reserved contracts in two of its additional provisions (disposición adicional). In its Additional Provision no.4, it establishes the obligatoriety of reserving contracts for Special Employment Centres (Centros Especiales de Empleo) (companies where at least 70% of the staff are persons with disabilities) and Insertion Companies (Empresas de Inserción). The reservation of contracts for Special Employment Centres is limited exclusively to those considered as social initiative centres, that is, those promoted or participated in more than 50 percent, directly or indirectly, by one or several entities, whether public or private, non-for-profit or with a social goal as established in their Statutes. Also, they must be committed by statutes or social agreement to fully reinvesting their profit in improvement of employability and creation of employment opportunities for people with disabilities, improvement of their competitiveness and their social economy activity, with the possibility to decide to reinvest their profit in the special employment centre itself or in other social initiative special employment centres. The criterion of quality-price ratio was established in the new legislation, as opposed to the price criterion, understanding quality as the application of social and environmental criteria. The possibility to reserve contracts as well as its lots will have a positive effect on Special Employment Centres and Insertion companies, which were usually excluded of big contracts. Additional Provision no. 48 reserves specific contracts related to social, cultural and health services to organizations with specific characteristics which fall under the social enterprises (European Platform for Rehabilitation, 2018; Observatorio de Contratación Pública, 2019). [5]

In Italy, municipalities use reserve contracts for contracting social services. For instance, the Municipality of Castelfranco Veneto contracted home care services for persons with disabilities. The call targeted social cooperatives (type A), their consortia and groupings only

[5] Observatorio de contratación pública. http://www.obcp.es/index.php/mod.opiniones/mem.detalle/id.337/relcategoria.121/relmenu.3/chk.0cdd096ec20ef22b2b51da23ca28f891

(reserved contract), for a duration of 3 years and established MEAT award criteria (quality 60%, price 40%) (Social Platform, 2015, p. 25).

In Norway, an amendment was introduced in the public procurement legislation in 2006[6], whereby public authorities could outsource services to non-profit organisations without using a competitive bidding procedure. The Norwegian public sector can award non-profit organisations contracts to produce services without putting them on the same line with for-profit producers (Martinelli et al., 2017, p. 225). The new provision explicitly stated that the full procedure of the EU procurement Directive does not apply for the award of contracts for health and social care services provided by non-profit organisations. Accordingly, local authorities in Norway are free to make agreements with non-profit care providers without being obliged to advertise their requirements on the national database for public procurements (Doffin) and without having to use competitive procurement procedures. This clause was regarded as ground-breaking for non-profit organisations' role in public welfare (Meagher & Szebehely, 2013).

In France, the field of social services is characterised by a mixed structure, which has favoured the enormous growth in this field of the third sector. Social services, is by far the major area of non-profit involvement, in spite of the sustained expansion of governmental provision in this field. The development of a mixed delivery system in the field of social services can partly be explained by a voluntarist policy toward decentralisation. In a context of budgetary crisis local governments contracted out the provision of many services. Since they have been contracting with for-profit providers for equipment, open spaces management, public construction and economic services, they have favoured the partnership with non-profit organisations for cultural and educational concerns and above all for social and employment policies. In fact, the area of social services is characterised by a system of strong interdependence between nonprofit organisations and public agencies.

Schematically, there is a distinction between residential facilities and light services. The establishments are more or less quasi-public associations. The level of government financing is very high, generally through the social security scheme or financing by the Département. The organisations are heavily regulated by state procedures and the accountability requirements are very high. Conversely, the small sized social services have more diversified resources and are therefore more independent of the central government. The establishments are run mainly by professionals whereas the light services by volunteers. The first ones are financed through grants, contracts and third party payments by the state or

[6] Anskaffelsesforskriften [procurement regulation] 04-07 no 402 § 2-1(3), Lovdata 2006.

Social Security, and the other ones are subsidised through general grants, sometimes rather symbolic, or even by in-kind support such as free housing or equipment (Archambault, 2017).

Non-profit organisations are also seen as important partners for local authorities and as the best private entities to restore social cohesion and prevent the social exclusion of frail or deprived populations in a period of growing unemployment. Non-profits are considered closer to people's needs than an impersonal bureaucracy; they are able to detect the coming issues and to propose innovative solutions. In the partnership between non-profit organisations and local communities, there seems to be a shift from global grants rather discretionary to special financing based on contracts; general activity contracts with reciprocal commitments are more and more taking the place of the classic system of general year-to-year funding. There are very few tenders, and more mutual agreements, except in the field of services for elderly people, in which they are developing.

The large-scale delegation in the field of social services to non-profit organisations is accompanied by various regulations related to the creation, costs and activities (quality standards, qualification and recruitment of employees...) of non-profit establishments. This field is indeed one of the most regulated areas of activity in France as non-profit organisations are fulfilling a public «social mission» (mission de service public). Different kinds of procedures allow the state to establish general regulations of the field:

1) As part of the general social security scheme, social establishments are submitted to a process of authorisation, called habilitation, involving an a priori control of their project and its feasibility, and then leading to the state financing (accréditation);

2) The status of “reconnaissance d’utilité publique”, is the official label of associations recognised as being of public utility; many associations providing social services are entitled to this status, which is quite difficult to obtain and not frequent in other fields.

3) The majority of the associations active in this field have also to receive an agreement (agrément). The agreement is, first, a kind of official recognition of the quality of activities performed in special fields; but overall and very often, these activities are possible only if the organisations carrying them out are accredited (agréées).

In these cases, the administration has a discretionary power of decision: it thus grants a kind of monopoly to perform some activities, that is to authorise (or not to authorise) a given organisation to fix its aim in the fields concerned and carry out the corresponding activities (and consequently to forbid all others to do so).

In spite of the recent entry of for-profit companies in some subfields as residential care intended for the elderly or home services, the non-profit organisations remain more challenged by the public than by the market economy. Inside the partnership with central or local government, incentives and targets mix criteria that are concerned with quantity, quality and equity. Competition is not very strong and invitation to tender is not as common as in some other countries and it is not considered by the state as the best way to establish contract on this basis (Archambault, 2017; Herrmann & Herrenbrueck, 2007, pp. 157–174; Matraeva et al., 2016).

Another type of reserved contracts are the so-called Open-house models.

Open-house models work as an admission system in which care providers can get contracted if they meet the requirements set by the public authorities. In 2016, the Court of Justice of the EU (CJEU) concluded in Falk (CJEU, C‑410/14) that standardized public contracts are not subject to the EU Directive on public procurement, in case the government concludes standardized contracts with every interested organization that meets predefined standard quality criteria. When using such an open contracting scheme the procuring government does not compare the economic operators, nor does it consequently award exclusive contracts to only a limited number of economic operators. This open contracting scheme is referred to as ‘open house model’, which has become the common term in the Netherlands where municipalities impose criteria with respect to quality and suitability, and each care provider that meets these criteria is admitted to a framework agreement.

In the Netherlands, since 2019, the procurement of Youth Care has changed and shifted towards an Open House Model. An Open House Model is not so much of a tender but more of an admission system in which care providers can get contracted if they meet the requirements set by the municipalities. Currently, the purchasing of youth care in the region of Twente is put out to tender via an Open House-model. The rules of this model are, that everybody who wants to participate can register and gets contracted, granted that they meet the requirements package, resulting in a large number of care providers. Since the municipalities establish the tariffs beforehand, market forces emerge between the care providers (Fisher, 2019).

3. User-centred models

In recent years there has been increased interest in providing people with more choice about who provides the public services they receive. In user-centred models, the user decides on the care provider he/she wants. For the purpose of this research, under the term of user-centred models, personal budgets and the voucher system have been included. Both are models for

organising and delivering social and healthcare services in a way that makes the person the central figure in deciding abouth their own care.

3.1 Personal budgets

By Personal budgets EASPD means an amount of funding which is allocated to an individual by a state body so that the individual can make their own arrangements to meet specified support needs. This innovative model is growing in popularity as it allows persons with support needs to have more control over how they wish to receive their support (Association of Service providers for Persons with Disabilities (EASPD), 2019a).

Personal budgets are becoming an international trend, with many countries experimenting with some form of individualised funding for covering the needs of their citizens, among which those of people with disabilities. Personal budgets vary widely across EU countries in terms of history, legislative approaches, target served, needs assessment, elegibility, amounts granted, etc.

In the UK (England), the government made a commitment to introduce personal budgets in 2007as part of its new approach to adult social care, which has been increasingly set within the context of personalisation. The idea behind personalisation is to enable citizens to shape their own lives and the services they receive. The goal of personal budgets is to give individuals greater control over how they receive support, operating under a self-directed, State-approved budget of individual social care needs. The Care Act 2014, which came into force in April 2015, creates a single, consistent route to establishing an entitlement to public care and support for all adults with needs for care and support. It creates a legal entitlement to personal budgets and to direct payments[7]. Local authorities have the responsibility for implementing the provisions of the Care Act 2014 in their areas.

Self-directed Support is the mainstream approach to social care in Scotland since 2014. It puts the person at the centre of the support planning process enabling people, carers and families to make informed choices about what their social care support is and how it is delivered. What Self-directed Support does is ensure that people who are eligible for support are given the

[7] A direct payment is one of four ways in which a personal budget can be managed; the other ways include a managed account held by the local authority, with support provided in line with the person's wishes; a managed account held by a third party, with support provided in line with the person's wishes; or a 'mixed package' that includes elements of the three means already identified. Direct payments were first introduced in England in 1997, under the Community Care (Direct Payments) Act 1996, for working-age adults. In subsequent years, eligibility was extended to older people, the parents of children with disabilities and carers; provision was then extended to people appointed to receive direct payments on behalf of individuals lacking mental capacity and those subject to mental health legislation.

choice and control over how their individual personal budget is arranged and delivered to meet their agreed health and social care outcomes.

In The Netherlands, personal budgets (persoonsgebonden budget, or pgb) were first introduced into the Dutch healthcare system in 1996 as a 'major innovation' of the Dutch welfare state, supported by both left-wing and right-wing parties, following active promotion and campaigning by the patients' rights movement and the disability movement throughout the 1980s and 1990s. Personal budgets were introduced as an alternative to care in kind. After a period of legislative changes and reform, a personal budget became available for care under several Acts: The Long-term Care Act (WLZ 2015); The Social Support Act (WMO 2015); The Youth Act (Jeugdwet 2015); The Health Insurance Act (ZVW).

In Flanders in 1987, some Flemish pioneers with a disability founded Independent Living Flanders (ILV) to raise awareness for people, associations and policymakers of the abilities of individuals with disabilities and the need for personal assistance. In 1997 for the first time in Flanders, an experiment started with the Personal assistance budget. 15 Flemish people with disabilities participated. The experiment was extended and reached 50 persons with disabilities. There was a growing political interest in this new phenomenon of people with disabilities organizing their own assistance. As a result, in 2000 the Flemish Parliament approved the personal assistance budget decree. Since 2017, the system has changed and now all adults who received services in natura and/or personal assistance budgets receive now a personal budget.

In Sweden, the disability movement was the main force in bringing about the Act Concerning Support and Service to Persons with Certain Functional Impairments and the Assistance Benefit Act, which were enacted by the Swedish Parliament in 1993 as part of a broader disability policy reform. The reform, inspired by the Independent Living philosophy, enables individuals to customize services according to their particular needs, with maximum control over everyday life. The need for personal assistance, however, grew faster than expected, and therefore the law and its interpretation have been amended many times.

A recent study published by the Health Research Board which carried out research on different approaches to personal budgets (Pike et al., 2016)[8] found out that:

- Satisfaction, well-being and quality of life are constant positive outcomes of personal budget evaluations, although measurement of these is often subjective.

[8] The countries studied are Australia, Canada, England (UK), The Netherlands, New Zealand and Scotland (UK).

- The level of control that individual budget holders have over their budgets varies greatly between different programmes and also within programmes, depending on the person's level of independence.
- The availability of choice should be a positive thing, but the exercise of choice can lead to apprehension and worry. Choice would suggest a greater availability of services, but the proliferation of services does not necessarily mean an increase in quality. Choice emphasises the individual's preferences, but this is not to say that they are necessarily cost-effective or that they represent the best use of resources needed for themselves or for society as a whole.
- For cost-effectiveness, the study cites a research (Glendinning et al., 2008) in which the authors conclude that personal budgets are cost-effective, although the pattern of cost-effectiveness varies between four sub-sections of people with disabilities – people with physical disability, learning difficulty, mental health and older people. Outcome gains were noticeable for people with mental health problems and for younger people (aged 18–30) with a physical disability. The evidence for people with learning difficulties was not strong, and there was no evidence of cost-effectiveness for older people. They also point to differences in social care costs and healthcare costs, noting that healthcare costs were higher for the people who had individualised budgets, whereas social care costs were the same for both groups.
- A number of studies have pointed to the fact that start-up costs for personal or individualised budgets have rarely been fully accounted for in costings. Start-up costs, together with the unpaid care provided by families and out-of-pocket expenses in traditional care have, in many cases been underestimated. Almost all schemes in the EU have underestimated the costs of implementation and this has been partially due to a failure to realise the level of demand, due to the cost borne by families or paid for from other income.
- Individual budgets will differ from those in place to deliver conventional care. There is a danger that rather than making the transition from one system to another, the new system may be added on to the old one. This results in double running costs. Therefore, it is critical to have the infrastructure in place and to use a strategic and phased approach to the introduction of such a scheme.
- Schemes which aim to improve the lives of people with disability will be universally welcomed, but it is essential that the financial arrangements which underpin them are robust (affordable now and into the future).

Within the area of Long-Term Care (LTC) and in response to increasing care needs, cash-for-care schemes represent a key instrument aimed at ensuring choice, fostering family care and

containing costs. Instead of services, these schemes give people monetary benefits, which they can use to purchase care services. In fact, the personal budgets described above fall wihtin this type of support. In other EU countries, LTC shemes are for example: “Indennitá di accompagnamento” in Italy; “Allocation Personalisée a l’ Autonomie” in France; “Pflegegled” in Austria; and “Attendance allowance” in Sweden.

Cash-for-care transfers include a variety of tools such as cash allowances for users (e.g. people who are not self-sufficient) or caregivers (family members providing informal care) or ‘personal budget’ or vouchers, more or less ‘ earmarked’, to be spent for purchasing services, often from a range of more or less regulated/ accredited providers. They have become quite fashionable among policy-makers for various reasons (Da ROIT & Le BIHAN, 2010; Martinelli et al., 2017, p. 401):

- cash transfers fit the goal of enhancing users’ choice, since the beneficiaries of cash transfers can in principle choose among a variety of services and/or providers and find the solution that best responds to their needs. However, how far this freedom of choice reaches, depends on financial and regulatory conditions, such as the entity of the allowance; the number of suppliers among which it is possible to choose; the degree of differentiation among suppliers and customisation of services; the availability of information concerning suppliers and services.
- cash transfers imply lower operational burden for the state: cash transfers require less organisational effort than providing in-kind services.
- cash transfers do not necessarily involve a reduction in public expenditures, since public support remains. They nonetheless involve a disengagement of the state from coordination and production, which are conferred to the market, the community or the family, within a more or less regulated framework.
- cash transfers have, in many countries, encouraged the development of a market of privately hired caregivers. The type of market and its social impacts depend very much on national regulation. In Mediterranean countries – but increasingly also in other European ones – it is a rather unregulated and informal market, which thrives for the larger part on often undocumented immigrant women originating from both Eastern European and extra-European countries, who live with the family, are not specifically trained as caregivers and, because of their fragile legal status, often suffer exploitative working conditions.

Italy is a good illustration of the intended and unintended consequences of the choice of cash transfers. In the 1980s the national government established a cash allowance for non-self-sufficient adults (Indennità di accompagnamento), which ended up being the main form of

support for older people. Being targeted to non-self-sufficiency, but not means-tested (the same monthly allowance of close to EUR 500 is granted to every qualifying person), it reinforces social stratification since richer beneficiaries can top up their allowance and purchase better services. Moreover, there is no control on how it is spent, and it is very often used to support the income of the family taking care of the beneficiary. Alternatively, it supports the expansion of the informal market of privately hired caregivers, i.e. immigrant – often undocumented – women (the so-called "badanti").

3.2 The voucher system

Vouchers are one strategy for organising and delivering social and healthcare services in a way that makes the person the central figure in deciding from who, when and where to receive services.

The Finnish voucher system was first piloted in the 1990s. Vouchers were then integrated into social legislation in 2004. In 2009, a specific law, the Act on Health and Social Service Vouchers (Laki sosiaali- ja terveydenhuollon palvelusetelistä 569/2009) was passed. This act made it possible for the municipalities to organize all social and health services through a voucher model, excluding emergency and involuntary services, such as involuntary placements in child protection and mental health care. It was justified with arguments that it would enhance customer choice and improve the effectiveness of services through competition. The main difference between outsourcing and service voucher system is that in the former case it is the local authority that arranges the competition between different providers, whereas in the latter case it is the service user who makes the decision between different service providers (Martinelli et al., 2017).

Public service provision is excluded from the voucher system and is thus an alternative to the voucher. Only for-profit and non-profit private producers can produce services for the voucher users. The municipality still always finances the voucher partly or fully. The municipalities are free to decide whether they want to introduce the voucher system; for which services they are to be offered; what is the value of the voucher; and to whom the voucher is offered. In Finland, being eligible for municipal services does not make a citizen eligible for a voucher and a free choice. The responsibility for access to services remains on the municipal authorities as they are in charge of allocating the vouchers, financing part of the voucher and providing

information on the available service providers. Also, the municipalities resolve the criteria for approving private service providers as service voucher producers[9].

