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Eurofound

Challenges and prospects in the EU: Quality of life and public services

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Eurofound Flagship Report series

Eurofound

European Foundation for the Improvement of Living and Working Conditions

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The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

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Abbreviations used in the report

AGS	Annual Growth Survey
AI	artificial intelligence
BMAS	Federal Ministry for Labour and Social Affairs (Germany)
CPD	continuing professional development
CSRs	country-specific recommendations
ECEC	early childhood education and care
EHIS	European Health Interview Survey
EQLS	European Quality of Life Survey
ET 2020	Strategic framework for European cooperation in education and training
EU-LFS	EU Labour Force Survey
EU-SILC	EU Statistics on Income and Living Conditions
IADL	instrumental activities of daily living
ICT	information and communications technology
ISCED	International Standard Classification of Education
IvAF	Integration of Asylum Seekers and Refugees
NEC	Network of Eurofound Correspondents
OECD	Organisation for Economic Co-operation and Development
SIB	social impact bonds
SIMHE	Supporting Immigrants in Higher Education
SMEs	small and medium enterprises
VDAB	Flemish regional public employment service

Country codes

EU28

AT	Austria	**FI**	Finland	**NL**	Netherlands
BE	Belgium	**FR**	France	**PL**	Poland
BG	Bulgaria	**HR**	Croatia	**PT**	Portugal
CY	Cyprus	**HU**	Hungary	**RO**	Romania
CZ	Czechia	**IE**	Ireland	**SE**	Sweden
DE	Germany	**IT**	Italy	**SI**	Slovenia
DK	Denmark	**LT**	Lithuania	**SK**	Slovakia
EE	Estonia	**LU**	Luxembourg	**UK**	United Kingdom
EL	Greece	**LV**	Latvia		
ES	Spain	**MT**	Malta		

Flagship perspectives

Eurofound's work consistently seeks to document and analyse the past with a view to helping to better shape and improve the future. Drawing on its wide-ranging analysis of quality of life and society in the European Union over many years, Eurofound aims to use this information, data and analysis to assist policymakers in understanding the progress made, defining the challenges which have emerged and outlining the steps that could be taken to improve the lives of all people living in the EU.

This flagship report brings together in-depth contributions in the area of quality of society and public services, based mainly on research carried out since 2016. Recognising the fact that the quality of people's lives is profoundly influenced by their access to quality provision in areas such as education, health, housing and social services, the report pays particular attention to regional and social inequalities and, where possible, changes over time.

The starting point is the European Quality of Life Survey (EQLS) which has, since its inception in 2003, included questions on various aspects of quality of society, notably societal tensions, social capital, institutional trust, and the quality of services that are key for the well-being of the public. The EQLS provides representative data for the adult population in each of the 28 EU Member States. Other comparative European surveys are also analysed and case studies are presented to illustrate policies and measures to improve the quality of services and quality of life. While the contributions examine provision to the general population, there is an emphasis on services aimed at meeting the needs of people with health, social or care problems. There is also a focus on younger people, including, for example, childcare services, schools, social services to meet the needs of teenagers and young adults, and services for the integration of refugees.

Overall, the report reveals positive developments in many fields, but also emphasises the continuing inequalities between countries and different social groups. There are notable gaps in provision of services, as well as diverse barriers to effective access. While the results present an uneven picture regarding service quality, they also give indications of how to offer more satisfactory support. The underlying message is that improving delivery of quality public services is fundamental to attaining the objectives of the European Pillar of Social Rights.

Progress

- *Some positives on social cohesion*: Trust in people remains largely stable and overall trust in institutions at EU level has recovered, alongside a decline in perceived social exclusion.
- *High visibility for public services*: Public services are recognised as a cornerstone of the European Pillar of Social Rights, with a particular focus on promoting access to quality services for all.
- *Improvements in quality*: Assessments of the quality of public services (particularly health care and childcare) have improved, particularly in countries where quality ratings were previously low.
- *Public services positively linked to trust*: Perceived quality of public services is a key driver for higher trust in institutions, pointing to the value of public participation in the co-design of services.
- *Active citizenship and civic engagement*: High levels of both reflect positive benefits, with great potential for further investment in this area to boost trust and cohesion.
- *Online services increasingly operational*: Growth of digital benefits are apparent in many areas – likely to be ongoing especially for young people and to improve access for hard-to-reach groups.
- *High potential for e-healthcare*: Most Member States have much potential to expand the use of e-healthcare, but this is a matter of staff training and incentives as well as ICT systems.

Challenges

- **Trust**: While levels of trust and social cohesion have recovered in the EU as a whole since the period of financial crisis, in nearly half of all Member States the average trust in national institutions was lower in 2016 than before the crisis.
- **Societal tensions**: Perceptions of tensions – between ethnic or racial groups, and between religious groups – was more common in 2016 than before the crisis, with a significantly negative impact on trust in institutions.
- **Social inclusion**: Rates of loneliness, poor mental health and social exclusion are particularly high for older people in central and eastern Europe – in part due to poorly developed care services.
- **Health care**: While satisfaction with different aspects of health care has improved, many people were dissatisfied with being informed and consulted about their care – and this proportion was higher among people with low income.
- **Digital impact**: The spread and uptake of digital technologies appears slow in health services and particularly in social services, with large differences between Member States.
- **Childcare**: Cost is a greater barrier – on average across the EU – in availing of childcare services than lack of places, distance or opening hours.
- **Young people**: There are strong indications of increased risk of mental health problems among those aged 12–24 years, with many hard groups to reach, such as persons with chronic health problems, living in rural areas and not in education or employment.
- **Integration of migrants**: Recent cuts to services for refugees in several Member States have had negative impacts on their sustainability and maintaining availability and quality.
- **Insecurities**: Perceived insecurities related to income, accommodation, and employment are increasingly recognised and often widespread, with negative impacts on well-being and on trust.

What next?

- **More comparative EU-wide information** needs to be obtained on groups in society with evident needs – such as teenagers, migrants, and people living in institutions.
- **Improved recruitment and training policies** are urgently required in some public services: for example, long-term care, where there are also difficulties in retaining staff (in part due to poor pay and working conditions.)
- **More attention must be given** to the growing feelings of unfairness (between countries, regions and groups), particularly with respect to access to quality public services.
- **Prompt and better access is required** to primary health care, social care and long-term care to trigger early intervention, monitor ongoing needs and prevent escalation of problems.
- **More guidance is needed** on how to blend formal services and informal care (family and friends) effectively.
- **More and better opportunities** are needed for older people to contribute beyond paid work – as well as better quality housing and local environments to enable sustained living in the community.
- **Public investment** should be directed at long-term care services, as well as at improvements in home care and help in Member States (almost half) with the lowest income.
- **Better monitoring** of mental health issues and providing psychological support is needed for refugees and asylum seekers, to speed up their integration into the community.
- **More collaborative and coordinated approaches** should be put in place to ensure optimal migrant integration, with specific female-focused initiatives prioritised to address the higher inflows of female refugees
- **The established role of local and regional authorities** can be used to address regional inequalities in the provision of public services and to drive the digitalisation of social services.

Introduction

The views of citizens on their quality of life are a product of their personal circumstances and living conditions but also of their experiences and perceptions of the quality of the society in which they live. Life satisfaction or discontent, trust or insecurity, are profoundly influenced by citizens' assessments of the quality of public life and public services. In Europe, there has in recent times been an emphasis in public and policy debate on the quality of its society, with concerns about immigration, declining trust in institutions and the negative impacts of globalisation.

This report focuses on the role of public services in addressing these issues and identifies opportunities, as well as challenges, in enhancing their contribution. The chapters draw on work at Eurofound in 2016–2018 and examine measures to address needs in health and care, social integration and social cohesion; this involves examining access to and quality of key services – health, long-term care, childcare and education.

The data from the fourth European Quality of Life Survey (EQLS) are the basis for several chapters, reflecting, in part, the survey's orientation to overall well-being. However, the EQLS has always included modules looking at the quality of the societies in which individuals live and work. These modules were extended in the 2016 survey, in particular to offer more data on quality of services.

Eurofound's approach to quality of life in Europe (Eurofound, 2003) was grounded in a concept linked to Eurofound's mission and therefore relevance to the needs of policymakers among public authorities and social partners. It recognised that people's everyday lives were played out in the context of living in a community and a society, framed by particular institutions and policies. Thus, the opportunities available to people to promote their quality of life fundamentally depend upon access to collective, as well as individual, resources – notably social provision in areas such as education, healthcare, housing and social services. In addition, the quality of people's lives is profoundly influenced by the quality of their social relationships, 'the extent and nature of their interconnectedness with others in the community and the broader society' (Eurofound, 2003, p. 16). This is captured in concepts such as social capital and social integration – emphasising the importance of both personal and institutional trust. These two elements, quality of public services and trust, are cornerstones of Eurofound's monitoring and analysis of the 'quality of society'.

European Union context

The erosion of trust is a longstanding subject of social research, but the importance of trust in institutions has recently been reinforced, with levels of trust emerging as a key factor in well-being (OECD, 2018) and social cohesion. Likewise, access to quality public services has been underlined as a pillar of European social policy (European Commission, 2017). A decade ago the EU highlighted the essential role of public services in the renewed EU Social Policy Agenda (European Commission, 2008a), specifically referring to education, healthcare and social services. These services are not only basic in dealing with deficits, but critical for personal and economic growth, as well as promoting access to employment, particularly for those furthest from the labour market (European Commission, 2008b). The aftermath of the financial and economic crisis ultimately stimulated the identification of new strategies to address unemployment and social problems, generating welfare reforms and the launch of the Social Investment Package (European Commission, 2013). Again, investment in human capital and capabilities throughout the life course is delivered through provision of quality public services – childcare, education, preventive healthcare and social services.

The challenges to translate strategies into action have been underlined by the most recent EU social policy agreement – the European Pillar of Social Rights (European Commission, 2017). This was proclaimed in November 2017 as a statement of 20 rights and principles structured around three categories: equal opportunities and access to the labour market; fair working conditions; and social protection and inclusion. It continues the theme of investment in people through ensuring access to fair and well-functioning labour markets and quality welfare systems. This is part of wider efforts to build inclusive growth, create employment and promote social cohesion. Access to public services is a feature of all three categories of the Pillar with specific references to education, care and health services.

The messages from the most recent Annual Growth Survey (AGS) (European Commission, 2018a) and the *Draft joint employment report* (European Commission, 2018b) are positive insofar as unemployment is falling in the EU and employment rates are reaching new peaks. However, the economic recovery is not reaching all citizens or all countries to the same extent; unemployment rates are still particularly high in several Mediterranean countries and the number of involuntary part-time workers remains higher than it was in 2008.

Rates of economic inactivity are high, especially among low-skilled workers and young people. Overall in the EU in 2017 almost six million young people aged 15–24 were neither in employment, education or training, raising concerns about risks of poverty, poor mental health and social exclusion. Similarly, rates of loneliness, poor mental health and social exclusion are high among some populations of older people, especially in central and eastern Europe (Eurofound, 2019a).

For the first time since establishing the Europe 2020 poverty target, the number of people at risk of poverty or social exclusion fell – to 113 million people in 2017 – below the pre-crisis level, but far from the targeted reduction of 20 million people. Persistent disparities remain between Member States, and in some countries the proportion of people at risk of poverty and exclusion was higher than in 2008. Also, for some groups the risk of poverty is particularly high – children, people with disabilities and people with a migrant background. Household incomes rose in almost all Member States in 2017, but more slowly than gross domestic product (GDP), so the gains of the economic recovery have reached only some households and only to some extent. Income inequalities declined slightly for the first time since the start of the financial and economic crisis, driven by faster increases in the incomes of lower income households, but only in a few countries and, in the longer term, remain above the pre-crisis level.

Measures to address persistent or deteriorating economic, social and employment problems consistently emphasise the role of social and other public services, but also the striking differences in provision of these services across Member States. This is evident with regard to availability and access to affordable and quality childcare and long-term care services; but there are also considerable variations in the capacities of public employment services between and within countries. Regarding measures to raise employment rates, the *Draft joint employment report* underlines the continuing importance of the active inclusion strategy but acknowledges that considerable scope exists to improve coordination with social services.

The report also urges Member States to ensure access to quality and inclusive education for young people – to help integration into the labour market but also to enable them to become engaged and active citizens, well-integrated into society (European Commission, 2018b). The reduction of poverty and social exclusion among children and other people in vulnerable situations remains a major challenge; again, the key European Semester reports identify priorities to address poverty through the development of adequate work–life balance policies with wider access to affordable childcare and long-term care services – to enable more opportunities for women and men to enter into and to remain in employment. More generally, access to quality public services is emphasised as a key means to address inequalities and the transmission of inequalities across generations, with education, housing, healthcare and childcare highlighted.

Eurofound context

Eurofound's multiannual programme 2017–2020 was framed by the experiences of economic and social dislocation since the financial crisis of 2007. The decade following the crisis was marked by high levels of unemployment, especially among young people, widespread economic and other insecurities, and increasing poverty. Positive developments from 2013 in the economy and in employment were translated slowly and unevenly into social progress and improved living conditions. The identification of priorities for the work programme drew on analyses of socioeconomic and policy developments, but also considered the areas of expertise established in Eurofound over the years.

Eurofound has developed a tool, the EQLS, for the monitoring and analysis of living conditions and quality of life in the EU (Eurofound, 2003). The survey involves asking for the same information in the same way across Member States, so the data are harmonised and fully comparable. The survey was first implemented in 2003, then subsequently in 2007, 2011 and 2016. It involves face-to-face interviews with randomly selected individuals aged 18 and over, living in the community (not in institutions), and provides results which are representative for that population in each of the 28 Member States. The questionnaire aims to capture quality of life in multiple dimensions, such as employment, education, housing, family, social participation, health, subjective well-being and quality of society. It includes both objective indicators and subjective assessments, enabling analysis of reported attitudes and preferences on one side and resources and living conditions on the other. The data enable comparisons of quality of life between different social and economic groups, as well as between Member States. The core questions, asked in each year of the survey, contribute to the monitoring of changes over time, but also to identification of emerging issues.

Fieldwork for the most recent EQLS took place in the last quarter of 2016 and the first months of 2017. The questions on quality of society were increased in this survey, particularly regarding access to and quality of public services. These data are used extensively in the chapters of this publication, but some analyses also figure in existing reports (Eurofound, 2017; 2018a; 2018b; 2019b).

Previous Eurofound research has highlighted that, in addition to individual circumstances and characteristics, the quality of society has a major impact on well-being (Eurofound, 2013; 2017). Declining trust in

society and institutions, societal tensions, economic and social insecurity, perceived inequalities and lack of fairness, are worthy of attention in themselves and also because of their impact on well-being.

Public services are an essential means for achieving high levels of social protection, cohesion and social inclusion. The perceived quality of public services is also a key determinant for the trust people put in governments and for the quality of society (Eurofound, 2013). The organisation of public services must adapt to the needs of ageing and more diverse societies, to the limitations of public budgets, and to the challenges and opportunities inherent in technological change. In addition to analyses from the European Quality of Life Survey 2016 other research has been carried out by Eurofound to give examples of 'what works', particularly integrated approaches and innovative partnerships for providing these services. It is recognised that 'how' services are delivered can profoundly affect their effectiveness.

The focus of Eurofound's work programme has been on those social services that have to respond to changing demography and population characteristics, addressing the needs of older people, migrants, young people or people with disabilities. In a second strand of research, Eurofound has looked at how digitalisation can impact the design and delivery of social services. Again, the focus of this work has been on how new technologies help to meet the needs of specific groups, like older people, especially those with care needs, or young people excluded from employment, or migrants and refugees.

Aims and content of the report

In its multiannual work programme (2017–2020), Eurofound designed a new format and a new series of reports, called 'flagship' publications. This new format is a main output from each 'strategic area of intervention' (SAI) over the programming period. This report from the SAI on 'Quality of Life and Public Services' is the first in the series. It is not intended to cover all the research from the last two years but to focus upon results from work on the theme of 'quality of society' and particularly regarding the role and contribution of (social) public services. In several cases the focus is on addressing the needs of specific groups in vulnerable situations – refugees and asylum-seekers, young people with mental health problems, and dependent older people.

This report draws upon results from recent publications but in all chapters adds new material; some chapters such as those on digitalisation of social services and on access to education are entirely new. The focus is on the results of Eurofound research and main messages for policy audiences. There are not extensive reviews of either the scientific or policy literature. The texts include case studies with brief presentations of good or promising practices. Finally, the different chapters point to emerging issues and potential approaches for research, practice and policy. The aim is to highlight the added value of research based on Eurofound surveys and studies, with commentary linked to current priorities under debate in the EU, such as implementation of the European Pillar of Social Rights.

The report examines developments in the quality of society and access to quality public services from the perspectives of both specific services and particular service users. It looks first at the critical societal context of trust and social cohesion, considering how quality of public services influences people's views on the trustworthiness of institutions. The following chapters explore issues around access to and quality of core services – healthcare, long-term care, childcare and education. These services were investigated in the extended EQLS module in 2016: the results show the diversity of arrangements across Member States with large differences in assessments of quality. The survey findings highlight countries where services appear to be less adequate, but also social inequalities within countries in the services received. One aim of the report is to include promising developments on reaching out to people in vulnerable situations and these are highlighted in the chapters on services for young people and on services to support the integration of refugees and asylum-seekers. Finally, the contribution, or rather the potential, of digitalisation to improve access and quality of social services is presented.

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Eurofound publications are available at www.eurofound.europa.eu

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1 Role of civic participation and public services in promoting trust and social cohesion

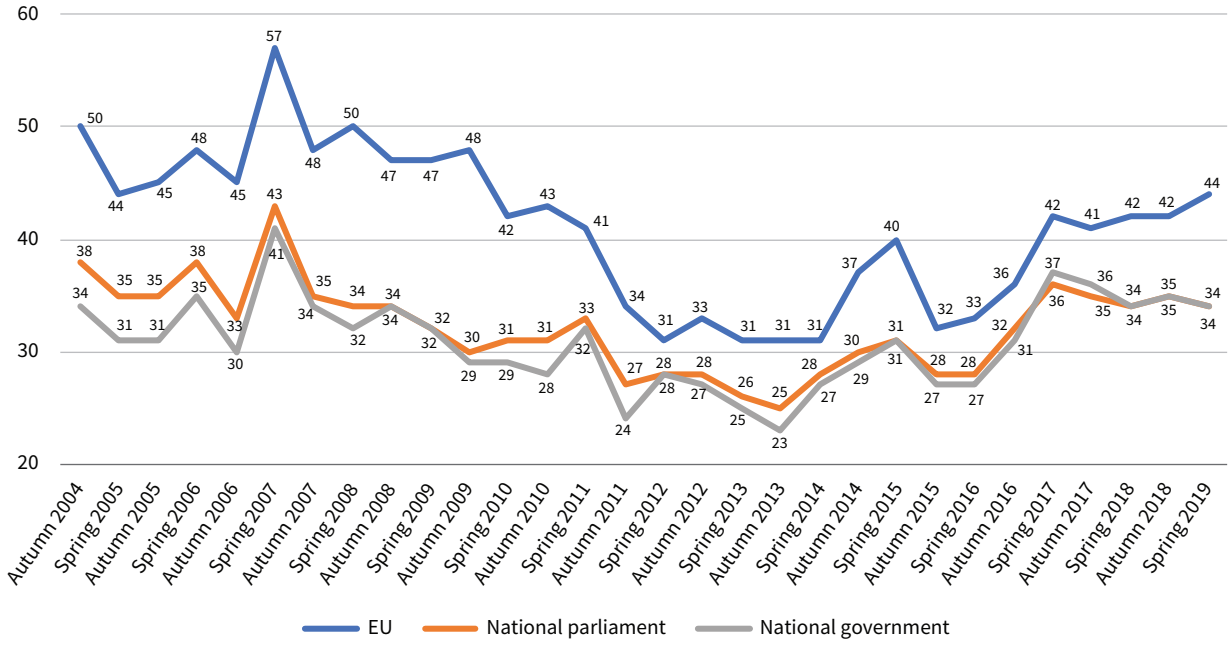
Introduction

Concerns about the quality of society have featured in the policy discourse, not least in international forums, over the last couple of decades and continue to feature prominently. Reflections on the quality of society – as well as its value – have appeared in commentaries on concepts such as social capital and have contributed to studies of civic participation and democratisation; the success of social policies has been evaluated in terms of their impacts on social inclusion and social cohesion; more recently, there has been a re-emergence of interest in institutional trust; and last but not least, a broad discourse has emerged on the need to understand social progress in ways that go 'beyond GDP'.

Several aspects regarding the quality of society have attracted attention in European policy circles in the context of the Great Recession (2008–2013). Aside from the central preoccupation with the urgent challenges of unemployment and public debt, it has been noted that trust in both national institutions and the EU was in decline across the Member States during the crisis. This has prompted the attempts to bring the subject of trust to the attention of policymakers, for instance, during the Dutch and Austrian presidencies of the Council of the European Union (ERCAS, 2015; Council of the European Union, 2018), by the European Commission (2017), and Eurofound (2018d), as well as the Organisation for Economic Co-operation and Development (OECD, 2017a; 2017b).

European Commission President Juncker's call in 2017 to make the most of the economic recovery ('the wind is back in Europe's sails') was made in the context of surveys showing that, over several measures, trust in both the EU and national institutions was increasing (Figure 1). However, this did not dispel concerns: distrust of elites and the polarising discourse of 'populism' were seen as rising in many countries and were increasingly referenced in discussions and forecasts in anticipation of the 2019 elections to the European Parliament (see, for example, Dijkstra et al, 2018).

Figure 1: Trust in the EU and in national institutions (government and parliament), 2001–2018 (%)



Note: *Percentage of respondents in the EU who 'tend to trust' respective institutions.*
Source: *Eurobarometer (European Commission, 2019, p. 5)*

Concern over the potential negative consequences of disenchantment with either national or European politics is a valid reason to examine changes in trust over time and to better understand the locus of societal tensions. However, in order not to succumb to pessimistic generalisations, it is important to be aware of the actual state of social cohesion and, at the same time, to keep promoting a healthy social climate.

This chapter aims to contribute to this by providing an overview of key recent trends in indicators of quality of society in the EU and by presenting findings from survey data that shed light on several factors affecting trust in institutions in particular. In monitoring social cohesion, Eurofound has followed a broad understanding that cohesion refers to quality of society, includes elements at individual, group and societal levels, and manifests itself via the capacity of a society to ensure the well-being of all its members (Eurofound, 2018b).

Several key findings emerge from recent explorations of trust in institutions and studies of anti-EU voting preferences. Some of these do not exactly match the stereotypical concern about the 'crisis of trust' or the presumption that lack of trust in the EU is the key locus of the trust problem.

Is there an ever-deepening crisis of trust in institutions in the EU Member States? Eurofound's (2018d) review of the EQLS data established that, in the EU as a whole, there has been a recovery of trust in national institutions over time. Overall trust in five national institutions (national parliament, national government, legal system, police and news media) in the EU was rated 5.0 on a scale of 1–10 in 2007; this dropped to 4.6 in 2011 but bounced back in 2016 with a rating of 5.1. Establishing that levels of overall trust in institutions have actually, by and large, recovered and even exceeded pre-recession levels is important since it provides evidence to counter the simplified apocalyptic view of a continuous erosion of social cohesion. It has to be acknowledged, though, that while a recovery of trust is seen when examining EU-level averages, certain Member States have specific problems. Thus, it is important to monitor the proportions of people with extreme distrust vis-à-vis institutions and to investigate specific factors at play and specific institutions affected.

Changes in trust with regard to national institutions and the EU follow broadly similar trends (Eurofound, 2018d; Dustman 2017a; also Figure 1), that is, increases or decreases of trust tend to go in parallel for both in most countries. This suggests that it may be difficult to resolve challenges to trust, and to constructively respond to citizens' discontent in Europe by addressing only one type or level of institution. Trust in the EU has remained higher than trust in national governments in most countries before, during and after the Great Recession, including in Member States with the lowest levels of trust in institutions. However, the proportion of those who 'tend not to trust the EU' was approaching half of all citizens in 2018 (European Commission, 2019, p.5).[1]

In a study of the effects of the Great Recession, Algan and colleagues (2017) found that economic disadvantage – in particular, unemployment – damages trust in institutions and contributes to anti-EU and anti-systemic attitudes. However, it has also been shown that support for populist parties is not limited to those who are at an economic disadvantage, and a 'cultural backlash' hypothesis – wherein traditional values and particular rather than universal allegiances are drivers of populist support – has been suggested (Inglehart and Norris, 2016). Recent exploration at regional level found that it is not in the poorest regions but in those with a long-term industrial and economic decline that people tend to vote for anti-EU parties (Dijkstra et al, 2018).

To understand where there are areas for concern from an EU-wide perspective, the next sections examine the key changes in distribution of social cohesion and trust levels across the EU Member States. The review of selected individual-level aspects in relation to social cohesion then follows. Finally, the chapter examines how quality of public services, perceived social insecurity and civic engagement affect overall trust in institutions.

Are EU societies becoming more similar or more diverse over time?

One way to review extensive information about changes across a range of diverse countries, such as in the EU, is by taking on a convergence perspective, which Eurofound has developed into a large monitoring platform.[2] This perspective helps to capture and summarise the extent of country differences. It includes assessing how countries change over time on average, as well as how distributions change, such as how far from or close to the average countries become. It analyses the distributions to establish whether countries become more similar or more diverse over time.

A selection of indicators of quality of society is presented below in a set of graphs covering trust in people, average trust in institutions, perceived social exclusion, perceived religious and racial/ethnic

1 As further illustration, a rise has been documented in the proportion of votes going to the anti-EU parties in national elections in the Members States since 2000 (Dijkstra, 2018, p. 3). However, it has also been noted that, although at times in the past the proportion of anti-EU-party representatives in the European Parliament was as high as that forecast for 2019, those levels subsequently declined (Sandbu, 2019).

