Project PESSIS: Promoting employers' social services in social dialogue

Country report: Slovenia

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List of abbreviations:

DEP – Developmental and experimental programmes

ESS – Economic and Social Council

FIHO – Foundation for financing humanitarian and disabled people's organisation in the Republic of Slovenia

MOLFSA – Ministry of the Labour Family and Social Affairs

NGO – non-governmental organisation

PSPP – Public social protection programmes

SORS – Statistical Office of the Republic of Slovenia

SPIRS – Social Protection Institute of the Republic of Slovenia

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1. Introduction

The report is divided into four parts. In the first thematic chapters (chapter two and three) we present the main characteristics of the social welfare system in Slovenia. These characteristics are important for understanding of the role of social services sector and its placement within the social dialogue. Here we focus on historic and socio-economic features of the development of the social welfare system and its impact on the characteristics of social services sector (especially along the public/private/non-profit lines). We do not present the whole system into great detail but instead limit our findings to the key groups of social services such as:

- NGO's social protection programmes co-financed by the state,
- long-term care for older people,
- social services for children and youth with special needs,
- social services for disabled people.

The size of the service sector, its logic of functioning, number of users, employers, workers and volunteers are presented in these two chapters. The fourth chapter of the report deals with the social dialogue and viewpoints of social services providers, state actors and other important stakeholders such as unions. In order to present all the relevant information, the desk search on social dialogue and the position of social services providers within the dialogue has been done as a basis for the interviews with the stakeholders. As the social dialogue has been at its peak (the government presented the measures to tackle the ongoing economic crisis) it has been impossible to organise an event where all the relevant stakeholders would take part. Therefore we opted for individual interviews which were held in April and May 2012. Following stakeholders have participated in the interviews: the *Association of Social Institutions of Slovenia*, *Slovenian Community of associations for Special Education Needs*, *Centre for Information Service, Co-operation and Development of NGOs (CNVOS)*, *government representatives*, *The Confederation of Trade Unions of Slovenia PERGAM*, *Centre for Vocational Rehabilitation*, *and National Council of Disabled People's Organisations of*

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Slovenia.[1] The conclusions from the interviews are presented in the light of previous findings from the desk search in the concluding chapter.

2. The main characteristics of the welfare system and the profile of the social services sector

Slovenia has seen one of the most successful transitions from a socialist to a market economy. The first cluster of reasons for this can be found in relatively high level of development even before the independence in 1991. The second cluster constitute the rejection of so called 'shock therapy' or 'big bang' approach in (de)regulation of social and economic subsystems that was made possible by a stable centre-left government(s) that have been in power until EU accession. Slovenia opted for slower and gradual transformation that resulted in retainment of generous social policies, avoidance of quick liberalisation of the financial markets and capital flows, in its own concept of privatisation with a limited role for foreign capital, in relatively rigid but (at least up to the economic crisis) secure labour market and in relatively all encompassing and publicly dominated social services (Boljka 2009, 11). The same can be said for the welfare system as an integral part of the broader socio-economic system. Here the Slovene socialist history played an essential part resulting in the prevalence of a social welfare system where the state was the owner, financer and the dominant actor in the social services provision. However; the services ensured by the state haven't been sufficient to satisfy all the needs of individuals 'forcing' the informal social networks (mainly family) to provide additional social protection. The civil society (private, non-profit voluntary organisations) before the transition to the market economy was weak and the same can be claimed for the market as a social services provider (Kolarič, Kopač Mrak, Rakar 2011, 288).

3. Provision of social services

3.1. NGO's social protection programmes co-financed by the state

The NGOs in the area of social services are relatively well represented in terms of share of all employees in the NGO sector. Even though these NGOs represent just 3,6 % of

[1] Several others stakeholders have been contacted but due to the intense social dialogue (on the topic of measures to deal with the economic crisis) decided not to participate in the interviews.

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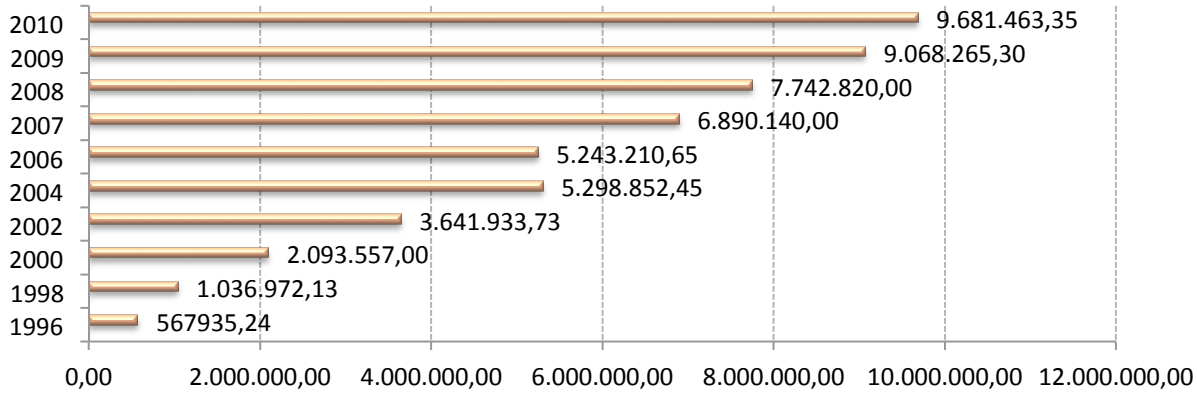
the so called third sector, they present 26,7 % of all employed in the whole sector. These numbers lead us to believe that the NGOs that are active in the social services provision are relatively professionalised and that they have assured the continued financial support from the state (Črnak-Meglič and Rakar 2009, 241-242). “The state was extensively financially supporting them (especially through a lottery fund, today’s FIHO) throughout. In these organisations, besides a well-developed voluntary structure, a relatively strong professional structure also developed which is growing stronger today” (Črnak-Meglič and Rakar 2009, 241-242). Before the transition, social services were almost exclusively performed by public institutions. Now, the state recognises the importance of other actors in the provision of social services and their ability to identify the needs of users (Črnak-Meglič 2006, 34-35). In accordance with that MOLFSA has since the beginning of the 1990s encouraged and supported the development of non-governmental sector and the pluralisation of social protection programmes. There is also an evident trend in increasing the co-financing of the social protection programmes (see Table 1).