4. Private investment

Private investment is the investment made by players other than conventional public sector bodies into social services. Although not used for the funding of the day-to-day service provision, private investment (especially loans) is playing an increasingly larger role to finance social infrastructure investments, as well as to explore new ways to finance innovative social projects. Private investment can include mechanisms such as capital or equity investment, public private partnerships, social impact bonds and payment-by-results contracts; in other words, instruments where investors finance projects in the social services sector but require a financial return on their investment or at least to expect to break even (European Association of Service providers for Persons with Disabilities (EASPD), 2019a).

4.1 Private banks

Various traditional banks have created specialised institutions or particular sections (e.g. Unicredit and UBI in Italy; BNP Paribas in France; BGK in Poland, which provide financial support within the framework of EU funds) that are conceived to address specifically the financial needs of non-profit organisations. Socially-oriented banks, like cooperative banks (which can be found for example in Belgium, France, Italy and Spain) and ethical banks (e.g. Banca Etica in Italy and Triodos Bank in Belgium and Spain), are in principle particularly willing to fund locally-based initiatives, such as the ones promoted by social enterprises (European Commission et al., 2016).

In Spain, Laboral Kutxa is a credit cooperative integrated into the Mondragon Group. It carries out its financial activity by providing products and services to more than 1,200,000 families and businesses. Laboral Kutxa will allocate 50 million euros to promote the development of the Spanish social economy . The new EaSI Social line, the largest in Europe, facilitates the granting of loans and credit accounts to projects promoted by companies that have a positive social impact. This initiative is supported by a guarantee belonging to the Program for Employment and Social Innovation (EaSI), financed by the European Union. This initiative opens up a financing line and will contribute to to financing not only to the companies and entrepreneurship projects within of the Social Economy.

[9] Care generating publicly governed markets – The Finnish voucher system. Olli Karsio, doctoral student, University of Tampere, Faculty of Social Sciences. Lina Van Aerschot post-doctoral researcher, University of Tampere, Faculty of Social Sciences

The amounts of the operations favored by this new agreement will not exceed € 500,000 for each applicant company. The maximum repayment term has been set at 10 years for loans and 3 years for credit accounts. No mortgage guarantees will be requested and refinancing operations are totally excluded. Laboral KUTXA has assumed the commitment to grant the total of the subscribed amount, 50 million euros, within a period of 30 months. The recipients of this new line of financing must credit sales volumes and assets on the balance sheet of less than 30 million euros. As for the legal form, they must be framed in Law 5/2011 on Social Economy: cooperatives, labor companies, fishermen's associations, mutual societies, social insertion companies, special employment centers and foundations or associations that exercise economic activity. The initiative aims to achieve a positive and measurable social impact, for which a series of indicators have been established that take into account the impact generated according to the type of activity of the applicant of the financing. Four sections of activity have been established: 1.- Social integration. 2.- Health. 3.- Knowledge and teaching. 4.- Industrial, productive, agricultural and other services companies. Depending on the activity in which the applicant is framed, social objectives and measurable impacts vary. Thus, for example, to companies in the field of education, among other indicators, will be taken into account the number of students instructed, and agricultural or industrial companies will be evaluated the evolution of their billing. Likewise, common meters will also be applied to all activities, such as the number of stable jobs generated or the quality certificates obtained (Confederación Empresarial Española de la Economía Social, 2017; Laboral Kutxa, n.d.).

4.2 Public–private partnerships (PPP)

Public-Private Partnerships (PPP) can be defined as ‘cooperation of some sort of durability between public and private actors in which they jointly develop products and services and share risks, costs, and resources which are connected with these products or services (Hodge & Greve, 2005).

PPP is on top of the agenda due to increase of social pressure on the economy and due to the the need to find the new ways of handling the growing demand for social services. According to some authors (Matraeva et al.), in this situation, a state will not be able to handle the growing demand for social services and be able to provide the necessary level of social security without attracting private investments.

Whilst there is a growing tendency of applying PPP in infrastructure projects, related to the basic social services because this sector represents a real market with calculated risks and capacities (which are determined on the basis of demand and supply), the area of social support (social security) does not provide the same opportunities for business. This is why

governmental social project incentives are actively applied here (Matraeva et al., 2016). There is far less experience in spheres of social security, such as education, social insurance or social support. As a matter of practice, the difficulty of implementing PPP projects in the social sphere lies in their specifics (adapted from Matraeva et al):

 Partners may have different goals. The public partner has a social goal whereas the goal of the private partner is economic. These goals must be clearly separated and non-conflicting terms must be introduced in a partnership agreement.

- Low project profitability level and high risks. Low profitability level of the social sphere is a serious obstacle for the PPP. The private sector may be not interested in providing such services.
- The projects are of a local nature and implemented at the local government level. Municipal administration initiates the PPP.
- Careful selection of the government control indicators is subject to the complexity of the object of the partnership and the need for overseeing and monitoring the implementation of the social goal.
- The necessity to consider additional opportunities for an investor in gaining profits during the operation of the partnership object is determined by the difficulties of profit generation and relatively low investment attractiveness of the social sphere objects. This is why the PPP social projects usually provide benefits and government guarantees.

One form of PPP is project financing (PF). This model is mostly used in the social sphere for the construction of socially significant facilities. There are four groups of stakeholders participating in PF: (i) A project company founded by private investors (known as a special purpose vehicle). It is directly engaged in project implementation from the beginning to the end; (ii) Government body - PPP project participant; (iii) Private investors (sponsors and institutional investors) participating in this ad hoc project company's capital. Potential contractors usually act as sponsors - including construction companies, technical services and maintenance companies; (iv) Creditors, most frequently represented by banks and national.

The special feature of project financing is that when granting a loan to a private project company, a bank pays attention, first of all, not to estimating its financial condition but to the value of the cash flows potentially generated by the project that needs financing. Without doubt, when granting a loan, a bank will demand to present a backing in the form of the project company assets acquired, mostly with sponsor financing. Therefore, a sponsor that has become a project company shareholder has to possess technical expertise and financial solvency, indirectly acting as a warrantor of the project completion which will apply a part of

its cash flow for covering the credit repayment. Credit backing is proportional to the project's risk level.

Another interesting example of private-public cooperation through project financing comes from the UK, with the Jo Richardson community school, a secondary school and center for the local community built under the Private Finance Initiative (PFI) program. This was the first school built in one of the poorest areas of London. The school now accommodates 1300 students aged from 11 to 18. A total of 80% of them come from poor families. Local authorities spent 18 months on drafting the project documentation. The Project tender included: provision of information and collecting applications - contractors; use of project samples; use of project quality data during selection; selection of the most economically advantageous offer. Public authorities (Barking and Dagenham Council) are responsible for: providing educational services to students; providing enhanced services to the local community (adult learning, social integration, healthcare, leisure); support services (reception, cleaning, meals, etc.) and; maintenance quality control. Private partner's role includes: design and construction (Bouygues); financing (BNP Paribas, DEXIA Group, NIB, Barclays Equity); maintenance (Ecovert); building structure material; mechanical and electrical units; healthcare and security; amortization fund management; technical support services.

Public–private cooperation for the construction of infrastructures and facilities has also been very much widespread in Germany. An example of a PPP alongside Germany's sector for social services is Computainer Vogelheim (Hodge & Greve, 2005) , which consists on a local service for children and young people in Essen, Germany's sixth largest city. Created in 2003, Computainer consists of 32 former construction containers, which lend the project its name. Its objective is to improve the social, health, educational and economic situation in an especially disadvantaged part of the city. Computainer is conceived for children and young people from socially weak families and their parents. It offers occupational counselling, monetary and other kinds of help in arranging for training, and support from the social department of the local district government.

The programme brought together many of the locality's inhabitants and organizations. The idea for a computer school came from the 'Fairnetzen' Foundation, a small IT-systems supply company in Essen. The city agreed to cooperate through the Department of Youth and Social Affairs. Personnel for social and occupational counselling and support services were drawn from public administration, the employment office and welfare agencies, and assigned to specific problems and situations. Computer training is conducted mainly by voluntary 'trainers' from the city quarter. A group of regional corporate investors contributed to the construction and operation of the building. Thus, full cooperation among local government

administrations, third-sector organizations, and companies seeking to build reputations as good corporate citizens in the community as well as in the market.

In Spain, a big public-private partnership between the government and civil society concerning universal accessibility was established in 2011, enabling not only millions of Euros of investment but a continuous flow of information and expertise between all stakeholders (Zero Project, 2014). The Framework Agreement between the Institute of the Elderly and Social Services (IMSERSO), under the Ministry of Health, Social Policy and Equality, and Fundación ONCE for the Cooperation and Social Inclusion of Persons with Disabilities is the biggest public-private partnership concerning 'design for all' in the world. Its purpose is to develop a programme of universal accessibility. Financial and technical support was available to manifold stakeholders, including public authorities, universities and non-profit entities.

The Framework Agreement lays out the respective financial contributions of the Institute of the Elderly and Social Services and Fundación ONCE, and allows both partners to sign collaboration agreements with other public and non-profit entities. These collaboration agreements need to state the objective, budget, responsibilities, and compliance requisites. The aforementioned entities can apply for funding and technical support in five different action lines: Performance appraisal and planning for accessibility, including a Universal Accessibility Plan and a study and project to improve accessibility; Corrective actions to achieve accessibility, including performance in the planning and building, as well as operations on environments, services and ICT-based systems; Precautionary actions or implementation of access management systems, including the implementation of a access management system according to UNE 170001 and/or for webpages or software; Actions to enhance the transport service of accessible taxis; and Awareness raising, training and innovation, including support for the innovation of Design for All persons; orientation measures for digital alphabetisation.

4.3 Social Impact Bonds or SIBs

Social Impact bonds (SIBs) are a new type of financing instrument under the impact investment area. They have attracted much attention in the aftermath of the financial crisis and have started to be implemented in a number of countries as they seem to be an attractive proposition for financing the delivery of social services. In a nutshell, they are an investment vehicle that makes use of private capital to achieve social goals (Center For Global Development, n.d.; Organisation for Economic Co-operation and Development - OECD, 2016; Social Finance UK, 2016; The Young Foundation, 2011).

Under a SIB[10], a payer (usually Government, at a national, regional or local level) agrees to pay for measurable improved outcomes of social projects, and this prospective income is used to attract the necessary funds from commercial, public or social investors to offset the costs of the activity that will achieve those better results. This approach is possible where better outcomes lead to tangible public financial savings.

Creating a social investment bond involves choosing a social issue, developing an intervention strategy, setting a budget and establishing outcome measurements (including controls), as well as a financial framework (including a time frame and rates of return). Once the bond is set up, investors have to be found. Typically, investors in social impact bonds include those interested in more than just a financial return, such as philanthropists and grant-making trusts, who are prepared to accept a lower financial return or greater risk in order to generate a social benefit.

SIBs offer the potential to bring in new sources of financial capital, to focus attention on preventive action, to transfer risk on new interventions and to provide new funding for civil society which faces very sharp cuts in its funding from government.

The potential scope for SIBs depends on the structure of a country's welfare state, civil society, and private sector. SIBs seem more appropriate for policy areas in which there are target groups that can be easily identified, when there are measurable outcomes, and when investors are familiar with non – profits, social enterprises and social policies. (EP Briefing 2016).

So far, SIBs implementation has spanned across various policy areas, such as social welfare, education, criminal justice and recidivism and employment. More precisely, social welfare SIBs have addressed issues such as homelessness, adoption and long-term foster care, family strengthening to avoid foster-care, support for disadvantaged youth.

At the outset, with the first wave of early adopters from the UK, US and Australia, there was scepticism that Social Impact Bonds were an(other) exotic idea of Anglo-American financial markets that had no place in a European social economy. But the second wave of early adopters has helped break down this early misconception. There are now eight European countries that have launched Social Impact Bonds: Austria, Belgium, Finland, Germany, Netherlands, Portugal, Sweden, and Switzerland.

[10] Social Impact Bonds have received different names in different countries: they are called "Social Impact Bonds" in UK and Ireland, "Pay for Success projects" in the US and "Social Benefit Bonds" in Australia.

Although EU SIB initiatives are most of them subscale, commissioned at municipal level and serving small populations, some as pilot projects, they share the desire to innovate in service delivery and focus on outcomes. All interventions show common traits:

- clarity about an identified problem (e.g. young migrant unemployment in Brussels);
- a recognition that innovation is needed, challenging the efficacy of old models; and
- determined public sector actors who are bold enough to see it through.

The size of SIBs in Europe—most in the order of €100,000-1.2m—reflects the limitations of contracting at the level of a single municipality. Municipal budgets typically have frontline responsibility for many social issues, but necessarily involve smaller target intervention groups compared to the regional or state level. Looking forward, these markets will need to develop models of scale— such as regional-level commissioning or a platform approach so that investment can be mobilized efficiently.

In certain European countries, SIBs have encountered resistance, finding the sentiment that the type of social issues targeted should be the domain of the state and that a private investment model has no role to play, or that it is inappropriate for investors to receive a return on investment from financing the delivery of social outcomes. Where such attitudes are present, Social Impact Bonds have been slow to gain traction and, where they have, any return to investors has generally been limited to a nominal amount. It is clear that the model needs to be aligned to the national culture and the social economy of a country.

The challenge for these markets as the model evolves is to demonstrate the value in bringing socially motivated private capital to support public sector investment in tackling prevention. If the case is not made convincingly and sensitively, these markets will find it difficult to develop larger scale Social Impact Bonds supported by a broader range of capital and investor support is likely to be limited to quasiphilanthropic funders.

In some countries, public sector unions see SIBs as a form of ‘privatization’ of public services. If Social Impact Bonds were funding private sector organizations to provide services which were previously provided by public sector employees, this concern would be valid. But in practice, early programs have mainly been additive, not a replacement for existing services, or have changed the contracting framework of services which were already delivered by outside service providers.

In spite of its advantages and innovative potential, SIBs are very complex instruments. They are not a panacea and cannot be used to solve any social issue. They involve multiple stakeholders coming from different sectors. Time, technical expertise and commitment to

collaborate are indispensable in order to establish a SIB. To date, SIBs remain a fairly new financial instrument aiming at social impact with limited evidence regarding their results. Therefore, further analysis is needed in order to develop a robust evidence base. For Social Impact Bonds to successfully take hold, or at least to be tested in a new market, the government, social sector, and funding community must be open to the concept of taking and sharing risk, paying for outcomes, working together and playing new roles.

The EU context

In February 2013, the Commission published a 'Social investment' communication that recognised the need for social enterprises to access private finance. To stimulate such funding, the Commission emphasised microfinance initiatives and a proposed European label for social entrepreneurship funds. The Communication also promised to facilitate exchanges between Member States of experiences with social impact bonds. In its response to the Communication, the European Parliament (EP) reiterated that the public sector was not the sole source of resources for social policies. The EP called on Member States to make more use of financial engineering through instruments such as Social Impact Bonds and asked the Commission to make more detailed proposals on new financial instruments that could leverage public social investments (European Parliament, 2014)

The following paragraphs present two examples of SIBs in the UK; one in the field of young people in care and another one in the field of children with special educational needs and disability.

In the county of Essex (UK), the number of young people in care is higher than the national average. Young people who grow up in the state care system often experience worse outcomes than their peers. Children often enter care because of multiple and complex behaviour problems, triggered at adolescence, which can lead to aggression, antisocial behaviour and family breakdown. By focusing on parenting and relationships in at-risk families, this Social Impact Bond aims to create more stable and supportive environments to prevent children from entering care. Since placing children in out-of-home care is also very expensive, with costs ranging from £20,000 to £180,000 per year per individual, this Social Impact Bond could therefore save Essex County Council a total of £10.3m in avoided costs to the care system, minus the cost of the intervention. In this SIB, Intensive Multi-Systemic Therapy (MST) is delivered over a period of 3-5 months to young people and their parents by specially qualified therapistst. MST is an evidence-based programme that seeks to improve parenting and rebuild positive family relationships, enabling families to manage future crisis situations themselves. The success of the Social Impact Bond will be measured by the reduction in days spent in care, as well as improved school outcomes, wellbeing and reduced

reoffending.The value of outcomes payments per placement day saved corresponds to a proportion of the costs savings for Essex County Council. Bridges Ventures and Big Society Capital provided cornerstone investment to encourage other investors, and target returns per annum are 8% to 12%. Returns increase incrementally with the number of placement days saved, up to a cap of £7m. Results are available for the first two years of the Social Impact Bond. As of February 2016, 208 adolescents had begun or completed the MST programme, with 82% avoiding care and remaining with their families. Progress is being tracked over 30 months, and of those who finish MST, 87% remain at home 12 months post-completion. Outcomes payments have been made to the Social Impact Bond holding company and will be recycled to pay for ongoing service delivery. An independent evaluation of the Essex project was published in February 2017.

In the UK, children with special educational needs and disability are entitled to free transport if they are unable to walk to school - usually via private buses, minivans or taxis. Whilst for many young people this is the best option for some, with the right support and training, they could be trained to travel independently. Acquiring a greater level of independence can have a huge and lasting impact on quality of life as children build valuable social skills and confidence. It also has positive benefits for their families, who can manage their affairs more flexibly. And it is also a positive outcome for local authorities, whose costs have been estimated at £6,000 for each child every year, equating to about £500m every year across the UK.

