Social Public Services: Quality of Working Life and Quality of Service – Overview of developments in Ireland, Sweden, the Netherlands, Luxembourg and Portugal

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Summary

This report gives an overview of the key changes and policy innovations that are taking place in the social public services in Ireland, Luxembourg, the Netherlands, Portugal and Sweden. It focuses particularly on the restructuring of social public services in the light of the growing demands, evolving risks and the multi-faceted needs associated with social exclusion and evaluates the impact of these changes on the quality of services and the quality of working life. The role of these shifting policy discourses are examined in relation to three client groups who face high levels social exclusion and for whom services are being reoriented in the light of a growing recognition that the needs and risks associated with dependency, social exclusion and disadvantage. They are dependent elderly people, disadvantaged young unemployed people and people with learning disabilities and mental illnesses.

Of importance to the study is the evaluation of mechanisms to improve the co-ordination and integration of services at national and local levels, the role of partnerships in policy formulation, the identification of needs, user-empowerment strategies and the shifting organisational and funding regimes leading towards new service provision. The report examines a number of examples of good practice and makes recommendations about the future development of social public services across Europe particularly as they relate to the quality of services and the quality of working life. The report is divided into three sections.

Section one shows that the restructuring of social public services in the five countries studied has led to a number of key areas of convergence in policy. Despite vastly differing regimes of policy, organisation, funding, family and household structures, and varying levels of state intervention a number of commonalities can be identified in a trend towards service restructuring and reform.

- First, is the growing awareness of the need for co-ordinated and integrated responses to tackling social exclusion that has resulted in national anti-poverty policy frameworks or strategies in all five countries. Some of these have greater local applicability than others this has resulted in different levels and types of state intervention.
- Second, is the movement towards more user empowerment strategies and a greater attempt to identify user needs in a climate of the priority to promote independence and autonomy, and therefore reduce welfare dependency.
- Third, the recognition of the particular, complex and multi-faceted needs associated with the most extreme forms of disadvantage has led the greater targeting of resources towards hitherto hidden problems and disadvantages. This has resulted in the reorganisation of state policies that focus on decentralisation and de-institutionalisation in order to target resources where they are most needed at local and community levels.
- Fourth, overriding these are new claims to services resulting from the active involvement of users, their advocates and families, and voluntary and community organisations who are asserting a new politics of articulation shaped in active, subjective and reflexive user identities.
- Fifth, this has put major pressures on unresponsive, bureaucratic and professional run services towards more citizen friendly and accessible services. The result is that all five countries have or are embarking on major reforms of public administration.
- Sixth, is a growing trend towards a mixed economy of provision, much greater contracting out of services to private and semi-public agencies, and a growth of provision in
the social economy where a growing level of provision is provided directly by community and voluntary organisations. Along with the need to provide more citizen friendly services has been the need to ensure that the quality of services in the increasingly diversified mixity of provision is not only improved but also made relevant to user needs and priorities. The result is that all five countries have, to differing degrees, been instigating major quality improvement initiatives, ranging form quality standards set at the national level to locally developed quality standards developed in partnership with providers and users of services. These developments have led to a greater level of service innovation and experimentation with new models of delivery. Central to these has been the shift to services that are locally based, responsive to a variety of different and increasingly complex needs, and which are resulting in projects and strategies to integrate and co-ordinate service provision in ways that are appropriate to local people and local communities.

Finally, and of crucial importance is that these developments have led to new employment practices, changing employment patterns, changes in work organisation and new thinking about how work can be organised in the climate of restructuring. Moreover, this has coincided with the need to ensure that working conditions also relate to the needs of women and families and accord with equal opportunities. At its worst the restructuring of services has led to a greater intensity of work, low staff morale, poorer working conditions, negative forms of flexibility and increasing pressures at work. At its best service restructuring has brought with it new opportunities to restructure work, new forms of partnerships between workers and managers, new concepts of learning organisations and lifelong learning, and positive forms of flexibility and equal opportunities that improve not only the quality of work, but link this to developing quality services.

In section two the restructuring of services to meet the needs of the three client groups are examined in more detail. It is in the care sector that the greatest mixity of services is in evidence as all five countries attempt to provide local community based responses to care. This has led to innovations and reforms that aim to decentralise resources, resource voluntary organisations and informal carers and empower users. The objective is to enable dependent elderly people, people with learning disabilities and people with mental illnesses to remain in their own homes or local communities for as long as possible. In some cases this had led to the identification of unmet and new needs in others it is to ensure that the care provided meets the needs of users within a climate of cost-containment.

In particular, this has led to a number of new innovations in providing integrated local services and a greater degree of user choice and independence. For young disadvantaged people there is also a growing recognition that traditional vocational services are inappropriate and ineffective in tackling multiple forms of disadvantage. This has resulted in a shift in policy towards the most disadvantaged young people, for example, to new strategies to tackle early school leaving and educational disadvantage amongst young people, or to tackle criminality and drug abuse and thereby support the integration and reintegration of young people into work and society. This section also shows that the integration of services and development of meaningful quality frameworks are an important route to meeting these multiple needs.

In section three seven examples of good practice are documented. These show, to varying degrees and in different contexts, the importance of integrated and co-ordinated responses to improved service delivery need and the meeting of unmet need. They reflect a range of examples from each of the five countries and each of the three client groups studied. It is clear
that these examples provide some interesting models of good practice that can be further explored at the European level. The examples outline issues related the quality of service, the participation of users and workers, the resourcing of the initiatives, the quality of work and the possibilities for the wider dissemination of the good practice.

In section four, the report draws on some key conclusions, lessons to be drawn from some of the examples of good practice and innovation in the different countries and recommendations for the development of social public services across Europe.

• First, these relate to the implications of restructuring on working conditions, working time, work organisation, and equal opportunities in a climate of ensuring the effective management of change. A number of recommendations are made regarding trade union and employer policies as restructuring brings both into new relationships with each other and with clients and users of services.
• Second, it is recommended that user empowerment strategies are further developed and more systematic ways of identifying user needs be introduced.
• Third, improved monitoring and evaluation of services improvements is recommended, particularly to ensure that service improvements are relevant to both providers and users of services.
• Fourth, a greater resourcing of partnership working is recommended in order to ensure that partnerships are truly representative of all stakeholders, particularly those from the voluntary and community sectors.
• Fifth, a number of recommendations are made for improving integrated and co-ordinated service delivery at local levels and for mainstreaming successful pilots, experiments and innovations.
• Sixth, a number of recommendations are made about making quality improvements meaningful and practical, particularly in ensuring that these are developed in a framework of participation.
• Finally, a number of important recommendations are made for the resourcing of restructuring, integration and partnership working methods.
Section 1: Introduction – The role of social public services

1.1 The structure, organisation and funding of social public services

For historical, political and cultural reasons, social public services have evolved differently across Europe. The Netherlands and Luxembourg have developed welfare systems based on a relationship between fulfilling social needs and merit/work performance, funded from employer and employee contributions to social or national insurance schemes and some direct taxation. The Swedish model has developed from a principle of the individual as part of a social collective, whereby universal services and the entry of women into the labour market became the mechanism for fulfilling social needs, financed through direct taxation. Although this model is based on production and financing by the public sector and institutionalised welfare, the recent trend has been towards more private sector solutions in social security systems and the introduction of market orientated services and contracted out care and welfare services. Finally, Portugal and to a lesser extent Ireland, developed rudimentary welfare systems based largely on family and voluntary systems of support. These countries are characterised by increased levels of state intervention in recent years. Appendix 1 provides an overview of the structure, organisation, funding and development of social public services in each country.

1.2 The key social and economic challenges in the social public services

In all five countries profound changes are taking place regarding the modernisation and restructuring of welfare services leading to new relationships between welfare and work, and between the state and the citizen. Whilst the organisation, delivery, and access to social public services across the five countries differ significantly, there is increased convergence of these systems typified by similar social and economic challenges facing the social public services. First, there are a number of common problems such as long term unemployment, growing levels of social expenditure on health care and social security systems (particularly in a climate of fiscal and budgetary consolidation), the ageing of the population, and growing evidence of multi-faceted needs and risks associated with social exclusion. This has led to new sets of challenges, strategies to promote social inclusion, and social and economic reforms in all five countries. Second, this is a response to the growing European and international debate about public service restructuring and the increased role played by international organisations like the EU, WHO and OECD, and of networks of users, NGOs, service providers and professionals across Europe. (These main priorities and challenges are summarised in Table 1). They have required new thinking and innovations about how work can be organised and how public services can be delivered in order to improve the quality of services and respond to user needs. In summary these include:

- Growing demands on services and a greater articulation of user needs
- Greater user involvement in services, including shifting provision away from client orientated dependency towards active user involvement and citizen empowerment
- A pattern of cost containment and cost cutting measures, particularly as the five countries studied had also been preparing their economies and budgets for EMU
- Greater use of marketisation in delivering services and the move towards a mixed economy of provision and improving public finances
- The introduction of quality initiatives linked to improved delivery of services, public service modernisation and new forms of public sector management
Of interest to this study is that these developments are critically linked to the modernisation of social public services. In the countries (Netherlands, Sweden and Luxembourg) which have comprehensive systems of care and social protection plans have been introduced to sustain these systems in the light of growing demands, particularly from ageing populations, alongside measures to reduce levels of welfare dependency. Those countries that have more rudimentary systems (Portugal and to a lesser extent Ireland) have been developing new strategies to promote social inclusion, improve the coverage of social protection and services. All five countries are concerned about tackling income inequality, poverty and social exclusion, developing employment opportunities for the most marginalised groups in society, and reforming social protection and health care systems.

1.2.1 Health care and social protection
The pressure on social protection systems has grown in all countries (Kalisch et al, 1998). This is perhaps the key policy issue shared in common with all five countries and has led to a vigorous debate about how the modernisation of social protection can take place alongside the protection of the most marginalised groups:

Member States’ social protection systems face a series of significant common challenges, for example, the need to adapt to the changing world of work, new family structures and dramatic demographic changes of the forthcoming decades. They must do so while balancing the clearly expressed wishes of citizens for continued high levels of social protection against the requirement that public services should become more efficient and respect budgetary disciplines. (European Commission, 1999:1)

In the health care sector a number of common trends can be identified, including the changing roles of the state and the market in health care, decentralisation to lower levels in the public and private sectors, greater choice for and empowerment of the citizens, and a greater role in public health (WHO, 1996). Equally relevant is the need to integrate health services with primary care and home care as part of a wider health care network (HOPE, 1996). The health care sector in all countries has been the subject of major reforms regarding quality, diversification of provision, marketisation, and improved co-ordination with other services.

1.2.2 Demographic changes and the ageing of the population
An important concern for all countries are demographic changes brought about by ageing populations and growing dependency ratios, and the implications that this has for health services, long term care, social security and pension systems. The restructuring of care services has been the most intense in this respect, with decentralisation to local levels taking place in Sweden and the Netherlands, and a greater diversification of provision taking place in all countries. With growing pressures on care budgets and as demands for better support have been made by users and their carers, most countries have increased the support given to families and informal carers. Personal budgets introduced in the Netherlands in 1996 and dependency insurance introduced in Luxembourg in 1998 are examples of this more user orientated support (see examples of good practice numbers 1 and 2 in chapter 3). Changing family/household relationships, typified by the entry of larger numbers of women in paid work, and a growing awareness of the role of informal carers, are relevant to this discourse. In Portugal, this has led to systems of family support being better resourced.
1.2.3 Developing active labour market measures and reducing welfare dependency

In all countries policy has increasingly led to active measures to integrate people excluded from the labour market into work. This results from a strategy to reduce welfare dependency and has resulted in a reorientation of funding targeted towards the most excluded people. An associated development is the emergence of a new relationship between welfare and work, representing a shift towards a discourse that stresses work incentives and a policy that is focused on employability. In part this is a response to concerns that disincentives to work and high unemployment are closely associated with generous welfare systems in the OECD countries (Haveman, 1996). In addition, the growing costs of welfare reveal the inability of the labour market to provide adequate protection (Heikkilä, 1999; Esping-Andersen, 1996). This shifting policy discourse links competitiveness, flexible labour markets and reduced public expenditure, with welfare restructuring.

This has resulted in measures in Sweden, Ireland, the Netherlands and Luxembourg to target women and disabled people; in Ireland, the Netherlands and Portugal to target early school leavers; and in all countries to integrate people from immigrant and ethnic minority backgrounds into education, training and work. In Sweden, long-standing principles of social solidarity and universalism have been consistent in their fight against social exclusion and the active integration of excluded people into the labour market, through active labour market policies. In Ireland, increasing the employment rate has been a strategic priority linked to measures to encourage more women to enter the labour market and to reduce long-term unemployment, by reforming social protection in order to encourage higher rates of employment.

1.2.4 Social housing

In some countries social housing has become an increasingly important area for development and is the subject of integration strategies in all countries, particularly as the move away from institutionalised care towards care in the community has grown in importance. In addition, tackling social exclusion by improving bad housing has been an important feature of government policy in Portugal and Ireland.

### Social housing in Portugal: tackling social exclusion

In Portugal, the link between poor housing and social exclusion has led to new public housing programmes at the municipal level. High and unregulated rents in urban areas are a particular problem of elderly people living alone and for young unemployed people who are dependent on their families for housing. An important social housing programme has recently been introduced with 80 per cent central government funding and 20 per cent municipality funding for housing refurbishment and new build. It began as an initiative by Lisbon town council and other municipalities have now taken up this model across the country.

Linking the social exclusion of young people to bad housing has resulted in an innovatory project in the inner city of Lisbon. The Ventoso project is a social housing and drug rehabilitation project located in an area of poor quality shanty housing where high rates of criminality and drug abuse have led to extreme forms of social exclusion, particularly amongst young people. The project is funded by Lisbon City Council and was introduced in order to break the association between bad housing, poverty and drug abuse; it led to new social housing and a pact with local residents regarding drug abuse. A health and rehabilitation project works with drug addicts, and health, housing and social services are all located on site in an attempt to tackle social exclusion by coordinating services locally. However, the high prices of land and the limited ownership of land by municipalities means that the social housing schemes have inevitably been limited. The Economic and Social Council has called for new legislation to control the price of land, (which, in Lisbon, remains amongst the highest in Europe) and therefore the availability of social housing.
1.2.5 Budgetary and fiscal consolidation
Of crucial importance to the restructuring of social public services is the impact of budgetary and fiscal consolidation. This has been particularly marked in Sweden where cuts in social programmes, from 1994, were designed to reduce the cycle of budget deficits. By the late 1990s Sweden achieved budgetary equilibrium and the pressure on public finances and the financing of social protection was overcome. Nevertheless, Sweden developed an equitable reconstruction programme to solve its budgetary problems. In contrast, in other countries improved government fiscal revenue has led to increased social expenditure. This is particularly in Ireland and to a lesser extent in Portugal.

1.2.6 The Mixed-Economy of Provision
In all five countries there is a diversification of provision towards a mixed-economy of welfare, marked by a shifting emphasis away from the state towards private, voluntary and informal networks of provision (Johnson, 1998). The restructuring of social public services has, to varying degrees, led to the introduction of market mechanisms and new forms of competition. For example, in the Netherlands, Sweden and Luxembourg care services are increasingly contracted out to private, semi-public or voluntary organisations. The modernisation of Irish services, particularly for the elderly and disabled has led to increased state funding of voluntary sector provision. The growth of the community and voluntary sector as providers of services and as agencies of user representation and empowerment is in evidence in all five countries, particularly Ireland. In Ireland the 1997 Green Paper Supporting Voluntary Activity led to a wide ranging debate about the future development of the sector vis-à-vis the state (Department of Social Welfare/Combat Poverty Agency, 1997).

1.2.7 The renewed debate about the social economy and local employment initiatives
One dimension of the restructuring of social public services towards a mixed economy of provision has been a renewed debate about the social economy and local employment initiatives (European Commission, 1995a, 1995b). The interest in the social economy, as a source of new forms of employment in local communities, has also led to concerns that this rather unregulated and unprotected area of the economy could lead to poorer working conditions than exist in the public sector and a replacement of existing public service provision. The Netherlands and Ireland have a higher proportion of employees in the not-for-profit sector than other European countries.

The SAOL project (see below) is an example of one of many publicly funded community based projects that is responding to acute social needs. The example of good practice Setubal Centre Against Unemployment in Portugal is another example of a community-based response to local need (see chapter 3, example no 5). In Ireland, the debate about the social economy has been set in the context of the growth of community development, often led by women in local communities, as a means of promoting employment “in response to local demand for services which neither the mainstream market nor the public sector could satisfy [and] on its potential to enhance the employment potential of growth and to improve the quality of life in areas and communities experiencing disadvantage” (Partnership 2000 Social Economy Working Group Report, 1998:4).

1 In 1998, 12.64 per cent of Dutch workers and 12.22 per cent of Irish workers worked in the non-profit voluntary sector (compared to the EU average of 6.9 per cent), a large proportion of whom were delivering social public services in schools, hospitals, social service organisations and community organisations (Irish Times, 22.6.99 Report says non-profit areas employ 125,000).
The SAOL project in the north inner city of Dublin

The SAOL project in Dublin’s inner city is an innovative community based drug rehabilitation project that works in partnership with statutory and voluntary agencies. It provides two-year programmes of pre-vocational training, support, confidence building and empowerment to women drug addicts whose addiction is now stabilised through methadone treatment programmes, but whose marginalisation and exclusion from society is acute. The project is located in an area of severe and endemic problems of drug abuse and disadvantage. The project is an essential dimension of the recovery of women in building new social and family relationships, gaining skills and accreditation for learning and participation in their own communities. The project works within a framework of community development and adult education through a structured and participatory learning programme. The community development approach has the objective of building a positive, long-term and cumulative effect on the local community.

The project emerged from the local community as a result of concerns that little or no state provision was available to assist young women in their transition from addiction to full participation in society, whether this be work, education and training, or participation in their local communities (Bowden, 1997). The project began in 1995 with statutory and EU funding and is now completing its second project. Seventeen women completed the first two-year programme and sixteen women have completed the second two-year programme. Outcomes include accreditation for courses at second level and the second programme took women through a third level women’s studies programme. For many women the project offers them a lifeline for their reintegration into society, their local communities and the longer-term objective of finding new opportunities in their lives.

Short term funding has meant that there has been continual uncertainty about the project’s duration and staff contracts have reflected this. As with other community-based projects of this nature employment is based on short-term contracts, with no entitlements to pensions and health insurance. The project has eleven staff (five full-time and five part-time – of whom two part-time staff are peer workers employed from the first SAOL project and one long-term job initiative worker who is separately funded). The project staff are experienced community development workers who are highly committed to their work and to the continuation of the project. However, they experience considerable pressures of work and stress, notably from running a project within a tight budget and with uncertainty about funding.

1.3 Recent national policy initiatives for reform and modernisation of social public services

The OECD defines service integration as the organisation of services delivered to people at local levels that should not result in new programmes superimposing existing programmes, rather “it is a process aimed at developing an integrated framework within which ongoing programmes can be rationalised and enriched to do a better job of making services available within existing commitments and resources” (OECDa, 1996:22). As a result programmes should be developed that coordinate service delivery for the benefit of local people, they should be comprehensive and result in the allocation of resources that are responsive to local needs. The co-ordination and integration of policy is both a top-down and bottom-up issue and has resulted in different national and local strategies and mechanisms in each of the five countries reviewed.

1.3.1 Co-ordination and integration of policy at the national level

The need to co-ordinate and integrate services is recognised as an important policy objective as all five countries seek to improve the quality, flexibility and responsiveness of the social public services to users. To date it is rare to find the full integration all of social public services in any one country, although interesting experiments have been introduced and piloted in all countries. These have led to some important questions about what should be

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2 Partners include the Eastern Health Board, Inner City Renewal Group, FÁS, Soilse, Ana Liffey Project
integrated, at what levels and whether this should take place formally or informally, about the resourcing of the process, and the avoidance of new forms of bureaucracy. National co-ordination and integration strategies in the social public services vary across Europe. The need for co-ordination and integration is now reflected in national policy documents in all five countries and this is increasingly the cornerstone of European discourses and the reform and modernisation of public administrations. (See Table 2 for a summary of the integration of health and social services in Ireland, the Netherlands, Portugal and Sweden).

Of importance to the success of these national strategies is their local applicability. The move away from institutional towards community based care and the recognition of the multifaceted needs and risks associated with social exclusion has led to policy responses that co-ordinate and integrate services at the national level. This has taken place through administrative reorganisation and decentralisation, for instance, in Sweden where integration between health and social services for older people has been in place since 1992. In some countries this has been client-led, for instance, through the introduction of Personal Budgets in the Netherlands.

However, co-ordination and integration has been difficult to achieve in practice because of established professional cultures, gatekeeping within established departmental boundaries, different funding bases and financial regimes, organisational complexities, a move away from crisis orientation in services, and a more diverse mixed economy of provision. Service needs have become increasingly fragmented in a framework of de-institutionalisation. As a result, Room concludes that these barriers “are in some cases not just barriers to co-ordination, but to the very development of social care services” (1997:5). For instance, in Luxembourg disparate ‘conventions’ existed between central government and private organisation, regulating the standards of service, the quality and levels of social services provided by private organisations, with varying levels of government control and supervision. New legislation in 1998 formalised and regulated the relationship between the state and these private organisations in order to better achieve co-ordination.

At national government level developing the base for strategically integrating activities and co-ordinating activities on social exclusion has led to new organisational structures and the improved delivery and quality of services in all five countries. Tackling income inequalities, low income, poverty and social exclusion has become an issue of strategic importance in Ireland, Luxembourg, the Netherlands and Portugal. In Luxembourg, the Government has prioritised activities that tackle exclusion resulting from lack of access to education, training, employment, health, accommodation and income, which includes the provision of a basic income scheme, the Revenu Minimum Garanti.

The Revenu Minimum Garanti (RMG) was introduced in Luxembourg in 1986 for excluded people of working age who are fit for work. It provides a basic guaranteed minimum income, combining social assistance and social support to integrate people into work. RMG includes personal and vocational counselling, budget management and social services support to assist with personal problems. Recipients can either opt for full-time community work or vocational training. A recent review of RMG has led to new measures to increase the range of complementary social activities, and its objectives to reduce poverty have been extended to include a reduction of social exclusion (Kalisch, Aman & Libbie (1998)).

In Portugal, a broad definition is given to social exclusion, with strategies that go beyond poverty to include economic and social citizen’s rights, and entitlements to services. This has been driven by the National Fight Against Poverty (Programa Nacional de lucha contra la
which prioritises the social integration of disadvantaged and excluded groups through employment, educational, housing, social and vocational measures, and a national minimum income (introduced in 1997) in partnership with public and private sectors, and local community groups at local levels. The Dutch anti-poverty strategy The other side of The Netherlands (Ministry of Social Affairs and Employment, 1995) is a preventative approach to combating poverty and social exclusion. Wide consultations and the introduction of monitoring systems have taken place since the publication of the document and this has encouraged public debate, the participation of excluded groups in the policy process, including the trade unions, the National Foundation of Service User Councils and other organisations representing poor and excluded people.

In Ireland a Cabinet Committee on Social Inclusion has been formed to coordinate policy nationally. This is chaired by the Taoiseach and brings together Ministers from eight Government Departments and this has given strategic importance to a number of activities that promote integration and co-ordination at local and national levels. This includes the National Anti-Poverty Strategy, Sharing in Progress: the National Anti-Poverty Strategy 1997-2007, the National Drugs Task Force and the formation of an Inter-Departmental Policy Committee which brings together Government Departments and agencies and the Combat Poverty Agency at an operational level.

The Irish National Anti-Poverty Strategy (NAPS) contains a broad reaching approach to a range of factors that contribute to social exclusion, including educational disadvantage, income adequacy, long term unemployment and urban and rural disadvantage. Concerns about poverty and exclusion has led to the creation of a cross-departmental policy which aims to keep issues of poverty and social exclusion at the forefront of Government policy and activity. The overall aim of the NAPS “Sharing in Progress” is to reduce the numbers of ‘consistently poor people’ from the existing level of 9-15 per cent in 1997 to 5-10 per cent in 2007. The anti-poverty strategy is integrated into government policy through a Cabinet Sub-Committee and is administered through an Inter-Departmental Policy Committee and the Combat Poverty Agency. The strategic aims of the NAPS relate to activities in five key areas: educational disadvantage, with a particular focus on reducing early school leaving; unemployment, with an emphasis on reducing long term unemployment; income adequacy, with an emphasis on providing people with sufficient incomes to move out of poverty; and to reduce the marginalisation of disadvantaged urban areas and the isolation associated with rural poverty. An important aspect of the implementation of the strategy is mechanisms to poverty proof policy.

The National Economic and Social Forum and the Combat Poverty Agency monitor the NAPS. The latter has the responsibility for liaising with the voluntary and community sector, project innovation, research and policy analysis, information and public awareness, and advising government departments.

1.3.2 Co-ordinating and integrating local services
Different forms of local integration are in evidence from the countries studied. They include co-ordinated information and service provision, inter-agency working (including case management), or the co-ordination of services and information in one location. For example, in Sweden, co-operation between health, social security, labour market organisations and employers at local levels has resulted from new active labour market approaches to the vocational rehabilitation of the long-term sick and unemployed. However, Lindqvist (1999) argues that co-operation has been difficult to achieve in practice because of the existence of a “highly sectored welfare model” based on different organisational models, and characterised by a shift towards goal-orientated working and conflicts between sectors. Nevertheless, recent Swedish government policy has emphasised inter-departmental working practices. Linqvist & Grape (1999) argue that local co-operation is crucial to the reform process:

Clients with diffuse and numerous problems are diverse problems are disadvantaged because they do not fit into the “boxes” of welfare bureaucracies…co-operation, when
initiated in local settings and supported by local managers and politicians may be a way to rejuvenate welfare policy (p 10)

The most common form of integration at the local level has been through inter-agency working and co-ordinated case management by inter-disciplinary teams, for instance, in community psychiatric teams, care teams for elderly people, and care management teams for children and young people at risk. Although these frameworks tend to be professionally led, an example of good practice can be found in chapter 3, based on the KrAmi project.

The more innovative and far-reaching integration approaches include those that integrate local communities and NGOs, that move beyond co-operating across disciplinary boundaries to developing systems changes through what Cullen (1997) refers to as “systems partnerships”. Cullen compares different integrative strategies, which range from networking, co-ordination, co-operation and collaboration and concludes that integrated services need to have both national policy support and local-implementing resources built in.

Local integrated service delivery varies across the five countries and its effectiveness is highly dependent upon the extent to which powers and resources are decentralised to local levels. In Ireland and Portugal the integration of social public services at local levels has resulted from a nationally led policy strategy, whilst in Sweden and the Netherlands this has been made possible because of decentralised powers to municipalities. In the Netherlands, poor coordination and duplication of services in local areas led to fragmentation of services in the 1960s and 1970s (Brenton, 1982). However, the modernisation of state services introduced in the 1990s as a result of the Dutch Social Renewal Policy has led to new powers for local government in the social and employment fields. Decentralisation from central government to municipalities has enabled co-ordination of services to take place with greater ease. In Portugal and Ireland, a highly centralised structure of government and limited devolution of resources and power to local levels has hampered local service integration. However, Portuguese municipalities are increasingly adopting innovative local integration strategies. A review of existing legislation is currently taking place with a view to decentralising responsibilities to municipalities to enable them to have the financing and competence to intervene locally. This has already been initiated in projects to develop social housing at municipal level.
The Loures Municipality: co-ordinating services for social inclusion

The Loures municipality in Portugal represents a good example of attempts to integration and co-ordination of services within limited budgets. Loures covers a population of approximately 300,000 people in an area of high levels of social exclusion, typified by low levels of schooling, high levels of school drop outs, low educational achievement for young people, high unemployment, and substandard housing. In addition the municipality is facing new problems associated with poverty, single parenthood, growth of prostitution amongst young women, and drug abuse. The municipality is communist controlled and spans rural and urban areas, and has had an innovative approach to developing co-ordinated municipal services for social excluded people. The view in the municipality is that it is at the local level that social problems are manifest, identified and best tackled. The Religious and Social Affairs Department was created in the municipality in 1997 to co-ordinate services to excluded groups and to work closely with local associations (many of whom operate on a volunteer basis and have few resources) by developing their skills and resources. This began with activities targeted to the ethnic minority community and families who rely on a basic income. Although the municipality has no resources to tackle problems of social exclusion it began its work by identifying excluded groups and the problems that they face.

This new approach to tackling social exclusion in a co-ordinated way has led to the development of services and networks of partnerships with government bodies, local religious and farming associations, employers, trade unions, local job centres, ethnic minority groups and migrant associations, handicapped associations, and elderly associations. One project works with the local immigrant associations to enable them to develop their own skills and to identify needs in their own communities. This teaching of community research skills has been a highly innovative response and works within a framework of inclusion and empowerment of local groups. Other initiatives have led to the involvement of local people in the co-ordination of services for dependent elderly people, young excluded unemployed people and people with learning disabilities and mental health problems.