Table 1: Funds (€) of MOLFSA aimed for co-financing of social protection programmes



Source: SPIRS 2011

The social protection programmes which have been co-financed by MOLFSA managed to get their funding from different sources. 25.727.797,94 € have been allocated to these programmes in 2010 which is an 14 % increase from the 2009. The main sources of financing has been MOLFSA amounting on average to 37,5 % in 2010. Other important financers are presented in the Table 2 (Smolej et al 2011).

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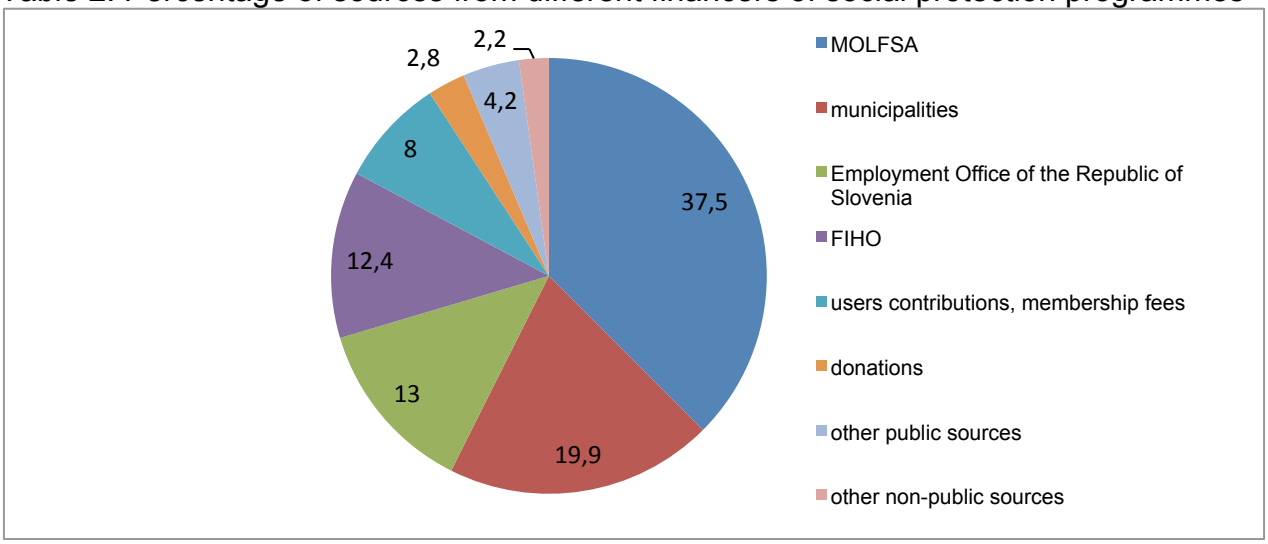
Table 2: Percentage of sources from different financers of social protection programmes



Source: SPIRS 2011

The MOLFSA allocated to social protection programmes 9.681.463,35 € in 2010. The most funds went to group homes for people with long term mental health problems, programmes of day centres and to centres for counselling for people with long-term mental health problems (PSPP 2) (Smolej et al 2011).

Table 3: Financing of social protection programmes from MOLFSA open call (2010)

Fields of co-financing of social protection programmes in 2010	MOLFSA funds (€)
Public social protection programmes – PSPP	
Programmes of maternity homes and shelters for women (PSPP 1)	1.458.265,66
Programmes for people with long term mental health problems (PSPP 2)	2.195.665,27
Programmes for the disabled (PSPP 3)	668.018,90
Programmes for drug users (PSPP 4)	1.575.993,26
Therapeutic programs for social distress due to alcoholism and other forms of addiction (PSPP 5)	252.381,66
Admission programs and shelters for the homeless (PSPP 6)	547.484,50
Intergenerational programs of regional centres with a network of social programs for the quality of life in old age (PSPP 7)	34.552,72
Specialized therapeutic programs of psychosocial support to children, adults and families, designed to resolve inter-personal problems (PSPP 8)	366.343,50
Admission programs and shelters for homeless drug addicts (PSPP 9)	123.124,94
Developmental and experimental programmes – DEP	
Programs for telephone counselling for children, adolescents and others in the personal distress (DEP 1)	152.890,72
Low-threshold programs for drug users (DEP 2)	587.876,52
Therapeutic programs and other programs for social distress due to alcoholism and other forms of addiction (DEP 3)	92.092,78
Programs to reduce social exclusion of old (DEP 4)	508.387,13
Programs of psychosocial assistance to victims of violence (DEP 5)	271.733,70
Programs aimed at children and adolescents (DEP 6)	557.675,88
Other programs focusing on minimizing the social problems that are not part of the open call of MOLFSA (DEP 7)	254.760,47
Slovenian Caritas: Care for victims of human trafficking - crisis accommodation	34.215,74
Together	9.681.463,35