In this SIB (Social Finance, 2017), HCT Group, a social enterprise bus operator, provides specialist travel training that gives young people the skills and confidence to travel independently on public transport. When a young person has completed the training and is travelling safely and independently, they will be signed off as able to travel independently. Young people will be monitored over 12 months to ensure travel independence is sustained. A first payment is made when a young person is first signed off as able to travel independently, a second is made if travel independence is maintained for one school term, and a third if travel independence is maintained for a full year.

In sum, the need to find new ways of handling the growing demand for social services in a situation characterised by austerity calls for attracting private investments. New financing credit lines, public-private partnerships (especially under the form of project financing) and Social Impact Bonds, are examples of private investment models that can help public authorities meet their social policy objectives. However, most of these instruments work on a project-based fashion; i.e. they are limited to finance single specific/ ad hoc projects (e.g. social infrastructure projects, innovative projects) rather than the basic provision of day-to-

day care and support services. In addition, they involve multiple stakeholders and therefore, in order to be successful, it is necessary that the public authorities, the social service providers, and the funding community (investors) are open to new ways of working based on collaboration and pro-active approaches.

To conclude, the four different models described in detail in this section are present across Europe to ensure the provision of social and care services.

Reserved contracts can be considered as the“classical”/traditional funding model for social service provision across Europe. They allow for stable and long-term cooperation between public authorities and service providers, which in most cases are not-for-profit. They also allow for continuity of the service with users, something which is very important, especially in the provision of services to people with mental disabilities. Reserved contracts usually lead to a collaborative/partnership-based relationship which provides financial stability to the service provider and avoids to have to regularly compete for new funding. A specific type of reserved contracts are the so-called Open-house models, which work as an admission system in which care providers can get contracted if they meet the requirements set by the public authorities. This scheme is being used in the Netherlands where municipalities impose criteria with respect to quality and suitability, and each care provider that meets these criteria is admitted to a framework agreement.

User-centred models, which include personal budgets and the voucher system, put the person at the centre of the system and provide individuals with more choice and control over the services they access. Personal budgets are becoming increasingly popular in Europe, and although with differences across countries (there is not a “standard” personal budget model; on the contrary the model varies according to the diversity of contexts and situations across Europe), they allow users to choose their care and have radically changed the way of service provision. In these models, service providers no longer engage with public authorites but they directly engage with the users, who control their own publicly funded personal budgets and can choose their prefered provider. Personal budgets are a way to empower persons with disabilities to have more freedom, citizenship and access to their human rights, in line with UN CRPD. Satisfaction, well-being, and quality of life are constant positive outcomes that have emerged from evaluations of personal budgets. Personal budgets often work on the basis that people can choose to control their budgets or they can choose to resort to other funding methods. Although personal budgets may be seen as the future model for the funding of social services they might not be suitable for all persons or situations. They have worked well in the field of social services for persons with physical disabilities, whereas more effort is required to ensure they can also work effectively for people with intellectual disabilities. It should also

be noted that whilst the availability of choice should be a positive process, the exercise of choice can lead to apprehension and worry in some individuals. Although choice would suggest a greater availability of services, however, the proliferation of services does not necessarily mean an increase in quality. As mentioned in the EASPD report "How to Fund Quality Care and Support Services: 7 key elements": "(...) the success of personal budgets relies on strong commitments, including financial, the development of monitoring and enforcement mechanisms to ensure quality, and a willingness for all stakeholders to engage creatively with one another and to respect each other's roles and responsibilities within the new system".

The private investment instruments studied in this report include private banks (traditional banks that have created specialised institutions or particular sections which provide financial support, sometimes with the support of EU financial instruments, that are conceived to address specifically the financial needs of non-profit organisations; Public-private partnerships, with project financing as the model most widely used in the social sphere for the construction of socially significant facilities; and Social Impact Bonds which are innovative but still too complex instruments to finance social issues.

Last but not least, public procurement has increasingly been used by local and regional authorities in different parts of Europe to fund social services, especially since the financial crisis, in response to growing pressures to reduce public spending. This has led to a decrease of the share of direct 'in-house' provision by local authorities and this tendency is giving for-profit organisations a stronger position. A progressive "marketization" of social services is taking place in Europe and one of the countries which has seen most opposition to competitive public procurement in social care has been Finland, with the launch of a citiziens' initiative to amend the Law on Public Procurement. The key message of the citizens' initiative is that competitive tendering is not a viable way of providing vital, life-long services for people with disabilities. Services provided to disabled people through public procurement and thus competitive tendering have often proved to be inadequate to the needs of service users. In competitive tendering, the purchase of services is priced at the expense of quality and the services purchased do not meet the needs of the users; continuity is not guaranteed; persons with disabilities do not have the right to choose; staff exchanges as a result of continuous re-tendering may have grave consequences on service users, to cite some of the problems.

The outcomes of the conference organized in Bucharest by EASPD in 2019, gathered in the report "How to Fund Quality Care and Support Services: 7 key elements" also point out in the same direction regarding the inadequacy of public procurement for social care provision. According to the report, "(...) public procurement has not proved to be an effective instrument

in the development of community-based and person-centred care services, in line with the UN CRPD". "(...) ...Perhaps the biggest issue is the sheer difficulty to combine the practical use of public procurement with the principles of the UN CRPD, where the end-users should have control over the services they wish and need". In addition, "(...) public procurement decreases the diversity of stakeholders; pushing many of the smaller providers out of the market as they cannot compete due to low prices, the high administrative costs, the increasingly complex legal frameworks and the tendency to procure out larger contracts".

In this context, it is necessary to shed light on the use of public procurement in the provision of social services and gather the views and opinions of the experts working in the field. The following section collects the perspectives of social care providers about the use of public procurement in social care, especially for people with disabilities.

Perspectives on the use of public procurement in social care

This section provides the perspectives from social care providers for persons with disabilities and local and regional authorities about the use of public procurement in social care. The content of this section comes from a total of 17 interviews carried out by the research team during November - December 2019. The experts interviewed come from different fields and institutions covering 8 countries representing the different European social care environments (Spain, Finland, Czech Republic, Belgium, Austria, Scotland (UK), France, and Romania). The majority were country experts specialised in social care provision, but also representatives from associations at EU level were interviewed, as it is detailed in the acknowledgement section of this report, coming from different disciplines: psychology, sociology, educational sciences and political sciences, among others.

Contacts for the interviews were provided by EASPD, once the experts and representatives from associations at EU level agreed to participate in the study. Then, the research team contacted them providing the template for the interview (see Annex), so they could have it as guideline during the interview. The possibility of answering in written was provided to experts to facilitate their participation. Finally, 64.7% of the interviews were carried out orally (through skype calls) and the other 35.3% of experts preferred to send their answers in written format (following the common interview template sent by the research team). In both cases, the personal data of the participants was anonymised and had been only used for this research in order to guarantee gender balance (56.94% female) and age coverage (from 37 to 62 years old).

During the interview, their opinion on Public Procurement as an effective instrument for procuring social services was gathered. Public procurement has been seen positively in some cases, especially in countries (Central/Eastern Europe) with limited resources and low budget destinated to social services and where public authorities are not always fully transparent in how they fund the provision of social care and support. In these cases public procurement guarantees transparency and offers the possibility to cover the entire costs of social services.

Concerns arise "by the way public procurement is evaluated and commissioned, which is usually based on the cheapest price rather on than the quality of the service..." In this sense, there is a common concern highlighted by experts in relation to the importance of reinforce the social criteria (specially users' needs) beyond the price "…it still concentrates on price before quality…". For instance, experts expressed their dislike to public procurement because the importance given to the price can jeopardize the quality of the services provided "…we don't like public procurement, because we think that it is a risk for good quality…". In fact, public procurement is seen as a good instrument, but not for providing social services; however public procurement "…could work if the focus was on quality and if budgets available were increased…"

In some countries the process has been changed in order to guarantee that the main weight is assigned to respond to users' needs. For that, experts stressed the importance to listen to the voice of disabled people through disabled persons organisations. Nevertheless, there is also a common claim about the complexity of using quality criteria even if the public authorities want to use them "…even if you want to use also the quality criteria it's very hard to describe them in an exact way…". Maybe because the limited budgets and the willingness of public authorities to have more control over the contracts, but also because the lack of training of the staff involved in the public procurement process "…they do not have the skills they need to be creative and to think beyond the standards…" Nonetheless, countries with limited resources stressed that the terms of contracts are very clear and that allow them to easily monitor and evaluate the service.

Moreover, public procurement is a quite expensive procedure that implies many working hours to prepare the related documentation by both, the public administration and the service providers. This high administrative burden for providers at the application stage also impacts on the extinction of small companies who do not have the staff or the resources to prepare the required documentation. Thus, the application procedure of public procurement is seen as a time-consuming procedure that requires staff capacities and management costs "…public procurement involves having the human resources and capacity to apply in short terms with an efficient cost…". Also small companies, in some regions, have disappeared due to the times

associated to public procurement that make it unsustainable for a small entity to survive a long period without contracts "…not for profit social services providers are at a disadvantage in public procurement as they do not have reserves or capital that can be transferred to cover deficiencies in the procurement process…"

In this regard the problem of offering long-term services through this model was pointed out because of changes in staff affect end-users. This is because the selection is made by the public authority and not by the user. This is especially relevant for the relationship between certain users and their caregivers "…it is especially difficult for the persons who have severe, intellectual disabilities, who really need the support of the staff (…), it might take years to get to know a person with severe disabilities and to establish a relationship with him/her based on trust…" "…through the process the staff changes which has negative effects to the quality and trust specially in life-long services such as housing services…" However, in some regions, although in theory the contracts are limited to a period, practically the contracts are renewed following a long-term cooperation. This avoids breaking the relationship between users and their caregivers unless one of the partners is not satisfied with the contract.

As a general rule, public procurement has not been implemented according to the UN CRPD because it is not respecting the users' rights, in particular the right to choose for disabled persons. Most municipalities look for the economic part of the services and highlight in detail the services they want to provide in the tender, not giving space for providers to personalise the services to end-users' needs. There is "…a risk of an excessive top down approach…". With public procurement the end-user is not a consumer because the negotiation is between the public administration and the service provider. It is seen as "…based on the principles of the liberal market in which the economic principles are dominating, and not the questions, wishes of the people with disability…" Of course, experts highlight variations between municipalities and, in countries with less budget allocated to social services, also the alignment of the national law with the needs' analysis and strategic planning in each community.

Some experts are aware about the advantages of the public procurement as a model intended to guarantee the principles of competition, publicity, transparency and non-discrimination; and are also conscious of the flexibility allowed for the provision of social services. In relation to competition, it depends on the country environment. In some cases, where the size of the region or municipality where public procurement is applied is small, there is no room for more than one provider or "…the number and density of providers is still low…". But in other regions, for-profit and international providers have pushed non-for-profit organisations out of the market. The role of profit organisations was pointed out in the interviews as experts rose the concern about the financial return that these organisations expect, and that impacts

against the quality of services provided "…we don't see why private investors would invest in care and support. They want a financial return…" Also, the negative impact on the caregivers working conditions was mentioned "…it has also a negative impact on the working conditions of the caregivers because of competition between the organisations".

As mentioned before, public procurement, as it is being implemented now, does not foster innovation as public authorities know exactly what they want and do not listen to the innovative ideas of organisations. Most municipalities are reluctant to innovation because they are focused on the economic part of the services (price) and for that reason provide a very detailed description of the services they want to be provided in the tender. Moreover, amounts are calculated by standard costs for each service category and this does not reflect the real cost of the services. Consequently, the quality is again affected, and small companies cannot access to provide the services with the quality desired with the stipulated prices. It also makes that public procurement is also not seen as an effective model because "...it favours very big organisations and threats the quality".

Further considerations on public procurement

The following paragraphs gather the views on public procurement of the European Commission's (DG Internal Market, Industry, Entrepreneurship and SMEs) representative interviewed by the research team.

For social service provision the EU Directive on Public Procurement allows contracting authorities to apply, instead of the full public procurement procedure, a more flexible regime with a reduced number of obligations to comply with, leaving more freedom to public authorities to choose how to contract social services. The emphasis of the light regime of the EU Directive relies on delivering quality services. There are different procedures across member states on how to deliver these services. How much the light regime and the emphasis on quality criteria have been understood by local authorites is yet to be seen. There are two main factors influencing this:

- Public authorities tend to be risk-adverse when launcing a procurement procedure and want to be on the safe side, ensuring that their procedure is legally sound and correct. The light regime allows for much flexibility but risk aversion prevents procurers from taking advantage of the flexibility offered by public procurment and its light regime.

- Integrating quality aspects/considerations requires a lot of work and creativity. Public authorites need to start integrating/involving all the actors operating in the field of social care

provision (users/beneficiaries, NGOs, different service suppliers). This requires effort and finding new ways to involve stakeholders.

In small local contracting authorities usually with reduced administrative capacity, it will be difficult to take into account quality considerations. It is therefore necessary to address the issue of the professionalization of the public procurement staff. It is necessary to create awareness at national level of the need of the staff, not only to know about the legal provisions and looking at budgetary savings but using the limited budgets to make the most out of them for the beneficiary of the service. Public procurement staff must be ready to deal with the complexity of quality versus more simple figures. Dealing with complexity and endowing staff with the necessary skills and instruments is a long-term objective that requires a change in strategy at national level. Member states need to develop strategies that allow people to do their job taking into account the complexity around the system.

Public procurement and the UN CRPD. It is possible to adapt the procurement procedures to make public procurement more in line with the UN CRPD. There are ways that allow contracting authorities to take into account the needs of the users. For example, it is legally possible for the public authority to involve users in the evaluation of offers. There is also the possibility to take into account accessibility criteria[11]in public procurement. When evaluating offers it can be agreed to give more points to an organization that guarantees high levels of accessibility.

Traditionally, public procurement has been seen as a contract with a very detailed description of the service and with many specifications. But this does not have to be the case. Instead of focusing on specifying the type of services, the focus could be on the outcomes/results, or on performance criteria, instead of describing the services in detail. The degree of personalisation of services has to be integrated with enough flexibility. It is necessary to come forward with quality proposals so to serve all individuals. Specifying outcomes is not a new thing. It has not been widely used in the past but it is an option that is available.

Public procurement and competition. The primary purpose of the EU procurement directive is to make sure all suppliers compete on an equal footing. In order to foster the participation of small service providers, public procurement gives the possibility to use reserved contracts for

[11] There is a legal obligation under EU Directives to define minimum accessibility requirements in technical specifications. However, at the moment, there is no legal act defining what this minimum should be and when it is fulfilled. The EU Accessibility Act will help clarify what is the minimum for a few products and services and related features/elements, and in some areas public buyers can rely on international standards. However, some uncertainty (practical and legal) will always remain. The systematic inclusion, by public buyers, of at least basic accessibility requirements in the specifications for all procurement meant for natural persons, could significantly improve outcomes, as well as help them sefaguard their legal interests.

specific categories but also to divide the contract into smaller lots to make it more manageable for smaller organizations and non-profits. Also defining the selection criteria for financial requirements appropriately will help not to exclude the small organizations.

Public procurement and control. Public procurement tends to be more bureaucratic for certain aspects but also it gives contracting authority more control on how the service is delivered.

In sum, experts interviewed have pointed out the limitations of public procurement and the problems created when social and care services have been procured through competitive tendering. In addition, in all cases examined, current public procurement procedures are not in line with UN CRPD since the voice of users is not taken into account, in particular the right tochoice and control for disabled persons.

Although in theory, the existing public procurement procedures would allow for freedom in the way services are procured, in practice, public authorities apply/implement public procurement procedures in the more traditional/restricted way. It could be argued that the issue would be then not in the instrument itself but in the way it is currently implemented by public authorities across Europe. Therefore, in the current context, characterized by the application of traditional public procurement procedures in most European countries, it becomes worthwhile to explore other models that (although imperfect) have revealed more effective in the provision of social services.

The following section describes and analyses in detail alternative models to public procurement in the funding of social care, especially for people with disabilities, that are used in different EU member states.

Main alternative to public procurement in the funding of social care

This section provides detailed information on alternative models to public procurement in the funding of social care, especially for people with disabilities, currently in use by different EU countries. The models presented have been identified through desk and field research. The field research has been carried out through 17 interviews with experts, as described in the previous section. A total of 10 alternative models have been found covering 7 different EU countries (UK, Belgium, Finland, The Netherlands, Sweden, Austria and Spain). The models identified are the following:

In the area of reserved markets:

1. Reserved contracts in Salzburg (Austria)
2. Reserved contracts in Spain
3. Open house model in The Netherlands

In the area of user-centred models:

4. Personal assistance budgets in Sweden
5. Personal budgets in the Netherlands
6. Personal assistant budget in England (UK)
7. Personal assistance budgets and personal budgets in Flanders (Belgium)
8. Self-directed support in Scotland (UK)
9. Voucher system in Finland

In the area of private investment:

10. Social Impact Bond in England (UK)

Each model is presented in a "info-fiche" containing detailed information on:

- The region/country where it operates
- The services targeted
- The year of establishment
- The target group(s)
- The main stakeholders involved
- How they operate (both legally and in practical implementation)
- How they were developed in a way which means they do not fall under the EU public procurement rules
- How they are seen by social service providers, local and regional authorities (barriers/enablers, advantages/disadvantages of the model)
- Evaluation/assessment
- Contact person and links to further information/material

1. RESERVED CONTRACTS IN THE SALZBURG REGION (AUSTRIA)

Name of the model /practice /procedure	**RESERVED CONTRACTS**
Country	**SALZBURG REGION (AUSTRIA)**
Model/practice/procedure coverage	□ National ✓ □ Regional □ Local - Municipalities
Beneficiaries (target group)	□ Older people ✓ □ People with disabilities ✓ □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration □ Private service providers (for-profit, non-for-profit) □ Informal caregivers □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	**1981**
Is it still working?	✓ □Yes □ No
Services involved	Social care services
Description	In Salzburg (Austria), reserved contracts are currently used to fund housing and work-related services (for persons with learning disability, high support needs - "unable to work"), early childhood intervention, therapies, kindergarten.
Legal framework	The "**Salzburg Disability Law" of 1981** (the name has been recently changed to **"Salzburg Participation Law"** (latest amendment of 2019)) and individual contracts with service providers regulate which types of services are provided and how they are funded.