2 See EU convergence monitoring hub at https://www.eurofound.europa.eu/data/convergence-hub.

tensions, and political participation and volunteering. These show the data available from the EQLS for all the EU Member States before (2007), during (2011) and after (2016) the Great Recession.[3] While this is admittedly a rather limited series of observations, it covers an important period, and the data cover a range of aspects of social cohesion.

It should be noted that many quality-of-life indicators went through a general pattern of decrease during the crisis and recovery after the recession, though variations exist among countries and for social groups, with some affected more adversely than others. However, with regard to social cohesion at the EU level, a number of aspects are in fact quite stable over time.

For instance, in the case of trust in people, as shown in Figure 2, the EU average did not change much (5.2 in 2007, 5.1 in 2011 and 5.2 again in 2016), half of the 28 Member States are relatively close to the EU average, countries with lowest and highest trust are at similar levels and overall variance of the countries remained similar. In sum, the stability of this aspect of social cohesion can be seen as reassuring, even if the level of trust has ample room to improve as an important element of social capital.

In another example, the overall EU level of perceived social exclusion was not dramatically affected, which is surprising as the crisis and the austerity policies that followed had significant adverse effects on many population groups in Europe: half of the countries with the middle levels of social exclusion have moved in a positive direction (i.e. a decrease in perceived exclusion), and the country at the high extreme of perceived social exclusion in 2016 is in a better position than was the case in 2007. A more concerning finding, however, is that the country with the lowest perceived social exclusion moved in the opposite direction (with a higher index value).[4] (For country-specific information, see Eurofound, 2018b.)

Trust in institutions is one of the indicators of quality of society that deteriorated most during the crisis (see Figure 2). However, as already suggested and not in line with the prevailing negative perspectives, the recovery of this indicator has also been positive: average trust of the EU population in national institutions in 2016 was in fact above the 2007 level; the least trusting country and the most trusting country had higher ratings than was the case before the crisis; and the overall variation has somewhat decreased, suggesting EU countries are less diverse than before. In other words, such a set of characteristics is a feature of positive, though modest, 'upward convergence'. This by no means denies the existing political challenges in national and international settings; however, it suggests that an informed debate on 'trends in trust' should specify in which countries and in what socioeconomic contexts the key challenges lie. (For country trends, see Eurofound, 2018d.)

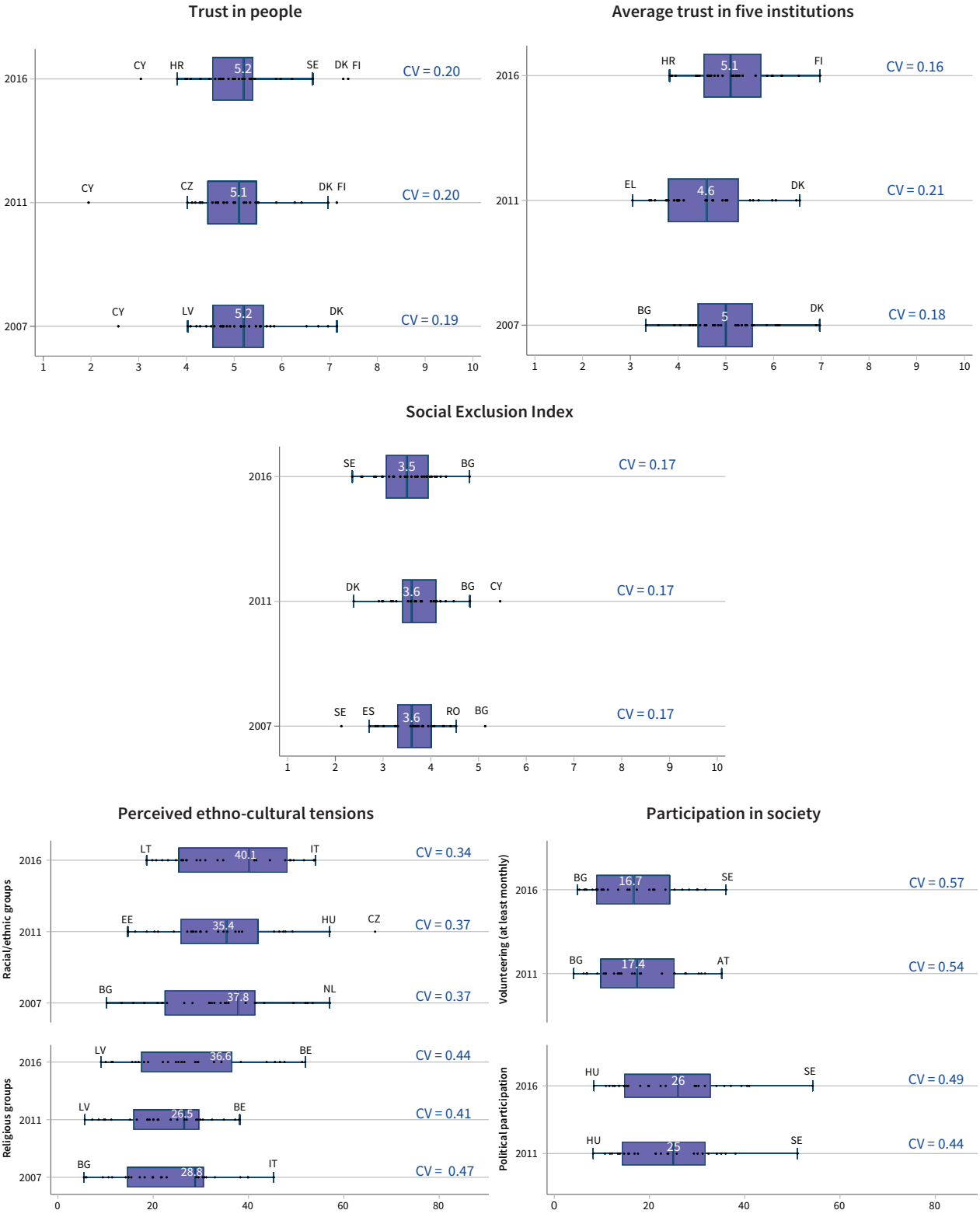
In contrast to the otherwise rather positive recovery of quality of life and quality of society indicators after the recession, there was a rise in perceived ethno-cultural tensions (see Figure 2). To put this in context, tensions between men and women (reported by 9% of the EU population in 2016) and between young and old people (reported by 11%) are at low levels compared to other types of tension. Socioeconomic tensions – such as between rich and poor people and between managers and workers – were high during the crisis, but by 2016 were lower than in 2007. In contrast, although ethno-cultural tensions decreased somewhat during the crisis, the proportion of the EU population reporting 'a lot' of tension between religious groups (37%) and between racial or ethnic groups (40%) in 2016 is higher than it was before the recession, in 2007. The immigration flows of 2014–2015, the continuance of refugee routes on southern EU borders and the experience of recent terrorist attacks can be alluded to as reasons affecting the perception of tensions in the 2016 survey in specific countries, but the broad European picture has also changed (Figure 2). First, the level of tension perceived in the lowest-scoring countries increased. Second, overall variation decreased for perceived tensions between racial or ethnic groups, which indicates that countries are becoming more similar in terms of perceived tensions. Contributing to this is a rise in perceived tensions in the Member States with the largest populations (Eurofound, 2018b). Reported tensions may capture limited tolerance and fear as well as awareness of discrimination, and in both cases, reporting might be affected by media discourse. There are obvious concerns that such undercurrents reflect risks to social cohesion and stability (Eurofound, 2017). Overall, perception of tensions is one of the strongest factors that decreases trust in institutions, which in turn can lead to disengagement and anti-systemic voting.

Addressing tensions may require working on social and economic integration, group relations and the discourse itself. However, unlike the case of socioeconomic tensions, where those in less advantageous social positions report more tensions, perception of ethno-cultural tensions is not strongly differentiated by social background. Relatively small socioeconomic variation in the perception of

3 For 'participation in society' (political participation and volunteering), only data for 2011 and 2016 are available.

4 In pointing out the stability of a number of reviewed indicators at European level, the social challenges in particular countries should not be overlooked; rather, the suggestion is that there might be a valuable 'critical mass' of countries that were able to persevere in the turbulence of the crisis and which might, at the least, provide a basis for cross-country learning.

Figure 2: Selected measures of quality of society across the EU Member States, 2007, 2011 and 2016



Note: *Note that EQLS trend information on types of political participation is limited due to changes in the questions asked to respondents. For all graphs, the coefficient of variation (CV) is based on 28 country-level estimates (mean and standard deviation). In contrast to other graphs, higher values on the Social Exclusion Index signal a negative phenomenon.*
Source: *EQLS 2007, 2011 and 2016*

ethno-cultural tensions makes it more challenging to identify agents and loci for action. Civic society and active citizenship could both provide channels for social integration and nurture skills for resolving the tensions.

However, with regard to civic and community engagement, there has been remarkably little change over recent years. Even though hypotheses have been raised about a long-term trend of declining citizen participation (European Commission, 2017), there is rather little change in the EU if seen in a convergence/divergence perspective (see Figure 2). Comparing data for the average rate of political participation and volunteering in 2011 and 2016 (for which EQLS indicators are available), the levels in the countries with most and least engagement and the overall variation across countries have not changed much. However, incentives to appreciate and improve participation in society are important; these include the positive associations between participation – in particular volunteering – and life satisfaction, a reduced sense of social exclusion and increased trust in institutions (Eurofound, 2017, p. 95).

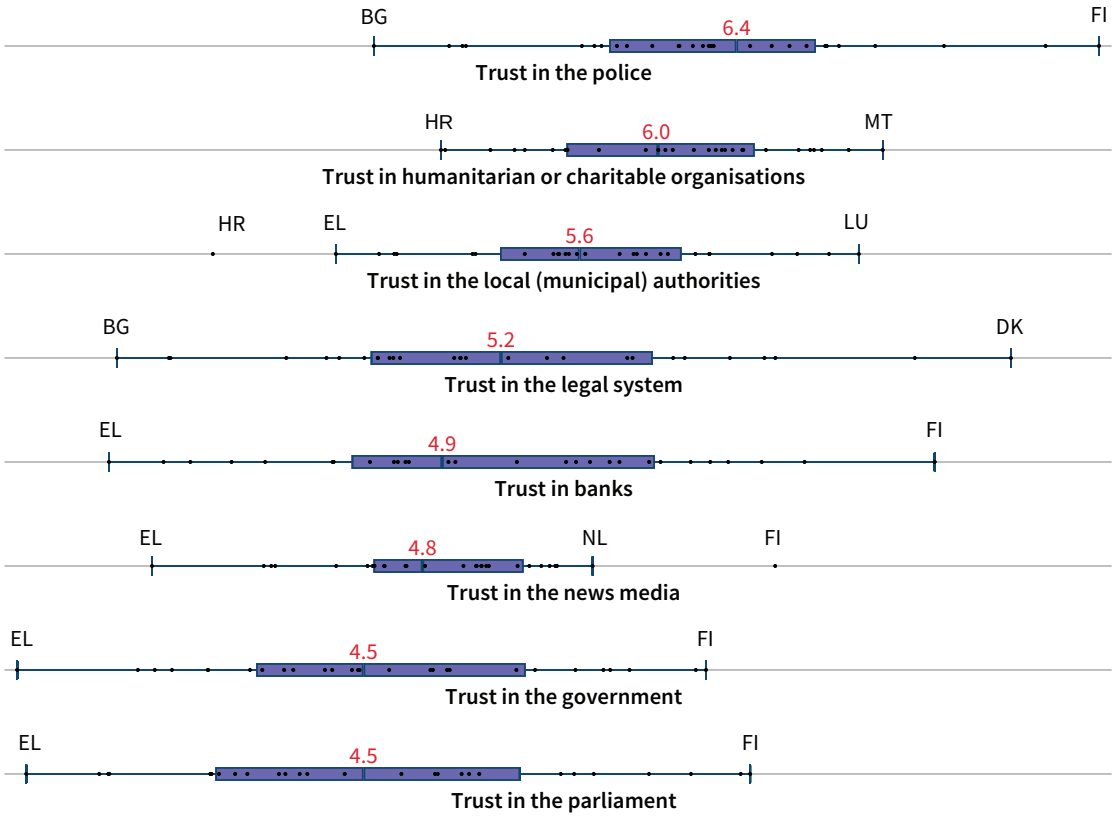
When country differences in trust levels are considered for specific institutions (see Figure 3), the following points stand out: national political institutions are, on average, trusted least, and the police are trusted most; humanitarian or charitable organisations are among the most trusted in most countries, and there is least variation across countries in relation to this type of institution. In relation to quality of democracy, a worrying finding is that of all institutions asked about, trust in the legal system is the most uneven across countries, though it followed a general pattern of returning to pre-crisis levels by 2016. The very uneven levels of confidence in legal systems underlines the EU emphasis on the rule of law as a key criterion of membership and reinforces the need for the rule of law to be taken seriously if it emerges as a subject of dispute by EU institutions vis-à-vis Member States (recently, in the case of Hungary and Poland).

Understanding trust in institutions

Benefits of building trust

One of the predominant concerns about decreasing trust in institutions relates to its consequences for the political landscape: there is a risk that populist and anti-systemic political actors who can build on public discontent may not necessarily be equipped to provide policy solutions. While understandable, this focus on negative consequences somewhat overshadows the potential practical gains from restoring and nurturing trust in institutions that facilitate engagement with, rather than disengagement from, society.

Figure 3: Distribution of trust in various institutions across EU Member States, 2016



Notes: *The scale is from 1 to 10. Ordered by EU population average.*
Source: *EQLS 2016*

There has been considerable recent interest in trust and its role in supporting well-being as well as social and economic progress, and a range of evidence has been reviewed (OECD, 2017b; Algan, 2018; Eurofound, 2018d). The evidence shows that trust in people and trust in institutions are correlated with the well-being of citizens, and trust is generally higher in more advanced and more affluent societies. Trust reflects institutional performance, but it is also an essential precondition for effective governance. Trust in people and in institutions is said to reduce transaction costs – that is, to make cooperation easier – between individuals as well as between individuals and public bodies such as tax or regulatory authorities. A recent finding that illustrates a useful consequence of trust relates to better payment of taxes (a lower gap in VAT payments) among those Member States that enjoy higher trust in institutions (Eurofound, 2018d, p. 41).

As with many elements of quality of society, identifying measures for generating trust that are straightforward and provide quick return on investment is not easy. This is related to the social nature of trust: for trust to grow, it requires broad societal engagement rather than isolated professional activity, and the benefits are diffuse rather than exclusive to those who 'invested' in promoting trust in society.

For these reasons, it may not be evident how particular organisations and institutions could be prompted into trust building. Nevertheless, several approaches can be suggested to help bring the broad concerns about overall trust in society closer to the interests of public service providers and policymakers. Examples of such interests include:

- a greater feeling of physical safety for people (of potential interest to: public safety providers/police; local businesses; public health promoters of walking and exercise)
- more trust in people providing public services (of potential interest to: front-line services; services using information or input by citizens; services seeking higher user satisfaction)
- greater integrity in the provision and use of public services, with less corruption and less free-riding (of potential interest to: governance-intensive services; tax and regulatory authorities)[5]

But what must be addressed in order to gain access to the benefits of trust? The OECD has listed key areas for public institutions to focus on to 'win back' trust: reliability, responsiveness, openness, better regulation, integrity and fairness, and inclusive policymaking.

Eurofound's recent policy pointers place strong emphasis on perceived quality of public services as a key determinant for improving trust in institutions (Eurofound, 2018d). The following sections suggest several other elements relevant to a discussion on measures that can help sustain and nurture trust, drawing attention to the need for a certain level of security for individuals as well as the significance of channels for civic engagement.

Importance of public services for trust in institutions

One of Eurofound's key contributions to research on trust is the inclusion in the EQLS of indicators on the perceived quality of a range of public services. Indicators on trust and confidence in institutions are well-known and widely used in the social sciences, especially in political science. However, research tends to focus on individual social background factors and on macro-level information, and analysis of how socio-political or welfare systems are experienced at an individual level is not always possible.

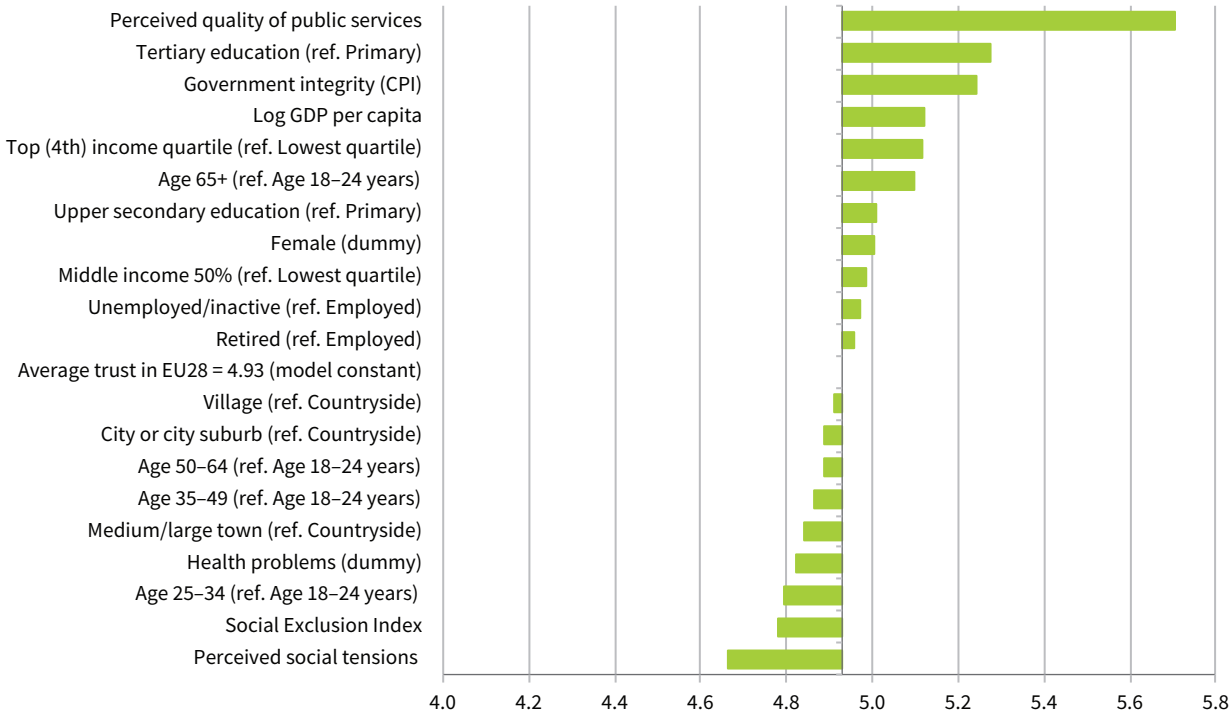
Since being included in analysis of the EQLS in 2011 and 2016 (Eurofound, 2013, 2017), the perceived quality of public services has consistently emerged as the most powerful determinant of trust in national institutions (see Figure 4). In addition, the crucial role of satisfaction with services for trust in institutions has been found in the OECD study of trust in six countries (OECD, 2018), and this is emphasised in the *OECD guidelines on measuring trust* (OECD, 2017a).

Given the strong empirical finding on the key role of quality of public services for trust, several comments can be made.

- In the context of the 'crisis of trust' in time of economic recession, and with disadvantaged groups exhibiting lower trust in national institutions, the importance of how an economy performs comes to the fore. However, the effect of public (social) services on trust seems to exceed the impact of individual socioeconomic background or country GDP. In other words, public services emerge as an important medium through which individuals experience how the economy or state functions (aside from through their own income).
- When considering the services affecting trust (used in this analysis), it is important not to limit these to the administrative functions of the governmental institutions – typically thought of when thinking about 'institutions' – but to include services for health (see Chapter 2) and care (see Chapters 3, 4, 5).

5 For a diverse set of exercises by public bodies that involved trust building, see OECD, 2017b.

Figure 4: Effects of individual- and macro-level factors on overall trust in institutions



Note: *Effect on average trust in five national institutions if the variable is increased by one standard deviation. Pooled data of EQLS 2007–2008, 2011–2012, 2016; EU28. CPI = Corruption Perceptions Index.*
Source: *Eurofound, 2018b, p. 36*

This is in line with the research suggesting a link between a certain level of social protection and satisfaction with democracy (Lühiste, 2014).

- With regard to understanding quality of services, the OECD (2017b, p. 106) has pointed out that:

  Confidence in public institutions is derived from factors beyond the conventional measures of service quality. This suggests that attention should be paid to the 'how' as well as the 'what' of public services. In other words, good policy design and public service improvement may not be sufficient to restore trust if citizens are suspicious of the policy-making process and perceive the distribution of costs and benefits as unfair.

  This observation emphasises that fairness should be part of the considerations when assessing quality of public services, yet also raises questions about mechanisms that can help citizens feel that they or their peers are part of policymaking and implementation.
- High correlation between perceived quality of public services and trust in national institutions suggests a further direction for exploration of indicators. Self-reported trust in institutions – as it appears in the EU-based data – could be: a less complex concept than is sometimes theorised about; more retrospective (based on judgement of what institutions have delivered or how they functioned) than prospective; and linked more closely to some dimensions of institutional performance than others.

Underlying resources for trust: Basic security

There are concerns that uncertainties in life are growing – seen in debates on globalisation, rapid technological change, automation, financialisation and continued challenges to the welfare state and its financial sustainability. Similarly, in societal developments, there are concerns about quality of democracy and political stability as well as situations that fuel and then lead to complex transitions, such as Brexit.

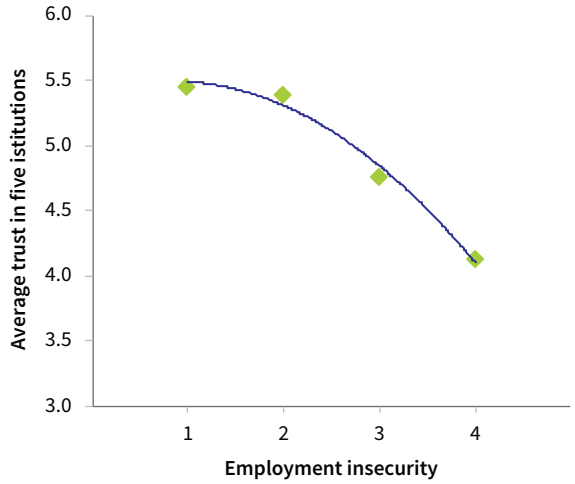
As previously established (Eurofound, 2017, 2018c), people experiencing insecurities have lower trust in government than those who do not feel insecure.

- On average, people who feel unsafe when walking alone after dark rate their trust in government lower (4.0 on a scale from 1 to 10, with 10 representing the highest level of trust) than those who do not (4.5). Trust in the police is also lower in the EU as a whole (and in almost all Member States) among people who feel unsafe when walking alone after dark (6.1 compared to 6.4) and, even more so, among people who feel unsafe when home alone at night (5.9 compared to 6.4).

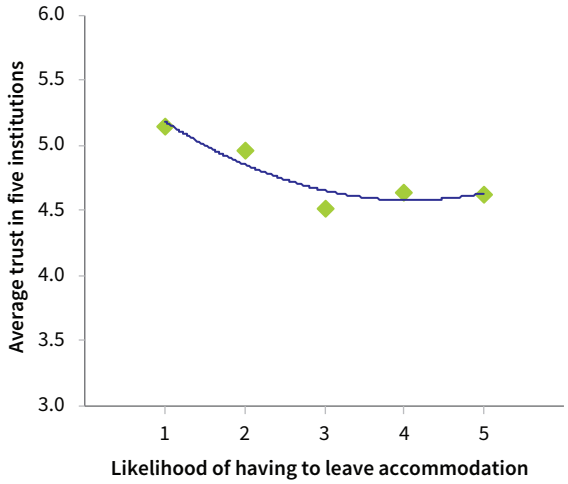
- People experiencing lack of absolute housing security also trust the government less on average (4.2) than those who are not (4.5).
- People experiencing employment insecurity have lower trust in government (3.4) on average than workers who do not think it likely they will lose their jobs and do not envisage problems in finding a new one if they do (4.7).
- People experiencing insecurity about income in old age give a lower rating for trust in government (4.1) than people who are not (5.0). Trust scores range from 3.1 for people who are extremely worried about their income in old age to 5.2 for those who are not worried at all.

Lack of security along different dimensions has a negative relation to trust in an entire set of national institutions (reflecting overall trust in institutions), including political and non-political state institutions as well as the news media (see Figure 5).

