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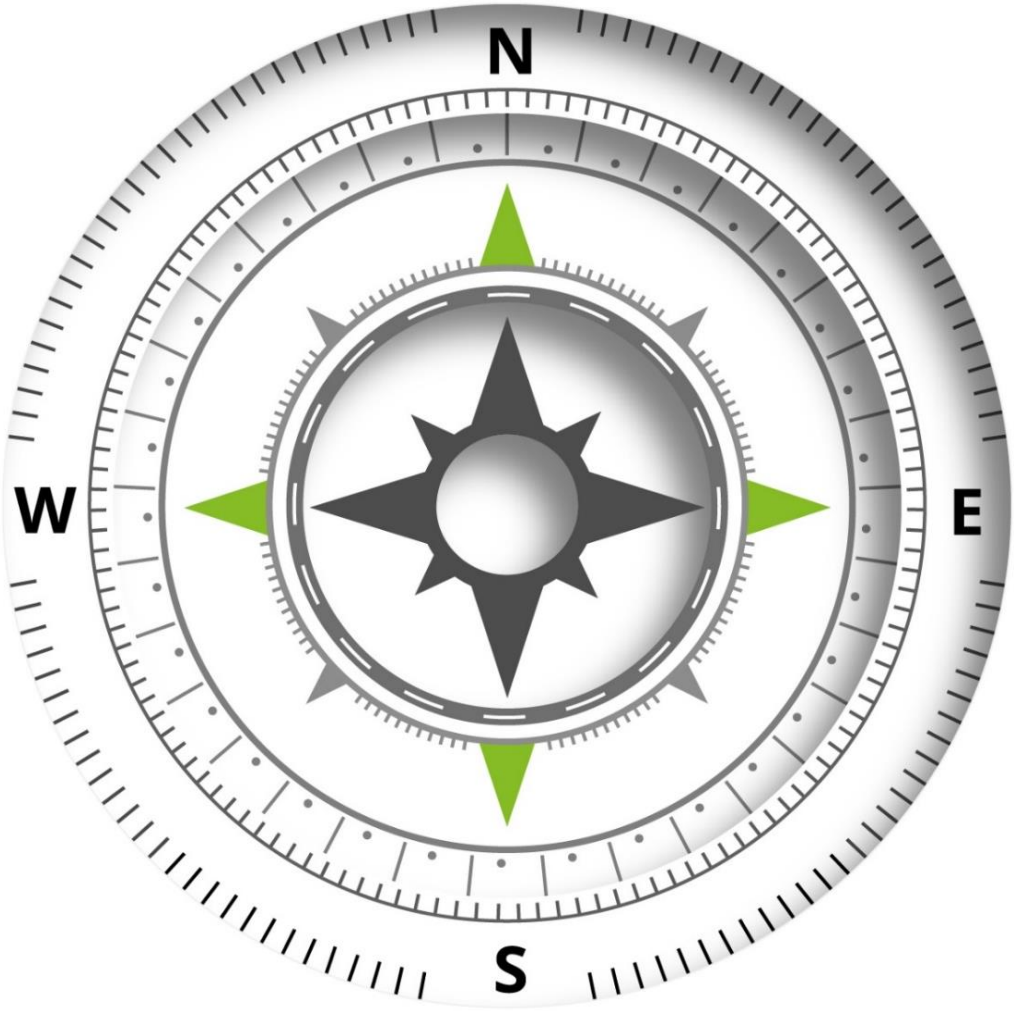
Report public procurement of social health services:

Study of regulatory burden and the level of cross-border dimension

Commissioned by the Dutch Ministry of Health, Welfare and Sport (VWS), the Department of Legislation and Legal Affairs (WJZ)



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Abstract

Dutch municipalities wanting to purchase social health services have since 2016 been required to put contracts with a value exceeding EUR 750.000 out to tender across the EU. They perceive this as a burdensome process which brings no offsetting benefits in terms of better quality care at a competitive cost. This study was commissioned by the government of the Netherlands to provide an independent investigation into whether that is the case, and to look at whether the provisions on tendering social health services in the 2014 EU Directive incorporating this requirement are achieving their objectives (i.e. are effective) and doing so in a way which is proportionate to the effort involved (i.e. are efficient).

In summary, this study has found evidence for the following conclusions:

- The cross-border dimension of social health services in Europe, more specifically home care and youth care, is negligible. Of the 830 contract award notices published between 2016 and 2018, only 0.5% of awards had a cross-border dimension;
- It is time-consuming and costly for both contracting authorities and care providers to adhere to the obligations stemming from the Directive, while this time and cost do not directly benefit the quality of youth and home care.

The fact that there is no cross-border dimension in social health services while contracting authorities and care providers experience a substantial regulatory burden leads to disproportionality. Therefore, it can be concluded that the rules that apply to public procurement of social health services are not efficient nor effective.

These conclusions lead to the recommendation that the current obligations arising out of the European Directive on public procurement as they currently apply to the social health services should be evaluated with a possible view to adaptations. In any such evaluation, the findings of this report should be taken into account.

Executive Summary

Background and purpose of this research

Dutch municipalities wanting to purchase social health services have since 2016 been required to put contracts with a value exceeding EUR 750.000 out to tender across the EU. They perceive this as a burdensome process which brings no offsetting benefits in terms of better quality care at a competitive cost. This study was commissioned by the government of the Netherlands to provide an independent investigation into whether that is the case, and to look at whether the provisions on tendering social health services in the 2014 EU Directive incorporating this requirement are achieving their objectives (i.e. are effective) and doing so in a way which is proportionate to the effort involved (i.e. are efficient).

The provisions governing tendering for social health services are in the European Public Procurement Directive (Directive 2014/24/EU[1]; henceforth "the Directive"). This entered into force in 2014 with a 2016 deadline for transposition by the Member States, which was thus the effective compliance date for contracting authorities and care providers. The Directive is based on the principle of fair access to public procurement for all companies within the European Union (EU). It is a revision of an earlier directive and introduced competition in social health services. In doing so, the Directive acknowledged the "limited cross-border dimension" of social health services, and that "those services are provided within a particular context that varies widely amongst Member States, due to different cultural traditions."[2] The Directive recognised this by establishing a higher threshold at which the obligation to put a contract out to tender is triggered.

This study looks at the extent of the cross-border dimension in the European market for social health services, specifically home care and youth care, and assesses the regulatory burden associated with the obligations arising from the Directive. It found evidence that cross-border provision of social health services is currently negligible and would be likely to remain so even if regulatory barriers were removed; it substantiates the perception that the new requirements are burdensome, given the time and cost involved in compliance. It recommends that the EU provisions governing the public procurement of social health services be evaluated and that the findings of this report be taken into account in that evaluation.

Methods

Cross-border dimension

Three analyses were carried out in parallel to assess the extent of the cross-border dimension – an analysis of European public procurement notices, a survey, and interviews, more specifically:

- Analysis of data on the CAN (contract award notice) and CN (contract notice) of tenders in scope of the study[3] on the Tenders Electronic Daily portal (TED[4]) on which all European public procurement notices are published. The address of the tenderer was used to differentiate between domestic and foreign successful bidders.
- A survey was distributed amongst contracting authorities and care providers based on the available contact details. As the TED database only includes information on successful care provider bids, this survey focused on the question of whether care providers had participated in foreign tenders in the past. The distribution of the survey was supported by municipality and industry associations across Europe.
- Interviews were carried out with care providers to better understand the reasoning behind the degree of interest of care providers in foreign tenders.

[1] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014L0025&from=EN

[2] Recital 114

[3] Tenders with CPV-codes under the light regime, and that are related to either youth or home care

[4] Tenders Electronic Daily (https://ted.europa.eu)

Regulatory burden

The Standard Cost Model methodology[5] was used to measure the regulatory burden that the obligations described in the Directive impose on contracting authorities and care providers in youth care and home care in six case-study countries[6].

This was also a three-step process, namely:

- Mapping of obligations that can be distinguished in the Directive.
- Measurement of the time and costs associated with the obligations based on interviews with care providers and contracting authorities across the six case-study countries, differentiated by the type of activity necessary to fulfil the obligation. In this measurement the costs of the "Normally Efficient Business" are determined based on the input gathered in the interviews on the reasonably expected time it would take a contracting authority or care provider to fulfil the procedural steps.
- Standardisation of the findings in the six case-study countries to all Member States to arrive at an approximation of the total regulatory burden associated with the Directive.

Results
The results of this study are structured by study question.

Cross-border dimension

1. How many procurement procedures are carried out annually in the Member States in social health services?

Based on the analysis of the TED database, there were 1 233 relevant contract notices and prior information notices in youth care and home care services between 2016 and 2018. The total number of relevant Contract Award Notices (CANs) was 830, an average of 411 notices and 277 awards annually.

2. How often does a foreign party participate in such a procurement procedure?

Contracting authorities answered that on average 0.6% of the organisations that participate in tenders originate in other countries; the figure given by care providers for their participation in cross-border tenders was 0%.

3. How often does a foreign party win a procurement procedure?

Based on data analytics from the TED database, in 0.5% (4) of the awards (830), a foreign party won at least one lot of the tender, and in all these tenders a minority of the lots were won by a foreign party.

4. What percentage of public service contracts in social health services are cross-border?

The 830 awards between 2016-2018 represented 3 609 lots. When winning is defined as winning a majority of the lots within a contract, none of the 830 awards was to a foreign party (0%).

Findings

The results indicate that there is a negligible level of cross-border activity in social health services, and that there is no single European market for these services. This is supported by the contracting authorities and care providers interviewed, who indicated that social health services are organised locally. Contracting authorities and care providers pointed out that the unique nature of these services, and cultural and linguistic barriers, are a disincentive to cross-border activity. Differences in law and regulation in social health services were mentioned as barriers, but removing these barriers would not dramatically increase cross-border activity as the remaining barriers weigh heavily.

[5] Tool 60 in the Better Regulation Toolbox that complements the better regulation guideline presented in SWD(2017) 350 https://ec.europa.eu/info/sites/info/files/better-regulation-toolbox.pdf
[6] Czechia, France, Germany, Italy, Netherlands and Sweden.

Regulatory burden

1. *What is the regulatory burden of the procurement procedures that are carried out annually in the Member States of the European Union in social health services, more specifically youth care and home care?*

The regulatory costs incurred by both the contracting authorities and the care providers per year for the EU-27 is EUR 103 million. Of this, approximately EUR 20 million is Business as Usual (BAU), i.e. costs that would have been incurred in any event; the remaining 81% is directly related to the Directive. This means that the total regulatory burden is EUR 83 million[7]. Perceived only from the time spent perspective, the contracting authorities and care providers need approximately 1 256 FTE to comply with the full procedures.

2. *What is the regulatory burden of those procurement procedures for contracting authorities?*

The regulatory costs incurred by the contracting authorities per year for the EU-27 is EUR 27 million. Of this, approximately EUR 4 million is Business as Usual (BAU); the remaining 87% is directly related to the Directive. This means that the regulatory burden is EUR 23 million[5]. Perceived only from the time spent perspective, the contracting authorities spend approximately 326 FTE to comply with the full procedures.

3. *What does the regulatory burden of those procurement procedures for contracting authorities consist of?*

This regulatory burden arises mainly in awarding and informing (27% of the total burden) followed by many hours spent on assessing the tenders (25%).

4. *What is the regulatory burden of those procurement procedures for care providers?*

The regulatory costs incurred by the care providers in total per year for the EU-27 is EUR 76 million. Of this, approximately EUR 16 million is Business as Usual (BAU); the remaining 79% is directly related to the Directive. This means that the regulatory burden is EUR 59 million[5]. Perceived only from the time spent perspective, the care provides spend approximately 930 FTE to comply with the full procedures.

5. *What does the regulatory burden of those procurement procedures for care providers consist of?*

The regulatory burden arises mainly in creating and submitting the tender documents (56%) and responding to notices and asking questions (20%).

In the qualitative interviews, when it was possible to make recommendations for further improvement of public procurement of social health services, interviewees indicated they experience the procurement procedures as inefficient and burdensome. Some contracting authorities do indicate that they value guidelines and structure, but not via obligations but rather as principles. Some interviewees did indicate that the requirement to follow European public procurement procedures has created a more competitive environment while previously the procurement atmosphere was more collaborative. This can be a sign of a more competitive market, which theoretically could be more efficient. However, given the sensitive nature of social health services in which it is necessary to establish trust between care provider and client, contracting authorities indicate that it is questionable whether this hardening of the relationship between contracting authority and care provider as well as between care providers themselves is beneficial to the clients. Most clients are vulnerable and receive care from different providers. They benefit when these providers collaborate with each other within the borders of competition law, and know local and personal circumstances.