In Ireland, the development of locally based integrated services has grown in strategic importance in recent years. This has resulted in a local area based approach to tackling poverty through community and local development. This is based on a recognition that from “the multi-dimensional nature of poverty, an integrated approach was required, which involves a partnership between the statutory and voluntary agencies” (Combat Poverty Agency, 1996). This approach has led to a national anti-drugs strategy that is locally delivered and area based partnerships to tackle long-term unemployment and social exclusion.

Towards an integrated drugs strategy in Ireland: connecting national and local strategies

One of the key areas for action in combating social exclusion amongst people in the most deprived areas of the inner city of Dublin, has been creation of structures to tackle drug abuse in a co-ordinated way, by linking national strategy to local activity (Department the Taoiseach, 1997). In 1996 the National Drugs Strategy Team, backed up by formation of the Cabinet Committee on Social Inclusion and Drugs in 1997, created national, regional and local structures to co-ordinate drug policy, based on partnership and inter-agency working, and the direct involvement of local community groups in the development of locally based strategies. It led to the creation of Local Drugs Forces in 1996 based on partnership of the key agencies (statutory and non-statutory) within a framework of inter-agency working. There are considerable variations in the effectiveness of the local drugs forces. The local drugs task force in the north inner city of Dublin works well, particularly because it has a background of inter-agency development which informed the setting up of the task force. However, frustration exists for many of the partners, especially from the community and voluntary sector, about the lack of concrete evaluation and reflection of the activities of the drugs force, in particular how the agencies are working together. Evaluation has been entirely focused at the project level and not on the broader impact of the partnerships. As a result benefits have been slow to be realised, although individual projects have achieved a great deal.
1.3.3 Integrated information and service provision

An important policy innovation has been the local development of one-stop-shops or citizens shops in Portugal, Sweden, the Netherlands and Ireland, to improve co-ordination, information and accessibility of services to citizens. In Sweden, integrated citizens shops have been in operation since 1992, providing a range of municipal, county and state administration services in one centre. This development has been supported through new information technology systems and staff training in new forms of work organisation and skills development (communication from Sara Eriksen, University of Karlskrona, 18.6.99).

In Portugal, providing accessible information has been a major plank of the reform of public administration and has resulted in a wide range of client-orientated initiatives based on user-friendly systems of technology. This has been spearheaded by the Secretariat for Administrative Modernization (SMA), formed in 1986 to improve the quality, simplicity and accessibility of services with an emphasis on client-orientation, improved user-friendly information and public participation (INFOCID, 1999). This has led to the development of information systems to make services accessible to the public, including the innovative Blue Telephone Lines and the citizens information service, INFOCID. The latter is an integrated database run by the Secretariat of State for Administrative Modernization and involves thirty different government ministries. The purpose is to give the public clear and accessible information about citizen’s rights and government services. Information can be accessed via thousands of user-friendly, 24-hour, self-service contact points in pubic places across the country. In addition, multi-media kiosks around the country have been highly successful in allowing for bill payments, printouts of relevant documents and forms and remote access to central files. There are now over 2000 enquiries a month per kiosk and users are asked to provide feedback on the accessibility of the service. The response has been very positive, information is up-to-date and accessible, and the investment in the system has reaped benefits for citizens. The creation of accessible one-stop shops has also been an outcome of this process of modernisation.

The Citizens Shop, Loja do Cidadão, in North Lisbon is a response to the reform and modernisation of public administration underway in Portugal and is rooted in partnerships with public service unions through negotiation. It is a one-stop-citizen-shop which provides 22 different public services under one roof. It is located in a three story state of the art building, opened in March 1999, with services provided in friendly and accessible ways with opening hours at weekends and evenings. All public services, as well as information about local voluntary associations, are located in the citizen’s shop. Other citizen’s shops are planned in Porto and five other cities on a pilot basis. The citizen shop is run as a private enterprise, funded by central government, and space is allocated to the different services on a rental basis. The shop has child care, coffee bars and meeting spaces, as well as information. All government departments, municipal services, information, cultural services, banks, post offices are located there. You can find out about training courses whilst paying your tax or gas bill, get a new passport whilst booking your holiday, have information about social security and health whilst finding out about childcare or elder care services.

In Ireland, the introduction of government gateways has aimed to integrate local authority services at local levels, particularly in rural areas. For example, the Sligo County Council has integrated local authority, local development services and local voluntary organisations under one roof at the Sligo Development Centre. This has had an important impact in co-ordinating local community and development activities, leading to a more integrated approach to local development. In Meath County Council a model IT development initiative has led to integrated IT management systems that enable to the public to access local authority services on-line through the Intranet Information Platform. This has led to training for staff and the location of locally based user-friendly customer service points (Humphreys, 1999).
The creation of an Integrated Social Service System (ISSS) in 1993 in Ireland is a result of longstanding concern about the lack of integration between income related social services and the confusions that result for individuals who are claiming a range of income related services from different departments, and for whom rights to certain services may be lacking. ISSS is based on the principles of improved customer service, the maximisation of resources, the integration of services, simplified systems and procedures, and a greater focus on staff as a resource (Department of Social Community and Family Affairs, 1996). Pilot projects have been underway in the disadvantaged communities of Tallaght and Ballymun in Dublin.

The role of locally integrated information services in Ireland has been the subject of some initial evaluation by the National Social Services Board. Of importance is that the research has highlighted user, rather than provider perspectives. Although numerous information services now exist in Ireland, it is apparent that the “multiplicity of information services did not enlarge the choice of the user” (1999:3). Rather there was evidence of poor co-ordination between information centres, with new centres being created with limited assessments of existing patterns of information provision. Problems were identified in replicating national government services at the local level that assume citizen knowledge and understanding of services, in creating centralised-single location models which can lead to services being inaccessible to people in rural areas where public transport is non-existent, and poorly developed and understood geographic boundaries. The research makes some useful recommendations regarding the planning of integrated information and social services:

The mobile user is faced with a bewildering choice of outlets providing social and information services of varying scale and scope in different locations. It would be desirable for planning to take account of the actual provision and gaps in provision in a location before restructuring. The needs of users who are not mobile by reason of age, disability or lack of transport has to be factored into the planning process [there is] also a need for investment in inter-agency training and co-ordination prior to restructuring (National Social Services Board, 1999:20).

The issues that arise from this and other experiences of inter-agency and integrated working methods is that integration has often been an add-on to people’s work loads. Inadequate resourcing of integration has meant that high levels of stress and additional workloads have resulted for public sector workers and workers in the voluntary and community sectors alike. In addition, there is a need to ensure that staff have adequate expertise in dealing with an increased range of services at one contact point. Conflicts between departmental boundaries and developing cooperative working methods are often implemented in a haphazard way. The process requires developmental time, reflection, building of new working methods and expertise, and resourcing. There has, to date, been inadequate monitoring and evaluation of these services particularly from a user perspective. Moreover, one-stop-shops can lead to local services disappearing and further distances to be traveled to reach the new locations. Although citizen’s shops may in theory bring the delivery of diverse services under one roof, they do not necessarily lead to co-ordination and integration. The creation of the Integrated Service Project in Ireland is a potential model of good practice in this respect (see example of good practice no 6, chapter 3).

1.3.4 Partnerships between local and national levels
Many of the initiatives outlined above are inextricably linked to the development of partnerships between national and local levels in all five countries. These have, to varying
degrees, brought the trade unions, employers, voluntary and community organisations and users into a participatory policy making and delivery approach. Indeed, it is clear that the success of locally integrated services is highly dependent on partnership working methods. All five countries have developed local and national partnership approaches, which have led to a greater involvement of users in the design and delivery of social public services. This is reflected in OECD (1996a) policy which emphasises client participation and consultation in service design, information about services, the level of services, sources of recourse and complaint, and the development of service quality initiatives with in-built performance targets. As needs and risks become more complex and as policy-making and provision of services becomes more diverse, it is increasingly important that citizens not only understand policy responses, but also support their development. This has been the subject of ongoing research and documentation of good practice by the OECD/PUMA’s Strengthening Government-Citizen-Connections and has resulted in national policy strategies of user empowerment and involvement.

1.3.5 The participation of users
Different levels of participation of users exist across Europe and these can be identified on a continuum of: information, consultation, partnership, delegation and control (Lunde, 1996, Humphries, 1998). This is reflected in the creation of user panels in Sweden and the Netherlands, and the development of local partnership structures in all countries. In Ireland, this has led to the involvement of community and voluntary organisations representing local or client interests in policy consultations. The emerging policy discourses resulting from these developments have raised new challenges about the delivery of services and professional structures and practices.

Social partnership has been firmly embedded in the structures of policy making in all five countries. This is reflected in national partnership agreements in the Netherlands, Ireland and Portugal. For example, in Portugal trade unions are represented on a wide range of government bodies and play an active role in developing active employment policies and local employment strategies through employment committees at the local and regional levels. The Strategic Social Pact 1996-1999, a partnership document drawn up by the Economic and Social Council, sets out key principles and goals for economic and social policy including:

   Fostering greater economic and social cohesion, whereby the level, quality and sustainability of jobs, reducing regional imbalances and fighting social exclusion are regarded as vital aspects of asserting the social dimension to development...” (Conselho Económico E Social, 1996, p. 13)

The negotiation for the 1996-99 pact and the subsequent negotiations for its successor have developed specific policies for disabled people, for instance, branch agreements have led to quotas for the employment of disabled people, including people with mental disabilities and illnesses. Job creation programmes for people with learning disabilities have been agreed whereby simple supervised tasks, backed up by training in gardening, cooking and traditional skills are proving highly successful.

In Ireland the experience of partnership and participation in policy formulation is well developed and advice to and consultation from Government are sought in the policy making process. The participation of community and trade union representatives is a feature of local area partnerships and the social partnership model is reflected in the Partnership 2000 for Inclusion, Employment and Competitiveness (1996). This national partnership agreement was
initiated in part to stabilise wage agreements, but has some important priorities related to the role of local communities and community development, the modernisation of services through improved quality, effective management, effective use of new technology, training and development of staff. Negotiations for a successor agreement suggest that a higher profile will be given to social inclusion, post-2000.

Partnership approaches to improving service delivery are also becoming more common place. Concerns about demands on elder care services and the difficulties in recruiting and retaining staff in elder care has led to an EU funded trans-national project involving the trade unions in the social care sector in the Netherlands, Sweden, Denmark and the UK. The project is developing models of good practice for tackling social exclusion at local levels in partnership with users, local authorities and voluntary organisations. This is being promoted through a ‘bottom up’ partnership approach through the involvement and exchange of staff members and participants in projects to support the integration of immigrants and the improvement of services to elderly immigrant people (SKTF, undated).

1.3.6 Identifying user needs

Although all five countries are strategically committed to developing services that are user-orientated, there is little evidence of systematic research to identify user needs. Indeed, much of the evaluation of integrated services has been primarily from a provider perspective. Even in those countries (Sweden and the Netherlands) where user involvement in service delivery is well established, methods of identifying user needs are limited in practice. In Ireland, identifying user perspectives has been the subject of initial research into the operation of integrated social service information points (National Social Services Board, 1999) and has been well developed through customer-satisfaction surveys in one government department, the Department of Family and Community Affairs.

In the Netherlands, trade unions have worked closely with user organisations in recognition that the new culture of client and user empowerment and participation strategies is of relevance to workers and users alike. Identifying user needs has been an important aspect of this process, which, according to user groups and the trade unions, has been poorly developed. The FNV trade union confederation have developed structures of support and training with user groups to enhance their roles in the policy process. This has resulted in a number of surveys and studies by the FNV of client roles in Employment and Income Centres (FNV, 1998a), client surveys of municipal social services (FNV, 1998b) and client participation in social service municipal policy (Kroom, Libregts and Moors, 1998). These surveys have been conducted in a climate of growing user participation in social security and social services. They have highlighted important user perspectives, identified gaps in services, and stressed the importance of developing clear rights and obligations in service delivery. This has led to policy implications for the development of services and in a number of cases the need for a greater integration of services. A great variation in client participation strategies is also identified across the Netherlands. The best example can be found in Utrecht where participation has been well developed through the formation of an independent client council working within a partnership framework. The recent formation of the National Network of Client Councils and the National Centre for Expertise on Client Participation will be important to further assisting and supporting client participation across the Netherlands (FNV, 1998).
1.4. The Quality of Services

All five countries have instigated programmes for the modernisation and reform of public services which aim to improve the quality, delivery and efficiency of services and reorientate the service provider relationship (OECD, 1996a, Humphreys, 1998, Boyle, 1995). This involves new approaches to public service management and new systems of quality, which are rooted in new forms of user empowerment. Many of these have been based on service delivery initiatives that stress transparency, participation, satisfying user needs and accessibility (OECD, 1997). According to the OECD (1996a) service quality initiatives giving greater client focus in the management and service delivery of the public sector have led to the public sector becoming more outward looking and to having to justify their existence as service providers. Indeed there now exists a greater use of benchmarking with reference to international standards and European networks are beginning to develop European standards, for instance, through the European Nursing Quality Assurance Network and the European Commission’s Network on Childcare.

Humphreys (1999) identifies a three-fold typology of public sector reform, showing a reorientation away from unresponsive bureaucratic organisational delivery in the 1970s, to reform strategies from the 1980s that were typified either by an emphasis on marketisation, competition and individual choices for consumers in some countries, or an emphasis on citizen empowerment strategies and involvement in others. The result was a new managerial approach that focused on the need to develop a more flexible and customer service approach which has as its aim “a more modern public service which is far more responsive to the competing pressures of the outside world and which will equip the public service more effectively to meet changing national socio-economic needs” (Humphreys, 1999:23). See Appendix 2 for an overview of public administration reform and modernisation processes.

These reform strategies have different roots. In Sweden, service quality improvements were initially driven by internal management reforms by management and staff in individual government departments. Whilst in other countries, for example, Portugal and Ireland, these initiatives have been centrally led. In Portugal, the reform process has led to a number of important national quality service initiatives, including improved administration and information. One important initiative has been the 1992 Public Service Quality Charter which was designed to modernise a largely bureaucratic and unresponsive public administration and to a large scale reform of public administration. Local municipal services in Portugal are also beginning to grapple with the need for quality frameworks. One outcome of the development of quality standards is the identification of the need for qualified people to provide social, medical and psycho-social support in order to improve the quality of services. Theses systems of quality control require further development, particularly in ensuring that they are accessible to staff and managers alike and workable in practice. In Ireland, improving service quality has been part of the public service reform process that has been underway since the late 1980s and developed through the 1994 Strategic Management Initiative and the 1995 policy document Delivering Better Government.

However, the growing demands for and increasing costs of health and social care to meet needs means that strategies to improve quality have not always led to increased budgets with which to do so. To different degrees, in all five countries, new systems of quality control and quality improvement have been introduced in recent years. They are also increasingly related to market competitiveness and cost effectiveness, alongside mechanisms to improve the quality of services, their social acceptability and legitimacy (Kalisch et al, 1998). The
restructuring of social public services and shifting welfare-mixes are inextricably linked to the introduction of market and commercial mechanisms and privatisation, alongside new business and private sector methods of management and of quality control (Wistow, Knapp, Hardy and Allen, 1994). For instance, Total Quality Management (TQM), a management concept with its roots in the private sector has increasingly been adapted to the social public services. This, along with other new management methods, has not been introduced without contention. Accordingly:

Quality has thus become a controversially debated and highly politicized feature both of social services and of the welfare state as a whole, between different actors – politicians, public managers, competitors, employees, service users and citizens – against a background of tight fiscal restrictions. (Oppen, 1997: 112)

Nevertheless, research does suggest that TQM can have some highly positive results in the development of client-orientated services owing to the central emphasis placed on the client and on the worker, via concepts of the learning organisation and worker participation in the process of quality (Oppen, 1997). It is evident that in the social public services new, more sophisticated and appropriate models of quality are being introduced which build on private sector models. These are both process orientated and integrate frameworks of inclusion, participation and empowerment of users (Evers et al, 1997). They are an integral part of the new public management which has been characterised by changes in organisation and delivery of services, alongside changes in human resource management (Pollitt, 1995). A particular emphasis has been in developing ‘service excellence’ rooted in evaluation, total quality management, client consultation and customer satisfaction surveys. At the same time the growth of consumer and user movements has led to pressure for improved service quality, and in some cases to “a range of counter-discourses in the politics of quality and consumption” (Rieper & Mayne, 1998:119). In other cases there has been the setting of professional standards for health and care providers, and consumer rights approaches typified by citizens charters and service standards. However, according to Rieper & Mayne (1998) Public Service Quality is a “relational and contextual” concept since it is defined in different ways by different actors and at different organisational levels. Good quality care raises important questions about the training and participation of workers and of user empowerment, and the extent to which services can be flexible within tight quality frameworks. Some of the best quality programmes are those that have directly involved users and workers in the design and the setting of performance targets. Good practice can be found in the Netherlands and Sweden.
Quality experiments in the Netherlands

In the Netherlands quality control and quality improvement has been on the policy agenda since the mid-1980s. Five-yearly national agreements have been developed on quality-control systems that have involved care providers, client-interest groups, insurance companies and government agencies. According to Verbeek (1997) these agreements on quality have had an impact on services and quality improvement and monitoring systems are “well-developed”. In the health sector the prominence of quality mechanisms and the appointment of quality managers to implement TQM is reinforced by the 1996 Dutch Care Institutions Quality Act, April 1996. This has resulted in policies and tools in quality improvement developed by the Dutch Association for Quality and Health Care (NVKZ), created in 1995 to promote the exchange of good practice and innovation in the field of quality.

Of importance has been the involvement of user organisations in the external development and monitoring of quality, and of workers in the internal development and monitoring of quality. Nevertheless, at the operational level, Verbeek identifies problems in combining a “client-oriented approach with professionalism”, that may actually be at odds with each other. In addressing this contradiction a number of experimental quality improvement projects have been developed in the Netherlands that aim to help professionals to problem solve and improve quality, to integrate client interests with professional standards for service delivery, alongside the centrality of user and worker perspectives to quality improvement. Legislation on clients’ rights and the introduction of Personal Budgets have been central to this by ensuring that services meet the needs of users as subjects rather than objects of policy.

One project has promoted the idea of ‘quality groups’ in the home help service provided for elderly people living independently and who need home help services in order to allow them to continue to do so. The home help service is provided by semi-skilled and unskilled women working part-time, who work autonomously with a group of clients who are visited at least once a week. The objective of the project was to monitor and improve the care provided by the home help workers. Integral to the project was the professional development and learning of the workers. This led to the creation of ‘quality groups’ made up of teams of home helpers who engage in problem-solving strategies for work related problems in order to develop more professional ways of working within a client-focused way. Three key perspectives were taken into account in the problem-solving activities: the role of the client, the role of the organisation, and their own role, organised into a quality triangle. The focus on problem solving techniques enabled the home的帮助 workers to develop ideas for improvements to the service, solutions to problems and decision making. In evaluating the role of ‘quality groups’ in the Netherlands, Verbeek (1997) looked at three home care organisations. The issues raised and plans for action drawn up by the professionals were compared to those issues and problems expressed by clients via a user panel. The evaluation found that the workers felt more satisfied in their work, that they were less isolated and more able to develop better relationships with their clients. Furthermore, many of the key areas and priorities drawn up by the workers corresponded to those drawn up by the users.

A second project in the home care sector involved mechanisms for professionals to gain ‘user feedback’ by relating the experiences of clients’ to quality improvements. In this project home-helpers and home nurses adopted simple research techniques to explore and record the opinions and experiences of the care provided to clients. The experiment revealed that it is possible to use client information and feedback to improve quality in both professional practice and in the delivery of services. In this experiment a number of changes were made to the service, resulting in a more client-orientated attitude amongst staff.
Quality experiments in Sweden

The move towards more market orientated service provision in order to improve the quality and value-for-money of local services and has led to the introduction of goal-orientated quality work in Sweden. In the City of Stockholm there is a shared commitment to the development of quality management of services that benefits users. Competitive tendering is viewed as one route to improved quality and efficiency in services on the basis that it can lead to innovation and lower costs (Bjelfvenstam, 1997). Of importance to the growing use of competitive tendering for personal social services is that contracts are drawn up which set clearly defined quality standards. Since 1996, the services, including personal social services, provided by Stockholm’s 24 District Councils have been opened up to competitive tendering and in 1999 this was extended to all municipal services. The City of Stockholm’s programme of quality work has also led to a system of Quality Awards. Awards are given for quality in co-ordinating and managing services in a goal-orientated setting, on improving the internal development and quality of services, including quality workplaces and recognition of user influence, and in guaranteeing quality in results. According to Stockholm City Council the awards have been important in stimulating quality development at the local level, in establishing models of good practice, and have formed a backdrop to the establishment of the City’s quality standards and for the introduction of benchmarking.

1.5. The quality of working life

The social public services employ between four and six per cent of all employees the highest proportions of which can be found in Sweden. (The distribution of employment can be found in Table 3) This is also a highly unionised sector of the economy and working conditions have been protected in all countries through national and local agreements. However, the shift towards diversified provision means that the working patterns and working conditions enjoyed by public sector workers might be eroded or altered.

1.5.1 Working time and work organisation

The restructuring of social public services has had important implications for the quality of working life, including issues related to work organisation, working time, equal opportunities and employment relationships. Labour market trends also suggest that the labour market will become increasingly flexible with a growth in the numbers of part-time and temporary workers. In all European countries and in all sectors of the public services the growth of non-standard forms of employment has been significant, with increased levels of part-time work, temporary work and new shift work patterns. Although many of the responses to flexibility originate from employer needs, it is increasingly the case that flexibility is becoming a preference of many employees who seek to reconcile family and work life, take long leave from the labour market, and increase leisure time. (See Table 4 for the number of part-time workers in each country and Table 5 shows the average working hours in the social public services). Changes in work organisation and working time alongside new forms of flexibility at work in the social public services have been developing in response to the crisis in welfare finding and the need for cost-savings, alongside growing demands to improve the quality of services and to extend provision. Where these developments have linked local service improvements to user needs and worker involvement, the result has been some highly innovatory experiments in local areas.

In all countries agreements on working time have enabled reductions in working time to be traded-off against extended service delivery and service restructuring. National agreements in Sweden, the Netherlands and Luxembourg have prioritised working time reductions and flexible working time as part of this restructuring process and employees are increasingly favouring working time in these countries. It is evident, too, that working time reductions are seen within the context of improving conditions of employment, for instance, to reduce work pressure, increase early retirement, leave from the labour market, and holiday time. The trend towards more decentralised local bargaining in the public services is closely tied up with greater flexibility in the labour market. Local and sectoral
agreements have become increasingly important to enable adaptations to working time to meet local service needs.

1.5.2 Equal opportunities

Equal opportunities between women and men is central to discussions about working conditions in the social public services since women are the main providers and users of services. Women represent the large proportion of carers, particularly in the home care services where work tends to be based on short term and part-time contracts unpaid (Bettio et al, 1998). Policies that aim to reconcile family and work life and to mainstream equality into public life are central to discourses on restructuring work, in the recognition that work needs to be organised within different time-frames for women (European Commission, 1998a, Rubery et al, 1995). This has led to experiments in making working time more flexible in Swedish municipalities and in the health and social care sectors in the Netherlands. In these countries the collective reduction and reorganisation of working time has become strategically important to achieving equality and the sharing of work and family life.

Equal opportunities in Sweden

In Sweden the growth of social public services was directly related to providing employment opportunities for women. Swedish equality policy is rooted in the belief that women and men should “enjoy equal rights, obligations and opportunities in all areas of society” (Regeringskansliet, 1999a). Sophisticated political machinery exists in Sweden to support equality through The Equal Opportunities Ombudsman, the Equal Opportunities Commission and the Council on Equality Issues. An important aspect of Swedish equality policy in recent years has been the application of gender mainstreaming to all areas of policy and all national and local government departments. It has been developed particularly successfully in local government where a pilot project (the JämKom project) run by the Swedish Association of Local Authorities developed greater awareness and knowledge of gender mainstreaming. In 1998 and 1999 this was followed up by training in gender equality analysis for project managers (Regeringskansliet, 1999b).

Of particular importance to Swedish equality policy has been the requirement for public and private sector employers to submit annual equality plans outlining their main strategies for achieving equality. These plans are monitored by the Equality Ombudsman (JÄMO) although no penalties are levied for non-compliance with the action plan. This requirement for annual equality planning has had the effect of making and shaping equality awareness and practice within organisations. (JÄMO, undated)

In the Netherlands a framework for a care and work law (Dutch Ministry of Social Affairs and Employment, 1999) has been developed to find a new balance between employment and care. The proposed General Act on Employment and Social Care (AWAZ) aims to equalise the rights of civil servants and other employees, to introduce time saving/banking measures so that additional time worked can be banked and taken as paid leave, and flexibility in working time, including reductions in working time for caring purposes. Workers will have the right to reduce their working hours and work part-time. Funding will also be available for experiments in the better use of time and for research into a new system of paid care leave. In a Sweden and the Netherlands there are ways in which employees (particularly women’s) choices about working time have become increasingly possible in this new climate of restructuring and flexibility. However, working time preferences are often constrained by inadequate state support services, for instance, for child or elder care, which in turn affect women’s participation in either full or part-time work.

1.5.3 Working conditions

The restructuring of social public services towards more mixed forms of provision has meant that employment status and working conditions are changing. For instance, in the Netherlands and Portugal large numbers of public sector workers hold a civil service status (including employees in education and the municipalities) with employment conditions that differ from
and are normally better protected than those found in the private sector. Both governments have recently been attempting to equalise conditions of employment and employee participation between the civil service and the private sector in order to abolish the specific status given to civil servants. Since 1997 public sector trade unions have been in dispute with the government over the reform of the civil service pension scheme, which aims to harmonise public and private sector pensions.

There is also evidence of growing importance of worker’s involvement in service restructuring in Sweden, Ireland and the Netherlands. It has had an important effect in shifting organisational cultures and in promoting new training strategies. In particular, partnerships and involvement in service restructuring that have directly involved workers have been highly successful in health and social care services in the Netherlands. In Sweden this has led to new concepts of the learning organisation, and in Ireland, Sweden and the Netherlands new strategies on lifelong learning are developing. In Ireland an attempt to improve both the services to the public and working conditions for employees and managers, management/trade union partnership committees were set up in government departments between 1998 and 1999 in order to respond to organisational changes. A similar framework was subsequently created for local government and the health sector. The initiative is supported by the National Centre for Partnership, which was established to support the development of partnerships.

1.5.4 Stress and work pressures

However, there is growing evidence of increased levels of stress and growing work pressures amongst staff in the social public services. In some cases this results from a larger amount of provision taking place in voluntary and private organisations where employment rights can be lower than those found in the public sector, and where greater uncertainties about funding and temporary contracts increase work pressures and adversely affect staff morale. In the public sector, new service quality requirements and integrated services strategies have not always been adequately resourced and staff burn out has become a regular feature of restructuring.

A recent survey found that Swedish public sector employees are facing greater stress at work, a faster pace of work, heavy workloads and long hours. The highest levels of stress were found in the health and social services sector where 69.8 per cent reported that their work rate had increased and 58.5 per cent felt they had too much to do. A number of local authorities have been ordered by the Labour Inspectorate to improve working conditions and reduce stress levels (Statistics Sweden, 1998). In many incidents stress has grown, as citizen’s entitlements have become more diverse. In the Netherlands, low average working hours have contributed to growing levels of stress, stress-related illness and absence from work from heavy workloads in the public sector. This combined with wage moderation in the public services has led to a number of disputes in the health and care sectors in 1998 (EIRO, 1998f).

1.5.5 Job creation and improving staffing levels

The social public services are one area where there is a large potential for job creation (European Commission, 1995a & b) and for increasing employment rates across Europe (European Commission 1998i). Extensions of services, pressures of work and the need staff to hold more diverse responsibilities, alongside the increasing demands for services has led to pressures to increase staffing levels in the social public services. In Sweden, new legislation was introduced in 1997 to provide SEK 8 billion investment to create new jobs in the municipalities and county councils in health care, geriatric care, childcare and education. This is based on the ‘Kalmar model’ developed by the Kalmar municipality in the south of
Sweden. It creates temporary jobs for young unemployed people, known as “quality raisers” as they increase the overall volume of employment. They receive payment in addition to their unemployment benefit. Cover is provided for people on education, parental, vacation or sick leave (EIRO, 1997a). The scheme is part of Sweden’s policy on activating the unemployed and although the lower status accorded to these temporary jobs has been controversial, the overall aim is to help integrate the unemployed into the labour market which has been achieved with some success.
Section 2: The needs of client groups and developments to meet these needs

This section identifies the needs of the three main client groups that are the subject of this research: dependent elderly people, disadvantaged young unemployed people, and people with learning disabilities and mental illnesses. It assesses the policy changes that are particularly impacting on these three client groups.

2.1 Dependent Elderly People

Ageing populations in all five countries have led to increasing demands on services and the need for new approaches to develop active ageing strategies and improve the quality of care for older dependent people (European Commission, 1999). The diversification of long term care for the elderly alongside consumer orientated services are increasingly at the forefront of care policies that recognise the preference of elderly people to remain in their own homes for as long as possible. This diversification has led to improvements in the quality of institutional care and to the extension and improved quality of home care and community based services in all countries (Kalisch, Aman and Buchele, 1998).

