

Answer to the European Commission
by the Federal Government of the Federal Republic of Germany
coordinated with the Federal Länder and taking account of the statements of
socially-relevant groups

Social Services of General Interest

Field 1 – Overview of the national SGI

1. What are the general characteristics of the national social SGI with regard to e.g. the following points?
 - **Organisation, design and structure** (geographical, market structure, administrative level);
 - **financing** (e.g. contributions, direct funding via government budget, payment of remuneration for the service, charity donations, mutualisation);
 - **service provider** (e.g. state and local authorities, public enterprises, public-private partnership, voluntary non-profit organisations, role of volunteers, private enterprises);
 - **definition of tasks/obligations** (what are these tasks/obligations and how are these laid down, i.e. contract, law or other);
 - **quality standards.**

The **principle of the social welfare state** laid down in the Basic Law (Art. 20 and 28 of the Basic Law [Grundgesetz]) cover social "services of general interest" as a fundamental task of the State. Social services of general interest are hence a part of the German social protection system. This is characteristic of the historically-based **variety of public and private organisations, as well as those orientated in line with the common interest**, whose cooperation must complement one another in the interest of those concerned (section 17 of Book I of the Social Code [SGB]). The following distinctions are to be used when referring to "**social services**" (including healthcare services) in the broader sense of the questionnaire:

1. Benefits of **social insurance** governed by Federal law (statutory health, long-term care, pensions, accident and unemployment insurance)
2. **Public welfare**: social services of the Länder and local authorities (rural districts, cities and municipalities)
3. **Charitable** social services in particular provided by **independent welfare**
4. **State and local authority investment promotion** (hospitals, long-term care and facilities for disabled persons, day facilities for children, social housing, emergency rescue services)
5. Independent **voluntary and self-help organisations**
6. **Private and commercial** social services

7. **Private insurance** and pension benefits (health and long-term care, private old-age pensions, company pensions et al.) that are **governed by social law**

Educational and training measures are **not social services** according to the German definition. The State's educational mandate is not derived directly from the principle of the social welfare state, but from the State's supervision of the school system and of the institutional guarantee applicable to institutes of higher education (Art. 7 and 5 of the Basic Law). The educational system hence differs structurally to the SGIs mentioned here, so that the conclusions of the consultation may not be transferred to educational and training measures, and the Commission may at most discuss these via the competent council of specialist Ministers. The following information refers largely to the abovementioned social services re 1.) - 4.).

re 1.) Organisations of statutory **social insurance** are corporations under public law which are subject to state supervision and are organised in accordance with the principles of self-administration. Their organs are equally selected by employers and insured parties (**principle of self-administration**). Furthermore, **involvement of those concerned** and of non-governmental organisations is entrenched in social insurance law. For instance, the patients' associations and self-help groups have a right of participation and application in the joint statutory health insurance self-administration bodies. In social long-term care insurance, associations of those in need of long-term care or of persons with disabilities may contribute towards the Federal recommendations on care provision, as well as the standards and principles to assure and improve the quality of long-term care. The **legislature defines the essential tasks and obligations**, the benefits and their preconditions, and in some cases the contribution rates.

A characteristic principle of the social security systems is the **solidarity principle**, i.e. **financing** is largely provided via a mutual exchange between insured parties and their employers. The amount of the contributions depends on the income from work that is subject to insurance as an expression of the amount the individual can afford to pay. As a rule, half of the contribution each is paid by employers and employees, the undertaking paying the whole amount in the statutory accident insurance. In some cases, considerable state subsidies are added (for instance in pensions insurance). Income is only assessed for contributions up to a limit specified by a statute (income limit for the assessment of contributions). Especially in statutory health insurance, obligatory membership applies only up to a certain obligatory insurance limit. It protects individuals against the consequences of misreading their own care needs (**protective function**).

The **benefits** of social insurance do not depend primarily on contribution payments, but also on certain personal circumstances, and hence take social aspects into account. In social insurance, the insurance risk compensation a matter of social compensation within the community of insured parties. This social compensation typifies the mutual nature of social

insurance, which also clearly depends on the welfare principle, in addition to the insurance law principle.

In **statutory health insurance, redistribution** between the healthy and the ill based on the insurance principle is supplemented by redistribution between recipients on high and low incomes, between the childless and parents, between old and young, as well as between women and men. Whilst therefore the assessment of the contribution does not equate to the risk, but takes place in line with what individuals can afford, all have an equal right to benefits. The benefits may not exceed the measure of necessity, must be economical and must correspond to the generally-recognised state of knowledge in medicine and care. Through **family insurance**, children and spouses who are entitled to maintenance are insured without having to make contributions if their total monthly income does not exceed a specific income threshold. Risk structure compensation takes place between the statutory health insurance funds aimed at creating the same competitive conditions among the funds. Different levels of contribution income and benefit expenditure are compensated for between the various long-term care funds in social long-term care insurance by using financial compensation.

The organisations of **health and long-term care insurance** have a statutory **mandate to ensure** blanket care of insured parties that meets needs in line with the generally-recognised state of knowledge. To this end, the organisations of long-term care insurance conclude care and remuneration contracts, as well as service and quality agreements, with the long-term care facilities. As to non-institutional care in statutory health insurance, the health insurance funds exercise the mandate together with the Associations of Panel Doctors and Associations of Panel Dentists.

re 2.) and 3.) In Germany, social services of general interest are not the sole responsibility of the Federation and the Länder, but are operated to a large degree by local authorities and by independent welfare organisations. **Charitable organisations** in particular make a major contribution towards the provision of social services in a mutual community, and hence deserve particular attention.

The organisations of **local authority welfare** (cities, rural districts and municipalities) are for instance active in the context of child and youth assistance, basic security for those seeking employment, social assistance, assistance for disabled persons and the elderly, as well as assistance for those at risk, offering benefits themselves (for instance offers and advice to debtors and others) and are organisations amongst others of hospitals, long-term care facilities and kindergartens. The social matters of the local municipality fall under the constitutionally-protected autonomy of the local authorities (Art. 28 of the Basic Law). This also means that they have a right to make their own decisions when it comes to organisation and financing.

