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(Ir)regular supporting services for the elderly in Europe

Supporting services and care-work migration – an introduction

With European populations ageing, demand for support services has been on the increase. This trend can be observed in similar forms in all countries of the European Union. The EU Commission therefore interprets this situation as representing potential for increased employment across the entire EU. Indeed, one type of elderly support service that has expanded at a tremendous pace is 24-hour care in private homes. As this is a service area that operates according to its very own mechanisms, its distinctive characteristics should be examined and understood.

As demographic change progresses, Europeans' need for family support services and especially for services targeting older people will continue to grow. This is partly because the available pool of care providers within families has decreased due to smaller numbers of younger people and to increasing employment rates among (especially older) women. The key challenge facing EU Member States in this context is how to adequately supply Europe's elderly population with high-quality personal and household-related services.

Against the backdrop of ageing societies in all EU Member States, the issue of support services for the elderly is increasingly recognised and taken seriously at a European level, and a variety of approaches are being discussed. The demography reports of the European Commission[1], the national demography reports[2] and the many national demography strategies that have already been elaborated demonstrate the importance placed on personal and household-related services for the elderly. The German demography strategy of April 2012, for example, announces that a key issues paper on support services is due to be published later this year.[3] Until mid-July 2012, the European

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Commission (DG Employment, Social Affairs and Inclusion) held an open consultation process in an effort "to exploit the potential of personal and household services".[4] At the same time, employees in the health and care sector[5] and employment opportunities resulting from the use of information and communication technologies (ICT)[6] have been shifting into the focus of public attention.

Rising demand for 24-hour care

Generally speaking, support services can be provided in two different ways: by families themselves, or "outsourced". Services offered in the market, however, can be purchased both as regular and irregular (i.e., illegal) employment. In addition, there is informal care, in other words care provided by relatives or by personal networks. Overall, the ratio of informal care to overall care services is decreasing, but nevertheless the fact still remains that most elderly people want to continue living independently in their own environment. This means that demand for 24-hour elderly care in private households is rising. There is nearly no way of satisfying this demand with locally available labour and at prices that users find affordable. At the same time, the European internal market now opens up the option of legal, intra-European migration. High wage differentials provide a strong incentive for labour migration across European borders.

Many women from Eastern and South-Eastern Europe, but also from non-EU countries, therefore migrate to satisfy the demand for these services in countries of Central and Western Europe. Within Europe, the preferred destination countries for these migrants include Germany, Austria and Italy. Many of the migrants come from Poland, the Czech Republic, Slovakia, Romania or Bulgaria. In addition to the wage gap, the structure of the welfare regime seems to determine where migration for care provision takes place. Migrant care providers can be found in greater numbers, for instance, in countries where the care system focuses more on family care and where direct transfers are offered for family care without these benefits being subjected to control.[7]

The situation of migrant care-givers

The exact number of women who migrate to provide care services is not known, but in Germany, for instance, it is estimated at around 100,000[8], and at 40,000 in Austria[9]. In general, these migrants live and work in the households of the persons for whom they are providing the care. They can therefore be described as "live-in" care-givers. They do household work and provide nursing care. Research has shown that pay and working conditions are often poor, and that rest periods are inadequate as a result of the lack of separation between work and private life.[10]

In general, these migrant women do not settle permanently in the country where they work, but "commute" between their home and host countries. Their families remain in the country of origin. Studies have examined the consequences of these new family configurations and identified both positive and negative effects (for instance improved financial resources but also insufficient care for the migrants' own children and old people back home).[11]

These are challenges that should also be taken into consideration in efforts to encourage regular employment in the field of personal and household-related services.

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Guest Column

Personal and household services as a job creation opportunity

By moving undeclared household and care work from the shadow economy to the official job market, job opportunities will arise, argues Patricia Pedelabat of the European Commission in this article.

In April 2012, as part of the employment package, the Commission adopted the staff working document on "exploiting the potential of the personal and household services".

Personal and household services (PHS) are often mentioned as a possible answer to the difficult employment situation of the relatively low-skilled. By encouraging the provision of housework services in the formal economy rather than in the shadow economy job opportunities for this target group can be created at a low cost for public finance. Moving these services from the shadow to the formal economy will also contribute to the creation and growth of micro- and SMEs and given that many of these services are provided by self-employed persons and small and medium-sized companies.