The ageing process itself has led to new reforms whose goal is to foster individual autonomy of older people “through an active ageing strategy in the various area of retirement income, caring arrangements, health and social services” (Jacobzone, 1999). The Swedish social democratic model of high levels of universal provision contrast sharply to the rudimentary model of welfare that exists in Portugal. However, a pattern of service provision has been emerging in the last five years in all countries typified by user involvement, decentralisation of services to local levels, a greater diversity in the delivery of services, an emphasis away from institutional care to care in the community, growing levels of support to informal carers (in Sweden, Portugal and Luxembourg), and greater motivations for the integration of services. Concerns about financing of long term care has led to charges for home care services in Sweden, the Netherlands and Portugal. Finally, there is more diversification and differentiation in care systems away from service provision to cash support and from substituting formal care with informal care across in all five countries (Pacolet et al, 1998). For example, in Sweden, support for carers and the provision of respite care for informal carers has been a growing area of activity, and municipalities are now required to provide support under an amendment to the Social Act implemented in January 1998.

Table 6 breaks down the percentage of the population who are over 65 years in each of the five countries and projections for 2020, whilst Table 7 looks at changing dependency ratios in the five countries. Whilst all five countries are experiencing an increasingly ageing population, this increase has been the most significant in Sweden and the Netherlands. For example, between 2000 and 2020 the numbers of 65 years will increase by 21 per cent in Sweden. The concerns are of the growing numbers of older elderly people over 80 years and the growing demands they will be making on health and social services. Since 1980 this group has grown by 48 per cent, and by 2000 it will have increased by a further 12 per cent.

2.1.1 The funding and provision of services

In each of the five countries there are different methods of financing, organising and providing of social services. According to Antonnen & Sipilä (1996) the statutory social care services for elderly people can be analysed by the extent to which they allow for autonomy
for elderly people and for their women carers. For instance they argue that Sweden and the Netherlands are characterised by generous social service and care systems for elderly people; in the Netherlands this is in contrast to the rather limited provision available for childcare. Levels of institutional care and home care vary across Europe. Institutional care and home care services are relatively low in Portugal, they exist at medium levels in Ireland, and are relatively high in Sweden and the Netherlands (European Commission, 1998). Sweden and the Netherlands represent countries with a higher proportion of GDP overall spent on institutional and home care services, with Swedish services based on a rights approach to care. High quality services for elderly people have been a cornerstone of the Swedish welfare state. In addition, the bulk of elderly people live in their own homes (92 per cent of all people over 65 years) and the municipalities are responsible for adapting homes to enable elderly people to live independently.

In contrast Portugal represents a country where old age is relatively under-protected within a rudimentary welfare state model is based on a traditional pattern of care provision by families, charities and churches. Although the growing demands for and increased provision of services for dependent elderly people is marked in all five countries, it is in Portugal that a crisis in care for elderly people living alone is currently being faced. The rising numbers of elderly people living alone is exacerbated by the breakdown of family systems of care as more women have entered the labour market. Many organisations in Portugal refer to the deficit between need and provisions, and a particularly acute problem is the need for adequate housing. Increasingly the municipalities have taken on some roles in providing home care.

2.1.2 Recent developments in services

It is in the sector of care for dependent elderly people that there is the greatest welfare mix, including state, market, private and family care. In particular, there is a high level of contracting out of services, payments for care to family members or the users themselves, and a high level of involvement of the non-statutory agencies and not-for-profit organisations. In Ireland, family based systems of care have increasingly replaced by higher levels of funding to private and voluntary care providers. In contrast, the Dutch system of social security is insurance based and is regulated by the state whilst private organisations, semi-state care organisations and local authorities are responsible for the provision of care.

There has been a growth of provision in each of the five countries with services increasingly tailored to individual needs with evidence of greater flexibility in provision, and a greater commitment to user empowerment strategies. In the Netherlands a more recent policy shift away from institutional care has led to larger numbers of elderly people living alone and in Portugal home care schemes have been developing in response to the need to provide basic citizens services. Dependency insurance in Luxembourg and Personal budgets in the Netherlands have been a client-orientated approach to supporting elderly people in their own homes in a climate of choice and empowerment.

The decentralisation of services has been a further important policy shift. In particular, the 1992 Ädel reforms in Sweden decentralised the administration, financing and delivery of long term care from the county councils to the municipalities (including day care facilities and institutional care, with the possibility for the management of district nursing, home care and other medical services to be decentralised under separate agreements as an incentive for municipalities to provide sufficient home care services in order to postpone institutionalisation). Increasingly services are provided by private organisations (Rostgaard T & Fridberg T, 1998). This has inevitably led to a focus on the quality of services provided in
both public and private sectors. The new Swedish Social Act implemented in January 1998 sets out the standards and organisational competencies in detail for the first time and considers the need for more support for informal carers.

Increasingly home care services have become the main source of care as a larger proportion of elderly people live alone (see Table 8 for a breakdown on expenditure and provision of different care services in the five countries). In Sweden just over 40 per cent of people over the age of 65 years live alone, compared to 30 per cent in the Netherlands (Rostgaard and Fridberg, 1998). Care in the community requires that older persons remain in their homes for as long as possible. However, this requires integrated policies in health and social care. Increasingly it is the municipalities as the lowest administrative unit of government that have led in providing care services for people in their own homes, although in an increasing number of cases they have moved away from being direct service providers to enablers and funders of services provided by private, semi-state and not-for-profit organisations.

Across Europe the debate about funding long-term care and an increasingly complex and diverse care-mix has led to questions about how care for dependent elderly people can be funded (Pacolet, 1998). This results from pressure on public finances and the growing numbers of elderly people who are dependent on state and other forms of support. In May 1998 a new dependency insurance scheme was introduced in Luxembourg and in the Netherlands a public insurance scheme exists for long-term care.

Attempts in the Portuguese municipalities to provide services for dependent elderly people have met with some successes, despite limited resources. Concern by the government at the growing numbers of elderly people living in their own homes who are unsupported has led to a proposal for a new initiative in Lisbon which will provide a free-phone telephone service with a screen which can be used in emergencies to provide direct nursing or care services to elderly people in their homes. (Similar schemes have already been pioneered by a number of Swedish municipalities). However, the strategy to support dependent elderly people has been to promote the use of volunteers and voluntary organisations and to proposals for volunteers to be properly training in lifting, bathing, administering medication and treatments, and social relations to respect elderly persons dignity and privacy.

The development of home care services is a direct response to the expression of preferences by elderly people for more autonomy and independence. Promoting home care has been directly related to policy to giving elderly people more autonomy in Luxembourg, and in Sweden and the Netherlands this resulted from the direct participation of elderly people themselves in decision-making processes. Pensioner’s organisations are strong players in political life in Sweden, the Netherlands and Portugal and have great influence in the development of policies for older people. For example, pensioners’ councils can be found in most Swedish and Dutch municipalities, and elderly people’s associations have been the main providers of day and other home care services in Portugal.
Planning for future ageing populations: the case of Sweden

In Sweden a recent review of services has led to a commission on the elderly and a new national action plan to improve services. The Commission on Response to the Elderly instituted by the Ministry of Health and Social Affairs (SOU 1997:170) was based on three principles: security, self-determination and dignity. It raised some important issues about the provision of care services in the future within the context of a new morality of care. The Commission actively consulted with organisations of the elderly and disabled, local authorities, county councils, government bodies, trade unions and employers organisations. It commissioned new research and mapped existing services. This led to a set of recommendations to increase funding for caring services for the elderly (Ministry of Health and Social Affairs, 1997). In the Spring of 1998 the government agreed to increase its grants to municipalities by MSEK 4,000 in order to improve services to the elderly, personnel, and an increase in the number of doctors providing care services for elderly people.

In 1998 a national action plan on policy for the elderly was agreed by the Swedish Parliament, with a budget of MSK 200 for activities between 1999 and 2001 to support families, conduct research, develop help-line services for elderly people, support experimental projects in domiciliary care and increase the competence and skills of care staff working with elderly people. MSEK 400 has been earmarked to extend care and raise the quality and standards of care services. The national policy has a number of key aims which include enabling elderly people to be active in shaping society and their own lives, to be able to grow old in security and independence, to be treated with respect and to have access to good quality care services. An important aspect of the National Plan is the priority given to the development of quality and of quality assurance. The active participation of elderly people in this process to be developed further. In order to implement the National Action Plan a special commission has been set up (Regeringskansliet, 1998).

2.1.3 Coordinating and integrating services

Pressures to integrate health and social services provision and therefore provide a seamless service of care for elderly people has led to an important debate about how to coordinate and integrate services in a framework of improving the quality of care. According to Kalisch et al (1998) this is not without its problems:

In the arena of long-term care services, there is a significant issue of how to coordinate and integrate services and improve the quality of care. Because long-term care services have been developed as a “patchwork quilt”, the contents of services have been somewhat fragmented and unorganised in many countries. These fragmented arrangements can hamper the improvement of quality of services” (Kalisch, Aman and Buchele, 1998:111)

Decentralisation has also enabled new systems of multi-agency care management systems to be introduced locally in Sweden, and in Luxembourg this has led to the establishment of inter-agency assessment and guidance units. The example of the integrated rehabilitation centre in Väntor in Sweden is a good example of the creation of integrated services and new working methods introduced in response to these reforms (see example of good practice 3, chapter 3).

In the Loures municipality in Portugal work has began to target isolated and dependent elderly people by coordinating day and residential services through a newly formed Department for Elderly Problems. One project has been developed to provide health support to elderly people in their own homes, run in partnership with the Ministry of Health. By coordinating services in the home the initiative has led to greater identification of need (by asking elderly people themselves what their needs are for nursing and basic care) and this has led to improved services in the home at all levels.
2.1.4 Quality issues

Improving the quality of services for older people has led to important service quality developments in all countries, the framework for which is set out in chapter 1. In the Netherlands two framework laws outline the most important quality requirements for home care organisations: the Act on the Quality of Care Institutions (which requires care institutions to adopt certain quality standards which are client-orientated) and the 1993 Act on Professions in Health Care (which sets certain quality standards regarding registration for professionals). In the former legislation care must meet user's needs, and annual reports must be published identifying how users were involved in developing quality policy. In Sweden the National Board of Health and Welfare is the main agency responsible for the supervision, planning co-ordination and follow up on matters regarding social services to older people. At the local level social welfare committees plan local services. They are relatively autonomous and are encouraged to consult with users and user representatives.

2.1.5 Working conditions

Home carers remain predominately women; indeed the need for “better employment and paid conditions for female care workers” was recognised as important in the European Commission’s (1998) report Care in Europe. It argues that the shift towards home care services encourages individualisation of care as well as having an important employment potential. However, the report warns against creating the expansion of underpaid female carers, particularly at times when female unemployment remains high. The report is clear that “publicly organised and supervised home care schemes can avoid these shortcomings by offering workers training as well as a professional career track” (1998:45).

The growing participation of women in the labour market has also put increased pressure on informal carers and has affected the extent of participation in paid work and the numbers of hours worked (Jacobzone, 1999). This has been felt particularly acutely in Portugal where family care has been made more problematic with the growing participation of women in urban employment. Finally, many women working in the home care sector have a relatively low status, contracts of employment are often temporary and work is often carried out on a part-time basis. However, there have been some important innovations in working time for home care staff in the Netherlands and Sweden, which has led to more choice and autonomy.

2.2 Disadvantaged young unemployed people

Declining unemployment across Europe has led to a corresponding decline of those under 25 years (the proportion of young people who are unemployed has fallen from 45 per cent in the mid-1980s to 25 per cent in 1998 in the EU). Levels of unemployment and training provision in Ireland, Luxembourg, Netherlands, Portugal, and Portugal can be found in Table 9.

2.2.1 National strategies for addressing the problems of disadvantaged young unemployed people

In all five countries there has been a greater targeting of disadvantaged young unemployed people, reflected in the 1998 National Action Plans on employment in each country. Reducing long-term youth unemployment through the development of active labour market measures has been a major priority in all countries. Integrating young people into employment has become an important priority in all five countries and has led to some innovatory projects leading to job creation and vocational training for disadvantaged young people in Luxembourg and Sweden. An important feature of the approach in Sweden, Luxembourg and the Netherlands is the development of individualised action plans mapping out the range of
support services that are available to young people. A further important element has been the reorientation and restructuring of public employment services within all of the five countries (European Commission, 1999). In Sweden young people have increasingly become a target of labour market measures as unemployment grew in the early 1990s. For instance, a special youth training scheme was created in 1991 for young people under the age of 25 years and special conditions exist for disabled young people. In summary:

- In Ireland, declining youth unemployment has led to more targeting of the most disadvantaged young people. Unemployment has been falling rapidly in recent years, from 16 per cent in the early 1990s to 7.8 per cent in early 1998; youth unemployment has similarly fallen from 25 per cent to 12 per cent in early 1998. All young people under 25 years of age, who have been registered as unemployed for six months, are contacted by the national training authority, FÁS. They receive a package of support including training, vocational guidance and advice, career planning, work experience, or a job, in order to move them off welfare dependency and integrated them into work. However, Back-to-Work and Community Employment, are restricted to people over 23 and 21 years respectively, and mainstream programmes have largely not benefited young people with educational disadvantages. This has led to a restructuring of employment services and new schemes to target young people who are long term unemployed and educationally disadvantaged. Active strategies are also developing in Ireland where the FÁS national training and employment authority has developed a wide range of training programmes ranging from apprenticeship schemes and vocational training to support the entry of the long term unemployed and disadvantaged groups into the labour market. The target for 1999 is to provide training and employment services to 45,200 long term unemployed people. In particular, the Government’s National Action Plan for Young People (1998) has been important in respect of the close co-operation established between FÁS and the Department of Social, Community and Family Affairs in providing young people with training, education and employment programmes.

- In Luxembourg, youth unemployment has, in comparison to the EU average, remained stable, although it is twice that of the 1980s. Measures to target young unemployed people include traineeships in companies, paid work induction programmes in companies for up to 52 weeks, and temporary job creation programmes in local voluntary organisations and public services. After three months of unemployment young people undergo an interview with the employment service that maps out their technical and social skills and their employability, resulting in a profile of the support required and the development of an employment plan. The plan can lead to training measures, traineeships and work experience.

- In the Netherlands, youth unemployment remains below the EU average. The 1992 Youth Employment Act has led to a comprehensive range of measures to support youth employment. Since 1998 these provisions have been integrated into the Job Seekers’ Employment Act (WIW) which provides for all unemployed young people to be taken through an individual integration programme which can lead to training or work experience. The programme is reviewed with the young person every two or three months. If no work is found within twelve months a young person is offered employment or an apprenticeship at the minimum wage in the public, voluntary or private sector (known as a WIW job). For young people who have high levels of distance from the labour market and for whom re-integration into the labour market is not possible, a special form of education can be followed through the WIW provisions.
Service to Citizens: project to provide initial work experience to young unemployed people in the north of Luxembourg

The Service to Citizens project was launched in October 1998 by the non-profit making association Forum for Employment. The Forum was set up in 1998 by the Luxembourg Confederation of Christian Trade Unions. The project aims to provide initial work experience and individualised training packages to young unemployed people. The project is funded by the national Fund for Employment, the European Structural Funds and funding from local and regional government.

The project began with training and work experience for ten young people who have renovated a former factory into the Forum’s main premises. The project employs five members of staff who were employed in April 1998. In November 1998 the Forum’s main activity of providing a “service to citizens” began. Services include the provision of a temporary home carer, assistance with gardening, cleaning, maintenance, repair and demolition jobs. In order to address the vocational needs of the young people participating in the project, individual training packages are drawn up with the Ministry of Education’s Vocational Training Services (EIRO, 1998a).

- In Portugal, the official youth unemployment rate remains below the EU average. The development of active labour market policies has led to funding that targets the reintegration of young people back into work through the Programme for Integration of Young in Working Life (PAIJVA). This focuses on educational and vocational guidance, vocational and professional training, and access into employment. In Portugal long term unemployment amongst young people is exacerbated by the absence of support from the state and dependence on family support. The rise in homelessness in urban areas is particularly associated with this as families are often unable to cope financially or socially with siblings dependent for many years. It is not untypical for young people to live with their parents until their late 20s.

- In Sweden, unemployment amongst young people has been above the EU average and has led to a much greater targeting of active labour market policies with an objective to ensure that no young person is unemployed for more than 100 days. Within 90 days the local employment office develops an individual employment action plan, if no job is found for a young person the municipality is responsible for developing employment or training measures for the young person. This includes vocational guidance, training, traineeships and work experience, improved preparation for the labour market and for education and training, with additional funding available for occupational labour market training through the adult education system and Folk High Schools. Young people lose their rights to benefits if they refuse to participate in the programmes.

Integrating young unemployed disabled people into employment in Sweden

A pilot project to assist young disabled people gain employment or take up education or training was run by the Swedish National Labour Market Board during 1986-87. The project was highly successful and the lessons learnt have been translated into national activity. A novel feature of the project was the requirement for the ‘UH’ coordinators working with the disabled young people to foster co-operation between different authorities and organisations involved in the project. The aim of the pilot projects was to help disabled young people find work and new work methods, staff training and networking were introduced in order to assist with this. An important part of the project was collaboration with disabled organisations, nationally, regionally and locally. The outcomes of the project were successful in that a larger number of disabled young people benefited by finding work, employers responded positively by adapting and creating special workplaces. Support measures included the appointment of workplace assistants for disabled people, flexible wage subsidies, and special regulations for disabled young people. (Linder, 1998).
2.2.2 Educational disadvantage and early school leaving

Tackling educational and other forms of disadvantage amongst young people has become a growing priority in all five countries, particularly since the bulk of vocational training provision has little relevance to educationally disadvantaged young people. Educational disadvantage is defined as:

The complex interaction of factors at home, in school and in the community (including economic, social, cultural and educational factors), which result in a young person deriving less benefit from formal education than their peers. As a result they leave the formal education system with few or no qualifications, putting them at a disadvantage in the labour market, curtailing personal and social development, and leading to poverty and social exclusion (Combat Poverty Agency (1996) The Demonstration Programme on Educational Disadvantage 1996-1999, Information Pack).

Evidence also suggests that early and unqualified school leavers experience poverty and higher levels of unemployment, and when in work they face greater risk of loosing a job (Combat Poverty Agency, 1999). As a result strategies have increasingly focused on the most disadvantaged young people who face long term unemployment, poverty, low independence and self-esteem, criminality and drug abuse. This is reflected in the OECD’s (1998a) study on coordinating services for children and young people at risk and highlights the role that integrated services are beginning to play across Europe in this respect. In Ireland, the Netherlands, Portugal and Sweden policy initiatives to tackle the high rates of early school leaving and educational disadvantage aim to encourage young people to stay on at school for as long as possible or to assist their transition into work through targeted training programmes. This is particularly the case in Ireland and Portugal where early school leaving has remained at high levels.

In Portugal, local municipalities have developed targeted educational projects in areas of acute disadvantage for young people who face disaffection from school; these include children from immigrant and traveler families and children in disadvantaged urban and rural areas. Early school leaving, low qualification levels and high rates of illiteracy have contributed to the exclusion of large numbers of young people in Portugal whose distance from the labour market is significant. This has led to a number of government initiatives that aim to address educational disadvantage amongst young people to prevent their long-term exclusion. For example, the Inter-Ministerial Programme for the Promotion of Educational Success, launched in 1987 integrates government department policies and implements these through local strategies via the municipalities to tackle educational disadvantage and exclusion. Although the programme has not yet been fully implemented there are positive results from the integrated methods of working at local levels (OECD, 1998a). Other initiatives that have led to integrated services for young disadvantaged people include Projecto Vida which provides collaborative programmes in the health, employment and social security fields for the treatment of drug and alcohol with grants available to voluntary organisations. In addition, the development of local community based centres against unemployment in Portugal have been an important source of support for young people. The Setubal Centre represents a good model of practice in its support for disadvantaged young people, reflected in partnership approaches that have led to high levels of trust and local identification amongst disadvantaged young people who rarely approach state employment services (see example of good practice number 5, chapter 3).
In the Netherlands, the introduction of a comprehensive Educational Priority Policy was introduced in 1986 in order to develop collaborative area action plans to tackle educational disadvantage. Although the evaluation of the project indicated that few collaborative outcomes were mainstreamed into local practices and services, specific projects that targeted the most disadvantaged young people and their parents, for example, the children of new immigrants had positive outcomes (Cullen, 1997).

In Ireland, local innovation in tackling educational disadvantage has recently focused on early school leaving, within the context of anti-poverty strategies. The Early School Leavers Initiative which began in September 1998 has led to a number of pilot projects in disadvantaged urban and rural areas in order to develop models of good practice. These demonstration programmes have been developed in a framework of partnership through the development of networks representing education and youth interests, including schools, parents, training agencies, Area Based Partnerships, youth and community groups and statutory agencies. The objective is to develop a more “integrated and imaginative response to the problem of educational disadvantage, and to influence policy at the national level” from pre-school education to early school leaving (Combat Poverty Agency, 1998:4). This is particularly important as co-ordination and strategic planning between agencies dealing with active labour market strategies has been lacking (O’Connell and McGinnity, 1997). Developing integrated services for children and young people at risk in order to tackle educational disadvantage has had some success, particularly in making the links between home, community and school. Cullen argues that the integrated approach “is seen as a way of tackling problems inherent in the relationship between home, school and community in circumstances where educational disadvantages persist” (1997:5).

Despite the fall in unemployment, many of those people who remain on the Live Register in 1999 face serious levels of exclusion and disadvantage. According to FÁS its strategy for 1999 includes providing “…intensive support to those disadvantaged in the labour market due to poor educational qualifications, long term unemployment and other social or personal disabilities” (FÁS, 1999:3). Young unemployed people have been targeted through a number of training and work experience initiatives, which aim to provide a bridge between school and mainstream FÁS courses. However, a problem with these schemes that have been introduced is that they fail to adequately tackle problems of educational disadvantage. The Combat Poverty Agency argues that educationally disadvantaged people “require more intensive one-to-one work over a prolonged period and in a setting that offers more flexibility than a training centre can accommodate” (1999:96). More effective preventative strategies are recommended, including appropriate development programmes of educationally disadvantaged young people and a better local co-ordination of training and education services for young people.

2.2.3 Integration of services for young people

The integration of services for young people has been high on the agenda in all five countries and has led to national and local strategies to target young people. In Ireland and the Netherlands there is an emerging discourse to tackle issues at local levels and in Sweden to provide integrated services for young people who have a history of drug abuse and criminality. The innovative integrated KrAmi project in Sweden has provided a model of good practice in this respect (chapter 3).

Attempts to integrate services for children and young people in the Netherlands have led to some innovative models of good practice at local and neighbourhood levels. This has resulted
from a growing priority given to addressing problems of school dropouts, juvenile delinquency and children roaming the streets in integrated and co-ordinated ways. The decentralisation of resources to the municipalities to tackle some of these issues has been important to targeting resources and activities on young people at risk. The development of co-ordinated services that link welfare and education services, alongside families and local community (Brinkman and Walraven, 1998).

**Tackling social exclusion and disadvantage amongst young people: Casa Pia, Lisbon**

One model project in Lisbon, Casa Pia, has been providing support and education for disadvantaged and excluded young people and children for two centuries. It is the largest Portuguese institution providing shelter, education, training and social integration of children and young people who have no family support and/or at risk of being socially excluded. In the last three years Casa Pia has been running vocational training projects for excluded young people, with support from local enterprises.

Casa Pia is funded by the Ministries of Social Affairs and Employment and has a philosophy to support the general, technical and professional education of young people. 4,050 young people and children of both sexes are supported by the project, 1,000 of who are from African origin. 700 young people and children are resident. Education and support services are provided via a network of eight colleges and each has responsibility for several group homes. In many respects Casa Pia is a model institution and provides opportunities for young people that are not generally provided through the Portuguese education system. It has buildings, educational facilities, social care provision and its partnership arrangements are exceptional in this respect.

Education is provided for children and young people who are in profound social need, resulting from poverty, family problems and family breakdown, social and emotional problems, and disability. The schools provide a network of services including residential group living, meals, social support, education etc. ranging from kindergarten to technical education. The Social Services Department assesses the social and economic or parental problems faced by the children. The average age is 15 years, although many stay on in vocational and technical training up to the age of 21 years. At Casa Pia there is a recognition that the young people who attend the schools do not just require an education, the philosophy is to support young people with additional tools for integration into society, including technical and professional skills. In this sense Casa Pia describes itself as an institution of social action geared to the social integration of the most disadvantaged young people. The additional support provided is aimed to build self-esteem and to help young people find a place in a society from which they have been excluded or rejected. As a result additional cultural activities are included in the programmes of education, which are designed to improve self-expression, confidence and integration into society. A crisis centre also exists to work with young people by providing counseling, advice, information and training opportunities.

Social workers, psychologists, nurses, doctors and therapists work within collaborative and integrated educational structures, which work closely with the families of young people. There is a total staff of 1279, of whom 429 are teachers and technical training staff. There is no doubt that Casa Pia offers a positive model of collaborative working not only within the organisation and externally with parents, local businesses and other governmental and non-governmental partners. The success rates of the young people who attend Casa Pia are equally high, with many leaving the organisation with job ready skills, life skills and self-confidence.

### 2.2.4 User perspectives

All five countries have seen the development of national youth organisations that represent the interests of young people. For example, the Conselho National de Juventude (CNJ), the national forum of youth organisations of Portugal, co-ordinates 24 youth organisations including youth parties, trade unions, catholic youth groups, arts groups and student organisations. It responds to youth issues particularly concerning child labour, the rights of young people and young unemployed people. It is funded by and liaises with the Secretary of State for Youth with a full time staff of five and has a number of youth commissions which have been investigating youth employment rights, including child labour and precarious
employment, and youth unemployment, for the purpose of providing information campaigns, political lobbying and seminars.

2.3 People with learning disabilities and mental illnesses

The development of disability policies (which include people with learning disabilities and mental illnesses) in creating initiatives to promote equal opportunities, training and access into employment, has been a response, on the one hand, to the development of civil rights for disabled people across Europe, and, on the other hand, to the strategic importance attached to integrating disabled people into work and reducing welfare dependency. This has included the creation of national commissions regarding disabled people, including separate commissions on people with learning disabilities and mental illnesses. For instance, in Ireland, the Commission on the Status of People with Disabilities, the Mental Handicap Services Consultative Committee and the Mental Handicap Services Development Committee were created to examine the extent to which the organisation and delivery of service met the needs of disabled people and to make proposals for legislative and policy changes to create more cohesive and comprehensive services in cost-effective ways. Both Ireland and the Netherlands outlawed discrimination against disabled people in the workplace in 1998. In Sweden, the Office of the Disability Ombudsman, created in July 1994, monitors the rights and interests of disabled people and monitors the progress of policies.

In all countries the need to improve the quality of services has to disabled people resulted from de-institutionalisation and a growing awareness of the rights of people with learning disabilities and mental illnesses. This approach can be summed up by the Irish strategy on policy toward people with learning disabilities:

The philosophy which underpins the provision of services to persons with mental handicap is to enable each individual to achieve his or her potential and to live within his or her family circle and local community where possible. The right of persons with a mental handicap to quality service which respect their dignity, which are provided within the least restrictive environment and which aim at the greatest possible inclusion of persons with a mental handicap in society, is recognised as a key principle guiding the development of services (Department of Health, 1997: 4).

In many respects services for these groups of disabled people have been the poorest in quality in all five countries. Concerns about poor quality institutional care in Ireland, the Netherlands and Portugal, revelations about eugenics policies in Sweden, the limited levels of support for families, and a growing user perspective have placed additional pressure on the need to reform and reorientate services. In Ireland, improving the quality of services for people with a mental handicap has led to proposals for a new partnership framework whereby health boards, the department of Health and voluntary sector mental handicap agencies work together to develop rights to quality services, a move to co-ordinated services and an agreed planning framework (Department of Health (undated a)). In addition, service quality guidelines, emphasising equity, quality of services and accountability, have been developed for people with mental illnesses. Of importance is that this has resulted in a guide of good practice that will be regularly reviewed and that “will form a basis for reflection and thought” amongst

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3 For the purposes of this study the term learning disabilities is used, although reference will be made to the definitions used in Portugal (mental handicap) and in Ireland (intellectual disability) will also be referred to during this section.
practitioners and administrators working in mental health services (Department of Health and Children, undated b).

It is in the area of care for people with a severe intellectual disability, and particularly for those living in institutional care, where the issue of quality has been the most vigorously pursued. In recent years this has led to mechanisms being developed by management and staff to guarantee and improve the quality of care. The main objectives of care and services, enshrined in legislation and policy documents, are to enable people with an intellectual disability to participate in society, to make their own choices regarding living conditions and personal future, to build relationships with others, to be treated with dignity and respect, and to receive support and training that develops their abilities. However, according to Zomerplaag (1996:1) “…this care vision provides too few starting points for testing and improving the quality. The notions are too vague and too abstract for that. There is a gap between the vision of care on the one hand and the actual practice on the other hand”.