How the model/practice/procedure does not fall under the EU public procurement scope	The Salzburg Disability Law allows regional authorities to enter into individual contracts with service providers (NGOs).
Practical implementation	The Salzburg Disability Law defines the following main issues: • Who is entitled to the services • Individual contracts with organisations are the basis for service provision • Duration 3 years (long-term-cooperation, continuous contracts, since they are automatically renewed after the 3-year period) • Types & subtypes of services • (Max.) number of users by subtype • Rates by person/ day per subtype (e.g. supported living: € 55 – 175 per person/ day) & investment • Accounting approach & valorisation • Quality assurance & control by authorities Provision and funding of day to day services works very well as it is based on decades of practice with the reserved market cooperation model between authorities and NGOs. Traditionally, over the past 40 years, regional authorities have contracted services from NGOs included in a service providers list. This is so for traditional services. For new types of services, a sort of “small procurement process” is put in place whereby public authorities send an invitation letter to all NGOs in the list, asking for their offers and choosing the service provider amongst the offers received. It is a very stable system, although rather reluctant to change and to innovation.
Enablers/ facilitating factors in their implementation	Decades of well-established practice between the public authorities and the NGOs. Long-lasting cooperation between authorities and NGOs.
Advantages/ benefits of the model	Positive aspects of reserved contracts can be summarized as: (i) high planning reliability for the service providers; (ii) high level of continuity for service users, staff, commercial partners (e.g. companies, banks); (iii) a certain level of quality is guaranteed. The model is very stable especially regarding planning and funding reliability and a high level of continuity for all stakeholders. Advantages in comparison to public procurement procedures are: focus on quality, simpler application procedures

	for service providers, long-term cooperation based on repeated contracts.
Disadvantages/ drawbacks of the model	There are also some drawbacks of the reserved contracts model, such as: (i) limited choices and flexibility for persons with disability (types of service, limited number of providers…); (ii) strict rules; (iii) limited comparability, transparency of costs and efficiency of structures; (iv) less choice and control for users (with respect to other models such as personal budgets and personal assistance). (v) reluctancy to innovation.
Evaluation: results/success /achievements	Whilst funding models themselves are not evaluated or compared in a systematic way, services are evaluated from different perspectives and in different ways: service providers, authorities (quality officers), independent control mechanisms (UN-CRPD Art. 16 (3)) – plus specific types of control for some types of services. Organizations in the Salzburg Region use different approaches. For example, Lebenshilfe uses a quality of life-oriented approach conducted by peer interviewers with intellectual disability and an elaborate complaint mechanism (focused on positive personal outcomes and human rights). Overall, results have been very positive for all types of services. Specific shortcomings and detailed feedback are used to improve services. “Quality officers” from local authorities visit local service providers, check on quality criteria and make recommendations or even requests for amendment (often administrative and formal issues). It is a constructive dialogue, and overall the quality officers are very satisfied. The independent control mechanism also visits local service providers, checks quality criteria (focused laws for service provision and human rights) and makes recommendations (quality)/requests (in case a law is being violated). Feedback so far focused on recommendations, no major violation of regulations/ laws.
Further information	Dr. Karin Astegger karin.astegger@lebenshilfe-salzburg.at Forschung & Entwicklung Lebenshilfe Salzburg gem. GmbH www.lebenshilfe-salzburg.at Tel: +43 662 820984-40 Resources:

	• Presentation of Astegger in the EASPD Conference 2019 (Astegger, 2019) • Salzburg Regional Government web page: (Land Salzburg, 2018) • Salzburg Participation Law, former Disability Law (Salzburg, 2019)

RESERVED CONTRACTS IN SPAIN

Name of the model /practice /procedure	**RESERVED CONTRACTS IN SPAIN**
Country	Spain
Model/practice/procedure coverage	✓ □ National □ Regional □ Local - Municipalities
Beneficiaries (target group)	□ Older people ✓ □ People with disabilities □ Children ✓ □ Excluded and disadvantaged groups, please specify: unemployed people in a situation of social exclusion □ Other: _____
Stakeholders involved	✓ □ Public administration □ Private service providers (for-profit, non-for-profit) □ Informal caregivers □ Formal caregivers □ NGOs, associations ✓ □ Others: Special Employment Centres and insertion companies
Year of establishment	2007 (although it was also provided for in previous regulations). The current regulation is from 2017.
Is it still working?	✓ □Yes □ No
Services involved	Social services and other services (see below)
Description	The Council of Ministers or the competent body of the Autonomous Communities and Local Entities sets a minimum percentage of contract reserves or contract lots for Special Social Initiative Employment Centres and insertion companies that meet certain established requirements.
Legal framework	Additional Provision 4 of Law 9/2017 of 8 November on Public Sector Contracts.
How the model/practice/procedure does not fall under the EU public procurement scope	Law 9/2017, of 8 November, on Public Sector Contracts, which transposes the EC directives that regulate reserved contracts.
Practical implementation	The Council of Ministers or the competent body of the Autonomous Communities and Local Entities sets a minimum percentage of contract reserves or contract lots for Special Social Initiative Employment Centres and insertion companies that meet the established requirements. It may also set a minimum percentage of reserve for the execution of these contracts within the framework of protected employment programmes. If there is no express agreement by the Council of Ministers, the State public sector contracting bodies must

	apply the minimum reserve percentage of 7 per cent, which will be increased to 10 per cent in the following years. This percentage is on the overall amount of the supply and service contracts included in the CPV codes listed in Annex VI to Law 9/2017 of 8 November, concluded in the financial year preceding that to which the reserve refers. These supply and service contracts which may be reserved are mainly the following: Cleaning services; Collection and recycling services; Forestry services; Laundry services; Hotel and catering services; Transport services; Printing services; Social services; Storage and delivery services; Accommodation and rural tourism services; Administrative services; Management and ancillary services; Mail and advertising services; Maintenance and repair services; Production and sale of seasonal plants, of compost, of plants and shrubs, of garden furniture; Production and sale of hand soaps; Production and sale of wooden kitchen tools; Production and sale of carpentry furniture; Sale and distribution; Articles for events; Business gifts and presents.
Enablers/facilitating factors in their implementation	Years of well-established practice.
Advantages/benefits of the model	– Assurance of a minimum percentage of contracts to be reserved for Special Employment Centres and insertion companies. – Greater employment of workers with disabilities or at risk of social exclusion who work in these Centres and companies. – Greater integration through work of these people with disabilities or in danger of social exclusion. – Continuity of work for several years. – A certain level of quality is guaranteed in the work of these Centres and companies due to their experience and dedication.
Disadvantages/drawbacks of the model	– Limitation to a certain type of supply and service contracts only. – Occasional non-compliance with this reservation of contracts.
Evaluation: results/success /achievements	This measure has always been considered basic for the better integration of many people with disabilities and for many people at risk of social exclusion. The results are positive as a certain number of contracts are secured for these Special Employment Centres and insertion companies. It is a very important measure for the continuity of these Centres and companies. The achievements will be greater as the number of reserved contracts increases.
Contact person & links to further information/material	Dr. Miguel Ángel Cabra de Luna Fundación ONCE Director of the Area of Alliances, Social International and Relations mcabradeluna@fundacionONCE.es Tel: +34 91 506 89 90-5144

2. OPEN HOUSE MODEL FOR YOUTH CARE IN THE NETHERLANDS

Name of the model /practice /procedure	**OPEN HOUSE MODEL FOR YOUTH CARE**
Country	**THE NETHERLANDS**
Model/practice/procedure coverage	□ National ✓ □ Regional ✓ □ Local - Municipalities
Beneficiaries (target group)	□ Older people □ People with disabilities ✓ □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) □ Informal caregivers □ Formal caregivers □ NGOs, associations □ Others: _____
Year of establishment	**2019**
Is it still working?	✓ □Yes □ No
Services involved	Support services for young people
Description	Open-house contracts are used when the public body chooses to contract with any and all interested service providers using pre-defined conditions, instead of contracting with only one or a limited number of providers.
Legal framework	The transformation of the youth care system in the Netherlands started in February 2014, when the Dutch government passed the bill on the Child and Youth Act. The new law stated that the tendering and the coordination of the youth care processes were to be the responsibility of the municipalities. This was new, since up to that point, the care system was always organised centrally by the twelve provinces. In June of the same year, the local municipalities started the budgeting processes. The Child and Youth Act was implemented on the 1st of January 2015. After the transformation in 2015, the NVG (Dutch Association of Municipalities) put out the recommendation to purchase Youth Care via a European tender. The fourteen

	municipalities of Twente decided to follow that advice, meaning that every care provider within the European Union could register for that tender. Since 2019, the procurement of Youth Care has changed and shifted towards an Open House Model.
How the model/practice/procedure does not fall under the EU public procurement scope	An Open House Model is not so much of a tender but more of an **admission system** in which care providers can get contracted if they meet the requirements set by the municipalities. On 2 June 2016, the European Court of Justice gave a preliminary ruling defining open-house contracts at the request of the Higher Regional Court of Düsseldorf (see below) and has now excluded them from the scope of classical procurement law[12]. There is no tendering duty of open house contracts. The Court of Justice of the EU (CJEU) concluded in *Falk* (CJEU, C‑410/14) that standardized public contracts are not subject to the EU Directive on public procurement, in case the government concludes standardized contracts with every interested organization that meets predefined standard quality criteria. When using such an open contracting scheme the procuring government does not compare the economic operators, nor does it consequently award exclusive contracts to only a limited number of economic operators. This open contracting scheme is referred to as 'open house model', which has become the common term in the Netherlands where municipalities impose criteria with respect to quality and suitability, and each care provider that meets these criteria is admitted to a framework agreement.
Practical implementation	The purchasing of care in the region of Twente, is put out to tender via an Open House-model. The rules of this model are that everybody who wants to participate can register and gets contracted, granted that they meet the requirements package, resulting in a large number of care providers. Municipalities establish the tariffs beforehand. There are national regulations which standardize the price-per-hour for every treatment.
Advantages/benefits of the model	Since the municipalities establish the tariffs beforehand, market forces emerge between the care providers.
Disadvantages/	Municipalities have the tendency to undercut the tariffs, which is problematic for larger care providers because they

[12] https://www.twobirds.com/en/news/articles/2016/germany/june/eugh-entscheidet-ueber-openhousevertraege

drawbacks of the model	cannot provide care for the set price. Smaller care providers do not have this problem, since they have less costs, like for example overhead costs. The result is a growing percentage of smaller care providers and a decreasing clientele for the larger organisations. Municipalities determine the treatment for the clients, and therefore set the boundaries in which the clients can choose their care provider, decreasing the power of the client. In addition, the approval for the treatment also lies with the municipality. It has been suggested that municipalities are in the habit of choosing an indication that requires cheaper care than what care providers consider necessary. Besides trying to convince the municipalities by argumentation, there is nothing the care providers can do, but accepting the terms. To reinforce their position within the discussions, organisations occasionally collaborate to form a power block. When necessary, an independent mediator is called in to moderate negotiations between care providers and municipalities.
Further information	Bibliography and other resources, in references: (Fisher, 2019; Uenk, 2019)

3. PERSONAL ASSISTANCE BUDGETS IN SWEDEN

Name of the model /practice /procedure	**PERSONAL ASSISTANCE BUDGETS**
Country	**SWEDEN**
Model/practice/procedure coverage	✓ □ National □ Regional ✓ □ Local
Beneficiaries (target group)	□ Older people ✓ □ People with disabilities (severe disabilities, major and permanent physical, mental, and intellectual impairments) □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) ✓ □ Informal caregivers ✓ □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	**1994**
Is it still working?	✓ □Yes □ No
Services involved	Support services related to Personal hygiene; Eating; Dressing and undressing; Communicating with others; Other help.
Description	The Swedish Personal Assistance Budget is a monthly sum allocated to disabled people to enable them to purchase self-directed personal assistance services from public and private entities.
Legal framework	The disability movement was the main force in bringing about the **Act Concerning Support and Service to Persons with Certain Functional Impairments (LSS)** and the Assistance Benefit Act, which were enacted by the Swedish Parliament in 1993 as part of a broader disability policy reform. Previously, persons with extensive needs for daily living were deeply dissatisfied with the municipal community-based home-helper or semi-institutional cluster home services, in which they had no influence. Many different, often unfamiliar,

	workers would come and assist with even the most intimate tasks. The reform, inspired by the Independent Living philosophy, enables individuals to customize services according to their particular needs, with maximum control over everyday life. In the spring of 1993, the bill on the Act Concerning Support and Service for Persons with Certain Functional Impairments was presented to the Swedish Parliament. On May 5 it was adopted and from January 1, 1994, implemented. In 1994, personal assistance became a legalized right in Sweden. Persons with extensive disabilities were granted direct payments. Then onwards, they could purchase personal assistance services through either the municipality or the Social Insurance Agency.
How the model/practice/procedure does not fall under the EU public procurement scope	Personal budgets are not considered as procurement, as the municipality/public body is not the buyer of care.
Practical implementation	Sweden legally entitles persons that belong to one of the three groups (specified in the Act Concerning Support and Service for Persons with Certain Functional Impairments) to a personal assistance budget (PAB): 1. Persons with an intellectual disability, autism or a condition resembling autism; 2. Persons with a significant and permanent intellectual impairment after brain damage in adulthood due to an external force or a physical illness; 3. Persons who have other major and permanent physical or mental impairments which are clearly not due to normal ageing and which cause considerable difficulties in daily life and consequently an extensive need of support and service. In addition, people have to require assistance with at least one of the following five fundamental needs: Personal hygiene; Eating; Dressing and undressing; Communicating with others. Other help (which requires detailed knowledge of the person's impairment). This monthly sum from the National Social Insurance covers 100% of service costs and enables individuals to purchase self-directed personal assistance services from public and private entities. The amount of the PAB is independent of the individual's or the family's finances. Personal assistance is not a means tested in Sweden. It is viewed as a legalized social right. Persons who need 20 or more hours of assistance per week for their needs are entitled to personal assistance payments from the Assistance Allowance Act (LASS). Payment for personal assistance from LASS is provided through the Försäkringskassa [Social Insurance Agency]. Persons who need less than 20 hours of assistance per week can apply

	for personal assistance services or direct payments to purchase services from their local municipality under LSS. Users who receive their assistance allowance from LASS can choose to purchase assistance services from their municipality, from private for-profit companies or employ their personal assistants themselves individually or collectively by joining a users' cooperative. Users who receive their assistance allowance from LSS can choose to have their personal assistance provided by the municipality. They can also choose to receive direct payment from the municipality, and purchase assistance services from private for-profit companies or employ their personal assistants themselves individually or collectively, in the same manner as users who receive their assistance allowance from LASS. The personal assistance budget goes to the user and is granted in the form of assistance hours, which are based on the individual's needs. The budget can cover up to 24 hours a day/7 days a week, and can even be used for more than one personal assistant, if needed. A monthly sum from the National Social Insurance covers 100 percent of service costs and goes directly to the users who, with maximum self-determination, can contract providers of their choice (municipality, company, or cooperative) or employ assistants by themselves (by starting their own private company).
Barriers to its implementation	Initially, it met with much resistance. The disabled people's movement had since long-time pleaded in favour of a system of cluster housing and was first unwilling to stray from that path. The trade unions feared that disabled people would not be able to act as good employers and in general, it was thought that personal assistance would only offer a solution to the 'elite'. After the pilot project in 1994 and various independent investigations, all those arguments were put aside.
Enablers/facilitating factors in their implementation	*Strong political support:* The LSS received strong political support from the liberal party Folkpartiet, both in Stockholm and nationwide. The issue of personal assistance in Sweden became a symbolic issue. For Folkpartiet, personal assistance and Independent Living became a symbol of general politics and ideology. *Proof of bad quality of home care services and cluster housing services:* In 1988, a Parliamentary Committee was charged with investigating the situation of persons with disabilities in order to suggest solutions. It also considered the living conditions of persons in need of assistance for everyday activities. This Parliamentary Committee confirmed the low quality of these services. Due to high turn-over rates among the personnel, persons with disabilities were never sure who would enter their doors; 54%, or 400 persons with disabilities receiving home care services or cluster housing

	services, stated that they had to rely totally or partially on family and friends in order to manage their lives.
Advantages/benefits of the model	Personal Assistance Budgets give disabled people control over their own lives by providing them the opportunity to steer their own support. This implies that disabled people directly receive the budget for their support instead of the government funding the care providers. With this budget, disabled people may engage their own personal assistants. They allow citizens with extensive disabilities not to live in institutions to receive services. They are free to choose where and how to live. By choosing their individual solutions, they can make their own plans and have greater equality of living conditions and enjoy fuller participation in community life. Personal assistance has proven to be a labour market tool enabling new groups to enter the labour market.
Disadvantages/drawbacks of the model	There is a large group of disabled individuals not having access to personal assistance services because they are assessed as not being a part of any of the three categories of specified personal requirements. Many children have a parent as personal assistant. In ordinary life, parents have always assisted their children. The difference is that many of them are now paid for that work. It has become visible. There are pros and cons of having parents as assistants. It can be difficult for a child to grow up in the constant presence of parents. It can be difficult for parents to separate their roles as parent and assistant. Recent research has indicated that children with parents as their only assistants tend to be more isolated than those with external personal assistants. And the family risks becoming economically dependent on the needs of the child, and thus unwilling to let the child move out.
Evaluation: results/success /achievements	Data from 2013 showed that: – In 2013 some 19,500 people received a personal assistance budget. – 98% of recipients pointed to personal assistance as the most important factor for their quality of life. – Close to two thirds of the beneficiaries said the hours of assistance they receive were adequate. One fourth said they needed more. – Most of them felt they had strong influence on the selection of assistants and scheduling of help. – More than 90 % of beneficiaries were satisfied or mostly satisfied with their assistants or assistant providers. About 30 % changed assistant providers, indicating the awareness of freedom of choice. – A large majority of beneficiaries considered assistance as absolutely crucial for participation in social interactivity and a meaningful life. In another survey, almost everyone