Source: SPIRS 2011

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3.1.1. Human resources of the social protection programmes

1.445 people were employed in 2010 in the co-financed social protection programmes. 65 % of the employed were employed for the indefinite period of time. Employed service providers have been largely financed by MOLFSA (35 %). Nearly a fifth of employment are financed by the municipalities, ESS has contributed funds for almost 18 %. (Smolej et al 2011). There are significantly more people employed in the social protection programmes than in developmental and experimental programmes where the volunteering is more common – 75 % of workers in these programmes are volunteers. There were 10.860 volunteers in these programmes. They represent 81,9 % of all service providers in social protection programmes (Smolej et al 2011).

Table 4: Human resources according to open call fields of MOLFSA

field	Number of employed		Number of other paid service providers		Number of volunteers	
	2009	2010	2009	2010	2009	2010
Public social protection programmes – PSPP						
PSPP 1	98	111	45	41	194	159
PSPP 2	251	300	88	82	558	642
PSPP 3	310	354	169	325	1.034	1.152
PSPP 4	106	111	38	41	273	249
PSPP 5	28	24	34	26	230	108
PSPP 6	74	86	17	24	135	215
PSPP 7	6	7	4	4	112	123
PSPP 8	43	35	34	20	93	77
PSPP 9	12	18	3	11	17	38
Developmental and experimental programmes – DEP						
DEP 1	22	29	22	25	688	551
DEP 2	59	59	101	55	240	189
DEP 3	15	21	68	53	113	133
DEP 4	34	48	41	101	3.982	4.582
DEP 5	46	43	20	19	83	93
DEP 6	108	112	80	67	670	723
DEP 7	77	87	72	64	412	1.826
Together	1.289	1.445	836	958	8.834	10.861

Source: SPIRS 2011

Table 5: Employments co-financed by MOLFSA

Number in percentage (%) of employed persons, co-financed by MOLFSA		
	Number	%
Full time employments fully funded by MOLFSA (2088 hours)	160	23,32
Part time employments fully financed by MOLFSA; full time employments partly financed by MOLFSA (50%); co-financed employments (2/3) (from 1044 to 2000 hours)	162	23,62
Employments co-financed by MOLFSA at lower rates or the total hours worked by employees throughout the year which are paid from MLFSA, don't amount to 1044 hours	364	53,06
Together	686	100

Source: SPIRS 2011

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3.1.2. Users of the social protection programmes

In 2010, there were 161.916 users and over 72.500 calls within the social protection programmes that were financed by MDDSZ. The most "popular" programmes were intergenerational and other self help groups and other residential programmes aimed at the reduction of social exclusion. (Smolej et al 2011).

Table 6: Number of social protection services users (2009 - 2010)

Field	Number of users	
	2009	2010
Public social protection programmes – PSPP		
PSPP 1	1.138	815
PSPP 2	4.237	5.117
PSPP 3	9.772	10.920
PSPP 4	6.854	4.591
PSPP 5	1.890	2.323
PSPP 6	1.637	1.974
PSPP 7	555	1.260
PSPP 8	4.349	3.650
PSPP 9	72	104
Developmental and experimental programmes – DEP		
DEP 1	84.015	72.517
DEP 2	5.097	3.870
DEP 3	3.935	5.547
DEP 4	86.959	81.169
DEP 5	6.968	4.970
DEP 6	11.768	11.748
DEP 7	43.046	23.858
Together	188.277	161.916

Source: SPIRS 2011

3.2. Long-term care for older people

Long-term care can be divided into 1. **residential** and 2. **community care**. They are still dominated by the public sector in Slovenia. Nevertheless NGOs do cover the so called grey spots in the state provision of services in this field. In Slovenia the following major forms of social services for older persons may be identified along the division lines of residential Vs community care.

3.2.1. Residential care

Services in residential care can be divided into:

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- **Institutional homes** – public social-care homes for the elderly, which provide all the basic services such as accommodation, meals, health care and nursing. This type of housing for the elderly is predominant.
- **Individual homes** – fully furnished small-sized flats, planned for the accommodation of older people, within the framework of housing blocks. It is meant for those old people who wish to continue living independently.
- **Sheltered housing** – new housing systems for the elderly have emerged in recent years funded by public sector (municipal housing funds, Retirement and Disability Insurance Real Estate Fund by private investors or as public-private partnership ventures.
- **Day-care homes** – open social centres intended for the daytime accommodation of older persons still living in their own homes but who cannot be left alone during the day or do not wish to spend the entire day by themselves (Flaker et al. 2011, 194-196).

Residential care is still predominantly characterised by institutional care. It is dominant in terms of being a well established system, comprising more than one third of people estimated to be needing long term care, but also in terms of cost being paid by the users, insurance system and the budget. Institutional care is mainly a public responsibility, in terms of the establishing and maintaining facilities as well as in developing the network of social care homes. The system of financing the institutional care is a combination of public and private responsibility: people have to cover the expenses of accommodation, food and social care services, but the state (municipality) supplements the payment up to the entire price if their income is insufficient. **In 2010 approximately 17.000 people older than 65 years lived in homes for the elderly**. This number meets the goal stated in the national programme of social care i.e. 5 % of all people older than 65 is included in this type of care. Special social care homes and centres for care and training include adult population (not only elderly) with disabilities (learning, physical or other disabilities, mental health difficulties) (Flaker et al. 2011, 194-195).