Findings

The total regulatory burden is EUR 83 million and 1 256 FTE. This falls primarily on the care providers (72% and 74% respectively). This is widely perceived as inefficient and burdensome.

[7] Differences can occur because of rounding; exact numbers can be found in the subsequent report chapters.

Discussion

Cross-border dimension

The database analysis provided solid results that are confirmed by the survey and interviews. The survey provided more detailed insights and interviews provided qualitative motivation. Thus, the results of the three data-gathering methods are in line with each other. This means that conclusions can be drawn with a high degree of certainty.

Regulatory burden

The results from the interviews that form the basis of the measurement of the regulatory burden associated with the Directive are relatively consistent across interviews. Thus, the measurement gives a good indication of the regulatory burden contracting authorities and care providers experience. This means that conclusions can be drawn with a high degree of certainty.

Conclusion and recommendations

It can be concluded with a high degree of certainty that the cross-border dimension of social health services in Europe, more specifically home care and youth care, is negligible. Of the 830 contract award notices published between 2016 and 2018, only 0.5% of awards had a cross-border dimension.

This finding is substantiated by the survey results that show that contracting authorities and care providers on average see cross-border activity in less than 1% of tenders, meaning that care providers are neither interested in, nor participate in, nor win procurement procedures in EU Member States other than the Member State they are registered in. Moreover, health care providers indicated that cross-border activity is not of interest to them. Even the removal of any perceived legal and regulatory barriers (stemming from public procurement rules or otherwise) in this sector would not change this. The key barriers are cultural and linguistic. All things considered, there seems to be no single European market in social health services.

The measurement of the obligations stemming from the Directive show that it is time-consuming and costly for contracting authorities and care providers to adhere to them. This time and cost do not directly benefit the quality of youth and home care. The Directive is experienced as inefficient and burdensome by both the contracting authorities and care providers. Some contracting authorities do indicate that they value guidelines and structure, but not via obligations but rather as principles.

The fact that there is no cross-border dimension in social health services while contracting authorities and care providers experience a substantial regulatory burden leads to disproportionality. Therefore, it can be concluded that the rules that apply to public procurement of social health services are not efficient nor effective.

These conclusions lead to the recommendation that the current obligations arising out of the European Directive on public procurement as they currently apply to the social health services should be evaluated with a possible view to adaptations. In any such evaluation, the findings of this report should be taken into account.

1 Introduction

1.1 Background and purpose of the investigation

Municipalities wanting to purchase certain forms of youth care or social support and wanting to select the best providers have to put their contracts out to public tender. In these cases, the rules of the European Procurement Directive (Directive 2014/24/EU[8]; henceforth "the Directive") apply. The rationale of this Directive is fair access to public procurement for all companies within the European Union (EU). However, the government of the Netherlands has identified an issue in contracting authorities experiencing the Directive as burdensome and a constraint in the procurement of social health services[9].

Therefore, the government of the Netherlands is seeking to assess how the efficiency and effectiveness of the Directive can be improved. The issue is whether the benefits of opening up the European Single Market in social health services in practice outweighs the regulatory burden that contracting authorities and care providers experience. In that context, the government of the Netherlands asked Deloitte to study the cross-border dimension of social health services and assess the regulatory burden associated with the obligations coming from the Directive.

This study focuses on assessing the extent of the cross-border dimension and regulatory burden of public procurement of social health services, specifically home care and youth care. The cross-border assessment focuses on how often care providers are interested in, take part in and / or win foreign tender procedures. The regulatory burden measurement provides insight into the time and cost that contracting authorities and care providers have to spend on procurement of social health services in scope of the Directive. Together these assessments can provide input into a future evaluation of the Directive.

To assess the cross-border dimension and regulatory burden of public procurement of social health services this report addresses two main research questions.

Research questions

1. What is the extent of the cross-border dimension of social health services in Europe?
2. What is the regulatory burden for contracting authorities and care providers associated with the Directive in social health services and what does it consists of?

The two research questions are discussed separately in this study. The approach is summarised below.

1.1.1. Cross-border dimension

The European Commission aims to remove barriers for companies looking to offer cross-border services. The public procurement directive aims to simplify these cross-border activities with the aim of creating a single market for services in the European Union.

However, it is questionable whether, in practice, social health services can be seen as a single European market given cultural, linguistic, legal differences and the geographic spread of these services. Therefore, in the assessment of the extent of the cross-border dimension of public procurement of social health services, an analysis was carried out into how often care providers are interested in, take part in and / or win in foreign tender procedures. This assessment is divided in four sub-questions:

1. How many procurement procedures are carried out annually in the Member States in social health services?

2. How often does a foreign party participate in such a procurement procedure?

3. How often does a foreign party win such a procurement procedure?

[8] The adjacent EU directives 2014/23/EU and 2014/25/EU cover public concessions and public procurement of water, energy, transportation and postal services. These directives are out of scope for this study as they are not relevant for social health services.

[9] Social support and care for vulnerable elderly and youth by organising their daily life / participation in daily life.

4. What percentage of procurement procedures in social health services is cross-border?

The answer to these sub-questions makes it possible to assess the extent of the cross-border dimension of social health services in Europe.

1.1.2. Regulatory burden

The regulatory burden associated with the Directive is an important input into any future evaluation of the Directive. To answer the second research question covering this aspect, this study measures and quantifies the regulatory burden that contracting and care providers experience in procurement of social health services. This assessment is divided into five sub-questions:

1. What is the regulatory burden of procurement procedures that are carried out annually in the Member States of the European Union in social health services, more specifically youth care and home care?

2. What is the regulatory burden of those procurement procedures for contracting authorities?

3. What does the regulatory burden of those procurement procedures for contracting authorities consist of?

4. What is the regulatory burden of those procurement procedures for care providers?

5. What does the regulatory burden of those procurement procedures for care providers consist of?

With the answers to these sub-questions, the regulatory burden associated with the Directive in social health services was assessed.

The outline of this paper is as follows. Chapter 2 describes the current procurement landscape. Chapter 3 provides an explanation of the methodology used. The results are in Chapter 4, followed by the discussion in Chapter 5. Finally, the conclusions and recommendations are in Chapter 6.

2 Current procurement landscape

2.1 Relevant European Directive and national laws

The context of provision of social health services (youth care, and social support and care for the vulnerable elderly to organise their daily life and participation in daily life, i.e. home care) varies greatly due to the different cultural traditions within the EU Member States.

Until the entry into force in February 2014 of the current European Directive on public procurement (2014/24/EU), public procurement of social and other specific services only had to be announced in advance if interest from other EU Member States could be expected. With the coming into force of the Directive, social and other specific services were brought under the new European procurement regime if they exceed a threshold value of EUR 750 000[10]. Member States had until 2016 to transpose the Directive into national legislation. The rationale for the threshold was that providers from other Member States might be interested in contracts above that level and they should therefore be marketed transparently across the EU.

The Directive does take into account the special character of such services: not only is the threshold higher than for other services, but a so-called 'light regime' also applies to the public procurement of social health services[11]. Though the exact procedure for the light regime can be determined by each Member State individually, examples of how the light regime differs from the normal regime are deviation from the standard award criteria and terms in the procedure. The procedural steps in the light regime that the contracting authority must still adhere to are that the contracting authority must:

- make a (pre) announcement of the contract (prior information notice);
- check whether the tenders meet the technical specifications, requirements and standards set by the contracting authority;
- draw up an official report of the award of contract;
- notify the successful tenderer after the contract has been concluded.

However, as is clear from recital 114 and Article 76 of the Directive, the selection of contractors must also observe the basic principles of transparency, equal treatment and proportionality.

Through this Directive, the European Commission aims to contribute to one of Europe's main cornerstones: the European Single Market. The objective of the Single Market is to remove barriers for European companies looking to offer cross-border services and to make it easier for them to do business within Europe.[12] To create a level playing field for businesses across Europe for services procured by public authorities, the Directive sets out the minimum harmonised public procurement rules for all Member States. To achieve this, the core principles of the Directive are defined as transparency, equal treatment, open competition and sound procedural management.[13]

The European minimum public procurement obligations are transposed and supplemented in the national legislation of Member States. Additionally, Member States have a variety of supplementary public procurement legislations and guidelines. Examples are the different legislations per *Bundesland* in Germany and the practical guide on proportionality in the Netherlands.[14]

While it is only mandatory to apply the Directive to social health service contracts above the threshold value of EUR 750 000, contracting authorities may choose to follow the same procedure for contracts below the threshold value.

2.2 Information obligations

The chapters and articles of the Directive describe the more specific, obligatory steps in the tender process applying to contracting authorities and care providers. In this report these steps are referred to as Information Obligations (IOs) as the Directive obliges these parties to provide information. The

[10] Article 4 of the Directive
[11] Title II, Chapter 1, Article 74 et seq. of the Directive
[12] https://ec.europa.eu/growth/single-market/services_en
[13] https://ec.europa.eu/growth/single-market/public-procurement_en
[14] Government of the Netherlands: "Gids Proportionaliteit", second revision, January 2020

IOs formed the basis in the research method for defining the 'regulatory burden' to create a complete picture of the tender process. A further explanation of this methodology can be found in Chapter 3.

Looking solely at the distinct IOs in the Directive, there are 39 IOs in scope, of which 34 relate to obligations for the contracting authority and 5 to obligations for the care provider. In addition to IOs described in the Directive, there are steps which are not specifically mentioned, but which must nevertheless be completed in order to comply with the IOs. These steps were taken into account in this study as well. They are described as 'necessary steps', of which there are 10 in all. Lastly, there are steps which are defined as 'discretionary steps'. These are not defined as an IO, but are common practice when fulfilling a tender procedure. There are 12 of these. Specific obligations for Member States are out of scope. These relate to facilitating the tender process and information exchange between contracting authorities and care providers.

The full list of IOs stemming from the Directive can be found in Table 12.Table 12: Open procedure, steps and sub-steps

3 Methodology

This section sets out the methodology used to arrive at the answer to the research questions. This section outlines:

- Scope of the research;
- Method for answering questions on the extent of the cross-border dimension;
- Method for answering questions on the regulatory burden.

3.1 Scope of the research

The assessment of the extent of the cross-border dimension and the measurement of the regulatory burden both have the same scope, namely, social health services. Before going into detail on the research questions, the exact definition of social health services is discussed.

Social health services consist of social support and care for the vulnerable elderly and youth by organising their daily life / participation in daily life. These services fall under the light regime described by the Directive[15]. All services described as "Healthcare, social and related services" by the Directive are used as a starting point[16]. This research was conducted at the level of social services, without any further distinction between youth care and home care services. The analysis distinguishes between two types of organisation, the care provider and the contracting authority.

All Member States of the European Union are within the geographical scope of this research. The temporal scope was 2016, 2017 and 2018, when the UK was still a Member State. However, data on the UK as a host country was excluded from the analysis.

3.2 Cross-border dimension

3.2.1 Data analysis on tenders

This section first lays out the method used to answer research questions 1 and 3:

1. How many procurement procedures are carried out annually in the Member States in social health services?

3. How often does a foreign party win such a procurement procedure?

To provide an answer to these questions, data from the of Tenders Electronic Daily (TED)[17] was used. In addition to the standard TED website, there are a contract notice (CN) database, a contract award notice (CAN) database and individual reports published in a specific data format on the TED website. These contain all information on European tenders and consist of a large amount of XML files per calendar year. By performing an advanced (big) data analysis, the number of tenders per country can be determined. As a starting point, the contracts were filtered according to the correct Common Procurement Vocabulary (CPV) codes. CPV codes are used as a specific classification system for public procurement to define different business sectors.

As the tenders in scope are all tenders in social health services that fall under the light regime, there is a specific set of CPV codes in scope, namely all CPV codes that fall under Article 74 (Award of contracts for social and other specific services). These are spelled out in Annex XIV, under the description "Health, social and related services":[18]

Supply services of domestic help personnel:

- 75200000
- 75231200
- 75231240
- 79611000
- 79622000

[15] Products do not fall under the light regime and are out of scope

[16] Annex 14

[17] Tenders Electronic Daily (https://ted.europa.eu)

[18] Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC

Supply services of nursing personnel:

- 79624000

Supply services of medical personnel:

- 79625000

Private households with employed persons

- From 85000000 to 85323000
- 98133100
- 98133000
- 98200000
- 98500000

Manpower services for households, Agency staff services for households, Clerical staff services for households, Temporary staff for households, Home-help services and Domestic services:

- From 98513000 to 98514000.