Traditionally, PHS are provided by and within the household, mostly by women. Parts of these tasks have been progressively externalised outside the house (catering, laundering, day nursery and institutions for elderly) or inside the home to external workers directly or indirectly employed by the household.

OECD[1] estimates show that adult household members in European member states of the OECD spend on average 2.5 hours per day on housework and care. Women are much more involved (3.5 hours) than men (1.5 hours). Most of the unpaid work involves routine housework tasks (cooking, cleaning, gardening and home maintenance) and care activities. The externalisation of some of these activities could represent an important source of new jobs (self-employment, creation or development of SMEs).

Increasing demand for care and household services

In the future, the demand for care and household services is expected to increase due to the major trend of population ageing in all Member States, combined with the expected decline of the number of potential carers within the family circle.

A Eurofound report[2] from 2011 concluded that about 80% of time spent caring for people with disabilities or dependent elderly persons is provided by informal care providers especially from within the same household, or among friends and neighbours.

Long-term care (LTC) services are necessary for people who depend on help to carry out daily activities such as getting up, eating, bathing, dressing, going to bed, or using the toilet. LTC is delivered either informally (see previous section) or formally by care assistants. Formal care is given at home or in institutions (such as care centres and nursing homes) and generally a part of the cost is supported by public authorities.

Some Member States have had reasonably comprehensive care services at home in place for many years and the LTC needs of the population are fully covered within the formal system. In other member states that have more family-oriented welfare traditions, comprehensive approaches to long-term care have only started to develop relatively recently. In contrast, large numbers of people do not receive formal care services and rely exclusively on informal care in other member states[3].

Without public support, formal employment in PHS is quite costly for the majority of the population and the formal market for PHS is quite limited. Hence, a noticeable part of PHS is provided informally by undeclared workers. This is clearly due to the difference between the net wage of the user

and the cost of the service provider for activities that the user can perform him or herself. Informal employment in private homes also has an impact on working conditions and the quality of the job.

Undeclared workers in household services

Due to its nature, undeclared work is very difficult to estimate. Only a limited number of studies have been conducted to shed light on the extent of undeclared work in the EU. A special Eurobarometer (no. 284) on "Undeclared work in the European Union"[4] based on a direct survey with interviews of 26,755 EU citizens aged 15 and older living in the 27 EU Member States was published in October 2007. According to the survey, the potential number of undeclared workers in the household services is estimated at 1 million.

However, this Eurobarometer-based projection may underestimate the real situation. In fact, recent data from Germany and Italy[5] alone seem to exceed this estimation. Germany is one of the Member States with the highest level of informal employment in private homes as it is assumed that 90–95 % of these activities in private homes are rendered informally. Informal work is especially widespread in the households of elderly people with at least 500,000 to 600,000 informal domestic workers. Italy has also a large share of informal employment in private households where most of the domestic work is carried out by irregular immigrants. The actual number of migrant care workers (called "badanti 24") is unknown, due to the nature of the phenomenon. However, their number is estimated between 0.7 and 1 million, which is far higher than the workers in the formal care sector.

Taking into account the importance of undeclared work in the PHS sectors, public authorities can consider intervening with the aim of encouraging the provision of PHS in the formal economy. This could notably take the form of a direct intervention in the price paid by the user via e.g. services vouchers which are targeted at specific tasks. The consumer pays only part of the real price (close to the price on the black market) and public authorities pay the difference. Studies in France and Belgium show the positive return effects of these public-sector interventions. These elements are important in times of public deficit reduction. Formal employment in PHS will also contribute to better quality of services and better working conditions.

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4 *http://ec.europa.eu/public_opinion/archives/ebs/ebs_284_en.pdf.*
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Quality jobs for quality social services

From the standpoint of Europe's social service providers, the European umbrella organisation SOLIDAR criticises the current EU consultation concerning personal and household services for concentrating on the wrong angle: not simply job-creation but the well-being of service recipients and quality employment should be the focus.