Charitable social services, in particular for **independent welfare**, cover a wide variety of mostly legally-independent organisations which are organised in national associations (Federal Working Men's Welfare Association [Arbeiterwohlfahrt Bundesverband e.V.], German Caritas Society [Deutscher Caritasverband e.V.], Social Service Agency [Diakonisches Werk] of the Evangelical Church, German Equal Representation Welfare Association [Paritätischer Wohlfahrtsverband], German Red Cross [Deutsches Rotes Kreuz], Central Welfare Office for Jews in Germany [Zentralwohlfahrtsstelle der Juden in Deutschland]). These social services are labelled by the specific **ethical ties of their organisations**. The organisations are characterised by a broad spectrum of humanitarian, philosophical and religious goals tied to the different value concepts in society. The charitable activity in particular of the Churches and their charitable associations is constitutionally protected (Art. 4 of the Basic Law, Art. 140 of the Basic Law in conjunction with Art. 137 of the Weimar Constitution [WRV]). The ethical ties are expressed in the mottoes and assistance concepts of the associations and their facilities, as well as in the assistance provided. It means a civil society added-value of common interest-orientated social services expressing itself in reliability, continuity and long-term responsibility, as well as in empathy for those concerned, who in turn lend them their trust.

Independent welfare also offers benefits independently of state promotion. In total, it offers a broad spectrum of social services with more than 90,000 facilities and services connected with health, long-term care, family, youth, the elderly, children and disabled persons (cf. Annex). This enables the addressees of the services to make a selection in line with their personal needs. Independent welfare relieves the burden on the State, and hence supports it in its social welfare state mandate. The staff-intensive social services provided by independent welfare include the **voluntary and civil commitment of volunteers**.

The **tasks and obligations** of independent and local authority service-providers are on the one hand set out in legal provisions, promotion guidelines and principles, support notices and on the other hand set out in contracts. Non-for-profit providers act on their own responsibility in the context of a statutory framework and take on tasks in the context of state programmes (such as the integration of ethnic German repatriates and refugees, deployment of those rendering alternative service and in the context of a voluntary social year). They develop assistance concepts for new necessities, independent of any special mandate. Because of their significance for certain groups of individuals such offers, which are also developed by voluntary and self-help organisations, can later be promoted by public institutions or become entrenched in the law as a legal right, as in the case of hospice work (section 39a of Book V of the Social Code). "Modernisation" here means adjusting to changed needs in the course of social change.

Funding is provided by

- state subsidies (for combined tasks, specific services, staffing costs, investment)
- fees for services (such as flat-rate case fees)

- project promotion and special programmes of public cost units (such as social advice to migrants)
- tax relief (charitable status)
- own funds (subscriptions, donations, discounts, foundations, Church tax, contributions from lotteries, funds from charitable promotion institutions)

The **services** provided by the common interest-orientated providers are **personal services** which are based on **close contact between the service-provider and the beneficiary**, such as with medical care and long-term care. They are provided in a regional or local-specific social and political context. These are legally-governed benefits on the basis of legal rights towards public benefit organisations on principle available to all citizens.

The **quality standards** are either set by law (e.g. training, construction standards and the like; for hospitals cf. sections 135a et seqq. of Book V of the Social Code) and / or in supply contracts and framework agreements (quality assurance, quality management). They are frequently local and regional in character. The organisations of independent welfare have set themselves additional specific quality orientations (orientation towards mottoes, users, citizens, volunteers, staff and to defined goals, taking account of a wide range of methods, sustainable use of financial and ecological resources, partnering and cooperation with cost units, quality management). The establishment of a quality database is planned to provide greater transparency with quality management procedures in this sector.

Reference is made to the **Annex** with regard to further details - in particular also on **hospital planning, social housing** and **voluntary insurance** in statutory social insurance.

2. **Please indicate whether and if so how these characteristics are likely to develop and change in the coming years. This with a view of the modernisation of these services (taking into account developing users' needs, quality standards and (financial) efficiency).**

The social, economic and demographic challenges will lead to changes in demand for social services, as well as to changes among providers to meet the changed situation. For instance, the Day-care Expansion Act (Tagesbetreuungsausbaugesetz), which enters into force at the beginning of 2005, amends the Act on Assistance for Children and Youth Assistance (Kinder- und Jugendhilfegesetz - KJHG), which has been in existence since 1991. The focus is on the gradual expansion of childcare services for the under-threes in play groups and with day-carers by local authorities by 2010.

Moreover, an increase can be observed in the number of private organisations and a reduction of supply capacities from the state (in particular in the hospital system), as well as refinement of existing quality assurance instruments. If there is a legal right, the guarantee function of the local authorities applies particularly in rural areas, unless suitable facilities are provided on a blanket basis by other organisations. People's increasing individualisation and mobility also goes hand-in-hand with changes in societal and social structures, which in

some cases have disadvantageous social consequences. Civil society commitment will hence continue to be highly important, and requires further mobilisation.

3. Are there examples of social SGI which use market mechanisms to fulfil their tasks; what could be learnt from these experiences?

The introduction of **social long-term care insurance** in 1995 established more market-type mechanisms in the supply of care services. Each long-term care facility is to individually agree its long-term care rate with the long-term care funds and the social assistance organisations. Each facility has its own competitive position on the basis of individual pricing. Those in need of long-term care as consumers of long-term care benefits in kind may choose the provider which they feel offers the best combination of service, quality and price. With regard to the provision of benefits in kind by registered service-providers, German long-term care insurance law is neutral in terms of competition. Each long-term care facility which meets the preconditions for registration has a statutory right to register and provide services. This applies independently of whether there is a need for the services of another service-provider. The principle applies that restrictions on registration are in contradiction of the goal of opening the market for long-term care insurance to competition. The special needs of those in need of long-term care are hence increasingly also being met by private providers.