CPV codes in this list that do not relate to home care or youth care were excluded, for example fire-brigade and rescue services, and domestic animal nurseries. When it is not completely clear if a CPV code would be in scope, it was not excluded in this step of the process.

In addition to filtering by CPV code, the data were filtered by different forms. There are 14 different forms on TED. The forms of interest in this research are the prior information notices (F1), contract notices (F2), and contract award notices (F3). There is also a specific form (F21) called 'Social and other specific services – public contracts', on which an organisation still needs to choose between whether it is issuing a prior information notice, contract notice or contract award notice. Therefore, this form is included as well.

As a last step to arrive at the tenders in scope, a list of keywords related to youth care or home care was used. The list was set up by carrying out desk analysis and validation interviews with experts in the field. This list was translated into all the official languages of the European Union and can be found in Table 5 in Appendix: cross-border dimension. By using this word list as a filter to get to the contracts in scope, only the exact word is taken and the assumption is made that there are no spelling mistakes.

The data indicates the number of tenders, as well as the number of lots per tender. As it is possible that lots within a contract are awarded across multiple countries, this research analysed the number of lots within contract award notices to answer the research questions.

To determine the extent of the cross-border dimension of tendering in social health services, the difference between domestic and parties in other EU countries was taken into account, as was the difference in the care providers that show interest in, participate in or win the tender.

To answer the four research questions as described in Chapter 1.1.1, the following definitions were used on the extent of the cross-border dimension.

Definition of *domestic* versus *foreign:*

- A domestic party is a care provider whose address listed in TED is in the same EU country as the country of the contracting authority listed in TED.
- A foreign party is a care provider whose address listed in TED is in a different EU country as the country of the contracting authority listed in TED.

The level of involvement in a tender is distinguished by three definitions: *show interest, participate* and *win:*

- Show interest: a care provider contacts the contracting authority on a specific tender (e.g. to ask a question).
- Participate: a care provider subscribes to participate in a specific tender.
- Win: a care provider is awarded a contract.

3.2.2 Survey and interviews

This section continues by explaining how the answers to research questions 2 and 4 were obtained.

2. How often does a foreign party participate in such a procurement procedure?

4. What percentage of procurement procedures in social health services is cross-border?

To provide an answer to these questions, the level of cross-border activity in European tendering needed to be investigated, from both the contracting authority perspective as well as the care provider perspective.

The TED data provides the number of tenders and the number of times a tender was awarded to a foreign party. However, the number of interested care providers cannot be distinguished from the database. To further investigate this, a survey was conducted across all European Member States. The following questions were asked:

Contracting authorities:

- Approximately what percentage of organisations that *show interest* in a tender originate from a foreign country?
- Approximately what percentage of organisations that *participate* in a tender originate from a foreign country?
- Approximately what percentage of organisations that *win* in a tender, originate from a foreign country?

Care providers:

- Of the European tenders you *show interest* in, how many originate from a foreign country?
- Of the European tenders you *participate* in, how many originate from a foreign country?
- Of the European tenders you *win*, how many originate from a foreign country?

This survey was distributed broadly across Europe to aim for a high response. The survey was sent via Qualtrics®, which is a secure (GDPR-compliant) tool. More specifically, the survey was sent to the following target groups: sector organisations across Europe (representing both contracting authorities and care providers), all contracting authorities in TED (but not the care providers, as these do not fill in their email addresses), and additional contacts gathered during interviews.

Based on the responses to the survey, follow-up interviews were conducted to further improve insights into the extent of the cross-border dimension in social health services. The focus here was on the barriers to participating in a foreign tender, and on testing potential interest in participating if these barriers were removed.

3.3 Regulatory burden

The method used to answer the research questions described in 1.1.2 Regulatory burden is the 'Standard cost model' method which is explained below.

3.3.1 Standard cost model

This research used the Standard Cost Model as defined in 'The Better Regulation Toolbox' of the European Commission[19]. This method provides guidelines on how to calculate the regulatory burden. In addition, it provides the possibility of extrapolating sample findings from the case study Member States to all Member States of the European Union.

In order to calculate the regulatory burden in the EU Member States, this analysis was performed in a selection of six Member States. Choosing a sample of six Member States provides enough results to extrapolate to all Member States of the European Union. To arrive at a selection of the six Member States, multiple factors were taken into account, such as the geographic spread, whether they are organised centrally or de-centrally, number of inhabitants, and the level of activity of European tendering in social health services. The following six Member States were selected:

[19] Tool 60 in the Better Regulation Toolbox that complements the better regulation guidelines presented in SWD(2017) 350 https://ec.europa.eu/info/sites/info/files/better-regulation-toolbox.pdf

- Czechia
- France
- Germany
- Italy
- Netherlands
- Sweden

The regulatory burden is considered to be a part of the procurement process that is only performed as a result of a legal obligation and is determined based on the average cost of the required execution activity (Price) multiplied by the number of activities performed per year (Quantity). The core of the standard cost model is the following equation:

$$\text{Regulatory cost} = \sum (P \times Q)$$

To determine which part of the regulatory burden is specifically attributable to the Directive, a standard is set for Business As Usual (BAU). BAU are activities that would still be carried out even if the obligations were not in place. Desk research was carried out, and interviews were conducted with contracting authorities and subject matter experts to determine which steps and activities, as well as which percentage of the step, fall under the BAU.

In the research and interviews, it was pointed out that some specific legal services are excluded from the Directive (Article 10). The steps and activities performed in procurement procedures of specific legal services were set as a standard for BAU as they are excluded from the Directive and therefore can be used as BAU standard. The specific steps listed in BAU can be found in Appendix Appendix: regulatory burden, Table 13.

As the regulatory cost still includes the BAU costs, the regulatory burden was calculated as follows, with BAU% being the percentage of BAU of each procurement step:

$$\text{Regulatory burden} = \sum \{(P \times Q) \times (1 - BAU\%)\}$$

This formula can be further broken down into the different components that determine the Price (P) and Quantity (Q). The section below explains in more detail how the P and Q are calculated.

3.3.1.1 Price

To calculate the procurement price by step (P), there are four components that are of interest. The average number of hours a step takes (Hours) were determined by standardising all results from the interviews into a number which is perceived to be normal for this step for a Normally Efficient Business (NEB). As the required hours per step are the main differentiator in comparing results between countries, this is discussed in more detail later in this section The frequency of the required activities is also taken into account here. The P was partly determined by conducting interviews in the Member States chosen. During these interviews, the necessary activities, the time spent per activity, frequency of activities, out-of-pocket costs and consultancy costs were discussed in detail. Another factor that determines the price is the hourly wage rate. For this study, standard hourly wage rates from via Eurostat[20] were used.

$$\text{Price (P)} = \sum \{(Hours \times Frequency\ per\ Information\ Obligation \times Wage\ rate) + Out\ of\ pocket\ costs\ (OOP) + Consultancy\ fees\}$$

3.3.1.2 Quantity

The quantity (Q) is the total number of procedures per year. The total quantity of the number of tenders for both contracting authorities as well as care providers can be calculated separately. For contracting authorities, this would be the average number of tenders conducted per year. For care providers, this would be the average number of tenders a care provider has participated in per year,

[20] Eurostat labour cost index for LCI (compensation of employees plus taxes minus subsidies) via http://appsso.eurostat.ec.europa.eu

multiplied by the average number of tenders conducted per year. These numbers are determined by using the data-analytics output of the TED database.

$$\text{Quantity (Q)} = Number\ of\ procedures\ per\ year$$

As described by the standard cost model methodology, standardisation is possible when there are at least three data points per segment. Given that interviews were to be conducted across both contracting authorities and care providers in six countries, this was to result in at least 36 interviews. However, additional interviews were conducted across organisation types and countries where needed and where possible.

To schedule these interviews, the contact information of both contracting authorities and care providers from TED was used. Interviews were scheduled via telephone or e-mail. To ensure organisations were motivated to participate in an interview, these interviews were conducted by native speakers.

3.3.1.3 Normally Efficient Business

To ensure that the correct costs are included, an assessment was performed of what the 'Normally efficient business' (NEB) would look like. A critical assessment was conducted per information obligation on how a NEB would spend time. Examples of information obligations that would fall out of scope could be when an information obligation is indirectly covered in other steps, or is fulfilled automatically via software. In both examples the time spent for a NEB process would be assumed to be zero. For all information obligations which stay in scope, an assessment was made of how many hours a NEB would spend on it. This was done by comparing the data points from the interviews.

3.3.1.4 Analysis using case-study countries

The data gathered during interviews needed to be standardised per country. This meant that the results retrieved were assessed for comparability. Consolidating the results retrieved using the standard cost model is not necessarily done by averaging the results. In some cases it may be necessary to exclude outliers or identify gaps in the data retrieved, filling it out through expert consultations. By further processing the standardised data, the regulatory burden was determined for the six Member States where the interviews were conducted, as well as a complete standardisation for the European Union.

4 Results

In this section the answers to the research questions are discussed in relation to the two parts of this study: the extent of the cross-border dimension and the regulatory burden of public procurement of social health services.

4.1 Cross-border dimension

Research question 1: How many procurement procedures are carried out annually in the Member States in social health services?

This question is answered by following the methodology described in Chapter 3.2.1. As visualised in Figure 1: Contracts in scope, the 1 574 374 contracts in the period between 1 January 2016 and 31 December 2018 listed in TED were filtered by the relevant CPV codes and forms. After that, the 57 147 remaining contracts were filtered by a list with keywords related to youth care and home care. This resulted in 7 163 contracts in the database.

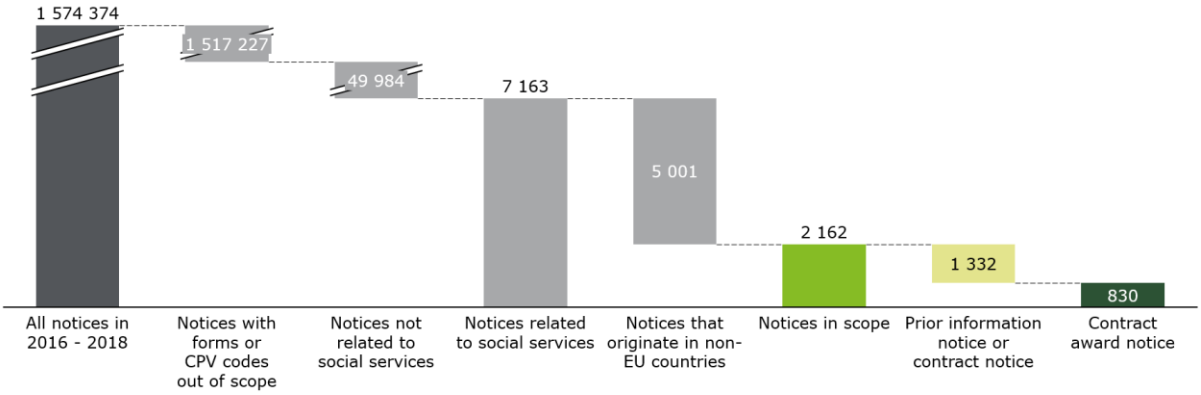

Figure 1: Contracts in scope.

Of the 7 163 notices, 5 001 originated in non-EU countries. Most of these originated from the United Kingdom, which was still a Member State during the period in scope. As described in the methodology, due to the forward-looking nature of this study, the results for the UK as a contracting authority were omitted from the analysis.

The number of remaining notices is 2 162, of which 1 332 are contract notices and prior information notices, and 830 correspond to contract award notices. This implies that of the 1 332 notices announced, 830 were awarded, whereas 403 were either cancelled or the contract awards were not registered.

When a contract was awarded, this implies that the full procurement procedure was completed. For procedures that were cancelled, it is difficult to estimate at which point in the procedure this happened and what costs might thus have been incurred. It can be said with certainty that at least 830 complete procurement procedures were registered and awarded in the period between 2016 and 2018. Incomplete procedures were not taken into account.

Annually, this comes down to an average of 411 notices of which 277 were awarded.

The exact numbers of contract awards were:

- 2016: 228
- 2017: 317
- 2018: 285

The averages per Member State over the period researched can be found in Figure 2: Contract award notices per EU Member State,.

