FRENCH COMMUNITY COMMISSION SHEET

CATEGORY	Social services
SECTOR	Health and long-term care

1. DESCRIPTION OF THE APPLICATION OF THE SGEI DECISION AND THE SGEI FRAMEWORK AND AMOUNTS GRANTED

Legal bases:

- 5 March 2009 – Decree (*Décret*) on outreach services in the areas of social work, family and health.
- 4 June 2009 – Order (*Arrêté*) of the Board of the French Community Commission implementing the Decree of 5 March 2009 on outreach services in the areas of social work, family and health.
- 18 February 2016 – Decree on the promotion of health.
- 17 February 2017 – Order No 2016/732 of the Board of the French Community Commission implementing the Decree of 18 February 2016 of the French Community Commission on the promotion of health.
- Decree of 13 May 2004 on subsidies for the purchase, construction, renovation, adaptation, equipment, extension and furnishing of certain centres, facilities, homes, agencies or sheltered housing initiatives falling under the social work, family and health policy.
- Order of 14 April 2005 implementing the Decree on subsidies for the purchase, construction, renovation, adaptation, equipment, extension and furnishing of certain centres, facilities, homes, agencies or sheltered housing initiatives falling under the social work, family and health policy.

Description of how the respective services are organised	
Type of services in the respective sector defined as SGEI. Contents of the services entrusted as SGEI.	**1. Mental health services: 22 approved and 1 federation** Mental health services have the following general tasks: 1. Offering an initial welcome, and assessing and, where applicable, directing the requests of beneficiaries. 2. Establishing a diagnosis and ensuring psychiatric, psychological, psychotherapeutic and psychosocial treatment for mental health problems. The diagnosis and treatment of mental health problems include the medical, psychiatric, psychological and social aspects. They basically aim to improve the mental well-being of patients in their usual living environments. 3. Organising, developing and participating in prevention activities. **2. Drug addiction services: 15 approved and 1 federation** Drug addiction services have the tasks of welcoming and informing drug users, and their friends and families, and at least one of the following general tasks: 1. Support Drug addiction services support beneficiaries in their request for help and, through personalised monitoring, provide in-house psychosocial and administrative guidance in liaison with the people and institutions concerned, in particular social, health, school and sociocultural operators.

	They can then direct or redirect beneficiaries, according to their needs, towards more appropriate people or institutions. 2. Care *a)* Drug addiction services establish a diagnosis and ensure the treatment of beneficiaries facing problems connected with drug use. The treatment of these problems includes the medical, psychiatric and psychological aspects. They aim to improve the well-being of beneficiaries in their usual living environments, which does not necessarily imply stopping their drug use. *b)* The service involves in the beneficiary's treatment, with the latter's agreement, the general practitioner designated by the beneficiary and, where possible, all professionals external to the service's team, who can help with the treatment. 3. Prevention *a)* Drug addiction services organise prevention activities or participate in the organisation of activities aimed at prevention, particularly the prevention of damage sustained by drug users. *b)* Prevention activities can in particular consist of: 1. informing, raising the awareness of and educating the population and also social, health, psychosocial, school and sociocultural operators about drug addiction and prevention of damage sustained by drug users; 2. specific prevention actions aimed at target groups, particularly people faced or likely to be faced with drug addiction problems. Drug addiction services can also have one or more of the following specific tasks: 1. Reintegration Drug addiction services offer the guidance needed to ensure the social, family, school and professional reintegration of beneficiaries. They work in collaboration with the people and institutions concerned, particularly social, health, administrative, school and sociocultural operators, and the world of work. 2. Liaison Drug addiction services carry out liaison work between the various people and entities supporting drug users. They organise collaboration so that the needs of beneficiaries are appropriately met. 3. Training Drug addiction services ensure the awareness-raising, training, continuing training and supervision of people faced or likely to be faced with the problems encountered by drug users. **3. Medical centres: 40 approved and 1 federation**