Quality standards for people with an intellectual disability in the Netherlands

In the mid 1990s the Dutch Care Association for the Handicapped and the Netherlands Institute of Care and Welfare developed an instrument to enable staff working with people with an intellectual disability to check the quality of care and services provided, whilst also ensuring that quality criteria be meaningful and practical for staff to use. The project worked closely with staff in group discussions, and with management, clients and their parents/relatives. In particular, the objective was to find out what role the professionals should take and how they would implement some of the quality standards that had been set. After initial group discussions a questionnaire set out the statements on characteristics that good care and service provision should meet. These characteristics were then ranked regarding the importance to the quality of care in the organisation in which they worked. This formed the basis of preliminary quality standards that were tested in practice and developed into definitive quality standards that were further related to the development and implementation of policy and strategy in care and service organisations. This model demonstrates that the practical implementation of quality can take place through exchange of ideas within teams, discussion of points of departure, beliefs systems and attitudes. In practice the instrument has proved to be useful in determining which aspects of care and service provisions need improving and as such is a useful aid to the process of making quality standards meaningful to staff and clients alike.

2.3.1 Coordinating and integrating services

Inter-departmental co-operation and consultative procedures have also been created in all countries. For instance, in Ireland, this has been through the creation of an Inter-Departmental Task Force that brings together relevant government departments. In the Netherlands the Inter-Ministerial Committee on a Coherent and Co-ordinated Policy for people with a Disability and/or Chronic Illness has been meeting since 1968 which led to an Inter-Sectoral Programme on Policy for the Disabled (1995-1998). In Portugal the Secretary of State for Social Integration has an important role in developing co-ordination, partnerships between the private, public and voluntary sectors, vocational rehabilitation programmes and social integration through the National Rehabilitation Policy, within a perspective of autonomy and independence.
Identifying needs: the Irish National Intellectual Disability Database

An innovative and internationally unique experiment in identifying the needs of people with learning disabilities has been conducted through a partnership of voluntary organisations and families supporting people with learning disabilities, of users of the services and The Health Research Board. In 1995 this led to the creation of a national database of service needs that has been translated into a service planning tool and subsequently into a national plan by the Ministry of Health and is “…intended to provide a comprehensive and accurate information base for decision-making in relation to the planning, funding and management of services for people with an intellectual disability” (The Health Research Board, 1997). The important features of this activity is that the creation of the database was carried out with the support and involvement of users, families and the voluntary sector. There are important ethical and moral issues at stake in developing a nation-wide database and issues of consent to information and data protection have been built in. Of crucial importance is that this exercise in needs identification has led to a greater understanding of the service implications of the move from institutional to community care and has led to the creation of £55 million in additional resources, to meet care needs.

Of equal importance is that there now exists an accurate picture of people with moderate, severe or profound intellectual disability and this is regularly monitored by the National Intellectual Disability Database Committee (made up of representatives of the Department of Health, Health Boards, the Federation of Voluntary Bodies Providing Services to People with a Mental Handicap and the Health Research Board). The database reveals an increase in the numbers of people with an intellectual disability since the 1981 Census of Mental Handicap in the Republic of Ireland, and particularly of older people in the categories of greatest severity. Accordingly the: “changing age structure among those with moderate, severe and profound intellectual disability has major implications for service planning” with implications “for changing patterns of care towards a more intensive range of services provision” (The Health Research Board, 1997). The availability of accurate information and additional services has resulted in a strategic plan to provide services for people with intellectual disabilities, 1997-2001 (Department of Health, 1997).

In Sweden, co-ordination of policies in the health, social care, housing, transport and education fields has developed since 1982 to address the multi-faceted needs of people with learning disabilities and mental illnesses. One of the most important features of the 1994 Act, Support and Services for Persons with Certain Functional Impairments, is the right to personal assistance. The local authority either directly employs personal assistants or financial support is given to disabled people who become the employers of the assistants. In 1996, 10,000 people were receiving personal assistants. In addition, the legislation has led to care and support for approximately 35,000 people with learning disabilities. This includes consultation and expert support, a companion service, respite and relief care for relatives, family and group homes for young people and homes with special services for adults. Additional measures are available for people with learning and mental disabilities to gain vocational skills and vocational rehabilitation. Approximately 31,000 people with occupational disabilities are now employed in the Samhall A B group of companies that provides sheltered employment skills development and meaningful work for people with occupational disabilities.

2.3.2 Decentralised services in local communities

One of the most important policy changes has been the shift from institutionalised care to the decentralisation of services at local community levels in all countries. For instance, 28 per cent of people with an intellectual disability were in full-time residential services in 1997, compared to 36 per cent in 1981. Care in the community has also led to increased provision of support services in the home, allowing people with an intellectual disability to live in their families. However, there is an age correlation between levels of community and institutional care, with institutional care being more prevalent for older people and day care more prevalent for younger people.
The Netherlands continue to have the highest levels of institutional care for people with a learning disability in Europe; in this respect the movement across Europe away from institutional care to community based forms of care has been slower to take place in the Netherlands than in Sweden. There are nearly 100,000 people with learning disabilities in the Netherlands and recent policy has emphasised the integration of people with learning disabilities into society through work, education and leisure activities so that they can live as independently as possible. These shifts in emphasis go back to criticisms of institutional practices in the 1970s and the resulting shift in the 1980s away from institutional to other community based and group forms of care. However, this did not altogether halt the increase in the number of institutional care places during the 1980s. In contrast to other European countries, parents or families were largely satisfied with the quality of care given to the residents in institutions. This was in part a reflection of the process of institutional reform which begun in the 1970s, and which developed group home living within an institutional setting. The Dutch government has resisted large-scale de-institutionalisation on the basis of the higher costs involved, particularly for people with severe learning disabilities.

Despite this the modernisation of care since 1990 has taken place outside of institutional settings through the provision of group homes, day care, day centres and other community based provision. The recent development of supported living (within his/her own home with flexible support and within a social network) has met with some successes. The debate about de-institutionalisation in the Netherlands has focussed on the need to develop individualised programmes of care, independence and self-determination, community provision of care, rehabilitation and training, in an environment that respects human and civil rights in as normal a community setting as possible (Van Gennep, 1997). This marks a distinct shift away from policies which created protected or sheltered living and working situations towards a policy of independence, autonomy and a pedagogical approach towards skills development, dignity and social competence. See the example of good practice number 4: DZB: Leiden for a more detailed assessment of one project which has led to real work opportunities for people with learning disabilities and mental illnesses (in chapter 3).

The evaluation of pilot projects which have experimented with community based living for people with a severe learning disability, for example in Rotterdam, have pointed to the feasibility of supported and/or group based living in the community for people with moderate and severe learning disabilities. For instance, a greater emphasis is now placed on developing meaningful day-time activities for people with learning disabilities and a shift away from sheltered workshops to supported work (Van Gennep, 1997). The DZB-Leiden project that provides supported work for people with learning disabilities and mental health problems is a good example in this respect (see chapter 3). In Portugal, the increasing attention given to locally co-ordinated strategies for people with learning disabilities and mental illnesses has focused on supporting families and local voluntary activity. For example, the Loures municipality has developed a project to support the inclusion of adults with mental illnesses and handicaps, leading to projects which address their health, education and access needs. The overall aim is to co-ordinate services though a working partnership with government bodies, social security and health departments for funding and support. Partnership is new to the municipality and to date has had some good results.
Developing user involvement: the case of Portugal

The development of a handicapped movement in Portugal progressed after 1974. The resulted from the establishment of parents associations who have worked closely with trade unions. In 1974 there was recognition of the need to develop expertise and knowledge in this area since people with mental illnesses and learning disabilities had largely been a hidden problem.

Pressures from the co-operative movement and parents associations led to subsequent legislation to respond to the care, education and rehabilitation needs, particularly of children. One project in Coimbra in the centre of Portugal has led to a project to support sheltered work for people with all disabilities in a factory producing wooden furniture, plastic cards, and agricultural products. Over 200 people are employed in the project and are paid for their work. The national movement of mentally handicapped people, CERCI, has also developed some joint projects with companies with agreements to integrate disabled people into work. The project has had a positive impact, particularly in the municipalities. Although legislation does exist to integrate mentally handicapped and mentally ill people into the labour market, with subsidies available to employers, CERCI consider this to be poorly enforced. Supporting adults with learning disabilities and mental illnesses has been an important role for the confederation of disability organisations, CNOD, set up in 1966. It co-ordinates three national handicapped organisations who are affiliated to the organisation and has campaigned for improved resources and user involvement in policy for people with disabilities. It has developed important priorities for the support of people with learning disabilities and has campaigned for their integration into work and society. A number of pilot projects have identified the learning and vocational support that people with learning disabilities need, although CNOD are clear that the state provision and funding is too limited to meet all needs, particularly in rural areas.

Representative organisations who are involved in policy making and in consultations with government. In Ireland, the Irish Council for People with Disabilities was formed in March 1997, funded by the Ministry of Justice, Equality and Law Reform; in the Netherlands, disability organisations are involved in bilateral negotiations with government ministries and are directly involved in policy formation through opinions or proposals. In Portugal, national disability NGOs are consulted on disability policies. In Sweden, disability organisations are represented in user panels in the social security and social care fields, as well as participating in regular meetings with government ministers. Swedish disability organisations receive funding from the state. In Ireland, because bulk of residential and day care for people with learning disabilities and mental illnesses is provided by the voluntary sector a close working relationship between the sector and the Department of Health has evolved. This articulated of users needs by the Federation of Voluntary Bodies Providing Services to People with a Mental Handicap has had a direct impact on new investment programmes for the care of people with learning disabilities.

These developments have increasingly tended to include people with learning disabilities and people with mental illnesses under the umbrella of disability strategies, although separate organisations represent the different interests of these groups within this broader disability context (European Commission, 1998). User empowerment strategies have been growing in importance in all five countries and have led to awareness raising and information campaigns to highlight the problems faced by people with mental illnesses and learning disabilities. In Sweden, an innovative partnership project between the employers, unions and organisations of the mentally ill led to the creation of learning materials and information More than Just Words (Mer än bara ord) targeted to those who work with people with mental illnesses 4.

4 Partners include the Swedish Municipal Workers Union, the Swedish Central Organisation of Salaried Employees, the Swedish Association for Social and Mental Health (RSMH), the organisation for schizophrenic and other psychotic conditions (IFSAP), the Swedish Association of Local Authorities, the Federation of County Councils, the Swedish Labour Market Board (AMS) and the National Social Insurance Board (RFV).
In Sweden, supporting people with mental illnesses and learning disabilities is geared to increasing independence and choice. The introduction of the Support and Service for Persons with Certain Functional Impairments Act (the LSS-Law) on 1 January 1994 marked a new development in Swedish provisions concerning the support of people with severe disabilities, including people with learning disabilities and mental illnesses. It introduces the right to a Personal Assistant who can provide daily support, as well as the right to support for parents caring for children with learning disabilities; the principle is that relatives can be paid for their caring roles or have the right to a personal assistant to support them in their caring role.

Supporting independence and autonomy: the role of the Swedish Folk High Schools

Supporting people with learning disabilities and mental illnesses through education programmes that promote independence and self-confidence has been pioneered by a number of Swedish Folk High Schools. The schools support popular education, particularly for the most marginalised and excluded people and courses are free. In recent years the Folk High Schools have been receiving extra funding for the rehabilitation of people with disabilities, including learning disabilities and mental illnesses. This has led the schools to develop new working practices and more co-ordinated working methods with local health and social care services. At the Foruboda School in the south of Sweden, a social worker is now employed to coordinate the different services and to liaise with local communities and families in supporting people with brain injuries and learning disabilities. The communications centre at Foruboda provides computer courses, pre-communication, technical workshops for young people with learning disabilities, as well as courses for Personal Assistants and family members of those with learning disabilities.

The Kristinehamns Folk High School has established a purpose built centre, the Stensta Centre, with programmes for people with learning disabilities, mental illnesses and brain damage. It is based on a partnership approach between the Folk High School (funded by the county council) the labour market board (AMI), private sector organisations, disabled organisations and health and social care services. Vocational education and training courses and programmes to prepare for into the labour market are run for people with traumatic brain injuries, for people with reading and writing disabilities, for people with psychiatric disabilities. In addition, there is a vocational course for local Ombudsman in co-operation with the handicapped movement, and a vocational course for Personal Assistants to develop greater knowledge about disabilities. A basic computer course for six people with schizophrenia has assisted in the development of their social, emotional and cognitive functions. The learners were all young people who had been “very neglected” and who had been receiving institutional or day care support. The personnel included teachers from the Folk High School, two occupational consultants from the AMI and a teacher from the TeleNova technology company. A teacher’s assistant was also employed to liaise with the psychiatric services and social welfare services. The programme provides an important starting point for people with schizophrenia, since many of them are not ready for the mainstream vocational rehabilitation programmes provided by the AMI (Ernholm, 1995).
Section 3: Examples of good practice

3.1 Home Care Experiments in the Netherlands: Personal Budgets

A direct payment scheme in the Netherlands allows people who has been assessed as needing home care to receive their own personal budget (Persoonsgebonden budget) to enable them to tailor their care to their own needs. The government regards its operation as highly positive for the independence of people receiving home care. Personal Budgets initially covered home care services for elderly people living independently at home and was extended to people with learning difficulties in 1995. In 1997 it became possible for care provided by spouses and partners to be covered under the Personal Budget. In 1995, 2,000 people applied for a Personal Budget, rising to 6,000 in 1996 and 7,500 in 1998.

Personal Budgets enable the user decides on the care provider they want. The user becomes the employer rather than the recipient of a service. According to Pijl (1997) some important contradictions exist in the extent to which different definitions of quality of care exist between the user and the professional and this in turn means that the care debate needs to be increasingly concerned about the values and personal aspects of care as an element of the criteria developed on the quality of care. District nurses, home care associations, and private organisations are required by law to meet certain quality standards, whereas this does not apply to individuals employed to carry out care. However, the qualities that the budget holder values may often be difficult to operate through a statutory or professional service.

Two experiments have to date been evaluated. The first experiment operated by the Dutch Health Care Insurance Council in the early 1990s covered 668 persons in two regions. An evaluation was made of those receiving standard care from the home care organisation and those receiving a Personal Budget for care. In the majority of cases all of the money was spent on purchasing care through the Personal Budgets, with the largest proportion being spent on care from a private person or relative. Full employment rights had to be given to a person who was privately employed and tax and social insurance premiums paid for those employed for more than two days a week. One of the main reasons that applicants opted for a Personal Budget was to enable them to arrange their own care and more than 90 per cent of participants were happy with this. Although no significant differences existed in the level of satisfaction with the quality of the services provided between the Personal Budget holders and those opting for the conventional care, those users with personal budgets had significantly more influence on their choice of who provided the care, the time that it was provided and the amount of help provided (Miltenburg et al, 1993, Pijl, 1998).

A second experiment in Rotterdam involved a home care organisation, which experimented with Personal Budgets for home help services for twenty-five clients. The participants viewed the Personal Budget as important to autonomy, motivation, choice, control, independence and quality of life. The majority of participants were happy with the services provided and that the

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5 In the Netherlands, home care is provided by around 150 home care organisations, funded by national health care insurance; in some areas these organisations integrate both basic home help services with district nursing services, in others these are separate. Applicants for care are assessed by the home care organisation who determine eligibility and the level of support.

6 This is the statutory body that provides funding for health care through the Dutch national health insurance system. The AWBZ insurance covers all Dutch employees, covering health and social care, including part of the costs of domiciliary care and home helps.
quality of the service improved because they were more able to specify their own needs and identify services from different helpers according to different activities and tasks being carried out (Pijl, 1998). Like the first experiment a large proportion of the care providers were relatives and neighbours, with whom 50 per cent had a written contract. Of interest is that many of the participants in the experiment did not feel that their helpers required professional qualifications, rather it was the ability to choose their helper and that trust, flexibility and a shared understanding that were important, rather than professional qualifications. In both experiments it was the control and choice over the care that led to a perception of improved quality, more continuity and equality with their carer. In addition, many of the budget holders felt less of a burden and their relationships with their carers improved.

According to a government-sponsored evaluation, the introduction of Personal Budgets “may have far-reaching long-term consequences for the position of care providers and care organisations on the labour market” (OSA, 1998). It was found that the extension of the scheme in 1996 and the government requirement for the formation of an association of budget holders to ensure that proper contracts of employment and the payment of taxes and social insurance is made for carers, resulted in a higher level of formal contractual agreements between budget holders and carers. Two Associations of Budget Holders had been formed after 1996 with the purpose of ensuring that agreements between budget holders and care providers were legally enforceable, including the introduction of model agreements.

Personal Budgets have highly controversial. They are favored by the users and their advocates and by voluntary organisations. The National Council of Persons with Disabilities and the National Organisation of Elderly Persons have developed their own projects to measure quality, and the National Institute of Care and Welfare has also provided guidance on quality criteria. These include criteria on availability and accessibility, the needs of the client as a central focus, continuity of care, independence, knowledge and skills for caring, the attitude of home helps, the rights of clients, and information.

However, concerns have been expressed about the growth of an unregulated home care market that offers little employment protection, professional development or minimum working conditions. This is neither good for the quality of the service nor for the employment relationship between user and assistant; it can lead to abuses of power, misuse of funding and difficulties in resolving conflicts and difficulties. Difficulties exposed by the experiments have been raised by the trade unions, home care organisations, and the Equal Opportunities Council. The main trade union organising home care workers, AbvaKabo, had been critical of the scheme at a time when the trade unions have been working towards the improvement of the professional status, pay, working conditions and training of home care workers. Concerns are also expressed that budget holders could be bad employers, who may exploit their carers, pay them minimum wages and benefits, and reduce their status as care providers. There were questions about how disputes and about the quality of the care provided.

However, these concerns have partly been resolved in the Netherlands. In order to prevent fraud and misuse of the Personal Budget only a small payment is made directly to the client. Indeed as Pijl (1999) has found there is very little improper use in the operation of the Personal Budget. In order to cut down on bureaucracy the Dutch government has introduced a simplified system of payments, taxation and administration that is now administered, following many teething problems, through the Social Insurance Bank. The initial antagonism from the trade unions to the growth of a casual home care market has been turned around into new strategies to promote the working conditions, employment protection and training of
home care assistants. This has brought the trade unions into a new role in supporting and providing training for the isolated care assistant, whilst measures to ensure that a proper employment relationship has been resolved through the creation of separate agencies that deal with pay and working conditions to avoid any exploitation.

This example shows the operation of a new way of organising care that has contributed to the autonomy and quality of care. However, it is clear that Personal Budgets work only when the user is relatively autonomous and able to negotiate an employment relationship with a carer. Pijl (1999) argues that risks are involved if the budget holder loses their autonomy, and are least likely to work for the most vulnerable groups of elderly and disabled people in the Netherlands.

3.2 Dependency insurance in Luxembourg

In Luxembourg the dual policy of supporting elderly and disabled people in their own homes for as long as possible and of developing user-orientated care strategies has led to the creation of a new dependency insurance. The growing numbers of older elderly people in Luxembourg has led the Luxembourg Government to think more strategically about how care needs can be met. For instance, dependency ratios are changing rapidly. In 1990 there were 35 elderly people to every 100 working people, by 2030 this will increase to 73 elderly people to every 100 working people.

The dependency insurance also represents a shift in state policy away from the state being the direct provider of services as part of a strategy to reduce dependency on state services, within a more co-ordinated system of care. However, it sits within an unprecedented framework of guaranteeing rights to quality social care as a result of dependency, and a choice about how the care will be provided, either directly by the state or by families/relatives. In Luxembourg a wide range of state, semi-state and private agencies are engaged in providing home care services for elderly and disabled people. An important feature of the legislation is its role in regulating the relationships between the state and organisations providing social, family and therapeutic support, which have hitherto been largely unregulated. Finally, it puts into place important systems of evaluation within an integrated framework.

In May 1998 new legislation was adopted for the introduction of a dependency insurance scheme as part of the contributory social security scheme. The scheme came into effect at the beginning of 1999 and was the result of wide ranging consultations with organisations representing elderly and disabled people and their carers, voluntary organisations and government departments. A Consultative Commission had been formed in 1991 for this purpose in order to enable users, their carers and voluntary and private organisations to participate in decisions about services for disabled and elderly people. This was an important source of consultation and advice in the creation of the dependency insurance scheme.

The scheme aims to give support to people who are unable to perform “activities of daily living” on their own. It covers dependent people with learning disabilities, people with mental health problems and people with physical disabilities. The objective is to support and enable these people to carry out activities of daily living (physical hygiene, eating, household tasks and mobility) with the provision of help with domestic tasks, shopping and cooking and support to increase motivation, providing encouragement and supervising people who are dependent. Payments in kind would be for up to a maximum of 40.5 hours a week, and a maximum value of FLUX 60,750, whilst cash payments would be for a maximum of 10.5
hours a week, with a maximum value of FLUX 7,875. A number of additional payments are available for equipment, adaptation of housing, the provision of pension contributions for the person providing home care on the basis of contributions at the minimum social wage, and holiday cover of three weeks a year for the person providing home care.

An important outcome of the dependency insurance system is that new systems of care will be put in place and a larger number of care providers will be employed. As a result a new system of training for social and family support functions has been developed. This provides professional training during employment in order to provide carers with basic social, family and psycho-social support skills. The training amounts to 450 hours of study carried out over two years and a number and specialised modules are followed. A Certificate issued jointly by the Ministry of Education and the Ministry of the Family accredits this. In order to develop this training a specialised teacher-training course has been set up. These include a number of core and specialist modules, including a module on older people that covers a range of medical, social and psycho-social issues relevant to the care of elderly people.

The benefit has been introduced in the light of concerns about reductions in the amount of family support provided for elderly and disabled people, at a time when policy has shifted away from institutional care to care in the community.

The administration of the benefit is rooted in an integrated inter-agency approach. Applicants for the benefit are assessed for eligibility and allocation of hours of support by an “assessment and guidance unit” made up of 16 doctors, psychologists, social workers, nurses and trainers. The benefit can be taken as a cash payment if support is provided by informal helpers (family or neighbour) or directly via services provided by professional care associations. It is also possible to combine payments in kind with cash payments. It is estimated that 9,000 people will be eligible for the benefit in 1999 (representing 75 per cent of elderly people), rising by 1.5 per cent annually. The level of benefit ranged between 1420 and 1500 francs per hour in 1999. Benefits can also cover cross-border workers and immigrants who have contributed to the scheme. The costs of the scheme are funded largely by the state, mainly from the national social insurance scheme, a 1 per cent levy on all incomes, and an energy tax (EIRO, 1998b).

Outside of the dependency insurance system Integrated Centres for Elderly People and Recreational and Guidance Centres for Elderly People have been formed as part of a strategy to integrate all gerontological services.

The dependency insurance scheme offers a model of good practice in that it promotes an integrated system of care based on a multi and interdisciplinary working methodology. By aiming to prevent dependency as a result of old age or disability it has the potential to reduce dependence on the state, by devolving funding and responsibility to family and social networks or social care organisations. This is an important step forward in empowering users and promoting their independence and self-worth, within a framework of a quality service. Finally, the development of the resources and skills of care providers highlights the importance attached to the quality and skills of the carer.
3.3 Joint Rehabilitation Unit for the Elderly and Disabled: Vantör District Administration

Vantör is a district in the south of Stockholm with a population of 34,025 people. The District has high levels of social exclusion; of the 2,204 people who are unemployed a large proportion have severe social problems. The District Council provides care services for elderly and disabled people in their own homes, in old people’s homes, group accommodation for people with senile dementia and nursing homes. Services are provided for people with learning disabilities in group accommodation and day-centres. Special accommodation, daily activities, training, jobs and care is provided locally for people with psychiatric illnesses who are no longer diagnosed as needing need medical care.

The creation of an innovative joint rehabilitation centre has enabled the District to co-ordinate activities for elderly and disabled people within one unit on the basis that the care and rehabilitation of elderly and disabled people “requires co-operation between managers, activities and professionals...a clear organisation, structure and guidelines, attitudinal changes and skills development” (Ekhammer & Larsen, 1998). This sums up the approach to the Söderled, Farsta and Vantör District experiment in developing a co-ordinated and integrated rehabilitation service for elderly and disabled people. It is the result of legislation that came into force on 1 January 1992, which decentralised the responsibility for care of the elderly to local authorities. A new approach was deemed necessary to co-ordinate services at the local level and this led to the opening of a new joint rehabilitation centre on 1 January 1999. Owing to a previous lack of co-ordination of services and the absence of a common approach between different municipal and central government services a Working Group was formed to identify a new organisation and structure based on co-ordination for rehabilitation and care at District level. The Working Group was made up of representatives of rehabilitation professionals, representatives of users and their advocates, and representatives of workers and their unions (SKTF, SACO and the Local Government Care Association). The Working Group met regularly, work demands were assessed, study visits were made, planning days were held and a final report with recommendations for a Joint Rehabilitation Unit was produced. The Working Group had the function of ensuring that all knowledge and perspectives – professional, worker, and user – contributed to the overall proposal and there is no doubt that the activities of the Working Group led to the creation of a spirit of cooperation:

The project has initiated a process in activities as regards co-operation and the need for rehabilitation for the elderly. There has in general been an increased understanding of the importance of rehabilitation as well as realisation that all professions are required for efficient care and rehabilitation” (Ekhammer & Larsen, 1998)

The overall aim was to increase the quality of services through a rational use of resources, by ensuring that rehabilitation resources met the needs of the individual, by developing common rehabilitation methods and creating a rehabilitative approach for staff and relatives. This led to the setting of a number of goals and strategies. First, these concerned the improvement of health and quality of life, prevention of physical deterioration via a rehabilitating approach, achieving awareness and understanding amongst users, relatives and staff of the benefits of a rehabilitating approach realised through training, information and guidance. A second set of goals related to counteracting isolation and enabling elderly and disabled people to live normal, active and independent lives through the provision of social day-care, training in daily living, information, and close working arrangements with staff and families. A third set
of goals aimed to create effective co-operation within the team and with other care providers. A final goal was to ensure the efficient use of resources.

The outcome is that rehabilitation services and resources have been extended and staffing levels increased as a direct result of the project, leading “to a positive change in activities from the point of view of rehabilitation” (Ekhammar & Larsen, 1998). For example, increased staffing levels has led to more care rehabilitation work taking place outside of institutional care in the client’s own homes or in day centres and therefore to changing working practices. In order to develop a smooth transition to these changes and respond to the need for improved co-operation in the care chain the project has led to the development of specific training for staff within a framework of rehabilitative work methods and attitudes. The objective is that teamworking will enable professionals to work to the same goals in the recognition that coordinated working can enable different care providers and different services to respond to the diverse needs of the elderly.

This has also led to an awareness of the need for joint actions and objectives to be developed through an integrated system of individual care planning between geriatric care, primary care and local authority care and through the operation of care-planning groups. This exists within a framework of an ‘unbroken rehabilitation care chain’ whereby the patient has the same physiotherapist or occupational therapist in hospital as in home, within an overall framework that integrates both medical and social aspects of care. The difficulties presented in this approach cannot be over-estimated. The County Councils have largely worked within a medical perspective, whilst the local authorities have worked within a social care framework. As a result it is clear that to “achieve active co-operation with common perspectives, knowledge and respect for each other’s professional areas and activities are required, but they must also make use of each other’s skills” (Ekhammar & Larsen, 1998).

The result is that these services have contributed to primary care in elderly person’s own homes. Co-operation has been facilitated by the earmarking of care chain resources designed for this purpose and training programmes for staff have successfully assisted in co-ordinated working practices. A quality framework has also been put in place, and along with the approach being adopted by Vantör District, the focus is on staff participation and ownership of the quality process. Its framework is based on expertise development, staff training, documentation, working methods, working environment, customer satisfaction and quality assurance and reporting. The municipality sums up this approach as follows:

Good quality is achieved through an active process where the content of the activity is constantly evaluated and developed with the aim of achieving better compliance with the employer’s requirements and the customer’s/target group’s needs and expectations, and also the staff requirements for participation and a good working environment” (Vantör, 1998).

There has been a high level of commitment from staff who have participated in the process of developing the service, supported by training and skills development. This has led joint responsibility and co-ordination of care for elderly people requiring rehabilitation and a place where staff, the elderly and their relatives can make contact and referrals. The effect is that joint budgets also facilitate the introduction of an assessment framework that ensure quality, co-ordinated organisation and staffing, an improved care chain, and the best use of resources. However, a number of problems regarding staffing levels have meant that the centre will not be fully functioning until the beginning of 2000. The requirement to keep to strict budget
targets set by the new conservative majority in Stockholm City Council has meant that cuts
have had to be made in other services and plans postponed. The result is that two posts have
had to be held vacant and one of the day-centres integrated into the unit has had to be closed
for six weeks during the summer of 1999. A longer-term objective is to integrate the services
directly with the health authority. However, plans are underway to introduce further cuts and
to separately privatise GP, District nursing services and medical services to homes and
institutions in the District, creating a plethora of small companies within the health service.