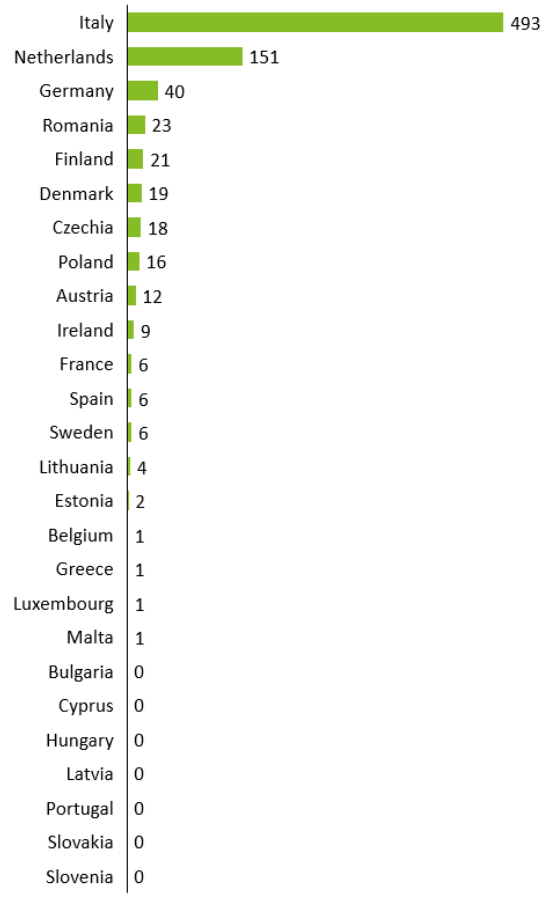

Figure 2: Contract award notices per EU Member State, 2016-2018.

Research question 2. How often does a foreign party participate in such a procurement procedure?

To answer this question, the results from the survey described in Chapter 3.2.2 were used. The exact survey questions can be found in Appendix: cross-border , Table 6Table 4. The results were validated by the estimate derived from the database.

A total of 69 responses were collected, of which 57 responses were provided by contracting authorities and 12 by care providers across multiple countries. As not all countries are filled in and a category 'Other' was included, it is possible that there are non-EU responses recorded.

Before analysing the data, a check was performed on the data quality. A selection of respondents who entered their contact details were contacted in order to improve the understanding of their answers.

Contracting authorities answered that on average they see 0.6% of the organisations that participate in tenders stemming from foreign countries; care providers indicated that they participate in foreign tenders in 0% of cases, as can be seen in Figure 3: Cross-border participation in tenders, survey results from contracting authority and care provider perspective.

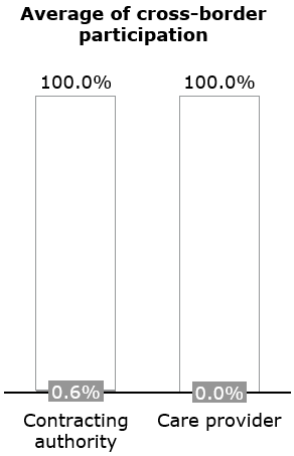

Figure 3: Cross-border participation in tenders, survey results from contracting authority and care provider perspective

The complete results of the survey can be found in Appendix: cross-border , Table 8 and Table 9.

This answer was cross-checked by database analysis as described in Chapter 3.2.1. Sub-question 4 covers in more detail how the figures were derived from the database. The cross-check confirmed that 0% of the contracts were won by a foreign care provider.

Research question 3. How often does a foreign party win such a procurement procedure?

To answer this question the method described in Chapter 3.2.1 was used. Subsequently, the answer was cross-checked with data collected through the survey described in Chapter 3.2.2.

As also described in Chapter 3.2.2, the definition of a 'win' is 'a care provider is awarded a contract'. However, contracts can be divided up into multiple lots, in which case the contract award applies to several parties. The data extracted from TED showed that a single contract tender could have up to 650 different lots assigned to it. As it is possible that some of those lots were won by foreign parties, the answer to this question is described at the lot level.

The 830 contract awards in 2016-2018 were divided in 3 609 lots. As visualised in Figure 4, 75 of the 3 609 lots were won by foreign parties (2.1%). Those 75 lots stemmed from 4 contracts across three Member States:

- Ireland: United Kingdom won 3/143 lots across 2 contract awards;
- Luxembourg: Belgium won 72/168 lots in 1 contract award;
- Netherlands: Germany won 2/185 lots in 1 contract award.

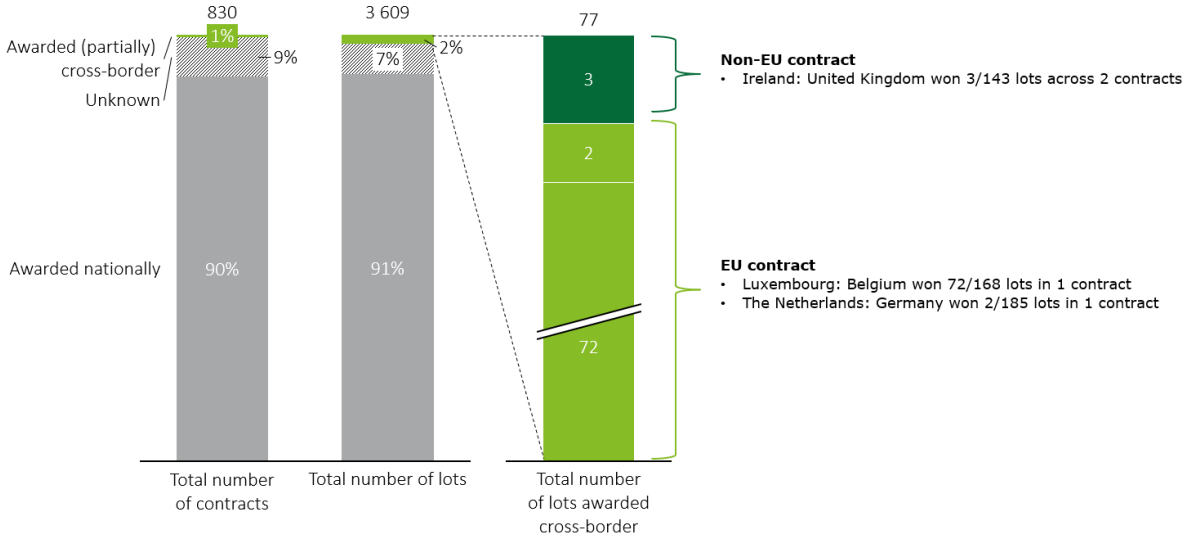

Figure 4: Number of foreign winners in a procurement procedure.

Zooming in on a 'foreign party win'

Type of service: youth care

Geographical area: Border triangular area between the Netherlands, Belgium and Germany

Cross-border activity: 2/185 lots (1%)

Although the address of the care provider who won two lots is just across the border, the company is registered in the home country's chambers of commerce. Furthermore, the company's website is written solely in the home country's language rather than the language of the country in which it was located by address.

Since the definition introduced in 3.2 states that *"A foreign party is a care provider whose address listed in TED is in a different EU country from the country of the contracting authority listed in TED",* the method classifies the tender described above as a partially cross-border contract. However, it is debatable whether this is truly a cross-border activity.

After analysing the very few cross-border lots, it became apparent that even in a border region, there was no cross-border activity.

After analysing the data in the database, a cross-check was performed with the data collected through the survey, of which the results are visualised in Figure 5.

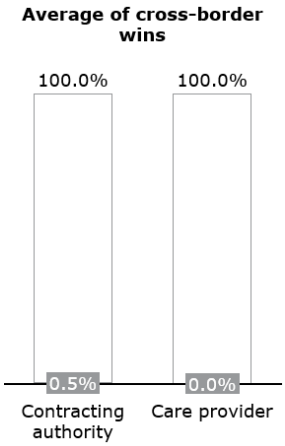

Figure 5: Average percentage of foreign winners in tenders, survey results from contracting authority and care provider perspective

Contracting authorities answered that on average they see 0.5% of organisations that win tenders originating in foreign countries.

Care providers indicated that they win foreign tenders in 0% of the cases (as they also never participate in these tenders, see answer to research question three).

The results of the survey validate the percentages derived from the database.

Research question 4. What percentage of public service contracts in social health services is cross-border?

This question was answered following the same method described in sub-question 3 but focuses on the contract level. As mentioned previously, there were 830 European contract awards in social health services between 2016 and 2018.

Knowing that a contract can be awarded partially domestically and partially to foreign parties due to the existence of multiple lots, the current definition of 'to win' still required interpretation for a complete answer to this question. Therefore, further development of the definition of a 'cross-border contract' was necessary and the interpretation used was 'a contract is cross-border when the majority (>50%) of the lots within a contract are won by foreign parties'.

Following this definition, the database analysis showed that none of the 830 contracts can be defined as cross-border (when >50% of the lots were won by a foreign party). There are four relevant contract awards[21]:

- Belgium won 72/168 lots in 1 contract award from Luxembourg – 43% cross-border
- UK won 1/8 lots in 1 contract award from Ireland – 13% cross-border
- UK won 2/135 lots in 1 contract award from Ireland – 1% cross-border
- Germany won 2/185 lots in 1 contract award from the Netherlands– 1% cross-border.

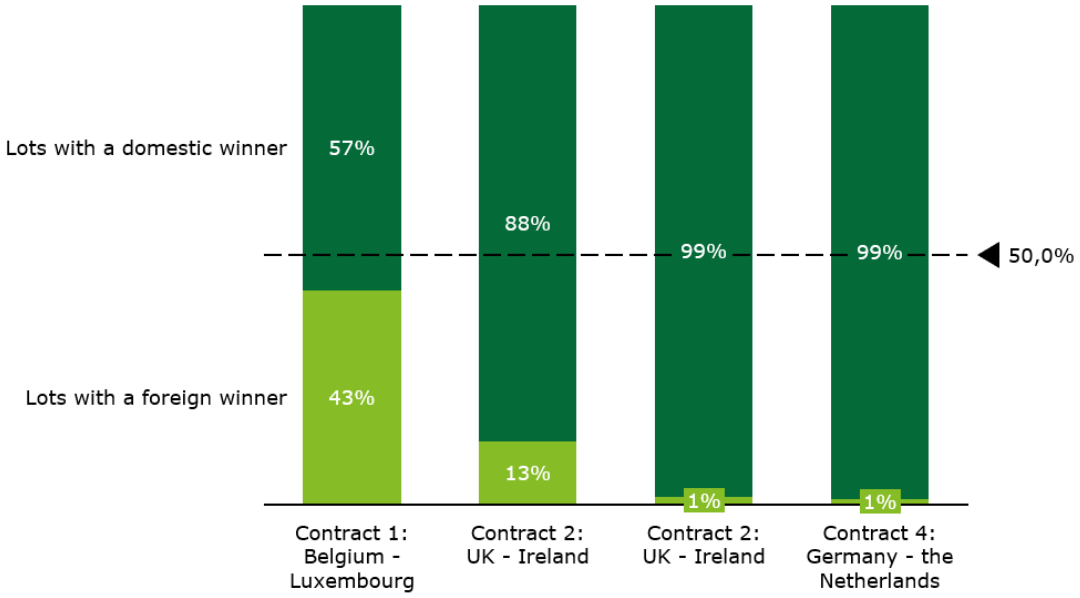

Figure 6: Identified contracts with at least one foreign winner of lots, split by number of lots with a domestic winner and number of lots with a foreign winner[22]

In follow-up interviews conducted with a subset of survey respondents, with contracting authorities and care providers, respondents confirmed that there was no cross-border dimension in social health services.

4.1.1 Additional findings

These results show that the option of a single European market is not currently utilised in social health services. The contracting authorities and care providers interviewed indicated that this is because social health services are organised locally.

Contracting authorities and care providers point out that the unique nature of these services and cultural and linguistic barriers hinder cross-border activity. In addition, there are differences in quality standards, differences in educational requirements for personnel, differences in the strictness of national certification requirements, differences in the systemic infrastructure and financing, and differences in law and regulation. However, removing or reducing these barriers would still not dramatically increase cross-border activity given the remaining cultural and linguistic barriers.

[21] One more contract award appeared to be cross-border, but closer investigation revealed that the country code for Iceland (IS) had been used by mistake when IT should have been used for the winner of an Italian tender.

[22] All round up to 100% when excluding rounding errors.

4.2 Regulatory burden

To determine the regulatory burden of the procurement procedures carried out each year the 'standard cost model' method described in Chapter 3.3.1 was utilised. This method looks at the costs of a single procedure.

This paper has chosen to research the open procedure tender process, as this is the all-encompassing procedure. This chapter first sets out the different steps in the open procedure tender process, and after a detailed analysis of the quantitative data, provides the results.