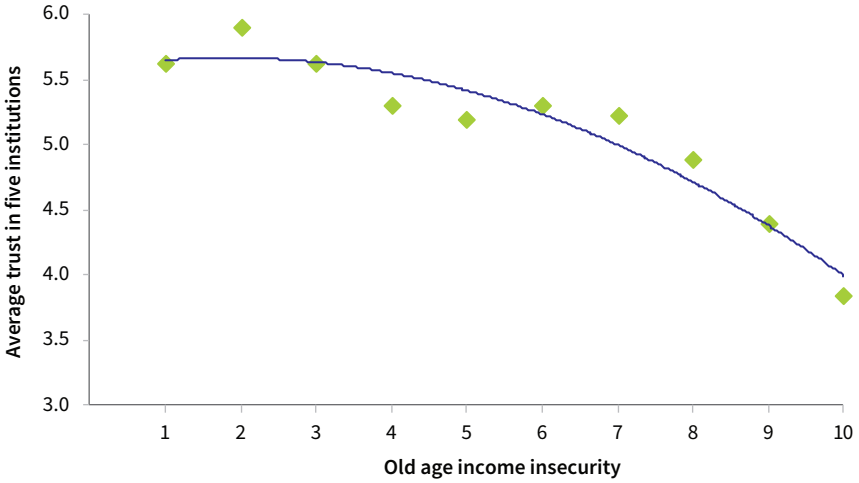
Figure 5: Social insecurities and trust in institutions, 2016



Note: *Trust estimates are shown for the following categories of employment insecurity (based on Q21 and Q22 of the EQLS 2016 and combining the likelihood of losing one's job in the next six months and likelihood of finding a similar one): 1) very unlikely to lose job and very likely to find another one, 2) rather unlikely to lose job and rather likely to find another one, 3) neither likely nor unlikely to lose job or to find another one, 4) very or rather likely to lose job and very or rather unlikely to find a similar one. (Only a subset of data representing the 'purest' variants of employment insecurity are shown; for a crosstabulation of the two variables (likelihood of losing one's job and likelihood of finding a similar one), see Eurofound, 2018c, p. 10).*



Note: *Trust estimates are shown for all the categories of likelihood of having to leave accommodation in the next six months, based on Q26 in the EQLS 2016: 1) very unlikely, 2) rather unlikely, 3) neither likely nor unlikely, 4) rather likely, 5) very likely.*



Notes: *Trust estimates are shown for every category of the scale from 1 (not worried at all) to 10 (extremely worried) that income in old age will not be sufficient (Q41 of the EQLS 2016).*
Average trust in five institutions refers to the following national institutions: parliament, government, legal system, police and news media. Trust is measured on a scale of 1–10. In the graphs, the relationship between two variables is illustrated with the polynomial curve.
Source: *EQLS 2016*

The data seem to support that the relation between trust in institutions and social insecurity is not linear: trust depends on the extent or degree of insecurity one experiences (see Figure 5). For housing insecurity, trust in institutions declines with greater insecurity, but there is a relatively small gap in trust levels between those who report absolute security (overall trust in institutions of 5.2), those with minor uncertainty (5.0) and others who reported lower housing security (4.5–4.7). With employment security, overall trust in institutions drops sharply for those who lack certainty of keeping a current job or finding another if the current one were to be lost (4.1 compared to 4.8 for those neither likely nor unlikely to lose their job or to find another one). A threshold is even more evident in the case of old-age income insecurity: among people who are worried beyond point 7 on a scale of 1 to 10, decline in overall trust is more marked.

High-quality social protection measures (or public services in a broad sense) can have a mitigating effect on overall trust in institutions, as illustrated in Figure 6 in relation to the quality of the pension system. There is a substantial part of the population that has high old-age income insecurity, and as shown in Figure 5, trust in institutions declines when people feel insecure about their income in old age. However, if they consider that the state pension system in their country is of good quality, their overall trust in institutions is considerably higher (see Figure 6; see more in Eurofound, 2018c, pp. 16–17).

It appears that a certain degree of security is critical. This is not to suggest that every uncertainty has to be removed, nor that requests for more security have to be dismissed. By acknowledging that security can be a resource (rather than, for example, merely a cost) for society, the debate on the European social model could be revitalised. It may be that a certain level of security not only contributes to individual well-being but also provides a foundation from which citizens can engage with institutions and participate in civic life. It could also be argued that having a certain level of resources and security makes it palatable (or there are less grounds to fear) to embrace change as well as the risks that could ensue.

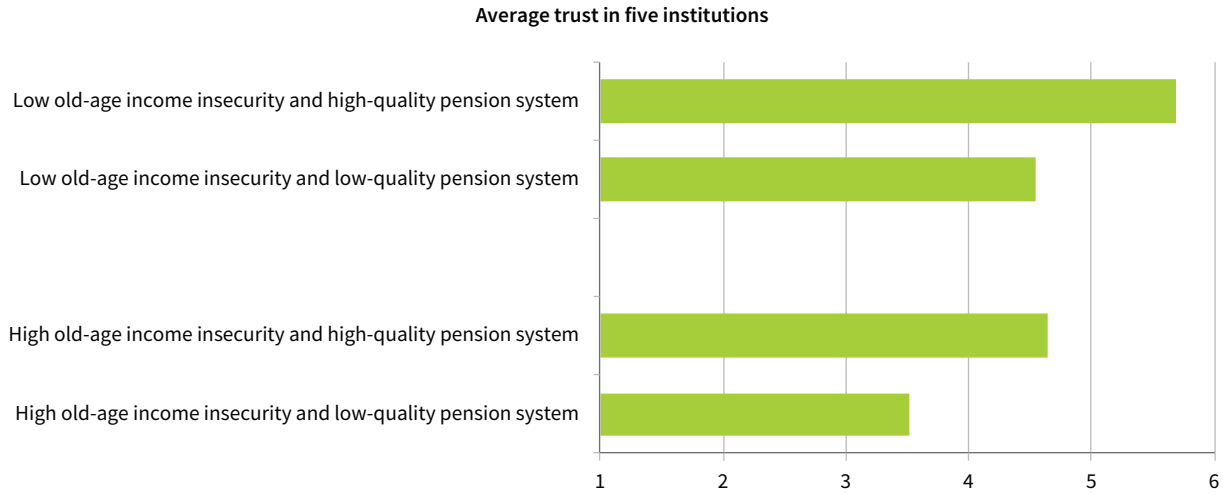
Positive impact of civic participation on sustaining trust

The empirical evidence suggests that participation in civic and social life is associated with higher levels of trust in institutions; the EQLS 2016 provides supporting evidence covering all EU Member States (Eurofound, 2017).

A positive and proactive approach to engaging citizens in consultative processes and deliberations can be seen as part of inclusive policymaking. There are examples of measures designed to promote citizen participation in policymaking: for instance, a programme in the Netherlands to improve citizen engagement in policymaking (OECD, 2017b, p. 30) and instruments such as the citizens' assembly (e.g. Gerwin, 2018). Good governance should be viewed as going beyond the narrow consultation of established stakeholder groups.

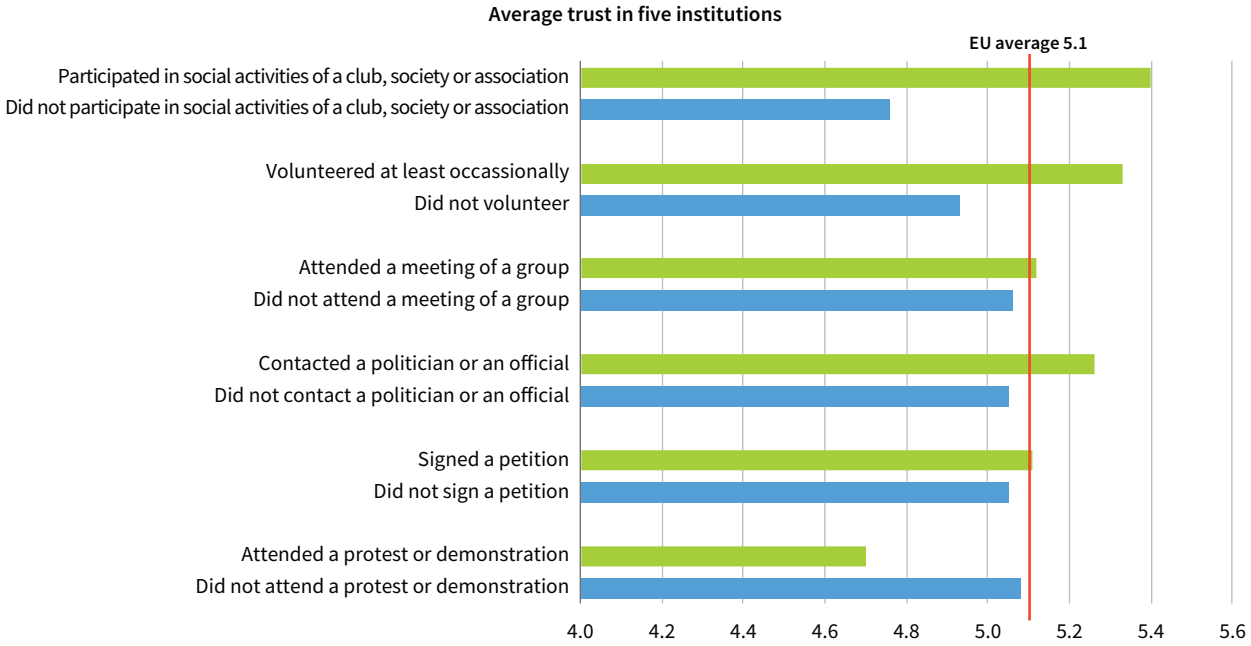
Given the concerns about rising Euroscepticism, especially with the elections to the European Parliament in 2019, some findings of research related to civic participation are of interest. For instance, the European Social Survey has provided evidence that people belonging to associations are less likely to vote

Figure 6: Trust in institutions by level of old-age income insecurity and perceived quality of pension system



Notes: *Average trust in five institutions refers to the following national institutions: parliament, government, legal system, police and news media. Trust in institutions is rated on a scale of 1–10, with 10 being the highest level of trust. Q41 has been dichotomised: Old-age income insecurity is considered high if respondents indicated values 9 or 10 (lower scores represent 'low insecurity'). Similarly, for quality of the state pension system (Q58g), values 1–5 indicate 'low quality' and values 6–10 indicate 'high quality'.*
Source: *EQLS 2016*

Figure 7: Overall trust in institutions by forms of civic or social participation, 2016



Notes: *Average trust in five institutions refers to the following national institutions: parliament, government, legal system, police and news media. Trust in institutions is rated on a scale of 1–10, with 10 being the highest level of trust. EU average = 5.1. Minor differences in the length of bars are not represented in the values shown due to rounding.*
Source: *EQLS 2016*

for populist parties (Boeri et al, 2018). This indicates that participation in civic and social life contributes to overall trust, as well as being a continued resource for maintaining the democratic qualities of society.

It is known that individual characteristics related to personal resources are associated with higher levels of involvement in civic and social life (Eurofound, 2017). People with higher levels of education, those with higher income and those in employment participate at higher rates, which in turn can lead to broader networks, better social connections, better use of public services and higher confidence in taking a stand vis-à-vis institutions if necessary, and in turn higher levels of trust in them. Thus, it may be relevant from the quality of society point of view to consider mechanisms for engaging groups in society that for various reasons may be less active in civic and community life and, hence, also have lower levels of trust in institutions.

EQLS data shed light on how different types of participation are related to trust in national institutions (Figure 7). People participating in clubs and associations have the highest trust advantage compared to those who do not; however, this may be related to the resources mentioned above (engaging with associations is higher among better-resourced people). It could be thought that contacting politicians or officials or attending party or interest group meetings can be mechanisms that bring people closer to engaging with institutions, but the effect on trust in national institutions is not large. Indeed, to understand the relation between participation and trust, different forms of engagement must be distinguished because political and civic activism can be driven both by trust and by distrust. Engaging in protest, for example, is evidently related to low trust in institutions. In addition, the effect of political encounters on trust in national institutions might be limited if most of such meetings are at a local level, with local groups and politicians. Trust in local authorities in the EU tends to be higher than trust in national governments. However, trust in both local and national authorities is higher among people who are satisfied with the quality of public services and those who experience fewer problems in their neighbourhoods (Eurofound, 2018a).

Further analyses confirm that volunteering (even if only occasionally) brings about higher trust in institutions once the effects of socioeconomic characteristics and country differences are taken into account (Table 1). However, there are exceptions to note: for example, in 2016 in Greece, Slovakia and Spain, people who volunteered in fact had lower trust in institutions than those who did not (a difference in overall trust of 0.3, 0.4 and 0.4 points, respectively). This may be related to 'involuntary volunteering' – efforts to help other people by providing assistance expected from the institutions responsible for public services – which can result in greater distrust. In 2011, these countries did not have this sort of 'reverse' pattern. These exceptions can be considered alongside the previous finding that trust in institutions relates to a certain degree of security.

Table 1: Overall trust in institutions with a focus on forms of civic engagement, 2016 (coefficients of regression analysis)

	Ordinary least squares regression coefficients	
Female (ref. male)	0.118***	(0.0291)
Age (Ref. 18–24 years)		
25–34 years	-0.206***	(0.0601)
35–49 years	-0.0782	(0.0521)
50–64 years	-0.0422	(0.0582)
65+ years	0.188***	(0.0631)
Education (Ref. Lower secondary/below)		
Upper secondary	0.0161	(0.0392)
Tertiary	0.254***	(0.0453)
Employment status (Ref. Employed)		
Retired	-0.0883*	(0.0516)
Unemployed/inactive	0.00594	(0.0368)
Income quartiles (Ref. First (bottom) quartile)		
Second quartile	0.0136	(0.0326)
Third quartile	0.0678*	(0.0365)
Fourth quartile	0.107**	(0.0415)
Urbanisation (Ref. Countryside)		
Village	-0.00157	(0.0702)
Medium/large town	-0.0602	(0.0812)
City or city suburb	0.0365	(0.0838)
Health problems (dummy)	-0.111**	(0.0530)
Living alone (dummy)	0.0227	(0.0288)
Perceived quality of public services	0.495***	(0.0161)
Perceived social tensions	-0.136***	(0.0118)
Social Exclusion Index	-0.0840***	(0.00852)
Accommodation insecurity (dummy)	0.0765*	(0.0433)
Old-age income insecurity	-0.0330***	(0.00685)
Safety walking alone after dark (dummy)	0.0643	(0.0387)
Safety at home alone at night (dummy)	-0.106**	(0.0413)
Volunteering (occasionally)	0.132***	(0.0272)
Participation in social activities (dummy)	0.0637	(0.0409)
Attended protest/demonstration (dummy)	-0.134**	(0.0617)
Attended meeting of trade union/political party/political action group (dummy)	0.124**	(0.0462)
Signed a petition (dummy)	-0.0702*	(0.0389)
Contacted a politician/public official (dummy)	0.000669	(0.0466)
Commented on political/social issue online (dummy)	-0.0760*	(0.0429)
Boycotted products (dummy)	-0.0915*	(0.0498)
Constant	3.190***	(0.186)
Country fixed effects	Yes	
Observations	21,264	
R-squared	0.414	

Notes: *Independent variables have been rescaled to 1–10 so that effects can be compared. Clustered standard errors in parentheses. Statistical significance: *** p<0.01, ** p<0.05, * p<0.1. This model follows the one shown in Figure 4 but additionally includes variables on forms of civic engagement. It is limited to individual-level analysis and to the year 2016, since some variables on forms of civic engagement were only available in the EQLS 2016.*
Source: *EQLS 2016, authors' calculations*

How might the benefits of volunteering in terms of overall trust in institutions be maximised? It is known that levels of volunteering differ considerably between Member States, and Eurofound has previously suggested that this may depend on more than civic attitudes, requiring infrastructure as well as support. The evidence above suggests that such support may pay back in terms of building and sustaining a resource of trust.

The role (both positive and negative) of volunteering in sustaining trust also provokes further reflections. On forms of volunteering, for example, a considerable proportion of people who do voluntary work do so via organisations providing community or social services. The input as well as the experience of these engaged citizens could be taken into account when designing and developing the quality of public services, the latter also having been identified as a factor critical for overall trust in institutions.

Conclusions

- There are several key findings from this review of trends in social cohesion and trust in institutions. Contrary to a generalised concern about a 'crisis of trust' in contemporary society and presumptions that the effects of the Great Recession will have a long-lasting effect on European societies, the data suggest that by 2016–2017 trust in national institutions had bounced back to pre-crisis levels. Trend evidence suggests the following observations.
- There has been a pattern of decline and recovery in social cohesion, as well as in quality of life and society more broadly, during and after the crisis. While diversity persisted with little evidence of convergence between Member States during and after the crisis (specifically, 2007, 2011 and 2016) on a number of social cohesion indicators, the relative stability of trust in people, the stability or decline in levels of perceived social exclusion and the recovery of overall trust in institutions can be seen as reassuring in terms of the core qualities of the European social model.
- However, this recovery of trust and certain measures of social cohesion to pre-crisis levels is not a reason for complacency: on average, only around 30% of citizens trust national political institutions and around 40% trust the EU, and the proportion of those who tend not to trust these institutions has grown since the early 2000s.
- Moreover, recovery in trust and social cohesion does not apply to all Member States, and therefore particular national contexts should be taken into consideration when searching for general trends.
- The prevailing pattern across most Member States is for trust in the EU to be higher than trust in national political institutions, and this should also be kept in mind when seeking to address problems with trust in institutions. Along with improving the democratic qualities of the EU's functioning, the performance of national institutions should be directly addressed.
- However, caution has to be applied when interpreting the survey findings on trust. In particular, the recovery of trust and social cohesion (or lack thereof) after the recession in the EU cannot be used to make direct inferences about potential electoral outcomes. The voting activity of people with various attitudes to and experiences of social cohesion may differ, so low-trusting and high-trusting people may show different levels of engagement in voting, and the extent of their electoral representation could also differ. Regional differences and features of the various electoral systems may also have an effect on political representation of differing groups and views in society.
- In contrast to the otherwise positive recovery of quality of life and quality of society after the crisis, perception of certain societal tensions increased. Perceptions of ethno-cultural tensions, referring to tensions between ethnic/racial groups and between religious groups, are higher than before on average, and the Member States have become more similar in this regard than they were in the past.
- Perception of tensions in society has the most detrimental impact on trust in institutions, while perceived quality of public services is a key driver for higher trust in institutions.
- The EQLS extends the evidence of the positive impact of civic participation on sustaining trust. In particular, volunteering, even if only occasionally, is associated with higher levels of trust.
- Survey findings also suggest that a certain level of perceived security is an essential factor for trust in institutions. People below certain thresholds of perceived security in terms of housing, employment or old-age income have considerably lower trust in institutions than people with higher levels of certainty.

Policy pointers

The following points provide a basis for further reflection and action.

- The evidence provides reasons to reconsider the role of insecurities and to seek to understand resilience in the context of social cohesion. The negative impact of disadvantage and high insecurity on trust in institutions was already known. However, the existence of a threshold of security that makes a substantial difference to trust in institutions suggests that security can be seen as a resource worth investing in.
- Public services emerge as an important medium through which trust in institutions is shaped. This invites reflection on how engaging with public services can be utilised as a form of participation in state and society and viewed as more than a simple transaction. Public services could be developed with a participation perspective in mind, exploring the potential of co-design and co-delivery of key social as well as local services.
- There is a relatively small variation across social backgrounds in perceptions of ethno-cultural tensions (compared to differences in perception of socioeconomic tensions). This makes targeting the groups with concerns less straightforward and suggests that a broad approach is needed in the long term to address societal concerns in this area.
- Active citizenship could be considered for nurturing skills and for creating channels for interaction between members of society with various backgrounds as well as for maximising opportunities for the necessary maintenance of contacts. Networks and mechanisms for developing and practising skills of engaging with other people and with institutions might be the social capital needed for successfully dealing with current problems, including social exclusion.
- For civic participation to work, addressing civic culture and individual attitudes may not suffice. Development of and support for volunteering infrastructure is important. If adequately appreciated, civic engagement could provide a mechanism that sustains overall trust in institutions as well as contributing to the design and delivery of public services.

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2 Healthcare services: Access and quality

Introduction

The European Commission and European Council's Joint Employment Report (2018a) notes that, as the EU population ages, demands for healthcare are growing and needs are changing. It sets as a guiding principle for Member States that access to quality healthcare and its effectiveness should be improved. The 2017 European Pillar of Social Rights calls for universal access to high-quality healthcare. In particular, it emphasises the importance of preventive healthcare. Access to quality healthcare and preventive care play important roles in reducing health inequalities (European Commission, 2014).

The Annual Growth Survey (AGS) is the first step in the European Semester process leading to annual country-specific recommendations (CSRs) by the European Commission to the Member States. The most recent AGS (European Commission, 2018b) emphasises the importance of good access to quality healthcare services for social inclusion, as well as the need for sustainability of these services in the context of an ageing population. It also calls for a greater focus on prevention. However, the Communication on the CSRs for 2019 (European Commission, 2019) reflects concern that progress has been slow in implementing CSRs in some areas, notably health and long-term care. The 2019 CSRs include recommendations to improve effectiveness, accessibility and sustainability of healthcare for more than half of the Member States.

There is great diversity in healthcare systems across the EU. The focus in this chapter is on messages that apply across these diverse systems, drawing on previous Eurofound findings and complemented by new analysis and discussion. The chapter is structured under general headings of access, quality, prevention, sustainability and improving survey data for policymakers. After some general coverage of these broad themes, sections focus on specific issues emerging from Eurofound's research that have received less attention elsewhere.

Access

More than 8 out of 10 (82%) people in the EU reported using healthcare services in 2016, ranging from 45% in Romania to 96% in Luxembourg (EU-SILC 2016). EQLS data indicate that even if individual respondents had not used healthcare services themselves, it is likely that someone else in their household had: about half of those who did not use primary, hospital or specialist healthcare services themselves in 2016 reported that someone else in their household had done so. EQLS data further reveal that this contact with healthcare services mainly involves primary healthcare and that most people are highly satisfied with this type of service (Eurofound, 2017a). On a scale from 1 to 10, 73% of people in the EU rated primary care services at 7 or above, and 54% rated these services at 8 or above.

Still, many people face access problems. Often these are financial. A spectrum of issues has been reported: not attending healthcare because of inability to pay; postponing care for financial reasons; finding it difficult to access care because of cost; and expecting difficulties if care should be needed (Eurofound, 2019). But difficulties with access to care go beyond financial problems alone (Eurofound, 2013). There may be physical barriers due to distance from the service provider, reachability of the provider or accessibility of the venue. Barriers may also relate to lack of timely access due to waiting times for appointments and referrals, waiting periods at the location of the healthcare provider and opening hours of the service. Here the focus is on 'informed access': how far the integration and clarity of the system facilitates prompt access to the most appropriate services. Subsequently, a group in a vulnerable situation is highlighted: people who are in the 'twilight zone'.

Ensuring prompt access to the right services

Timely access to good-quality services can prevent people from attending care that is more expensive and less appropriate. However, case studies in Portugal show that sometimes people attend primary healthcare services because they experience poverty and seek support (Eurofound, 2014). Social isolation or lack of access to home care or help at home can also cause people to turn to primary care even when their needs may be better addressed by other services. Another example concerns reports from across the EU of people with debt problems attending mental healthcare services because they lacked access to debt advisory services or debt settlement procedures which could address their situations on a more structural level (Eurofound, 2012). Similar mismatches can be identified within the healthcare system itself. For instance, where primary care is less accessible, people have turned to emergency care for entry into the healthcare system, because co-payments are lower or less likely to be enforced, or opening hours are better (Eurofound, 2014).

The European Commission's AGS underlines the need to integrate primary, specialist and hospital care (European Commission, 2018b). It also promotes integration beyond the healthcare sector, specifically with social care. Eurofound's case studies provide specific examples of how such integration can be achieved. For instance, better information mechanisms were established in the case studies mentioned above. Box 3 in the next chapter also provides an example of reducing demand for hospital beds through better triage and GP (general practitioner) visits to nursing homes. Eurofound (2014) includes another example in which a primary care centre was located on the grounds of a Swedish hospital to increase trust in primary care, as it was seen that people attended hospital emergency care because of their higher trust in hospital services than primary care. Sweden (with Finland) are the exceptions in the EU, where the average perceived quality of hospital care is higher than that of primary care (Eurofound, 2019).

Improving the ease of navigating the care system

Healthcare systems can be hard to navigate. The European Commission (2014) emphasises that 'patients may find healthcare more difficult to access if health systems are complex and lack transparency' (p. 8). Such complexities can prevent people from getting the care they need, and they can lead to a sense of unfairness when some people find their way to entitlements, while others do not. Effective navigation through the benefit and care systems depends partly on the information people receive from their social networks. Thus, attention should be paid to people who lack social support (Eurofound, 2015).

A policy priority should be to make care systems less complex, more transparent, more proactive and better integrated. If people face complex application procedures in order to receive their entitlements, then information and support needs to be provided to mitigate this. However, it is more efficient to prevent such obstacles in the first place. Information and communications technology (ICT) can play an important role here (see, for instance, the case study in Box 1). Still, caution is required to ensure that the drive to reduce complexity does not lead to adjustment of entitlement criteria based on clarity rather than the reflection of real needs (Eurofound, 2015).

Simplification of systems or of information provision usually requires upfront investment, so it is

Box 1: Automated system for increased medical reimbursement

What? Databases linked (within privacy constraints) in order to proactively contact potential cases of non-take-up of increased reimbursement of healthcare expenditure

Where? Belgium

When? Automated pilot conducted between 2015 and 2017

By whom? Cooperation between the tax office, the National Institute for Health and Disability Insurance (RIZIV/INAMI) and health insurance funds.

Belgium has a healthcare system based on social insurance whereby patients generally pay upfront and are then partly reimbursed.

In January 2014, different ways of obtaining increased reimbursement for medical costs were integrated into a single measure: *verhoogde tegemoetkoming/intervention majorée* (increased reimbursement). Besides the automatic attribution based on a social benefit or a particular status, a proactive procedure based on means testing was implemented.

One complication for data linkage was that the tax authorities are not authorised to share data with non-public organisations like the health insurance funds. The following mechanism was developed to deal with this: the health insurance funds shared with the RIZIV/INAMI the names of people who did not take up increased reimbursement. The RIZIV/INAMI then passed these names to the tax authorities. The tax authorities in turn shared with the RIZIV/INAMI the information they had available. The RIZIV/INAMI then provided the health insurance funds with a code indicating whether the person's income was likely to fall below the maximum threshold for increased reimbursement. It was then up to the health insurance funds to decide, based on the code and their own data, whether they should contact the person concerned. This person still needed to complete a signed declaration to obtain the increased reimbursement. Besides identifying non-take-up, the automated system was also used to assess whether people who received increased reimbursement were still entitled after one year.

The procedure could be repeated on an ad hoc basis or systematically. Tentative evidence suggests that it reduced non-take-up (Van Gestel et al, 2017).