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Table 7: Number of employed persons providing health and social services in institutional care

	2007			2008			2009			2010		
	TOGETHER	Women	Men	TOGETHER	TOGETHER	Men	TOGETHER	Women	Men	TOGETHER	Women	Men
Employed - TOGETHER	2979	2579	400	3353	2926	427	3573	3104	469	3701	3189	512

Source: SORS 2012

3.2.2. Community care

Services provided within the community care can be divided into:

- **Home nursing** – provided by community nurses, who perform preventive and health education services, health-related services at home and to a certain extent also home help services. They are one of the first professional workers to identify health and social hardship as well as the needs of individual insured persons and their families for home and long-term care. In the second half of the 1990s the promotion of non-institutional forms started, awarding concessions to private practitioners and promoting the activities of non-governmental organisations in this area (Flaker et al. 2011, 198).
- **Home help** – in the public sphere there are different institutions providing home help such as centres for social work and homes for the elderly and in the private sphere institutions with concessions and licensed institutions or individuals. There were 75 organisations providing home care in 2010, the providers are mainly public institutions (as homes for the elderly, centres for social work, institutions for the home care). In 2010 there were 6.575 people using home help (Nagode et al. 2011).
- **Personal assistant** – persons with disabilities that require long-term care may opt for institutional care or may select one of the forms of help at home. Therefore; in some parts of the country **personal assistants** are available. This programme is run by persons with disabilities themselves, and is financed by the state, local community and user funds (Flaker et al 2011, 198). By 2007 there were 24 organisations with 353 personal assistants (almost half of them working voluntarily) providing personal assistance for 705 people (Nagode and Smolej 2007).

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- **Family assistant** – people who would otherwise be institutionalised have the right to choose a family assistant. The family assistant provides support for every-day living activities and enables the person to stay at home; the services of a family assistant are financed by a combination of public and private sources.

Community care is a relatively new phenomenon in Slovenia. The provision of long-term care in Slovenia was initially based on institutional care. Home care was only introduced in late 1980s and started to develop more intensively at the end of the 1990s. Before that, help at home was provided through the community nursing service within the primary health sector, but was only available to a limited extent. In the second half of the 1990s, non-institutional forms of long-term care were increasingly facilitated. Concessions were awarded to private practitioners and the activities of non-governmental organisations in the area were promoted (Flaker et al., 2011: 196-198). Community care is a mixed (public and private) responsibility with national and local responsibility. There is a more pronounced impact of NGOs in the field of disabilities and mental health, though in comparison to the amount of institutional care, community institutional care provided by NGOs is insufficient and marginal (ratio approximately 30:1). The funding is almost exclusively public. In the public sector, community care is provided by the centres for social work, home help organisations, homes for the elderly, day centres, (and family assistants); in the for-profit sector there are private institutions (organisers of private health care, meals delivery services) and in the non-profit sector there are organisations related to churches and other secular, specialised NGOs (mental health, disabilities) (Flaker et al., 2011: 196-198).

3.3. Child care services for children and youth with special needs[2]

Slovenia has a strong network of institutions for children and youth. From the systemic point of view Slovenia's social services in the field of disadvantaged children and youth can be divided into care for: 1. children and youth with moderate, severe and profound mental disabilities, 2. children and youth with functional disabilities and with mild or moderate mental disabilities, and 3. emotionally and behaviourally disturbed children

[2] We did not include child care as it is not considered to be part of social services but part of educational policies.

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and youth. Services vary according to the types of children and youth included. According to that the institutions and services differ in goals they want to achieve, levels of care provided to the children and youth, length of stay of children, stuff requirements, educational and qualifications options for youth and children, provision of full-time care or provision of daily care. Looking at the overall picture there were **1,400 children with special needs in centres, institutions and youth homes, of whom 1,260 in residential full-time care and 140 in daily care** (Ložar 2011).

Out of them, 369 children and youth with **moderate, severe and profound mental disabilities** resided in centres for training, work and protection, while 143 only attended daily care activities in these institutions. Half of employees in centres were health and social care staff, while educational work represented only 21 % and was conducted by 134 special pedagogues-defectologists, who (Ložar 2011).

Table 8: Children and youth with moderate, severe and profound mental disabilities in residential and daily care, Slovenia, 2010

	Centres for training, work and protection	Residential full-time care	Day care
Number of children and youth - total	512	369	143

Source: SORS 2012

There were 258 children with **functional disabilities** and 233 **children with mild or moderate mental disabilities** in institutional care in 2010. These are children who are not in the position to be educated in the place of permanent residence and are incorporated in institutional care – blind and weak-sighted children, deaf and partially deaf, children with motive impediments and slightly or moderately mentally handicapped children. They reside in homes intended for such children or in special units in the scope of boarding homes. In 2010, 233 children with mild intellectual disabilities were included in institutional care (Ložar 2011). Looking at the human resources in these institutions the numbers reveal that the majority of professional staff was educators and special pedagogues-defectologists (39%) and other health professionals (25%) (Ložar 2011).