The Act to Modernise Statutory Health Insurance (**Gesetz zur Modernisierung der gesetzlichen Krankenversicherung**) of 14.11.2003 created greater transparency in statutory health insurance, patients individual responsibility and participation rights were enhanced, the working conditions for the staff and independent professions improved, high-performance structures created, bureaucracy reduced and the mutual competitive system refined. The mutual competition system is in particular refined by the promotion of various forms of supply, such as the medical supply centres, GP-centred care or integrated supply projects based on individual contracts. Further market-orientated standards of the Act are the instructions provided for a public call for tender to conclude contracts to ensure GP-centred care, of contracts to supply with aids, as well as of contracts to involve pharmacies in contractually-agreed special supply forms. By facilitating mail order with drugs, a regulated, supervised service is provided that accommodates less mobile patients in particular.¹ With the introduction of mutual competitive elements which do not question the non-economic nature of the activities of the health insurance funds (scope in setting the amount of contributions, member acquisition),² in this respect positive experience has been collected.

Moreover, where the State has a duty to guarantee the supply of a service, market mechanisms are limited. Market mechanisms can as a rule ensure greater competition, innovation and transparency, but are not a guarantee that sustainability, quality and efficiency will be ensured. A comparative study on the "Privatisation and liberalisation of

¹ Following ECJ case C-322/01 (Doc Morris) a European arrangement would hence be welcome in the interest of consumer protection and drug safety.

² cf. ECJ judgments AOK-Bundesverband (cases C-264/01, C- 306/01, C-354/01 and C-355/01).

public services in the EU" from 2003 reaches the conclusion that for consumers tangible increases in the range of services and reductions in the expense of services only take place if real competition is possible and remains so in the long term.³ There are for instance examples in which a low price was achieved by the use of tendering and contract award procedures, but the offer had no solid base and an established regional structure was destroyed.

Field 2 – Definitions of social SGI

4. Is there at national level a notion or definition of social SGI or social services generally?

No. Because of the wide range of social services offered, there is **no definition capable of generalisation**. This also applies to the term (social) "services of general interest".

5. It has been argued that social SGI are different to other SGI – Do you agree with this? Is a more detailed analysis of these possible differences – especially in relation to networks industries – a way forward to gain more certainty?

The particular nature of social services has already been stated in the White Paper on services of general interest. This applies in particular with regard to social insurance benefits, which as a rule are provided by a monopoly of state organisations, and to welfare benefits. Because of their personal connection and purpose, benefits of social protection and social security are as a rule not economic goods that could be freely exchanged on the market. The vast majority of benefits are funded from taxes, social charges or own funds of charitable organisations, and have not been "paid for" by the user in a concrete case. Hence, the conditions for products and pricing orientated in line with the market differ from those applying to other services. Having recourse to forms of service provision organised along market-orientated lines can make sense in isolated cases to exploit efficiency potentials. For instance, long-term care facilities are only partly funded from social charges and taxes. The fee shares of the long-term care facilities not covered by these are paid by the beneficiaries of the long-term care services. If the benefits of long-term care insurance, the amount of which is limited, are insufficient, social assistance covers the entire long-term care requirement in cases of financial need.

The following characteristics particularly apply to social services without it conversely being possible to derive statements therefrom on the other services of general interest:

- Social services primarily aim to enhance **social coherence** by accommodating the special needs of groups within society which are at risk. They apply to **persons and groups with special needs** for help and support who as a rule can only be restrictedly regarded as independent, informed consumers with purchasing power.

³ Österreichische Gesellschaft für Politikberatung und Politikentwicklung: Privatisierung und Liberalisierung öffentlicher Dienstleistungen in der EU, Vienna, May 2003

- Social services are orientated to **safeguard elementary basic rights**. Benefits of child and youth assistance serve to implement the right of all persons to promotion of their development and to be educated to become a self-responsible personalities capable of making a contribution towards the community. Benefits for persons with disabilities must promote their self-determination and equal participation, and must counter discrimination. In implementing the benefit, justified wishes of the beneficiary must be accommodated. Social services hence pursue social goals over and above the direct awarding of benefits. They supplement benefits provided in families, and help families to overcome difficult situations. They are hence afforded particular respect by society.
- Social services as a rule have a **local and personal connection**, i.e. they are only provided to natural persons. They are services linked with personal contact between the benefit-provider and the beneficiary, and cannot be exchanged at will. The beneficiaries are particularly interested in continuing supply. With certain social services, such as street social work, the beneficiary must be actively sought out.
- With personal services (advice, care, long-term care, etc.) it is not only the economy, but also the local social culture and the **ethical ties of the providers** which is significant. Independent welfare meets special needs by involving the social environment, "holistic" orientation, mobilising voluntary and civil commitment, participation by the users, developing innovative solutions and approaches towards assistance. It also carries out the task of a **social counsel**.
- In some cases, for instance in the area of health and long-term care provision, there is a **special potential risk**. Falling standards endanger the health and life of patients and those in need of long-term care.
- **Social fee structures**: Social services must be accessible to and affordable for the respective target group. If a fee or co-payment is charged, social aspects are accommodated. The amount of the fee is typically not orientated towards making a profit, and as a rule does not cover costs.

6. In case you feel that social SGI are different to other SGI please indicate what could then be the elements for a description at European level of these specificities of social SGI's, taking into account the diversity of general interest missions related to social services in the Member States and the general principles?

Could the elements worked out in the "Key issues" of the Conference "Social Services of General Interest in the EU" (28 and 29 June 2004) be a good base for this description in the European context? Which elements have to be added; which have to be amended?

Social services serve to implement and **lend concrete form to the principle of the social welfare state**. This grants the legislature the mandate "to ensure compensation for the social contrasts, and hence for a fair social order". Beneficiaries of the principle of the social welfare state are only natural, i.e. not legal persons. Social services hence link particularly to the principles of human dignity, solidarity, social justice and social coherence. They aim to

implement social basic rights. As a rule, their use is based on individual legal rights; they foster social participation of people with special needs. They therefore react to social needs and shortcomings in society which the market cannot adequately satisfy. In terms of their social policy objective, special requirements also emerge as to their organisation, regulation, funding and quality. Their promotion by the state is subject to conditions.