Source: Updated from Eurofound, 2015

understandable if governments have not prioritised this in the context of limited budgets. Support for people to navigate healthcare systems was cut in some countries during the financial crisis, without necessarily having made the systems easier to navigate. For instance, governments in Portugal and Slovenia cut support by social workers, part of whose role is to facilitate access to healthcare (Eurofound, 2014).

Groups in vulnerable situations: The twilight zone

There is profound debate around social inequalities in health and in access to care. One vulnerable group that emerged from Eurofound's (2014) research has not received much attention: people in the twilight zone – those with incomes above the threshold that would entitle them to state support but which do not enable them to easily pay for care themselves. This group is diverse, both within and across countries. It includes people who do not qualify for waivers of co-payments or for support to purchase complementary or basic insurance that improve access to good-quality care. Recent research confirms that the vulnerability of this group persists even though economies have largely recovered from the crisis in terms of GDP (Forster et al, 2018).

In general, people in the bottom (first) income quartile are more likely to report difficulties due to cost of accessing primary care services (21%) than those with higher incomes. However, some countries stand out, with people in higher income quartiles reporting problems with cost of access as often (or even more often) than those in the bottom income quartile. In some countries, the second income quartile is most affected (Croatia, Greece, Italy and the UK); but in others, it is the upper half of the income distribution (Austria, Cyprus, Ireland, Poland and Romania) who are more likely to report access problems due to cost. These groups may not earn enough to easily access the primary care they need (due to formal or informal fees) and may not be entitled to benefits.

Quality

Quality of healthcare has many dimensions. Eurofound's recent research has focused on user views on quality (Eurofound, 2017a). Here, two aspects of user views are highlighted: firstly, satisfaction with being informed about the care received and secondly, perception of unfairness in relation to care. The former received the lowest average ratings of all the aspects of satisfaction covered by the EQLS. The latter is highlighted because perceptions of unfairness seem to relate strongly to low overall ratings of health services (Eurofound, 2019) and seem under-explored.

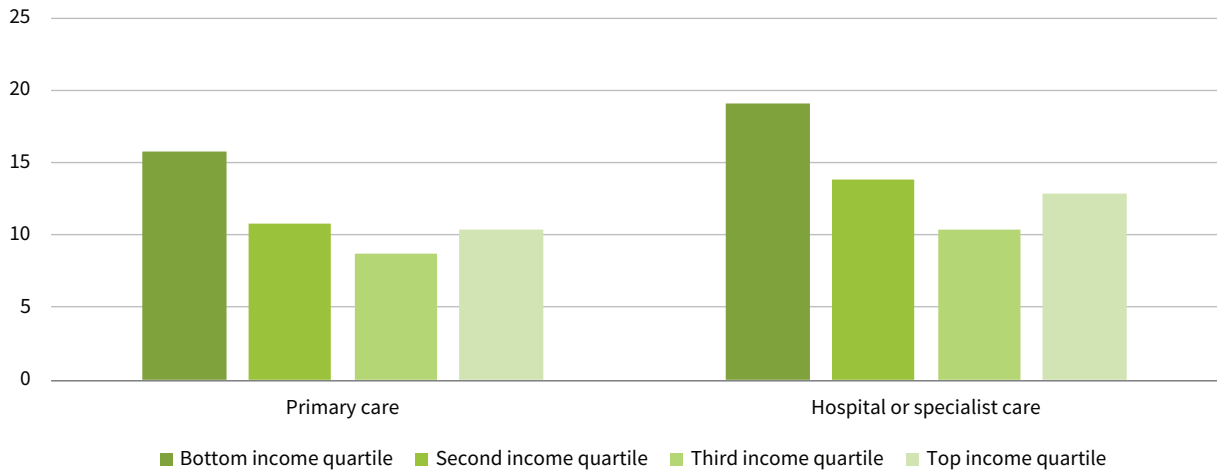
Informing users about their care

EQLS data shed light from a user perspective on potential improvements to care provision. When healthcare users are asked about their satisfaction with different items, all items get quite high average scores. The best scores are given to the 'harder' aspects of quality such as quality of the facilities and expertise of staff. Users give lower scores to the personal attention they were given and – in particular – to being informed or consulted about their care (Eurofound, 2017a).

The average rating given by users of primary care in the EU regarding satisfaction with being informed or consulted about their care is 7.8 on a scale from 1 to 10 (10 being the highest score). Users of hospital or specialist care give an average rating of 7.6 for this aspect of care. Not only are these scores lower than those for the other satisfaction items, but they are also ratings affected by the respondent's income. This is slightly more marked for scores relating to hospital or specialist care, with users in the top income half rating this indicator on average at 7.8, while those in the bottom half give a rating of 7.5. Users of primary care who are in the top income half rate it at 7.9 and those in the bottom half, 7.7.

These averages conceal the fact that a considerable proportion of people are dissatisfied with this aspect of their care. Almost one-fifth (19%) of people in the bottom income quartile who themselves used hospital or specialist care in 2016 rated their satisfaction with 'being informed or consulted about your care' at 5 or lower – that is, they were dissatisfied (see Figure 8). This compares to 10–14% in the higher income quartiles. A smaller proportion indicated they were dissatisfied with primary care, but still 16% of users in the lowest income quartile gave a rating of 5 or lower (9–11% in higher quartiles). People in the top (4th) income quartile are more likely to be dissatisfied than those in the third quartile, likely due to higher expectations, but the bottom income quartile clearly stands out in terms of low ratings both for primary care and hospital or specialist care.

Figure 8: Dissatisfaction with being informed or consulted about care (primary or hospital/specialist) by income quartile, 2016 (%)



Notes: *'Dissatisfied' refers to people who rated their satisfaction 5 or below in the following questions. Q62: 'You mentioned that you used GP, family doctor or health centre services.' Q64: 'You mentioned that you used hospital or medical specialist services.' Both questions then read: 'On a scale of 1 to 10 where 1 means very dissatisfied and 10 means very satisfied, tell me how satisfied or dissatisfied you were with each of the following aspects the last time that you used the service' and 'd. Being informed or consulted about your care'.*
Source: *EQLS 2016*

Addressing unfairness

In the EU, 22% and 18% of people disagree (i.e. give a score of 1 to 5 out of 10) with the statement 'All people are treated equally in these services in my area' for hospital or specialist care and primary care, respectively. Slightly lower proportions agree (i.e. give a score of 6 to 10 out of 10) with the statement 'Corruption is common in these services in my area': 20% for hospital or specialist care and 17% for primary care.

Thirty-nine per cent of people in the EU report at least one of these types of unfairness. The proportion is higher among people who report difficulties in accessing healthcare than it is for those who do not: 51% vs 25%. Perceptions of unfairness in healthcare are higher in urban than in rural areas, but differ more with income in rural areas (Eurofound, 2019).

In Denmark, Finland, the Netherlands, Spain and Sweden, a quarter of the population or less report for at least one of these types of unfairness. At the other end of the scale, for Croatia, Cyprus, Greece, Hungary and Romania, proportions are 65% or above.

These overall rankings conceal different patterns. For instance, in Austria and Hungary, unequal treatment is near the EU average for primary care; the problem lies in perceived unequal treatment (Austria) or corruption (Hungary) in hospital or specialist care. This concurs with recent high-profile corruption cases in hospitals in Hungary and a 2016 protest by healthcare workers against such corruption. For Austria, an explanation may be that it appears to be particularly common for patients to be asked to go for a private consultation when treated in a public hospital (European Commission, 2017). In Bulgaria and Italy, perceived unequal treatment for both hospital or specialist care and primary care is below the EU average. There is a problem, however, in relation to corruption. For some countries (most notably Spain), perceptions of corruption are particularly low in healthcare compared to other sectors (Eurofound, 2019).

Prevention

Prevention is key to maintaining high levels of mental and physical well-being effectively and efficiently. Despite this, only small fractions of healthcare budgets are dedicated to prevention, and levels of political attention and stakeholder engagement are low in this area (European Commission, 2017; OECD and European Commission, 2018). Smoking, alcohol consumption and obesity are important health risk factors and often the focus of calls for prevention, with a key role for changing individual behaviour. Policymakers have many preventive measures at their disposal to effectively tackle these issues and others, such as promotional tools incentivising healthy lifestyles, vaccinations and screening programmes, as well as measures in a range of other policy areas, including education, sports, urban planning, marketing and taxation (European Commission, 2017). Prompt access to primary care is key to addressing healthcare issues as early as possible.

The environments in which people work and live also play an important role in prevention (Eurofound, 2017b). These are not easily changed. Individuals with limited financial resources cannot readily change jobs or move. This serves to amplify inequalities. Two environmental factors were the subjects of recent research by Eurofound but have received relatively little attention: housing and the local area.

- Good-quality housing can play a part in prevention of mental and physical healthcare needs. Examples include absence of mould and humidity preventing or containing respiratory diseases, appropriate surfaces preventing falls, adequate insulation and heating or cooling systems preventing heat- or cold-related illnesses, sufficient space contributing to reducing social tensions and absence of specific hazards to health (e.g. radon gas, lead in drinking water). Eurofound (2016) estimates the healthcare costs of inadequate housing and presents case studies of policy measures to address these.
- Good-quality local areas can contribute to better physical and mental health; for instance, by offering good air quality, absence of problems with noise and high social cohesion. Eurofound (2018a) provides an overview of studies that have estimated the healthcare cost of such issues and includes illustrations of policies to address them. Physical activity is particularly effective in promoting health and can be built into common routines such as commuting to work or school, visiting friends or shopping (Box 2). Local areas should thus be designed to make walking, cycling and public transport use as convenient as possible (Patterson et al, 2018). Policies that aim to stimulate physical activity may be futile in areas where such conditions are absent. Furthermore, physical activity may only have limited positive impact on health where pollution is high and traffic unsafe.

Box 2: User-input app to encourage regular physical activity among children

What? User-input app for children to encourage cycling, walking and use of public transport to get to and from school

Where? Oslo, Norway

When? Launched in February 2015

By whom? Agency of Urban Environment (*Bymiljøetaten*), Norwegian Centre for Transport Research (who developed questions for the app), Norwegian Research Council and Cap Gemini (who developed the app)

The Norwegian National Transport Plan states that increases in demand for transport should be served by pedestrian movement, cycling or public transport use, not car use. To facilitate non-car travel for children going to and from schools, the Agency of Urban Environment was given the task of mapping the need for traffic security measures along Oslo's school cycling and pedestrian routes. The Agency found that this required assessment of all roads and introduced a bottom-up approach whereby children report areas for improvement through the 'Traffic Agent' app.

The app has the appeal of a game, giving schoolchildren the role of 'secret agents'. It pins children's advice for improvements on an electronic map. This advice is checked every morning, and the aim is to address straightforward issues (slippery roads, dense vegetation, incorrectly parked cars) immediately. As one example of action taken, when several students reported that they felt safer walking through privately owned land on part of their journey to school, the municipality agreed with the owner of the land that it would maintain the area in exchange for permission to build a crossing and a path with a handrail. A pavement was built on a narrow hill where cars tended to speed up and walking and cycling were difficult.

The app also asks for feedback to assess what works. Feedback is further used for planning in relation to location and needs of new schools and for determining catchment areas of schools. By April 2019, four other Norwegian municipalities had adopted the app.

Source: Updated from Eurofound, 2018a

Sustainability

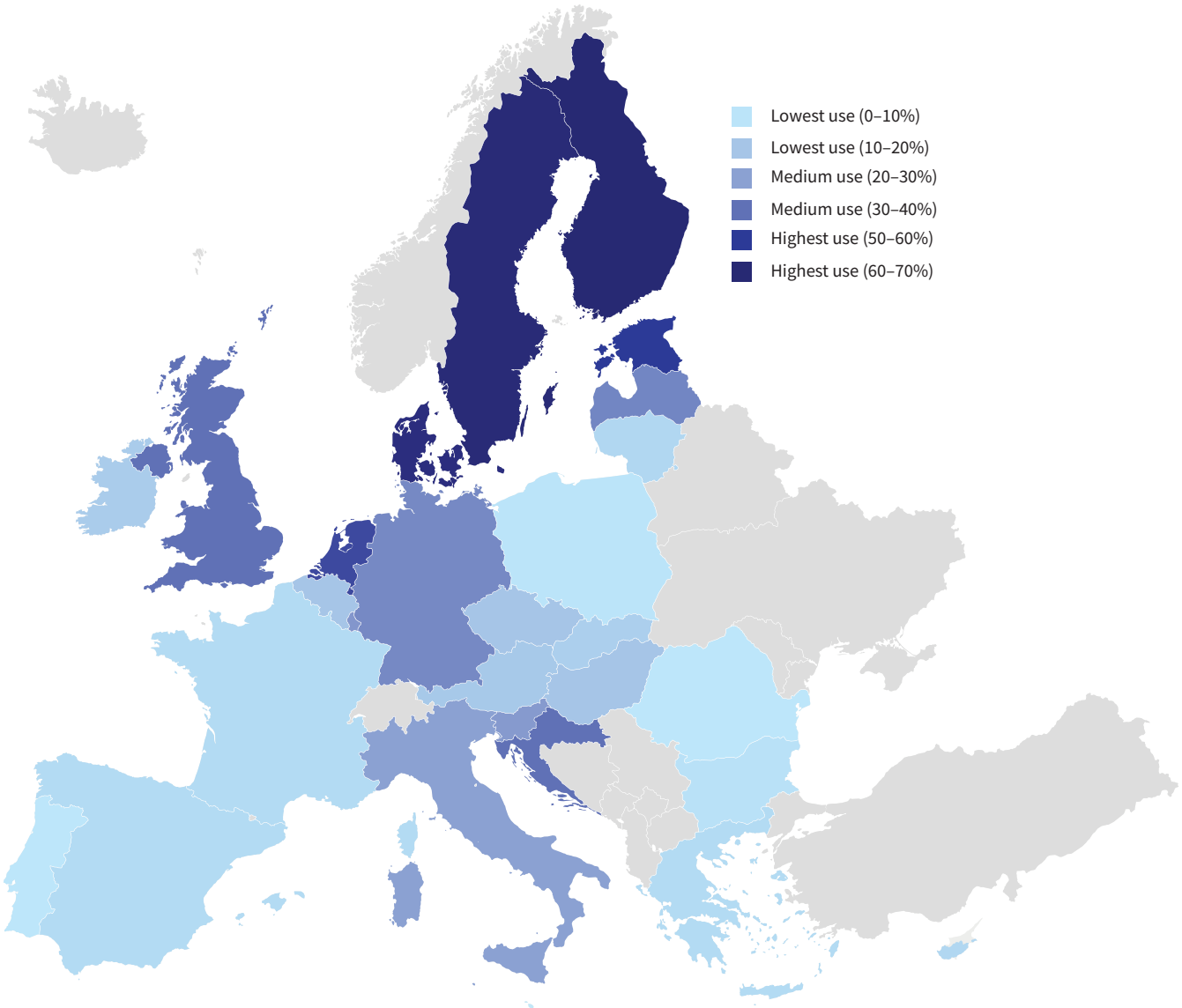
Effective prevention can reduce the need for services and, as a result, contribute to financial sustainability of the care system. However, given that there is a certain level of demand for services, there are measures that can be applied in care provision which have the potential to increase sustainability while also improving access and quality. One example is the use of e-healthcare (Vriezinga et al, 2018). This can reduce pressures on the system, freeing up staff time so that attention can be directed to people who need support.

In its 2018 *Communication on enabling the digital transformation of health and care in the Digital Single Market; empowering citizens and building a healthier society*, the European Commission notes that:

> *The uptake of digital solutions for health and care remains slow and varies greatly across Member States and regions. Further action at EU level is crucial to accelerate the meaningful use of digital solutions in public health and healthcare in Europe. (p. 3)*

ICT is a common resource for people in the EU for information on health and healthcare. However, when it comes to patients using ICT in their contact with healthcare providers – that is, while in receipt of care – half of the Member States have a particularly long way to go to reach the level of those where this is most common (Figure 9). Overall, e-prescriptions, ordered

Figure 9: E-healthcare use in the EU by country, 2016



Notes: *Includes those who responded 'yes' (for themselves) to the following questions. Q60: 'Have you or someone else in your household used any of the following services in the last 12 months?', 'd. Ordering prescriptions online or by telephone' and 'e. Medical consultation online or by telephone'. Includes those who responded that they have used any or both these services themselves.*
Source: *EQLS 2016*

online or by telephone, are more common than e-consultations. E-consultations mainly seem to follow visits to a doctor rather than replacing them (Eurofound, 2017a, 2019).

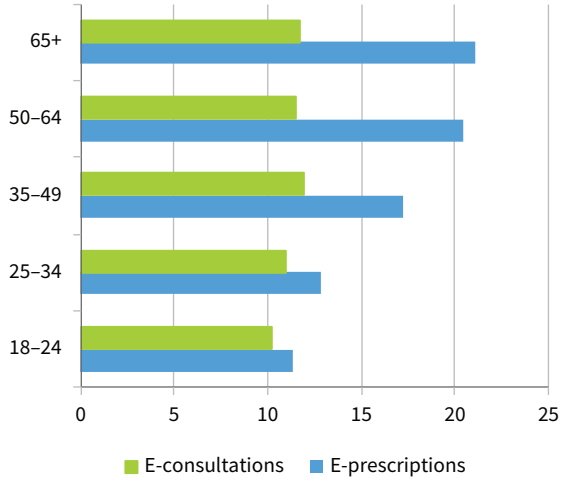
The EQLS data have limitations. For instance, it is not possible to identify which modes of e-healthcare are included by respondents when answering questions in the EQLS. When considering whether they used e-prescriptions, people may have included ordering medicines on the internet, especially in countries where more people are unfamiliar with e-prescriptions. This may explain, for instance, why 29% of people in Germany reported use of e-prescriptions – well above the EU average – whereas use of e-consultations is relatively low at 12%. Also, in relation to e-consultations, the data do not differentiate between online and telephone contact. Despite these limitations, EQLS data give a general impression of the extent to which ICT has made its way into people's use of healthcare services and reveal differences between population groups beyond the country level (Eurofound, 2017a).

A key function of e-healthcare involves improving access to services and aspects of quality of care for people in rural areas. EQLS data suggest that e-healthcare is more often used by people living in cities or city suburbs: 19% ordered an e-prescription and 13% had an e-consultation in the last year, compared to 17% and 11% of those in less urban areas. However, this difference applies to the group of low-use countries but not to the high-use countries (Eurofound, 2019). This suggests that only when e-healthcare becomes more common overall does it start reaching people in rural areas.

The EU Disability Strategy promotes the potential of online medical consultations for people with disabilities. Analysis of EQLS data has shown that use of online or telephone prescriptions is significantly more common among people of working age with disabilities (Eurofound, 2018b).[6] Overall, people in the EU who have a disability are more likely to have used e-healthcare (28% compared to 13% of those who do not have a disability). This holds even after controlling for factors including health status.

Of course, users must have ICT skills in order to benefit from e-healthcare. If the forms of e-healthcare addressed in the EQLS replace rather than complement other modes of service provision, there are likely to be negative consequences for access by groups in vulnerable situations. Lack of ICT skills is often associated with older people, but this is not reflected in the use of e-prescriptions and e-consultations (Figure 10). Among people aged 75+, 23% report e-healthcare use in 2016 and this proportion was 25% among people aged 65-74. Still, lack of ICT literacy must be taken into consideration, and as already noted, the data presented here do not distinguish the precise modes of e-consultations and e-medicine, nor whether users are satisfied with it. That said, e-healthcare is already used by many older people.

Figure 10: E-healthcare use by age group, 2016 (%)



Notes: *Includes those who responded 'yes' (for themselves) to the following questions. Q60: 'Have you or someone else in your household used any of the following services in the last 12 months?', 'd. Ordering prescriptions online or by telephone' and 'e. Medical consultation online or by telephone'.*
Source: *EQLS 2016*

One type of e-consultation which does not preclude benefits for people who lack ITC skills involves the facilitation by primary care providers of e-consultations with a medical specialist. Case studies involving primary care in rural areas of Portugal and Romania have shown that as service providers are increasingly sending digital images to specialists in hospitals, the need for some patients to travel to hospital and be absent from work has been avoided (Eurofound, 2014). In the Romanian case study, this also seems to have contributed to transparency, reducing under-the-table payments. From these two case studies and from an e-healthcare initiative in Luxembourg, it seems that use of this form of e-healthcare depends largely on how specialists are remunerated and the ICT training of medical staff.

6 This refers to those reporting to have a chronic (long standing) physical or mental health problem, illness or disability, and to be severely or to some extent limited by it in daily activities.

Improving data for policymakers

There are many approaches to measuring access and quality in healthcare; here, the focus is on survey data.

Access

Access to healthcare is difficult to measure (SPC and European Commission, 2014). An important and widely reported indicator of access to healthcare is self-reported 'unmet medical needs'. Relevant data have been available for years through the annual EU-SILC and the multi-annual European Health Interview Survey (EHIS).[7] For EU-SILC, countries collect data through various national questionnaires, capturing the data with questions along the lines of: 'Was there any time in the last 12 months when, in your opinion, you personally needed a medical examination or treatment for a health problem, but you did not receive it?'

In some countries, the proportion of unmet needs is relatively low; and it might be concluded that improving access does not need to be a policy priority. However, even where analyses focus on the low proportions of people with unmet needs, some groups may not be captured. They may be too small to be picked up in the sample, or they may be excluded from the sampling procedure in the first place.

'Unmet needs' are at one extreme on the spectrum of access problems. People without unmet needs may still experience difficulties in accessing healthcare. Furthermore, the data say little about the characteristics of healthcare services that are associated with access problems.

Quality

Quality of healthcare covers a broad spectrum. The Social Protection Committee captures important indicators in its Joint Assessment Framework exercise in the area of health. Specifically in relation to quality perceived by users, there are few data available for the EU level beyond general ratings of a country's healthcare services. Regarding user satisfaction, EQLS 2016 results demonstrate that there is value in collecting more detailed data on satisfaction with different aspects of structure and process of care. A relatively large proportion of people in the EU are not satisfied with being informed and consulted about care, and more detailed data would help in better understanding the problem (Eurofound, 2017a). Perception of unfairness is another area in which there appear to be significant problems; again, more information is needed in order to better understand this finding.

Conclusions

Access

- Almost all people in the EU reported that they and/or members of their household had used healthcare services in 2016. Still, many people experience problems with being able to afford healthcare services, receiving services promptly and being able to physically access or reach services (Eurofound, 2019).
- Needs and services must be better matched through, among other things, provision of information. As primary care is an often used, trusted service with high quality ratings, this offers a place for information provision about alternative services. It is important to increase the proactivity of services and support systems in making sure people get the services they need and that they are entitled to. This is also likely to contribute to improved perceptions of fairness in society.
- While people in vulnerable situations need support, it is important for policymakers to also recognise groups in the twilight zone. Incremental income thresholds for services may be better suited than fixed ones to avoid the creation of a twilight zone. While such thresholds may be more difficult to administer, in the new context of digitalised benefit and tax administration, some practical hurdles to implementing incremental approaches can be mitigated. This too is likely to contribute to improved perceptions of fairness in provision.

Quality

- To improve user satisfaction with services, more attention is needed to provision of information and consultation with users. This tallies with the *Voluntary European quality framework for social services*, which mentions 'participation and empowerment' as a quality principle for the relationships between service providers and users. Allocating more time to users is likely to increase satisfaction with care, and better training for care providers on information provision can help. A larger role could be considered for staff other than physicians in informing and consulting patients about their care. Furthermore, there is a role for ICT; for instance, staff could use screen-based approaches to take patients through high-quality information, guiding the conversation by providing information that is as accurate and clear as possible while also allowing room for interaction.
- Perceptions of unfairness in treatment are reported by large numbers of people but differ between countries, regions and groups. It is important to investigate the causes of these views and for policymakers to seek to address them.

7 Since 2014, the EHIS has covered all Member States; it is conducted every six years (previously every five years).

Prevention

- Calls for prevention often focus on changing individual behaviours through information campaigns. However, other factors also play a role, such as the environments where people work and live, and the resources they have.
- To prevent healthcare needs from developing, it is essential to look beyond healthcare sectors and health budgets. This chapter highlighted how mental and physical health can be promoted via adequate housing and high-quality local areas that enable healthy behaviours. This is particularly effective when people are enabled to build physical activity into their daily routines.

Sustainability

- Policymakers seeking to improve sustainability, but at the same time improve quality and access, may find a useful tool in e-healthcare. Most Member States clearly have much potential to expand use of e-healthcare. It is not just a question of establishing ICT systems. Training of medical staff and compatible remuneration systems are important success factors.

Survey data

- In analyses of access, the focus is often on self-reported 'unmet medical needs'. This chapter argued for the measurement of access problems along a broader spectrum including, for example, postponement in seeking care, or difficulties in access due to cost or waiting times. More information is needed on the types of healthcare that access problems relate to. With regard to quality, more detailed data would help identify what precisely is meant when people express dissatisfaction with being informed or consulted about care.
- Some groups in vulnerable situations may be too small to be captured by standard surveys. Vulnerable groups, such as people who are homeless, prisoners and those in long-term care institutions, are not even factored into most sampling procedures. More attention should also be paid to the relationships between different levels of income and access to good quality services.

Policy pointers

Access

- Policymakers should consider not only people with unmet medical needs but also those who have difficulties accessing care or feel insecure about being able to access care in the future.
- Financial problems associated with access are fundamental, but physical aspects of access (through improved availability and reachability) and timely access (via reduced waiting lists and waiting times) must also be addressed.
- Needs and services should be better matched, in particular by effective provision of information and referral to help guide people through the systems.
- People in the twilight zone – earning too much to be entitled to state support but too little to easily access care – should not be overlooked. Introducing more graduated income thresholds for entitlements could benefit this group.

Quality

- More attention should be paid to better informing and consulting users about the care they receive, especially in relation to hospital or specialist care and for people in the bottom income quartile. Training of healthcare providers and staff-guided use of ICT can contribute.
- Perceptions of unfairness (in terms of both unequal treatment and corruption in service delivery) are prevalent, in particular in urban areas and among people in the bottom income half. These sentiments must be acknowledged, explored and redressed.