4.2.1 Open procedure tender process

As described in Chapter 2.3, the analysis of the procurement process was developed by analysing the Directive for the relevant IOs, necessary steps, and discretionary steps. A visual representation of the procurement process is shown in Figure 7: Open procedure tender process steps by actor and phase.

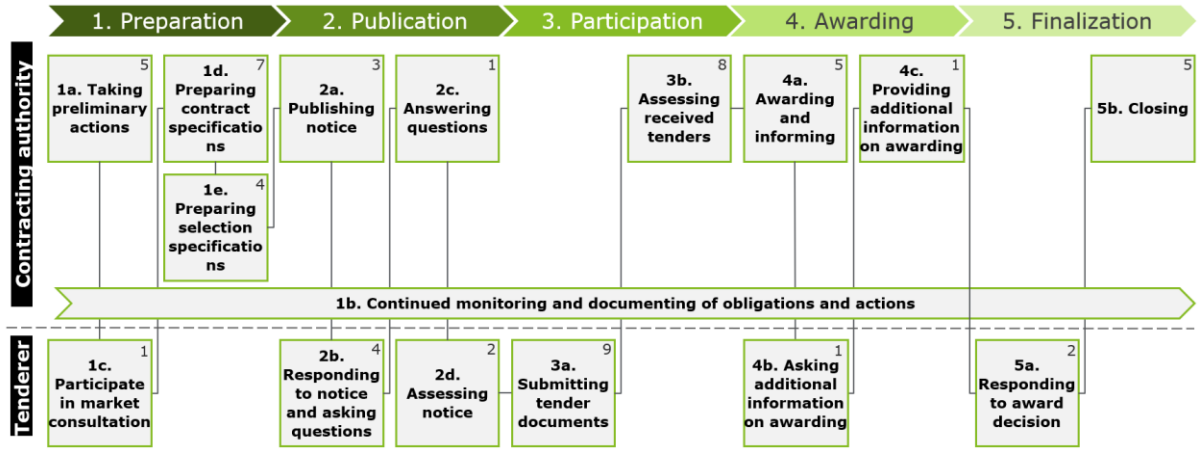

Figure 7: Open procedure tender process steps by actor and phase

A number of sub-steps are included per step. These relate to all the different IO's of the Directive. These sub-steps, including the articles of the Directive relevant to each sub-step they are referring to, can be found in Table 12.

In determining a NEB, a number of steps were excluded from the analysis. These can be found in Table 1. The reasons for excluding a step can be because it is automatically covered electronically, it is covered in another step of the procedure, or it happens so rarely that it is not perceived to be standard. A detailed description of the steps in a NEB is set out below.

1a: Taking preliminary actions (contracting authority)
The procurement procedure starts with the first specific preparations for the contract. The first preliminary steps include verifying the applicability of the Directive given the nature of the envisaged contract and whether it is estimated to exceed the threshold value. In a NEB, to aid the design of the specifications, a preliminary market consultation is used to test the market's know-how, preferences and interest. The goal of the market consultation is to obtain a better understanding of the type of services care providers offer.

1b: Continued monitoring and documenting of obligations and actions (contracting authority)
Throughout the entire procurement procedure, the contracting authority needs to ensure compliance with the fundamental aspects of the Directive. While the Directive mandates these steps, most are covered in other steps or are automatically covered via electronic means. Therefore, in a NEB, these steps do not require additional activity.

1c: Participate in market consultation (care provider)
As explained in step 1a, contracting authorities can request that care providers participate in a market consultation. When there is a market consultation, care providers are eager to participate, as they perceive it to be beneficial in preventing miscommunication later in the process. In a NEB,

market consultations are conducted via e-mail, with multiple care providers responding to a number of questions.

1d: Preparing contract specifications (contracting authority)
Once the preliminary actions have been completed, the contract specifications need to be drawn up. In addition to the technical specifications, the following need to be determined: number of lots, time limits for subsequent steps in the process, the relevant CPV codes (nomenclatures), and the award criteria on which the care providers will be assessed. All these steps are part of a NEB.

1e: Preparing selection specifications (contracting authority)
The contracting authority determines selection criteria upfront, through which they can ensure that the desired type of care provider will participate in the tender, since care providers are only allowed to participate if they meet the criteria. Preparing selection specifications is part of a NEB.

2a: Publishing notice (contracting authority)
When all contract specifics have been decided on, the contract notice has to be published on the European TED platform. In a NEB, a prior information notice is also published to announce the intention to publish a contract.

2b: Responding to notice and asking questions (care provider)
Care providers assess potential opportunities for notices they might be interested in. They mostly become acquainted with these via connections with contracting authorities. New opportunities can also be found on the TED database or on a national platform, though this is not part of a NEB. When interested in a contract, care providers have the opportunity to ask the contracting authority questions about the notice. This happens in multiple rounds in a NEB.

2c: Answering questions (contracting authority)
The contracting authority is obliged to answer all questions received and publish the answers to all participants. The number of questions can greatly vary depending on (among other things) the complexity of the procedure. Asking questions is part of a NEB (step 2b), therefore answering questions is as well.

2d: Assessing notice (care provider)
Based on the information that care providers receive, they need to decide whether to respond to the notice. In a NEB, a care provider will also assess the answers to the questions of other care providers, and based on all the information available, there will be an internal meeting to decide whether to enter the tendering process.

3a: Submitting tender documents (care provider)
The care provider needs to comply with a list of documents to be submitted in order to participate. Of these, the proposal takes the most time to complete as it contains new information. In a NEB, other obligations, namely proof of economic standing, statement of conduct of behaviour, European Single Procurement Document (ESPD), reliance on the capacities of other entities, means of proof, and a compliance checklist are provided by adapting existing documents.

3b: Assessing received tenders (contracting authority)
The documents submitted by care providers are assessed and checked against the selection criteria. An assessment of the completeness and correctness of the documents will determine whether a tenderer will remain in the process. In a NEB, all documents from all care providers are assessed.

4a: Awarding and informing (contracting authority)
Proposals from care providers who met the selection criteria will be awarded according to the predetermined award criteria. If the list of care providers is long, a contracting authority may reduce this by drawing up a shortlist, though this is not part of a NEB. All care providers need to be informed of rejection or awarding and the reasons behind the decision. In a NEB, contracting authorities submit a completed checklist to care providers in their motivation of rejection or awarding.

4b: Asking for additional information on awarding (care provider)

If the contract is not awarded to the care provider, the care provider can request additional information on the rejection. As contracting authorities have already sent their reasons for the decision, care providers do not require additional information in a NEB.

4c: Providing additional information on awarding (contracting authority)
As outlined in the step above, it is not part of a NEB that care providers ask for additional information on awarding. However, if a care provider requests additional information, the contracting authority is required to provide this.

5a: Responding to award decision (care provider)
If a care provider has won the contract, it needs to be signed. As care providers will not normally win all tenders in which they participate, this step is part of a NEB, even if it does not apply in every case. A care provider who is unsuccessful can choose to appeal the result. The contract cannot then be signed until the appeal process has been completed. Though this step is possible in a NEB, it does not occur in every tender.

5b: Closing (contracting authority)
In the closing step, it is assumed that the contracting authority will always spend time on contract signature at the end of a complete procurement procedure, therefore signing is part of a NEB. As explained in step 5a, care providers can appeal against the tender outcome. If any appeals or review procedures are pending against the contracting authority, these need to be settled before the contract can be concluded. As mentioned above, this is possible in a NEB, but does not always occur. When appeals are completed or the deadline for appeals has passed, the contract can be signed, and the contract award notice needs to be sent to the European Commission. In a NEB, the contracting authority will evaluate the tender process.

The out-of-pocket costs and consultancy costs were also determined in a NEB. It was determined that there are no specific out-of-pocket costs in a NEB. It is considered not to be part of a NEB for a contracting authority to involve external legal advice when drawing up a contract, as contracting authorities often have these capabilities in house. When a care provider appeals, both the care provider and the contracting authority require external legal advice, which is part of a NEB. In addition, it may happen that a care provider requests the help of an accountant when filling in forms, but this is not part of a NEB.

Table 1: Sub-steps excluded from Normally Efficient Business

Sub-step excluded from NEB	Reason
Treaty principles	Assumed that this is part of other IO's
Rules applicable to communication	This is already automatically covered in the procedure
Confidentiality	This is already automatically covered in the procedure
Electronic availability of procurement documents	This is already automatically covered in the procedure
Informing candidates and care providers	This is already automatically covered in the procedure
New opportunities EU	Most organisations do not spend any time on this step in the process
New opportunities national platform	Most organisations do not spend any time on this step in the process
Prevent exclusion	Most organisations do not spend any time on this step in the process
Reduction of the number of tenders and solutions	Most organisations do not spend any time on this step in the process
Abnormally low tenders	Most organisations do not spend any time on this step in the process
Data destruction	This is already automatically covered in the procedure

4.2.2 Quantitative results

After applying 'normally efficient business', the 'standardisation' and 'business as usual' principles from the standard cost model method as explained in Chapter 3, the research questions can be answered. First research questions 2 and 3 are answered for contracting authorities, then research questions 4 and 5 are answered for care providers before then answering research question 1.

Research question 2: What is the regulatory burden of those procurement procedures for contracting authorities?

Research question 3: What does the regulatory burden of those procurement procedures for contracting authorities consist of?

The regulatory burden of an average European procurement procedure in social health services by sub-step for contracting authorities is shown in Table 2. Following the methodology described in Chapter 3.3, this table shows the number of hours spent on a particular step taking into account the number of times this step was carried out in a procurement procedure (the frequency as described in Chapter 3.3). The number of hours is multiplied with the average rate per hour in Europe of EUR 39.10[23]. The potential external costs, which often consist of legal advice, are added to these costs. Together this makes up the total regulatory cost per step. Subtracting the BAU from the regulatory costs and adding up the sub-steps provides the total regulatory burden for a contracting authority of an average European procurement procedure in social health services. This is on average approximately EUR 85,000 per procedure. Adding up the total number of hours means that a contracting authority requires approximately 1.2 FTE[24] on average per procedure to comply with the Directive.

The number of procedures per year, the Q in the equation described in Chapter 3.3, is derived from the TED database and is based on the number of Contract Award Notices (excluding the United Kingdom, Norway and Switzerland as non-EU countries). Based on this assessment the total number of tenders for the EU-27 per year for CANs is assumed to be 277. This is the Q in the methodology

[23] Eurostat labour cost index for LCI (compensation of employees plus taxes minus subsidies) via http://appsso.eurostat.ec.europa.eu

[24] When assuming a FTE is 2 080 hours, source: https://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:Full-time_equivalent_(FTE)

described in Chapter 3.3. Not all procedures are announced in the TED database because a wrong CPV code can be used or the form has been submitted incompletely, but it is the best estimate for the yearly number of procedures in Europe. Therefore, the total regulatory burden is in reality likely to be higher than the measured regulatory burden, when the Q is corrected for all procedures not correctly registered in the TED database.

Multiplying the regulatory costs per procedure by the number of procedures comes to approximately 326 FTE spent by contracting authorities on the full procedures. After excluding the BAU, the total regulatory burden for contracting authorities for the EU-27 is approximately EUR 23 million.

The largest part of this regulatory burden arises in phase 4, where awarding and informing takes up 27% of the total burden. In addition, many hours are spent on assessing the tenders received: 25% of the hours are spent on this. This is not surprising as assessing the proposal takes substantial time, especially when many care providers take part in the procedure. This is a common thread for contracting authorities; their time spent on the procedure depends to a large extent on the number of care providers that takes part in the procedure.

Table 2. Regulatory burden for contracting authorities

Phase	Step		Organisation type	Cost in hours (h)	External costs (EUR)[25]	Regulatory cost (EUR)[18]	Regulatory burden (EUR)[18]	% of total
1. Preparation	1a.	Taking preliminary actions	CA	407	0	15 917	13 099	15
	1b.	Continued monitoring and documenting of obligations and actions	CA	49	0	1 916	1 916	2
	1c.	Participate in market consultation	CP					
	1d.	Preparing contract specifications	CA	318	0	12 429	9 461	11
	1e.	Preparing selection specifications	CA	71	0	2 762	2 762	3
2. Publication	2a.	Publishing notice	CA	22	0	874	874	1
	2b.	Responding to notice and asking questions	CP					
	2c.	Answering questions	CA	214	0	8 351	6 681	8
	2d.	Assessing notice	CP					
3. Participation	3a.	Submitting tender documents	CP					
	3b.	Assessing received tenders	CA	539	0	21 080	21 080	25
4. Awarding	4a.	Awarding and informing	CA	650	0	25 429	22 639	27
	4b.	Asking for additional information on awarding	CP					
	4c.	Providing additional information on awarding	CA	91	0	3 578	1 789	2
5. Finalization	5a.	Responding to award decision	CP					
	5b.	Closing	CA	88	1 500	4 959	4 301	5
Total per procedure for a CA[18]				2 450	1 500	97 295	84 602	100
Yearly tenders for EU-27 for CAs			277					
Total for all procedures for CAs[18]				678 517		26 950 654	**23 434 880**	

[25] Outcomes may not add up due to rounding differences

Research question 4: What is the regulatory burden of those procurement procedures for care providers?