On 18 April 2012, the European Commission (EC) issued its "employment package", a policy communication on "job-rich recovery"[1] accompanied by a series of Staff Working Documents[2], in which the EC seeks to carry forward the objectives of the Europe 2020 Strategy and its flagship initiatives. The Communication lists the health and social care sector as a fast growing sector with important job creation potential due to an ageing population and an expansion of service needs. As a consequence, the EC proposes an action plan for the EU health workforce, including a consultation on the employment potential in personal and household services.[3]

The consultation is based on the related staff working paper[4], which mentions a broad range of activities contributing to families' and individuals' well-being at home: child care, long-term care, cleaning, remedial classes, home repairs, gardening, support by information and communication technology (ICT), etc. Questions focus on measures to monitor the employment levels in the sector, on the utility of sharing experiences as well as on ways to ensure the quality of services and jobs. Several of the services mentioned cover activities carried out by SOLIDAR member organisations. Thus, Social Services Europe[5], of which SOLIDAR is a founding member, took the opportunity to set out its view and replied to the EC consultation.[6]

EU policies require a holistic approach towards social services

SOLIDAR as well as other Social Services Europe members, first and foremost, welcome the increased attention to and recognition of challenges in the sector, which require answers regarding, notably, the recruitment and retention of qualified staff as well as the improvement of working conditions in the sector. Nevertheless, we consider the definition and scope of personal and household services extremely narrow and confusing. The range of services mentioned in the staff working paper covers only some of the categories in the EC's previous definition of social services of general interest[7], which includes social support services for people furthest away from the labour market and suffering social exclusion, crisis and emergency social and health services. The narrow definition that is given now is problematic as it no longer has a holistic approach to the definition of social services that is essential for current and future developments. Social services face many of the same challenges, whether provided at home, in the community or in institutional settings. These challenges are often interlinked and cannot be addressed individually by singling out personal social services delivered at home. Instead, an EU strategy tackling the full range of challenges to the sector is needed.

Furthermore, it is crucial to avoid confusion between personal social services and household services. Although there is an interpersonal dimension in household services (i.e. home repairs, gardening), this dimension plays a much more important role in social services, such as child care/long-term care. Neither does the service user's health, nor well-being depend on household services in the same way as the target group of social services. Social and health services also require a much higher qualified staff. Finally, social services play a preventive and social cohesion role facilitating social inclusion and safeguarding fundamental rights. Not taking into account this dimension plays down the responsibility of public authorities to guarantee the availability, accessibility and affordability of high quality integrated social and health services for all.

Ensuring the quality of services

From SOLIDAR's point of view, another shortcoming in the staff working paper and the consultation is the EC's approach, linking the development of the sector to its job creation potential rather than to the needs of service users and their families. However, creating a separately financed and regulated sector for personal and household services would surely lead to further fragmentation in health and social care provision with negative effects on a high quality integrated service provision for all. Focussing on job creation and the sharing of experiences with a specific attention to cost effectiveness, the EC ignores the primary aim of social services, namely that of improving the well-being of the people who use the services and ensuring decent working conditions for the staff providing them. Sharing experiences should therefore concentrate on effective and innovative practices that best meet users' needs and improve their quality of life and work. Additionally, EU level coordination should be developed to examine working standards and conditions in the social service sector, sharing best practice and drawing up common commitments and proposals.

To ensure the quality of services, their organisation, funding and delivery need to be supported, particularly where reduced coverage through insurance benefits and private savings limit individuals' access to and the affordability of such quality social and health services. Governments must ensure a coherent policy and financial framework with a long-term investment approach. The EU should support them in achieving the social objectives of the Europe 2020 Strategy and in implementing the Voluntary Quality Framework for Social Services, adopted in 2010.[8]

Quality service provision requires quality staff in decent work and quality employment. It is not only about creating more jobs, but quality and sustainable jobs. Staff should be paid a decent living wage according to their skills and the value they provide in the service. Wage negotiation mechanisms, collective bargaining and collective agreements are effective means to secure competition based on the quality of the service rather than on the lowest price. SOLIDAR therefore calls for the development and strengthening of a sectoral social dialogue and calls upon Member States to ratify ILO Convention 189 on Domestic Workers. In addition, quality vocational training and tailor-made lifelong learning opportunities are key to a greater professionalisation of services. Social and health services can only unfold their full potential if Member States adopt a proper framework aiming to recognise the qualification of workers, especially those obtained by migrant workers in third countries, better use existing skills, competences and knowledge, create learning workplaces and ensure the availability of retraining. With this in mind, SOLIDAR recommends developing and implementing Operational Programmes that could help promote some of these ideas and initiatives in the future funding period of the European Social Fund (2014–2020).