The characteristics worked out at the conference provide a helpful basis to describe social services. The above characteristics should be emphasised (Question 5).

7. Which of the different sectors outlined under Field 1 should have priority for the examination at European level

The Community has no fundamental competence to examine **non-economic** Services of General Interest at European level, nor is there a need for the Community to act. With services of general economic interest, the Community should restrict itself to fields which have significance for the whole Community by virtue of their size and structural interconnectedness. This does not apply to social services, unlike telecommunication, post, etc. The Commission's Communication should carry out such a clarification.

Field 3 – Experience with EC internal market or competition rules

8. Please indicate for the services identified under question 7 with regard to the EC rules listed below (see also background document) whether:

- a. it is established (in case-law or by way of Community law) that these services fall outside the scope of these rules
- b. it is established (in case-law or by way of Community law) that these services are falling within the scope of these rules
- c. it is unclear if these rules apply to these services, there is a need for clarification ("grey zone")

- Internal market rules;
- Art. 81 and/or Art. 82 EC;
- Art. 86 EC;
- Art 87;
- Public procurement rules;
- External trade negotiations.

The **competition rules (Art. 81, 82, 87-89 EC)** are applicable if the service establishments and providers are undertakings. The term "undertaking" is not defined by the Treaty, and is determined not by an institutional view, but by a functional view. This applies in particular also to the provision of social services in the general interest. It is a bone of contention in individual cases as to when an active institution is to be regarded as an undertaking within the meaning of the law on competition. The organisations of social insurance are now already afforded special status by the case-law of the ECJ (cf. on this also the Annex).⁴ The

⁴ The organisations of social insurance are recognised as purely social undertakings (cf. ECJ judgment Poucet/Pistre, lastly AOK-Bundesverband). In the field of social security, it is therefore the case that social

applicability of the law on competition also means moreover that inapplicability in accordance with Art. 81 para 3 may apply. Where the application of the competition rules prevents the provision of the services of general economic interests, in accordance with Art. 86 para 2 these are not to be applied. Public promotion is frequently conditional on the charitable nature of the organisation. This promotion may influence the local market in individual cases, but is not thus against the EU competition rules. With preconditions on the law on subsidies, cross-subsidies of other benefits are ruled out.

Accordingly, the provisions on freedom to provide services (Art. 49 EC) do not apply if the mutual aspects which show an activity as non-economic within the meaning of the law on competition also deny it to be a service.⁵

9. Please describe experiences concerning the influence of these EC rules on social SGI (may be "good" or "bad" examples; e.g. have these rules enabled the efficient provision of certain services or have they limited the freedom to realise national social policy goals)?

Regardless of the boundaries on the Community's competence, **most of** its statements and proposals to date have **not explicitly excluded social services**. Restrictions have as yet only been made for the organisations of social insurance and – with regard to notification duties on the basis of the law on state aid – have been considered for the areas of hospital supply and social housing. In connection with the casuistic case-law of the ECJ and various communications from the Commission, the influence of primary EC law, which in Art. 16, 49, 55 and 86 EC only describes general instructions, has led to a practical situation in which considerable uncertainty has arisen with regard to the social services as to the circumstances in which the conditions imposed by EC law apply. The communication should help clarify and remedy these uncertainties.

It should be emphasised here that a measure can only be in breach of Community law if it is able to impair trade between the Member States and hinders, restricts or falsifies competition within the internal market. As a rule, **benefits which are offered and consumed locally close to people's homes** will therefore not give rise to a problem under Community law (cf. Question 7). The background paper correctly states that social services of general economic interest which are local in character do not as a rule influence trade between the Member States.

In the case of **Ambulanz Glöckner** (C-475/99), the ECJ considered a major part of the internal market to be affected, but according to this judgment, it may be justified to afford a competition privilege to certain providers in order to guarantee suitable service-provision at all. The ECJ has regarded such restrictions of competition as necessary which enable the mandated suppliers to carry out a task which is in the general interest at all – emergency

facilities are not undertakings within the meaning of the competition rules if their activities are based on the principle of solidarity and are carried out on a non-profit basis and they provide their statutory benefits independently of the amount of the contributions.

⁵ Federal Social Court (BSG) judgment of 11.11.2003, ref.: B 2 U 16/03 R; ECJ case C-355/00 (Freskot).

transport in this case – under economically-balanced conditions. The Court largely based its view on the possibility of private entrepreneurs to concentrate on lucrative ambulance transportation services, thus endangering the economic viability of emergency transport services provided by the ambulance services, hence placing their quality and reliability at risk (see marginal no. 61).

10. Are there examples where the mentioned EC rules were taken into account in advance when planning or reforming national social policy?

The preconditions of EC law are taken into account in reform projects in the field of national health and social policy. One recent example in which EC rules were taken into account in reform projects is the addition to Book V of the Social Code concerning cost refunds with medical treatment in other Member States. Over and above this, there are plans to amend the Apothecaries Act (Apothekengesetz) to allow apothecaries seated in another Member State to supply German hospitals with drugs, which previously was not possible by law.

Field 4 – Further steps at European level

11. Are there specific fields of European law and activities which necessitate further clarification with regard to their impact on social SGI (see also question 8), like e.g.:

- **Internal market rules;**
- **Art. 81 and/or Art. 82 EC;**
- **Art. 86 EC;**
- **Art 87;**
- **Public procurement rules;**
- **External trade negotiations.**

Firstly, distinguishing between "economic" and "non-economic" benefits or between "services" and "services with an exclusively social character" comes up against practical problems. Although there is broad agreement on the elementary definition of the characteristics, it is difficult to apply the abstract characteristics to mostly complex and many-faceted circumstances, in particular where non-for-profit facilities are concerned. The problems of delimitation are hence less at the level of the definition than at the practical level of subsumption. In this area, a communication could ensure greater clarity and legal certainty.