Prevention

- A broad approach to prevention should be adopted, including consideration of how investment in good-quality housing can contribute to preventing mental and physical ill health.
- Aspects of the local areas where people live and work can promote health directly: for instance, through better air quality. But local areas can also facilitate healthy behaviours. Enabling people to conveniently walk, cycle and use public transport encourages them to build physical activity into their daily routines.

Sustainability

- E-healthcare is already a feature of healthcare in some Member States, and for diverse groups in the population. Extension of its use requires not only ICT systems , but also training and the right incentives for medical staff.
- To address inequalities in access to e-healthcare, policymakers should focus on people with low incomes and those who live in rural areas. While people in rural areas potentially have the most to benefit from e-healthcare, it only seems to reach them to more similar degrees as people in urban areas in countries where e-healthcare is more common.

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3 Long-term care services: Access and quality

Introduction

The 2017 European Pillar of Social Rights calls for universal access to affordable long-term care services of good quality, in particular home care and community-based services. The European Commission and European Council's *Joint employment report* for 2019 notes that, as the EU population ages, demand for long-term care is growing and needs are changing (European Commission, 2018a). It sets as a guiding principle for Member States to have good access to quality long-term care and that its effectiveness should be improved. Digitalisation plays an increasing role (see Chapter 8). The European Commission's 2018 'Ageing' report identifies a 'clear need for a broadening of formalised coverage of the European population with long-term care services' (European Commission, 2018b, p. 155). It also emphasises the need to take into account financial sustainability, identifying long-term care as a key contributor to age-related public expenditure, after healthcare and pensions.

The Annual Growth Survey (AGS) 2019 stresses the importance of good access to quality long-term care services for social inclusion (European Commission, 2018c). It further emphasises the need for the sustainability of these services in the context of an ageing population. The 2018 CSRs included comments and recommendations relating to long-term care for several Member States. Some of the CSRs note that the availability of long-term care services is low (e.g. Cyprus and Czechia) or argue that formal long-term care costs may be unsustainable (containing costs – Austria, Belgium; or simply underline the fact that long-term care costs are high – Luxembourg, Malta and the Netherlands). Some CSRs highlight that levels of informal care and lack of formal (affordable) care contribute to low female employment rates (Croatia, Czechia, Italy and Poland). However, progress in implementation of CSRs around long-term care has been slow (European Commission, 2019).

Despite the diversity of systems that are in place for long-term care, the focus here is on messages that apply across the Member States. As in the previous chapter, this chapter discusses access, quality, prevention, sustainability and survey data for policymakers. It examines how these can be improved, building upon existing Eurofound findings, complemented with new analysis and discussion.

Access

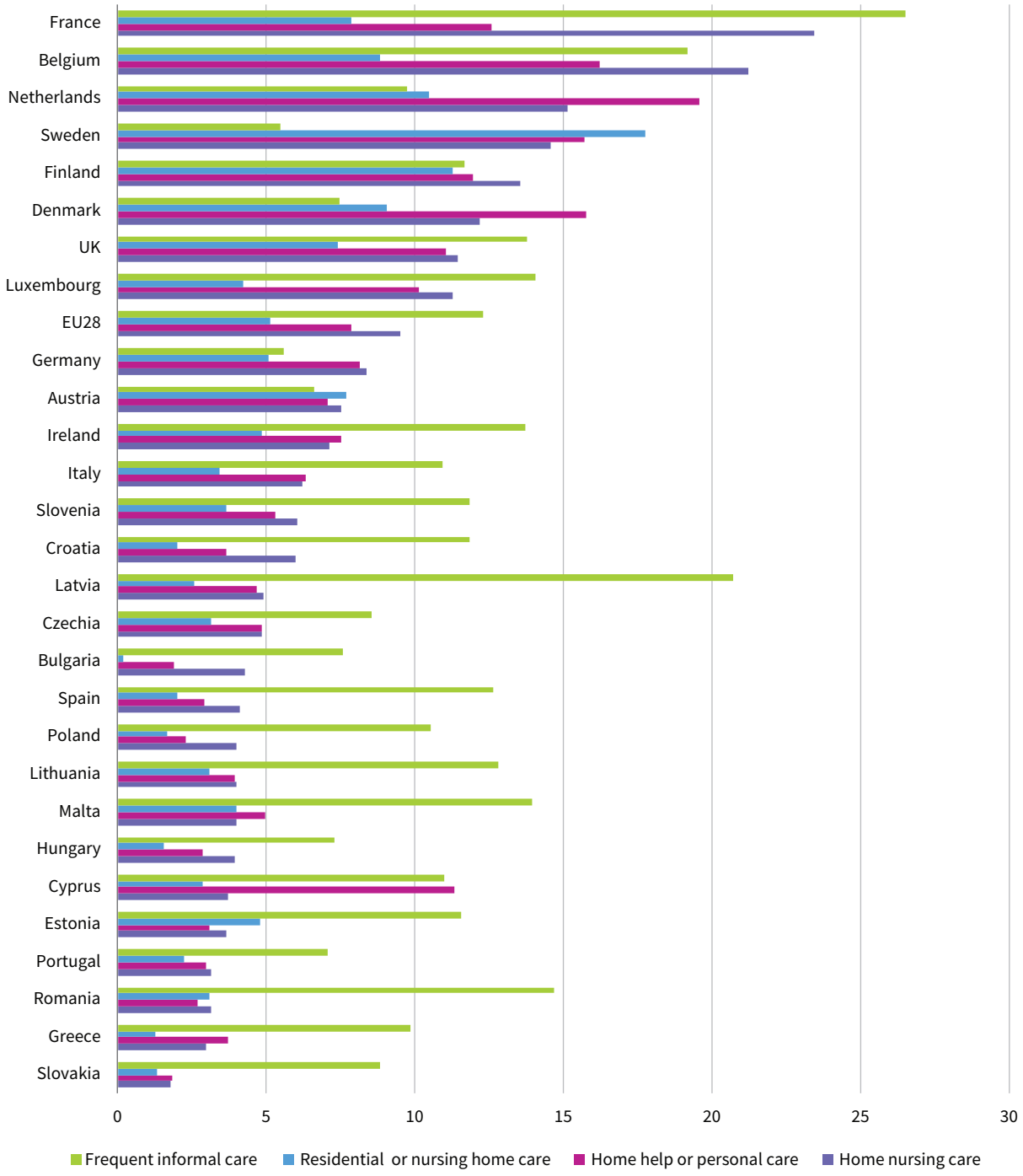
Improving access to formal long-term care

There are several important dimensions of access to long-term care, including basic availability and affordability, which varies immensely between Member States (SPC and European Commission, 2014; Eurofound, 2017, 2019). Here, the focus is on the extent to which integration and clarity of the system facilitates prompt access to the most appropriate services. But first, the use of long-term care services is discussed broadly, drawing on data from EQLS 2016.

Figure 11 shows the proportion of people reporting that they or someone close to them had used various types of formal long-term care services in 2016.[8] It also indicates the proportion of people who at least three days per week provide informal care for disabled or infirm family members, neighbours or friends (hereafter 'frequent carers'). In all Member States there is heavy reliance on informal care, but some countries stand out in terms of the proportion of frequent carers (Belgium, France, Latvia and Romania – all 15% or over). In other countries, a relatively high proportion of residential or nursing home care is provided (Finland, the Netherlands and Sweden – all 11% or over). Home help or personal care are also particularly prevalent in some of these countries (Belgium, Finland, France, the Netherlands and Sweden) as well as in Denmark.

8 In this chapter, the focus is often on both users and people close to users. This aims to address the following limitations of the EQLS sample: people in institutions are not included; some user groups may be underrepresented (even after weighting) due to interviews not being designed to include them (this applies, for instance, to people with certain disabilities); and for some groups, low sample numbers do not allow for valid analysis.

Figure 11: Use of long-term care (by respondents and/or someone close to them) and provision of frequent informal care, 2016 (%)



Notes: *Percentage of people reporting the use of formal long-term care in the last 12 months, either themselves and/or by someone close to them as a proportion of the total number of respondents. 'Someone close' is defined by respondents themselves. Frequent carers are those who at least three times per week provide care for disabled or infirm family members, neighbours or friends of any age. This relates to the following question. Q42: 'In general, how often are you involved in any of the following activities outside of paid work?', 'd. Caring for disabled or infirm family members, neighbours or friends under 75 years old', 'e. Caring for disabled or infirm family members, neighbours or friends aged 75 or over'. Possible answers were: 'Every day', 'Several days a week', 'Once or twice a week', 'Less often', 'Never'. The countries are ordered by the proportion of people receiving nursing home care.*
Source: *EQLS 2016*

Figure 12: Use of formal long-term care in previous 12 months by respondent or someone close to them, country groupings, 2016 (%)

High use		Medium–high use		Medium–low use		Low use	
France	28	United Kingdom	16	Ireland	11	Spain	6
Netherlands	27	Luxembourg	16	Malta	10	Portugal	6
Belgium	27	Cyprus	15	Italy	10	Poland	6
Sweden	26	Austria	15	Slovenia	9	Lithuania	6
Finland	22	Germany	14	Czechia	9	Hungary	6
Denmark	21			Latvia	8	Greece	6
				Estonia	8	Romania	5
				Croatia	8	Bulgaria	5
						Slovakia	3

Notes: *Proportion of people responding 'yes, I have' or 'yes, someone close to me has' in relation to use of at least one of three formal long-term care services: nursing home care, home help or personal care, or home nursing care.*
Source: *EQLS 2016*

The proportion of people reporting that they or someone close to them receive at least one of the three forms of formal long-term care shown in Figure 11 ranges from 3% in Slovakia to 28% in France. These formal services can include a wide range of types of care for people with disabilities beyond only support with activities of daily living (ADL), such as eating and washing. They also include services which support independent living or those that support people's so-called instrumental activities of daily living (IADL) such as shopping or managing finances (OECD, 2018).

There are challenges in terms of the EQLS data reported here. They offer an imperfect proxy for long-term care use. Furthermore, community care – where people receive care from a provider in the community, such as a day centre, rather than receiving that care at home – may not be captured. And as with all survey data, they are based on self-reports and rely on respondents' interpretations of survey questions. However, it is also difficult to compare countries, for instance, according to expenditure on long-term care because of national-level variations in data collection (OECD, 2018).

Acknowledging these limitations, Figure 12 distinguishes four country groups based on use of the three formal long-term care services shown in Figure 11. In the upper two groups are countries at or above the EU average (14%), and in the bottom two groups are countries that fall below the EU average.

Population age structure and related long-term care needs differ between Member States, but this is unlikely to explain the large differences in formal long-term care use. The 17 Member States in the bottom two country groups have a large gap to bridge. There is also a considerable gap between countries in the 'medium–high use' and 'high use' country groups. In all Member States there is a high reliance on informal care.

Improving access to formal home care

Options for long-term care can be improved across the board, but community and home care deserve special attention. These have been singled out in the European Pillar of Social Rights, and access and quality can be improved even in the countries where they are most used. The EQLS does not provide data on long-term care services which are provided in the community (by a provider other than a residential or nursing home) rather than at the user's home, so the focus here is on 'home care services', which includes 'home nursing care' and 'home help or personal care' services in the home.

It has become a hallmark strategy across EU Member States to seek to provide care for people in the community or in their homes rather than in institutions (Ilinca et al, 2015). This is in line with the European Disability Strategy 2010–2020, which promotes the transition from institutional to community-based care.

Figure 13: Use of home care services vs GDP per capita by Member State, 2016 (%)

Note: *Logarithm of real 2016 GDP per capita from Eurostat (vertical axis); percentage of respondents or someone close to them who used 'nursing care services at your/this person's home' or 'home help or personal care services in your/this person's home', or both (horizonal axis).*
Source: *EQLS 2016, Eurostat*

The financial and economic crisis impacted this development in two different ways (Eurofound, 2014).

1. Cuts were made in community care and home care services in some countries. For short-term relief on public budgets, such services are easy targets when workers are employed on temporary or zero-hours contracts. In Ireland, funding decreased for formal home care (including home help, nursing and physiotherapy), with hours of service provision down from 13 million in 2008 to 9 million in 2013.
2. The de-institutionalisation of people with disabilities was accelerated in some countries. However, replacement of institutional care by well-developed community care and home care services was often not ensured (e.g. in Greece and Latvia). Sometimes reduced use of residential long-term care did not come about due to government decisions but emerged bottom-up. In some cases, older people moved from care in institutions to informal care by their families and their pensions became an important addition to household incomes. In Hungary and Latvia, the number of clients in care homes decreased during the crisis partly for this reason.

There is a marked gap in access to home care services between lower- and higher-income countries. Based on EQLS 2016 data, in the 14 Member States with a real per capita GDP of €20,000 or less per year, at most 7% of people report that they, or someone close to them, had used home care services (see Figure 13). In contrast, in all 14 Member States with the highest incomes, the proportion is above 7%, and for most the proportion is at least double that.

Among countries with higher incomes, there is large variability in the use of home care services. Belgium and France have the highest proportions of people reporting formal home care use. As seen in Figure 11, these countries also have high rates of frequent informal care provision (19% and 26%, respectively). This combination of high use of both home care services and informal care could indicate that home care services facilitate informal care. For instance, people may only be able to provide care themselves if home care services take over for some hours on certain days of the week or provide support in other ways. In other countries, high rates of informal care (e.g. Latvia with a rate of 21%, Romania at 15%) may be filling a gap in availability of home care services – but the relationship between use of formal and informal care demands more research.

Individual socioeconomic differences in access to long-term care are under-explored and this topic has received considerably more attention in healthcare (Ilinca et al, 2017). The EQLS data indicate that the proportions of people using home care services vary little between income groups, with 13% in each of the bottom two quartiles and 12% in each of the top two quartiles using this form of long-term care. This is true across age groups, ranging from a difference of just two percentage points between the bottom income half compared to the top half (11% vs 9%, respectively) among those aged 25–34, to just one percentage point

(13% in the bottom income half vs 14% in the top income half) among people aged 50-64. When comparing use of long-term care among the top and bottom income halves across countries, Sweden stands out with higher use among the upper income group by six percentage points. In other countries, either there is hardly any difference in use between the bottom and top income halves or use is lower among the top half. However, recent research in the Netherlands using administrative data, and controlling for a range of factors, suggests that people with more financial resources do have better access to formal home care. People with fewer financial resources are less likely to access formal home care and seek care in nursing homes earlier (Tenand et al, 2018).

Ensuring prompt access to the right services

Timely access to good-quality long-term care services can eliminate or delay the need for more expensive – and sometimes less appropriate – care. Accessible and flexible community care and home care services can prevent people's living conditions at home from deteriorating and thus reduce the need for more residential care and healthcare. If well designed, these services can identify and address emerging problems at an early stage. This is the case for people with advanced limitations in their daily activity, but also those for people with more modest limitations (such as to their IADL).

The European Commission's AGS 2019 proposes strengthening the links between healthcare and social care, in particular to meet the needs of an ageing population (European Commission, 2018c). Eurofound's case studies include examples where holistic thinking led to better integration. For instance, GP visits to nursing homes in the surrounding areas of a hospital have contributed to reduced demand for emergency and hospital care (see Box 3).

Improving the ease of navigating the care system

Long-term care systems can be complex and hard to navigate. This is particularly the case, for instance, for people with early dementia. Navigation through the benefit and care systems relies to a large extent on the information and support provided by social networks (Eurofound, 2015). Access to formal long-term care can be improved if the person in need of care has an 'advocate', usually someone close to them, providing support to navigate the system (Ilinca et al, 2017). Special attention should be paid to people who lack such informal support.

To address these issues, care systems need to be more transparent, proactive and integrated (Eurofound, 2015). Providing some support to people who do not (yet) have more intense limitations in basic activities of daily living (but rather to IADL) can help. This allows people to access the system when they are more likely to be able to find the appropriate services and support at the right time; formal carers can then proactively identify when more support is needed and provide help to access it.

Box 3: Reducing demand for hospital beds via GP visits to nursing homes

What? Reducing demand for hospital beds by better triage and GP visits to nursing homes

Where? Blanchardstown, Dublin, Ireland

When? From 2010

By whom? Hospital management steering group, local health office and senior clinicians

Connolly Hospital provides a range of medical inpatient, day care and outpatient services to a growing catchment population. From 2009 to 2013 its staff and budget were cut, while demand increased.

Many of the emergency attendances and readmissions were older people from nursing homes. A service was developed by a steering group from the hospital, the local health office and senior clinicians to support older people through the process of early discharge back to nursing homes and to provide onsite visits to nursing homes by GPs, who could issue referrals to specialists.

In 2010, resources were invested to improve care for elderly people and to decrease demand for emergency and inpatient services in the hospital. There was also an increased focus on phone and email triage and training of emergency department staff, nurses and GPs. The team that developed the service says that emergency attendances and hospital admissions of the nursing home cohort reduced by 24% and 37%, respectively, by the end of the project.

Source: Eurofound, 2014

Quality

While quality of long-term care is multifaceted, the focus here is on user views of quality. As in the previous chapter, two aspects are highlighted in the EQLS: satisfaction with being informed about the care received, and perceptions of unfairness in relation to care.

Informing and consulting users about the care they receive

Long-term care aims to compensate for a loss of functional capacity, which in many cases cannot be reversed and often deteriorates further. Maintaining well-being and quality of life are, thus, appropriate outcomes for long-term care (Rodrigues, 2017), and the interpersonal relationship between users and carers plays a key role in terms of quality of care (Rodrigues, 2019). As user perspectives are a key indicator of the quality of long-term care, it is worrying that users give relatively low satisfaction ratings to 'being informed and consulted about care' (Eurofound, 2019).

Addressing unfairness, taking into consideration the urban–rural dimension

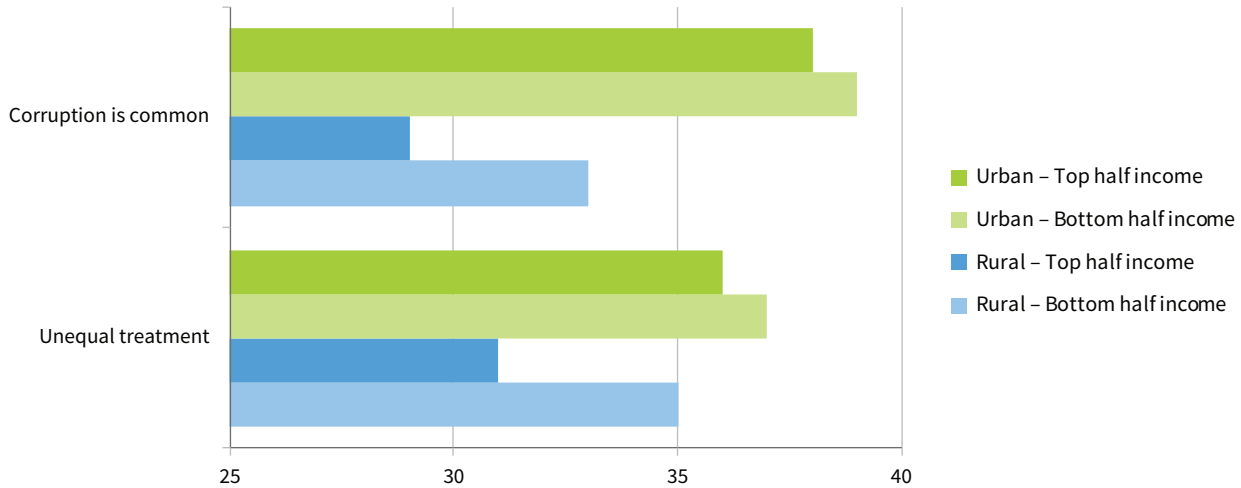
The EQLS provides new knowledge on perceptions of unequal treatment and corruption in long-term care (Eurofound, 2017). Almost one-third (32%) of people in the EU gave a rating of 5 or more out of 10 (where 10 reflects complete agreement) to the statement that 'Corruption is common in these services in my area'. In relation to the statement 'All people are treated equally in these services in my area', 25% gave a rating of 6 or below out of 10. People in urban areas were more likely than those in rural areas to perceive that each of these aspects of unfairness exists. However, in rural areas, there were greater income inequalities in perceptions of unfairness: for both unequal treatment and corruption, there was a 4-percentage-point difference between the top and bottom income halves in rural areas compared to a 1-percentage-point difference in urban areas (the bottom income halves being more likely to perceive unfairness) (see Figure 14).

Prevention

The AGS 2019 calls for greater emphasis on prevention. Prevention of long-term care needs works partly through prevention of health problems over the life course (European Commission, 2018c). Prevention also includes good access to primary care and long-term care for people with more moderate long-term care needs, with a role for early intervention to prevent escalation of needs in the future. Looking beyond formal health and care services, housing and the local area can also contribute to the prevention of long-term care needs (as discussed in Chapter 2 in relation to healthcare needs).

Appropriate housing: Well-being is promoted in quality accommodation through, for example, avoidance of slippery surfaces, absence of mould and humidity, and the ability to maintain the dwelling at appropriate temperatures. In addition to general housing quality, housing adjustments or features which address loss of function, such as handrails in bathrooms and access to elevators or absence of stairs, can reduce long-term

Figure 14: Unfairness: perception of corruption and unequal treatment in long-term care, 2016 (%)



Notes: *Results relate to the following question. Q75: 'To what extent do you agree or disagree with the following statements about long-term care services in your area? Please tell me on a scale of 1 to 10, where 1 means completely disagree and 10 means completely agree. a. All people are treated equally in these services in my area; b. Corruption is common in these services in my area.' For equality, the bottom 6 scores (1–6) are taken as perception of unequal treatment. For corruption, the upper 6 scores (5–10) are taken as perception that corruption is common.*
Source: *EQLS 2016*

Box 4: Targeted door-to-door visits to assess houses in need of improvement

What? Going door to door in targeted areas to assess how homes can be improved

Where? Liverpool, UK

When? From 2009

By whom? Liverpool City Council

The Healthy Homes Programme involves 'engagement officers' going from door to door in selected neighbourhoods to assess – with the help of a short questionnaire – how houses can be improved, focusing on hazards, dampness and energy efficiency. The initiative targeted privately rented accommodation, requesting landlords to act. In 2015, the need to focus on rented accommodation was lessened as a Landlord Licensing Scheme was introduced with strict requirements for dwellings that are let out. From 2017, the programme has focused on areas with a concentration of owner-occupied homes, and energy poverty among older people has emerged as a key issue. In 2018, the programme led to improvements in energy efficiency in 1,029 homes. This was funded by Public Health (about GBP 1 million in 2018), Energy Company Obligation funding (mandatory payments/measures by energy companies to contribute to CO2 reduction, about GBP 0.5 million) and partnering energy companies (about GBP 0.5 million).

In 2018, a Health Liaison Officer post was established to engage with care professionals to identify people who are ill due to cold homes. In 2018, there were 48 referrals resulting in actions taken (by GPs, social workers and long-term care providers). For instance, the discharge team for a patient being treated at the Royal Liverpool Hospital following a stroke found that the patient's home was too cold to return to; this was due to an old boiler and poor insulation. The issues were addressed, and the patient returned home with a long-term care package.

Source: updated from Eurofound, 2016b

care needs (Eurofound, 2016b; Box 4). Van Hoof and colleagues (2010) reviewed housing interventions for people with dementia; these covered activities such as toileting, bathing and personal care, dressing and doing laundry, sleeping, cooking and dining as well as general safety and security at home. Often these measures are low cost (such as removing toilet lids and moving beds against the wall), and it is argued they should be considered before medications are prescribed.

High-quality local environments: Good social, physical and service aspects of the local area can also prevent long-term care needs. For instance, wide and even pavements with good street lighting and convenient crossings enable people to move around with walkers or wheelchairs. Having good access to services such as shops and cafes enables longer lives in the community. Neighbourhood contacts help people stay integrated, promoting mental health and facilitating help when needed (see case studies on Düsseldorf and Lisbon in Eurofound, 2018).

Sustainability of informal care

Informal care is provided mainly by family but also by friends, and it is the cornerstone of long-term care in all Member States (Spasova et al, 2018; Eurofound, 2017). Questions have been raised about its sustainability in the context of ageing societies with more people to care for and fewer people available to act as informal caregivers. However, there is no evidence from the EQLS surveys since 2003 that the proportions of people providing informal care have declined (Eurofound, 2017). Aside from this issue, informal care inevitably comes with costs for society (Wimo et al, 2007). These may include loss of workforce, lower pension accumulation and increased public expenditure on social protection for those unemployed or 'economically inactive'. In addition, providers of informal care can experience social isolation, deprivation and mental and physical health problems, which also come with costs for society and reduced quality of life (Eurofound, 2017).