	— 98 % — pointed to personal assistance as the most important factor for their quality of life. – Approximately 80,000 people work as personal assistants – 2% of the labour force. (2014 Ref.) – Taxpayers have saved an estimated €3 billion since 1994, compared to the costs of home-helper services. (2014 Ref.) – Only 3% of the assistance users are employing their own personal assistants. Most users are unwilling to take on this responsibility. At the beginning, it was believed that many more assistance users would use the option of employing assistants themselves, but the percentage has remained constant over time.
Further information	Kenneth Westberg Independent Living Institute Storforsplan 36,Stockholm-Farsta, Sweden www.independentliving.org admin@independentliving.org Bibliography and other resources, in references (Independent Living Institute, 2013; Westberg, 2010; Zero Project, n.d.-b)

4. PERSONAL BUDGETS IN THE NETHERLANDS

Name of the model /practice /procedure	**PERSONAL BUDGETS**
Country	**THE NETHERLANDS**
Model/practice/procedure coverage	□ National □ Regional ✓ □ Local - Municipalities
Beneficiaries (target group)	✓ □ Older people ✓ □ People with disabilities ✓ □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) ✓ □ Informal caregivers ✓ □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	**1996**
Is it still working?	✓ □Yes □ No
Services involved	Health and social care services
Description	A personal budget in The Netherlands allows clients to buy and organise their own care instead of receiving care in kind. Personal budgets are available for and are regulated under various pieces of legislation.
Legal framework	Personal budgets (persoonsgebonden budget, or PGB) were first introduced into the Dutch healthcare system in 1996 as a 'major innovation' of the Dutch welfare state, supported by both left-wing and right-wing parties, following active promotion and campaigning by the patients' rights movement and the disability movement throughout the 1980s and 1990s. Since the 2015 reform, personal budgets are available for care under all the following Acts: The Long-term Care Act (WLZ 2015), which covers all forms of care for people with serious, long-term care needs who require intensive care or supervision at close hand 24 hours a day, including vulnerable old people and people

	with severe disabilities. Care is granted on the basis of a care needs assessment. The Social Support Act (WMO 2015), whose primary objective is to enable individuals to live independently for as long as possible in their own homes and to participate in society. The Dutch municipalities have responsibility for the implementation and policy making for this Act and have significant latitude in how social support is offered and delivered. The Youth Act (Jeugdwet 2015, which covers all care provided for people with a mental disorder, including mental health care, parenting support and social support provided to children under the age of 18 years It is also implemented by the municipalities. The Health Insurance Act (ZVW), which covers additional benefits in kind (e.g. Care related to sensory disabilities; District nursing services (and a personal budget for district nursing services).
How the model/practice/procedure does not fall under the EU public procurement scope	The Dutch personal budget is not considered as procurement as the municipality is not the buyer of care services.
Practical implementation	The Dutch government, the municipalities and the health insurer are jointly responsible for long-term care, including personal budgets, and the vast majority of personal budget payments (for personal care and domestic care) are made under the Social Support Act 2015. Personal budgets for elements of long-term care and for nursing care are also covered under the Long-term Care Act and the amended Healthcare Insurance Act, respectively. The amount of the personal budget should be sufficient to purchase the care/support needed, following a needs assessment by the municipalities. Budget holders can have multiple personal assistants in order to support different care needs.
Barriers to its implementation	There are hidden transaction costs at the start-up.
Advantages/ benefits of the model	A personal budget favours a more client-driven system and allows clients more freedom to purchase the care they need. It also enables members of informal networks to provide support.
Disadvantages/ drawbacks of the model	Although the Dutch personal budget system allows clients (who have sufficient capacity to manage their personal budget) optimal freedom of choice in the selection of their care provider(s) and increases their autonomy, the personal budget is also associated with increased risk of fraud.

	In a 2017 study, 13.000 clients receiving a personal budget were visited by researchers. In 220 cases (1,7%) the researchers suspected fraud, leading to follow up criminal investigations (Poortvliet, Gerwen, & Bosch, 2018 in Commissioning of Social Services by Niels Uenk). While the reported percentage of suspected fraud is low, fraud with personal budgets receives much political attention.
Evaluation: results/success /achievements	Kremer (2006) asserts that the personal budget strengthens patients as consumers, increasing patients' control, power, and autonomy and it also increases competition between providers, thus increasing efficiency. Patients have gained a stronger voice but the problem, as Kremer points out, is that the quality of care is not only a matter of consumer choice but is also heavily dependent on the qualities of the caregivers.
Further information	Bibliography and other resources, in references (Health Research Board, 2016; Kremer, 2006; Uenk, 2019).

5. PERSONAL BUDGETS IN ENGLAND

Name of the model /practice /procedure	**PERSONAL BUDGETS**
Country	**UK/ ENGLAND**
Model/practice/procedure coverage	□ National □ Regional ✓ □ Local
Beneficiaries (target group)	✓ □ Older people ✓ □ People with disabilities □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) ✓ □ Informal caregivers ✓ □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	**2015**
Is it still working?	✓ □Yes □ No
Services involved	Personal budgets for: health, education, and social care services
Description	Personal budgets in social care are sums of money allocated by a local authority to service users to be spent on services to meet their care needs. They can be managed on behalf of users by the authority, or a third party, or given to users as direct payments (money to spend themselves). Personal budgets aim to empower people regarding the treatment and services they receive by encouraging them to take control over how money is spent on their care. In England, personal budgets do not necessarily imply giving people the money itself. Personal budgets can work in many ways, including: (i) a budget managed by the local authority in line with individual wishes. It looks after the money, makes arrangements for care and support and pays the fees out of the personal budget assigned to that individual. (ii) a budget managed on the individual's behalf by a third party; (iii) a cash payment to the person or their carer. This is also known as a 'direct payment'. Thus, direct payments are a funding choice in personal budgets.
Legal framework	From April 2015, under the Care Act 2014, all adults in England who have been assessed as eligible for support from social services (including carers of adults) are required to have a personal budget.

	The statutory guidance which accompanies the Care Act 2014 states that the personal budget must always be an amount sufficient to meet the person's care and support needs, and must include the cost to the local authority of meeting the person's needs which the local authority is under a duty to meet, or has chosen to meet. Personalisation principles are central to the Act, which provides the legal basis for adult social care. The Care Act 2014 required local authorities to give all eligible users a personal budget from April 2015, embedding the personalisation of care services into the legal framework for adult social care. The Care Act 2014 applies to the whole of England only. There are separate Laws about social care in Wales, Scotland and Northern Ireland. (https://www.disabilityrightsuk.org/personal-budgetsthe-right-social-care-support)
How the model/practice/procedure does not fall under the EU public procurement scope	Services purchased under direct payment arrangements (i.e. when the personal budget is given directly to the person or to his/her carer who administers the money) do not go through the regular commissioning (public procurement) process. In these circumstances, providers need to do business directly with service users. When the personal budget is managed by the local authority, the purchase of the service can still be carried out by the local authority, so something like a conventional commissioning relationship with a provider continues.
Practical implementation	With the implementation of the Care Act, there is a duty upon councils to produce a care and support plan and offer a personal budget following an assessment to ensure that disabled people and carers' needs are adequately met. For the first time in law, local authorities have a legal obligation to offer personal budgets and conduct a care and support planning that were previously stated only in guidance as part of the Personalization agenda. This is an important change in the personalizing care and support process as it enables people to have maximum and full control over how their needs are met. A personal budget is defined in the Act as having three parts: 1. overall cost to the local authority of meeting the person's needs (i.e. the eligible needs it is legally required to meet or the needs it decides to meet) 2. charge payable by the person (after he/she has had a financial assessment using a means test) 3. net amount the local authority must pay to meet the person's needs.
Barriers to its implementation	Users with personal budgets in the form of direct payments generally use them to employ personal assistants. They therefore need support to be an employer, to manage aspects such as salaries, pensions, sick pay and even the possibility of having to take disciplinary action against their employees. Without support to do this, some users will be reluctant to take on the responsibilities of a direct payment. A survey carried out in 2012 (the Community Care's 2012 annual personalisation survey[13]) found out that the implementation of personal budgets has been affected by excessive bureaucracy. 82% of social care professionals

[13] https://www.communitycare.co.uk/the-state-of-personalisation-2012/

	said there was more bureaucracy in their role as a result of personalisation. Explanations put forward include long and complex assessment forms and the need for personal budget support plans to be signed off by council panels, rather than social workers themselves. The following barriers have been found in Manthorpe et al.: - lack of clarity as to how the self-directed support interacts with other welfare services; - a lot of the processes and procedures were under-developed, leading to uncertainty; - staff were concerned about their job security and continuing role in the light of change; - fear that self-directed support may worsen working conditions for social workers; - some feel that the administrative burden is too great; - users do not always want the responsibility of managing their own money or services; - employing personal assistants is not simple; - employing family members is not always best; - rules and legal procedures may not be clear and may change, causing confusion; - what happens a pilot scheme may not be sustainable.
Enablers/ facilitating factors in their implementation	Skills for Care, a body funded by the Department of Health, provides practical tools and support to help develop the adult social care workforce. A good practice guidance for people employing personal assistants is also available. The following enables/facilitators have been named in Manthorpe et al.: - agreement on policy helps to clarify what is permitted and what the new system is intended to bring about (managing expectations); - action plans to translate aspirations into working practices; - clear procedures to reassure staff about employer's aims - training and skills development are needed so that practitioners can be better equipped in the new system and explain it to others; - information on self-directed support needs to be accessible and widely available; - comprehensive support for carers and users can help when they are thinking about change and what might be needed over time; - employing family members is welcome by some; - brokers and advocates, independent of local authorities, can help; - plans to deal with emergencies; - inspirational leadership and champions of self-directed support can help with start-up; - a steering group helps spread the load and enables messages about good practice and knowledge.
Advantages/ benefits of the model	When implemented well, personal budgets allow users to try new ways to meet their social care needs, give them more choice and control over the care they receive and give them the opportunity to achieve the outcomes they want from their care.

	In the study *An international comparison of care for people with intellectual disabilities* (2018[14]), according to some experts, the personalisation of care and support in the form of personal budgets is a morally and ethically good idea. Personal budgets give people the freedom to choose how and when they receive care and support. Personal budgets enable informal networks to provide support. That could be parents who help their intellectually disabled child, but also a classmate who supports his or her peer with learning disabilities to get on the bus to school.
Disadvantages/ drawbacks of the model	There are also lots of criticism and risks around implementing personal budget schemes. The most obvious challenge is that more vulnerable users, and those who lack mental capacity, will find it more difficult to take control of their care. They are less likely to be able to make good decisions on their own about how best to meet their care needs. In the study An international comparison of care for people with intellectual disabilities (2018), English an Flemish interviewees doubt whether people with intellectual disabilities or their networks are capable of managing their resources adequately, and feel that this may be beyond their competence. In addition to this, yet in more advanced countries like the UK, the government has not gathered enough evidence yet on what are the best ways to personalise care services to maximise the benefits to users. This is why UK report "Personal Budgets on Social Care" recommends for the central government to set up a robust system to monitor personal budget schemes. Also, the bureaucracy associated with personal budgets was cited as a drawback by experts in the 2018 study.
Evaluation: results/success /achievements	A number of studies have shown significant benefits for service users from personal budgets and direct payments: – A 2010 report by charity In Control found that 68% of service users said that their lives had improved since they started using a personal budget (Community Care). – The 2011 National Personal Budget Survey[15] of 2,000 users and carers in England found that personal budgets were generally likely to have positive effects, with most users saying they had seen improvements in 10 out of 14 outcome areas from using personal budgets. – As of March 2012, 53% of ongoing users of community services in England were on personal budgets – some 432,000 people – were using personal budgets, according to the Association of Directors of Adult Social Services' annual survey of councils (Community Care 2007). – In 2014–15, local authorities spent around £6.3 billion on long-term social care for users in the community, including around 500,000 users whose social care services were paid for through personal budgets. – The National Personal Budget Survey found that outcomes were better where service users were informed about the value of their personal budget, fully involved in the support planning process, alongside family

15 https://www.thinklocalactpersonal.org.uk/News/National-Personal-Budget-Survey-of-service-users-and-carers-released-by-Think-Local-Act-Personal/

	carers, relatively free of constraints and bureaucracy, and where they had a direct payment rather than a council-managed personal budget. (Community Care). – Skills for Care conducted research in 2014 that found that not all local authorities are providing adequate support to users who employ personal assistants. – 80% of 4,000 users responding to a survey in 2014 reported that personal budgets made a significant difference to the quality of their care and the quality of their lives (Public Accounts Committee Oral evidence, 2016). – Research by the Charity Scope found that the mechanism of a personal budget was the biggest factor enabling users to have more choice and control over their care services. Personal budgets under the form of direct payments work very well for younger adults with disabilities who are keen to live full and independent lives and have the capacity to take control of their lives. More vulnerable users, and those who lack mental capacity, will find it more difficult to take control of their care. They are less likely to be able to make the good decisions on their own about how best to meet their care needs. When assessing users' needs and planning their care, local authorities and providers, in conjunction with the user and their family, should be satisfied that the form of personal budget is appropriate to the user's circumstances. Older people have proved much more likely than younger disabled adults to take their budget in council-managed form, rather than as a direct payment. Figures for 2011-12 from the Health and Social Care Information showed that 85% of older personal budget users had an entirely council-managed budget, compared with 54% of younger disabled adults. Take-up of personal budgets has also traditionally been lower among people with mental health problems, and there are longstanding concerns that not enough has been done to make personal budgets work for older people, people with mental health problems and those with the most complex needs; these issues have been raised in a number of reports (Community Care 2007). In the study *An international comparison of care for people with intellectual disabilities* (2018), English (and Flemish) interviewees doubt whether all people with intellectual disabilities or their networks are capable of managing their resources adequately, and feel that this may be beyond their competence.
Further information	Bibliography and other resources, in references (Broome, 2019; Community Care, 2007, 2012; House of Commons, 2016; House of Commons & Committee of Public Accounts, 2017; Manthorpe et al., 2011; Think local, act personal, 2011; Woittiez, 2012)