Secondly, against the background of the distinction between "economic" and "non-economic" benefits and of the functional definition of "undertaking" there is also uncertainty as to when provision of social services by facilities in public organisation types is subject to the rules of European competition law.

Activities meeting a mandate defined by a statute, which are largely funded from public coffers or from charges and which are not carried out for profit, should with regard to the sovereignty of the Member States to draw up their own social policy be strongly privileged in

terms of competition and state aid law. Appropriate legal certainty should apply, not only to state and local authority agencies irrespectively of their legal form, but also to facilities for which the State has ultimate organisational responsibility, and which do not act for profit.

12. Should the work to be carried on only concern social services of general *economic* interest and concentrate on e.g. competition rules and certain internal market rules or should social SGI both of an economic or non-economic nature be subject for further work?

With activities at Community level, it should be taken into account that **no Community competence** exists for social insurance and for social services of general interest, the vast majority of which are non-economic (cf. Question 7). Particularities of the social services must however be recognised irrespectively of whether the activity is to be qualified as economic under Community law. This particularly applies to the exception of social services from the duty to notify under the law on state aid. Reference is made to the communication of the Federal Government to the European Commission of 13 April 2004 on the so-called Monti Package.

13. What should be the concrete aim (especially concerning further steps) of the Communication of the Commission on social SGI including health services?

The EU should recognise and ensure that social services belong in the responsibility and competence of the Member States for their social protection system. This applies in particular, but not exclusively, with regard to the **responsibility for the organisation of their healthcare system and medical care** (Art. 152 para 5 EC). It should be emphasised that the organisations of statutory social insurance and public mandate-holders such as the Länder and local authorities as such are neither undertakings within the meaning of competition law nor service-providers, and the entitlement to sovereign monopolies is not questioned in the social protection field. It must become clear why social services are usually provided in highly-regulated systems and that a pure market management cannot ensure supply in line with need. The determination of quality standards, volume-related admission regulations for medical service-providers, reservations of approval when using institutional services abroad are all needed for instance, in order to manage the healthcare system as required. The Member States are in particular to be granted autonomy to plan in the institutional field.

Furthermore, a **contribution to legal security** is expected **for non-for-profit providers of social services**. The design of the social services as an element of the European Social Model should be explained in greater detail. In doing so, the Member States' are to retain their ability to determine their own ways of fulfilling their obligations, and national, regional and local variety should be safeguarded. It must be explained how the approach to accommodate these specialities of social services can be refined as a fixed element of the

Community rules. To this end, the delimitation between economic and non-economic services should also be examined to see how it can be improved.

Paths should be shown with regard to potential conflicts against the background of the abovementioned legal provisions as to how economic and non-economic providers may work side-by-side where appropriate, and how to ensure that the population's needs are met.

14. Do you consider the use of the open method of co-ordination (existing or new) an appropriate means for further steps? If so, what should be the concrete task of this method? (e.g. common objectives, exchange of good practices, evaluation etc).

No. The use of the open method of co-ordination in the field of social services, and hence over and above the previously-agreed policy areas (old-age pensions, social integration, health and long-term care) is rejected. Such an expansion of the area of application would not be compatible with the efforts to make the agreed coordination processes leaner, and is not feasible in practice with regard to the wide variety of social services organisations in the Member States. The effort required would be disproportionate to the anticipated benefit.

15. Could at some stage and without prejudging the right of initiative of the Commission, legislative acts be considered as an appropriate means for further steps (under the assumption that a valid legal base can be found), and if so what should be the concrete task of these instruments (Directives, Regulations, Recommendations)? The following additional questions seem to be possible:

- **Should these legal acts limit the scope of EU rules and their application to social services?**
- **Should these legal acts establish common standards for social services, allowing EU rules, like the Internal Market rules, to be applied while taking into account fully the social policy goals?**
- **Should there be legally defined criteria, e.g. criteria concerning quality, affordability, accessibility or solidarity at European level?**

A horizontal framework directive for the entire social services field is rejected. The proposal of a directive on services in the internal market must also take account of the particularities of social services. In light of the priority of responsibility of the Member States, Germany considers in this instance that there is neither a competence nor a need to determine criteria of quality, affordability, accessibility and solidarity in Community law.

At most, one could consider legal acts limiting the area of application of EU rules to social services and ensuring greater legal certainty. In this sense, we welcome an inapplicability arrangement favouring social services in the Monti Package (see above). A codification of the case-law of the ECJ on cost refunds when using healthcare services in another Member State is also welcomed in the context of the coordination of the systems of social security. Particularly in the field of social services, the subsidiarity principle must be carefully examined and adhered to.

The new social policy Agenda should moreover serve as a discussion framework for the topical area of social services.

Annex

Notes on individual social services

1. Public and independent welfare

The broad, and in terms of the organisational and funding structure also heterogeneous, range of target group-orientated social services, can only be illustrated by way of example and with no claim to completeness. The social assistance provided by public and independent welfare is based on legal rights towards state/local authority instances and towards social insurance organisations or on voluntary benefits provided by the local authority or special statutory arrangements (integration programmes, etc.) of the Federation and the Länder. Over and above this, benefits are offered independent of state institutions. The services are provided with all methods of social work (personal assistance, individual and group work, community work) and in the framework of non-institutional, partly-institutional and institutional assistance. Even organised voluntary and self-help services are supported by the welfare associations, such as by a social insurance law ensuring accident insurance, as well as by training and further training.