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5 *Social Services Europe brings together nine Europe-wide networks of not-for-profit providers of social and health care services who each have a track record in providing value-driven services for the most vulnerable in our societies. The network aims to strengthen the profile and position of social services, and promote the role of not-for-profit social service providers in Europe. See www.socialserviceseurope.eu.*
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Sociopolitical Developments in Europe

Supplemental care services for the elderly in Austria

In this article, Tom Schmid describes the path taken by Austria to dismantle the black market for care services: comprehensive legal changes and the subsidisation of social security costs for caregivers have encouraged the creation of legal jobs.

The Austrian nursing care insurance was introduced in 1993. It consists of:

- a seven-tiered nursing care allowance
- a comprehensive range of social services available nationwide
- non-contributory social insurance for caregiving relatives
- external quality control of care services

Since the threshold for the lowest care allowance level, at 60 hours of nursing and other care per month, is relatively low, the number of persons receiving care benefits at one of the seven levels (435,000 persons) is quite high in relation to the overall population (8 million). In most Austrian states, entitlement to a nursing care allowance is a prerequisite for entitlement to family support social services; often a higher allowance level is necessary (usually level 3 or 4) for care in a nursing home (70,000 persons in 2011). More than half of all care allowance recipients are over 80 years old, and about 80 % of them are older than 60.

The situation of nursing care services in Austria

The lion's share of care work in Austria is provided by families, and within the families mainly by women. 16 % of persons requiring care are nursing home patients; another 18 % receive mobile family support services once or several times a week, while another 30 % are connected to a mobile emergency call system. Some 4 % of care patients are assisted by 24-hour support staff, usually in addition to the care provided by mobile services. This means that about two thirds of persons in care situations are looked after exclusively by their families, and for at least half of this group additional help can be organised

quickly in an emergency or a care crisis.

The nursing and supplemental support services offered by social service organisations are provided by members of various professional groups (qualified nurses, geriatric caregivers, domestic helpers, etc.), in most cases with the additional involvement of the family doctor. These persons hold full or part-time jobs with charity organisations (non-profit organisations). The 40,000 or so household caregivers who provide 24-hour care are, in the vast majority of cases (over 90%), freelance professionals with an appropriate business licence.

Since the legalisation of supplemental household services ("24-hour care"), this area has been growing rapidly: persons and companies providing such care currently account for approximately 10% of all unincorporated companies in Austria, in spite of the fact that they cover the needs of only about 5% of households where care is needed. Legalisation has created legal certainty in this segment and freed affected households from the danger of prosecution as "clandestine employers".

Reducing clandestine work through legalisation

The legalisation process covers three areas. In terms of benefit entitlement regulations, the "Home Care Law" and an amendment to the Commercial Code have opened up the possibility of legal household employment with relatively flexible working hours and relatively long periods of care. This type of work can take the form of formal employment in the household (extremely rare in actual practice), of employment by a welfare agency (about 10%), or of freelance work as a home caregiver. In each case, the caregiver must have a private room in the household. As in Austria all forms of employment (employed, self-employed, freelance) are subject to full social insurance contributions, the legalisation process has generated additional costs in each of the three forms, automatically making the service more expensive. To ensure that the legalisation process is accepted, therefore, a new regulation was adopted under funding law, to the effect that households making use of home care services can receive a subsidy in most cases equivalent to the total additional costs caused by the legalisation (consisting mainly of social contributions for the caregivers). The care costs themselves are not subsidised. This means that home care does not become cheaper as a result of legalisation, but it does not become more expensive either. And finally, under professional law, the minimum qualification required for licensing as a caregiver was set at a minimum of 200 hours of theoretical training. For the practical part of the training, "on the job" experience is considered acceptable. Thus, caregivers have a qualification level equivalent to that of employees of regular social services providers at the lowest of three levels.

For affected families, the cost of 24-hour care after deduction of the subsidy is about € 1,500 per month (thus corresponding to the cost of former black market employment prior to legalisation).

There are about 40,000 people working as home caregivers; as there are generally two caregivers working in a 14-day rhythm, we can assume a total market of 20,000 households. Some 80% of caregivers come from other EU countries, and a fifth from Austria. They are generally recommended by agencies that also handle applications for business licences and social insurance. With this solution, the problem of 24-hour care has been removed from the sphere of clandestine employment and from the political debate. The problem remains that the vast majority of families who need care services still receive no adequate family support (neither on the black market nor on a legal basis) – they are left alone with their nursing care problem and at most take advantage of neighbourly assistance.