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Table 9: Institutional placement of children and youth with functional disabilities and/or with mild or moderate mental disabilities, Slovenia, 2010

	Number of institutions	Number of children	Boys	Girls
Type of institutions - total	**13**	**491**	**287**	**204**
for blind and weak-sighted children and youth	1	22	17	5
for deaf and partially deaf children and youth	1	48	33	15
for children and youth with motive impediments	2	188	102	86
for children and youth with mild and moderate mental disabilities	9	233	135	98

Source: SORS 2012

Table 10: Institutions and homes for lodging and care of children and youth with functional disabilities and/or with mild or moderate mental disabilities, Slovenia, 2010

		for blind and weak-sighted children and youth	for deaf and partially deaf children and youth	for children and youth with physical disabilities	for slightly or moderately mentally disabled children
Employees - total	**322**	**6**	**14**	**176**	**126**
women	278	2	10	165	101
educators, assistant educators	100	5	13	27	55
medical staff	81	1	-	72	8
special pedagogues, defectologist	25	-	-	16	9
advisers	5	-	-	3	2
other professional personnel	13	-	-	10	3
management staff	10	-	1	5	4
other personnel	88	-	-	43	45

Source: SORS 2012

Furthermore there were 398 persons in **institutions for emotionally and behaviourally disturbed children and youth** in 2010. They live in so called reformatory, re-education and youth homes with the aim of better adaptation to problems of growing up and/or to have better conditions for living than at home. (Ložar 2011).

Table 11: Institutions and homes for emotionally and behaviorally disordered children and youth by organisation of educational work, Slovenia, 2010

	Total	Reformatory homes	Reeducation home	Youth homes
Number of institutions/homes	11	7	1	3
Number of children and youth	398	235	32	131
Organisation of educational work				

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number of housing groups	19	10	-	9
number of educational groups	38	26	6	6

- no occurrence of event
Source: SORS 2012

3.4. Social services for disabled people

3.4.1. Institutional care for special categories of population

In 2008 there were 12 public institutions, including 6 special welfare institutions and 6 units for special care for adults inside the residential homes for elderly or as a separate unit in of the residential home. Table 14 shows that the number of applicants is on the rise (1.097 in 2004 to 1.377 in 2008). The number of all users is however in the decline, the number of employed on the increase (for the detailed info see Table 14 and 15).

Table 12: Users and employed in special welfare institutions and rejected applicants, 2004-2009

	2004	**2005**	**2006**	**2007**	**2008**	**2009**
The number of special welfare institutions	15	14	14	14	12	12
The number of applicants	1.097	1.424	1.303	1.417	1.377	1.160
Accepted applicants	354	(470)	(430)	488	400	339
Rejected applicants	355	698	651	626	748	619
Users (all)	2.746	2.674	2.590	2.531	2.478	2.500
Men	1.292	1.265	1.263	1.275	1.257	1.267
Women	1.454	1.409	1.327	1.256	1.221	1.233

Source: SORS 2012; () approximation

Table 13: Number of health care, social and welfare personnel in special social welfare institutions, Slovenia, annually

Employed persons	**2008**			**2009**			**2010**		
	TOTAL	Men	Women	TOTAL	Men	Women	TOTAL	Men	Women
health care personnel[3] - TOTAL	832	82	750	741	84	657	722	87	635
social welfare personnel[4] - TOTAL	642	129	513	713	141	572	727	138	589

Source: SORS 2012

[3] Health care personnel is comprised of hospital nurses, physiotherapists, work therapists, guardians, nurses, attendants, others.
[4]Social welfare personnel is comprised of attendants, teachers of practical lessons, social pedagogues, social workers, psychologists, receptionists, cooks, assistant cooks, servers, bursars, drivers, caretakers, dressmakers, pressers, launderers, cleaners, clerks and others.

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3.4.2. Centres for protection and training

According to SORS there have been 3077 users in centres for protection and training in 2010. The number is steadily increasing during the years as evident from the bellow data.

Table 14: Number of proteges in centres for protection and training by sex and age groups, Slovenia, annually

	2008			2009			2010		
	TOTAL	Women	Men	TOTAL	Women	Men	TOTAL	Women	Men
TOTAL	3016	1342	1674	3038	1351	1687	3077	1379	1698

Source: SORS 2012

Table 15: Numbers of centres for protection and training and the number of users (protégés) 2000, 2005 - 2009

	2000	2006	2007	2008	2009	2010
Number of centres	40	70	71	88	99	/
Number of users (proteges)	1.976	2.587	2.621	3.016	3.038	3.077

Source: SORS 2012

In the centres for protection and training there were 920 persons that have been providing different social care services in 2010. There has been a considerable increase from the year 2007 as then just 757 persons were employed.

Table 16: Number of employed in the centres for protection and training providing different social care services Slovenia, yearly

	2007			2008			2009			2010		
	TOGETHER	Women	Men	TOGETHER	Women	Men	TOGETHER	Women	Men	TOGETHER	Women	Men
Employed	757	556	201	893	642	101	872	631	241	920	649	271
Office officials	62	57	5	72	70	2	69	65	4	64	59	5
Others	24	19	5	30	22	12	41	31	10	50	41	9

Source: SORS 2012

3.4.3. Home care assistant

Persons entitled to institutional care can choose a home care assistant over the daily institutional care. The institute of home care assistant plays an important role in

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maintaining the quality life in advanced years of persons with disabilities. It is primarily intended to persons with disabilities who believe that institutions cannot offer adequate intimacy, individuality, solidarity, personal communication, homeliness and heartiness (MOLFSA 2012). A home care assistant contributes to the adequate care or appropriate satisfaction of the wishes and needs of a person with disability by carrying out the following tasks: personal care, medical care, social care and organization of leisure activities, housework assistance. According to MOLFSA there were 1.245 people entitled to the service of home assistant (as at 2 February 2007). Most of them being severely physically impaired 848 (68%). At the same time there were 1.349 home care assistants.