The joint rehabilitation unit has led to a new culture of working and a new identity for staff
who have displayed enthusiasm to these changes. The effect of a new professional leadership
is improved communications, better understandings of the rehabilitation process, more
effective documentation of people using the unit and a greater flexibility in the use of
resources. The unions were very positive to the new way of working and the fact that staff
were directly involved in developing the organisational structure gave staff ownership of the
process and eased the transition to new working methods and the taking on of new
responsibilities.

3.4 The KrAmi Project: addressing criminality and drug abuse amongst young
people through a co-ordinated service

The KrAmi project is an innovative approach to the provision of an integrated employment
and social skills education and labour market programme for excluded unemployed young
people who have a history of criminality, drug abuse and asociality. The aim is to provide
young people with real alternatives to criminality and to prevent recidivism taking place. It
was developed in the mid-1980s in response to the need for authorities to co-operate prior to
the release of young people from prison or correctional care and the inadequacies of the
Probation and Correctional Care Services to prevent re-offending. The approach is based on
the need to tackle re-offending by integrating young people (between the ages of 18 and 30
years) into social and economic life by ensuring that they find housing, have access to training
and sustainable employment, alongside support from social services and health services.

The uniqueness of the project (at least to Sweden) is the model for integration of services and
co-operation between municipal and central government services (social services, the
probation service and the labour market authorities). Accordingly, the KrAmi programme is
“an example of how ‘practitioners’ have driven the idea of co-operation farther than just
authorities working together” (Siv & Soydan, 1999). The staff are paid by one of the three
authorities and each of the authorities pay a contribution towards the running costs of the
project. The staff work together within a common framework and method, supported by
training and staff development activities. This common method of working has had positive
results. The staff have experienced changing working methods and they have learnt to work
together in a multi-disciplinary setting and this has been seen as a positive development by all
staff. The new working methods have led to higher levels of satisfaction at work. The new
knowledge base resulting from co-operation has contributed to this, alongside permanent
funding. Different departmental cultures and rules have, through a process of training and
sharing of working methods, led to new working methods that are focussed on the goals of the
project.

The impact of the integrated approach has been an efficient use of resources, reductions in
bureaucracy, cost savings and positive results in terms of providing an innovative approach to
tackling disadvantage and exclusion amongst young people. Indications from a current
evaluation of the project’s resources suggest that significant costs savings have been made from the integrated approach, whilst improvements in services and outcomes have been realised.

The programme runs for six months, although this can extend to several years for young people who require a longer programme. Strict programme and ground rules are put in place and attendance on the programme is based on adherence to these rules. Participants on the project agree to adhere to these rules. The bulk of participants are men and special activities are run separately for women. Referrals to the programme are made from the Probation Service and participation is voluntary.

The programme contains four main areas of activity: induction, counselling, practical work experience and recreational activities. An important part of the programme is to build the trust and confidence of young people. The bulk of the programme is spent in work experience programmes where young people learn about work demands, gain experience and learn about searching for work. Often several different work placements may be tried out before the ‘right’ one is found that matches the young persons interests, experiences and needs. An added incentive for employers taking on what could be considered to be a risky group of potential employees is that a wage subsidy for employing a young person on work placement can be received from the Labour Market Board. It is also worth stressing that the young people entering the programme are also committed to finding work and the programme build on this initial commitment. The aim overall is to help the young people find work that interests them and then to build this into a work training position. An important part of the programme is the practical help and support that individual participants receive in order to help the young people understand socially acceptable behaviour, to understand how to create good relationships with others, manage their own social lives, solve everyday problems and find and keep jobs.

No quality control procedures have been implemented to date, but the staff conducts an evaluation of the programme on a monthly basis and external evaluation takes place on a regular basis. In order to assess the effects of rehabilitation and treatment programmes for young offenders an in-depth evaluation has been conducted by the National Board of Health and Welfare’s Centre for Evaluation of Social Services (Siv & Soydan, 1999). The evaluation tracked the progress of 62 of 140 participants KrAmi participants between 1996 and 1997 through personalised interviews and assessment of progress against the Addiction Severity Index. It focussed on key indicators of employment, criminality, family and relationships, alcohol and drug abuse, and physical and mental health.

The project evaluation is based on two groups located in Malmö and Örebo. The participants are between the ages of 18 and 35 years, all of whom are unemployed and many of whom have had low levels of schooling and educational achievement. They all share a weak position in the labour market and the majority have criminal records, have been through correctional care and addiction treatment. Large proportions of the participants have problematic family relationships, for some this is a result of physical and sexual abuse, and low self-esteem.

The evaluation of the project suggests that the objectives and methods of the KrAmi project are well integrated and that the particular focus on employment, social interaction, interpersonal and skills development have proved highly successful. In particular, the individualised approach, methods to compare deviant with socially acceptable behaviour and the emphasis on developing supported practical work training placements have been highly
successful features of the project. The project has had a high rate of success in creating employment opportunities, reducing the incidence of criminality, improving family and relationships and in providing ongoing support for reduction in substance abuse and health promotion.

This evaluation is part of a wider study comparing the outcomes of the KrAmi programme against conventional activities provided through the Probation Service. Although the results of this have not yet been published, initial results from this second stage evaluation suggest that KrAmi has achieved significant results in integrating disadvantaged young people into work compared to the programmes run by the Probation Service. It is interesting to note that the project backs up other research undertaken in Sweden that shows that projects which are focused on work and on finding work have been more successful in terms of reducing the social exclusion of young people than projects that are non-work related.

The project has represented a model of good practice in Sweden and new projects have been set up in Gothenburg and Stockholm as a result. Some of these projects provide specific services for young women and plans are underway to develop projects in Kalmar and in the North of Sweden. The integrated working methods, the emphasis on work placements and the importance of establishing social relationships for the groups of excluded young people who participate in the project, suggest that these approaches have been highly appropriate to the client group. The spreading of the model to other cities in Sweden is also based on an awareness that this model can be applied nation-wide.

3.5 Unemployment and social exclusion amongst young people: the role of the Setubal community centre against unemployment

Rising unemployment for young people in Portugal has brought with it very specific forms of exclusion, dependence on family support and severe limitations regarding state support. In addition, early school leaving and educational disadvantage are particularly significant problems contributing to high numbers of young people being socially excluded. A level of mistrust and lack of identification with statutory services amongst young people is compounded by limited provision for severely disadvantaged young people and significant gaps in provision.

Setubal is a town south of Lisbon where unemployment stands at twice the national average, primarily resulting from factory closures in the predominantly metal working industry. A community-initiated response to unemployment has been developed. Young people face particular high levels of exclusion with 74,000 young people (under 25 years) registered unemployed in the city out of a total of 380,000 registered unemployed (March 1999). In addition, there are high levels of early school leaving and disaffection from school amongst young people in Setubal.

The Centre Against Unemployment Centro de Apoio aos Desempregados was created in 1996. It has five employees (four of whom are part-time) and a network of volunteers. It is a community-based initiative supported by local trade unions, local groups and individuals, and the church. It organises unemployed people and lobbies on their behalf and has set up specific training and other projects that offer an alternative service to that provided by the local statutory employment services. The importance of this approach cannot be underestimated in an area of high levels of deprivation and where a mistrust of state services has led to a lack of engagement between local people and statutory employment and training services.
The centre was set up in response to large scale unemployment in the area brought about by the closing of the local fish canning industry and other manufacturing related employment in the area, particularly car manufacturing. The centre has provided a model for other such initiatives in other parts of Portugal, in recognition of the need for a specifically user-orientated approach and a service that is trusted and supported by local people. Similar centres now exist in other areas of high unemployment including Vale do Ave, a region north of Porto which has been adversely affected by the closure of textiles; Covilhã in the centre of the country which has been affected by industry closures; and Portel, a rural area which has been dependent on farming. This has led to a national network of unemployed people across the country and to two national conventions on unemployment.

Whilst the bulk of the centre’s activities have been geared to providing training and support services for older unemployed people, a growing area of activity has been a focus on long term unemployed young people, with a particular emphasis on the children of long term unemployed adults, and children who are early school leavers, with low levels of literacy and numeracy. The centre has developed good working relationships with government and has developed clear and concrete proposals that have led to legislative change.

The centre has no core funding. The local authority provides free space (a small building with office and meeting space). Funding is applied for on a project-by-project basis in order that specific training and guidance projects can be run. One highly successful project which runs training for the creation of small and micro enterprises led to the creation of 76 micro enterprises in 1998, well above the aim of 20. Other training programmes include traditional tapestry work for women (1998) and IT training (1997). A particular focus is on providing training for excluded minority ethnic groups. The projects are funded under the ESF Integraar programme and the Ministry of Labour and Solidarity. Between 1989 and 1999, 800 permanent and 900 temporary jobs were created. The average age of those who found jobs was 42 years.

One of the concerns currently being addressed is the lack of technical and professional education and training in schools. This means that many young people leave school with poor skills and job readiness. In the recognition of the specific problems faced by young people who have multiple forms of deprivation, the centre has developed a successful project called UNIVA. The project is geared to identifying those young people who have had no contact with the employment service, education or training organisations and whose access to the labour market is hindered by low levels of educational achievement and low levels of literacy.

Many of the young people targeted are immigrants from Africa and East Timor. Five hundred young people have been through the project since it began in 1996. The project provides a bridge between the local employment centres, vocational training organisations and local industry. It is funded by an annual renewable grant from the Department for Employment. The project provides intensive counseling and guidance, confidence building measures and links to local companies. Working in partnership with local companies has enabled the centre to assessment enterprises in the area, job opportunities and to develop possibilities for work placements and training to match the skills that local employers require. An important aspect of this work is to map of local labour market trends.

An important feature of this project is that it has engaged young people locally and has built their trust. The importance of local networks has meant that the project has been successfully
publicised through word of mouth, links with NGOs, youth organisations, neighbourhood councils and leaflets distributed locally. Generally the centre has a high profile the town. In addition, the UNIVA project has led to spin-off projects including exchanges of young people across Europe and to the creation of a youth festival in the city funded the EU’s Youth programme.

In a separate project the centre has been providing support for excluded young people who are at risk of early school leaving. The city has a problem of large number of young people finishing school before the compulsory nine years of education required for entry into the labour market. The project targets the sons and daughters of unemployed and ethnic minority families by providing assistance with homework and literacy, in partnership with local schools. It also provides opportunities for young people to gain the necessary three years technical training outside of a school environment, meaning that the young people do not have to return to the traditional schools where they had been lagging behind. A significant problem in Portugal has been the growth of precarious and unprotected forms of employment for young people. In the north of the country this problem is more acute with high rates of child employment and the limited sanctions against companies employing child labour. As a result a key activity of the centre has been to work in partnership with local employers to ensure that young people can find meaningful and secure work, rather than work that is poorly paid and precarious.

The centre has built up a high level of activity based on the creation of local networks and partnerships. Equally important is that the centre is accessible to local people and is trusted by young people. The creation of a friendly and welcoming atmosphere has been important to this. However, the centre works within limited, unpredictable and short-term budgets and for this reason there is continual uncertainty about its role in the future. This has the effect of making long term and strategic planning problematic. As with many community-based projects of this nature there is a high level of commitment on the part of paid workers and volunteers. However, there are concerns about staff burnout and continuing funding for paid workers. Nevertheless, the centre thrives because of the high levels of commitment given by volunteers, who are considered to be critical to the centre’s survival and to their community connections.

3.6 Supported work and training for people with learning disabilities and mental illnesses in the Netherlands: DZB-Leiden

The model DZB-Leiden project was created in 1996 out of the Municipal Department of Social Job Creation, which had previously provided sheltered workshop facilities for people with learning disabilities and mental illnesses. The newly formed DZB-Leiden was created as a private limited company in order to develop a market and business based approach to providing jobs and training. Leiden is a medium sized city north of The Haag with relatively high levels of long term and youth unemployment, a low skills base, poverty and social exclusion. Leiden has implemented an innovative Social Renewal Policy and a new method of working that emphasises a local neighbourhood approach, decentralisation and deregulation, a central role for the municipalities and the involvement of citizens in the execution of policy activities. The emphasis is on an integrated approach to tackling social and economic problems, based on notions of co-operation and participation in policy.

According to one member of staff at DZB has the long term objective is to enable unemployed people, people with learning disabilities and mental illnesses to lead as normal as
life as possible, through a process of emancipation, empowerment, social activation and independence. DZB-Leiden is a highly innovative and successful project, whilst it aims to provide subsidised labour it does so on a commercial basis that is neither patronising nor based on notions of dependency. In practice any unemployed or disabled person can apply for a job at DZB and specific target groups include young excluded unemployed people, people with learning disabilities and people with mental illnesses.

The management, job-coaches and team leaders all come from social welfare, health service and employment service backgrounds, rather from the commercial sector and yet the project displays a high level of commercial awareness and is highly successful in making profits that are then ploughed back into the company for further development of its employment activities for the most socially excluded people in the area. It relies heavily on the subsidised labour scheme operated by the Dutch government, whereby the maximum of 120 per cent of the national minimum wage is paid to people who work within the company under the Law of Social Job Creation. Approximately 1,500 people are employed at DZB the bulk of who have learning disabilities. An important aspect of this is that the people employed feel that they are working in real jobs based on a commercial activity. An essential component of DZB is that every handicapped person in the area has the opportunity to take a job where the working conditions are adapted to the specific needs of the person employed. A Works Council made up of thirteen people working in DZB works closely with policy formulation and management.

DZB works in close co-operation with external agencies: local businesses and industry, employment, education and welfare organisations, social security office, municipal services and disabled persons networks and organisations. It represents a good example of co-operation and its success can in part be measured by the close proximity it has to local networks and external agencies. DZB is divided into four main areas of activity. The first is Products and Projects covering metal working, assembly lines, a print shop, textile centre and wheelchair servicing. The second is Parks and Gardens Maintenance covering building maintenance, cleaning jobs, gable cleaning, streetpaving, garden construction and maintenance and plant cultivation. The third is the Provision of Services which provides catering, boat trips, the guarding of bicycles, security and the secondment of employees to other companies. The fourth is the Provision of Products, which has a large commercially successful chocolate packing factory and which provides employment for 225 people with learning disabilities. The canteen at the DZB headquarters is run on a commercial basis, the employees are people with learning disabilities who also learn catering skills. These activities take place in four different factories and locations, including an administrative headquarters. In addition the longer term goal of DZB is to see the employees integrated into regular work within the City, with on-going support and job-coaching provided and job-placements in public sector organisations and in local government have already begun to taken place.

Team work enables people with moderate or severe learning disabilities to perform functions that provide them with job satisfaction and skills development is targeted at their own particular abilities and needs. A job-coach supervises their training and work activity and the team leader is employed by DZB to supervise the team based work approach. The work environment is supportive and co-operative. High levels of support within a real employment setting have had significant effects in terms of creating high levels of work motivation, satisfaction, and overall health and social well being. As one of the job coaches stated, the DZB project has had the effect of saving resources in other areas of social welfare since the
people working at DZB tend to have better health and greater levels of independence than they would if they had not had the opportunity to work there.

A further development of DZB in 1996, resulting from the development of the municipality’s Social Renewal Policy, led to DZB operating a new project to provide work experience and training for long term unemployed people in order that they can gain normal employment. One project was targeted under the Law of Job Guarantee for Young People to young people who faced high levels of social exclusion and who needed support in gaining the confidence and skills to find regular work.

In 1998, a new project Leerwerkbedrijf (The Learning-To-Work Enterprise) was created to provide job placements, job experience, training and subsidised employment for people with mental health problems. This developed from a successful pilot project run between the health authority and DZB, which developed a model of practice that proved highly successful. The pilot project Ondergrensproblematiek Geestelijke Gezondheidszorg (Below Boundary Problems mental Health Care) was initiated between DZB and a day centre for people with psychiatric problems. The model has now been successfully mainstreamed into DZB and provides individually tailored learning-to-work programmes that are agreed between the company and the person with mental health problems. Work placements are organised and supported by the job coach and an evaluation of opportunities for education, training and further placements are made at the end of the work placement.

The DZB initiative also links into two other community based projects in the area:

The Route is a community-based project, which targets those people whose distance from the labour market is the greatest. It is based on co-operation between social welfare and labour market agencies to provide an intensive person-centred model to provide employment advice, guidance, job coaching and job placement support, to enable unemployed people to find jobs, voluntary work or education/training. A personal counsellor supports the unemployed person through this process. The target group are long term unemployed people who have little previous education, psycho-social problems, lack of motivation and low incomes. Although it is not targeted specifically at young people it is a good example of co-operation between a number of agencies (social security, local neighbourhood groups, urban consultative bodies, community and social work organisations, employment, education and welfare organisations). The Route has been successful in providing routes into paid, subsidised and voluntary work.

The Community Labour Company is a community based project which aims to create paid and voluntary jobs and subsidised jobs in local community services for socially excluded people, and thereby improve the quality of life of local people in Leiden-Noord. It integrates services from local educational, welfare and employment organisations, local community and neighbourhood groups, the probation service and other community based projects. Although the project is targeted at the long-term unemployed, people on probation, and people who are socially isolated, it has a specific project targeted at young people who are at risk of social exclusion. This sub-project the Pocket Money Project for school aged children aged 15 years and over, gives socially vulnerable young people the opportunity to gain work experience and earn some pocket money.
3.7 Integrated Services Project in Ireland

Improving the quality, accessibility and transparency of local social public services and their effect in seriously tackling social exclusion has led to an innovative pilot project in Ireland: the Integrated Services Project. In 1998 a research project focussing on the needs of local people in disadvantaged areas of the Dublin was carried out in an attempt to gain some feedback on service provision and identify needs in order to improve the services. The rating on the quality of services was very low and discussions began about how to improve services within an integrated framework. This led to the creation of an Integrated Services Project in four pilot areas of the City. The project is managed by Area Development Management Ltd (an intermediary company developed with EU and Government funding to manage and support locally based area partnerships and community development, through integrated action to tackle long term unemployment, economic marginalisation and social exclusion). It was recognised that the problem lay not only with a lack of resources, but the means by which existing resources were co-ordinated via different government departmental budgets and programmes. As a result an important role of the project is to develop co-operation between state agencies.

The designated areas (Dublin’s North East Inner City, the Canal Communities, Jobstown in Tallaght, and Togher in Cork) are areas of high levels of social exclusion, urban deprivation, poverty, high unemployment, early school leaving and truancy, drug abuse and drug-related crime. Four development staff are employed to liaise with local communities and an Implementation Team made up of representatives of seven state agencies take a strategic role in working with local communities to establish needs, priorities and targets for integrated activity. Within each of the four pilot communities thematic task groups have been set up to address key priorities. A member of the Implementation Team leads each task group.

In launching the scheme on 4 December 1998, the Minister of State, Chris Flood TD stated that “Service integration is not a programme to be superimposed over existing programmes – It is a process aimed at developing an integrated framework within which ongoing programmes can be rationalised and enriched to do a better job of making services available to communities, within existing resources”. Issues to be targeted in a co-ordinated way include housing and the environment, social order, community development, health, childcare, education, recreation, youth initiatives, training and employment.

The first stage of the project is nearing completion. This first stage involved the development of co-operation and new integrated working methods between state agencies and the development of targets for local integrated activity in co-operation with the local communities. There has been a high level of engagement between the state agencies represented in the Implementation Team that is unprecedented in Ireland. However, there has been a danger of staff burn out and overload as the representatives from the various state bodies have developed this work as an ‘add-on’ to their existing jobs. It has been recommended that they be provided with additional support in order to prevent this overload in the future.

Extensive consultations with local communities has led to the setting of targets for the development of new integrated activities and proposals for integrated services are now being formulated by the Implementation Team. The priorities for activity include (by order of priority set as a result of local consultation) early school leaving, support for families, localisation of services and information, and youth issues.
The next stage of the project will begin to implement local integrated services based on priorities that have been established during the first stage. This will need to be carefully and closely evaluated in order to establish whether integrated service strategies can work in practice, and more importantly that they can have a real impact improving services to users at local levels.

It is difficult to give a definitive assessment of the impact of this project since at this stage the project has only been established for one year. However, there are indications that the project is working well and that there has been a good start in developing a new culture of working and has led to new forms of co-operation between state agencies and local communities. Whilst much of this groundwork has been based on high levels of commitment from representatives of government departments and agencies, the project now requires a much greater strategic national co-ordinating focus in order for local integrated service provision to be realised. Indeed, experience has shown that it has been harder to achieve real integration of services at the national level than at the local level. Nevertheless, the project has high level political support. In addition, the monitoring and evaluation of the project, from user as well as a provider perspectives, is a crucial element of the project and external evaluators will be regularly monitoring and evaluating progress from autumn 1999.

Because social public services in Ireland remain high centralised it will be important to establish how far ISP will be able to shift local provision away from previous models of local service integration which have reproduced national services at local levels. Finally, the project is rooted in a model of integrated state provided services. This raises important questions about the role of voluntary, community and private providers of services, particularly in the care and welfare fields, in the provision of integrated services.
Section 4: Conclusions and recommendations

4.1 Introduction

This report has highlighted a number of major contextual changes in the organisation, delivery, and funding of social services that has resulted in the restructuring of services in Ireland, Luxembourg, Portugal, the Netherlands and Sweden. In some cases these result from a shift towards more individualised rights, away from mass universal, state provided, bureaucratically run and professionally delivered services, and in others they are a result of partnerships between emerging state, community, voluntary and private market relationships. Increasingly, there has been an emergence of new forms of identity and human agency that have deepened understandings and responses to the increasingly complex and differential needs, opportunities and risks associated with social exclusion and welfare dependency.

Whilst many of the key challenges leading to reform programmes are shared by all five countries, this report has also shown that there are marked differences in approach, including different levels of funding, state intervention, decentralisation and de-institutionalisation in the five countries. These are typified by different welfare regimes (Esping-Andersen, 1993, 1996).

Reference to good practice has been an important purpose of this report. Whilst there are many problems associated with the restructuring of social public services, not least in ensuring that adequate funding is put in place, that the reform process is meaningful to users and that this does not lead to adverse working conditions for workers, it is important to show how good practice can be built upon. Some of these models can be built upon and important lessons can be drawn for the provision of social public services across Europe. As a result a number of recommendations for the development of social public services across Europe are made at the end of this section.

In Section 1 of the report the background to the recent development of social public services was discussed. A particular objective was to identify similarities and differences between the five countries and to focus on the recent reform processes that have led to integrated and co-ordinated strategies to improve the quality of services in a more user-orientated framework. In particular, the growing use of partnerships in the delivery of services, the growing importance of user empowerment strategies, quality control mechanisms and the growth of the voluntary and community sector as providers of social public services were highlighted as contributing to this process of change. Finally, the impact of these changes on working conditions was discussed with a view to identifying the key pressures that have led to a growth in flexible working initiatives and equal opportunities, and as services have restructured the impact that this has had on staff morale and work pressure.

In Section 2 an overview of the key areas of restructuring towards more client-orientated services and improved quality was discussed with reference to dependent elderly people, young disadvantaged unemployed people and people with learning disabilities and mental illnesses. The greater targeting of resources to these client groups is reflected in the shifting demands and needs of these groups, and a greater awareness of the impact of multiple forms of disadvantage that can lead to dependency, isolation and social and economic exclusion.
In Section 3 seven examples of good practice are presented. These represent different client groups and a range of different national and local initiatives selected from the five countries studied.

In the first example, the implementation of the innovative and user-orientated Personal Budget was introduced to improve both the quality of home care services for dependent elderly and disabled people and improve the choice and control users have over their care. Of interest is that the development of new forms of organisation and training (spearheaded by the trade unions) have helped to prevent isolation and exploitation of care providers, whilst the Personal Budgets have improved the quality of care and autonomy of users.

In the second example, the introduction of Dependency Insurance in Luxembourg is a good example of an integrated system of care that works within a multi-disciplinary framework to prevent dependency arising because of old age or disability. By allowing choice of carer the insurance scheme empowers users and recognises the importance of resourcing informal sources of care. Finally, an important feature of this system is the emphasis placed on the quality and skills of the carer.

In the third example, the development of a joint rehabilitation unit for elderly and disabled people in Väntor District Council in Sweden presents a good example of a participatory approach to the development of a local integrated service. It is important to note that this approach became possible as a result of the decentralisation of resources and powers to the municipalities after 1992. This project has had some highly successful outcomes regarding the creation of a quality local service that involved users, staff, the unions and management in developing quality improvement and integrated working methods.

In the fourth example, the innovative KrAmi project was discussed in order to show that it is possible to integrate a wide range of agencies into a single model of working with highly successful results. The role given to the development and training of staff and to the regular evaluation of work has been crucial to ensuring that the project has relevance to the client group’s needs. This has facilitated an integrated approach to successfully tackling the multiple problems faced by young people whose history of drug abuse and criminality has led to their exclusion from work and society. The success of the project is based on it’s focus on the integration of young people into work and in developing the social and inter-personal skills of the young people to do so through work placements. Another important feature of the project is that it now has core, permanent funding and the model has been reproduced around the country.

In the fifth example, the Setubal Centre Against Unemployment in Portugal was identified as a model of good practice of a community-based initiative that is rooted in local networks and with a strong identification with local people. In particular, the project had initiated a number of important projects with excluded young people who had no contact with local statutory employment services. The project is innovative and the commitment from staff and volunteers is impressive. However, the project suffers from a problem of short-term funding.

In the sixth example, the DZB-Leiden project in the Netherlands provides work and training opportunities for disadvantaged young people, people with learning disabilities and people with mental health problems and presents a model of good practice for the integration of these excluded groups into work and society. Of importance to the project are its wide networks, local support, systems of job-coaching and on-the-job training, and statutory funding through
the supported work scheme. Working within a market and productivist model, the project is rooted in a commitment to combating social exclusion and empowerment through supported work.

The seventh example, the Integrated Services Project in Ireland provides an interesting model for the development of local services, achieved through the local integration of nationally provided statutory services. An important feature of the project is the identification of local problems, in partnership with local people that require an integrated approach to new service delivery and quality of service. The development of the project through local working groups and the resourcing of the initiative through additional staffing in each of the pilot areas has been important to ensuring that there has been adequate preparation to identify needs and respond to these with new integrated service initiatives.

4.2 User empowerment, partnerships and new routes to policy formulation

To varying degrees all five countries are embarking on new forms of user empowerment, new ways of articulating and identifying user needs, new partnerships and routes to policy formation. The growth of local, national and international networks of users has led to a greater level of expertise and sharing of good practice across Europe. Overriding the changes to services are emerging challenges and growing demands for improved services from client groups, for instance, older people, rooted in the emergence of a new climate of user empowerment and user demands in all countries. This growth of user movements asserting new forms of user control and welfare citizenship stress the role of users as agents of their own welfare destiny who are increasingly articulating differential welfare needs (Williams et al, 1999). This shift has been particularly marked in services for older dependent people, people with learning disabilities and mental illnesses, as direct challenges to inadequate statutory and voluntary provision have led to new statutory and quality frameworks designed to enhance service quality, user empowerment and a break with the past that recognises rights to decent services.

In many respects these new movements of change have resulted from a progressive movement based on equity, social rights and citizenship that have emerged from new social movements around gender, disability, class, race and age. In other contexts, these shifts emerge from new social problems, a growing recognition that the social exclusion brings with it multiple risks and needs, to which traditional social systems of welfare delivery have failed to respond. The effect is to see the trend towards more individualised solutions to welfare needs and more targeting of services to the most disadvantaged, for example, young people who are excluded because of drug addiction, educational disadvantage or early school leaving. A further trend evident in all five countries is the shift away from bureaucratic and professional led and delivered services to a policy framework increasingly based on managerialism.

One good example of this change has been the new understandings of the relationship of care and service provider to users. One clear trend has been the growing recognition of gender divisions in informal care and the significant role played by informal carers (Lewis, 1997). The greater articulation of informal carers and the growing body of evidence of their roles has led to some important outcomes in policy, whereby increasing statutory support (including carers payments, relief and respite care, and home care support) is now provided. This has led to increased funding for care of the elderly and disabled in all countries; in Sweden this has been important to prevent the increasing costs associated with institutional and other
community based forms of care; in Portugal and Ireland this has been a response to the need to support and develop the important informal and voluntary care infrastructure. This has led to more individualised packages of care and a greater level of user choice and articulation of their own care needs. The examples of good practice discussed in Chapter 3 of Personal Budgets in the Netherlands and of Dependency Insurance in Luxembourg are evidence of this greater individualisation of care, of user empowerment, and improved perceptions of quality amongst users.

4.3 Shifting policy discourses

Many of these developments are crucially linked to the growing awareness that social exclusion is caused by an increasingly complex set of problems. New understandings of these multiple problems and risks associated with social exclusion are now recognised in public policy through the development of more strategic and targeted anti-poverty programmes in all countries. Of importance is that this policy shift is directly related to the role of social public service and the need for improved delivery of services through integrated and co-ordinated policy responses and improved resources resulting from the identification of new needs. Whilst these programmes recognise the importance of local activity and of local involvement, they have tended to be based on high level governmental and political statements of intent which are beginning to filter into new thinking about service delivery. One of the problems encountered in these programmes is that they tend to co-ordinate national policy activity and that making these strategies meaningful at local levels requires radical organisational changes. Nevertheless, the significant movement towards decentralisation of power and resources to local levels has had a powerful effect on service delivery in the Netherlands and Sweden. Ireland and Portugal are beginning to grapple with these problems and new strategies are being discussed to decentralise services to local levels.