Social services cover in particular advice and support, education, training and care, employment, long-term care, above all for the following target groups:

- **Children and juveniles** (nurseries, children's homes, youth careers assistance, education advice, leisure services; in accordance with section 24 of Book VIII of the Social Code, there is a right to attend a kindergarten from the age of three until starting school. Local authority co-funding for independent facilities is dependent on acceptance in the local plan of requirements, and can only be granted to organisations of independent youth assistance. A voluntary benefit can also be granted to facilities not included in the plan of requirements independently of the type of organisation. The Land grants voluntary subsidies towards operating costs, depending on the number of children to be cared for and on the care time, to recognised organisations of facilities which have operating licences to care for small children.)
- **Families and sole parents** (marriage and pregnancy advice, life counselling, family care, recovery for mothers, recreation for families)
- **Those seeking work**
- **The elderly** (senior citizens' meetings, meal services, old-age and long-term care homes)
- **People with disabilities** (early promotion, non-institutional assistance, self-help groups, kindergartens, schools, vocational promotion and vocational education agencies, workshops for persons with disabilities, day centres and residential homes)
- **The sick** (hospitals, day clinics, day care facilities, care and rehabilitation facilities, advice agencies of social psychiatric services for the mentally ill, emergency rescue)

- **Those in need of long-term care** (measures to offer respite to caring relatives, support for volunteer helpers, hospice work, services for family care and village assistance as low-threshold, freely-accessible offers in the run-up to and the environment of the need for long-term care to prevent and avoid the need for long-term care arising)
- **Migrants** (social counselling, counselling of ethnic German repatriates, psychosocial centres for refugees, integration projects, homework, language and learning assistance)
- **People in social need** (accommodation for the homeless, debt counselling, railway mission, telephone chaplaincy)

2. Statutory social insurance

a) **Statutory health insurance** (Book V of the Social Code) has as a mutual community the task of retaining, restoring or improving the health of the insured parties. To this end, the benefits of the health insurance funds are financed through contributions. The members and employees make contributions which as a rule are in line with members' income subject to contributions. For co-insured family members, contributions are not levied if their income does not exceed a certain income threshold. Up to a certain amount of income, membership of statutory health insurance is obligatory. With higher incomes, there is an option to belong to statutory health insurance as a voluntary member, to become a member of a private health insurance fund or to bear the cost of healthcare themselves. In Germany, 88.5 % of the population have statutory health insurance (74 % obligatory members and co-insured relatives, 15 % voluntary members); 8.9 % of the population has private health insurance; 2.4 % are in special forms of insurance (such as independent medical care of soldiers), only 0.2 % are not insured.

b) **Social long-term care insurance** (Book XI of the Social Code) is intended to help to alleviate the physical, mental and financial burden of the need for long-term care. It is to ensure a basic supply and hence guarantee that in the vast majority of cases those concerned no longer rely on social assistance because of their need for long-term care. Long-term care insurance provides for benefits for domestic, partly-institutional and institutional provision of long-term care. Assistance for domestic long-term care is given priority in order to enable those in need of long-term care to remain in their customary domestic and family environment as long as possible. Long-term care facilities (long-term care homes and long-term care services) as social facilities of the community and of the healthcare system are only to be provided by the state if supply is not ensured by charitable and private organisations. The responsibility for the long-term care infrastructure lies with the Länder. The introduction of long-term care insurance has led to an expansion in the long-term care infrastructure in both the non-institutional and the institutional areas. Hence, one may presume sufficient long-term care infrastructure, so that unrestricted access to long-term care is guaranteed for all those insured.

The contractual partners of the long-term care administration (long-term care funds, social assistance organisations and facility organisations) agree amongst other things the **requirements for the quality** of the services at Federal, Land and facility level. The quality of services is examined by the medical services of the health insurance on request by the Land associations of the long-term care funds. The facilities are legally obliged to carry out their own quality assurance and quality management. This system may not be undermined by providers from other Member States not being bound by these valid standards because of the **country-of-origin principle**.

c) With roughly 33 million working insured parties, **statutory pensions insurance** covers roughly 82% of those in work. As the first pillar of old-age pensions (Book VI of the Social Code) it protects insured parties when their ability to work is endangered or reduced, or in old age, and protects their surviving dependants in the event of death. The link to dependent employment with regard to the group of individuals involved is characteristic, as well as the attained income with regard to the calculation of contributions and benefits. Their **benefits** include rehabilitation, pension payments (because of age, reduced ability to work, death) as well as education and advising insured parties. The **group of those obliged to be insured** consists of blue- and white-collar workers, trainees, disabled persons in recognised workshops, those rendering military and alternative service, certain groups among the self-employed, long-term carers, beneficiaries of health and unemployment benefit, as well as persons providing childcare in the first three years of their children's lives.

The competence of the pensions insurance **organisations** is currently orientated by the type of vocational activity. For instance, the Federal Insurance Institute for Salaried Employees is responsible for salaried employees' insurance and the regional Land insurance agencies for workers' pensions insurance. Further organisations are the Federal Miners' Insurance Fund (for miners), the Mariners' Fund and the Railway Insurance Agency. With the organisational reform of pensions insurance in 2005, the organisations will be combined to form the German Pensions Insurance.

Employees and employers each pay half of the **contributions** (2004: 19.5% of the gross salary up to the income limit for the assessment of contributions of currently Euro 5,150). Those with voluntary insurance and the self-employed pay their contribution alone. The Federation subsidises the expenses of the pensions insurance.

d) Roughly 65 million persons are insured in **statutory accident insurance** (Book VII of the Social Code), about 15 million of whom are children, pupils and students. Its task is to prevent accidents at work and work-related diseases, as well as professional health risks, to ensure effective first aid, to support those insured after an accident at work in restoring their ability to work, to alleviate the consequences of an injury and to compensate family members or surviving dependants through monetary benefits. Statutory accident insurance only

applies to accidents suffered by those insured in connection with their professional activity or on the way to or from their place of work and for work-related diseases. Its benefits cover in particular: medical, vocational and social rehabilitation (such as medical treatment and vocational assistance), monetary benefits to insured parties (such as replacement wages and pensions) and - in the case of death – to their surviving dependants (such as surviving dependants' pensions).