6. PERSONAL ASSISTANCE BUDGETS & PERSONAL BUDGETS IN FLANDERS (BELGIUM)

Name of the model /practice /procedure	**PERSONAL ASSISTANCE BUDGETS & PERSONAL BUDGETS**
Country	**FLANDERS (BELGIUM)**
Model/practice/procedure coverage	□ National ✓ □ Regional □ Local – Municipalities
Beneficiaries (target group)	□ Older people ✓ □ People with disabilities (adults) □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) ✓ □ Informal caregivers ✓ □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	Personal Asssitance Budgets (PAB): from 2000 untill 2016 Personal Budgets (PB): Since 01/01/2017
Is it still working?	PAB □Yes x □ No PB x □Yes □ No
Services involved	Care and support services needed by disabled people
Description	Before 2017, the person with disabilities (or their representatives) received a budget and the budget holder decided who worked as an assistant, for which assignments, at what time, where and how the assistance would take place. Since 2017 all adults who received services *in natura* received a personal budget. The personal budget is a personalised annual sum which can be used by people with a disability to purchase care and support from within their own network, volunteers, individual companions, professional carers and VAPH-accredited care providers. The personal budget is for adults who require intensive or frequent disability-specific support as a result of their disability.
Legal framework	Flemish regional legislation. In 2000, the Flemish Parliament approved the decree for personal assistance budgets (PAB). Before that date, back in 1987, some Flemish pioneers with a disability founded *Independent Living Flanders* (ILV). ILV raises awareness for people, associations and policymakers of the abilities of individuals with disabilities and the need for personal assistance. In 1997 for the first

	time in Flanders, an experiment started with the Personal assistance budget. 15 Flemish people with disabilities participated. The experiment was extended and reached 50 persons with disabilities. There was a growing political interest in this new phenomenon of people with disabilities organizing their own assistance. Since January 2017 all adults with a disability who were supported by a social service provider financed by the Flanders Agency for People with a Handicap (VAPH) or did have a personal assistant budgets received a personal budget. Since then, every new demand for support is now translated into a personal budget. The transition to the personal budget system in Flanders has been possible thanks to the collaboration among the main stakeholders (user representatives of people with disabilities; umbrella organisations of the social service providers and the government) who believed in the benefits of the system and collaborated together in its development.
How the model/practice/procedure does not fall under the EU public procurement scope	Personal assistance budgets and Personal budgets are not considered as procurement, as the public body is not the buyer of care. It is the budget holder who chooses and organises his/her own care.
Practical implementation	PABs were administrated by the Flemish Agency for People with Disability (VAPH) and funded by the Flemish Government Ministry for Welfare. All people less than 65 years old with a disability (any type of disability) had a 'theoretical' right to it. In reality, the number of budget holders was limited by the available amount of money that was allocated yearly for PAB and there were many people in waiting lists. Nowadays, in order to obtain a personal budget, it is necessary to follow a rather long, complex request or application procedure/process: 1.The first step is to make a support plan. The applicant has to describe his/her actual situation, what are his/her needs and what do he/she wants to achieve with a personal budget, what are the possibilities of other resources of support, and what is the demand for disability specific support. 2.When the government approves the person's support plan they can go to a recognised multidisciplinary team who will determine the 'weight of care' and the intensity of support, using a support tool. 3.Based on the services asked for by the person (day activities, living in a residential living group, assistance at home, guidance…) and the score obtained in the support tool that measures the 'weight of care', the government calculates the person's personal budget. 4.Since the financial resources assigned to a personal budget are limited, people will be asked to indicate the urgency of their demand and a 'priority committee' will define their priority (there are three priority groups: very urgent, urgent, less urgent). 5.Once the personal budget has been assigned, the person has to choose between different options: – Cash budget: the person gets the budget on a specific bank account and he/she buys the needed support (people are not obliged to rely upon licensed/accredited by the government. They

	can recruit their own personal assistants, or even rely upon other initiatives). They can also use the cash budget to get support from a subsidised service provider. If this is the case, the person has to justify the use of your personal budget to a government agency. – Voucher system: to get support, people have to rely upon a licensed/accredited subsidised service provider (SSP). People will negotiate with the SSP about the support they want, and this will be translated into an individual service agreement. Then the SSP registers this agreement in a registration system of the government and the SSP will get the money directly from the government. With this system the person is not responsible for the administrative burden/stress. – A combination of the two options: cash budget and voucher. The amount of the personal budget varies between 10.000 and 85.000 euros. The person with disabilities can get support from 'assistance organisations' to manage his/her budget.
Barriers to its implementation	The request/application for a personal budget and also managing the budget require certain skills/competences from the PwD. For instance example, they need to have a good insight of their needs; they must know what they want to achieve and they must translate this into the demand that will be adequate for them. In addition, they will have to negotiate with professionals about their support. When the PwD does not have these skills, then they have to rely on a strong social, familial network (which increases the dependence). To increase and improve these skills, good information and communication is very important and a necessary condition. It is necessary to have enough information, knowledge of the system if you want it to use it in an efficient way. General communication (website, information brochures, information session) is necessary but it has to be more targeted, aligned with the diversity of the group of PwD. The new system needs a kind of "mental/cultural switch/change". People has to learn to deal with new concepts and how to use them ("You can change a structure, but it takes more years to change a culture"). Not only people, but also service providers need to adapt to this new situation. There are organisations who can adapt very well to the new context and who can succeed in profiling themselves in the new market as a dynamic, attractive and professional organisations but there are also organisations who have difficulties in adjusting to this new context. They experience difficulties in the more "client-oriented" approach that is necessary. Traditional social service providers are rather reluctant, reserved about those new initiatives. The risk is, what can be called 'delay support'. Due to the complexity of the system, the novelty and the lack of understanding, PwD might hesitate to start the application process and they cannot get the support they need. Or once they have the personal budget, they do not know what to do with it, how to manage it, leading to a situation where they do not get the appropriate support.

	PwD can ask for support from an 'assistance organisation' to help them manage their budget. However, only 20 % make use of this. One reason is that they have to pay for it from their personal budget. Another barrier has to do with enough budget. There are now 24.179 PwD who have a personal budget in Flanders, but there are about 14.607 persons who are in the waiting-list. Thus, more resources are needed.
Disadvantages/ drawbacks of the model	In the study *An international comparison of care for people with intellectual disabilities* (2018), Flemish (and English) interviewees doubt whether people with intellectual disabilities or their networks are capable of managing their resources adequately, and feel that this may be beyond their competence. This study also mentions that that the system of personal budgets has been promoted by disabled people themselves for some time, but mostly by people with a physical disability, and typically not by people with intellectual disability. The question may be asked as to whether people with intellectual disability or their networks are always capable of managing their resources adequately.
Evaluation: results/success /achievements	An experiment supported by scientific research was carried out in Flanders before fully introducing the system. A comparison was made between two groups: people who got a personal budget and people who got support by a SSP ('care in kind' or "care in natura" directly subsided by the government). The scientific study showed that: •90% of the persons with disabilities (PwD) wo had a personal budget were satisfied with the possibilities of participation they have in the management/organisation of their support. 65-70 % of the PwD who relied on 'care in natura' were satisfied with the participation in the management of their support. •Both groups were equally satisfied with the support they received. When looking into who is most satisfied, then: 35-40 % of the persons with a budget and 15-20 % of the people of 'care in natura'. PwD were not dissatisfied with the old system. But with the system of personal budgets they increased the satisfaction: they got a 'supplement'. •Results also showed that when a person got a personal budget the general score wellbeing increased. Thus, it could be concluded that the system is oncoming the expectations concerning more possibilities of choice, more impact on the organisation of their support and improved general wellbeing. However, these results might be biased since the PwD who participated in the experiment did it voluntarily. There was a large group (mostly people with cognitive disabilities), which withdrew from the experiment.
Further information	Bart Sabbe bart.sabbe@dominiek-savio.be Dominieksavio. Flanders (Belgium) Diane Serneels (diane.serneels@vlaamswelzijnsverbond.be) Vlaamswelzijnsverbond. Flanders (Belgium) Kurt Asselman, VAPH Kurt.asselman@vaph.be

	ENIL PA Table – Belgium – 1/3/2013 Bibliography and other resources, in references (Beule, 2016; VAPH Flemish Agency for People with a Disability, n.d.; Woittiez, 2012; Zero Project, n.d.-a)

7. SELF DIRECTED SUPPORT IN SCOTLAND (UK)

Name of the model /practice /procedure	**SELF DIRECTED SUPPORT (PERSONAL BUDGET)**
Country	**SCOTLAND (UK)**
Model/practice/procedure coverage	□ National □ Regional ✓ □ Local
Beneficiaries (target group)	✓ □ Older people ✓ □ People with disabilities ✓ □ Children ✓ □ Excluded and disadvantaged groups, please specify: All categories of persons in need of social assistance. Self-directed social care applies to all user groups and age groups. □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) ✓ □ Informal caregivers ✓ □ Formal caregivers ✓ □ NGOs, associations □ Others: _____
Year of establishment	**2014**
Is it still working?	✓ □Yes □ No
Services involved	All social and care services needed by the person. Support ranges from assistance with everyday tasks such as dressing and preparing meals to helping individuals live fulfilling lives at home, at work and in their families and communities.

Description	Self-directed Support is Scotland's mainstream approach to social care. Self-Directed Support (SDS) puts the person at the centre of the support planning process. It enables people, carers and families to make informed choices about what their social care support is and how it is delivered. Since the 2014 Act it is the legal way in which all social care must be delivered. What Self-directed Support does is ensure that people who are eligible for support are given the choice and control over how their individual budget is arranged and delivered to meet their agreed health and social care outcomes. Local authorities have a legal duty to offer people eligible for social care four options on how to use their personal budget. (1) A Direct Payment (a cash payment); (2) An Individual Service Fund (a budget held by the local authority and allocated to a provider of the person's choice); (3) tThe local authority arranges support on the person's behalf; (4) A mix of these options for different types of support.
Legal framework	**The Social Care (Self-Directed Support) Scotland Act 2014 (SDS Act)** provides for individual choice over care and support. This legislation applies to all categories of persons in need of social assistance, including those with a disability, and carers.
How the model/practice/procedure does not fall under the EU public procurement scope	Services purchased under direct payments (i.e. when the personal budget is given directly to the person or to his/her carer who administers the money) do not go through the regular commissioning (public procurement) process. Direct payments mean that choice, control and responsibility pass to the supported person.
Practical implementation	The SDS Act specifies four statutory principles to help achieve the underlying aims or 'spirit' of the legislation. They apply to the initial assessment of need and to the provision of choice in order to meet those needs. The four principles are: 1. Participation and dignity: the supported person should have the same freedom, choice, dignity and control as other citizens at home, at work and in the community. 2. Involvement: the supported person must have as much involvement as he/she wishes in both the assessment and in the provision of support associated with that assessment. 3. Informed choice: the supported person must be provided with any assistance that is reasonably required to enable him or her to express views about the options available to them and to make an informed choice about their options for support. 4. Collaboration: the professional must collaborate with the supported person in relation to the assessment of the person's needs and in the provision of support or services to the person. The intention is that these four statutory principles will ensure a human-rights-based approach to the assessment, support planning and

	support provision process, which in turn will improve outcomes and lead to person-centred and outcome-centred service delivery. After a local authority has identified a person's needs – in collaboration with the adult, child/family or carer – it is required to offer the four options mentioned above in relation to the relevant support identified at the assessment stage. In case of people who do not meet local eligibility criteria, councils have to inform individuals about where else they can find help, for example voluntary groups and charities, or the local community. The persons are assessed financially (means tested) to see whether they should contribute some money to help pay for the service. As SDS gives people more choices about their support and more control over how they use their budget, more people are likely to choose a combination of different services and support. They may purchase services from more than one provider, choose services not regulated by the Care Inspectorate (e.g., personal assistants or cleaning agencies), and use their budgets more creatively to purchase support other than existing services.
Barriers to its implementation	In a review of what helps and hinders the move to self-directed support and individualisation, Manthorpe et al. completed a systematic search of the literature examining the issues in the UK as a whole and then applied some of this knowledge to what was happening in Scotland at the time. They found the following barriers: - Lack of clarity as to how the self-directed support interacts with other welfare services; - A lot of the processes and procedures were under-developed, leading to uncertainty; - Staff were concerned about their job security and continuing role in the light of change; - Fear that self-directed support may worsen working conditions for social workers; - some feel that the administrative burden is too great; - users do not always want the responsibility of managing their own money or services; - employing personal assistants is not simple; - employing family members is not always best; - rules and legal procedures may not be clear and may change, causing confusion; - what happens a pilot scheme may not be sustainable.
Enablers/facilitating factors in their implementation	People in need of care can contact their local support organisations, which can help with a range of issues, such as general employment practice, payroll or peer support. The following enables/facilitators have been cited by Manthorpe et al.: - Agreement on policy helps to clarify what is permitted and what the new system is intended to bring about (managing expectations); - Action plans to translate aspirations into working practices; - Clear procedures to reassure staff about employer's aims - Training and skills development are needed so that practitioners can be better equipped in the new system and explain it to others;

	• Information on self-directed support needs to be accessible and widely available; • Comprehensive support for carers and users can help when they are thinking about change and what might be needed over time; • Employing family members is welcome by some; • Brokers and advocates, independent of local authorities, can help; • Plans to deal with emergencies; • Inspirational leadership and champions of self-directed support can help with start-up; • A steering group helps spread the load and enables messages about good practice and knowledge.
Advantages/benefits of the model	Self-directed support offers the person a lot of flexibility, but managing it is also a responsibility. An important part of SDS is that a person can take on as much or as little responsibility they want depending on the options they choose.
Disadvantages/ drawbacks of the model	Local councils should ensure that they have the right balance of services in their area to meet people's social care needs. To do this, they should develop a strategy that sets out the services people are likely to need in the future and where there are gaps in current services. If councils do not have clear strategies and do not work closely with providers, they risk leaving gaps in the services available. This risk is higher in rural or remote areas where there may already be a lack of choice or a shortage of some types of services. The risk is also greater for specialised types of services that relatively few people need. Evidence from case studies and third sector organisations shows that people with mental health problems may experience less choice and control over the way they receive social care services. Mental health conditions can fluctuate over time and more flexible approaches are therefore needed in order to provide the right support at the right time. With careful planning, SDS should be flexible enough to meet an individual's changing needs.
Evaluation: results/success /achievements	The "Self-directed support 2017 progress report" prepared by Audit Scotland highlights the following key facts of the SDS in 2015/16: – Amount committed by Scottish Government to support SDS implementation: Almost £70 million – Amount spent by social work services: £3.4 billion – Number of people choosing an SDS option (estimated): At least 53,000 – Number of adults who received non-residential support from social work services: Almost 208,000 – Number of children and their families supported by social work services: Over 17,000 The Progress Report also states that despite many examples of positive progress SDS has not yet been fully implemented in Scotland. Key messages: – Although most people rate their social care services highly (the national Health and Care Experience Survey 2015/16 found that 81% of people receiving formal social care services rated their overall help, care or support services as either excellent or good. Two-thirds of

	people felt they had a choice over how their social care was arranged) and there are many examples of people being supported in new and effective ways through SDS, however, not everyone is getting the choice and control envisaged in the SDS strategy. This includes people with mental health problems, who often need more flexible support. There can be good reasons for lack of choice, including protection from harm or limited options in rural or remote locations, but some people feel they have been denied the opportunity to access more effective ways to improve their quality of life. – People using social care services and their carers need better information and help to understand SDS and make their choices. More reliable data is needed on the number of people choosing each of the SDS options. – Social work staff are positive about the principles of personalisation and SDS but a significant minority lack understanding or confidence about focusing on people's outcomes, or do not feel they have the power to make decisions with people about their support. – Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services. Within this context, changes to the types of services available have been slow and authorities' approaches to commissioning can have the effect of restricting how much choice and control people may have. In particular, the choices people have under option 2 are very different from one area to another. Authorities' commissioning plans do not set out clearly how they will make decisions about changing services and re-allocating budgets in response to people's choices. – There are tensions for service providers between offering flexible services and making extra demands on their staff. At the same time, there are already challenges in recruiting and retaining social care staff across the country owing to low wages, antisocial hours and difficult working conditions.
Further information	About SDS: info@sdsscotland.org.uk. Tel. 0131 475 2623 Scottish Government https://www.gov.scot/publications/self-directed-support-implementation-study-2018-report-1-sds-change-map/ About SDS https://www.sdsscotland.org.uk/wp-content/uploads/2019/09/SDS-Factsheet.pdf My Support My Choice research https://www.sdsscotland.org.uk/mysupportmychoice/ Organizations offering support and information to people to manage their SDS: http://www.sdsscotland.org.uk Bibliography and other resources, in references: (Audit Scotland, 2017; Cunningham & Nickson, 2012; Manthorpe et al., 2011; Pike et al., 2016) CCPS enablers and barriers, in references: (Providers & Personalisation (P&P), 2016, 2018)

8. THE VOUCHER SYSTEM IN FINLAND

Name of the model /practice /procedure	**VOUCHER SYSTEM**
Country	**FINLAND**
Model/practice/procedure coverage	□ National □ Regional ✓ □ Local – Municipality level
Beneficiaries (target group)	✓ □ Older people ✓ □ People with disabilities ✓ □ Children □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) □ Informal caregivers □ Formal caregivers □ NGOs, associations □ Others: _____
Year of establishment	**2009**
Is it still working?	✓ □Yes □ No
Services involved	All social and health services, excluding emergency and involuntary services, such as involuntary placements in child protection and mental health care. There are vouchers for services for people with disabilities, for example the City of Helsinki offers several service vouchers for the disabled: – Service voucher for the statutory vacations for support for informal carers – Service voucher of sheltered housing, according to the Disabled Services Act – Service voucher for personal assistance, according to the Disabled Services Act Only for-profit and non-profit private producers can produce services for the voucher users.
Description	A municipality or a municipal federation may use service vouchers in organising social and healthcare services, which are provided by the private sector and approved by the municipality. Service vouchers can be used to complement and support municipal services for the good of the residents and for increasing their freedom of choice. The service

	voucher enables clients to choose a provider from a list of approved providers to meet their care and support needs. A service voucher system was introduced in the beginning of the 2000s in the field of services for the elderly. The legislation has enabled the use of service vouchers for certain municipal services since 2004. Since 2009 the municipalities have been entitled to offer service vouchers for all the social and health services that they are in charge of, with the exception of urgent and involuntary treatment. By law, in Finland, people in need of care have the right to individual needs assessment and the right to receive a decision or plan for care and services based on that assessment. The national legislation determines the principles of public care services. The municipalities finance the services to a significant extent, arrangethem and organize needs assessment processes as public elder care in Finland is needs-tested but not means-tested. The municipality finances the voucher partly or fully. There is wide variation in the intensity and extent of care between municipalities. The municipalities are free to decide whether they want to introduce the voucher system; for which services they are to be offered; what is the value of the voucher; and to whom the voucher is offered. In Finland being eligible for municipal services does not make a citizen eligible for a voucher and a free choice. The responsibility for access to services remains on the municipal authorities as they are in charge of allocating the vouchers, financing part of the voucher and providing information on the available service providers. Also, the municipalities resolve the criteria for approving private service providers as service voucher producers. Three different approaches of using and understanding service vouchers in care services for older people have been identified: 1. Some municipalities have set offering the possibility of making choices as their priority. In these municipalities the value of the voucher is income-related and thus a realistic option for the clients with low incomes who would otherwise not have the financial resources for choosing a private service instead of using a public one. 2. The voucher may be used as a tool to pursue the economic and productional interests of the municipality. The voucher is only given to those clients who can pay a larger part of their services out of pocket than they would if they were using public services. 3. The vouchers for care services may be a tool for individualization and personalization in some of the municipalities. In these cases, the voucher is only offered to those clients who have the financial resources, ability and cognitive capacity to make choices regarding the care services they need.
Legal framework	The service voucher is based on a national act: the Act on Health and Social Service Vouchers (Laki sosiaali- ja terveydenhuollon palvelusetelistä 569/2009), which was passed in 2009. A municipality or a municipal federation may use service vouchers in organising social and healthcare services, which are provided by the private sector and approved by the municipality. Service vouchers can