	In the context of developing integrated healthcare, medical centres have the following tasks: 1. providing primary healthcare, i.e. front-line care provided at the surgery and in the home, and preventive monitoring; 2. carrying out community health work, i.e. developing activities coordinated with the entire psycho-medical-social network and creating the conditions for the population to actively participate in the promotion of its health; 3. acting as a front-line health observatory, i.e. gathering information allowing the population served to be epidemiologically described, objectives to be assessed and the activities of the medical centre to be self-assessed with a view to improving quality of care; 4. carrying out reception work. **4. Home care and services coordination centres: 5 approved** Home care and services coordination centres: 1. organise, at the request of beneficiaries or their representative and in collaboration with their general practitioner, all the care and services needed to keep beneficiaries in their home; 2. organise, at the request of beneficiaries or their representative and in collaboration with their general practitioner, all the care and services allowing continuity of care and services to be ensured, as well as 24/7 monitoring to avoid or shorten hospitalisation. **5. Palliative and continuing care services: 5 approved and 1 federation** Palliative and continuing care services have all or some of the following tasks: 1. organising and coordinating, at the request of patients or their representative, in collaboration with their general practitioner and in liaison, in particular, with the hospital team and any coordination centre, all the home care and services allowing continuity of care and services to be ensured, as well as 24/7 monitoring; 2. organising and providing palliative and continuing care, in close collaboration with the general practitioner and any coordination centre; 3. organising and providing psychosocial care, in particular psychiatric care needed by patients who have received a terminal prognosis and support for their friends and family, in close collaboration with the general practitioner; 4. raising the awareness of, providing theoretical or practical training and continuing training to, or supervising professional or voluntary workers external to the service who need to treat or support patients who have received a terminal prognosis, and their friends and family. **6. Helpline centres: 2 approved** Helpline centres have the following tasks:

	1. they organise 24/7 telephone support and, where applicable, guidance that best suits the situation or difficulties motivating the call; 2. they are available to the public by telephone; 3. they supervise the activity of call-takers. **7. Networks: 14 approved** The aim of networks is to improve the coordination, complementarity, multidisciplinarity, continuity and quality of services and activities targeted at beneficiaries and/or the population in the territory served. **8. Initiatives** : **70 projects in 2018 and 68 projects in 2019** Support for actions aimed at promoting, improving, protecting, assessing, maintaining or restoring the population's health. **9. Health promotion: 57 projects** Responsibility for this was transferred to the French Community following the sixth state reform of 2014. Support for health promotion support services and for the various operators. **10. Institutions that chose COCOF following the sixth state reform: One joint psychosocial therapeutic structure and one sheltered housing initiative** Agreements transferred to the French Community following the sixth state reform of 2014. These involve the following: • A joint psychosocial therapeutic structure which, as at 30 June 2014, had several physical rehabilitation agreements in place with INAMI (National Institute for Health and Disability Insurance). In addition to care in the context of a multidisciplinary outpatient practice, this offers therapeutic support and accommodation options for people suffering from mental disorders. • A sheltered housing initiative with approval that was issued, in particular, based on the Law of 7 August 1987 on hospitals. This offers accommodation and support to people who do not need ongoing treatment in hospital, but who, for psychiatric reasons, must be helped in their living and accommodation environment to acquire social skills and for whom adapted daily activities must be organised.
Forms of entrustment	**1 to 7**: Ministerial approval and subsidy order **8:** Subsidy order **9:** Designation order and annual subsidy orders **10:** Ministerial approval and subsidy order + agreements
Average duration of the entrustment (in years)	**General principle** - two years, renewable once only, for the provisional approval - unlimited for the final approval.