Research question 5. What does the regulatory burden of those procurement procedures for care providers consist of?

The number of procedures per year in which care providers take part, the Q in the equation described in Chapter 3.3, is based on the total number of tenders for the EU-27 per year times the average number of care providers that take part in a tender. Both numbers are derived from the TED database. The total number of tenders for the EU-27 per year is the same as in Table 2, namely 277, and is based on the number of Contract Award Notices (CANs). The average number of care providers per procedure is based on the TED database and estimated to be 33. An estimated average of the number of tenderers is needed as the database is not complete and not all fields are completed for all CANs. This means that the total number of tenders for the EU-27 per year for CPs is 9 141. This is the Q in the methodology described in Chapter 3.3. Similarly to the Q determined for CANs, not all procedures are announced in the TED database because a wrong CPV code can be used or the form has been submitted incompletely, but it is the best estimate for the yearly number of procedures in Europe. The total regulatory burden is in reality therefore likely to be higher than the measured regulatory burden.

Multiplying the regulatory costs per procedure by the number of procedures for care providers then comes to approximately 930 FTE[15] spent by care providers on the full procedures. When excluding the BAU, the total regulatory burden for care providers for the EU-27 is approximately EUR 59 million.

These costs arise mostly from creating and submitting the tender documents (56%) and responding to notices and asking questions (20%). This is not surprising as care providers are likely to spend most of their time on drawing up the technical proposal.

shows the regulatory burden for care providers of an average European procurement procedure in social health services by sub-step. Similar to Table 2, this table shows the number of hours spent on a particular step, taking into account the number of times this step is carried out in a procurement procedure (the frequency, as described in Chapter 3.3.). The number of hours is multiplied by the average rate per hour in Europe (EUR 39.10/h). Together this makes up the total regulatory cost per step for care providers. Subtracting the BAU from the regulatory costs and adding up the sub-steps provides the total regulatory burden for an average European procurement procedure in social health services for a care provider. This then calculates to the total regulatory burden for an average European procurement procedure in social health services for a care provider of approximately EUR 6,000.

The number of procedures per year in which care providers take part, the Q in the equation described in Chapter 3.3, is based on the total number of tenders for the EU-27 per year times the average number of care providers that take part in a tender. Both numbers are derived from the TED database. The total number of tenders for the EU-27 per year is the same as in Table 2, namely 277, and is based on the number of Contract Award Notices (CANs). The average number of care providers per procedure is based on the TED database and estimated to be 33. An estimated average of the number of tenderers is needed as the database is not complete and not all fields are completed for all CANs. This means that the total number of tenders for the EU-27 per year for CPs is 9 141. This is the Q in the methodology described in Chapter 3.3. Similarly to the Q determined for CANs, not all procedures are announced in the TED database because a wrong CPV code can be used or the form has been submitted incompletely, but it is the best estimate for the yearly number of procedures in Europe. The total regulatory burden is in reality therefore likely to be higher than the measured regulatory burden.

Multiplying the regulatory costs per procedure by the number of procedures for care providers then comes to approximately 930 FTE[15] spent by care providers on the full procedures. When excluding the BAU, the total regulatory burden for care providers for the EU-27 is approximately EUR 59 million.

These costs arise mostly from creating and submitting the tender documents (56%) and responding to notices and asking questions (20%). This is not surprising as care providers are likely to spend most of their time on drawing up the technical proposal.

Table 3. Regulatory burden for Care Providers

Phase	Step	Organisation type	Cost in hours (h)	External costs (EUR)[26]	Regulatory cost (EUR)[19]	Regulatory burden (EUR)[19]	% of total
1. Preparation	1a. Taking preliminary actions	CA					
	1b. Continued monitoring and documenting of obligations and actions	CA					
	1c. Participate in market consultation	CP	19	0	730	584	9
	1d. Preparing contract specifications	CA					
	1e. Preparing selection specifications	CA					
2. Publication	2a. Publishing notice	CA					
	2b. Responding to notice and asking questions	CP	44	0	1 712	1 327	20
	2c. Answering questions	CA					
	2d. Assessing notice	CP	23	0	890	641	10
3. Participation	3a. Submitting tender documents	CP	117	0	4 556	3 645	56
	3b. Assessing received tenders	CA					
4. Awarding	4a. Awarding and informing	CA					
	4b. Asking for additional information on awarding	CP	4	0	142	71	1
	4c. Providing additional information on awarding	CA					
5. Finalization	5a. Responding to award decision	CP	6	0	244	229	4
	5b. Closing	CA					
Total per procedure for a CP[19]			212	0	8 273	6 497	100
Yearly tenders for EU-27 for CPs		9 141					
Total for all procedures for CPs[19]			1 934 153		75 625 400	**59 391 521**	

Research question 1. What is the regulatory burden of the procurement procedures that are carried out annually in the Member States of the European Union in social health services, more specifically youth care and home care?

The regulatory burden for contracting authorities for the EU-27 is approximately EUR 23 million, and the regulatory burden for care providers for the EU-27 is approximately EUR 59 million. Together, this comes to a total regulatory burden of EUR 83 million[19] in the EU-27 for contracting authorities and care providers together.

4.3 Additional findings

In addition to providing information on the investment in time of the procurement procedures, contracting authorities and care providers provided additional information during the interviews on their experiences in European procurement procedures in social health services. The general view that emerged from the qualitative side of the interviews is discussed briefly below.

[26] Outcomes may not add up due to rounding differences

During the interviews care providers indicated that, although some steps in the procurement procedure may take relatively little time, e.g. filling in various standard forms, these steps are experienced as cumbersome. One example included a request by a contracting authority to a care provider for a reference which was a reference that needed to be requested by the care provider from the same contracting authority. The reference from the contracting authority was then submitted again to the same contracting authority by the care provider. These steps are especially cumbersome when large care providers have to go through the same procedure several times for various tenders in different regions.

Contracting authorities during the interviews were ambivalent in their perspective on the efficiency of the Directive. Some do indicate that they value guidelines and structure, but not via obligations but rather as principles.

Some interviewees did indicate that the requirement for a European procurement procedure has created a more competitive environment where procurement previously took place in a more collaborative atmosphere. This can be a sign of a more competitive market, which theoretically could be more efficient. Given the sensitive nature of many of social health services in which it is necessary to establish trust between care provider and client, contracting authorities indicate that it is questionable whether this hardening of the relationship between contracting authority and care provider as well as between care providers themselves is beneficial for clients. Most clients are vulnerable and receive care from different providers. They benefit when these providers collaborate with each other within the borders of competition law, and know local and personal circumstances.

5 Discussion

To be able to use the results on the extent of the cross-border dimension and the measured regulatory burden in the evaluation of the Directive, the validity of these results needs to be substantiated. This discussion is separated into the two parts of this study followed by a summary.

5.1 Cross-border dimension

To assess the level of the cross-border dimension of social health services in Europe, three data-gathering methods were used. Data analytics provided high quality data which gave a clear and convincing answer to the research questions. The cross-border activity that was found was then validated. This revealed data quality issues in some cases. For example, an Italian contract won by Iceland turned out to be use of the wrong country code (IS instead of IT).

The results of the survey were consistent with the outcome of the data-analytics output. In the rare cases where the survey results were not consistent with the data-analytics output, follow-up interviews showed that survey respondents had made a mistake in filling in the survey, leading to revision of their answer. In general, the survey results showed a large degree of consistency with the data-analytics output. It is most likely that clarification of any remaining uncertainty would have resulted in confirmation of there being very limited cross-border activity in social health services.

Results from the three data-gathering methods (data-analytics output, survey, interviews) were consistent. The database analysis provided solid results that were confirmed by the survey and interviews.

5.2 Regulatory burden

The results from the interviews that form the basis of the measurement of the regulatory burden associated with the Directive were consistent across interviews. The measurement provided a good indication of the regulatory burden on contracting authorities and care providers.

5.3 Summary

The validity of the results of the two parts of this study taken together means that the results provide a clear convincing view on the (absence of the) cross-border dimension of social health services in Europe and a good indication of the regulatory burden associated with the Directive in social health services. These results can be used with confidence in the further evaluation of the Directive.

6 Conclusions and recommendations

6.1 Conclusions

It can be concluded with a high degree of certainty that the cross-border dimension in social health services in Europe, more specifically home care and youth care, is minimal to non-existent. Of the 830 published contract award notices in the period between 2016 and 2018, only 0.5% of contracts had a cross-border dimension. This conclusion was substantiated by the survey results that showed that contracting authorities and care providers on average see cross-border activity in fewer than 1% of tenders, meaning that care providers are neither interested in, nor participate in nor win procurement procedures in EU Member States other than the Member State they are registered in. Moreover, health care providers indicated that cross-border activity is not of interest to them. Even the removal of any perceived legal and regulatory barriers (stemming from public procurement rules or otherwise) in this sector would not change this. The cultural and linguistic barriers would still be an insurmountable barrier to cross-border provision of services. All things considered, there seems to be no single European market in social health services.

The obligations stemming from the Directive measured in this study show that it is time-consuming and costly for contracting authorities and care providers to adhere to the obligations. This time and the cost do not directly benefit the quality of youth and home care. The Directive is experienced as inefficient and burdensome by both the contracting authorities and care providers. Some contracting authorities do indicate that they value guidelines and structure, but not via obligations but rather as principles.

The fact that there is no cross-border dimension in social health services while contracting authorities and care providers experience a substantial regulatory burden leads to disproportionality. Therefore, it can be concluded that the rules that apply to public procurement of social health services are not efficient nor effective.

6.2 Recommendations

These conclusions lead to the recommendation that the current obligations coming from the European Directive on public procurement as they currently apply to the social health services should be evaluated with a view to possible adaptation. In that evaluation the findings of this report should be taken into account.

7 Appendices

7.1 Appendix: cross-border dimension

Table 4: Number of prior information notices and contract notices, and number of contract award notices, per country

	Prior Information Notices and Contract Notices	Contract Award Notices
AT	12	12
BE	2	1
CH	2	1
CY	2	0
CZ	7	18
DE	83	40
DK	30	19
EE	1	2
ES	10	6
FI	38	21
FR	8	6
GR	2	1
IE	15	9
IS	5	1
IT	868	493
LT	3	4
LU	1	1
MT	2	1
NL	202	151
NO	40	26
PL	17	16
PT	1	0
RO	19	23
SE	8	6
SI	1	0
SO	1	1

Table 5: Key words list in all official EU Member State language

Language	Key words: home care	Key words: youth care
English	• Home care • Protected living • Social care • day treatment • Help with housekeeping • Elderly care • Care at home • Domestic help • Wheelchair taxi • Assisted living • Older people care • Elderly home • Caregiver • Medical care • Social work services • Care services • Assisted living residence • Domestic help • Wheelchair taxi • Help with housekeeping • Elderly care • Social care • Social support	• Youth help • Youth Services • Youth problems • Foster care • Day treatment • Special education • Dyslexia • Educational aid • Child help • Youth care • Special youth care • Youth protection • Child protection • Youth at risk • Forced care • Services for children at risk • Family treatment • Family support • Youth education • Youth social work • Youth consultation • Youth welfare office • Social care • Social support • Child abuse • Young offenders • Social welfare
Bulgarian	• Домашни грижи • Защитен живот • Социални грижи • дневно лечение • Помощ в домакинството • Грижи за възрастни хора • Домашни грижи • Помощ у дома • Такси за инвалидни колички	• младежка помощ • младежки услуги • младежки проблеми • приемна грижа • дневно лечение • специално образование • дислексия • образователна помощ • помощ за деца • Грижи за младежта • Специални грижи за младежта • Младежката защита • Защита на детето • Децата в риск • Приемна грижа • Принудителни грижи • Услуги за деца в риск • Семейно лечение • Семейни помощи
Croatian	• Kucna njega • Socijalna skrb • dnevno liječenje • Pomoc u vodenju domacinstva Pomoć u kući/ • Njega starijih osoba • Skrbi u domu/ Skrb kod kuće • Pomoc u kuci • Taksi za invalidska kolica • Pomoć i njega u kući • Njega i skrb za starije osobe • dom za starije	• pomoć mladima • briga o mladima • problemi mladih • udomiteljstvo • dnevno liječenje • specijalno obrazovanje • disleksija • obrazovna pomoć • Pomoć za dijete • Briga o mladima • Posebna briga o mladima • Zaštita mladih • Zaštita djece • Mladih u riziku • Udomiteljstvo • Prisilna njega • Usluge za djecu u riziku