	be used to complement and support municipal services for the good of the residents and for increasing their freedom of choice.
How the model/practice/procedure does not fall under the EU public procurement scope	The main difference between outsourcing and service voucher system is that in the former case it is the local authority that arranges the competition between different providers, whereas in the latter case it is the service user who makes the decision between different service providers. Vouchers fall outside the scope of application because it is the citizen/patient/customer that actually chooses the service provider. The idea is: if the contracting authority has no room for discretion, this discretion does not have to be subject to rules on procurement. Certain government contracts are not subject to Directive 2014/24/EU. This applies when a public government does not exclusively award public contracts, but rather publishes an authorization scheme to conclude contracts with every supplier (in this case care provider) that meets suitability criteria and that accepts the terms and conditions of the contract. In Finland this manner of contracting is known as the service voucher system, which is regulated in national legislation (Commissioning of Social Services, 2019). The Finnish municipality does not have a formal public contract with the care provider, rather the client using the voucher is in a formal consumer relationship with their care provider of choice. Thus, the contract is between the consumer of the service and the provider, and the Consumer Protection Act (38/1978) is applied in case of contractual disagreements.
Practical implementation	The municipality sets, in a rulebook, the criteria for the care providers and the service that have to be met. Rulebooks determine the legal relationships between the municipality, the service provider and the customer. Rulebooks are currently available in a number of areas (e.g. rulebooks for primary health care, for specialised care, for orthopaedic, for eye diseases, for oral health, for rehabilitation, for services for the elderly, for disability services, for day care). The municipality must approve all providers that apply to become voucher providers and meet the standards set in the rulebook. By signing up, the contractors verify that they meet the criteria and agree to deliver the service as per the standards set. The municipality establishes the value of the voucher, which can depend on a client's income, or can be fixed as the same for all clients. In each case the provider can set the price of the service as they wish and the client must pay the difference. When using service vouchers, the municipality does not have a contract with the providers. The municipality has the right to unanimously alter the criteria in the rulebook, and if the provider does not accept, they must resign. The contract is between the consumer of the service and the provider, and the Consumer Protection Act (38/1978) is applied in case of contractual disagreements.
Barriers to its implementation	In the case of vouchers for elderly home care, a care manager carries out an estimation of needs and decides what kind of help and assistance the elderly will receive. Based on this estimation, a client may be offered a voucher or referred to publicly provided care. Municipalities may thus

	restrict the voucher's use. As a result, the proportion of services delivered through a service voucher has remained low. (Commissioning of Social Services, 2019).
Advantages/benefits of the model	The Voucher system aims to improve efficiency in delivery of services by competition on the supply-side and choice on the demand-side. Instead of service users citizens are defined as consumers. At the same time, however, the control stays at least to a certain extent with the public body that allocates the vouchers. Thus, the voucher system represents a mixture of consumer-centered ideas, promotion of market-based welfare services and public control. The Act on Voucher System in Social and Health Care System 2009/569 stated as aims of the voucher: improving quality through competition, improve the availability of services, boosting employment, and giving smaller companies an opportunity to participate in service production The service voucher offers a new way of choosing and using social and healthcare services. The customer may choose the service provider based on his or her own preferences and needs. The objective is to increase the customer's freedom of choice, improve the availability of services, diversify service production and promote cooperation between municipalities, business services and private service providers. (Sitra's website)
Disadvantages/drawbacks of the model	The features and legal boundaries of voucher in Finland have enabled creating a voucher system with many preconditions and restrictions. Even if choice is considered as the most relevant goal of the voucher, there are still many obstacles for the elderly customer to receive it and use it. The individual's personal resources, incomes and cognitive capabilities play an essential role. E.g. since the voucher usually implies that the user has to pay part of the service from his/her pocket, if the person has a difficult financial situation, public officials in charge of offering vouchers to customers would not offer them to that person. Thus, the financial situation of the person, the cognitive capability to choose, willingness to choose and the simplicity of the service in question are considered as decisive factors when deciding whether the voucher is offered. Evaluating the individual's situation and capability to receive and use voucher is part of the voucher legislation. Whether the users of elderly care services have a chance to choose a voucher or not, is defined at the local level of municipalities. In addition, individual public officials have a lot of power in deciding to whom the voucher is offered.
Evaluation: results/success /achievements	Based on the results carried out by a study involving 27 expert interviews of municipal civil servants managing eldercare services (Karsio, Van Aerschot), the authors concluded that the Finnish voucher system might seem arbitrary and unpredictable from citizens' perspective, because the aims of the voucher vary. Varying local approaches to the voucher result most likely in different kind of choice practices and thus in varying markets.

Further information	• Bibliography and other resources, in references: (Anttonen & Karsio, 2017; Karsio & Aerschot, 2017; Kindl & Hubkova, 2014; Uenk, 2019) • SITRA's website: https://www.sitra.fi/en/topics/service-voucher/#what-is-it-about • City of Helsinki: https://www.hel.fi/sote/en/services/service-voucher/

9. SOCIAL IMPACT BOND IN ENGLAND (UK)

Name of the model /practice /procedure	**SOCIAL IMPACT BOND**
Country	**ENGLAND (UK)**
Model/practice/procedure coverage	□ National □ Regional ✓ □ Local
Beneficiaries (target group)	□ Older people □ People with disabilities ✓ □ Children (11-19 year olds with special educational needs) □ Excluded and disadvantaged groups, please specify: _____ □ Other: _____
Stakeholders involved	✓ □ Public administration ✓ □ Private service providers (for-profit, non-for-profit) □ Informal caregivers □ Formal caregivers □ NGOs, associations ✓ □ Others: Investor: Bridges Social Impact Bond Fund
Year of establishment	**2017**
Is it still working?	✓ □Yes □ No
Services involved	Special educational services for children with disability
Description	In the **UK,** children with special educational needs and disability are entitled to free transport if they are unable to walk to school - usually via private buses, minivans or taxis. Whilst for many young people this is the best option for some, with the right support and training, they could be trained to travel independently. Acquiring a greater level of independence can have a huge and lasting impact on quality of life as children build valuable social skills and confidence. It also has positive benefits for their families, who can manage their affairs more flexibly. And it is also a positive outcome for local authorities, whose costs have been estimated at £6,000 for each child every year, equating to about £500m every year across the UK.
Legal framework	Legal framework that allows the establishment of contractual relationships between the local authority and the investor, in which the local authority pays the investor back the principal plus a rate of return only if specific results are achieved *(paying-for-results contracting).* There are several possible contract structures.

How the model/practice/procedure does not fall under the EU public procurement scope	Under the SIB model, a payer for results, usually a local authority agrees to pay investors if specific measurable results previously agreed upon are achieved. Thus the contractual relationship is between the local authority and the investor. Typically, investors in social impact bonds include those interested in more than just a financial return, such as philanthropists and grant-making trusts, who are prepared to accept a lower financial return or greater risk in order to generate a social benefit. In this SIB, there are two payers for results: the Lambeth Council and the Big Lottery Commissioning Better Outcomes Fund who will pay the investors (the Bridges Social Impact Bond Fund) if specific results are achieved (see practical implementation) by the service provider HCT Group (a social enterprise).
Practical implementation	In this SIB, the HCT Group, a social enterprise bus operator, provides specialist travel training that gives young people the skills and confidence to travel independently on public transport. When a young person has completed the training and is travelling safely and independently, they will be signed off as able to travel independently. Young people will be monitored over 12 months to ensure travel independence is sustained. A first payment is made when a young person is first signed off as able to travel independently, a second is made if travel independence is maintained for one school term, and a third if travel independence is maintained for a full year.
Barriers to its implementation	SIBs can not be applied in all situations. They should only be applied under certain conditions: 1. Preventative intervention – The intervention is preventive in nature and sufficient funding for the intervention is currently unavailable; 2. Improves wellbeing in an area of high social need – The intervention improves social wellbeing and prevents or ameliorates a poor outcome; 3. Evidence of efficacy - The intervention is supported by evidence of its efficacy and impact, giving funders confidence in the scheme's likely success; 4. Measurable impact – Whether it is possible to measure the impact of the intervention accurately enough to give all parties confidence of the intervention's effect, including a sufficiently large sample size, appropriate timescales and impacts that closely related to the savings and relatively easy to measure; 5. Aligns incentives - A specific government stakeholder achieves savings or lower costs as a result of actions undertaken by others. These savings need to be cash releasing and provide an actual saving to government stakeholders; 6. Savings greater than costs - The savings for the specific government stakeholder are relatively immediate and much greater than the cost of the intervention and transaction costs. This provides investors with enough return to absorb the risks inherent in the scheme, and can provide significant funds for social investment; and

	7. Government preference for a SIB - Government is keen on or at least open to the use of a SIB. In addition, the following must be taken into account: *Political and legal conditions* should be taken into consideration. Political commitment and support for the services provided are crucial for fulfilling SIBs mission. Legal conditions are also very important as they may equally enable or hinder the development and implementation of a SIB. *Cultural barriers*: In certain European countries, SIBs have encountered resistance, finding the sentiment that the type of social issues targeted should be the domain of the state and that a private investment model has no role to play, or that it is inappropriate for investors to receive a return on investment from financing the delivery of social outcomes.
Enablers/facilitating factors in their implementation	If the model is aligned to the national culture and the social economy of a country it will be easier to implement.
Advantages/benefits of the model	– The risk is transferred to the investor – Up-front capital is available – There is room for innovation, new ways of doing things, flexibility – Results/performance are measured
Disadvantages/drawbacks of the model	– SIBs are not easy to manage – They are a relatively new instrument. Not much knowledge and experience on how to implement them – There are transaction/management costs associated to the SIB – Requires commitment and collaboration from all stakeholders involved (public authority, investor, service provider, intermediaries…) – Requires a new mindset to social service provision
Evaluation: results/success /achievements	For this specific SIB evaluation is not available yet.
Further information	Robert Pollock (Robert.pollock@socialfinance.org.uk) Susan MacDonald (susan.mcdonald@socialfinance.org.uk) • Social Finance UK https://www.socialfinance.org.uk/ • Social Finance Database: https://sibdatabase.socialfinance.org.uk/ • GoLab-Oxford: https://golab.bsg.ox.ac.uk/knowledge-bank/resources/sib-template-contract/ • Bridges Ventures: http://bridgesventures.com/portfoliolist/hct-group-independent-travel-training/ • Travel Training: http://www.travel-training.org/

Further considerations on alternative funding models

The following paragraphs present some interesting insights and opinons gathered from the experts interviewed on funding models different from public procurement that are currently applied in their regions/countries.

In the **Basque Country (Spain)**, the instruments most widely used for the provision of social services are the **Collaboration Agreements** ("Convenios"), a modality of reserved contracts between the public administration and the third sector (non-profit organizations). These agreements have to comply with several requisites that are stated in the Basque Law of Social Services of 2008. The 2015 Decree ("Decreto de Cartera de Prestaciones y Servicios del sistema vasco de Servicios Sociales") contains the list of all the social services and the requisites service providers have to comply with. Collaboration agreements are simple, easy to manage and to implement, and are renewed every 1 or 2 years. They ensure continuity and stability. They also ensure a fair price for the social service. The agreement model (and the upcoming "Decreto de Concierto"[16]) is seen as a good instrument and the third sector ogranizations as the right partners to provide social services based on quality and service personalization, allowing people to make choices.

In **Flanders (Belgium),** there is a reserved market for services provided to children with disabilities. Licensed not for profit organizations provide mobile, day care and residential care services. They provide tailored care according to the need of the child and the family. They can combine mobile guidance at home, ambulant sessions, daycare and residential care according the needs. For example, 5 days a week day care, 2 nights stay in the group home and two hours a week mobile training at home. These organisations are called "multifunctional centres". The advantage is the flexibility and the possibility to give really quality tailored care. Around 11.000 children are being served by multifunctional services in Flanders. Although the system works very well, the budget is not enough (the government

[16] Currently, work is being carried out on a new collaboration regulation between the third sector entities and the public administration for the provision of social services ("Decreto de Concierto", which is outside public procurement law).

does not give enough licences and means to organisations) and around 2.300 children are on a waiting list.

In **Styria (Austria),** services for people with disabilities are provided through the **voucher system.** It was put in place 15 years ago and it allows people to choose the service provider they prefer. An example of a service provided through vouchers is mobile services for early intervention for families. The families apply to the public authority and if, after a evaluation, a specific service is the right support, then the family gets a voucher. The family chooses the service provider to support them and the service provider invoices the public authority. The voucher has full coverage in early intervention (support to families and small kids up to 6 years old) and it covers an amount of hours per year in the support for family relief. The system is perceived to work well although there is an excess demand. A drawback of the system is the assessment of needs. Since the organization in charge of carrying out the needs assessment is an association owned by the public authorities, in some cases the real needs may not be properly reflected (underestimated).

Summary and conclusions

The views of experts regarding the use and effectiveness of **PUBLIC PROCUREMENT** as an instrument for procuring social services revealed that:

- ✓ Public procurement has been seen positively in some cases, especially in countries (Central/Eastern Europe) with limited resources and low budget destinated to social services and where public authorities are not always fully transparent in how they fund the provision of social care and support. In these cases, public procurement guarantees transparency and offers the possibility to cover the entire costs of social services.
- ✓ Concerns arise by the way public procurement is evaluated and commissioned, which is usually based on the cheapest price rather on than the quality of the service. In this context, public procurement is not perceived as the right instrument to procure

social services since the focus is on price and this will jeopardize the quality of the services provided.

- ✓ Public procurement could work if the focus was on quality, social criteria (specially users' needs) were reinforced and if budgets available were increased. However, in practice, using quality criteria is perceived as a complex task. Likewise, with this procedure it is also very difficult to take into account users' wishes.
- ✓ Public procurement has not been implemented according to the **UN CRPD** because there is very little evidence of it respecting the users' rights, in particular the right to choice for disabled persons. Although in theory it would be possible to adapt the procurement procedures to make public procurement more in line with the UN CRPD (there are ways that allow contracting authorities to take into account the needs of the users; for example, it is legally possible for the public authority to involve users in the evaluation of offers), in practice, however, public authorities are not taking advantage of these posibilities as they are perceived as complex tasks for which public procurers do not have the required skills. Likewise, instead of focusing on specifying the type of services, public procurement allows to focus on the outcomes/results. Specifying outcomes is not a new element; it is an available option which has not been sufficiently used by public authories. In practice, most municipalities look for the economic part of the services and highlight in detail the services they want to provide in the tender, not giving space for providers to personalise the services to end-users' wishes.
- ✓ Moreover, in practice, public procurement is a quite expensive procedure that implies many working hours to prepare the related documentation by both, the public administration and the service providers. This high administrative burden for providers at the application stage also impacts on the extinction of small companies that do not have the staff or the resources to prepare the required documentation. Thus, the application procedure of public procurement is seen as a time-consuming procedure that requires staff skills and involves considerable management costs.
- ✓ A major concern was related to problems with continuous changes of staff. Personnel changes, as a result of continuous tendering, have tremendous effects on users. This

is especially true for people with severe disabilities, where there is a very close, trust-based relationship between the user and the caregiver that usually takes time to consolidate.

- ✓ Some experts are aware about the **advantages of the public procurement** as a model that guarantees the principles of competition, publicity, transparency and non-discrimination; and are also conscious of the flexibility allowed for the provision of social services. In relation to **competition**, it depends on the country environment. In some cases, where the size of the region or municipality where public procurement is applied is small, there is no room for more than one provider. In other regions, for-profit and international providers have pushed non-for-profit organisations out of the market. Concerns are raised regarding the role of for-**profit organisations. The** financial return that these organisations expect has a negative impact on the quality of the services provided. Although it may lower the costs on the short-term, there is evidence that it increases the costs over a period of time when the market is covered by a limited number of for-profit multinationals, the so-called "too big to fail" issue. In addition, competition among organisations has also a negative impact on the working conditions of the staff (care professionals). At a time of staff shortages and major challenges in recruitment and retention, public authorities must ensure that any funding model they use includes workforce development as part of their funding strategies.
- ✓ Last but not least, public procurement, as it is being currently implemented, does not foster **innovation** as public authorities know exactly what they want and do not listen to the innovative ideas of organisations, without even taking into account improvements in cost-effectiveness. Most municipalities are reluctant to innovation because they are focused on the economic part of the services (price) and for that reason provide a very detailed description of the services they want to be provided in the tender. Moreover, amounts are calculated by **standard costs** for each service category and this does not reflect the real cost of the services. Consequently, the quality is again affected, and small companies cannot access to provide the services with the quality desired with the stipulated prices. It also makes that public

procurement is also not seen as an effective model because "...*it favours very big organisations and threatens the quality*"

In sum, it could be said that, although in theory, public procurement and the EU Directive leave a considerable degree of freedom to public authorities to choose how to contract social services, this has not been translated into practice in reality. Most public authorities across Europe still follow the "traditional"/strict procedures based on prioritizing price rather than quality criteria and using detailed specifications instead of specifying the outcomes. Prioritizing price as the main selection criteria has inevitable consequences on the quality of the service and on the staff and their working conditions. Specifiying the service to the detail impedes innovation and generates standardized services as opposed to personalized services. Since the voice of users is not often taken into account, current public procurement procedures are not in line with UN CRPD since they are not taking into account users' rights, in particular the right to choose for disabled persons.