In all countries the marked shifts towards more active labour market measures is a reflection of the growing costs of welfare dependency and new relationships between welfare and work that are supporting the most disadvantaged people. For example, developing supported work programmes for occupationally disadvantaged people in Sweden has been tied into the need to support independence and autonomy and thereby reduce dependency. In Ireland, the Netherlands and Portugal tackling multiple forms of disadvantage that are rooted in early school leaving and educational disadvantage has led to a reorientation of policy away from standard vocational training measures to more targeted and individualised based programmes. Reductions in unemployment has led to the most disadvantaged young people being targeted in labour market programmes, particularly as their problems and disadvantages have become more visible.

In summary, the key themes related to the impact of the restructuring of social public services on the quality of services and the quality of working life are working within a policy environment that stresses:

- Improved efficiency and quality of public services as some countries face budgetary constraints, a mixed economy of provision and growing user demands
- Decentralised services to local levels to improve the ability for care systems to be flexible and integrative, particularly in response to de-institutionalisation
- Improved public finances and public management
- The promotion of social inclusion and ensuring that everyone has access to basic minimum income and service entitlements
• New policy directions that are beginning to respond to new social risks such as increasing family poverty or educational disadvantage
• Reducing welfare dependency and promoting greater self-reliance through active rather than passive measures, for example through active labour market measures that lead to training, rehabilitation and work experience. This is increasingly linked to benefit payments
• A greater role for the not-for-profit voluntary and community sectors in the delivery of services, through partnerships or direct funding from government.

4.4 The Quality of Working Life

The quality of working life is directly related to the supply of social public services and the interaction of these in facilitating or restricting women’s entry into the labour market, policies on family friendly working practices, union agreements on equal opportunities, or factors mitigating against the provision of informal care services, for example, cost of housing in Lisbon. There is no doubt that new employment relationships resulting from an increasingly mixed economy of provision, new forms of flexible work and new patterns of women’s employment are radically altering established patterns of public service employment. Nevertheless, public service trade unionism remains high in the five countries studied and there is evidence of a modernisation process taking place within the unions themselves in their responses to public service restructuring (Olsen, 1996, Martin, 1998, Pillinger, 1998).

However, the restructuring of social public services has brought with it new forms of stress, heavy workloads and in a growing number of cases staff ‘burn out’. Throughout the course of this study this was a common source of complaint from staff working on innovative projects that were experimenting with new forms of co-operation and integration. This includes representatives in the community and voluntary sectors whose lack of time and resources made partnership working problematic and for whom short term funding adversely affected morale. Increasingly, also, staff in government departments and municipalities who were developing co-ordinated and integrated working methods, new forms of quality control and new organisational structures, regularly experienced overwork, as integrated working tends to be an add-on to existing jobs.

In addition, the growing number of voluntary and community sector service providers, particularly in Ireland and Portugal, has resulted in an increasing incidence of short term project-based funding which can lead to problems of continuity and consistency in provision and staffing. The example of good practice of the Setubal Centre Against Unemployment identified the problems for community based projects of this nature, which have led to difficulties in providing continuity of provision.

The factors affecting working conditions can be summed up as follows:

• Cost cutting measures are leading to problems in working conditions – in Portugal one of the most significant concerns about young people’s employment is the precarious nature of the labour market and limited opportunities for well paid and secure jobs.
• Modernisation of public administration has brought with it new approaches to working hours, flexibility at work and trade-offs for flexible hours
• Trade union partnerships remain strong and a partnership approach to modernisation has been in evidence.
The challenges faced by public service trade unions and public service employers are enormous in this respect. The restructuring of services in all countries has had a major impact on changing work organisation in the social public services and to new patterns of employment that are less likely to be based in the public sector and therefore accorded differential rights and levels of protection than those enjoyed by public sector workers who have been protected by strong trade unions. Nevertheless, national agreements in Sweden and the Netherlands, and new legislation in Luxembourg, Portugal and Luxembourg, have to differing degrees protected employment rights or equalised employment relationships and contracts between the private, voluntary and public sectors. Although this has not been without contention, trade union strategies have increasingly been focused on the rights of non-public sector workers who are delivering social public services, resulting in campaigns to recruit and represent workers in the voluntary and community sectors and in the private market sector.

The European Foundations EPOC survey has similarly revealed the important role given to direct participation of employees in the social public services, particularly in the public sector which tends to be highly unionised across Europe and backed up by collective agreements that tend to offer employment protection (European Foundation, 1998). Indeed, it is clear that the best working conditions have evolved where there are good employee-employer relationships, cemented in collective agreements at national and local levels. The trend towards more localised bargaining structures in all countries has been a reflection of the need to orientate working conditions to local circumstances and needs. This works particularly well in Sweden and the Netherlands where local bargaining takes place within a national collective agreement framework. In Ireland, the national agreement has been important in setting national priorities for collective bargaining around pay and conditions of employment in the public sector.

The effect is that new challenges to public service trade unionism and public service management have evolved based on a number of new imperatives, that can be summed up as follows:

- Flexibility in working time, developing choice and equal opportunities as a direct result of service improvements and extended services
- Negotiating new forms of work organisation, including partnerships between unions and employers in organisational change at all levels of the occupational hierarchy
- Developing new concepts of training and learning organisations that are flexible to change, including the negotiation of leave for training, family or sabbatical purposes
- Recruiting and protecting workers in the growing not-for-profit sector and ensuring that managers and staff alike are supported
- The development of alliances and joint strategies between trade unions and user groups.

The massive changes taking place in social public services suggest that there is a parallel transformation in working conditions, new forms of work organisation and new perspectives on training. Indeed the reform of public management in all five countries stresses the need for continuing training, greater flexibility over the employment cycle and new lifelong learning strategies. The concept of the learning organisation experimented in Sweden and the Netherlands is a step forward in this respect.

Co-ordinated and integrated services means that employment and skills requirements are changing and new employment structures and regimes are developing. The management of
change is crucial to providing continuity of services and of working conditions, as was the case in Sweden after the 1992 Ådel reforms. In Portugal, many of the significant changes in public administration and the creation of new methods of delivering services and providing information, for example, through one-stop-shops has been achieved through high levels of consultation and involvement with the public service unions.

Likewise national government priorities to support women’s roles as carers and as workers have led to important new initiatives in all countries, particularly the Netherlands and Sweden. The changes in the Dutch labour market resulting from the shift from low levels of women’s participation in the labour market towards higher participation rates has resulted in government policies that aim to complement the support of carers’ and their needs. For example, the introduction of a career break and emergency leave schemes has enabled more carers to combine paid work and caring roles.

Greater flexibility in service provision has had an impact on working hours and working time. For example, in the Netherlands and Sweden home help services can now be provided on a 24-hour basis. This includes the growth in the numbers of qualified and unqualified home helps, as well as specialised home helps for people with multiple and complex psycho-social problems. Alpha carers carry out similar tasks to the unqualified home help but the user of the service employs them; most are middle-aged women returning to the labour market. The vast bulk of these carers in the Netherlands (77 per cent) have no formal qualifications and this has led to new strategies by the public service trade unions to organise these workers and to support their own professional development.

4.5 Quality of services

There is no doubt that changes in work organisation leading to more flexible, responsive and client-orientated services is a major factor contributing to the improved quality of services. This report has shown evidence of a growing commitment to quality in all five countries and has shown an emerging quality framework based on service quality initiatives, Total Quality Management, quality groups and new methods of evaluation and organisational reflection. This discourse of quality has not been without its contentions or difficulties, particularly where notions of quality may differ between providers and users.

The best examples of quality initiatives are those that involve both users and providers in meaningful and practical quality improvement. These localised initiatives that sit within national quality improvement frameworks, are increasingly found in all five countries. This is emerging in Portugal at local levels and in the process is revealing the need for better quality and trained staff. Best practice at local levels can be found in the use of quality groups of users and workers in the home care service in the Netherlands, and in the development of a system of quality in the example of good practice to creation of a joint rehabilitation centre in Väntor in Sweden.
4.6 Recommendations for the development of social public services across Europe

4.6.1 Working conditions, working time and work organisation

- Improving working conditions is central to improving the delivery of social public services. The importance of the relationship between the quality of work and the quality of services needs to be built into programmes of restructuring.
- This is particularly important to the success of experiments and innovations in service delivery and in the light of the need to ensure that the management of change is carried out in the most effective and participatory way.
- Developing flexible working times and new forms of work organisation that empower workers and allow for greater choice and equal opportunities are crucial to this process.
- It is equally important that the growth in demand for services is properly staffed and resourced. Evidence of shortage of and problems in recruiting nursing and care staff in all countries means that pay levels, employment conditions and opportunities for flexible working need to be implemented that recognise the value of health and social care staff to the economic and social inclusion.
- The development of care in the community (away from institutional care) requires new staffing structures, new staff competencies and new working practices. This must be reflected in staff training programmes and continuity of employment and conditions of employment for staff shifting from institutional based care to community based care.
- Job creation programmes in the social public services should be developed to take account of the expansion of social public services. The Kalmar model in Sweden and the citizens service in Luxembourg could be further explored with a view to developing public service job creation programme, particularly for young long-term unemployed people who can gain valuable work experience whilst contributing to social inclusion. It is important, however, to ensure that these job creation programmes do not lead to the a dual labour market and a growing division between core, permanent workers who are properly protected through labour law and the newly created temporary posts.
- The growth of provision in the voluntary and community sector has led to a great deal of innovation in service delivery that has connected with disadvantaged local communities. The expansion of this sector needs to be adequately supported so that concerns about funding do not detract from the important role played in service provision. It is vitally important that the growth of this sector is not undermined by insufficient funding, poor continuity in funding and short-term project based regimes.
- This growth of the social economy, typified by a growing role in service provision by the voluntary and community sectors should be further encouraged. In particular, it is crucial that the employment rights of staff in this sector are not at levels below those existing in the public sector. This has important implications for trade union strategies and in ensuring that employment conditions set by statutory funding agencies are at levels comparable to the public sector.
- As care needs grow, volunteering can be further developed through resourcing and training. In particular, active-ageing strategies can equally be developed through the involvement and participation of elderly people in both service design and service provision.
- Making the best use of existing networks, volunteering and community activity through programmes of participation and training can only enhance the quality of services, the
ownership of these at local levels and the development of new notions of civic and citizen responsibility.

- As greater user empowerment strategies lead to more user choice in the care field, it is important that the development of a casual care market of unprotected workers does not develop. This has implications for trade unions strategies in providing support and training to providers of care who are directly employed by elderly and disabled people. The experience of supporting carers in the Netherlands and Luxembourg can be further built upon in all countries.

### 4.6.2 Equal opportunities

- Equal opportunities is central to new forms of service provision, not least in ensuring that the delivery of services recognises new forms of identity and the articulation of needs around race, class, gender, disability, sexuality and age.
- There is an important imperative to ensure that the restructuring of services leads to flexible working conditions that are responsive to the needs of parents, and particularly of women. Taking proper account of equal opportunities, the need to reconcile family and work life and the development of family friendly working practices, must be the responsibility of all stakeholders, employers, trade unions and governments. This is particularly important in the light of the need to make employment in the health and social care attractive to women and parents and therefore to ensuring that adequate staffing levels are in place as greater demands are placed in social public services.

### 4.6.3 User empowerment strategies

- User empowerment strategies are central to the development of innovative and user centred services. A greater degree of direct user involvement and identification of user needs is still needed in all five countries. This user involvement needs to be developed at both national and local levels and be properly resourced.
- Independence and autonomy are central to the development of user empowerment strategies. Models of good practice that can be further developed and applied in all countries include: the creation of personal assistants for people with learning disabilities and mental illnesses in Sweden; Dependency Insurance in Luxembourg and Personal Budgets in the Netherlands; rehabilitation care and education models in Sweden and the Netherlands; and supported work programmes in the Netherlands and Sweden.
- In Ireland, the identification of the needs of people with learning disabilities through the *Intellectual Disability Database*, is a model of good practice that can be applied as a tool for service planning at local or national levels. It is important that where service needs are identified that these are translated into planning tools that reflect shifting needs and resources. This model can be applied to all client groups and requires the creation of data collection and information systems to ensure that the results are translated into practical tools that determine services needs.
- Trade unions and user organisations should be encouraged to develop closer partnerships and alliances, in so doing making important connections between user and worker perspectives on service needs. The experience of this in Sweden has been important in developing new systems of information and education relevant to users, workers and the general public in the mental health field and can be applied as a model of good practice in the care sector overall. In the Netherlands and Portugal, partnerships between trade unions and users have led to some interesting experiments in user perceptions of services and in identifying user needs. These models can be further built upon in Sweden, the
Netherlands and Portugal and can be applied as important relevant models in Luxembourg and Ireland. These developments should be supported by statutory funding.

4.6.4 Partnerships

- The increasing orientation to partnership working is highly welcomed. However, in order to ensure that partnership working is inclusive of all partners (particularly representatives from local voluntary and community groups and organisations) there is a need for adequate training and resourcing of time spent in partnership meetings. This will ensure that the full participation and integrated of all groups into the decision making process is implemented in practice.

4.6.5 Integrated service delivery

- Integrated strategies need to be based on strategic national policy supporting mechanisms that build-in resources for local implementation.
- Integrated service delivery must remain a clear priority in all five countries and should not be undermined by funding or organisational inertia. This report has shown that extensive preparation, staff training, and resourcing is required before service integration strategies can be effectively implemented. They cannot be developed as an add-on to existing staff loads and they cannot be expected to operate without extensive training of staff in statutory and non-statutory agencies.
- Integrated and co-ordinated services must be developed for the benefit of local people, particularly in the most disadvantaged communities. This requires flexibility on the part of government departments and policies that ensure that decentralisation be properly resourced. The allocation of resources needs to be responsive to local needs and these should not be undermined by short-term budgetary cuts.
- Integrated services are vital for targeting the most disadvantaged young people, since their needs extend beyond traditional vocational training provision. Partnerships between schools, state agencies, employment services, families and local communities are increasingly needed to tackle the multiple causes of educational disadvantage and early school leaving.
- Within this framework there is a particular need for employment services to co-operate with other agencies in order to respond with more flexible, integrated, preventative and individualised programmes that recognise the interplay of multiple forms of disadvantage faced by young people. This requires new staff competencies and expertise in all countries.
- The co-ordination and integrated planning of services in the care field present some important lessons for active labour market strategies in all countries where co-ordination is less well developed.
- Where collaborative activities have been developed at the national level these need to be mainstreamed into local practices, services and projects.
- There is a need to ensure that innovation and experimentation is encouraged through additional statutory funding earmarked for this purpose. As soon as innovative projects have been deemed to be successful it is imperative that core funding be made available for the dissemination of models and to ensure the sustainability of innovative projects into the future.
- Further systematic research, evaluation and monitoring of the impact on integration on provider relationships, working patterns and work organisation, as well as user perceptions of the effectiveness of these in delivering more user-orientated and locally
relevant services. To date it is difficult to assess the effectiveness of these experiments given the early stage at which many of these are and further work needs to be developed to ensure the most appropriate levels of service integration.

- National strategies on integrated service delivery have resulted in a plethora of national structures that are not necessarily adequately co-ordinated, since they have sometimes led to chaotic structures and duplication of issues. The practice in the Netherlands and Sweden of ‘super’ government ministries dealing with all aspects of social affairs has been one way forward in forging closer co-operation and integration across government services. This has enabled the complex needs of different client groups to be responded to in integrated and co-ordinated ways. This is a particularly important lesson for Ireland and Portugal where new inter-departmental committees have attempted to co-ordinate existing centralised government structures.

- It is clear that experiments in local service integration have worked well in the Netherlands and Sweden because of the devolution of powers and resources to the local levels. This has begun to take place in Ireland and Portugal. The success of local integration strategies therefore requires devolution of responsibilities and powers to local levels.

4.6.6 Quality improvements

- Quality improvements need to be developed in ways that are meaningful to both users and front line staff. The successful implementation of quality improvement is highly dependent on national frameworks, which allow for local adaptability to local needs. Crucially, this means that both the providers of the services, from managers to front line staff and users of services are fully involved in determining quality measures, including service improvement, performance indicators and practical methods of evaluation and monitoring.

- Quality standards for people with learning disabilities in the Netherlands developed in partnership with staff, management, users, parents and relatives offers a model of good practice for implementing quality through teamwork that also works on changing belief systems and attitudes amongst the stakeholders. Similar models of ‘quality groups’ and ‘quality raisers’ in the care sector in the Netherlands and of ‘quality awards’ in Sweden can be developed for all social public services in all five countries. These models should be explored as a way forward for the practical implementation of good quality standards in care.

- Giving more rights to users to determine their own care is of great importance to improved quality. User empowerment through Personal Budgets in the Netherlands and the creation of the Dependence Insurance scheme in Luxembourg are a good model for other countries to adopt since they provide for much greater user choice and flexibility in care.

- Good quality care needs to be measured against the extent to which it contributes to independence and autonomy of users.

4.6.7 Resourcing restructuring, integration and partnership working methods

- Integrated and co-ordinated working methods need to be developed within a framework of partnership with users, managers and staff, voluntary, community, private and government agencies.

- Of importance is that sufficient resources are needed to prepare for integrated and co-ordinated working, including initial research to identify existing provision, new needs
and the types and levels of co-ordination and integration. Co-ordination and integration inevitably leads to new organisational structures and methods of delivery. It is crucially important that these structures do not reproduce and replicate existing structures and therefore create new forms of bureaucracy, cycles of meetings and duplication of issues within a variety of structures and settings.

- Resourcing of integrated and co-ordinated services also requires significant inputs into staff training in order to breakdown established organisational and departmental cultures and develop staff expertise. This sits within a broader framework of the need for lifelong learning and new forms of ‘learning organisation’ that can respond to change (technological and organisational) in flexible and innovative ways.

4.6.8 Monitoring and evaluation of service improvements

- There is a clearly defined need for more research that identifies user needs. The evidence in this study suggests that this is relatively under-developed.
- In addition, this study has identified the need for a more systematic monitoring and evaluation of the new models emerging in the social public services, particularly related to the impact of integrated service developments on working conditions and improved quality and delivery of services that are user focused.
- This report has shown that the development of national and local policies to combat social exclusion has been important in initiating the restructuring of social public services. However, there is limited systematic data collection on the actual impact of these strategies in reducing social exclusion at the national and local levels. It is vital that there are systematic systems of data collection and evaluation at national and local levels.
- Evaluation of new service integration initiatives has often focused on the providers of services and whilst these may show that initiatives may be progressing well and leading to new service approaches, they contain limited evidence from users themselves about new forms of service delivery. This is not to say that user and providers necessarily have different perspectives about service improvements, it is simply that this evidence is not widely available. As a result user surveys before, during and after the implementation of service integration initiatives are an important element of measuring the success or otherwise of new projects.
- The dissemination of good practice should be properly funded and the sharing of good practice across Europe should be further encouraged and co-ordinated through transnational exchanges, project dissemination and the resourcing of networks of users, professionals, front line staff and voluntary and community organisations.
Appendix 1: Overview of national situations

Ireland

In Ireland social public services are provided through a combination of state, voluntary and charitable organisations and in recent years there has been growing pressure to coordinate these various services. Although Ireland’s social public services have led increasingly to an institutional model of provision, their origins lie in church, charitable and voluntary provision, which has increasingly been regulated and funded by the state. In Ireland the voluntary and community sector have always been significant providers of community based services. In this respect the development of the social economy is seen as a positive way forward in Ireland and has led to locally based social economy projects that have been supported by FAS, European and national government funding. A particularly good example is the Tallaght Social Economy Unit developed by the Tallaght Partnership in Dublin that has been operating since 1997. It has developed initiatives to support community businesses, social enterprises and co-operatives that are focused on tackling social exclusion and which provide jobs and services in the local community.

Ireland, in contrast to other European countries, has been slower to decentralise services and the bulk of its social public services remain centralised and delivered within a national framework. Many organisations refer to the problematic nature of this, particularly since it has led to a top down approach that does not lend itself well to local service co-ordination. Co-ordination is also difficult because the administrative and geographic boundaries of the centralised government services via the Health Boards, the national training providers FAS, social services and education do not always coincide. However, in the field of social public services the co-ordination of health and personal social services functions has been operating since the creation of regional Health Boards under the 1970 Health Act. This provides for a continuity of hospital/institutional and community based care for people with learning disabilities and mental illnesses and elderly people that do not exist in other European countries.

Ireland’s transition into a modern economy is reflected in its strong economic performance and a reduction in unemployment from 17 per cent in 1993 to 7.1 per cent in December 1998. There has been a corresponding rise in employment rates, marked by larger numbers of women, particularly working part-time. High growth rates have resulted in pressure being placed on the government’s public sector pay policy, with strikes by nurses and other public sector workers claiming higher wages. High growth rates in Ireland (averaging 4.9% a year) are shared with the Netherlands. Ireland will introduce a statutory minimum wage by 2000 (proposed at IEP 4.40 per hour).

Despite record levels of growth, Ireland continues to have high levels of poverty. According to the 1999 report of the Anti-Poverty Strategy, since 1997 the numbers of people who are consistently poor has fallen from between 9 and 15 per cent to between 7 and 10 per cent. Unemployment has fallen from 11.9 per cent to 6.4 per cent and long-term unemployment has fallen from 6 per cent to 3.1 per cent.

Ireland has been adopting an increasingly active labour market policy in recent years, including skills training, employment subsidies and direct employment schemes. Tackling unemployment has been an important focus of activity and this has been implemented widely.
through the development of local Area-Based Partnerships which have been made possible through the EU Global Grant for Local Development. This is administered through the Area Development Management Company and has led to the creation of thirty-eight urban and rural partnerships in areas of high long-term unemployment. They were introduced in the early 1990s to tackle social exclusion in a spirit of decentralisation and participation. They are made up of representatives from local voluntary and community groups, employers, trade unions, representatives of national social welfare, training and economic development authorities. To date the partnerships have provided a model of local community participation, particularly in initiating local employment initiatives.

**Youth unemployment**

However, long term youth unemployment remains a problem in Ireland. Indeed this is reflected in the emphasis given to this in the Irish National Action Plan on Employment submitted to the EU in 1998. The national training agency, FÁS, recognises that the problem of early school leavers contributes to social exclusion of young people. As a result it has developed specific services for early school leavers which were further expanded in 1999. An important measure is a major investment programme in Community Training Workshops and improved literacy and numeracy programmes, to enable early school leavers to improve their chances of finding jobs. This includes targeted vocational training (including linked work experience, customised and specific skills training, introductory training and personal development programmes for disadvantaged young people), counselling and guidance and steps to discourage early school leaving. In addition the Advocacy Programme that operates in 14 areas develops personalised career plans for young people, including counselling, guidance and psychological support through the YOUTHREACH programme. The YOUTHREACH programme is targeted to young people between 15 and 18 years of age and provides basic training leading to the Foundation Certificate, covering a range of vocational skills, general education and work experience. It exists in 100 locations across Ireland. The success of the FÁS training schemes: 40 per cent of unemployed young people referred to FÁS for interview in September 1998 had left the Live Register by October 1998 (FÁS, 1999).

The success of the Irish economy has led to record levels of job creation, with total employment increasing by 95,000 in the year to spring 1998. FÁS activities have been successful in this process of employment growth. For example, FÁS services for jobseekers have led to 70 per cent of those completing courses finding jobs. In addition, the Community Employment (CE) programme has led to the employment of 37,500 people (90 per cent of whom are long term unemployed) on 3,000 CE projects. The CE projects have been important in supporting the development of local community projects and services within the social economy. However, they are only available to people over the age of 21 years, and a review of the scheme is currently underway to look at its future and possible extension to younger people.

Programmes to support long-term unemployed young people began in the 1980s at a time of high youth unemployment. However, more recently early school leavers have been targeted by FÁS and the Department of Education and Science, on the basis that of the 18 per cent of young people, who leave school without the Leaving Certificate, their unemployment rate remains 29 per cent higher than average youth unemployment. Unemployment rates of school leavers show that 59.1 per cent had no qualifications, whilst only 7.4 per cent held the Leaving Certificate (ESRI, 1997). Providing programmes and services for early school leavers is now a priority for FÁS and this has resulted in a new investment programme in
Community Training Workshops, literacy and numeracy programmes, and guidance and advocacy services for young people. In 1999 the scheme was expanded to include measures to prevent early school leaving, counseling and guidance, alongside a collaborative literacy project between FÁS, the National Adult Literacy Agency and the Irish Association of Community Training Organisations to enhance literacy and numeracy training. A joint Youthstart Pilot Project between FÁS and the National Youth Federation has provided part-time and introductory ‘Gateway’ training and assessment of young people’s potential and preventative measures to support young people in work. In addition the Youthreach projects FÁS and the Department of Education and Science provides counseling, guidance and psychological support for young excluded people. However, in evaluating the scheme the Combat Poverty Agency (1999) highlights the lack of coordination between the different agencies and the poor progression from this scheme onto mainstream training programmes.

Services for older dependent people, people with learning disabilities and people with mental illnesses

In Ireland, services for elderly dependent people, people with learning disabilities and mental illnesses are co-ordinated by the Health Boards who provide a range of services from institutional care to care in the community, including home help and meals-on-wheels services, day care services, public health nursing services, along with extended and respite care for dependent elderly people and their carers (Department of Health and Children, 1999). However, the bulk of care is provided by voluntary agencies and there is increasing state funding of this sector to provide core home and institutional based care. Many dependent elderly people rely on voluntary organisations to provide them with meals on wheels and other domiciliary care, whereas state services are more likely to provide medical and psycho-social care.

The development of home care services, outpatient services, day-centres, community residences, and domiciliary visiting by community psychiatric nurses reflects the shift from institutional to community based provision. In addition, rehabilitation and vocational training services are provided for people with a mental illness that co-ordinate Health Board activity with those of national training provision. Similar services are provided for people with a learning disability, including community based services: public health nursing service, home help service, social work service, alongside day care and residential care services. The Health Boards work in close co-operation with a number of voluntary agencies that provide support, day care, residential care and financial allowances. The Health Board can also provide training fees for people with learning disabilities and the National Rehabilitation Board co-ordinates vocational rehabilitation services for people with disabilities in order to assist them in finding employment (Department of Health and Children, 1999).

Social partnership

The Irish social partnership programmes have created innovative policy approaches in the areas of tackling unemployment and poverty: through local area partnerships and the national anti-poverty strategy. The three-year Partnership 2000 programme sets out the parameters for pay in the public and private sectors and establishes the framework for partnership and negotiation in a wide range of economic and social policies. This is developed strategically through the National Economic and Social Council which has the task to “provide a forum for the discussion of the principles relating to the efficient development of the national economy and the achievement of social justice, and to advise the government through the Taoiseach, on their application” (O’Connor, 1997:2).
The partnership approach has also extended beyond the traditional social partners to include community and voluntary groups, women’s groups, unemployed groups and the creation of the National Economic and Social Forum to tackle social exclusion and inequality embraces a wide partnership. In a review of these arrangements, the National Economic and Social Forum’s (1997) report acknowledges the importance of these wide-ranging and inclusive partnership arrangements. However it does suggest that these arrangements have not been fully inclusive and that consensus has sometimes been exaggerated. A number of recommendations are made to enhance the inclusion of all groups into decision-making processes and to translate national representation into local action.

Coordination and integration
Generally there is poor co-ordination of services at local levels owing to a highly centralised state that organises national services. The co-ordination and integration of services is high on the agenda in Ireland and attempts to decentralise services to local levels have taken place in a number areas, improving the possibilities for integrating and co-ordinating services. For example, the creation of local area partnerships for the delivery of locally integrated services and local drugs tasks forces have led to a more localised focus for services, within a national framework. This framework, however, sits within a national policy context whereby local authorities have limited roles in the provision of social public services. The June 1999 referendum on the status of local authorities has the potential to strengthen the democratic base of local authorities and enhances the possibility for greater local authority competencies and activity in this area. A recent example of the decentralisation debate is a proposal from the Ministry of the Environment and Local Government to give local authorities the same roles in social and economic planning as they currently hold in physical planning. The question remains as to whether local authorities would be given a statutory and resource base in order to perform this function.

However, Area Based Partnerships and local Drugs Task Forces in Ireland exclude local government. As a result there is a growing consensus that the restructuring of local government in Ireland is necessary to link local government into local development. The absence of local government in these processes has resulted in a lack of strategic planning and co-ordination at local levels within an overall context of integrating services locally. A Task Force on Integration of Local Government and Local Development Systems (Department of the Environment and Local Government, 1998) has led to a new policy to integrate local services post-1999 in order to improve the effectiveness of state agencies and community and development activities locally, by developing models for co-ordinating economic and social policy at county and city levels.