		• Obiteljski tretman/Obiteljski smještaj • Obiteljska podrška/ Podrška obitelji
Czech	• Domácí péče • Chráněné bydlení • Sociální péče • denní ošetrení • Pomoc s úklidem • Péče o seniory • Péče doma • Domácí pomoc • Taxi pro invalidní vozíky	• pomoc s mládeží • péče o mládež • problémy s mládeží • pěstounská péče • denní ošetrení • speciální vzdělání • dyslexie • pomoc se vzděláním • pomoc dětem • Péče o mládež • Speciální péče o mládež • Ochrana mládeže • Ochrana dětí • Mládež v riziku • Pěstounská péče • Nucená péče • Služby pro ohrožené děti • Rodinné ošetření • Podpora rodiny
Danish	• Hjemmepleje • Beskyttede boliger • Social indsats • Dagbehandling • Hjælp med husholdning • Ældrepleje • Pleje i hjemmet • Hjælp i hjemmet • Handicapkørsel	• Ungdomshjælp • Ungdoms pleje • Ungdoms problemer • Plejebarns ordning • Dagbehandling • Specialundervisning • Ordblindhed • Uddannelseshjælp • Hjælp til børn • Ungdomstilbud • Særlige ungdomstilbud (or "aflastningstilbud") • Beskyttende ungdomstilbud • Beskyttende børnetilbud • Udsatte unge • Familiepleje • Tvangsanbringelse • Serviceområder for børn i fare • Familiebehandling • Støtte til familier
Dutch	• Thuiszorg • Beschermd wonen • Maatschappelijke opvang • Dagbehandeling • Hulp bij huishouden • Ouderenzorg • Zorg aan huis • Huishoudelijke hulp • Rolstoeltaxi	• Jeugdhulp • Jeugdzorg • Jeugd problematiek • Pleegzorg • Dagbehandeling • Bijzonder onderwijs • Dyslexie • Opvoedingshulp • Kinderhulp • Jeugdzorg • Bijzondere jeugdzorg • Bescherming van jongeren • Kinderbescherming • Risico's voor jongeren • Pleegzorg • Gedwongen zorg • Diensten voor risicokinderen • Gezinsbehandeling • Familie ondersteuning
Estonian	• Kodune hooldus • Turvaline elu • Majapidamistööde abi	• Noorteabi • Teenused noortele • Kasuperekonna hooldus • Erivajadustega õpilaste haridus • Õpiabi

		• Lasteabi • Noorteabi • Erivajadusega lapse hooldus • Lastekaitse or noortekaitse • Lastekaitse • Riskirühma kuuluvad noored • Kasuperekonna hooldus • Sotsiaalhoolekanne
Finnish	• Kotihoito • Suojattu asuminen • Sosiaalihoito • päivähoito • Kotitalousapu • Vanhustenhoito • Kotihoito • Kotiapu • Pyörätuolitaksi	• nuorten apu • nuorisopalvelut • nuorten ongelmat • sijaishoito • päivähoito • erityisopetus • lukihäiriö • koulutusapu • lapsilisä • Nuorten hoito • Nuorten erityishoito • Nuorten suojelu • Lastensuojelu • Riskiryhmään kuuluvat nuoret • Sijaishoito • Pakkohoito • Palvelut riskiryhmään kuuluville lapsille • Perhehoito • Perhetuki
French	• Soins à domicile • Vie protégée • Prise en charge sociale • traitement de jour • Aide à domicile • prise en charge des personnes âgées • Soins à domicile • Aide domestique • Taxi en fauteuil roulant • Aide à domicile • Aide ménagère • Taxi pour personnes à mobilité réduite • Transport de personne à mobilité réduite • Résidence services non médicalisée • Aide au ménage • soins pour personnes âgées • soins des personnes âgées • Assistance aux personnes âgées • résidence pour personnes dépendantes • Services d'aide à domicile • prise en charge pour les personnes âgées	• aide aux jeunes • services aux jeunes • problèmes de jeunesse • famille d'accueil • traitement de jour • éducation spécialisée • dyslexie • aide pédagogique • aide aux enfants • soins des jeunes • service spécialisé jeune • Protection de la jeunesse • Protection de l'enfance • Jeunes à risque • Famille d'accueil • Soins forcés • Services aux enfants à risque • Traitement familial • Soutien de famille • Soutien familial • aide à la jeunesse • services de la jeunesse • éducation spéciaux • aide aux jeunes • soins des jeunes spécialisée • protection judiciaire de la jeunesse • Jeunesse à risque • Jeunes vulnérables • Soins obligés • Adolescents délinquants • Services aux enfants en danger • Services aux jeunes à risque • Traitement de famille
German	• Häusliche Pflege • Geschütztes Leben • Sozialfürsorge • Tagespflege • Hilfe bei der Hausarbeit • Altenpflege	• Jugendhilfe • Jugendbetreuung • Jugendprobleme • Pflegefamilie • Tagespflege • Sonderpädagogik

	• Pflege zu Hause • Haushaltshilfe • Rollstuhltaxi	• Legasthenie • Bildungshilfe • Kinderhilfe • Jugendbetreuung • Spezielle Jugendbetreuung • Jugendschutz • Kinderschutz • Jugend in Gefahr • Pflegekinderhilfe • Zwangspflege • Dienstleistungen für gefährdete Kinder • Familienbehandlung • Familienunterstützung • Jugendbildung • Jugendsozialarbeit • Jugendberatung • Jugendamt • Zwangserziehung • Pflegeeltern • Kinderbetreuung • Jugendpflege • Kinderpflege
Greek	• Oikiakí frontída • Prostatevméni diavíosi • Koinonikí mérimna • therapeía iméras • Voítheia me tin kathariótita • Frontída ilikioménon • Frontída sto spíti • Oikiakí voítheia • Taxí me anapirikó karotsáki	• voítheia neolaias • frontída ton néon • provlímata neolaías • anádochi frontída • therapeía iméras • eidikí agogí • dyslexía • ekpaideftikí voítheia • frontida gia paidia • Frontída gia neous • Eidikí frontida gia neous • Prostasía gia neous • Paidikí prostasia • Neolaía se kindino • Anádochi frontida • Anankastikí frontida • Ypiresíes gia paidia se kindino • Oikogeneiakí therapia • Oikogeneiakí upostirixi
Hungarian	• Oikiakí frontída • Prostatevméni diavíosi • Koinonikí mérimna • therapeía iméras • Voítheia me tin kathariótita • Frontída ilikioménon • Frontída sto spíti • Oikiakí voítheia • Taxí me anapirikó karotsáki	• ifjúsági gondozás • ifjúsági problémák • nevelogondozás • napi kezelés • speciális oktatás • dyslexia • oktatási segélyek • Gyerek támogatás • Ifjúsági támogatás • Speciális ifjúsági gondozás • A fiatalok védelme • Gyermekvédelem • veszélyeztetett fiatalokat • Nevelőszülői gondozas • Kényszerápolás • Szolgáltatások veszélyeztetett gyermekek számára • Családkezelés • Családi pótlék
Irish	• Cúram baile • Maireachtáil chosanta • Cúram sóisialta • cóireáil lae • Cabhair le cúram tí • Cúram do dhaoine scothaosta • Cúram sa bhaile	• cúnamh óige • cúram óige • fadhbanna óige • cúram altrama • cóireáil lae • oideachas speisialta • disléicse

	• Cabhair intíre • Tacsaí do chathaoireacha rothaí	• cúnamh oideachais • Cabhair leanaí • Seirbhísí Óige • Cúram óige speisialta • Cosaint daoine óga • Cosaint leanaí • Rioscaí do dhaoine óga • Cúram altrama • Cúram éigeantach • Seirbhísí do leanaí atá i mbaol • Cóireáil teaghlaigh • Tacaíocht teaghlaigh
Italian	• Assistenza domiciliare • Vita protetta • Assistenza sociale • trattamento diurno • Aiuto per le pulizie • Assistenza agli anziani • Cura in casa • Aiuto domestico • Taxi per sedie a rotelle • Badante • Casa di riposo	• Assistenza ai minori • assistenza ai adolescenti • problemi giovanili • trattamento diurno • educazione speciale • dislessia • aiuto educativo • Aiuto per bambini • Servizi per i giovani • Assistenza speciale per i giovani • Tutela dei giovani • Protezione dei minori • giovani a rischio • Affidamento • Cure forzate • Servizi per bambini a rischio • Trattamento familiare • Supporto familiare
Latvian	• Aprūpe mājās • Sociālā aprūpe • Ārstēšanās dienas stacionārā • Palīdzība mājas darbos • Vecāka gadagājuma cilvēku aprūpe • Aprūpe mājās • Palīdzība mājas darbos • Taksometrs ar ratiņkrēslu	• Palīdzība jauniešiem • Pakalpojumi jauniešiem • Jauniešu problēmas • Audžuģimenes jautājumi • Ārstēšanās dienas stacionārā • Speciālā izglītība • disleksija • Izglītības atbalsts • Palīdzība bērniem • Palīdzība jauniešiem • Īpaša jauniešu aprūpe • Jauniešu aizsardzība • Bērnu aizsardzība • Riska grupas jaunieši • Audžuģimenēs • Piespiedu aprūpe • Pakalpojumi riska grupas bērniem • Ģimenes ārstēšana • Ģimenes atbalsts
Lithuanian	• Globos namai • Apsaugotas gyvenimas • Socialinė priežiūra • Dieninis gydymas • Namų tvarkymo pagalba • Pagyvenusių žmonių priežiūra • Priežiura namuose • Pagalba namuose • Socialinis taksi • Socialinio darbo paslaugos • Priežiūros paslaugos	• Pagalba jaunimui • Jaunimo rūpyba • jaunimo problemos • globa • Dieninis gydymas • specialusis ugdymas • disleksija • Švietimo parama • Pagalba vaikams • Jaunimui skirtos paslaugos • Speciali jaunimo priežiūra • Jaunimo apsauga • Vaikų apsauga • Grėsmę patiriantis jaunimas • Priverstinė priežiūra • Paslaugos riziką patiriantiems vaikams • Šeimos gydymas

			• Šeimos parama
Maltese	• Kura d-dar • Hajja protetta • Kura socjali • Ghajnuna fix-xoghol tad-dar • Il-kura tal-anzjani • Kura d-dar • Ghajnuna domestika • Siggu bir-roti		• ghajnuna ghaz-zghazagh • Servizzi ghaz-zghazagh • problemi taz-zghazagh • trawwem il-kura • trattament ta 'kuljum • edukazzjoni specjali • dyslexia • ghajnuna edukattiva • Ghajnuna ghat-tfal • Servizzi ghaz-Zghazagh • Kura specjali ghaz-zghazagh • Protezzjoni taz - zghazagh • Protezzjoni tat-tfal • Zghazagh f'riskju • Kura sfurzata • Servizzi ghat-tfal f'riskju • Trattament ghall-familja • Ghajnuna ghall-familja
Polish	• Opieka domowa • Chronione zycie • Opieka społeczna • leczenie dzienne • Pomoc w utrzymaniu porządku • Opieka nad osobami starszymi • Opieka w domu • Pomoc domowa • Taxi dla wózków inwalidzkich • Opieka społeczna • Pomoc społeczna		• pomoc dla młodzieży • opieka dla młodzieży • problemy dzieci i młodzieży • piecza zastępcza • leczenie dzienne • edukacja specjalna • dysleksja • pomoc pedagogiczna • pomoc dla dzieci • opieka dla młodzieży • Opieka specjalna dla młodzieży • Ochrona młodych ludzi • Ochrona dziecka • młodzież z grup podwyższonego ryzyka • Opieka zastepcza • Przymusowa opieka • Usługi dla dzieci z grup podwyższonego ryzyka • Leczenie rodzinne • Wsparcie rodziny • opieka zastępcza • oddział dzienny • pedagogika specjalna • Opieka społeczna • Pomoc społeczna • przemoc wobec dzieci
Portuguese	• Assistência ao domicilio • Residencia assistida • Assistência social • tratamento de dia • Ajuda com tarefas domésticas • Cuidados a idosos • Cuidados em casa • Ajuda ao domicilio • Táxi adaptado para cadeira de rodas		• Apoio á juventude • Servicos para jovens • problemas da juventude • Familias de acolhimento • tratamento de dia • educação especial • dislexia • ajuda educacional • Apoio infantil • Cuidados para Jovens e crianças • Assistência especial a jovens • Protecção de jovens • Proteção infantil • Jovens em risco • Orfanato • Cuidados forçados • Serviços para crianças • Cuidados familiares • Apoio famíliar