As the Austrian care allowance is a tax-financed benefit and not provided on the basis of insurance coverage, it can not be exported. This means that entitlement lapses if the beneficiary is abroad. Therefore, the alternative to home care open to families in other EU countries, i.e. to have the patient nursed in low-wage countries of Eastern Europe or Asia, is possible only for a very small minority of cases in Austria, as such care cannot (unlike in Germany) be funded by social benefits.

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The Italian long-term care system in a time of crisis

The consequences of the economic crisis for long-term care in Italy are the topic of this article. With less public money for social spending and families having less money to pay for care services, Annamaria Simonazzi and Sara Picchi anticipate a consolidation of the Italian care model which is traditionally based on families.

In Italy, the long-term care (LTC) system has traditionally been characterised by a low level of public provision and funding. Most public funding is channelled into residential settings (amounting to 0.40% of GDP) and cash for care schemes (0.66% of GDP)[1], with home care covering only 6.2% of the elderly population (0.24% of GDP)[2]. The inadequate public system has been complemented by the considerable capacity of family and kinship networks to internalise caring functions. For a long time, these two elements have constituted the principal traits of what has been called the Italian "familist model".

This model has come under pressure because of the emergence of two new trends: the rapid ageing of the population and the significant increase in female participation in the labour market, particularly among younger women. Given the institutional inertia at the central level and the residual role played by service in-kind, more and more dependent elderly people came to rely on cash benefits. Families' reduced caring capacities have been counterbalanced by the spectacular growth of a private – mostly irregular – care market. This growth, partly sustained by unconditional monetary transfers, has been favoured by the Italian migration policy, characterised by recurrent amnesties[3]. In 2009, migrant carers accounted for 81% of total carers, one in three irregular[4].

The characteristics of the Italian LTC model, based on cash transfers, (irregular) private market and family care, have cushioned, at first, the impact of the economic crisis on the sector. However, its final effects are still far from completed: the worsening of the fiscal crisis does not look promising for the future of the Italian personal services system. In the following section, we consider two issues – concerning policy actions and gender – that are very likely to take centre stage in the future debate.

What future for local services?

The fiscal consequences of the economic crisis have severely affected the public care sector. In order to reduce the public deficit, the national funds for financing social spending have been cut or zeroed. The previous government reduced the funds dedicated to social policies (from 2.5 million euro in 2008 to 200000 in 2013) by 92% while zeroing the recently introduced National Fund for dependent people. Drastically reduced financial transfers to local authorities have met with the increasing care needs of households, whose purchasing power was being eroded by the crisis[5]. During the past decade, most regions (responsible for the provision of most services) had launched programmes to overhaul the local system of care[6]. Faced with cuts in financial transfers from the centre, it is now becoming clear that it will be increasingly difficult for the local authorities to proceed with these programmes or even to preserve what had been achieved.

Migration, gender and care

During these four years of crisis, the media had emphasized the resilience of the female employment – both native and migrant – in the service sector. Indeed, between 2009 and 2010, 70% of the increase in foreign women's employment was due to domestic workers and family assistants[7]. Meanwhile, the difference in the employment levels between native and migrant female care workers has been narrowing, as Italian women re-entered the care sector in great numbers[8]. While the initial isolation of this sector from the economic crisis had sheltered the female employment, the worsening of the fiscal crisis, together with the reduced purchasing power of Italian families, are opening up a new phase, where the comparative advantage of female (and mainly foreign) employment is likely to be eroded. With the crisis deepening, impoverished Italian families might have to cut back on care expenditure. Two partly conflicting forces may be at work: on the one hand, drastically reduced pur-

chasing power will push families to reinternalise caring activities previously outsourced to the market; on the other, the increasing male unemployment will force an increasing number of women to look for work opportunities in the care sector, one of the few dynamic sectors remaining, though at risk of progressively worsening working conditions[9].