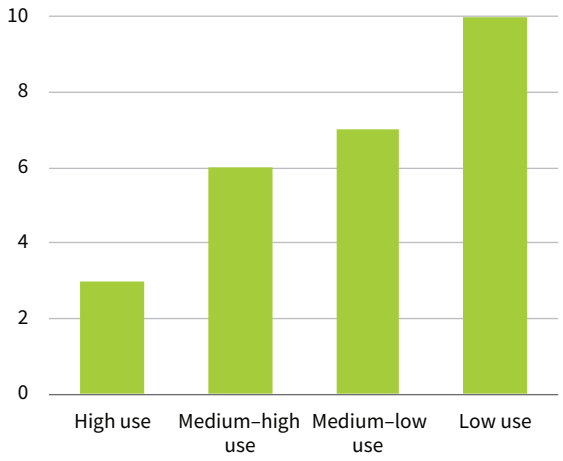
Here, the focus is on 'frequent carers': people who provide informal care for disabled or infirm family members, neighbours or friends, of any age, on at least several days per week. Most of the frequent carers in the EU are female (62% compared to 38% male). The 50–64 age group is particularly overrepresented with almost one-third (32%) of frequent carers falling in this group. Frequent carers are more likely than non-carers to have low secondary as their highest education level (37% compared to 33% of non-carers). Over a quarter (28%) of frequent carers are retired (a higher proportion than non-carers, 25%), while, across all age groups, 46% are in employment (lower than the proportion of non-carers, 52%). Social exclusion and deprivation are more pronounced among frequent carers than others: the EQLS Social Exclusion Index is 2.3 on average for frequent carers (2.1 for others) and the EQLS Material Deprivation Index is 1.3 (1.0 for others).[9]

The relation between employment and informal care provision is complex and goes beyond the scope of this chapter (Eurofound, 2017; Walsh and Murphy, 2018). Figure 15 shows that, in countries where formal long-term care is least commonly used, the employment rate among frequent carers is 10 percentage points below that of other people. In countries where formal care is most commonly used, this employment gap is just 3 percentage points. Various explanations are possible. For instance, people in employment may be less likely to provide frequent informal care if there is a good quality alternative and if being a carer implies loss of employment; thus, in countries with greater availability of formal long-term care, it is likely that the employment gap will be lower.

One policy approach is to facilitate combining informal care with work through flexible work arrangements (Eurofound, 2011). This can enable informal carers to hold on to their jobs, associated income and social contacts. This can help those already involved in caring, and it might also enable those who have not been able to provide informal care previously due to employment demands to start providing informal care.

The age profile of frequent carers is also related to problems associated with return to previous working arrangements. As noted above, those in the 50–64 age group make up a high proportion of frequent carers,

Figure 15: Gap in employment rate between frequent carers and others by formal long-term care use country group, 2016 (%)



Notes: *Employment includes people who are at work as an employee or who are an employer/self-employed, regardless of whether they are on leave or receive a pension. 'Frequent carers' are those who report to care for disabled or infirm family members, neighbours or friends (of any age) at least three days per week. The formal long-term care use country groups are shown in Figure 12.*
Source: *EQLS 2016*

and this age group may be more likely to experience difficulties reintegrating into employment after time spent caring. It is easier to reintegrate into the labour market if one remains at least partially attached to it. To avoid inactivity or retirement when caring responsibilities emerge, partial retirement schemes could assist older workers to reduce working hours by replacing loss of income with a partial pension. Such systems can prevent material deprivation among carers and can stimulate acceptance in society of reduction in working hours. Many partial retirement schemes currently in place were designed for other purposes, and some are non-reversible (such as those in the Netherlands). However, reversal is possible within some schemes, and other sectors or countries can learn from these. Examples can be found in Finland, France, Norway and Sweden (Eurofound, 2016a).

Another approach to sustaining informal care and employment would be to partially replace it with community care, formal home care or nursing care.

9 See Eurofound (2017) for details of these indexes.

There is little information on the dynamics of the link between formal and informal care, particularly regarding what could facilitate people staying at home for longer. The EQLS does not collect data on the use of community care, but it does have data on formal home care. The data suggest that in the EU, informal care is rarely relieved by formal home care. More specifically, only 7% of frequent carers reported that they or someone close to them received home nursing care, home help or personal care at home in 2016. Even in France, the country where the combination of frequent informal care and formal home care appears most common, fewer than one in five informal carers said that they or a person close to them was supported by some form of formal home care.

However, the indicator is far from ideal; most obviously, frequent carers may be reporting formal home care received by someone close to them who is not the person they care for.

Improving survey data for policymakers

Access

There is a lack of survey data on access to long-term care, and it is difficult to measure (European Commission, 2014). The main limitations are that most surveys do not include nursing home residents, and, in population surveys, service user groups are often too small for meaningful analysis to be carried out.

The Survey of Health, Ageing and Retirement in Europe provides data on long-term care, but its sample is limited to people aged 50+, and before 2019, the survey did not cover all Member States. There are some national data on the numbers of people using specific types of care, but there can be challenges in collecting these data, for instance, obtaining data from private sector long-term care providers. These data do not always permit social or economic analyses; nor do they reveal types of access problems or preferences of users and their informal carers.

Quality

Even scarcer at the EU level are survey data on quality of long-term care. Here, the focus is on user views. The few data sources that exist tend to cover very general ratings of a country's long-term care services. The discussion above suggests there is particular mileage in collecting more detailed information on informing and consulting users. Also, more needs to be understood about feelings of unequal treatment and perceived corruption within national contexts.

Conclusions

Access

- Formal long-term care provision needs to be expanded across the board, but in particular in the 17 Member States where use is lowest. There is also urgency specifically for improvement of home care and help in the half of Member States where income is lowest. There is a need to examine further within Member States the relationship of income to availability and use of long-term care services.
- Accessible and flexible community care and home care services can prevent deterioration of people's living conditions at home. If well designed, these services can identify and address emerging problems at an early stage. This is the case for people with advanced limitations in their daily activity, but also for people with more modest limitations. Such early intervention helps to reduce unmet need and improve access to entitlements and support by people with little informal support and those with diminishing cognitive abilities.

Quality

- The interpersonal relationship between users and care providers is an important component of long-term care and adequacy of communication appears to be an issue for many users.
- Improving this aspect of care tallies with the *Voluntary European quality framework for social services* (SPC, 2010) which mentions 'participation and empowerment' as a quality principle for the relationships between service providers and users. Quality may not be found only in the time given by the provider, but rather in the method of communication. Incorporating better training for care providers on information provision to users and people close to them can help.
- A high proportion (one third) of users express concerns about fairness (in relation to corruption and unequal treatment) in long-term care provision and ratings were worse for long-term care than for healthcare (Eurofound, 2017). These data clearly signal the need to explore the causes of these feelings and find ways to address them.

Prevention

- Long-term care needs can be postponed and prevented by measures throughout life, similar to the prevention of healthcare needs. Given some loss of function, good access to primary healthcare and home care services can prevent long-term care needs from growing. Two issues that can contribute to fewer long-term care needs and to longer lives in the community have received less attention in policy and literature: good-quality local environments and adequate housing, with adjustments as necessary to maintain function.

Sustainability

- This chapter has focused mainly on sustainability of the significant role of informal care. Informal care comes with social and economic costs for both carers and society, including loss of employment, social protection expenditure and healthcare needs among informal carers. The policy focus should not be confined to supporting current carers, but also ex-carers who are interested in returning to or taking up employment. Reversible partial retirement schemes can support people when caring commitments reduce or cease. Measures for reconciliation of work and care have received attention but it is also important to support informal carers and ex-carers who do not seek employment, including retirees.

Survey data

- Few EU-level or comparative country data are available on access to and quality of long-term care. Surveys are often not always designed to include people with disabilities, and nursing home residents are excluded from samples. Furthermore, the numbers of long-term care users are usually too small for meaningful analysis to be carried out. The potential of survey data lies particularly in exploring the subjective dimensions of how well long-term care services meet the varying needs and preferences of users and their informal carers.

Policy pointers

Access

- Formal long-term care provision needs to be expanded greatly in most Member States, improving access to a range of flexible options.
- Access to home care services needs to be improved, especially in the half of EU Member States with the lowest incomes.
- Early intervention to address emerging long-term care needs can moderate growing dependency. This is particularly important for people without 'advocates' and those with decreasing cognitive abilities.
- It is essential to consider integrated approaches going beyond the long-term care sector alone to ensure prompt access to healthcare as well as social care. For instance, regular visits by GPs to nursing homes can reduce demand for hospital care.

Quality

- User and informal carer satisfaction is an important aspect of quality of long-term care, as well-being is a particularly important outcome (as opposed to cure, which often is not possible).
- To improve user satisfaction, there is scope to inform and consult users better about the care provided: for instance, through training of formal caregivers. Such inter-human aspects are key in long-term care.
- Policymakers should explore how widespread sentiments of unfairness can be explained in their specific contexts and address their causes. This is particularly an issue in urban areas and to a greater extent among people in the bottom income half in rural areas.

Prevention

- Prompt access to primary healthcare, social care and long-term care can stimulate early intervention, monitoring of changing needs and prevent escalation of long-term care problems.
- Long-term care needs can be mitigated by good-quality local areas and appropriate housing. Measures to promote these can also reduce inequalities in long-term care needs.

Sustainability

- Costs of informal care go beyond the caring period with, for example, challenges for informal carers seeking to reintegrate into the labour market. Facilitating partial connection to the labour market – for instance, through partial retirement schemes – can reduce this negative impact.
- Reconciliation of work and informal care through promotion of flexible work arrangements should be combined with measures which increase gender equality.
- Good access to home care services facilitates combining care with work or – for carers who do not work – provides relief, while also enabling longer lives in the community. However, combining informal care with such formal care arrangements appears to be little developed.

Survey data

- More information is needed on use of and access to formal long-term care and how the needs and preferences of users and their informal carers are addressed.

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4 Early childhood education and care services: Affordability and quality

Introduction

The AGS 2019 points out that wider access to high-quality childcare services 'would ensure more opportunities for women to enter or stay in employment and reduce the risk of poverty and social exclusion among children and vulnerable groups' (European Commission, 2018a, p. 12). The country-specific recommendations given to seven Member States in 2019 dealing with childcare (Austria, Cyprus, Czechia, Ireland, Italy, Poland, Slovakia) reiterate this message. Most of these countries were reminded that accessible and affordable childcare contributes to the narrowing of the gender gap in the labour market. Similarly, the 2019 *Draft joint employment report* points out that lack of or unequal access to childcare worsens the effect of parenthood on women's employment (European Commission, 2018b).

Cost stands out as the main barrier to use of early childhood education and care (ECEC) services. The EQLS 2011 and the EU-SILC 2016 ad hoc module identify cost as a greater source of difficulty in making use of services than lack of places, distance or opening hours. The importance of cost is reflected in the European Pillar of Social Rights, which includes the statement 'children have the right to affordable early childhood education and care of good quality'. The main initiative at the EU level in relation to quality is the Council Recommendation on High Quality Early Childhood Education and Care Systems (Council of the European Union, 2019). The implementation of the recommendation by Member States is supported by the Working Group on Early Childhood Education and Care, established in late 2018. This working group, which will end its mandate in 2020, focuses on the professionalisation of staff and the accessibility and inclusiveness of services.

EQLS 2016 data on affordability and user satisfaction can contribute to monitoring the implementation of this Council recommendation. This chapter presents findings from other research on the situation in Member States to contextualise the findings of the EQLS on affordability, quality and user satisfaction with ECEC services. The first part presents information from the EQLS and other sources about the affordability of services. The second part presents research on factors influencing quality and how it is linked to parents' satisfaction with services.

Affordability

In the EU, cost makes access to ECEC services difficult for 39% of users of formal childcare services, according to the EQLS 2016. The EU-SILC 2016 module on access to services shows that 31% of households found it difficult to afford formal childcare services.[10] Overall, there is a positive relationship between the share of users reporting in the EQLS 2016 that they have no difficulties in accessing services due to cost and the rate of use (or take-up) at the national level: in other words, the proportion of users of formal childcare is higher in countries where fewer users are burdened by cost.

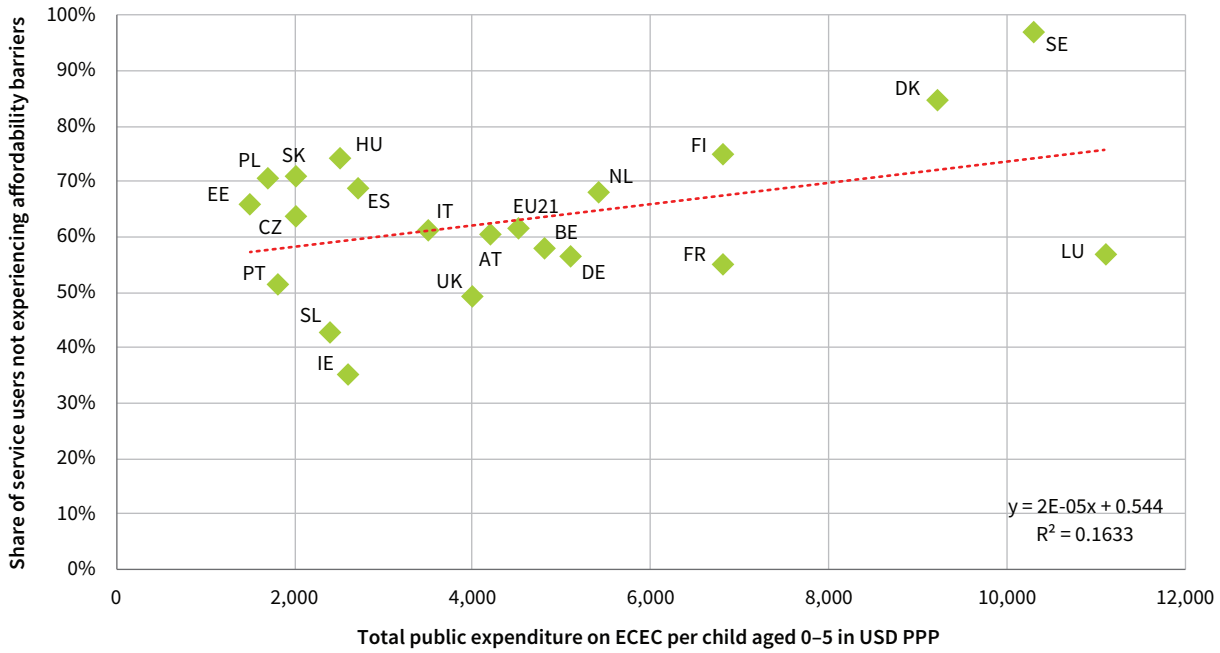
A study using EQLS 2011 data found that ECEC services were perceived as more accessible in countries that:

- do not have private, for-profit provision of pre-primary ECEC (i.e. there is only public and not-for-profit provision for children older than 3)
- have a unitary system (i.e. services for children of all age groups are organised and delivered in the same setting)
- have higher public spending per child (Ünver et al, 2018)

EQLS 2016 data show that there is a medium positive association (Pearson correlation coefficient = 0.4) between the total public expenditure on ECEC per child aged 0–5 and cost not making access difficult (see Figure 16). As it is an association of medium strength, countries with large differences in spending may have similar proportions of respondents for whom cost did not make it difficult at all to use childcare services.

10 The data from the EU-SILC 2016 ad hoc module are based on children usually cared for by formal arrangements other than by the family in a usual week. The data from the EQLS represent respondents availing of formal childcare facilities or after-school care for their youngest child over the previous 12 months.

Figure 16: Affordability of ECEC and total public expenditure on ECEC per child aged 0–5



Notes: *Total public expenditure on ECEC per child aged 0–5 (OECD). PPP = purchasing power parity. Percentage of service users for whom cost did not make it difficult to use childcare services.*
Sources: *EQLS 2016 (Q 82), OECD Social Expenditure Database (2013 and latest year available, data available in 21 Member States)*

The Country Specific Recommendations received in 2019 by Cyprus, Ireland and Slovakia underlined the need to ensure the affordability of services. The 2019 *Draft joint employment report* mentions ongoing reforms in Finland, Spain (in both countries more than two-thirds of users did not experience any affordability issues) and Ireland (almost two-thirds of users experienced affordability issues) to increase the affordability of childcare services (European Commission, 2018b).

Quality and user satisfaction

The EQLS 2016 includes questions for parents with children in formal ECEC (i.e. formal childminding or centre-based services) about their satisfaction with services. This involves questions about the expertise and professionalism of staff; the personal attention their child receives (including attitude of and time devoted by staff/carers); the quality of the facilities; being informed or consulted about childcare; and the curriculum. As reported elsewhere, all aspects of user satisfaction are highly correlated to one another (Eurofound, 2019). Thus, countries tend to have a similar level of user satisfaction on all five dimensions listed above. As Table A1 (p.51) shows, in 2016 Ireland provided the highest satisfaction ratings in the EU across all aspects and Italy the lowest (Eurofound, 2017). The EQLS also asks all interviewees (regardless of whether they are service users or not) for their views about the quality of childcare services. There is a weak correlation between the general quality ratings given by all interviewees and the satisfaction of service users (Eurofound, 2019).

This section looks at aspects of service provision for which there is evidence of their impact on the quality of services (OECD, 2018a). Changes over time, current policy reforms and differences across Member States are documented. Even though differences in the satisfaction of parents cannot solely be explained by these aspects of service provision, this contextual information complements, with objective measurements, the subjective assessments (for which, in some countries, the number of respondents was too low to perform certain statistical analyses). More specifically, the focus is on continuing professional development (CPD) and the number of children each staff member is responsible for. Both these aspects have an impact on children's well-being and learning outcomes. The Council Recommendation on High Quality Early Childhood Education and Care Systems and the staff working document associated with it reflect this and recommend that Member States support the professionalisation of staff by improving their initial education and CPD.

Box 5: Recent reforms of continuing professional development

Malta: Malta is experiencing a situation whereby an increased number of children under 3 enrolled in ECEC has led to shortages of qualified staff. Education institutions are supporting staff already working in ECEC centres for children under 3 to obtain qualifications through work-based learning programmes (European Commission, 2019).

Ireland: In November 2018, the Irish government presented a cross-departmental strategy from 2019 to 2028 to support babies, young children and their families. As part of this strategy, a workforce development plan will be prepared in 2019–2020. This plan will improve access to CPD opportunities and support employers in offering more favourable working conditions to attract and retain staff. This will be achieved by developing a national CPD programme for the ECEC workforce and through a review of graduate training options. There will also be requirements ensuring that training is specific to early childhood and that staff are supported to take part in CPD (Government of Ireland, 2018).

Finland: The Act on Early Childhood Education and Care introduced in September 2018 in Finland states that providers of ECEC must ensure that staff can avail of in-service training that maintains and develops their professional skills. A working group will be established to develop initial and in-service training and cooperation between different levels of education. The Finnish National Agency for Education now provides grants for professional development (Kahiluoto, 2018).

Continuing professional development

In-service training or CPD can be defined as formal and non-formal professional development activities about particular subjects or pedagogical training. An OECD meta-analysis found that CPD is the most consistent predictor of positive staff–child interactions, even to a greater extent than formal pre-service qualifications (OECD, 2018a).

Other research has also found that in pre-primary education (ECEC for children older than 3, classified as Level 02 in the International Standard Classification of Education – ISCED), specialised in-service training has a more positive impact than pre-service training on process quality. The quality of interactions in turn has an impact on the well-being of and outcomes for children. The meta-analysis shows that the quality of staff–child interactions impacts on children's outcomes such as literacy and numeracy. Negative interactions are associated with poorer behavioural/social skills among children (OECD, 2017, 2018a).

Data from Eurydice – a network providing information about education systems and policies in Europe – show that, in 2016/2017, CPD was a professional duty and/or necessary for the promotion of staff dealing with children under age 3 in 12 Member States. In another 12, CPD was necessary in ECEC for all age groups (European Commission et al, 2018; see Table A2 in the Annex). As presented in Box 5, recent reforms in Finland, Ireland and Malta aim to increase the training opportunities of the ECEC workforce.

Not all forms of CPD are equally effective. A systematic literature review carried out by Fukkink and Lont (2007) shows that specialised training improves pedagogical competencies, mainly in terms of professional attitude but also in relation to knowledge and skills. Large-scale training programmes were found to be less effective than training that involves fixed-curriculum courses. Eurofound's systematic literature review includes studies in several EU languages that assess the impact of CPD on children's learning outcomes and experiences, including staff–child interactions (Eurofound, 2015b). These studies show that CPD interventions that are integrated in day-to-day work, that provide opportunities for reflection about practice and curricula and that enable the introduction of changes are more effective. In the case of training lasting less than six months, the incorporation of video feedback increases effectiveness in terms of improving care and language stimulation by practitioners. This in turn means that children's language acquisition and cognitive development improve in the short term. Training lasting longer than six months improves children's cognitive and social development to a greater degree when such training is provided by coaches or counsellors that give pedagogical support in reflection groups.

In addition, there are newer training formats that have proved useful at different education levels. In particular, the use of ICT and other digital technologies in training can be combined with reflection in groups on professional practice. For example, Teaching Channel provides online videos for the professional development of teachers in different levels of education (including ECEC). It also includes an online community where ECEC staff can exchange experiences and ideas and ask for guidance (Vuorikari, 2018).

Number of children per teacher

In most European countries there has been an increase in the numbers of both children and staff in ECEC. The take-up of services is monitored in the Social Scoreboard with an indicator on the percentage of children aged under 3 in formal childcare. On the basis of this indicator, the *Draft joint employment report* for 2019 refers to the low level of enrolment of children in 2016 in Bulgaria, Czechia, Greece, Poland and Slovakia (where enrolment rates were around 10%) as a critical situation. France, Luxembourg, the Netherlands and Portugal are pointed out as 'best performers', with half or more of children under 3 enrolled in ECEC (European Commission, 2018c). Since 2011, the biggest increases in participation in ECEC among children under 3 took place in Estonia, Germany, Ireland, Italy, Malta and Romania. Use during this period decreased in Greece and Slovakia (European Commission, 2018c).

The data from the OECD Social Expenditure Database (see Table A2 in the Annex) show that between 2005 and 2016 the number of children enrolled increased the most in Czechia, Poland and Slovenia. Germany, Hungary and Italy experienced a small decrease during this period. As for the number of teachers in pre-primary education, the highest increases between 2005 and 2016 took place in Luxembourg, Poland and Slovenia, with Hungary and Portugal being the only countries where the teacher numbers decreased.

As a result of changes in the number of staff and children enrolled in ECEC over the last decade, reductions in the number of children per teacher in pre-primary education can be established for 11 Member States. The biggest reductions during 2005–2016 took place in Luxembourg, Germany and Poland (see Table A2 in the Annex). In three countries – Czechia, Hungary and Portugal – the changes in the number of children and staff led to a higher number of children per teacher in 2016 than 2005. In Czechia, the number of children has increased faster than the number of teachers. In Hungary, the numbers of children and staff both decreased during that period, though this was more pronounced in the case of staff. The number of children decreased in 2013 and 2014 as a result of migration and demographic change. Since 2015, pre-primary education has been compulsory in Hungary (Hungarian Central Statistical Office, 2015, 2018; OECD, 2016). In Portugal, the number of children enrolled was fairly constant but the number of teachers declined (OECD, 2018b). These changes do not seem to be reflected in the user satisfaction ratings reported in the EQLS in these three countries – although the numbers of users are also relatively low. The same applies for the user satisfaction ratings reported in the EQLS for countries where the number of children per teacher decreased (Eurofound, 2019).

In 2016 the average child-to-teacher ratio was 12 in the 23 Member States for which data were available. In these 23 countries, there were fewer children per staff member in ECEC for children under 3 (ISCED Level 01) than was the case for older children in pre-primary education (ISCED Level 02). On average, the child-to-staff ratio in the case of older children was 12 and the child-to-teacher ratio was 13. For children under 3, the ratios were 7 and 8, respectively (see Table A2 in the Annex).

Even though research shows links between these ratios (see Box 6), class size and the quality of the interactions between staff and children, the evidence gathered by the OECD shows an unclear association and no relationship between child-to-staff ratios and emerging academic skills (i.e. early literacy and early numeracy) (OECD, 2018a). Eurofound's systematic literature review included studies assessing the impact of working conditions on children's learning outcomes and experiences, including staff–child interactions. Only five studies were considered robust enough to be included (these were Palmerus, 1996; Sundell, 2000; Blatchford et al, 2002; Sandstrom, 2012; Hayes et al, 2013). These studies confirm that child-to-staff ratio and class size influence the quality of interaction between staff and children and the practice of staff (Eurofound, 2015b).

Box 6: Group size, child-to-staff ratios and quality of ECEC services

A study of the characteristics and quality of preschool education in Seville (Spain) found that teachers in charge of a large number of children were not able to care for and supervise children effectively. These teachers gave limited feedback to children and had less elaborate discussions with children than those who had smaller groups of children and/or the support of a teaching assistant. As a consequence, children had fewer opportunities to expand their language and vocabulary. Even those teachers trained and motivated to carry out different interactive activities had to rely on lesson books and follow a standard curricular plan in order to control their classes (Sandstrom, 2012).

Factors influencing user satisfaction

Parents' satisfaction with the quality of childcare is a rather under-researched topic. Many factors may play a role, including parental beliefs, access to information and access to different types of childcare (Kelesidou et al, 2017). External (objective) measures of quality may be in line with parental satisfaction (Lehrer et al, 2015). Analysis of the EQLS 2016 and evidence from the literature indicate that parental evaluations of quality do not necessarily reflect the quality assessments provided by observers and/or standardised measurements of quality (Torquati et al, 2011). This is because parental evaluations can be affected by information bias or be related to more practical arrangements of childcare that help them, for example, to reduce work–life conflict, influencing their positive evaluation regardless of the quality of the service for their children. Objective measures of quality can be taken from Eurydice (group size regulations and participation rates, split vs integrated system) and the OECD Family Database (public spending on early education and care, child-to-teaching staff ratio, gross childcare fees). However, objective indicators of quality seem to be quite independent of user satisfaction. Only the coefficient of child-to-teacher ratio matters statistically, but this association is low.

Linear regressions confirm that, in the EU, parents with upper secondary education have higher satisfaction with most of the quality dimensions than parents with lower secondary or lower education. Households above the income median have higher satisfaction with the quality of facilities than those with lower income (this was also the case in Goldring and Hausman, 1999). This might be related to the fact that these income groups can afford better-quality facilities.

As noted earlier, the five measures of user satisfaction in the EQLS (satisfaction with building, room and equipment; expertise and professionalism of staff/carers; personal attention given to the child; being informed or consulted about the child's care; curriculum and activities) are highly interrelated. The correlation between these items is relatively high and beyond 0.6 in all cases. Factor analysis confirms that the five EQLS user satisfaction items create a single index. Therefore, additional analyses can be performed by using a single index encompassing the five aspects of user satisfaction.