Romanian	• Îngrijire la domiciliu • Trăi protejat • asistență socială • tratament de zi • Ajutor cu menaj • Îngrijirea batrânilor • Îngrijire acasă • Ajutor domestic • Taxi pentru scaun rulant	• ajutor de tineret • îngrijirea tineretului • probleme de tineret • asistență maternală • tratament de zi • educație speciala • dislexie • ajutor educațional • Ajutor pentru copii • Servicii pentru tineret • Îngrijire speciala pentru tineret • Protecția tinerilor • Protecția copilului • Riscuri pentru tineri • Asistenta maternala • Îngrijire forțata • Servicii pentru copii cu risc • Tratament familial • Suport familial
Slovenian	• Nega na domu • Zaščiteno življenje • Socialna oskrba • dnevno zdravljenje • Pomoč pri gospodinjstvu • Nega starejših • Nega na domu / pomoč na domu • Pomoč na domu • Taksi za invalide / prevozi invalidov • Oskrbovana stanovanj	• pomoč mladim • prostovoljsko delo mladih • mladostniški problemi • rejništvo • dnevno zdravljenje • Izobraževanje otrok s posebnimi potrebami • disleksija • izobraževalna pomoč • pomoč otrokom • pomoč otrokom in mladostnikom • varstvo otrok s posebnimi potrebami • Zaščita mladih • Zaščita otrok • Mladi z večjim tveganjem • Rejništvo • Prisilna oskrba • Zaščita otrok v težkih okoliščinah • Družinska terapija • Pomoč družinam
Slovak	• Domáca starostlivost • Chránené bývanie • Sociálna starostlivost • denné ošetrenie • Pomoc s upratovaním • Starostlivosť o seniorov • Domáca starostlivosť • Pomoc v domácnosti • Taxik pre invalidný vozik	• pomoc s mládežou • Služby pre mládež • problémy s mládežou • pestúnska starostlivost • denné ošetrenie • špeciálne vzdelávanie • dyslexia • vzdelávacia pomoc • Pomoc dieťaťu • Starostlivosť o mládež • Špeciálna starostlivosť o mládež • Ochrana mladých ľudí • Ochrana detí • Mládež v ohrození • Pestúnska starostlivosť • Nútená starostlivosť • Služby pre deti v ohrození • Rodinné zaobchádzanie • Rodinna podpora
Spanish	• Cuidado domiciliario • residencia protegida • Ayuda social • tratamiento diurno • Ayuda en las tareas domesticas • Cuidado de ancianos • Cuidar domiciliario • Ayuda al domicilio • Taxi adaptado	• ayuda a jovenes • servicios para jovenes • problemas juveniles • Familias de acogida • tratamiento diurno • educacion especial • dislexia • ayuda educativa • Ayuda infantil

		• Atencion a jovenes • Atencion especial a jovenes • Protección de jóvenes • Protección del menor • Menores en riesgo • Orfanato • Cuidados forzados • Servicios para niños/menores en riesgo • cuidados familiares • Apoyo familiar
Swedish	• Hemvård • Skyddat boende • Socialvård • dagbehandling • Hjälp i hushållning • Äldreomsorg • Hemvård • Hushollshjälp • Rullstolstaxi	• ungdomshjälp • Ungdomstjänster • ungdomsproblem • fostervård • dagbehandling • specialundervisning • dyslexi • utbildningsstöd • Barnhjälp • Ungdomsomsorg • Special ungdomsomsorg • Ungdomskydd • Barnskydd • Hotade ungdomar • Fostervård • Tvångsvård • Tjänster för riskfyllda barn • Familjebehandling • Familjestöd

Table 6: Survey cross-border dimension

Introduction:

This mini-survey, for the Ministry of Health of the Netherlands, is assessing the level of cross-border European tendering (based on Directive 2014/24/EU), across all Member States of the European Union. The scope of this survey is the field of social health services, more specifically youth care and home care. Please keep this scope in mind when filling out this mini-survey. This mini-survey will take less than 5 minutes to complete.

1. In which Member State is your organisation based?

2. In which segment is your organisation predominantly active, youth care or home care?

3. In which area is your organisation predominantly active, as a provider of care services, or as an organisation that handles the procurement of care services?

Follow-up questions for provider of care services:

To determine the level of cross-border activity of tendering in youth care and home care, we acknowledge the difference in domestic and foreign parties, and distinguish tendering parties that show interest, participate or win the tender. These are defined as follows:

Show interest: A care provider contacts the contracting authority on a specific tender (e.g. to ask a question)

Participate: A care provider subscribes for participation on a specific tender

Win: A care provider wins a specific tender

1. Out of the European tenders you show interest in, how many originate from a foreign country?

2. Out of the European tenders you participate in, how many originate from a foreign country?

3. Out of the European tenders you win, how many originate from a foreign country?

Follow-up questions for procurer of care services:
1. How often do you tender in the EU in this segment?

To determine the level of cross-border activity of tendering in youth are and home care, we acknowledge the difference in domestic and foreign parties, and distinguish tendering parties that show interest, participate or win the tender. These are defined as follows:

Show interest: A care provider contacts the contracting authority on a specific tender (e.g. to ask a question)

Participate: A care provider subscribes for participation on a specific tender

Win: A care provider wins a specific tender

2. Approximately what % of organisations that show interest in a tender, originate from a foreign country?

3. Approximately what % of organisations that participate in a tender, originate from a foreign country?

4. Approximately what % of organisations that win in a tender, originate from a foreign country?

Closing (for both surveys)

Can we possibly contact you via telephone for follow-up questions regarding this survey?

If yes, please fill in your contact details:
- Name of your organisation
- E-mail address
- Telephone number

Closing:
Thank you for participating in this survey!
This survey is compliant with data security regulations, and your answers will be safely stored.

If you have any further questions or comments you can contact us at:
avanderhoorn@deloitte.nl

Table 7: Survey respondents

	Contracting authority	Care provider
The Netherlands	36	1
Italy	4	2
Germany	2	0
Belgium	0	1
Sweden	0	5
France	0	1
Czechia	0	2
Other	15	0
Total	**57**	**12**

Table 8: Responses contracting authorities

	Home care (n = 2)	Youth care (n = 19)	Both (n = 36)	Total (n = 57)
How often do you tender in the EU in this segment?	2 times per year	1,2 times per year	4,4 times per year	3,4 times per year
Approximately what % of organisations that show interest in a tender, originate from a foreign country?	0.0%	1.4%	0.3%	0.7%

Approximately what % of organisations that participate in a tender, originate from a foreign country?	0.0%	1.4%	0.2%	0.6%
Approximately what % of organisations that win in a tender, originate from a foreign country?	0.0%	1.4%	0.0%	0.5%

Table 9: Responses care providers

	Home care (n = 3)	Youth care (n = 3)	Both (n = 6)	Total (n = 12)
Out of the European tenders you show interest in, how many originate from a foreign country?	0.0%	0.0%	0.0%	0.0%
Out of the European tenders you participate in, how many originate from a foreign country?	0.0%	0.0%	0.0%	0.0%
Out of the European tenders you win, how many originate from a foreign country?	0.0%	0.0%	0.0%	0.0%

7.2 Appendix: regulatory burden

Table 10:List of activities

Number	Activity description
1	Familiarising with the information obligation
2	Training members and employees about the information obligations
3	Retrieving relevant information from existing data
4	Adjusting existing data and Producing new data
5	Designing information material (e.g. leaflet conception)
6	Filling forms and tables (including recordkeeping)
7	Holding meetings (internal/external with an auditor, lawyer etc.)
8	Inspecting and checking (including assistance to inspection by public authorities)
9	Copying (reproducing reports, producing labels or leaflets)
10	Submitting the information to the relevant authority (e.g. sending it to the relevant authority)
11	Filing the information
12	Buying (IT) equipment & supplies (e.g. labelling machines) to specifically used to fulfil information obligations
13	Other

Table 11: Regulatory burden interviews conducted per country

Country	Contracting Authority	Care provider	**Total**
Czechia	3	3	6
France	1	2	3
Germany	2	1	3
Italy	4	4	8
Sweden	4	4	8
The Netherlands	13	7	20

Table 12: Open procedure, steps and sub-steps

Phase	Step	Sub-step	Article no.	Organisation
1. Preparation	1a: Taking preliminary actions	Applicability of EU guideline	1.1	CA
		Applicability of EU guideline (threshold value)	4	
		Preliminary market consultations	40 (discretionary step)	
		Choice of procurement technique	33	
		Choice of procedure	26	
	1b. Continued monitoring and documenting of obligations and actions	Treaty principles	18.1	CA
		Procurement dossier	84	
		Rules applicable to communication	22	
		Confidentiality	21	
		Electronic availability of procurement documents	51	
		Informing candidates and care providers	55	
	1c. Participate in market consultation	Participate in preliminary market consultation	40 (discretionary step)	CP
	1d. Preparing contract specifications	Environmental characteristics	42.3 (discretionary step)	CA
		Lots	46.2	
		Time limits	47.1	
		Variants	45.1	
		Award criteria	56	
		Nomenclatures	23	
		Technical specifications	42	
	1e. Preparing selection specifications	Selection criteria	58	CA
		Conflict of interest	24	
		Exclusion	41	
		Prevent exclusion	41	
2. Publication	2a. Publishing notice	Prior Information Notice	48 / 51 (discretionary step)	CA
		Contract notice	49/51	
		Publication of notice on national platform	52 (discretionary step)	
	2b. Responding to notice and asking questions	New opportunities EU	-	CP
		New opportunities national platform	- (discretionary step)	
		Potential opportunities	-	
		Additional information - questions	- (discretionary step)	
	2c. Answering questions	Additional information – answers	53.2	CA
	2d. Assessing notice	Potential of opportunity with additional information	-	CP
		Decide to enter	-	

3. Participation	3a. Submitting tender documents	Proof of economic standing (T)	60.3	CP
		Statement of conduct of behaviour (T)	-	
		ESPD (T)	-	
		Reliance on the capacities of other entities (T)	63	
		Means of proof (T)	60.1	
		Proposal (technical specifications)	-	
		Selection (Standards)	42.6	
		Submit proposal and forms	-	
		Prevent exclusion	57.6 (discretionary step)	
	3b. Assessing received tenders	Proof of economic standing (CA)	60.3	CA
		Statement of conduct of behaviour (CA)	57	
		ESPD (CA)	59	
		Reliance on the capacities of other entities (CA)	63	
		Means of proof (CA)	60.1 (discretionary step)	
		Assess prevention of exclusion	57.6	
		Quality assurance standards and environmental management standards	62	
		Online repository of certificates (e-Certis)	61	
4. Awarding	4a. Awarding and informing	Awarding criteria	67	CA
		Awarding decision	-	
		Reduction of the number of tenders and solutions	66 (discretionary step)	
		Abnormally low tenders	69	
		Informing	55.3	
	4b. Asking additional information on awarding	Additional information on rejection	- (discretionary step)	CP
	4c. Providing additional information on awarding	Additional information on rejection	55.2	CA
5. Finalization	5a. Responding to award decision	Complaints / trial about procedure (T)	-	CP
		Sign contract - T	-	
	5b. Closing	Complaints / trial about procedure (CA)	-	CA
		Sign contract - CA	-	
		Contract award notice to EC	50/51	
		Evaluation	-	
		Data destruction	-	

Table 13: Business As Usual per sub-step

Organisation	Sub-step	Business As Usual
CA and T	Preliminary market consultations	20%
CA	Choice of procurement technique	20%
CA	Preparing contract specifications: lots, time limits	10%
CA	Preparing contract specifications: technical specifications	30%
T	Assessing potential opportunities	30%
T	Asking additional information	20%
CA	Providing additional information	20%
T	Potential of opportunity with additional information	5%
T	Decide to enter	50%
T	Proposal (technical specifications)	30%
T	Submitting proposal & forms	10%
CA	Awarding criteria	10%
CA	Awarding decision	50%
CA	Informing	10%
T	Asking for additional information	50%
CA	Providing additional information	50%
CA and T	Signing contract	100%
CA	Evaluation	10%

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