	For initiatives - one year, renewable. **For health promotion:** – Support services and pillars are designated for a renewable period of five years. – Operators are appointed for a period of three years, which can be extended for two years. – The networks are designated for a period of three years, which can be extended for two years. – Initiatives are granted for one year renewable.
(Typically) exclusive or special rights assigned	The tasks entrusted to outreach services are defined in the Decree of 5 March 2009.
Aid instruments (direct subsidies, guarantees, etc.)	**1 to 7:** Fixed subsidies paid in four quarterly advances (3*25% and 20%) and a balance (5%). The advances are paid on 15 February, 15 May, 15 August and 15 November. The balance is paid on 31 October of the following year. **8 :** lump sum subsidies paid in two instalments (80/20) **9 :** for designated services and networks: lump-sum subsidies index-linked annually and paid in three instalments (85/10/5); for initiatives, annual lump-sum subsidies paid in two instalments (85/15) **10 :** lump-sum subsidies paid in four quarterly instalments (3* 25% and 20%) and the balance (5%). Advance payments are made on 15 February, 15 May, 15 August and 15 November.
Compensation mechanism as regards the respective services, including aid instrument used. Methodology used to determine the compensation	**1. General principles** Fixed compensation determined by the regional authority based on: - the number of full-time equivalents needed to carry out the tasks; - the percentage of staff costs that can be subsidised in terms of the worker continuing training costs; - maximum eligible amounts for the operating costs (operation of the service and costs associated with accounting and administrative management tasks). Sixty per cent of the compensation must be justified by staff costs. Every five years the regional authority produces a programme that includes a number of services by sector and that takes into account the existing offer and the needs identified in sociological, geographical, epidemiological and socio-economic terms. **1. Mental health services** The minimum team must consist of at least one FTE psychologist, one FTE social worker and one FTE doctor specialising in psychiatry. The position of FTE doctor specialising in psychiatry can be occupied, for a maximum of 0.5 FTE, by a doctor with complementary skills in adult psychiatry. The calculation method and maximum eligible amounts for the operating costs are: 1. EUR 17 800 for 4 full-time equivalents; 2. EUR 19 250 for 5 and 6 full-time equivalents;

	3. EUR 20 700 for 7 and 8 full-time equivalents; 4. EUR 22 150 for 9 and 10 full-time equivalents; 5. EUR 23 600 for 11 full-time equivalents or more. An additional amount of EUR 3 100 is granted per additional approved place of work. **2. Drug addiction services** FTE and operating costs are calculated as follows according to: 1. the number of people received: from 201 to 500 + 0.5 FTE; from 501 to 1,000 + 1 FTE; +1 000 + 1.5 FTEs. 2. Number of places of work: two places of work + 0.5 FTE; three places of work or more + 1 FTE. When the additional staff work part-time in two places of work, EUR 2 479 can be granted for operating costs. When the additional staff work part-time in three places of work or more, EUR 4 958 can be granted for operating costs. When the additional staff work full-time in two places of work, EUR 4 958 can be granted for operating costs. When the additional staff work full-time in three places of work or more, EUR 9 916 can be granted for operating costs. 3. the amount of financial contributions from other institutions: No financial contribution from other institutions means that an additional 0.5 FTE and EUR 2 479 for operating costs can be granted. 4. the specific nature of the project and the target audience, such as: - 24/7 service, team mobility or tasks carried out in hospitals and prisons, means that a maximum of an additional 2 FTEs and EUR 29 747 for operating costs can be granted. - Combined exercise of several missions and the total number of FTE for the approved services means that the following are possible: four missions with 0.5 FTE, five missions with 1 FTE and six missions with 1.5 FTE. Where the team comprises between two and three FTEs, it is entitled to EUR 2 479 for additional running costs. Where the team comprises more than three FTEs, it is entitled to an additional EUR 4 958 in running costs. **3. Medical centres** The operating costs subsidy is capped at EUR 8 100. This subsidy is index-linked and therefore adjusted annually at 1 January in line with the consumer price index. **4. Home care and services coordination centres** The category is determined based on: 1. the annual average number of beneficiaries for whom a support plan has been produced:

	category 1: 80 category 2: 160 category 3: 240 2. the percentage of services provided outside working hours and days (by type of service): category 1: 3% category 2: 6% category 3: 9% 3. the choice of menus and the possibility of tailored menus: category 1: optional category 2: optional category 3: mandatory 4. the use of a questionnaire to be completed by beneficiaries or their friends or family on the care and services provided: category 1: mandatory category 2: mandatory category 3: mandatory Subsidised working hours are as follows: 1. Category 1 has 2 FTE coordinators. The number of working hours taken into account for calculating the subsidy cannot be less than 0.5 FTE. 2. Category 2 has 3 FTE coordinators and 1 FTE administrator, as well as 0.5 FTE management staff. The number of working hours taken into account for calculating the subsidy cannot be less than 0.5 FTE. 3. Category 3 has 4 FTE daytime coordinators, 4 FTE night-time coordinators and 1 FTE administrator, as well as 1 FTE management staff. The number of working hours taken into account for calculating the subsidy cannot be less than 0.5 FTE. The total annual fixed amount for operating costs, which can be justified in full by operating costs, is set as follows: 1. EUR 17 700 for a category 1 centre; 2. EUR 35 400 for a category 2 centre; 3. EUR 66 650 for a category 3 centre. The fixed allowance per provider and per meeting is set at EUR 15. The maximum annual amount of these allowances is set at: 1. EUR 2 950 for a category 1 centre; 2. EUR 5 900 for a category 2 centre; 3. EUR 8 850 for a category 3 centre. The home care allowance for nursing staff of the category 3 service is set at EUR 26 per night or per public holiday during which the provider is on call. **5. Palliative and continuing care services** - Category 1: 0.25 FTE university graduate and 0.5 FTE secretary. - Category 2: 0.75 FTE university graduate and 0.5 FTE secretary. - Category 3: 0.5 FTE university graduate and 1 FTE non-university higher education graduate.

	- Category 4: 1.5 FTE non-university higher education graduates and 0.5 FTE secretary. - Category 5: 0.75 FTE university graduate, 2.5 FTE non-university higher education graduates and 1 FTE secretary. Under Article 25 of the Decree, if non-hospital accommodation is organised with a minimum of 15 beds and an occupation rate of at least 80%: 0.5 FTE university graduate, 6.5 FTE nurses with a degree or diploma. The operating costs are a minimum of EUR 10 000, to which EUR 7 500 can be added per additional task. If non-hospital accommodation is organised with a minimum of 15 beds and an occupation rate of at least 80%, EUR 8 960 can be added to the maximum eligible amounts of the subsidy for operating costs per service. Part of the operating costs can be allocated to care costs. **6. Helpline centres** The subsidy for staff costs covers the salary costs of: - 3 FTE, including a manager, a training officer and a secretary when the centre employs over 60 volunteer staff; - 1.5 FTE, including a training officer and a secretary if the centre employs between 40 and 60; - 0.5 FTE responsible for training if the centre employs fewer than 40. The subsidy for operating, equipping, training and recruiting volunteers and promoting the service amounts to: - EUR 24 789 for a centre employing over 60 volunteer staff; - EUR 11 155 for a centre employing between 40 and 60; - EUR 6 197 for a centre employing fewer than 40. These amounts are index-linked and therefore adjusted annually at 1 January in line with the consumer price index. These amounts can be increased on the basis of: 1. the number of telephone calls: - from 15 000 to 25 000 telephone calls: EUR 12 395; - from 25 000 to 40 000 telephone calls: EUR 37 184; - over 40 000 telephone calls: EUR 74 368. 2. the number of volunteers: - from 60 to 80 volunteer staff: EUR 24 789; - Over 80 volunteer staff: EUR 47 184. These amounts can be earmarked for operating costs or additional staff costs. They are revised annually on 1 January in line with the consumer price index. **7. Networks** The minimum fixed subsidy granted to the approved network is EUR 20 810. **8. Initiatives** Compensation granted per call for projects. Contribution to staff and operating costs based on a supporting budget.

	9. Health promotion Granting of compensation for each call for projects and in accordance with the criteria laid down in the Health Promotion Plan Contribution to staff and operating costs based on a provisional budget. **10. Institutions that chose COCOF following the sixth state reform: One joint psychosocial therapeutic structure and one sheltered housing initiative** These 2 institutions receive non-index-linked lump-sum subsidies. They cover staff, operating and training costs.
Typical arrangements for avoiding and repaying any overcompensation control, and inspection by the Administration's inspection service:	- in relation to compliance with the conditions of approval and rules imposed, on-the-spot consultation of evidence and documents needed to carry out the task - monitoring the use of subsidies granted on the basis of an annual supporting dossier and activity reports.