The principle applies of the **statutory insurance obligation** without the insured parties having to pay contributions. In particular, insurance is obligatory for all persons employed on the basis of an employment, service or training contract, the unemployed, children while attending child day-care facilities, pupils, students and certain groups of the self-employed and persons who are active in the common interest (such as in welfare or in the healthcare system, assistants, volunteers, blood and organ donors). Entrepreneurs, the self-employed and freelancers may **insure** themselves and their co-working spouse **voluntarily** if they are not already obligatorily insured by law or on the basis of provisions of statutes.

The commercial and agricultural Employment Accident Insurance Funds are accident insurance **organisations**, as are the public insurance organisations at Federal and Land level, municipal accident insurance associations and fire accident funds. The **funding** of accident insurance takes place in the adjustable contribution procedure, i.e. the amount of the contributions to be made by undertakings alone is measured such that they cover the amount of business done in the last year. In the commercial field, the contributions are largely determined by insured parties' income and by risk classes.

e) **Benefits for participation for disabled persons** and persons threatened by disability (Book IX of the Social Code) are provided for medical rehabilitation, for participation in working life and in life in the community, as well as securing maintenance and other supplementary benefits. The rehabilitation organisations are obliged to cooperate and to conclude joint agreements in this matter. To guarantee equal access to social services by persons with disabilities, the organisations of social insurance work together with other service organisations, in particular charitable or private rehabilitation services and facilities. Cooperation also covers the rehabilitation organisations and authorities with various regional competences.

The special nature of these social services lies above all in the statutory obligation to promote the **self-determination and the equal participation** of persons with disabilities, or to prevent or counter disadvantages. The justified wishes of the beneficiaries are to be met in the decision on and implementation of the benefits. The special needs of women and children with or at risk from disability must be accommodated. The special needs of mentally-disabled persons or of persons at risk of such a disability must also be accommodated in coordinating the benefits.

The **quality standards** of social services in the area of prevention, rehabilitation and participation of persons with and at risk from disability, vary widely within Europe.⁶ The specialist requirements are governed by law in Germany (sections 19 and 20 of Book IX of the Social Code). On this basis, the rehabilitation organisations and others involved in providing barrier-free social services for persons with disabilities have also agreed "Joint Recommendations" which more clearly differentiate between the qualitative requirements. Also, the rehabilitation organisations have determined quality standards for their own facilities and for facilities of third parties which are continually evaluated.

3. Voluntary social insurance

Persons who are not subject to obligatory insurance may conclude voluntary social insurance under certain preconditions. As an annex to obligatory insurance, voluntary insurance combines elements of individual option with the concept of the mutual community. A need for protection is presumed to exist with the group of individuals who are entitled to choose. Depending on the type of insurance, the members of certain professional or income groups are not included in obligatory insurance, or only up to a certain income amount, or to a certain age. Voluntary insurance is in particular made available if persons "grow out of" the group considered as being "in need of protection" in the course of their working lives, but then perhaps have difficulties to obtain suitable insurance on the private market in later life. This situation may also occur if they move abroad. Finally, there are groups with which a need for protection cannot be generally presumed even in a typical view. The option is restricted in that the decision, once taken, is difficult to reverse. Voluntary insurance is hence the expression of tension between the social policy goals of accessibility to the mutual community, the right to autonomous life and the duty to participate in a mutual community.

Voluntary statutory health insurance shares major elements of statutory obligatory insurance, and must hence be regarded as a part of the social structure. The following characteristics can be identified using it as an example:

- There is little option when it comes to **access**. Voluntary insurance is as a rule only possible as further insurance after sufficiently long membership of the obligatory insurance system (section 9 of Book V of the Social Code). As a rule, access to voluntary insurance is provided because those previously insured in statutory health insurance are unable to obtain private health insurance under acceptable conditions (for instance because of illness or age). If the access preconditions are met, there is a right to conclude voluntary insurance regardless of the insurance risk.
- **Funding** is via contributions the amount of which is set by organisations only in a close framework by statutory instructions (section 240 of Book V of the Social Code). The

⁶ cf. 2003 MISSOC report "Social protection of people with disabilities", according to which Germany has a particularly highly-developed rehabilitation system.

contribution is assessed on the basis of the solidarity principle, meaning that the contributions are measured by the economic ability to pay, and not by the insurance risk. The contributions are made to a system which is not covered by capital, but which is funded by an adjustable contribution procedure on a non-for-profit basis which is very much social in nature.

- Also **benefits** are not set by the organisations, but by the statutory provisions. Benefits are not granted in line with the amount of the contributions paid, but by medical needs (cf. section 11 of Book V of the Social Code on the benefits of statutory health insurance)

Voluntary pensions insurance is closely linked to the purpose and structure of obligatory insurance. It offers the possibility to avoid gaps in contributions in an insurance career since these have a disadvantageous effect on the amount of pension, and above all on the pension claim itself. On the basis of the increase in the number of volatile career biographies, there is a need to be able to work towards an uninterrupted insurance career within the security system of statutory pensions insurance. It is therefore a task of the State to enable those who for various reasons are no longer obliged to have insurance to remain part of the security system. Also the **judgment** of the ECJ in the case of **Danner** (C-136/00) does not open up a "grey area" in this sense, in that the freedom to provide services is only declared applicable to voluntary old-age pension systems in that contributions made in another Member State can be fiscally allowed. On principle (cf. ECJ **judgment Humbel**, case C-263/86) by establishing such a system (in this instance in the educational sphere), the State does not carry out a for-profit activity tied to fees, and no fee structure exists.

In the statutory **accident insurance** entrepreneurs and their co-working spouses who are not subject to obligatory insurance, as well as persons who in corporations or commercial partnerships as a rule are self-employed as entrepreneurs, may have voluntary insurance. From 1.1.2005, this will also apply to elected voluntary office-holders in charitable organisations and to persons who work voluntarily in bodies of associations and commissions for employees' organisations and trade unions. The application leads to insurance under public law, the preconditions and scope of benefit corresponding to the insurance by law.