Although Local Authorities in Ireland have relatively limited powers, they are responsible for public housing and in recent years to working closely with other services in the recognition that poor housing is part of a wider picture of social exclusion that includes access to services, education, work, welfare and so on. For example, Dublin Corporation now works more locally to integrate housing provision with other services by providing facilities for local services that are provided by other agencies. Examples of this are the creation of local cooperatives employing local people for the maintenance of housing, and a local treatment centre for drug addicts whereby the premises are funded by the Local Authority and medical and welfare staff are employed by the Health Board.

The growing importance attached to improving service delivery reflected in government strategies to introduce service quality initiatives, performance targets and user involvement
has been part of the modernisation of public administration and management. Indeed, the National Economic and Social Forum (1995) report on the Quality Delivery of Social Services, had highlighted the poor record in the social services of client participation, of administrative coherence, of information, of appeal procedures and of integrated service delivery. The report recommended that rights to consultation and participation, information and advice, more choice and greater simplicity, improved access to services, and better systems of redress is implemented. In the recognition of the absence of integration in service delivery the report also recommended the introduction of integrated planning of services at the national and integrated delivery at local levels. The report states that:

Social services are administered by and through different bodies and there is little, if any, inter-Departmental or inter-Agency communication or planning. Unemployment and other forms of social exclusion give rise to financial, housing, education and social needs that are addressed by a disparate array for services. Yet the users of these discrete services are mainly the same people. (NESF, 1995:31)

In order to put these recommendations into practice the report also recommended that a partnership with employees and unions would need to be developed with new systems to improve the quality of staff and communications.

**Working conditions**

Flexibility in working time has grown in importance in trade union priorities. Working time reductions are not seen to be a priority by the public service unions in Ireland and the emphasis has been on improving opportunities for flexible working through job schemes and policies to reconcile family and work life. A pilot scheme has been introduced in the Department of Social Security, which allows for term time working providing for 75 per cent of an employee’s weekly or monthly salary. Because promotion in the Irish Civil Service is based on seniority, it was found that women who had taken term time working and job sharing were losing out on promotion. As a result of a decision in the European Court of Justice, full credit for seniority is now provided for job sharing or term time working, and this has been reflected in the reorganisation of the Civil Service in Ireland.

In the Irish civil service a Flexible Working Hours System of attendance was first piloted in 1977 and is now widely used by employees. Job sharing schemes have been introduced in the civil service, 80 per cent of which is taken up by women. In a new drive towards modernisation programmes in the civil service a recent agreement has increased the possibilities for part-time and flexible working, with pro-rata terms and conditions of employment for part-time workers. In addition, an agreement was signed in 1998 to introduce a worksharing scheme into the Irish Civil Service. The scheme develops an existing jobsharing scheme by helping staff to combine work and family responsibilities, and enabling staff nearing retirement to reduce their hours in order to ease the transition from full-time work to retirement. Leave averages 50 per cent of the hours worked, and pay is on a pro-rata basis and can be taken in a variety of ways, including one week on/one week off, split weeks, mornings only, afternoons only, four day week, two weeks on/two weeks off, three weeks out of four. Employees can initially participate in the scheme for six months, extended to twelve months (Department of Finance, 1998).

In the public sector in Ireland trade union concerns about employer demands for greater flexibility and changes in work organisation, have led to new partnerships at the workplace,
based on a shift towards greater flexibility being negotiated with the full participation and consultation of all workers.

Luxembourg

Luxembourg has developed a comprehensive range of social public services, many of which are provided directly by private and voluntary organisations with state funding. The problems in coordinating these diverse and unregulated arrangements led to legislative reform in 1998.

The social security system in Luxembourg evolved over a relatively long period of time to include all groups in the population. The Law of 26 July 1986 introduced a minimum wage that consists of a supplementary benefit paid irrespective of the causes of low income and a basic income was introduced in 1997 (RMG) covering all low-income households. The importance of this is reflected in the greater attention that Luxembourg has given to tackling social exclusion in recent years and the real attempts to address disadvantages associated with old age, youth and disablement. Like other European countries the growth of social security expenditure has risen to 30 per cent of GDP. 40 per cent of funding of social security comes from the state, with employers’ and employees contributions forming the rest; social security now takes up about 50 per cent of entire benefits followed by health insurance.

The standard of living in Luxembourg is relatively high and Luxembourg has the highest GDP per capita in Europe. Life expectancy is relatively high – 72.6 years for men and 79.1 years for women (1990-92). By 1993 the infant mortality rate had fallen to 6 per cent. Luxembourg works on the premise of strict budgetary equilibrium. Between 1970 and 1994 government expenditure grew by an average of 10.5 per cent and is seen as evidence of growing government intervention in economic affairs. In 1994 transfers to the public sector formed the largest share at 33.3 per cent, particularly for government funding for social security.

There has also been a significant increase in the labour market participation of women particularly in the growing service sector of the economy. In addition, the Luxembourg labour market is characterised by a large proportion of foreign workers – who in 1998 represented more than 50 per cent of the labour market. Increasing demands on services has led to an increase in the government budget from 10.1 billion LUF in 1980 to 56.7 billion LUF in 1998. The population over 80 years has more than doubled in the last 25 years and in 1998 they represented 3.3 per cent of the total population.

In 1998 unemployment averaged 3.1 per cent (compared to 3.6 per cent in 1997). Although this is a relatively low unemployment rate, it is exceptionally high for Luxembourg. A number of job creation programmes, supported and subsidised work, work placements, and vocational training schemes have been developed in recent years. A new Fund for Employment (Fonds Pour L’Emploi) has been established and has been extended to cover the integration of all unemployed people into work. In addition a new “back-to-work” training scheme has been introduced. The overall objective is to create 1,8000 new jobs within 18 months (EIRO, 1998d). There has been a creation of new jobs at an annual rate of 3 per cent-5 per cent over the last decade. Luxembourg remains a strong economy with a growth of 5.5 per cent of GDP.

Luxembourg has a well-established tripartite structure of decision making, involving government, employer’s organisations and trade unions. In Luxembourg, the negotiations for
the 1998 National Action Plan included new provisions on working time, flexible-working times and reductions in working time have been negotiated. A survey of working time in the public sector in Luxembourg identified a strong preference for more flexible working hours, particularly amongst women. Many of the respondents to the national survey carried out by the Ministry of the Public Sector and the Ministry for the Advancement of Women showed that many public sector workers were prepared to trade off shorter working hours for loss of pay (EIRO, 1998f).

**The Netherlands**

The Netherlands is characterised by a social democratic model with high levels of welfare spending and access to universal and comprehensive benefits, although influenced by Christian Democratic ideology and a social insurance model. The social partnership model between government and interest groups (e.g. trade unions, client organisations) operates through advisory bodies and committees.

The Dutch partnership model (the ‘Polder’ model) which has introduced wage moderation, control of public spending and control on social security has had some remarkable successes. This led to an agreement to trade off wage moderation for an increase in jobs between the social partners, a reform of the social security system, including cost containment, cuts and measures to reintegrate people into work. The ‘polder model’ also led to new systems of consultation; discussion and consensus building activities that were also applied to the health service through systems of self-administration at local levels, alongside the introduction of marketisation of services.

The recent success of the Dutch economy can be measured by growth rates that have exceeded those in the EU as a whole, between 1994 and 1996 this represented 2.7% of GDP, compared to 2.3 per cent in the EU. Employment growth has been another success, with employment growing at a faster pace than other EU countries, with an average growth in employment of 1.2 per cent per year.

An important objective of Dutch government policy is the prevention of social exclusion and the promotion of social participation, through investment in social infrastructure. Despite the success of the Dutch economic model in producing high growth rates and relatively low unemployment, Dutch society is increasingly marked by polarisation and divisions between different economic and social groups and the growing number of people who are on the margins of society, a large proportion of whom are from ethnic minority groups (Ministry of Health, Welfare and Sport, 1997c). The reform process in the Netherlands began in the 1970s when high levels of public debt forced the Netherlands into a cost-orientated system. An important shift took place during this time in shifting the Netherlands towards a society recognising the importance of families and relatives in the provision of care and a greater attention to individual and civic responsibility and the participation of the voluntary and community sectors in determining and implementing policies. Health and welfare policies were also decentralised as part of this reform process from central government to provincial and municipal authorities. In addition Dutch social policy strategy emphasises the importance of the integrated and co-ordinated approach to tackling social problems, for instance in the field of family policy this has led to inter-departmental policy co-ordination and a number of experiments in integrating education and welfare policies. This is reflected in the 1994 Welfare Act and the mission of the Social Policy Department which is: “To prevent and remove social exclusion and to promote social cohesion through mediating between
exclusion-related policy areas and actors in society” by “developing a common ground in other policy areas, cross-sections for joint initiative development” (Ministry of Health, Welfare and Sport, 1997c). This has resulted in a policy model that integrates co-ordination at the national level between ministries and consultation with social partners and users in determining policy.

An emphasis on policy has been the creation of ‘locally-based social renewal’ strategies for medium sized cities and ‘Major Cities’ policy (1998-2000) in the cities of Amsterdam, Rotterdam, The Hague and Utrecht. These policies which target areas of urban deprivation through integrated local community based initiatives. Improving services to citizens has also led to the development of one-stop offices for citizen’s inquiries through the public front office 2000 project (Overheidsloket 2000) alongside the development of local authority pilot projects that provide information on care and welfare services for elderly and disabled people.

An important activity of the Social Policy Department has been the development of an emancipation policy which aims to improve the position of women as providers of services, particularly women employees in the care sector, and improve the position of women users of services. For instance the Ministry of Health, Welfare and Sport argues that by taking gender differences “into account can improve the quality of services” (1997d).

Despite a health economy and a relatively low rate of unemployment, long-term unemployment and poverty amongst the most excluded remains a problem. Unemployment amongst ethnic minority groups is five times higher than the indigenous population. In the four largest cities – Amsterdam, Rotterdam, The Hague and Utrecht – 24 per cent of the population lived off a minimum income, half of whom had been on a minimum income for three or more years (Ministry of Health, Welfare and Sport, 1997b). The social policy of the Dutch government is firmly rooted in policies that take account of citizen’s perspectives in policy formulation. According the to Ministry of Health, Welfare and Sport (1997a) “These matters find expression in aspects such as poverty policy, encouraging social participation, family policy and the promotion of social independence” (1997a:1)

In 1995 the Dutch cabinet produced an anti-poverty document The other side of The Netherlands (Ministry of Social Affairs and Employment) which aims at a preventative approach to combating poverty and social exclusion. Wide consultations and the introduction of monitoring systems have taken place since the publication of the document and this has encouraged public debate, the participation of excluded groups in the policy process, including the trade unions, the National Foundation of Service User Councils and other organisations representing poor and excluded people.

The development of social public services
The Netherlands has highly decentralised services and a high level of provision, its services are universal. Local government is based on 549 municipalities and 12 provinces. The bulk of welfare is provided by non-profit organisations who are funded by the state, local authorities and social insurance, these organisations have moved from being charities to professional service providers; there is a limited provision by commercial and profit making provision. The emphasis is on public funding and private provision of care and the development of a market-orientated and needs-led service. A high priority is given to client empowerment and local user forums and these have been developed at the municipal level for this purpose.
In the social care field the bulk of care is provided by private care organisations, whilst the state’s role has become increasingly that of enabler, funding private organisations, supervising their activities and regulating the quality of care through quality standards. Increasingly the Dutch approach to social care has become overly complex and this has led to new efforts to coordinate and integrate services. This has been achieved by establishing care programmes or packages. It has led to new packages of delivery and new ways of financing whereby funding is made available to programmes rather than distinct areas of care. The impact on working practices is that there has been a similar move away from individual professional workers working independently of each other into professional organisations that are able, via team working, to respond to change and provide coordinated responses to needs.

Since 1998 services have been further integrated and moved towards a client orientated approach regarding welfare, housing and care services, and the creation of one body giving older people a unified access to all services; this has had the effect of raising the standard of old people’s housing and thus preventing one of the main reasons for the entry into institutional care. However, the Netherlands has a strong tradition of informal care (especially by women) reflected in low participation rates in the labour market. The greater co-ordination and integration of services is encouraged and supported by the Ministry of Health, Welfare and Sport, for example between social and health care in providing an integrated home care service.

At the same time the care system went through major reforms with the state taking the responsibility for the planning and administration of care, with private associations providing the care. The decentralisation of services to local levels was also a mechanism to provide more caring services for elderly people within their own homes, rather than in institutions. However, the high costs of providing home help services led to a shift away from central government funding to funding provided by a mixture of users, health insurance and public subsidies and the introduction of the Alpha help scheme in 1982 to further reduce the costs of care and provide cheaper help with basic household tasks. An important development in 1987 was the publication of the report of the Dekker Committee on the future of health and social care, with recommendations for the integration of health and social care, the marketisation of services and a needs-led approach. This led to the financing of social care through a new health insurance scheme, which was revised and extended by the incoming 1989 Christian Democratic/Socialist government. The effect was to shift the financing of social care away from the state towards employers, individuals and the municipalities.

The modernisation of the Dutch welfare state since the 1990s has resulted in a policy of cost-containment and a greater emphasis on the co-ordination of services, for instance between housing and care services, a client-orientated approach, and greater individual choice and user empowerment, manifested in the introduction of the Personal Budget in 1994. Since 1993 a major reform programme has been introduced in social security that has resulted in streaming benefits and the privatisation of social security agencies (Nierop, 1999). Equally important has been the emphasis placed on the quality of services. For instance, legislation passed in November 1993 the development of quality control in health and care institutions has led to the creation of quality control officers in hospitals and a national quality care policy has been agreed between insurance companies, patient and consumer organisations and the government, which allows care to be tailored to different needs and organisational settings.

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7 The Individual Health Care Professionals Act. The Act focuses on the quality of professional practice in institutional and non-institutional settings. It stresses the freedom of choice available to the patient.
(Ministry of Health, Welfare and Sport, 1997). In addition, devolving services to local levels has been introduced to reduce bureaucracy and to reduce the gap between the state and the citizen. The 1996 Municipalities Act further decentralised services to the municipal level by allowing municipalities with populations over 100,000 to set up their own district councils; to date this has been implemented in Amsterdam and Rotterdam. Services in the Netherlands are organised through twelve provinces (with responsibility for social work, planning, environmental management, sport and cultural activities) and 548 municipalities (with responsibility for traffic, water supply, housing, schools, social services, health care, sport, recreation and culture).

**Tackling unemployment**

Unemployment fell to 6.5% in 1998. However, high rates of long term unemployment remain a feature. The government is also tackling long term unemployment with targets to reintegrate long term unemployed people into the labour market within five years. This has led to the implementation of plans to provide assessment of the training and work experience of unemployed people with a view to them gaining employment. This has brought together both social security and job creation functions of the government alongside vocational training.

In 1998 a new structure to co-ordinate labour market policy was introduced through the creation of local Centres for Work and Income (Centrum voor Werk en Inkomen, CWI). The aim of the centres is to co-ordinate services providing benefits and access/integration into the labour market. An objective of the centres is that they will be managed and run by private organisations, as part of a wider development to privatize the social security system. (EIRO, 1998g). In 1999, additional resources are also earmarked for integrating the long-term unemployed into the labour market, improving working conditions, extending subsidised jobs for long-term unemployed people and disabled people.

In 1998 the Job-seekers Deployment Act (WIW) brought together two previous pieces of legislation (the National Labour Pool and the Guaranteed Youth Employment Act) into one framework. The new legislation requires local councils to assist benefit recipients, young people and long term unemployed people to find paid employment. The objective is to create 20,000 new jobs for long term unemployed people. The government’s lifelong learning action plan also aims to prevent early school leaving in attempt to ensure that young people have qualifications when leaving school. (EIRO, 1998f).

**Working conditions**

Consensus in collective bargaining in the Netherlands has created a dynamic form of industrial relations that has shown itself able to respond to work flexibility in innovative ways. In particular, Dutch workers have agreed on working time reductions on the basis of minimal or nil pay increases and the public service unions have agreed to lower pay increases if these are traded off for jobs or shorter working hours.

The Netherlands has a low average working week for full-time workers and there has been a sustained campaign since the late 1970s to reduce working hours overall. In particular there has been an important issue of equity in these campaigns in order to make it possible for part-time (predominantly female) workers and full-time (male) workers to redistribute their working hours. For historical and cultural reasons a larger proportion of the population works part-time than in any other European country and this is characterised by longer part-time hours than most other countries (O’Reilly et al, 1998, Pillinger 1998).
By the 1990s trade unions began considering different models of working hours and the FNV introduced a target of a four-day week, to be introduced through sectoral agreements. In the public services working time negotiations have led to collective agreements for a 36-hour working week in the education sector, national government and hospitals. The 1996 Working Hours Act allows for reductions in working hours from 38 to 36 weekly hours with state supported job replacement built into some sectors. New legislation to be introduced in 1999 further aims to extend the rights to work part-time and introduce mechanisms by which working and caring responsibilities can be combined.

**Portugal**

Portugal's particular relationship to its citizens and the provision of services is rooted in its recent history. Portugal emerged from fascism in 1974 with a modern democratic system, with citizens rights firmly embedded in the constitution and a new system of social partnership. For this reason the development of social public services has taken place relatively quickly. In recent years Portugal has moved into a vigorous era of public sector management reforms as it has begun to grapple with a new role of a modern state that is increasingly orientating its services to citizens needs. The Portuguese Economic and Social Council firmly embedded trade union, employer and government relations into this model. Successive governments have, until recently, promoted the role the state as the main provider of services, in a highly decentralised system based on democratic elected local municipal executives, assemblies with local legislative powers, and neighborhood councils at sub-municipal levels. The success of the reforms introduced post-1974 are reflected in the universal provision of health care and education.

Portugal remains a poor country, its economic development and GDP, and rates of poverty and exclusion remain the lowest in Europe. Approximately 30% of families are defined as poor. In areas of high deprivation in Lisbon, Porto and Setubal over 50 per cent of young people between the ages of 14 and 24 years had not completed compulsory basic education. The high levels of poverty and exclusion in Portugal today has led to a large number of anti-poverty and inclusion initiatives, projects and experiments, many of which are directly linked with local community and voluntary organisations (Evans et al (1998).

Portugal is a highly centralised country. There are 350 municipalities whose roles are relatively limited. In 1991 two metropolitan areas in Lisbon and Porto were created in response for the need to manage large and expanding urban areas. The Lisbon metropolitan area has 2.7 million inhabitants covering 18 municipalities, Porto has 1.2 million inhabitants covering 9 municipalities.

**The development of social public services**

Portuguese social public services exist within a rudimentary welfare system, whose roots are based on informal family and church provided services in the care field. More recently the expansion of social public services has taken place by increasing the role of private sector initiatives and their management to the private social solidarity institutions (IPSS). For example, education services are provided in the public and private sector and vocational training has been developing in recent years from extremely low levels of provision. The introduction of a national apprenticeship scheme in 1986 and the higher targets set for vocational training in 1993 are a breakthrough in this respect. Portugal does, however, have a universal National Health Service where primary health care and hospital services are provided free to all of the population regardless of their economic or social position. The
social security system, whilst rudimentary, does aim to provide support for all citizens and targets the most disadvantaged; it is financed through contributions from workers, employers and general taxation.

Social public services in Portugal are currently facing major changes, resulting from the restructuring and reorienting of services. There are three main dynamics of these changes. First, a significant factor in this process of change has been the shift towards the privatisation of social public services and/or the state funding of private and NGO providers. Like other European countries this trend is geared to finding cost-effective solutions to the rising costs of social public services, although the Portuguese response to these has differed from other European countries. Second, changes in family and household relationships, critically linked to the supply of affordable housing in urban areas and to the sparse provision of services in rural areas, highlight the significant problems facing the modernisation processes underway in Portugal.

The unavailability of affordable housing, particularly in urban areas has led to the highest number of families with three generations living together across Europe (OECD, 1998a). Along with a growth in divorce and single parenthood and the increasing participation of women in the labour market the pool of informal carers has declined. The Portuguese state has had to respond to this development, although resources remain relatively low to tackle the growing care needs.

However, the Portuguese system based on family care has become less likely to exist in its traditional model. Greater migration, particularly to urban areas, and the unavailability of affordable housing, particularly in Lisbon, means that families, especially women, are less able to provide informal care in the home. This problem is particularly marked in Lisbon where housing costs and unregulated rents are amongst the highest in Europe. Larger numbers of women are entering paid work, one the one hand, to fulfil their own desire for independence and self-fulfillment, whilst on the other hand housing can only normally be afforded if two partners are in paid work. The emerging 'crisis' in care becomes more pronounced with reduced fertility; the current generation of potential pool of family carers are significantly reduced as a result. Furthermore, growing youth unemployment and limited state support for young people has resulted in a situation where large numbers of young people are dependent on their families for support; indeed Portugal has the highest average age of young people living with their parents in Europe (at approximately 27 years). For long term unemployed people the pressures on their families are significant. This situation was worsened with the introduction of a package of labour laws introduced in 1998 which removed the entitlement of many young job seekers to social security benefits alongside new labour market solutions for young people based on non-contractual, precarious employment possibilities. According to the CGTP trade union confederation this has had the effect of worsening the living and working conditions for young people.

Like other European countries Portugal has seen a decline in fertility rates leading to smaller and more diversely spread families, and an increase in the divorce rate has led to an increase in single parent households. However, Portugal has the third highest number of households with five or more children (16.6%) and the highest number of families with three generations living together. Third, cuts in public expenditure, in part introduced in order to reduce public deficits to enable Portugal's entry into EMU has coincided with a growth in demand for services resulting from an ageing population and high levels of youth unemployment. For example, there currently exists a major shortage of nurses in Portugal, estimated by the
government to be 8,000 and by the CGTP as 12,000 which is placing significant demands on existing nursing staff and which in turn means that nursing care in the home is very limited. Fourth, these new pressures on services, the breakdown of family systems of care are often at odds with Portugal’s policies on citizen orientated services.

**Changing health care**
The marketisation of social public services has been under debate in Portugal. The most important area has been the privatisation of Portuguese hospitals. Workers in the public health services threatened strike action in 1997 on the basis that this would result in poorer quality services. The CGTP argues that proposed annual budgets for the administration of hospitals will affect the employment security of staff, making employment more precarious, and also the quality of care to patients. Working conditions in the private sector are worse than those in the public sector hospitals (EIRO, 1997b). The marketisation of health care has led to an experiment in private management of a public hospital (Amadora /Sintra hospital). The model has not worked well and there are doubts about its transferability. Staff have poorer conditions of employment and fewer contractual rights than exist in the public sector.

The provision of universal, state-funded health care is fundamental to Portuguese society and to the state's relationship to the citizen. In recent years a fundamental change has been taking place in the delivery, funding and management of health care, leading to a package of reforms in 1999 to facilitate state funding of private health and hospital care. A severe shortage of nurses has worsened the availability of community based and hospital based care. The Portuguese national health care service was created after 1974. It has been a largely hospital based system of care, with limited community or home based services compared to other countries. In the last two years a number of experiments have been made to integrate hospital based care provision with primary health care and community provision in the creation of new community based health care units. The objective of these centres is to take health care into local communities and thereby reduce the dependence on expensive hospital based care. To date there has been no integration of municipal provided care services, although discussions have taken place about how this further integration of services can be developed in the future. Trends towards more private sector solutions to health care are now being developed into new legislation to be introduced in 1999.

**Reform of social security**
Portugal is currently undertaking a major reform of the social security system as a result of concerns about the social and economic challenges and the future financing of the system (EIRO, 1997c). In 1997 the Portuguese Government introduced a guaranteed minimum income as a means of combating social exclusion and poverty. It comprises a cash benefit alongside new programmes to enable people who are excluded and marginalised to be integrated into training and work. Employers and unions, as well as government agencies are included in the local monitoring committees that have the role of approving and monitoring social integration programmes. These are based in the municipalities, and following a successful initial pilot scheme, the programme has now been extended to cover the whole of the country (EIRO, 1997d).

**Care of the dependent elderly people, people with learning disabilities and mental illnesses**
Care provisions are limited to weekly meals on wheels and laundry services. Day centres in some neighborhoods, organised by neighborhood councils or charities, provide for social activities on a weekly basis. Government departments and municipalities provide support to
charitable and church organisations. In rural areas, where no local support is available the Ministry of Social Security provides services. The bulk of the day centres for elderly people are created through the local structures of the national Confederation of Elderly People - MURPI - that now has many sites across the country. A relatively small proportion of the dependent elderly reside in residential or nursing homes. The state co-operates with these homes and their costs are subsidised through social security and from a contribution from the elderly person themselves, dependent upon their income. The bulk of these homes, until recently have been run by NGOs and charities. In more recent years there has been a growth of private profit nursing homes, subsidised by the state, some of which had previously been state owned. There are long waiting lists for the homes and the result is that many elderly people are left at home with no care. However, these are poorly regulated and a set of recent scandals of abuse of elderly people has led to the closing down of a number of homes and a call for greater regulation and inspection. The National Confederation of Elderly People and the Retired members organisation of the CGTP have been lobbying for increased government support for elderly people on the basis that the dignity and quality of life of older people is being neglected. An interdepartmental government committee with representatives from the trade unions and user organisations recently reported that improved inspection and improved quality of care should be a priority, including a recommendation for improved levels of home care support. This has led to government proposals to regulate homes and to find new practical solutions to the problems presented.

In addition, some municipalities have provided holiday schemes for dependent elderly people who remain relatively mobile, through the creating of the state run Mitel institution which provides subsidised holiday breaks for elderly people to off season coastal hotels. This initiative which began in 1994 in partnership between the local and central government and charitable organisations is currently expanding its operating to a larger number of hotels. Pensioners pay a charge proportional to their incomes. It is viewed as a highly successful initiative, it takes the burden off families for a short break and provides older people with social support and cultural initiatives, which have important social and health benefits. 4,000 elderly people have so far participated in the scheme. However, there is concern that this scheme only exists for the relatively active elderly, whereas the dependent elderly face many problems including isolation, disability and poverty.

Vocational training
The official unemployment rate in Portugal is relatively low, however, there are large numbers of unqualified and poorly trained young people. For this reason issues of education and vocational training have been a high priority in Portugal (reflected in the 1998 National Action Plan and subsequent declarations by the government and social partners) (EIRO, 1998e).

In some cases the trade unions have been direct providers of training and other services. For instance, a UGT/Sintap project developed a mobile training bus with equipment for vocational training that has been targeting second generation Africans in poor quarters. CGTP has been a direct provider of training services for a number of years. One model vocational training project has been set up by the CGTP trade union confederation, and funded under a protocol established with the Ministry for Education, which provides vocational training for young people between 15 and 19 years of age. The project aims to equip young people with relevant vocational skills at the equivalent of the national school leaving qualification at level 3. The scheme that has been recognised as an exemplary case by the European Commission provides training on nine different sites across the country for up to 800 young people. The
training is linked to the skills gaps existing in each of the areas covered and is responsive to the needs in urban and rural areas. This result is a high rate of employability compared to other school or training providers. The CGTP view the project to be an important extension of their roles, notably to equip young people with the skills required in the labour market. A further initiative, Innovinter, is a jointly financed Centre for Employment and Training, by the Ministry of Labour and the CGTP. 80 per cent of the funding come from the Ministry of Labour. The centre primarily runs courses for workers, although in recent years their activity has led to new programmes being developed for young unemployed people.

Working conditions

In 1998 a new Decree Law (Law 259/98) was introduced to increase flexibility in working time in order to extend the opening times of public services, allowing for part-time work and greater management flexibility in defining work organisation. An important aspect of the Law was the mechanisms introduced for informing and consulting trade unions (EIRO, 1998e).

The 1996-9 tripartite Strategic Concertation Pact (Acordo de Concertação Estratégica) has a number of goals related to social exclusion including measures to increase employment and competitiveness, improve productivity, working conditions and productivity, development of active policies on employment, education and training, reform social protection and tax, and modernise and reform public administration. However, the social partners are clear that measures in the Pact have been slow to be implemented, particularly in the areas of social security, labour legislation and education (EIRO, 1998g).

The breaking down of the distinctions between workers in the Portuguese public administration and employees in the private sector has been a policy response to the introduction of market approaches to the delivery of services (EIRO, 1999a). Concerns about poorer working conditions in Portugal resulting from the increasingly precarious nature of the labour market has led to a diminution of the legally protected contract of indefinite duration contract that has typified employment relationships in the public sector.

Sweden

Sweden has a long social democratic tradition of universal services for its citizens that continue to be at one of the highest levels across Europe. However, Sweden’s public debt doubled in the early 1990s, unemployment tripled and the budget deficit increased ten-fold to 10 per cent of GDP, at that time the highest of all EU countries. The new government elected in 1994 instituted a series of spending cuts on welfare, pensions, health insurance, unemployment, family assistance and child allowances. However, by the mid-1990s budgetary stability was achieved and unemployment in Sweden fell from 9.1 per cent in December 1997 to 7.5 per cent in December 1998.