Total SGEI government expenditure by legal basis (millions EUR)

	Type	Appropriations committed	Appropriations paid
Compensation for services of general economic interest 2019 (adjusted budget and gross figures)	Mental health services	EUR 16 705 000	EUR 16 585 000
	Helpline centres:	EUR 892 000	EUR 881 000
	Palliative and continuing care services:	EUR 1 720 000	EUR 1 719 000
	Home care and services coordination centres	EUR 1 727 000	EUR 1 725 000
	Medical centres	EUR 4 159 000	EUR 4 154 000
	Drug addiction services	EUR 6 118 000	EUR 6 063 000
	Networks	EUR 760 000	EUR 760 000
	Initiatives	EUR 1 289 000	EUR 1 293 000
	6th state reform institutions	EUR 8 075 000	EUR 8 075 000
	Health promotion	EUR 4 978 000	EUR 5 033 000
Compensation for services of general economic interest 2018 (adjusted budget and gross figures)	Type of services	Appropriations committed	Appropriations paid
	Mental health services	EUR 16 141 000	EUR 16 010 000
	Helpline centres	EUR 858 000	EUR 858 000
	Palliative and continuing care services	EUR 1 380 000	EUR 1 379 000

	Home care and services coordination centres	EUR 1 618 000	EUR 1 617 000
	Medical centres	EUR 3 972 000	EUR 3 969 000
	Drug addiction services	EUR 5 723 000	EUR 5 690 000
	Networks	EUR 745 000	EUR 743 000
	Initiatives	EUR 1 611 000	EUR 1 731 000
	6th state reform institutions	EUR 7 884 000	EUR 7 884 000
	Health promotion	EUR 5 161 000	EUR 5 397 000

2. DIFFICULTIES WITH THE APPLICATION OF THE SGEI DECISION OR SGEI FRAMEWORK

a) Conceptual difficulties

- the SGNEI and SGEI concepts, as defined by the European Commission, suffer from a lack of terminological clarity;
- the flexibility that the Member States are allowed by the European Commission in defining general interest tasks, which is at the discretion of the subsidising authorities, creates legal uncertainty;
- it is difficult to precisely identify when remuneration forms an economic consideration for the service provided;
- it is difficult to determine when a given market exists, which is characterised by the interaction of supply and demand;
- in the absence of complaints, it is difficult to determine whether calls for proposals that are selective by nature may also lead to distortions of competition;
- the concept of 'general interest task' is often confused with a series of specific activities to be carried out.

b) Methodological difficulties

- it is difficult to differentiate between SNEGI, SGEI or SSGI activities within an undertaking;
- an undertaking pursuing the same object can receive public aid from different levels of government; it is sometimes complicated to identify whether these activities come under the same general interest task;
- where one level of government assigns a general interest task through an entrustment and grants public aid, another level of government may fund activities through a call for proposals; in this case it is not easy to distinguish between 'de minimis' aid (less than EUR 500 000 over three years) and State aid compatible with the market (up to EUR 15 million per year);
- for some undertakings, one level of government grants approval, but not public aid; this distribution of responsibility by level of government complicates the application of the SGEI Decision.

c) Specific analysis difficulties

- a financial contribution threshold needs to be defined so that it can be decided whether or not an activity is economic (subscriptions, contributions to costs, minimum acceptable contributions);
- information on public aid granted to undertakings situated in one region is not being regularly exchanged between the different levels of government (need to carry out analysis based on balance sheets);
- it is difficult to identify in balance sheets whether the total amount of public aid has been granted to one SGEI or several SGEI (which results in the public aid received being combined);
- it is difficult to identify in balance sheets the amounts for an SNEGI (where its funding is not regarded as falling under de minimis aid) and those covered by a de minimis regulation;

- it is difficult to identify and weight in financial terms aid in kind and indirect financing received by undertakings (provision of premises, staff, equipment).

3. COMPLAINTS BY THIRD PARTIES

None

4. MISCELLANEOUS QUESTIONS

None