Lack of skilled staff together with risk-adversion and lack of political support make it difficult for contracting authorities to try new ways of doing things. Dealing with complexity and endowing staff with the necessary skills and instruments is a long-term objective that requires a change in strategy at national level. Member states need to develop strategies that allow people to do their job taking into account the complexity around the system. It is therefore important for public authorities to consider funding models which may be better suited to achieving their objectives and implementing their social policy objectives.

ALTERNATIVE MODELS to public procurement are in place across Europe in social care service provision. The majority of the models found fall within the "reserved contracts" and "user-centred models" categories.

1. Reserved Markets

✓ Reserved contracts can be considered as the "classical"/traditional model for social service provision across Europe. They allow for stable and long-term cooperation between public authorities and service providers, which in most cases are not-for-profit. By engaging in a partnership with the provider, reserved markets can help to ensure that services are more tailor made and more flexible to meet local needs. In

addition, co-production can also be used in the context of reserved markets far more easily than in public procurement. They also allow for continuity of the service with users, something which is very important, especially in the provision of services to people with mental disabilities. Reserved contracts usually lead to a collaborative/partnership-based relationship which provides financial stability to the service provider and avoids to have to regularly compete for new funding. In the Salzburg region in Austria, for instance, reserved contracts are the preferred instrument to fund housing and work-related services for persons with disabilities and early childhood intervention. This model is deemed to be very stable especially regarding planning and funding reliability and a high level of continuity for all stakeholders. Advantages in comparison to public procurement procedures are the focus on quality, simpler application procedures for service providers, long-term cooperation based on repeated contracts.

- ✓ Open-house models are a specific type of reserved contracts which work as an admission system in which care providers can get contracted if they meet the requirements set by the public authorities. This scheme is being used in the Netherlands where municipalities impose criteria with respect to quality and suitability, and each care provider that meets these criteria is admitted to a framework agreement. In the region of Twente, in the Netherlands, support services for young people are being contracted through this model whereby the public body chooses to contract with any and all interested service providers using pre-defined conditions, instead of contracting with only one or a limited number of providers. The Open House Model has been excluded from the scope of classical procurement law and thus, there is no tendering duty of open house contracts. One of the advantages of this model is that, since the municipalities establish the tariffs beforehand (there are national regulations which standardize the price-per-hour for every case), market forces emerge between the care providers. However, since municipalities determine the care and support for the user, therefore setting the boundaries in which the users can choose their care provider, this generally decreases the power of the user.

2. Personal Budgets

- ✓ Most of the alternative models identified by the research team within the area of user-centred models take the form of **personal budgets**. Sweden, The Netherlands, UK (England and Scotland), and the region of Flanders in Belgium have established personal budget systems in their legislation. Personal budgets do not fall under the EU public procurement scope since the municipality/public body is not -directly- the buyer of care services. It is the budget holder who chooses and organises his/her own care. In personal budgets, choice, control and responsibility are transferred to the supported person.
- ✓ When implemented well, personal budgets allow users to try new ways to meet their social care needs, give them more choice and control over the care they receive and give them the opportunity to achieve the outcomes they want from their care. Personal budgets favour a more user-driven system and allow users more freedom to purchase the care they need. They also enable members of informal networks to provide support. Personal budgets are seen as a way to empower persons with disabilities to have more freedom, citizenship and access to their human rights, in line with UN CRPD. Satisfaction, well-being, and quality of life are constant positive outcomes that have emerged from evaluations of personal budgets. Personal budgets increase users' control, power, and autonomy and they also -in principle- increase competition between providers, thus increasing efficiency.
- ✓ It should also be noted that whilst the availability of choice should be a positive thing, the exercise of choice can lead to apprehension and worry in some individuals. Although choice would suggest a greater availability of services, however, the proliferation of services does not necessarily mean an increase in quality. Put in other words, even though personal budget users have gained a stronger voice, the problem is that the quality of care is not only a matter of choice but it is also heavily dependent on the qualities of the caregivers.
- ✓ Although personal budgets may be seen as the future model for the funding of social services they might not be suitable in all cases, as some may prefer other models such as Reserved Markets for the funding of their care and support. Personal budgets have worked well in the field of social services for persons with physical disabilities,

whereas for people with intellectual disabilities it might be more challenging. In the study An international comparison of care for people with intellectual disabilities (2018), Flemish and English interviewees pose the question of whether people with intellectual disabilities or their networks are capable of managing their resources adequately, and feel that, in some cases, this may be beyond their competence. As a reasonably new funding model, more work is needed to ensure that personal budgets can also work for persons with intellectual disabilities; if that is their choice.

- ✓ Regarding personal budgets and staff, there is the fear that personal budgets may worsen working conditions for social workers.This has been reported for England as well as for Scotland, where the *"Self-directed support 2017 progress report"* cited the existence of tensions for service providers between offering flexible services and making extra demands on their staff. Also challenges in recruiting and retaining social care staff owing to low wages, antisocial hours and difficult working conditions have been reported.
- ✓ Other difficulties or disadvantages of personal budgets have to do with the management of the budget, which requires certain skills/competences from the users (people with disabilities). For instance, they need to have a good insight of their needs and must know what they want. They will also have to negotiate with professionals about their support. When people with disabilities do not have these skills, then they will have to rely on a strong, social, familial network (which increases the dependence). Support systems are in place in most countries through 'assistance organisations' to help users manage their budget. In some cases (Flanders) few people use it as they have to pay for it from their personal budget. Assistance and support are of paramount importance when personal budget holders use their budget to employ personal assistants. In this case, they need support to be an employer, to manage aspects such as salaries, pensions, sick pay and even the possibility of having to take disciplinary action against their employees. Without support, some users will be reluctant to take on responsibilities.
- ✓ In some countries (e.g. UK) the implementation of personal budgets has been affected by excessive bureaucracy and there are also many hidden transaction costs

at the start-up. Enough financial resources are needed to implement a personal budget system.

- ✓ The implementation of personal budgets needs a "mental/cultural switch/change". People has to learn to deal with new concepts and how to use them *("You can change a structure, but it takes more years to change a culture").* Not only users, but also service providers need to adapt to this new situation. There are organisations that can adapt very well to the new context and that can succeed in profiling themselves in the new market as a dynamic, attractive and professional organisations but there are also organisations that might have difficulties in adjusting to the new context. As mentioned in the EASPD report "How to Fund Quality Care and Support Services: 7 key elements": "(...) the success of personal budgets relies on strong commitments, including financial, the development of monitoring and enforcement mechanisms to ensure quality, and a willingness for all stakeholders to engage creatively with one another and to respect each other's roles and responsibilities within the new system".

3. Private Investment

The need to find out new ways of handling the growing demand for social services in a situation characterised by austerity calls for attracting private investments. New financing credit lines, public-private partnerships (especially under the form of project financing) and Social Impact Bonds, are examples of private investment models that can help public authorities meet their social policy objectives. However, most of these instruments work on a project-based fashion; i.e. they are limited to finance single specific/ ad hoc projects (e.g. social infrastructure projects, innovative projects) rather than the basic provision of day-to-day care and support services. In addition, they involve multiple stakeholders and therefore, in order to be successful, it is necessary that the public authorities, the social service providers, and the funding community (investors) are open to new ways of working based on collaboration and pro-active approaches.

To finalize, the following paragraphs describe some important elements that a funding model of service provision for people with disabilities should look to ensure. During the interviews,

the research team gathered the experts' suggestions on important elements/characteristics that funding models should take into account, which are the following:

- **Community-based**
- **Person-centred:**
    - it must respond to the persons/users' needs and provide special attention to persons with disabilities and other groups in need of protection so they can be fully integrated into the social life and in the labour market;
    - it should allow users to choose and control if they wish, but also, for some specific groups or functions, it should allow that the public administration directly contracts the service;
    - it should be flexible to respond to changing users' needs in the long term;
    - it should provide easy and friendly information to the end-users and corresponding accompanying/support measures when needed.
- **Long-term**: it should guarantee the commitment of long-term provision of care through service providers with roots in the community.
- **Equal and accessible**: it must fully guarantee the benefits of the model to all people, regardless of their economic capacity and needs.
- **Efficient**: it should include instruments to prevent misusing the public and personal budget or prevent financial wasting.
- **Optimised value for money**: resources should be exploited in order to respond users' wishes and need and to avoid waiting lists.
- **Open to innovation**: flexible to be adapted to users' needs and market opportunities and give room for innovation in service provision.
- **Quality and trust**: it should guarantee the quality of the service beyond the price with a balance of control from the public administration and freedom for service providers to tailor their services to users' needs. There is here a common concern about the participation of for-profit organisations in delivering quality services; it is important to ensure that the price does not prevail over the quality of the service.
- **Integrated**: all the steps of the system should work together (sound need analysis, proper budget allocation, skilled staff from public administrations, decision makers

and service providers). In addition, the ideal model should also offer a "global plan" which includes all the domains that are important for the person with a disability.

- **Transparent**: the process should allow social service providers to participate on an equal footing, with the same information and avoiding excessive bureaucracy.

In relation to the person-centred characteristics mentioned in the first place, funding models should analyse the real needs of end-users from the ground, co-production the services with end-users and sharing this information with decision makers.

Funding models should be implemented together with **professionalisation and sensibility** plans for civil servants or the persons in charge to implement it. They need specific training on the rights and needs of persons with disabilities.

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Annex: Template for the interviews

Research on alternatives to Public Procurement in Social Care

As part of its Annual Work Programme 2019 - (Re)connect: EU4you, EASPD is carrying out research to produce a report on **"Alternatives to Public Procurement in Social Care"**. The report will provide an overview of how local and regional authorities fund the provision of social care with means alternative to public procurement. The European Commission re-affirm that "Public Authorities are entirely free to choose whether to outsource the provision of services or whether to provide them themselves or by means other than public procurement". Yet, Social Service providers and Public Authorities often re-affirm that this is not the case in practice and that the latter often feel obliged to use EU public procurement rules. Thus, the report will look at clarifying the alternatives to public procurement in social care across Europe.

The research will be implemented in different phases, which include **a qualitative research to identify perspectives and practices on the use of public procurement in social care** and **a**n overview of the **alternatives to public procurement through interviews with experts from different EU countries covering different welfare and care provision models and schemes**.

The following questions are part of the above-mentioned qualitative research. The questions are divided in three sections, with an introductory part with some basic concepts to take into consideration.

Firstly, we will ask you s**ome demographic and background related questions to help us describe the sample of experts interviewed**. Secondly, we will ask you a couple of **general questions related to the provision of care and support services in your region/country**. These general questions can be answered in written and sent it by email. They will not be asked during the interview not to take time to the core questions. Thirdly, we will focus on the **key elements of the research**; i.e. a battery of **open questions related to funding models for care and support services in general and for people with disabilities in particular.**

Thank you for accepting to participate as an expert in this study. Your personal data will be anonymized and only used for the purpose of the mentioned research, following EU regulation for personal data protection. In order to facilitate the

transcriptions, interviews will be recorded. Should you not wish your interview to be recorded, please let us know. You will have the opportunity to revise your answers at any time and/or give up the study by asking mferrando@kveloce.com to do so.

If interested, you will be informed about the updates and key results within this study.

Brief introduction to the research concepts

Funding Models in the provision of social and care services

Four main funding models have dominated the scene across Europe in the last decade:

1. Reserved markets
2. Public Procurement
3. Personal budgets
4. Private investment

It should be taken into account that there are differences between these models across the EU countries. At the same time, a Public Authority can use different models for funding different types of care and support services.

Reserved markets. By reserved markets, EASPD means a system where public authorities can reserve access to specific public markets for organisations responding to certain characteristics (for instance, not-for-profit entities). Organised differently across Europe, this is a common model for the funding of not-for-profit social services.

Public Procurement is the way through which public authorities purchase goods, works and services, including the provision of social care and support services. This model has grown in influence the last decade as public authorities have looked at ways to better manage more limited budgets, as well as due to the influence of EU legislation in this field.

Personal budgets. By Personal budgets EASPD means an amount of funding which is allocated to an individual by a state body so that the individual can make their own arrangements to meet specified support needs. This innovative model is growing in popularity as it allows persons with support needs to have more control over how they wish to receive their support

Private investment is the investment made by players other than conventional public sector bodies into social services. Although not used for the funding of the day-to-day service provision, private investment (especially loans) is playing an increasingly larger role to finance social infrastructure investments, as well as to explore new ways to finance innovative social projects. Private investment can include mechanisms such as capital or equity investment, public private partnerships, social impact bonds and payment-by-results contracts; in other words, instruments where investors finance

projects in the social services sector but require a financial return on their investment or at least to expect to break-even.

The UN Convention on the Rights of Persons with Disabilities (UN CRPD)

The Convention on the Rights of Persons with Disabilities and its Optional Protocol[17] (A/RES/61/106) was adopted on 13 December 2006 at the United Nations Headquarters in New York. It is the first comprehensive human rights treaty of the 21st century and is the first human rights convention to be open for signature by regional integration organizations. The Convention entered into force on 3 May 2008.

The Convention follows decades of work by the United Nations to change attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.

The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.

Now ratified by the EU and all of its Member States, the UN Convention on the Rights of Persons with Disabilities (UN CRPD) is a game-changer for social service providers and all those involved. The UN CRPD requires a paradigm shift in the way in which many care and support services are provided: away from a segregating medical model towards community-based services which enable the full inclusion of all. This is also the same vision provided by Europe's new social compass, the European Pillar of Social Rights, which calls for enabling forms of services, for more homecare and community-based services and much more. There is now little doubt as to how social services should be developed.

[17] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

The European Pillar of Social Rights

The proclamation of the European Pillar of Social Rights[18] (EPSR) represented a decisive step towards reinforced upward convergence between Member States by putting fair and well-functioning labour markets and social protection systems at the heart of a more Social Europe. Putting social services at the centre of its implementation stage is needed to fulfil such a promise.

Implementing the Pillar in a holistic manner, in line with a person-centred approach to service needs, will make the most of the synergies and complementarities that can be established between different types of interventions and principles enshrined in it. To this aim, implementation should be based on the provision of quality services supported by adequate funding and underpinned by innovative design and implementation that maximize the positive transformative power of social interventions.

Semi-structured interview to identify perspectives on the use of Public Procurement in Social Care

Section 1. Sociodemographic data of the interviewee

This data will be used in aggregated manner for statistical purposes, your name and contact details will be not public.

1.0 Name of the interviewee

_____

1.1 Gender

□ Women □ Men □ Not answer

1.2 Could you please let me know your region, country?

_____

1.3 And your nationality?

_____

1.4 What is your affiliation?

[18] https://docs.wixstatic.com/ugd/9f45fc_0607b2737f5f4b039c9dc25ae0329c32.pdf

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1.5 What is your area of work/position?

_____

1.6 How old are you?

_____

1.7 Which is your professional and/or education background?

_____

Section 2. (a). Care and support services in your region/country – General questions

You can answer to these questions in written and send them by mail.

2.1. Can you briefly explain how care and support services are covered/paid in your country (public expenditures, private coverage, insurance schemes, others?

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2.2. Can you briefly mention which actors are involved in providing care and support services in your country (national government, region, municipality, private sector, NGOs, etc)?

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Section 2. (b). Care and support services in your region/country – Research-specific questions

2.3. Which models to fund social and care services are currently used in your country/region?

- Reserved markets (Yes/No)
- Public procurement (Yes/No)
- Personal budgets (Yes/No)
- Private investment (Yes/No)
- Others, please specify (Yes/No)

_____

2.4 Out of them which one is currently the most used in your region/country?

2.5. Can you explain each of the models you have ticked in the previous question in terms of:

- How do they operate, both legally and in practical implementation
- Legal/practical barriers in their implementation
- Legal/practical enablers in their implementation
- Advantages/benefits of the model
- Disadvantages/drawbacks of the model
- Evaluation and its results
- Personal opinion/perception

2.6 What is your opinion/perception about each model?

We are particularly interested in knowing your opinion regarding the use and adequacy of these models in the provision of social and care services, especially of public procurement.

In your opinion public procurement:

- is an effective instrument for procuring social services, why?
- is an effective instrument in the development of community based and person-centred care services in line with UN CRPD, why?
- has fostered competition amongst suppliers, why?
- provides equal opportunities for any type of organization to compete for contracts, why?
- any other issues you deem interesting

You can also provide **examples** to illustrate your answers

2.7. In your opinion, in order to improve the provision of care and social services in terms of quality, community-based orientation and tailored to individual needs, which one would you recommend? Please explain your answer

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2.8 According to your expertise and opinion, what are the characteristics/features that an "ideal model" for care and social service provision should have?

Section 3. Care and support services in your region/country for people with disabilities

3.1 Which of the models above is used to provide social and care services por persons with disabilities?

- Reserved markets (Yes/No)
- Public procurement (Yes/No)
- Personal budgets (Yes/No)
- Private investment (Yes/No)
- Others, please specify (Yes/No)

3.2. For those whose answer is <u>not</u>, could they be somehow adapted to serve the needs of persons with disabilities? Please explain the specificities/modifications that would be needed.

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3.3 In your opinion, which model work better when dealing with services for persons with disabilities? Why?

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Thank- you for your collaboration!

EASPD

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EUROPEAN ASSOCIATION OF SERVICE PROVIDERS FOR PERSONS WITH DISABILITIES

EASPD is the European Association of Service providers for Persons with Disabilities. We are a European not-for-profit organisation representing over 17,000 social services and disability organisations across Europe. The main objective of EASPD is to promote equal opportunities for people with disabilities through effective and high-quality service systems.

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