The challenge for the Italian LTC system is to prevent the consolidation by default of the familist model. Lacking measures to support welfare policies at the local level and to favour reconciliation, families will have to invent new (or old) solutions to meet their caring needs. The fiscal crisis is pushing in this direction. Two pension reforms will make reconciliation of work and care more difficult. The first reform increased the retirement age of female public employees from 60 to 65, the same is that for men. To compensate for the greater amount of unpaid work carried out by women there was a commitment to earmarking the savings for reconciliation measures. However, in the end, the so called "women's trove" (about 4 billion euro between 2010 and 2020) got lost in the large hotchpotch of public debt reduction. The second reform increased the retirement age for men and women working in the private sector alike to 67 years, without compensation for caring duties. This will aggravate the reconciliation problems of the so-called "sandwich generation", with a concrete risk of reinstating the Italian model of care at its worst. The previous government had defended the familist model as the one more akin to its philosophy of a "caring family"; the fiscal measures of the new government are implementing it.

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1 *In 2012, the attendance allowance, the main monetary transfer specifically targeted at dependent persons, amounts to 492.97 euro per month.*
2 *NNA Network 2010.*
3 *In the 2009 immigration law, Italy made illegal entry and residence a criminal offence, leading to immediate deportation and high fines. In the same year, Italy allowed migrant personal and home care workers to regularize their situation. About 300,000 applications were made by employers who wanted to regularize their workers. This is much lower than previously estimated: the conditions were deemed too expensive by the families and the amnesty was considered a failure.*
4 *IRS 2011.*
5 *Between 2008 and 2012, household consumption has decreased by 5% (Bank of Italy 2012).*
6 *In particular, Regional Funds for dependency and care allowances to regularize irregular care workers.*
7 *Istat 2011.*
8 *Between 2008 and 2010, Italian care workers increased by 10%, compared with an increase of 3% between 2005 and 2007 (Inps, Observatory on domestic workers).*
9 *A new regularization is now closing. Unlike the 2009 amnesty, this one is not exclusively directed at irregular migrant care workers. However, it requires a greater financial effort (+ 500 EUR). In view of the disappointing results of the previous one, this does not promise well.*

Background

Care-work migration

A growing need for care in connection with high costs: these are reasons for the rising need for affordable caregivers, who are often not available locally. The consequence is the migration of care workers – usually women – to wealthier countries where demand is high. On the one hand, these migrants include professionaly trained nurses who emigrate permanently and are legally employed in nursing homes or hospitals. Another large group consists of women who are professionally qualified, but not as nurses. These women assume household tasks and light care duties for the elderly and other persons in need of care, thus allowing them to continue living at home. These care-work migrants commute between their home countries and limited working periods of several weeks in the host country, where they live in the patient's household and are thus available around the clock.[1]

Global care chains

The migration trend triggered by the need for care workers runs from east to west across Europe, with the migrants' main countries of destination being Germany, Austria and Italy. Many of the migrants come from Poland, the Czech Republic, Slovakia, Romania or Bulgaria. But these countries themselves are already the destination of other care-work migrants. There are, for instance, Ukrainian care workers who migrate to Poland. This concatenation of migration trends has been described with the term "global care chains". The term, which also extends more generally to other "caregiving tasks" usually performed by women, is not restricted to the nursing care sector. It was coined by Arlie Hochschild, who also describes the connection that comes from care work and migration: a care-work migrant has her own children cared for in her home country by a caregiver who is herself a migrant to this country. This second migrant's children, in turn, are cared for by the eldest daughter.[2] Because care workers have families who also have care needs, the concept of a global care chain forces us to look at the consequences of care-work migration in the country of origin of the care workers.

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Observatory for Sociopolitical Developments in Europe

1 *Cf. Schirilla, Nausikaa/ Waldhausen, Anna (2012): Preface. In: Hitzemann, Andrea/ Schirilla, Nausikaa/ Waldhausen, Anna (eds.) (2012): Care and Migration in Europe. Transnational Perspectives from the Field. Freiburg im Breisgau: Lambertus, pp. 29–36. The book provides examples of the effects of migration on the country of origin.*
2 *Cf. Lutz, Helma/ Palenga-Möllenbeck, Ewa (2011): Das Care-Chain-Konzept auf dem Prüfstand. Eine Fallstudie der transnationalen Care-Arrangements polnischer und ukrainischer Migrantinnen. In: Gender. Zeitschrift für Geschlecht, Kultur und Gesellschaft 3 (2011), S. 9–27.*

Please Note

New on our website

http://www.sociopolitical-observatory.eu

The conference report of the international conference "New opportunities or new restrictions: Social innovation and providers of social services in Europe" will be available on our website soon after the conference. The Observatory for Sociopolitical Developments in Europe organises this European convention in Berlin on 17 and 18 December 2012.

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