Contrary to expectations, further analyses (see Table A3 in the Annex) show that the higher the investment in ECEC at the national level, the more negative the satisfaction of higher-educated parents compared to those with lower education. In addition, the higher the group size in preschool, the more positive the satisfaction of higher-educated parents compared to those with lower education. Although these results might be subject to different interpretations, two are plausible: educated parents may have more realistic information about the overall quality of ECEC but may also have better access to services of higher quality, which do not necessarily correspond to average quality of the national systems. In the latter case, their evaluations will be less susceptible to changes in average quality of the system. The data do not allow for distinguishing between different types of service, which is why the experiences of different parents can become lost in the collective assessment. For this reason, these results need to be taken with caution.

Conclusions

- The evidence available highlights the importance of continuing professional development (CPD) for the quality of interactions of staff and the outcomes for children, indicating that CPD should be a priority when it comes to investment in ECEC. This is particularly relevant in a context of increasing enrolment rates, which could potentially lead to shortages in the number of properly qualified staff.
- Eurofound's systematic literature review identified specific aspects of training, such as video feedback, that have proved effective in different settings in several EU countries and, therefore, could be prioritised when it comes to funding. In addition, the use of ICT and other digital technologies in training can be combined with reflection in groups on professional practice.
- Interventions need to be evaluated properly. A review of 15 evaluations of resources promoting the inclusion in mainstream ECEC of children with disabilities or learning difficulties or children coming from disadvantaged backgrounds found that the evaluations did not consider the views of the children or the long-term impact of interventions and that they were not carried out independently by external experts (Eurofound, 2015a).
- Parental evaluations of quality do not necessarily reflect the quality assessments provided by observers and/or standardised indicators of quality. However, even if the use of parental assessments of quality is problematic, this is nevertheless a useful and relevant exercise in itself. Highly educated parents and those with higher income tend to be less satisfied with the quality of childcare.

Policy pointers

- Public expenditure on ECEC is linked not only to a better perception of the accessibility of services but also, indirectly, to higher user satisfaction.
- Parental satisfaction with formal childcare services is important but poorly understood. User satisfaction should be monitored but also examined more rigorously in relation to structure and process of childcare provision.
- Member States should prioritise investment in CPD to promote service quality. This is particularly important in a context of increasing enrolment rates that could lead to shortages of qualified workforce and thus a trade-off between quantity and quality of service provision. The Erasmus Plus programme provides funding opportunities for this purpose.
- The evidence regarding 'what works' is incomplete in the case of some types of training and other ECEC interventions. A useful resource that Member States can avail of is the European Platform for Investing in Children, which provides an online repository of practices for which there is robust independent evaluation of effectiveness, transferability and impact over time.
- The exchange of experiences of implementation and trade-offs in the ET 2020 (strategic framework for European cooperation in education and training) Working Group on Early Childhood Education and Care concerning the professionalisation of staff may also be useful for Member States (see European Commission, undated, for more details).

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Annex to Chapter 4

Table A1: User satisfaction with early childhood education and care services (ECEC)

Member State	Quality of facilities		Expertise and professionalism of staff/carers		Personal attention given to children		Being informed or consulted about childcare		Curriculum and activities	
	User satisfaction	EU ranking	User satisfaction	EU ranking	User satisfaction	EU ranking	User satisfaction	EU ranking	User satisfaction	EU ranking
Austria	8.8	3	8.8	5	8.8	5	8.9	2	8.8	4
Belgium	7.8	23	7.7	27	7.9	26	7.6	26	7.4	27
Bulgaria*	8.4	9	8.4	10	8.2	14	8.3	12	8.4	11
Croatia*	7.5	27	8.0	22	8.2	20	8.1	19	7.5	26
Cyprus*	7.8	22	7.9	24	8.0	25	8.3	14	8.2	19
Czechia*	8.6	6	8.7	6	8.8	6	8.7	6	8.5	7
Denmark	8.2	14	8.6	7	8.2	18	7.5	27	7.9	23
Estonia*	8.3	11	8.6	8	8.4	11	8.5	10	8.5	9
Finland*	8.3	10	8.9	3	8.8	3	8.8	4	8.7	5
France	8.0	19	8.1	18	8.0	24	7.8	24	7.7	25
Germany	8.0	20	8.1	20	8.1	23	8.0	22	8.1	21
Greece*	8.2	12	8.3	13	8.2	17	8.5	9	8.5	10
Hungary*	8.2	15	8.1	19	8.1	21	8.3	13	8.2	15
Ireland*	9.1	1	9.1	1	9.2	1	9.2	1	9.1	1
Italy	7.0	28	7.2	28	7.3	28	7.1	28	7.0	28
Latvia*	7.7	25	7.8	26	7.8	27	7.7	25	7.8	24
Lithuania*	8.8	4	8.9	2	8.8	2	8.9	3	8.9	2
Luxembourg*	8.6	5	8.5	9	8.5	8	8.6	8	8.5	8
Malta*	8.4	8	8.3	14	8.2	15	8.2	15	8.4	12
Netherlands	8.2	13	8.0	21	8.5	9	8.1	21	8.3	13
Poland	8.2	16	8.2	17	8.1	22	8.0	23	8.0	22
Portugal*	8.1	17	7.9	25	8.3	13	8.1	20	8.2	16
Romania*	8.6	7	8.2	16	8.8	4	8.6	7	8.6	6
Slovakia*	7.7	26	8.3	11	8.2	16	8.2	16	8.2	17
Slovenia*	8.0	21	8.3	12	8.4	10	8.4	11	8.2	20
Spain	8.1	18	7.9	23	8.3	12	8.2	17	8.2	18
Sweden	7.8	24	8.3	15	8.2	19	8.2	18	8.2	14
United Kingdom	8.8	2	8.8	4	8.8	7	8.7	5	8.9	3
EU average	**8.1**		**8.2**		**8.2**		**8.1**		**8.1**	

Source: *EQLS 2016*

Table A2: Continuing professional development (CPD) and ratio of children to staff by Member State

		Ratio of children to staff in full-time equivalents, by type of ECEC service						Index of change between 2005 and 2016 (2005 = 100) in number of children per teacher in pre-primary education (ISCED 02) (based on head counts)		
		ISCED 01		ISCED 02		Total (ISCED 0)		Change in number of children enrolled	Change in number of teachers	Change in number of children per teacher
	CPD as professional duty or necessary for promotion 2017/2018	Children to contact staff (teachers and teachers' aides)	Children to teaching staff	Children to contact staff (teachers and teachers' aides)	Children to teaching staff	Children to contact staff (teachers and teachers' aides)	Children to teaching staff			
Austria	The entire ECEC phase	6	9	9	13	8	12	118	148	79
Belgium	The entire ECEC phase	m	m	15	15	m	m	112	123	90
Bulgaria	Children aged 3 years or more	m	m	m	m	m	m	m	m	m
Croatia	The entire ECEC phase	m	m	m	m	m	m	m	m	m
Cyprus	Children aged 3 years or more	m	m	m	m	m	m	m	m	m
Czechia	Children aged 3 years or more	a	a	13	13	13	13	137	125	109
Denmark	CDP is optional	m	m	m	m	m	m	m	m	m
Estonia	The entire ECEC phase	m	8	m	8	m	8	m	m	m
Finland	The entire ECEC phase	m	m	m	10	m	m	m	m	m
France	Children aged 2 years or more	a	a	15	23	15	23	m	m	m
Germany	The entire ECEC phase	5	5	9	10	7	8	98	128	76
Greece	Children aged 4 years or more	m	m	m	m	m	m	115	132	87
Hungary	The entire ECEC phase	10	10	12	12	12	12	95	87	110
Ireland	CDP is optional	a	a	m	m	m	m	m	m	m
Italy	Children aged 3 years or more	a	a	13	13	13	13	97	99	98
Latvia	The entire ECEC phase	m	m	m	10	m	10	m	m	m
Lithuania	The entire ECEC phase	7	10	7	10	7	10	119	121	98
Luxembourg	The entire ECEC phase	a	a	11	11	11	11	116	155	75

		Ratio of children to staff in full-time equivalents, by type of ECEC service						Index of change between 2005 and 2016 (2005 = 100) in number of children per teacher in pre-primary education (ISCED 02) (based on head counts)		
		ISCED 01		ISCED 02		Total (ISCED 0)		Change in number of children enrolled	Change in number of teachers	Change in number of children per teacher
	CPD as professional duty or necessary for promotion 2017/2018	Children to contact staff (teachers and teachers' aides)	Children to teaching staff	Children to contact staff (teachers and teachers' aides)	Children to teaching staff	Children to contact staff (teachers and teachers' aides)	Children to teaching staff			
Malta	Children aged 3 years or more	m	m	m	m	m	m	m	m	m
Netherlands	CDP is optional	a	a	14	16	14	16	m	m	m
Poland	Children aged 3 years or more	a	a	m	14	m	14	138	190	73
Portugal	Children aged 3 years or more	m	m	m	17	m	m	100	91	110
Romania	The entire ECEC phase	m	m	m	m	m	m	m	m	m
Slovakia	Children aged 3 years or more	a	a	12	12	12	12	107	119	90
Slovenia	The entire ECEC phase	6	6	9	9	8	8	146	151	97
Spain	Children aged 3 years or more	m	10	m	15	m	13	127	144	88
Sweden	CDP is optional	m	m	m	m	5	13	m	m	m
UK	Children aged 3 years or more	m	m	m	m	m	m	m	m	m
EU average		**7**	**8**	**12**	**13**	**11**	**12**	**116**	**130**	**90**

Notes: *Professional duty means that it is described in working regulations/contracts/legislation or other regulations of the teaching profession (European Commission et al, 2016). In Scotland, CPD is a professional duty or necessary for promotion for the entire ECEC phase. Data for France represent public and government-dependent private institutions only. For Germany, the year of reference is 2006 instead of 2005. a = Data are not applicable – the category does not apply. m = Data are not available – either missing or the indicator could not be computed due to the low number of respondents.*
Source: *European Commission et al, 2018; OECD, 2018b – see Source section for more information and Annex 3 for notes*

Table A3: User satisfaction with childcare and objective indicators of quality, EU28 (individual and macro indicators)

Variables	1	2	3	4
Sex = 2, Female	0.005	0.005	0.006	0.004
Age	−0.002***	−0.002***	−0.002***	−0.002***
Income quartile = 2, q2	−0.005	−0.002	−0.004	−0.007
Income quartile = 3, q3	0.036**	0.038**	0.039**	0.034**
Income quartile = 4 (top), q4	0.042	0.041	0.041	0.042
Household size = 2, 2	0.007	0.016	0.018	0.006
Household size = 3, 3	0.008	0.011	0.015	0.010
Household size = 4, 4	−0.002	−0.002	0.005	−0.002
Household size = 5, >5	0.032	0.036	0.042	0.032
Single parent = 1, Single parent	−0.029	−0.031	−0.032	−0.029
Lives with partner = 1, Lives with partner	0.032	0.032	0.029	0.035
Lives with partner/children = 1, Lives with partner/children	−0.050	−0.053*	−0.054*	−0.052*
Education: three categories = 2, Upper secondary or post-secondary	0.040***	0.086***	0.022**	−0.223*
Education: three categories = 3, Tertiary	0.014	0.133***	−0.027*	−0.350***
Born in another country than the surveyed country = 1, Born in another country	−0.028	−0.029	−0.027	−0.029
Elementary education#Child-to-teacher ratio		0.000		
Secondary education#Child-to-teacher ratio		−0.003***		
Tertiary education#Child-to-teacher ratio		−0.008***		
Child-to-teacher ratio	0.001	0.005	0.001	0.001
Public expenditure in ECEC	−0.020	−0.013	0.055	−0.021
Preschool group size	−0.005	−0.004	−0.004	−0.015***
Elementary education#Public expenditure in ECEC			0.000	
Secondary education#Public expenditure in ECEC			−0.050*	
Tertiary education#Public expenditure in ECEC			−0.117***	
Elementary education#Preschool group size				0.000
Secondary education#Preschool group size				0.011**
Tertiary education#Preschool group size				0.015***
Observations	910	910	910	910
R-squared	0.064	0.072	0.074	0.070

Notes: *The table presents coefficients of regression analysis. The reference categories are: men, first income quartile, one-person household, living without a partner, lower secondary or lower education, being born in the same country. Model 1 is a general model. Model 2 includes interaction between parental education and child to teacher ratio. In model 3, education is interacted with public expenditure in ECEC, while model 4 incorporates group size in preschool interacted with parental education. *** p<0.01, ** p<0.05, * p<0.1*

5 Education services: Access and quality

Introduction

Education impacts life in multiple ways beyond increasing competence and adaptability, and education certificates often serve as a proxy for skills (Jackson et al, 2008). Various other outcomes at later stages in life (e.g. health outcomes) are also highly correlated with educational attainment, directly or indirectly (e.g. through income). In addition, education is correlated with a whole range of non-economic aspects, including attitudes by facilitating the evaluation of complex social situations, widening the individual's knowledge and horizon of experiences, and promoting civic rights and responsibilities (EENEE, 2018). There is ample research on the connection between education and quality of life. Education is key in promoting social inclusion and learning about European integration (Edgerton et al, 2012; European Commission, 2018).

Education systems shape occupational opportunities for individuals most when they join the labour market. Indeed, one of the most relevant objective outcomes of education and training is 'enhancing employability to meet current and future labour market challenges' as specifically mentioned in the strategic framework for European cooperation in education and training (ET 2020) (Council of the European Union, 2009). Initial education has a more or less long-term implication for a career and success in the labour market (Allmendinger, 1989). Many empirical studies in sociology have shown the link between educational attainment and labour market institutions across different countries (e.g. DiPrete et al, 2017). In a very general way, education systems reflect and interact with the organisation of work and support the functioning of the economy but also reproduce social stratification.

The nature of vocational education in different countries is affected by labour market coordination (e.g. Estevez-Abe et al, 2001). Coordination often takes place at the industry level, where supply and demand of skills can be addressed by the social partners.

The ET 2020 (Council of the European Union, 2009) defined targets to be achieved at European level by 2020:

- The rate of early leavers from education and training aged 18–24 should be below 10%.
- At least 40% of people aged 30–34 should have completed some form of higher education.
- At least 95% of children should participate in early childhood education.
- Fewer than 15% of 15-year-olds should be under-skilled in reading, mathematics and science.
- At least 15% of adults should participate in lifelong learning.
- At least 20% of higher education graduates and 6% of those aged 18–34 with an initial vocational qualification should have spent some time studying or training abroad.
- The share of employed graduates (aged 20–34 with at least upper secondary education and having left education one to three years ago) should be at least 82%.

The first two of these targets make up the education target of the Europe 2020 strategy (see European Commission, 2010).

Evidently not all education is provided by public authorities, as some providers of education are private market actors, nor are all skills taught in a school environment. It is often difficult to make the distinction between public and private services. For example, some schools are organised privately, but the teachers are paid by the state, or the buildings provided by the state. A lot of public–private partnerships are making it difficult to discern which schools are private or public. In nearly half of the Member States, private schools make up less than 10% of all secondary schools, but in some countries, like Belgium and the Netherlands, most schools are private (Eurydice, 2000; Dronkers and Robert, 2003).[12]

12 In 2015, non-educational private sources contributed 18% of total expenditure on education in the EU, peaking at 24% in Cyprus and 28% in the UK (see Eurostat, undated-a).

Education systems have changed a lot over the years. Asking a respondent in their fifties about their education will certainly yield a very different result to asking someone in their twenties. And last but not least, education takes place over an extended period, usually 9–16 years. It is impossible to take account of all these caveats when dealing with a survey such as the EQLS that includes only ten variables related to education, most respondents having ended their initial formal education some time previously.

This chapter treats 'access to education' as educational achievements: What proportion of the population possesses tertiary education? What share of adults have low levels of achievement?

Variety of education systems in the EU

The structure of the education system varies for each country and also occasionally within countries and regions/states (e.g. in Germany). Differences concern the point in time when pupils are separated and selected to go to different schools ('streaming' or 'tracking'). The division into one or more types of school may happen immediately after lower secondary or after primary school, and in some systems the possibility to move on to higher tracks is given at the end of each school type.

Aspects of the school system

Every school system is path dependent and tends to reproduce the power structures of the society it is embedded in. Each system is shaped according to fundamental beliefs of citizens, the elites and interest groups in the country (Archer, 1984). It is theorised that education reflects and reproduces class inequality (Bourdieu and Passeron, 1977). But education organisations also have their own autonomous dynamics, shaping and reshaping social stratification (Collins, 2000). Some of the major structural characteristics of education systems are in the following (non-exhaustive) list:

1. the extent to which vocational students are taught specific occupational skills as opposed to more general ones
2. the extent to which the curricula and certificates awarded in the systems are standardised
3. the degree of stratification of secondary education in the different countries
4. the proportion of recent cohorts who attained post-secondary qualifications

Standardisation is the level to which education meets the same standards in a given territorial unit, such as a nation state (item 2 above). The level of standardisation is reflected in teacher training, curricula, school budgets and the centralisation of school-leaving examinations.

Stratification can be reflected in the proportion of a cohort that attains the maximum number of school years provided by the education system (item 3 above). This is obviously related to the degree of differentiation (tracking) within a given education system. It is commonly accepted that cross-national variation in the impact of education on labour market outcomes largely reflects differences in the level of institutionalised vocational specificity of education (e.g. Breen, 2005).

Secondary-level tracking reduces the number of people eligible to access tertiary education, but also means that fewer people require tertiary-level qualifications to obtain desirable positions in the labour market. In a system where vocational education is unspecific, vocational credentials are less accepted than general academic credentials. Where vocational training is more specific, and the outcome standardised, vocational degrees are accepted and sought after by employers to the same extent as more academic leaving certificates, though for different positions. Further, vocational specificity indicates the extent to which education tracks prepare students for occupation-specific skills (item 1 above). Vocational specificity is obtained by institutionalised apprenticeship training that combines work experience in regular firms with schooling that is designed to improve students' occupation-specific skills.

Countries with highly stratified education systems, strong vocational components and extensive early tracking tend to provide pupils with a set of qualifications that are closely related to the expectations of potential employers. Countries with less vocational training and stratification are producing students with a high level of general skills but fewer occupationally relevant skills (Allmendinger, 1989). The theoretical rationale for this finding is straightforward: the more stratified and vocationally specific the education system, the more transparent potential employees' qualifications are to employers and, thus, the stronger the match between education and occupation.

In stratified education systems, there is a tight coupling between the system and occupational structure, while in unstratified systems, this coupling is loose. More training needs to be provided for school leavers to be able to integrate into the labour force. The effect of the tight coupling between education and occupations is to reduce job shifts at the beginning and over the course of working life.

Typology of school systems

Education in Europe is path dependent, and there seems to be a clear distinction between geographical regions and language regions: the countries of Germanic origin (Austria, Germany, Luxembourg and the Netherlands) seem to have developed a similar

Table 2: Typology of school systems in the EU, 2018–2019

Eurydice (primary and secondary education)	Description	Countries
Single structure	Education is provided in the same structure from the beginning to the end of compulsory schooling, with no transition between primary and lower secondary education, and with general education provided in common for all pupils.	Croatia, Denmark, Estonia, Finland, Poland, Slovenia, Sweden
Common core curriculum	After successful completion of primary education (ISCED 1), all students progress to the lower secondary level (ISCED 2) where they follow the same general common core curriculum.	Belgium, Bulgaria, Cyprus, France, Greece, Ireland, Italy, Malta, Portugal, Romania, Spain, UK
Mixed	Common core and single structure coexist.	Czechia, Hungary, Latvia, Slovakia
Differentiated branches	After successful completion of primary education, students are required to follow distinct education pathways or specific types of schooling, either at the beginning or during lower secondary education. In some countries, students follow different tracks in vocational, technical or general education. In others, they are enrolled in different types of general education. At the end of their studies, they receive different levels of certificate.	Austria, Germany, Lithuania, Luxembourg, Netherlands

Source: *European Commission et al, 2018*

education system and labour market type, while the countries with Latin roots (Italy, Portugal, Spain, etc.) have adopted a different pattern of education and labour markets.

The term 'education system' describes all institutions that actively provide education to children, young people and adults, either on a full-time or a part-time basis. An education system determines the curricula, ties and linkages between different levels of education: preschool/kindergarten, preschool/nursery school, primary school, lower secondary school, vocational upper secondary school, general upper secondary school or gymnasium/grammar school/lycée, high school, vocational school and, on the tertiary level, polytechnics/Fachhochschule, universities and institutions of adult education.

Three basic models of school systems have emerged in Europe over the past century: the Scandinavian model of comprehensive schooling; the more traditional tripartite system in central Europe (with a strict separation of vocational and academic tracks and early selection); and the mixed systems in most of the other EU Member States, where vocational training is school based, there are possibilities to move from one segment to the other more easily and selection usually happens at a later stage.

Education systems vary between countries and sometimes within, as noted above. Each system prescribes when and according to which criteria pupils are separated and selected to go to different types of school. Such a separation may happen immediately after four years of initial schooling, as in Germanic countries, or after primary school, as in countries with Latin roots (Belgium, France, Italy and Spain).

In other systems, schooling is more comprehensive during the first nine years, as is the case for countries that have a single structure (mostly Nordic countries). Although the different education systems vary according to the inclusion of selective or comprehensive schooling, all systems can be classified according to the ISCED, with specific levels of formal and non-formal education (Unesco Institute of Statistics, 2011).

Comparative research has concluded that a substantial share of the quality of national education systems is determined by differences in the institutional context across countries (Bishop and Wössmann, 2001). Among the key factors are the size and type of public and private schools, the role of the governance and autonomy of schools and the opportunity for school choice.

Data on quality and satisfaction

The following sections make use of EQLS 2016 data on rating the quality of the education system in the respondent's country (from 1, very poor quality, to 10, very high quality) (Q58) as well as self-reported satisfaction with the respondent's own education (Q6). Satisfaction with one's education is a straightforward indicator of the subjective assessment of the education system as one has experienced it. The scale also used ranges from 1 to 10, with 1 representing very dissatisfied and 10 very satisfied.

A further set of five questions (Q85a to Q85e) about quality aspects of schools were asked of respondents with children or someone else in the household who had attended school in the previous 12 months; this corresponds to about 22% of the respondents in the survey. The indicators are 'quality of the facilities (building, room, equipment)', 'expertise and

Table 3: Macro-level statistical indicators regarding education in the EU, 2016–2017

Eurydice classification of education systems	Respondents in education, training or employment ('000s)	Quality indicator of schools (average)	Satisfaction with own education	Satisfaction with public education	Share of people with secondary education	Share of people with tertiary education	On-the-job training propensity	Industrial Relations Index
Single structure	30,446	7.9	7.5	7.1	50.0%	37.9%	45.3%	57
Common core	145,984	7.5	7.2	6.6	43.5%	34.1%	31.0%	50
Mixed	14,300	7.7	7.4	6.4	54.0%	26.0%	35.3%	46
Differentiated branches	63,872	7.7	7.5	7.1	40.8%	39.5%	46.1%	63
Total/average	254,601	7.7	7.4	6.8	47.1%	34.4%	39.4%	54

Notes: *School quality is the variability of an indicator for quality of education services in each Member State. The indicator is based on five items in Q85 of the EQLS 2016. The two variables measuring satisfaction with education (own and in general) are questions Q6 and Q58 of the EQLS 2016. Satisfaction is scored on a scale of 1–10, with 10 being the highest level of satisfaction. Educational attainment is taken from the tables 'Population by educational attainment level, sex and age', EU Labour Force Survey (EU-LFS), aggregate data from the Eurostat website for the year 2017. On-the-job training is measured as the incidence of job-related training in the 12 months prior to the EQLS survey. The Eurofound Industrial Relations Index (Eurofound, 2018) represents the strength of five dimensions of industrial relations on a scale from 1-100.*
Source: *EQLS 2016; EU-LFS 2017*

professionalism of staff/teachers', 'personal attention given, including staff/teachers' attitude and time devoted', 'being informed or consulted about this person's education' and 'the curriculum and activities'. As these questions are asked to only a subset of survey respondents, the results must be treated with some caution.

Finally, in 2018, Eurofound developed a new index to measure the quality of industrial relations. This maps all key dimensions of industrial relations defined as 'the collective and individual governance of work and employment relations'. The conceptual framework behind the indicator has identified four key dimensions of industrial relations: industrial democracy, industrial competitiveness, social justice and quality of work and employment. The index combines a dashboard of 45 individual indicators to provide a tool to analyse national industrial relations systems across the EU (Eurofound, 2018).

Findings are presented in Table 3. In 2016, overall 255 million Europeans aged 18 or more were in education, training or employment. This represents about 50% of the total population. The quality indicator for schools (a summary indicator[13] of Q85a–e, as described above) is highest in countries with single-structure secondary education (7.9), followed by countries with differentiated branches (7.7). And then those with a mixed school system (7.7). Common core schools (7.5) have the lowest perceived service quality of all four school types.[14]

Looking at the level of satisfaction with one's own education, the highest satisfaction is found for respondents in countries with a single-structure system and in countries with differentiated branches (both 7.5), and this is statistically significantly higher than in mixed systems (7.4) and common core schools (7.2). And again, for ratings of the quality of the education system, single-structure countries and differentiated branches have the highest scores (both 7.1), followed this time by common core schools (6.6) and mixed systems (6.4).

Further, the results for educational attainment are similar: the highest shares of tertiary graduates among adult populations are in countries with differentiated branches (39.5%), followed by single-structure countries (37.9%) and common core schools (34.1%), with the lowest level found in countries with a mixed school system (26%). For both on-the-job training and industrial relations, the differentiated branches system comes top. Overall, there is a clear distinction with higher values for macro variables in countries with differentiated branches and single-structure education and lower values for countries with the other two systems.

13 The five indicators are used to construct a single summary indicator reflecting the subjective assessment of each respondent of the quality of their child(ren)'s school(s) (Cronbach's Alpha = 0.91).