High unemployment in Sweden in the early 1990s led to the objective to halve unemployment by the year 2000 with a work strategy to achieve this. A particular focus has been on the support that can be given to young excluded unemployed people, thus avoiding the likelihood of their permanent dependence upon social security. In addition, there are concerns about widening social divisions, social exclusion and inequality, particularly amongst young people, single parent families, and immigrants (National Board of Health and Welfare, 1998). In particular there has been a growth of poverty (measured as those below the social assistance threshold), criminality and substance abuse among young people, and of multiple and persistent problems associated with social exclusion. The 1997 Social Report for Sweden
documents that the most severe multiple problems are experienced by young people, single parents and immigrants, with five per cent of young people between the ages of 20 and 29 years having great difficulty in entering the labour market. Many of these young people come from single parent, blue collar and/or immigrant backgrounds. Finally the 1997 report shows that eight per cent of the elderly who live alone are insecure and vulnerable, experiencing financial problems and ill health, with older elderly women and immigrants being the most vulnerable (National Board of Health and Welfare, 1998).

In the 1970s and 1980s the Swedish model has as its focus active labour market policies, social service expansion and gender equalisation, by maximizing employment and equalizing the status of women (Esping-Andersen, 1996). However, the model was based on a full-employment model that has been threatened with growing employment problems. In particular full employment and the rise in women’s employment was dependent on public sector jobs - and accounted for 80 per cent of total net job growth in the 1980s - and in the late 1990s this had fallen to 30 per cent.

The movement towards decentralisation and privatisation in Sweden and trends towards more emphasis on work and training programmes has led to a shift in priorities in favour of the young people and long-term unemployed adults. These were groups that in the traditional full employment setting were assumed to require only marginal welfare state intervention. According to Esping-Andersen: “In a sense what is emerging is a new life cycle definition of social policy with the recognition that contemporary family and employment transformation poses new risks and needs over the active, adult phase of people’s life courses” (1996: 14).

The growing importance attached to retraining policies, lifelong learning, schemes to facilitate job and geographic mobility, to joint parental leave provision are what Esping-Andersen refers to as a “manifestation of an emerging ‘social investment’ approach” (1996:14).

John Stephens (1996) documents the rise of Swedish social democratic approaches to the welfare state: based on full employment, women’s participation, active labour market policies and universal benefits based on notions of citizenship and entitlement, and social corporatism typified by social partnership approaches to policy making and bargaining. The beginning of a break up of the model can be seen from the down-turn in Swedish economic performance, rising budget deficits and massive increases in employment, although Stephens argues that the model remains intact, and that privatisation is only considered where this results in cost-effectiveness and improved efficiency. As a result a high priority is now attached to the reform of welfare to reduce its abuses and adverse effects and to improve the effectiveness and efficiency services. This has led to decentralisation of services to the local level, the greater involvement of user and community participation, and a partnership approach to service planning.

Active labour market policy
Active labour market policy in Sweden has its roots in social democracy and full-employment. However, the growth of unemployment in the last decade has led to a restructuring of labour market policy. The National Labour Market Board (AMS) is the central authority which deals with labour market policy and issues guidelines to the County Labour Boards which has responsibility for labour market affairs, employment offices, employability institutes and working life services at the county level. Local Employment Services Committees are responsible for local employment services. Additional resources are earmarked for job seekers who are occupationally handicapped (defined as people who
because of physical, mental, intellectual or social disability have difficulties in finding or keeping paid employment. This special support, provided by The Employability Institute (AMI), includes information on vacancies and job placements, vocational rehabilitation and targeted training programmes, work experience schemes. Employers receive wage subsidies for employing occupational handicapped people and grants are paid towards the cost of a workplace assistant to help with work tasks. In 1997 approximately 83,000 occupationally handicapped persons were registered as job seekers, and of these 27,000 were participating in labour market programmes. A young disabled scheme exists to support young disabled people and a growing number of vocational rehabilitation resources are being developed to provide specialist expertise and services for people with socio-medical, mental and intellectual disabilities (Arbetsmarknadsverket, 1998). During 1998 and 1999 employment was rising in Sweden as a result labour market policy shifted to supporting the most vulnerable people. For instance, one of the strategic priorities for 1999 is the provision to offer all young people under 25 years of age regular employment, suitable training, work experience, or other related programme formulated through an agreement and individual action plan within 100 days of becoming unemployed. In addition, an expansion of special programmes to cover 55,000 occupationally handicapped people has been introduced in 1999 (Arbetsmarknadsverket, 1999a, 1999b).

According to Korpi (1994) Swedish labour market policy has been instrumental in targeting those people with the worst employment prospects and finding jobs or job related programmes and successful in increasing levels of psychological well-being.

**Services for dependent elderly people, people with learning disabilities and people with mental illnesses**

In Sweden 95 per cent of services continue to be directly provided by the municipalities who can choose to purchase private services; cost constraints have forced many municipalities to operate within a cost containment framework and to contract out - leading to an increase in services to the private sector. Five per cent of care for the elderly is now provided commercially in the private profit sector.

The 289 municipalities and 22 county councils are responsible for providing social services to older people. 40 per cent of GDP is spent on social expenditure (22 per cent from the state, 33.9 per cent from municipalities and county councils, with contributions from individuals and employers covering 43.9 per cent. Municipalities have responsibility for social welfare, including care of the elderly and disabled people, primary and secondary schooling, housing, electricity and environmental protection. The social welfare budget takes up 41.3 per cent of municipal budgets. The social welfare budget is largely financed from taxation, although 8-10 per cent of the costs of care for the elderly is covered by user charges. In addition, new ways of managing social services are being developed, with a greater role given to contracting out of services to the private sector. The county councils are responsible for health and medical care, via local health centres and hospitals. The Swedish Association of Local Authorities is the strategic body that represents all municipal authorities to support and develop local self-government, to defend the interests of local authorities, to promote cooperation between local authorities and to assist with service and expert advice. One of its areas of responsibility is on general municipal policy that includes elder care. It has 23 regional organisations.

The municipalities and county councils have a strong tradition of self-government and autonomy from central government. The municipalities and county councils also levy local
and regional income taxes, albeit with greater restrictions placed on local taxes by central government during the 1990s.

The 1982 Social Services Act also requires that alternative housing be made available for people who are no longer able to live independently and since 1992 this has been the responsibility of the municipalities. At the end of 1995 there were 135,000 elderly people living in special housing schemes, including 20% of those aged over 80 years. These included service houses which provide sheltered accommodation, old peoples homes, nursing homes and group dwellings, the latter of which have increasingly been developed as an alternative to institutional care and normally involves small housing groups of 6-8 persons, for instance, for people with dementia. The growth of home help services in Sweden is a reflection of the larger numbers of people living in their own homes, the level of which has trebled since the 1970s. In 1995 10 per cent of people over 65 years and 21 per cent of those over 80 years received some form of home help service. In the 1990s the services have faced rationalisation and cuts, with help targeted to the most needy. Increasingly these services have provided round-the-clock care, including the night and weekends. In addition, there is good provision of day centres in Sweden. An important shift in policy and practice has been for these day centres to be run by elderly people themselves. In addition, a growth in the number of specialist day centres for elderly people with dementia have been important in providing respite and relief care for families. The Social Services Act and the Health and Medical Services Act set out the framework of provision, although there is no direction given about how these should be organised at municipal level.

During the 1990s a growing gap between needs and funding was experienced as the economy suffered decline. The ageing of the population has had particular consequences in Sweden with the numbers over 80 years increasing from 100,000 in 1950 to 400,000 in 1995. The reform of care systems in 1992 with decentralisation from county to municipal levels and new legislation in 1994 and 1995 covering the care of people with mental illnesses and learning disabilities, has meant that the costs of care locally have increased. The result was a significant shift in the services (including nursing homes and long term care hospitals, day care centres, group homes for people with dementia, and health care and rehabilitation for elderly and disabled people). In addition, a reduction in hospital and geriatric care beds has been replaced by support to people in their own homes and a shift in the home help service away from domestic service to individual care. This also resulted in the transfer of 55,000 employees from county to municipal employment. It is anticipated that as demands for care grow an increase in personnel will be required, one estimate argues that 180,000 new jobs will need to be created by 2010 (Jennbert, undated).

From 1 January 1997 Swedish municipalities were given more powers, greater local autonomy and accountability following legislation which decentralised certain social welfare functions to district level. The aim was to increase local democracy and increase the efficiency and quality of services. For instance, the City of Stockholm now organises and delivers its services through 24 district councils, whilst the City Council and City Executive Board acts much more as a strategic authority.

Value for money in services has become a matter of urgency as Sweden has also faced budgetary restrictions in recent years owing to reduced tax revenues associated with increasing unemployment, reductions in state funding, and growing demands on services, particularly from an ageing population. An additional pressure is the development of quality standards for municipal services, resulting from a greater pressure to contract out and
privatise services within a cost-effectiveness framework. A new model for this has been developed by Stockholm City Council as part of its strategic plan to be implemented and applied at the City and District level in 2000.

**Working time and work organisation**

The Swedish 1998 sectoral collective bargaining round was characterised by moderate pay increases, flexible working time and working time reductions, and training/skills development for the workforce. This was also linked to additional government funding to enable local authorities to create new jobs in schools, health care and social services (EIRO, 1998f). The trade unions representing workers in the social public services report that workers now have much greater freedom in choosing their working time; indeed reduced and flexible working hours have been an important trade off for extending services into evenings and weekends, and to improve the quality of life, reduce stress and reconcile family and work life.

In Sweden new models for the flexible scheduling of working hours have been developed in local government. These models, which set minimum and maximum staffing levels for each shift, allow employees to draw up their own work timetables. These schemes have worked well, allowing for individual preferences in working time. Many of these have led to experiments that have improved the quality of work and family life, improve services and enable rationalisations to take place through changes in work organisation. For some employees reductions in working time has led to job creation (Pillinger, 1998).
Appendix 2: Developments in public management and administration to improve the quality of services

Ireland

Modernising the public sector and introducing new public management have become a high priority in Ireland. In 1997 a major review of public administration was completed and this was followed up by a package of human resources management initiatives aimed at developing more flexible working practices and performance related pay as part of the Government’s Strategic Management Initiative (SMI). SMI aims to reform public service management in order to improve the quality of services and actively encourage citizen participation. A central part of this is the Delivering Better Government programme, introduced in May 1996, to improve the quality of service in the public sector through human resource management and partnerships with employees, the introduction of service quality initiatives within government departments and a partnership approach with the voluntary and community sector in order to improve service delivery. An important aspect of this document was the priority given to improving service in order to address unemployment, social exclusion and local development. In 1997 an important Quality Customer Service Initiative was introduced which required all government departments and agencies to set standards of service quality, based on a set of principles that had been agreed by the government.

The 1997 Public Service Management Act consolidated these guidelines in legislation and government departments were required to publish their statements of strategy. The Act states that each government department should prepare work programmes by 1 January 1999 in order to translate Statements of Strategy into practice, to enhance the effectiveness, transparency and efficiency of public services. A good example of a strategic approach to quality improvement can be found in the 1994 Strategy for Health, which introduced an improved quality framework and more accountability for the regional health boards. This was linked to improved performance management, and new organisational and management structures. Eight regional health boards are responsible for delivering health services and each has to produce an annual report on activity, with suggestions on how improvements can be made for improving the services (Department of Health and Children, 1994).

A greater orientation towards customers of services is in evidence from these plans. According to Humphreys (1998) this has resulted in a wide range of approaches by government departments which have not fully taken a customer focus on board from the design to the delivery of services. However, although the “plans lack consistency” this has led to a “process of reflection and change in some organisations” (p.76). He goes onto suggest that further work needs to be carried out in order that further develop and evaluate the further integration of services.

In 1999 a national framework for a local partnership approach to improving the quality of services and strategic goals was introduced in local government (Department of the Environment and Local Government, 1999). Local partnership committees have the responsibility for developing strategic plans for service delivery, delivering quality services, modernising services and introducing more customer-friendly services locally, alongside the implementation of local responses to national policy through the creation of small task and project focussed groups or functional groups.
**Luxembourg**

In November 1996 important new administrative reforms were introduced in Luxembourg in order to adapt and modernise public administration to new socio-economic and technological challenges. This is to be achieved by making the public sector more efficient and more responsive to citizens within a framework of public service quality based on transparency, equality, efficiency, human resource development, and reform of public sector pensions schemes.

**The Netherlands**

In the early 1990s new performance management and service delivery targets were set. These were further developed by the incoming Government in 1998 in a framework of marketisation and price fixing for goods and services. This has resulted from a priority since 1994 to develop agencies and semi-privatised services within the public sector. The implementation of the 1998-2002 agreement has also led to the development of autonomous semi-public bodies to deliver services. The most recent priority has been to develop autonomous administrative authorities to deliver social security.

The Netherlands has been managed through a consensus model of wage moderation. This has had an impact on the social public services including cuts in funding and improved quality services. In the Netherlands 15.6 per cent of the total working population is employed in the public sector. Employment levels in the public sector have fallen by about 10 per cent in the last decade, the national agreement for 1998-2002 plans to reduce this by a further 5 per cent.

**Portugal**

In the last decade public management reform has been central plank of the development of a modern and economically efficient state. The reform has been based on three key planks: first, to improve the relationship of the administration with citizens, second to improve public administration and third to simplify procedures and make them less bureaucratic. “The aim has been to create an internal dynamic for modernisation and for a client-oriented approach to service quality. A further aim has been to provide greater safeguards for citizens and to involve them more closely in the administration’s decisions and in the process of administrative change” (OECD Puma, 1998). Several municipalities have developed their own quality charters and the Secretariat for Administrative Modernisation (SMA) provides technical assistance, support and training quality for municipalities.

In the late 1980s the modernisation of the public administration towards more client-orientated approaches began in Portugal. This was necessary in an overly bureaucratic administration that had 18,000 points of contact with the public and 1,500 different licenses covering the public services. In particular the use of information technology has enabled this administrative modernisation to move ahead rapidly. The creation of a Secretariat for Administrative Modernization (SMA) was formed in 1986 to improve the quality, simplicity and accessibility of services. This led to an emphasis on service and client-orientation, business and result-orientated management, public participation, better information for citizens, deregulation and reductions in bureaucracy, user friendly procedures and the implementation of new information technology systems (INFOCID, 1999). An important outcome of this has been the development of information systems to make services accessible.
to the public. The same regime and regulations as those for central government officials with civil service status cover employees in municipalities.

**Sweden**

Public management and public administration have gone through some significant changes in the last decade in part a response to the need to reform the budgetary process in the light of economic problems faced during the early 1990s. Although the budgetary crisis has now been resolved there is a clear commitment to use resources in the most efficient ways. One strategic policy has been to delegate decision-making power from the government to separate agencies. In addition, the municipalities have been given greater freedom from the State regarding organisation and financing and this has led to decentralised decision-making to committees and boards.

In 1997 a public management Bill Central Government Administration in the Citizens’ Service was presented to Parliament (Bill 1997/8:136). It sets out mechanisms for improving the quality of central government administration and improving employee’s skills. This requires services to be accessible and user friendly, in order to gain the full confidence of the citizen. Quality and skills are seen to go hand-in-hand on the basis that citizens are entitled to high quality administration on the basis that the “agencies should provide good service in a citizen’s perspective and improve the skills of their employees” (OECD, 1998b).

The modernisation process in the public sector since the 1990s has led to a policy that state activity should increasingly take place through semi-state and private agencies. During the 1990s reform and restructuring of local government and the Local Government Act allows the municipalities to choose their own organisational structure and priorities. In the last few years it has been possible for education, childcare, care of the elderly to be run by private contractors. Six per cent of total service volume is now provided by private contractors and in many cases has reduced costs.

The National Council for Quality and Competence exists to actively and strategically influence public administration and supporting the modernisation process. Its primary responsibility is to develop initiatives on total quality management (TQM) and support this through training and information.

In the late 1990s Sweden achieved a balancing of its public finances. This led to new strategies within public administration that focus on the development of quality and of the skills of employees in order to improve the quality of services from a citizens perspective. This has also led to more benchmarking and systematic quality developments. In January 1999 a new agency was set up to promote quality developments, including improved performance management and the enhancement of the skills of employees. This has also led to proposals to launch a service improvement programme that actively engages citizens in dialogue about new service quality initiatives. A particular priority is to develop systems to create citizen’s electronic self-service initiatives.
## Appendix 3: Statistical information

### Table 1: Main social policy priorities and challenges in Ireland, Luxembourg, the Netherlands, Portugal and Sweden

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>Income adequacy, low employment rate and social exclusion are the main key issues of direct relevant to social policy. Unemployment is the main cause of poverty in Ireland, but there are also other factors. The financing of social insurance pensions is becoming an issue together with the issue of adequate retirement incomes.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Current priorities in the social arena are:</td>
</tr>
<tr>
<td></td>
<td>- Improve social protection of those receiving care from a third person, through a dependency insurance scheme</td>
</tr>
<tr>
<td></td>
<td>- Combat poverty and unemployment</td>
</tr>
<tr>
<td></td>
<td>- Preserve state pension schemes in the medium and long term</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Has a specific focus on reducing unemployment and promoting employment. Need to address pressures of ageing population on the labour market, pensions system and care services.</td>
</tr>
<tr>
<td>Portugal</td>
<td>General priorities for social policy include:</td>
</tr>
<tr>
<td></td>
<td>- Widespread review and reform of the social security system, considering aspects of efficiency, sustainability, social justice, effectiveness</td>
</tr>
<tr>
<td></td>
<td>- Intensifying the value of solidarity</td>
</tr>
<tr>
<td></td>
<td>- Providing more support to families as a key element in society</td>
</tr>
<tr>
<td></td>
<td>- Promoting new social policies against social exclusion</td>
</tr>
<tr>
<td></td>
<td>- Reforming the health-care system, to achieve greater accessibility, quality and lower costs</td>
</tr>
<tr>
<td></td>
<td>- Improved access to suitable housing, especially for impoverished populations</td>
</tr>
<tr>
<td></td>
<td>- Investing in human resources</td>
</tr>
<tr>
<td>Sweden</td>
<td>The overall objective is to develop a higher-degree of social integration. Within this framework specific priorities are:</td>
</tr>
<tr>
<td></td>
<td>- To halve the level of unemployment by the year 2000</td>
</tr>
<tr>
<td></td>
<td>- To establish a stable pension system and secure financing for long-term care</td>
</tr>
<tr>
<td></td>
<td>- Family policy, the rights of people with disabilities and social protection against misuse of alcohol and drugs</td>
</tr>
</tbody>
</table>

Source: *Kalisch (1999: 6-8)*
### Table 2: Integration and tailoring of services (between health and social services)

<table>
<thead>
<tr>
<th>Country</th>
<th>Integration of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>Health and social services fall within the responsibility of the Department of Health and Children and so integration is at a reasonable high level</td>
</tr>
<tr>
<td>Netherlands</td>
<td>The General Act on Exceptional Medical Expenses (AWBZ) covers long term care such as institutional/home care, as well as out-patient psychiatric care or other services not covered by compulsory or private health insurance</td>
</tr>
</tbody>
</table>
| Portugal | • Health services are, in principle entirely responsible to ensure the necessary health care regardless of service providers or of the place of services  
• However, practically there is a problem in allocating funds between health care services and social services  
• In the Integrated Home Care settings, the measures are implemented through pluri-disciplinary actions and care rendered at home, supported by various fields of professionals |
| Sweden   | • Municipalities are responsible for health and medical care in both institutional/home care settings  
• Boundary problems still exist after the Ådel reform, and improve co-operation and co-ordination is needed between the two sectors. At the local level, district nurses and needs assessors are to co-operate in joint planning for care provision, in the area of rehabilitation etc. |

Source: Kalisch (1999:189)

### Table 3: Distribution of employment: services in 1997 (% population 15-64)

<table>
<thead>
<tr>
<th>Country</th>
<th>Public Administration*</th>
<th>Education</th>
<th>Health and Social Work</th>
<th>Other Services**</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU-15</td>
<td>4.6</td>
<td>4.1</td>
<td>5.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Ireland</td>
<td>3.2</td>
<td>4.0</td>
<td>4.7</td>
<td>3.1</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>6.4</td>
<td>3.6</td>
<td>4.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>4.8</td>
<td>4.1</td>
<td>8.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>4.5</td>
<td>4.5</td>
<td>3.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>3.6</td>
<td>5.2</td>
<td>14.1</td>
<td>3.8</td>
</tr>
</tbody>
</table>


* includes public administration and defence; compulsory social security. Not disaggregated by national, regional and local administration and based on different national reporting systems.

** Sewage and refuse disposal, sanitation and similar activities; activities of membership organisations; recreational, cultural and sporting activities, and other service activities; private households with employed persons; and extra-territorial organisations and bodies.
Table 4: *Part-time work in Europe (% of total employment), 1997*

<table>
<thead>
<tr>
<th>Country</th>
<th>Men and women</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU-15</td>
<td>17.7</td>
<td>5.5</td>
<td>33.1</td>
</tr>
<tr>
<td>Ireland</td>
<td>13.7</td>
<td>6.1</td>
<td>23.2</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>8.5</td>
<td>1.0</td>
<td>20.9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>38.4</td>
<td>16.7</td>
<td>68.1</td>
</tr>
<tr>
<td>Portugal</td>
<td>5.3</td>
<td>1.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>25.2</td>
<td>8.7</td>
<td>41.8</td>
</tr>
</tbody>
</table>

Source: *Labour Force Survey, 1998*

Table 5: *Average Weekly Hours (employees), 1997*

<table>
<thead>
<tr>
<th>Country</th>
<th>Public Administration*</th>
<th>Other Services**</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU-15</td>
<td>37.7</td>
<td>33.0</td>
</tr>
<tr>
<td>Ireland</td>
<td>38.4</td>
<td>32.2</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>37.5</td>
<td>34.4</td>
</tr>
<tr>
<td>Netherlands</td>
<td>35.2</td>
<td>28.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>39.3</td>
<td>34.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>37.7</td>
<td>33.6</td>
</tr>
</tbody>
</table>


* includes public administration and defence; compulsory social security

**  Education; Health and Social Work; Sewage and refuse disposal, sanitation and similar activities; activities of membership organisations; recreational, cultural and sporting activities, and other service activities; private households with employed persons; and extra-territorial organisations and bodies.

Table 6: *Percentage of the population over 65 years in 1995 and forecast for 2020*

<table>
<thead>
<tr>
<th>Country</th>
<th>1995</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>11.5</td>
<td>17.0</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>14.3</td>
<td>19.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>13.1</td>
<td>18.0</td>
</tr>
<tr>
<td>Portugal</td>
<td>14.8</td>
<td>17.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>17.4</td>
<td>21.0</td>
</tr>
<tr>
<td>EU average</td>
<td>15.0</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Source: *Pacolet et al, 1998*
Table 7: Evolution of dependency ratios, 1960-2030

<table>
<thead>
<tr>
<th>Country</th>
<th>1960</th>
<th>1990</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>73.2</td>
<td>63.1</td>
<td>56.8</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>47.4</td>
<td>44.9</td>
<td>64.3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>63.9</td>
<td>45.1</td>
<td>68.5</td>
</tr>
<tr>
<td>Portugal</td>
<td>59.1</td>
<td>50.6</td>
<td>58.8</td>
</tr>
<tr>
<td>Sweden</td>
<td>51.4</td>
<td>55.6</td>
<td>69.0</td>
</tr>
</tbody>
</table>

Dependency ratios: population aged 0-14 and 65 and over as a per cent of the working-age population
Source: Kalisch (1999:25)

Table 8: Care systems in Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated spending on LTC % GDP (1992-5)</th>
<th>Estimate public spending on LTC % GDP (1992-5)</th>
<th>Share of population over 65 years in institutions - % of total</th>
<th>Share of population over 65 years receiving formal help at home - % of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>0.86</td>
<td>n/a</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>n/a</td>
<td>n/a</td>
<td>6.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2.7</td>
<td>1.80</td>
<td>8.8</td>
<td>12</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.39</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Sweden</td>
<td>2.7</td>
<td>2.7</td>
<td>8.7</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Source: Kalisch (1999:28)

Table 9: Unemployment and training: young people, 1997

<table>
<thead>
<tr>
<th>Country</th>
<th>Unemployment rate</th>
<th>Youth unemployment (% of labour force 15-24)</th>
<th>Youth unemployment (men)</th>
<th>Youth unemployment (women)</th>
<th>15-19 year olds in education/training (%)</th>
<th>20-24 year olds in education/training (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>10.1</td>
<td>15.7</td>
<td>16.5</td>
<td>14.9</td>
<td>81.2</td>
<td>28.5</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2.6</td>
<td>7.7</td>
<td>5.7</td>
<td>10.0</td>
<td>92.7</td>
<td>34.9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>5.2</td>
<td>9.2</td>
<td>8.1</td>
<td>10.4</td>
<td>80.7</td>
<td>49.4</td>
</tr>
<tr>
<td>Portugal</td>
<td>6.8</td>
<td>15.0</td>
<td>11.9</td>
<td>18.9</td>
<td>73.8</td>
<td>40.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>9.9</td>
<td>20.6</td>
<td>20.0</td>
<td>21.0</td>
<td>76.2</td>
<td>30.7</td>
</tr>
</tbody>
</table>

Appendix 4: List of interviews held

Interviews were held with the following people:

Ruth Barrington, Chief Executive, The Health Research Board, Dublin, Ireland
Francis Fletcher, Department of Health and Children, Ireland
Ann McGrane, Department of Health and Children, Dublin, Ireland
John Cullen, Department of the Environment and Local Government, Dublin, Ireland
Sean Moloney, Assistant Principal, Dublin Corporation, Ireland
Hugh Fraser, Combat Poverty Agency, Dublin, Ireland
Senan Turnball, ADM Ltd, Dublin, Ireland
Deidre Caroll, Department of Family, Community and Social Affairs, Dublin, Ireland
Peter Humphreys, Institute of Public Administration, Ireland
Bernard Harbor, IMPACT, Dublin, Ireland
Sile O’Connor, National Economic and Social Council, Dublin, Ireland
Council for the Status of People with Disabilities, Dublin, Ireland
National Council on Ageing and Older People, Dublin, Ireland
National Association for Mentally Handicapped of Ireland, Dublin, Ireland
Pedro Renquinha Dia, President, Conselho National de Juventude, Portugal
Claudia Cunha, Conselho National de Juventude, Lisbon, Portugal
Ana Cisa, União Geral De Trabalhadores (UGT), Lisbon, Portugal
Maria Fernanda Carvajal, National Secretary, SINTAP, Lisbon, Portugal
Maria Cecília Santana, Treasurer, CAD, Lisbon, Portugal
Teresa Paula Sanaiva, Secretary, CAD, Lisbon, Portugal
Fraklim Martins Melo, President, CAD, Lisbon, Portugal
Ana Critina MatosNeto, Secretariat, CAD, Lisbon, Portugal
Conceicid Barroqueiro, Head of Department of Religious and Social Affairs, Loures Municipality, Porgutal
Dr Maria José Brandão, Responsible for Mental Handicap, CNOD, Lisbon, Portugal
Albertino Flores Santana, International Secretary, CNOD, Lisbon, Portugal
Nuno Santana, CNOD, Lisbon, Portugal
Henrique Mendouça, Vice President, CNOD, Lisbon, Portugal
Fernando Mauricio, International Secretary, CGTP, Lisbon, Portugal
Ulisses Garrido, CGTP, Lisbon, Portugal
Ruz Carols Santos, InterFouer/CGTP, Lisbon, Portugal
EnueLinda da Comceied Hiveira, Inter-Reformados, Lisbon, Portugal
Jose Antonio Sukeura Sutil, CGTP, Lisbon, Portugal
Maria Do Carmo Tavares, Social Affairs Department, CGTP, Lisbon, Portugal
Fernando Caravajal, International Secretary, SINTAP, Lisbon, Portugal
Bertan Granja, Porto, Portugal
Luis Manuel Martins Rebelo and staff, Casa Pia de Lisboa, Portugal
Staff from: Centro De Apoio Aos Desempregados De Setúbal, Setubal, Portugal
Lise-Berg, Deputy Ombudsman, Stockholm, Sweden
J Zomerplaag, NIZW, Utrecht, Netherlands
Tessa Kelder, NIZW, Utrecht, Netherlands
Michel Grosse, FNV, Amsterdam, Netherlands
Frank Bliminck, Abvakabo, Zoetermeer, Netherlands
Pim Van Loon, Abvakabo, Zoetermeer, Netherlands
Edith Snoey, Abvakabo, Zoetermeer, Netherlands
Bart Lambooy, Jobcoach, DZB, Leiden, Netherlands
Frans Pas, Project Leader, DZB, Leiden, Netherlands
J Lesterhuis, Beleidsmedewerker, DZB, Leiden, Netherlands
Maij Pijl, Independent Researcher, Den Haag, Netherlands
Bodil Omegard, Kommunal, Stockholm, Sweden
Lise Berg, Deputy Ombudsman, Jamo, Stockholm, Sweden
Erling Ribbing & Kenneth Abrahamsson, Swedish Council for Work Life Research, Stockholm, Sweden
David Taylor, Vantör District Council, Sweden
Elizabeth Spjuth, Quality Section, Stockholm City Council, Sweden
Cécile Creisch, Ministère de La Famille, Luxembourg
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