3.4.4. Vocational rehabilitation

"Vocational rehabilitation services are services implemented with a view to qualify the disabled for the appropriate line of work, employment, keeping of an employment, promotion or change of a professional career. Vocational rehabilitation constitutes a right of the disabled persons to individual services, such as counselling, encouraging and motivating the disabled for active participation, the drawing-up of an opinion on the level of working capacity, skills, working habits and occupational interests, provision of assistance in the area of acceptance of invalidity and acquaintance with the possibilities for the integration in training and work, provision of assistance in the area of selection of appropriate occupational objectives, development of social skills and provision of assistance in the area of finding appropriate work and employment, respectively. The disabled are eligible for the exercise of right to vocational rehabilitation provided that they do not have the right to equal services under other regulations" (State portal of the Republic of Slovenia 2012). The social services of vocational rehabilitation have been implemented by 17 institutions which provide a geographically impartial access to service. The field of vocational rehabilitation is dominated by employees who are aged between 26 and 45 years (72 %). Most are aged between 26 and 35 years. There is a significant proportion of people aged over 46 years (27,1 %). The field is dominated by women (85,6 %). Majority of them work for full time. Legal regulations state that the professional work in the field of vocational rehabilitation can be performed by workers

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with a university or higher education of psychological, sociological, social, pedagogical field or by workers with other appropriate knowledge in the field of rehabilitation, employment or disability, acquired through specialization, additional education or training.

Table 17: Vocational rehabilitation

	2008	2009	2010	2011
The number of disabled dealt with by the rehabilitation committees	653	720	954	1.066
The number of disabled included in the service of vocational rehabilitation	1.165	969	2.034	1.945

Source: Employment office of the Republic of Slovenia 2012

4. Social dialogue in the social services sector

4.1. The Economic and Social Council and stakeholders of social services sector

Social partners in Slovenia cooperate at national level in the Economic and Social Council (Ekonomsko Socialni Svet, ESS). ESS was established in April 1994 as a central body for tripartite cooperation in Slovenia. From then onwards, ESS has contributed to the successful implementation of basic economic and social reforms and the process of transition. The consultative function of ESS is realised through its activity in the preparation of legislation and other documents (such as social agreements and pay policy agreement) and giving opinions on working and draft documents that are relevant to the scope of ESS work: industrial relations; conditions of work; labour legislation etc. and broader issues affecting workers; employers and government policy. ESS discusses all reports or documents that in international/EU practice demand the opinion of the social partners. The ESS has 15 members (five representing each of the three parties) and adopts its decisions unanimously. In case of differences in opinions, these are reported. ESS has working groups (members are representatives of all three parties, and sometimes independent experts) that contribute to resolving of issues on the ESS's agenda (e.g. drafting of law proposals, evaluating reforms of social security system and various tripartite agreements). Although ESS opinions and suggestions are not legally binding, they are taken into account in discussions and decision-making. The administrative costs of the work of ESS are covered from the state budget. The main

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social actors agreed that social dialogue is the precondition for successful joint and individual actions. Thus social partners conclude 'social agreements' that cover important social and economic topics such as employment and unemployment policies, income policies, tax reforms, social policies, living and working conditions (Kanjuo-Mrčela 2006, 4).

Social partners who participated in the interviews and are active in the field of social services provision see the social dialogue (as it is defined trough the Economic and Social Council) as an important tool for promotion of their interests. However; understanding of the social dialogue at a formal national level varies from one stakeholder to another. Not all of stakeholders are directly included in it. The unions representing the workers employed in the social services sector are part of the Economic and Social Council. The union's representatives see the Economic and Social Council as a central point for negotiating the collective agreements that regulate the social services sector. The quality of the social dialogue depends on the topic which is being negotiated and the strength of the social partners.

The organisations representing the service providers in the social services sector are not considered to be directly involved as social partners in the Economic and Social Council. The same can be claimed for NGOs which are active in the field of social services provisions. They all express the view that it would be wise to consider some changes to the organisation of the Economic and Social Council – meaning to the organisation of the social dialogue. These changes would include broadening the composition of the Council adding NGOs and social services providers associations to the Council's gatherings (at least when their interests are at stake). NGOs representatives Centre for Information Service, Co-operation and Development of NGOs (CNVOS) expressed that there is currently too much opposition to the inclusion of NGOs coming from other social partner in the Council. The lobbying to include them has so far proven to be unsuccessful.