4. Private insurance companies

In contradistinction to social insurance, private insurance companies such as private health and private long-term care obligatory insurance companies are funded in the capital cover procedure. Although these are not corporations entrusted with obligatory social tasks, certain characteristics applying to the social services in the broad sense of the word may also apply to them. Private long-term care insurance follows social insurance law requirements. The premiums are largely in line with the age of the person insured on conclusion of the insurance policy. The calculation is also carried out on the basis of social frameworks defined

by law. Employees with private insurance receive a subsidy from their employer the amount of which is limited to the employer's share of social long-term care insurance, up to a maximum of half the amount that the employee actually pays for their private long-term care insurance. Those eligible for medical expenses assistance receive the medical expenses assistance benefit instead of the employer subsidy. The premiums may not exceed the maximum contributions applicable in social long-term care insurance (with those entitled to medical expenses assistance not more than 50% of the maximum of these amounts). The benefits correspond to social long-term care insurance.

5. Hospital planning and funding

Hospital planning is a matter for the Länder. It aims to guarantee to meet the needs of the population as to high-performance, independently-managed hospitals and to contribute towards socially-acceptable fees. To this end, each Land adopts a hospital plan and an investment programme. The subject of the planning is for instance locations, specialist departments and numbers of beds. A hospital which is included in the plan has a right to state investment cost funding and benefit remuneration from statutory health insurance. The applicable principle is that of the plurality of organisations (public, independent-charitable and private organisations). In addition, there are private hospitals which exclusively treat private patients, and are excluded from the rules.

The hospital sector is based on **dual funding**. The Länder fund the investment costs which are set by the investment programme (special arrangement for investment costs of University clinics: 50 % Federation, 50 % Land). The German system of state hospital planning and investment funding grants to the individual hospital an actionable right to public promotion if it is included in the hospital plan of a Land. The statutory procedure for inclusion in the hospital plan and the concomitant right to public investment promotion guarantee that public subsidies are awarded in a transparent and competitive manner.

The operating costs of the hospitals in the plan are largely funded by the service fees paid by the statutory health insurance, as well as via private patients' service fees. To this end, the health insurance funds negotiate a budget with the individual hospitals for the respective facility. This hospital budget is invoiced to the patients or their health insurance funds using daily or case flat-rates. For acute hospitals, a DRG (diagnosis-related groups) case flat-rate system has been introduced. In 2005 to 2009, this system is to be used to gradually transfer the different hospital budgets to a Land-uniform price level, and hence adjusted in line with performance. The type of the fees and their evaluation ratios are agreed by the self-administration partners at Federal level, the price level as a whole using base case values at Land level. The base case value applicable Land-wide and the hospital budgets are approved by the Länder (legal supervision). A uniform price system is to be introduced for all hospitals of a Land from 2009 onwards.

There is in addition a limited individual contract system with individual price agreements in the framework of integrated care. Individual contracts are a market-orientated tool which enables the health insurance funds to reach specific agreements on special care services. In contradistinction to collective contracts, there is no obligation to contract. This makes encourages competition inter alia between hospitals and between health insurance funds. This is to develop and test innovative possibilities for structural changes in the German healthcare system. No experience is yet available, since major competition tools were not introduced until 1.1.2004.

It is to be expected that the transparency of the hospital services will increase as a result of the new **case flat-rates** (DRGs) and the refinement of quality assurance. Hence, competition between hospitals will also increase in the collective contract system.

Hospitals have a statutory obligation to introduce internal **quality management** and to participate in comparative quality assurance measures. Hospitals will publish a quality report every two years from 2005. Hospitals which do not achieve binding minimum volumes for certain services may no longer offer those services. Over and above this, the Joint Federal Committee as a vital self-administration decision-making body sets minimum requirements as to the quality of the structure and of the results. The recently-established "Institute for Quality and Economic Viability in the Healthcare System" is under construction. Amongst other things, evidence-based guidelines will be evaluated for the diseases that are most important in terms of epidemiology, and expert reports will be drafted as well as statements on matters of the quality and economic viability of services.

6. Social housing promotion (social housing construction)

Market mechanisms have been used for many years in Germany to deal with problems in providing housing (the share of independently-funded housing has continually increased) and also in the area of social housing (now: social housing promotion) the problem of providing housing is solved on a market economy basis with the aid of public-private partnerships.

Accordingly, housing is largely provided via the general housing market by rented accommodation and owner-occupation. Households whose income is insufficient to obtain adequate housing are supported with **housing benefit** (a monetary benefit paid on request to economically ensure suitable housing meeting the needs of families) and by **social housing promotion**. The purpose of social housing is to provide housing for households which have problems in gaining access to the market, either because of a low income or because of other social characteristics.

Promotion takes place such that funds from public budgets are granted in return for granting rights to occupy housing and rents below the market level. In supporting the construction of rented accommodation, the beneficiaries of the subsidies are the landlords themselves (housing associations, cooperatives, individual private landlords), while with the promotion of

owner-occupied housing it is the household seeking accommodation itself. The subject of the promotion is to create, maintain and improve cheap housing and its environment for needy households through subsidies, loans and guarantees. Promotion is carried out by the Länder, the Federation contributes through financial aid. Federal law regulations provide a general framework for the use of the funds, objectives and purposes of promotion. It is up to the Länder to shape promotion in detail. In light of the fact that housing markets in Germany differ greatly from one region and from one place to another, a further shift of responsibility to the Länder and local authorities can be seen, since this is where because of their proximity to the market, housing provision problems can be recognised more easily, and frequently also solved more efficiently.

The impact of promotion is purely local. Since landlords must provide economically-equivalent services in return, the promotional measures are not likely to distort competition. The question as to whether granting subsidies for measures of social housing is subject to a duty to notify from the point of view of EU law on state aid leads to uncertainty in some cases. In the area of the law on state aid, the restrictive clarification is required that social housing in its German manifestation is not subject to mandatory notification.