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4.2. Social dialogue in the social services sector

Understanding of the quality of the social dialogue in the social services sector varies from one stakeholder to another. However; they all recognise the social dialogue as an important tool for promotion of their interests and agree that the most important decisions in regard to provision of social services cannot be made without the social dialogue. The social dialogue is understood much broader than just collective agreements agreed upon within the scope of the negotiations within the Economic and Social Council. According to the interviewed stakeholders the social dialogue is viewed in the scope of their influence on the decision-makers and policy-makers in the policy process. Such a view of social dialogue can be understood in the light of the fact that social services providers (especially the non-governmental actors and representatives of the services providers) are not directly involved in the social dialogue at the highest level (Economic and Social Council). All stakeholders expressed the view that they would like to be more actively involved in the highest formally recognised form of social dialogue in Slovenia (tripartite Economic and Social Council) as well as more actively involved in all the phases of the policy process (especially early stages of policy design) which, according to them, influences the position of all stakeholders and quality of service provision in the long run.

There are several particularities of the social dialogue that can be ascribed to the characteristics of the social protection system in Slovenia. According to the representative of the Association of Social Institutions of Slovenia there is pending issue of unclear roles of the social partners in social services sector's social dialogue. For instance: MOLFSA represents the interests of the employers and at the same time represents the interest of the users. There is a tendency that the interest and protection of the users prevails over the interest of the employers (public institution). Parallel to that, public social institutions have to bear in mind the rights of the workers agreed in collective agreements which have been negotiated by the unions. In practice this means that public institutions need to maintain low prices for their services to ensure their provision and implementation of workers' rights. It turns out that this financial burden falls on the social services providers. There are many situations in which the negotiated

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rights of users and workers (from collective agreements) are not accompanied by suitable financial support by the state who is the ‘owner’ of the public institution, but has to come from the already existing financial sources. This is the direct result of the fact that the social services providers associations do not participate in the social dialogue at the highest level.

Similar attitude is expressed by the representative of the Slovenian Community of associations for Special Education Needs. The negotiated rights of workers are not always accompanied with new financial sources. This is the most evident in the wage policy when the services providers are faced with the pressure to increase the wages which proves to be problematic if this 'new' right is not accompanied by new financial sources. Furthermore he emphasizes that they sometimes as service providers do not feel like partners in social dialogue. For example: the state has been preparing the new policy package to tackle the economic crisis which will inevitably affect the quality and standards of social services in Slovenia. Nevertheless the service providers have not been consulted in this regard. Even when the services providers want to participate in the earlier policy designs they find it rather difficult to influence the policy designers and decision makers. Furthermore; there is no system in place how services providers would get involved in the ‘elite’ parts of the social dialogue and participate as full members in the Economic and Social Council. Again there is a problem with the representation of the social services provider’s interests in the Economic and Social Council as their representatives feel more represented by the unions of the public sector than the representatives of employers (which is in the case of public sector the state). In this regard the social dialogue is lacking. It is not easy to protect the interest of the services providers within the existing arrangements of the social dialogue and show the decision makers that the professional discussion matter. Another problem is the lack of professionalization on behalf of social services social providers associations.

NGOs representatives Centre for Information Service, Co-operation and Development of NGOs (CNVOS) expressed the view that the NGOs are not part of the formal social dialogue. In their opinion, employed in NGOs, which are funded by MOLFSA to perform social services, do not have the same rights as do the employed in public institutions

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providing similar services. The solution could be (in their opinion) the long-term financing and equal treatment of employees in terms of their rights in the programmes which have been verified by MOLFSA and offer social services to users. Only then can the long term provision of quality social services be ensured also by NGO sector.

We can therefore conclude that not all of the stakeholders offering social services are appropriately represented in the social dialogue. For instance: in the private sector the workers are represented by the employers' associations but in the public sector or in the social services sector the interests of the workers are represented by the state who should act as a regulator of the social dialogue system rather than (as it is the case in Slovenia) a negotiator.

4.3. General collective bargaining, the bargaining coverage rate and the quality of social dialogue

The present collective bargaining structure in Slovenia is highly centralised and inclusive. According to Stanojević (Kanjuo-Mrčela 2006, 211) "there are three levels of collective agreements in Slovenia: general agreements (for private and public sector); sectoral agreements and agreements for certain professions (e.g. doctors and journalists); and agreements at the level of company (except for micro employers – up to 10 employees). The two general agreements are the result of the bargaining of the main trade union confederations, the main employers' organisations (two chambers and two associations) and the government for the public sector. The sectoral agreements are negotiated by sectoral trade union organisations and corresponding employers` associations".

The bargaining coverage rate in Slovenia is extremely high. Almost the total labour force is 'covered' by the provisions of collective agreements. The only two categories of employees that are not covered by collective agreements in Slovenia are managers (who have individual contracts) and higher administrative employees in the state administration and the administration of municipalities (Skledar in Kanjuo-Mrčela 2006, 11). This coverage rate of collective agreements is therefore high also in the social services sector.

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Social partners who participated in the interviews did not find the bargaining coverage rate to be problematic but firstly emphasized that their interests (especially stakeholders representing NGOs in the social services sector and the representatives of service providers associations) could not be expressed successfully at the highest level of the social dialogue – Economic and Social Council due to its composition, and secondly they questioned the results and the outcomes of the social dialogue in the form of collective agreements.

However; the social partners who participated in the interviews predominantly expressed the view that their interests are taken into consideration in the previous stages of policy design which is in their view also part of the broader social dialogue. Of course their opinions on how strong they can influence the policy process differ. This is also the opinion of the government representatives who participated in the interview. They think that the social dialogue should be defined in the broader sense (not just the ongoing in the Economic and social Council). The non-governmental stakeholders have the opportunity to express their opinions in the earlier stages of the policy process trough their participation in different working bodies, projects councils and working groups established to enable their incorporation in the policy design as well as standards and normative of the social services determination. These are later formalised within the Economic and Social Council. The government representatives are exactly because of that convinced that the non-governmental stakeholders are not neglected and overlooked in the bargaining process. This is also the opinion of the representative of the National Council of Disabled People's Organisations of Slovenia and the representative of the state Centre for Vocational Rehabilitation (part of University Rehabilitation Institute of the Republic of Slovenia) Their view is that the social services sector is involved in the policy as well as bargaining process trough formalised ways of cooperation with the government before the decisions are formalised trough the Economic and Social Council. In spite of that different governments differ in their preparedness to cooperate and include the proposal coming from NGOs and services providers associations.

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4.4. Key labour issues

The key labour issues discussed in the negotiations are working conditions, working time, absence arrangements, redundancy terms, training and a range of procedural issues such as dispute resolution, trade union facilities and information arrangements etc. The collective agreement includes particularly the following topics: the employment contract, the probation work, internship, procedures for determination of ability to perform the job and the quality of work performance, distribution of workers, work from home, the rights of laid off workers, working time, annual leave, absence from work with compensation or without compensation earnings, training of employees, protection of workers' rights, termination of employment, safety at work, general provision, basic salary, evaluation of difficult working conditions, wage compensation, reimbursement of expenses related to work, innovations, salaries of trainees, salaries of trade union representatives etc.

The social partners who participated in the interviews focused mainly on the broader topic of representation in the social dialogue, especially on the lack of their representation in the Economic and Social Council. They did not problematize the content of collective agreement for the sector except of the social services providers associations which expressed the lack of government insight into the problems faced by services providers when they are faced with the obligation to fulfill the rights negotiated in the social dialogue with limited financial sources. They are faced with the strictly determined employment structure negotiated within the social dialogue which does not allow much flexibility when managing the human resources in the public institution. In their opinion the real quality of the social services should come from the assuring that users have the choice to choose whatever social services provider available therefore forcing the providers to offer quality services. In their opinion the quality of the services cannot be solely assured by the state prescribed human resources structure and standards of services especially when this is not followed by additional financial sources by the owner of public institution offering services – the state.

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4.5. Social dialogue at European level

Social dialogue at European level has not been ascribed too much importance by the stakeholders who participated in the interviews. The prevailing impression of the stakeholders is that the national level is where the real decisions influencing the social services sector are negotiated. However some social services providers as well as union representatives are part of the international associations which are part of the European social dialogue. The state representatives however do attach greater importance to the European level social dialogue than other stakeholders. They are convinced that the activities of the social dialogue at the European level influence the decisions of the stakeholders and their actions in the national social dialogue as well as the outcomes of the social dialogue which can be seen in the final decisions of public policies and collective agreements.

The social services providers associations are part of broader European initiatives in this field, the same can be said for NGOs providing social services. This cooperation is not seen as part of 'official' EU social dialogue and these stakeholders do not ascribe too much influence on the social dialogue on the national level. The union representatives however see the value of the social dialogue at the European level especially in the exchanging of the examples of best practices. They are not in favour of a more centralised European social dialogue extensively regulating labour issues on a national level. The government representatives do not share the same view. They see the social dialogue at the European level having indirectly positive effects on the social dialogue on a national level as it brings together many different state and non-state stakeholders representing national level interest in the EU. Furthermore; they see the EU level social dialogue finalised in a European legislation having the direct effect on national policy making, legislation and social dialogue.

5. Conclusion

Slovenian social services sector is relatively diverse. The services are provided by public, non-governmental and private actors. Characterized by the unquestioned monopoly of the state in the social service provision in the socialist era, the public sector

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still holds to its dominant role. Nevertheless; more and more fields of social services are covered by the NGOs therefore addressing the so called grey spots in the coverage of the user's needs. This is evident by the increasing funding of the NGOs in this field by MOLFSA, by good representation of employees in terms of share of all employees in the NGO sector (even though these NGOs represent just 3,6 % of the NGO sector, they present 26,7 % of all employed in the whole sector) as well as some social services appearing on the market.

The coverage of the workforce by collective agreements has never been an issue as practically all the Slovenian workforce is covered by them. The labour market is heavily regulated in these terms. Social partners in Slovenia cooperate in the Economic and Social Council which represents a central tripartite cooperation bringing together representatives of the state, employers and workers. The Economic and Social Council is an important factor in the social dialogue as it has a consultative function and deals with the preparation of legislation and other important documents such as social agreements and pay policy agreement. It represents social dialogue at the highest level. Our interviewed stakeholder, however do understand social dialogue in a much broader terms. The social dialogue is the whole process of influencing the policy making and not just the collective agreements which are the results of the negotiations within the Economic and Social Council. Such a view of social dialogue can be understood in the light of the fact that social services providers (especially the non-governmental actors and representatives of services providers) are not directly involved in the social dialogue at the highest level – they do not take part in the Economic and Social Council. This is the issue that will need to be addressed in the future if we want to make social dialogue at the highest level more inclusive and to assure that the actors providing more and more social services will be better heard.

Interestingly; the stakeholders did not attach too much importance to the social dialogue at the EU level. They are aware of it, some (unions) are taking part in it, and other stakeholders are part of the international associations of the service providers associations and other NGOs associations that are active at the EU level. The national

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level social dialogue is ascribed relatively more weight in the final outcome of the public policies and especially collective agreements regulating the social services sector.

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