14 All indicators presented in the table were tested using analysis of variance to test for significant differences at the 95% confidence level. The resulting statistics are not shown.

Associations[15] among the macro variables included in Table 3 are also interesting: industrial relations has a positive and highly significant association with training propensity, which mirrors findings commonly reported in the literature (Rainbird and Stuart, 2011; Eichhorst et al, 2015; Stuart, 2019). In the same way, the quality of industrial relations has a positive impact on employability. In countries with common core schools or mixed secondary education, vocational training is organised in schools (workshops) and tracking is weak, so the occupational specificity of secondary vocational education is low. Training on the job is mostly used for initiation as it is risky for employers. In fully competitive labour markets, there is an under-provision of training because of the poaching hazard: employers provide training to new recruits who then leave for another employer paying a wage premium for the training they have received.

As signalling is important, school differentiation is more likely to exist in countries with no differentiation of the school system or curriculum. School heterogeneity has a significant negative association with satisfaction with public education (−.17) – the higher the variation in school quality, the lower the satisfaction with education as a service – but a weak (and not significant) association with satisfaction with one's own education (0.015). School differentiation is negatively associated with satisfaction with public education as a service and satisfaction with one's own education in countries with a single system or differentiated tracks.

Access to education

Access to education is a universal human right; but access alone is not enough if this does not guarantee quality education and training for every pupil – that is, the possibility to enrol in a school that provides high-quality teaching, learning and support. A good education system also supports the pupil in choosing from a series of education pathways which meet students' learning needs and aspirations (European Commission, 2013). In past decades, education systems in all OECD countries have managed to provide universal access to basic education, and participation in education is now expanding to upper and tertiary levels of education.

At the primary and secondary levels, increasing demands for quality and equity in education, growing pressures for public accountability and transparency, a trend towards more decentralisation and school autonomy, and a greater capacity for knowledge management have resulted in increasing interest in evaluation and assessment in education. Many countries have introduced a wide range of measures to evaluate students, teachers, school leaders, schools and education systems. These tools are essential to a better understanding of how well students are learning, to provide information to parents and society at large and to improve schools, school leadership and teaching practices. The Programme for International Student Assessment, carried out by the OECD every three years, shows the performance of school systems in the delivery of key subjects up to the age of 15 (OECD, 2018).

Each education system has specific impacts on school attendance by age and particular options after leaving initial schooling. School attendance at 18 is highest in countries with a single education structure. It is a common phenomenon in the Nordic countries that after graduation from ISCED 3 (upper secondary), individuals first garner some professional experience before returning to school and completing some form of tertiary education (Hämäläinen and Uusitalo, 2008; Böckerman et al, 2009). The lowest attendance rate between 18 and 21 is for the countries with common core-type schooling. In a similar way to countries with a single structure, there is an increase in participation around the age of 21 before attendance drops to the lowest point by the age of 30. This indicates participation in post-secondary non-tertiary education but also in short-cycle tertiary education. Post-secondary attendance is lowest in countries with a mixed school system after the age of 20.

For countries with a differentiated tracking system, attendance is the highest of all systems up to 20 years of age, due to participation in post-secondary non-tertiary education and tertiary-level technical education. Participation in education starts to increase after the age of 21 in countries with a single-structure education system.

Education outcomes

In the following section the performance of education systems is gauged by the proportion of individuals who achieve each level of schooling. In Table 4, the shares of the population aged 15–64 having successfully completed ISCED 2 (lower secondary level) at most, ISCED 3 or 4 (upper secondary or post-secondary non-tertiary) and ISCED 5 to 8 (post-secondary tertiary education) are presented.

15 Associations are measured as Pearson's pairwise correlations with significant tests at the 95% confidence level. The results are reported here with no detailed statistics.

Table 4: Population share by educational attainment level (aged 15–64), 2017 (%)

EU Member States by education system	ISCED 0 to 2	ISCED 3 to 4	ISCED 5 to 8
Single structure	**19.0**	**50.2**	**30.7**
Poland	13.9	59.8	26.3
Croatia	19.9	59.6	20.6
Slovenia	16.7	54.6	28.7
Estonia	16.8	48.4	34.7
Finland	18.4	45.2	36.4
Sweden	21.1	42.9	36.0
Denmark	26.4	41.2	32.4
Common core	**31.2**	**40.0**	**28.7**
Romania	27.0	57.7	15.3
Bulgaria	21.4	54.1	24.5
Greece	29.3	43.6	27.2
France	25.3	43.3	31.4
Italy	40.9	42.6	16.5
UK	20.0	41.2	38.8
Cyprus	22.9	39.0	38.1
Ireland	21.8	37.8	40.4
Belgium	27.2	37.1	35.6
Malta	45.6	32.3	22.1
Portugal	51.7	26.6	21.7
Spain	41.8	24.9	33.2
Mixed	**15.8**	**61.0**	**23.3**
Czechia	12.1	66.5	21.4
Slovakia	14.8	64.5	20.7
Hungary	21.1	58.0	20.9
Latvia	15.2	54.8	30.0
Differentiated branches	**21.6**	**47.3**	**31.1**
Germany	19.8	55.4	24.8
Lithuania	12.0	53.2	34.8
Austria	19.3	51.0	29.7
Netherlands	26.6	41.3	32.1
Luxembourg	30.5	35.4	34.1

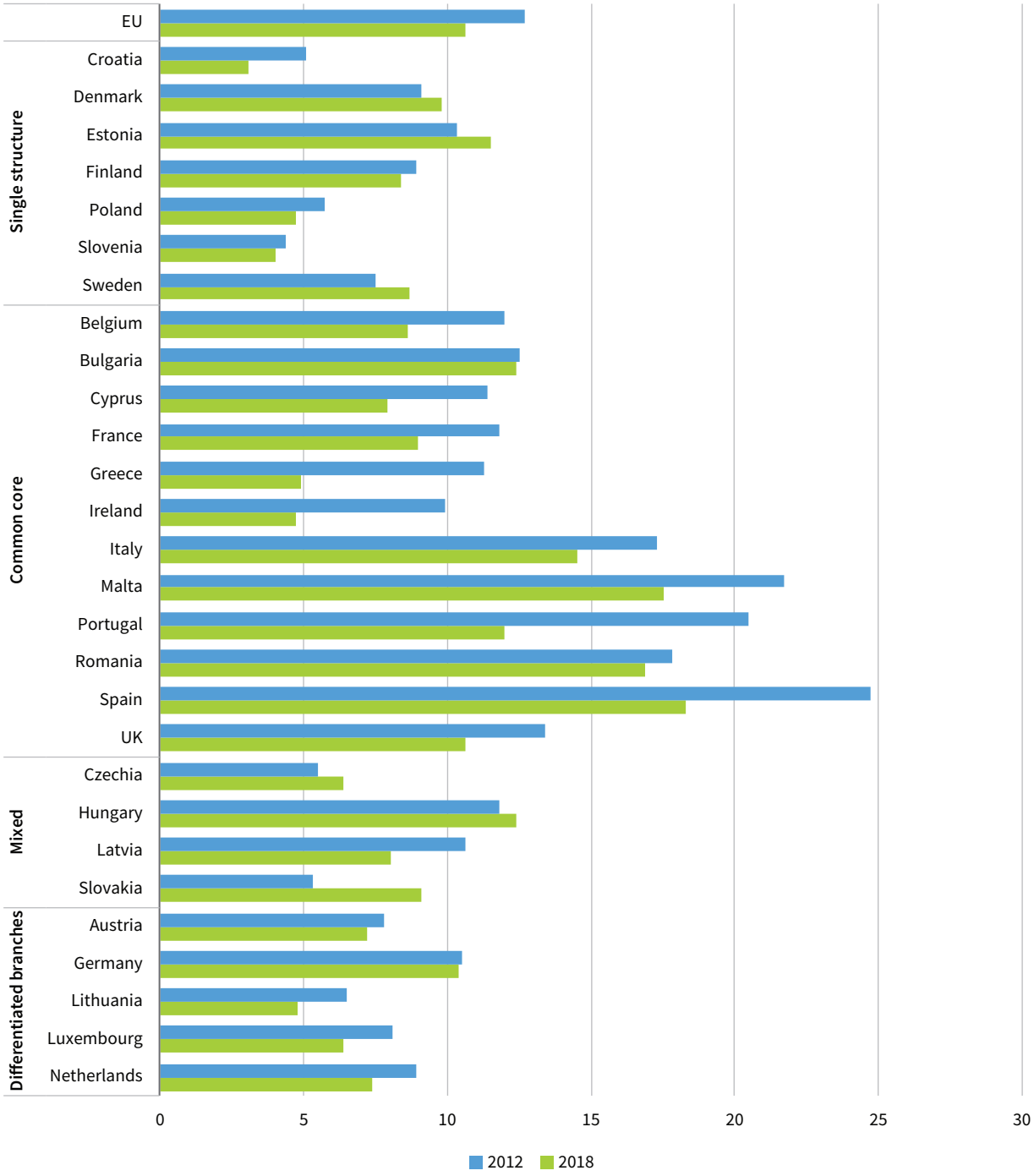
Notes: *The table presents data on the highest level of education successfully completed by individuals in a given population. The Member States are grouped by the Eurydice education system classification; within each group, Member States are sorted by the share of ISCED 3 to 4, descending.*
Source: *The data shown are calculated as annual averages of quarterly EU-LFS data, downloaded from Eurostat, undated-b*

Low educational achievement

One way of measuring school achievement is to see how many adults have left initial full-time schooling without completing upper secondary education. The higher the share of those who do not enter lower levels of secondary or drop out of school before completing upper secondary level, the more problematic the delivery of education by a school or national education system. The EU Member States agreed five 'European benchmarks' to support the strategic objectives outlined in the ET 2020. One of these benchmarks is for the share of the population aged 18–24 with lower secondary education or less and who are no longer in education or training to be lower than 10% (EU-LFS).

In 2018, 10.6% of people aged 18–24 in the EU had obtained, as their highest level of education, ISCED 2 or below – down from 12.7% in 2012 (see Figure 17), just a little above the benchmark set in 2009 (Council of the European Union, 2009). The problem is most acute among countries with common core secondary education, where in 2018, the percentage of adults with only low educational attainment was as high as 18.3% in Spain, followed by Malta (17.5%) and Romania (16.9%). The lowest shares are among countries with differentiated branches and those with single-structure education, both groups with 7.2% of early school leavers aged 18–24 in 2018.

Figure 17: Share of people aged 18–24 with low educational achievement, 2012 and 2018 (%)



Notes: *Early leavers from education and training. Percentage of the population aged 18–24 with, at most, lower secondary education and not in further education or training.*
Source: *EU-LFS [t2020_40]*

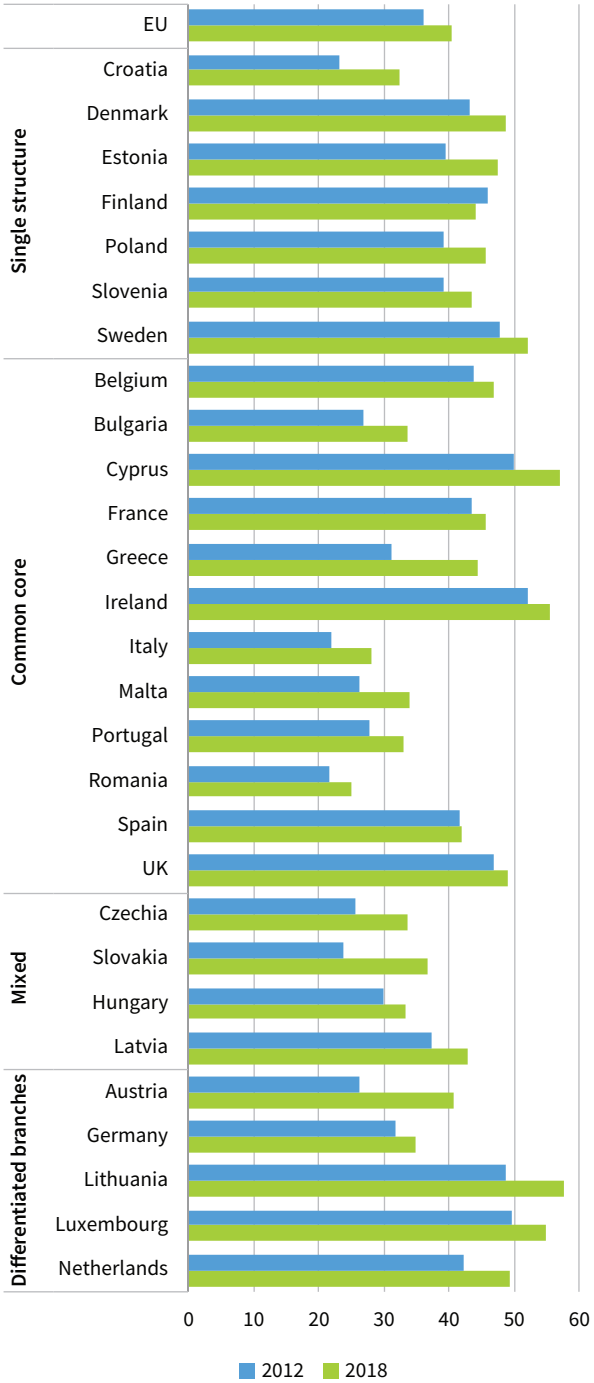
Tertiary education

In a modern economy, the level of general education becomes more and more important. It is widely acknowledged that the share of tertiary graduates is important for innovation capacities in a market economy (OECD, 2004). Recognition that tertiary education is the major driver for economic competitiveness and increasingly determinant in a knowledge-based global economy has rendered tertiary education more important than ever before. The imperatives for countries are to raise higher-level employment skills, to sustain a globally competitive research base and to improve knowledge dissemination for the benefit of society. The third of the agreed benchmarks (Council of the European Union, 2009) stipulated that by 2020, the share of those aged 30–34 who have successfully completed tertiary education should be at least 40%. While acknowledging the equal importance of medium-level vocational education and training, raising tertiary education attainment levels among young people will accompany and support the targeted research- and innovation-oriented smart growth. This will also help meet the increasing demand for a highly qualified workforce.

In 2018, 40.5% of people aged 30–34 had attained tertiary-level education in the EU, up from 36% in 2012 (see Figure 18) – hence, the Europe 2020 target of 40% has already been surpassed. The highest levels of tertiary education attainment are reported in Cyprus, Ireland, Lithuania, Luxembourg and Sweden (all with above 50% tertiary graduates among those aged 30–34 in 2018). In contrast, in Italy and Romania, less than 30% of this age group had tertiary-level attainment.

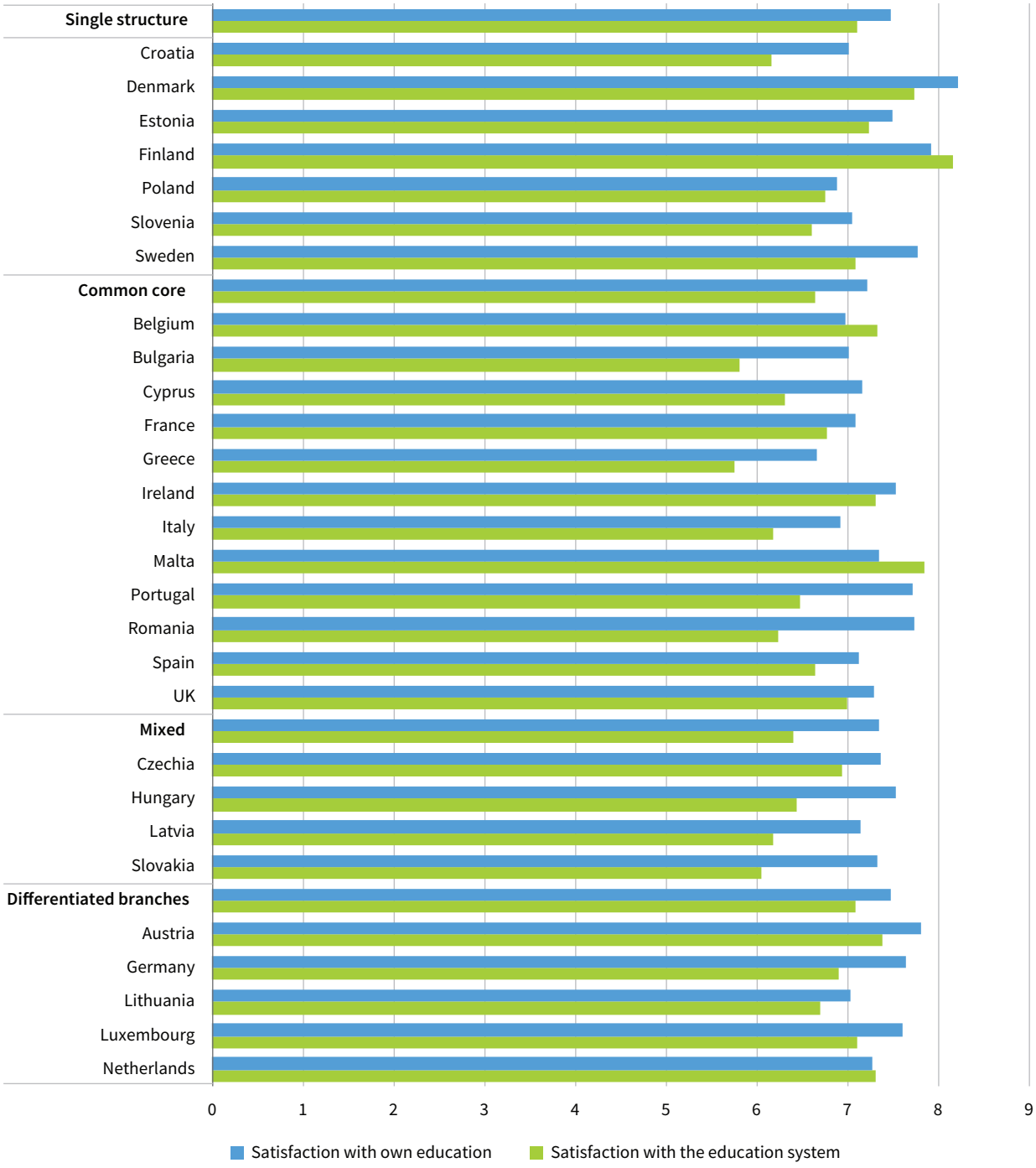
The share of tertiary graduates is highest (47%) in a group of countries with differentiated branches (Lithuania, Luxembourg and the Netherlands), although the shares are much lower in Austria and Germany and lowest (36%) in countries with mixed secondary school systems (Czechia, Hungary, Latvia and Slovakia). Countries with single-structure secondary education shown, overall, a high level of tertiary-level attainment, with all countries except Croatia having over 40% of adults with tertiary education (the average was 45% for these countries in 2018).

Figure 18: Share of people aged 30–34 with a tertiary-level qualification (ISCED 5 to 8) by type of education system, 2012 and 2018 (%)



Notes: *The indicator is defined as the percentage of the population aged 30–34 who have successfully completed tertiary studies (university, higher technical institution, etc.). This educational attainment refers to ISCED 1997 Levels 5–6 for data up to 2013 and ISCED 2011 Levels 5–8 for data from 2014 onwards.*
Source: *EU-LFS [t2020_41]*

Figure 19: Satisfaction with one's own education and the quality of the education system by type of education system, 2016



Notes: *Satisfaction and quality are measured on a scale from 1 to 10, with 10 representing the highest level.*
Source: *EQLS 2016*

Satisfaction with education

The EQLS 2016 asks: 'Could you please tell me on a scale of 1 to 10 how satisfied you are with your education?' (see Figure 19). As we have seen earlier, this subjective indicator is closely associated with other more objective measures. The highest levels of satisfaction with one's own education were observed in Denmark (with a score of 8.2 out of 10), Finland (7.9), Sweden (7.8) and Austria (7.8), while the lowest levels were found in Belgium (7.0), Italy (6.9), Poland (6.9) and Greece (6.7).
The difference between the two extremes is, however, only 1.56 on a 10-point scale. The characteristics of the education system of countries at both ends of the scale offer no conclusive results, only that five of the top seven countries are Nordic (single structure) or central European (differentiated branches). At the other extreme, five of the seven countries with the lowest levels of satisfaction with one's own education are from

either southern Europe or central eastern Europe and have either a common core education system or a mixed one.

The results for ratings of the quality of the education system in their country of residence follow a similar pattern. Finland (8.2), Denmark (7.7) and Austria (7.4) are the countries with the highest ratings when it comes to the quality of the education systems, while Italy (6.2), Bulgaria and Greece (both 5.8) are found at the lower end of the spectrum.

The indicator for school quality (explained above) correlates very highly (.46) with self-reported assessments of the quality of the education system (Q58), but the correlation is lower (.16) with self-reported satisfaction with one's own education (Q6), not surprisingly, as the current school system (and quality level) may have little relation with past education. Satisfaction with one's own education varies with covariates as follows.

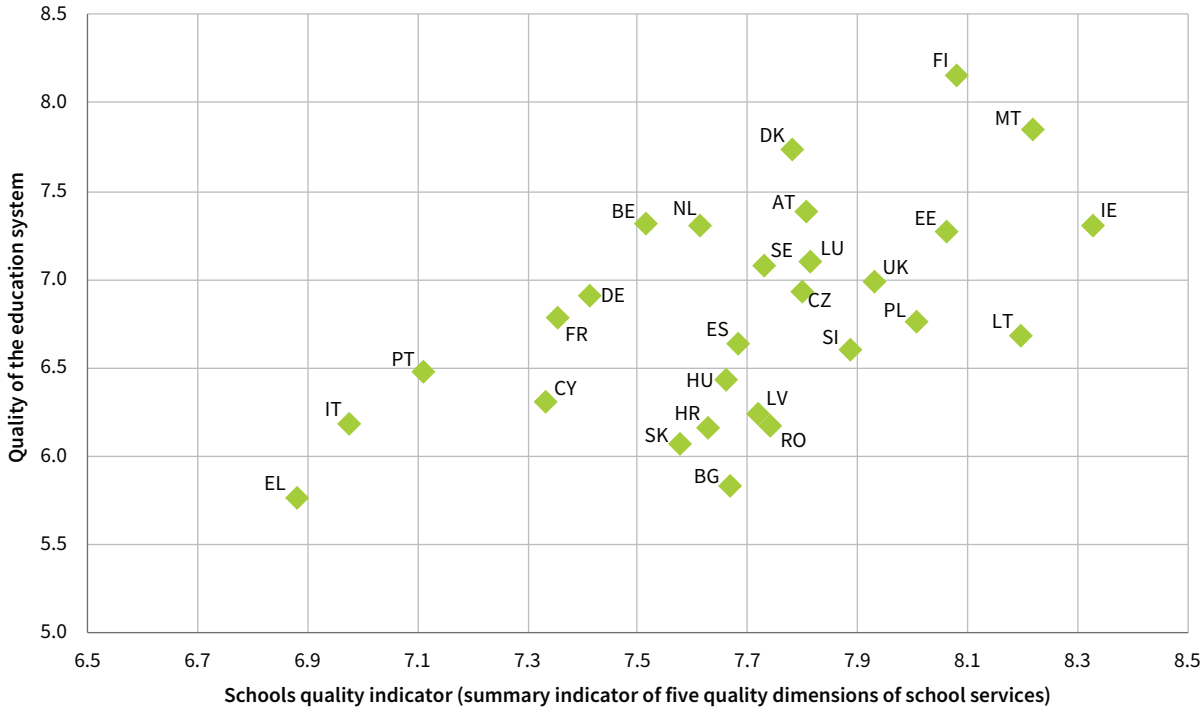
- Everything else being equal, respondents who are older give relatively high ratings to their own education. The relationship is, however, U-shaped, so younger respondents also have higher satisfaction with their own education than prime-age respondents.
- Everything else being equal, respondents with tertiary-level education are the most satisfied followed by those with secondary-level education, and finally, the least satisfied are those with only basic education.
- Everything else being equal, respondents in countries with differentiated tracks are the most satisfied, while the least satisfied with their education are respondents from countries with a common core education system.

Satisfaction with education as a public service is a more indirect measure. The questions about school quality are only asked of those individuals who have children attending school. Nevertheless, there is a clear correlation between the 'quality of schools' indicator and ratings of the quality of the education system (see Figure 20).

Overall, a regression analysis with quality of the education system as a dependent variable and including controls for sex, age, migration status (own and father's), school quality, highest level of education and education system yields the following results (everything else being equal).

- Women rate the quality of the education system slightly above the average.
- Migrants gave ratings of the quality of the education system above the average.
- The highest ratings of the quality of the education system were attained in countries with single-structure education, followed by those with differentiated branches and common core education, and were lowest in mixed education systems.

Figure 20: Quality of the education system, 2016



Note: *Quality is measured on a scale from 1 to 10, with 10 representing the highest level.*

Conclusions

- Today at least four types of education system, with different origins, can be distinguished in the EU, depending on whether there are different tracks after the first part of secondary education or whether education is offered in the same fashion for all pupils enrolled until they have reached the end of mandatory schooling age or until finishing secondary education. Furthermore, differences in the vocational content of the education system are important.
- These education systems range from universal comprehensive schools in the Nordic countries to the early streaming of pupils into separate tracks of general academic and hands-on vocational education to prepare pupils for a clearly defined set of occupations. Somewhere in between are the common core countries where education is mostly general and differentiation is achieved by curricula containing more or less vocational components, although vocational training in special workshop settings is always considered as inferior. The following four main types have been identified: single-structure education; common core curriculum provision; differentiated lower secondary education; and mixed provision (see Table 2).
- The proportion of those aged 30–34 with tertiary education is highest in countries with single-structure education and those with differentiated branches. The share is lowest in countries with common core education. Participation in tertiary-level schooling after the age of 18 is highest in countries with a single-structure education system where it has become usual to return to higher education after a period in the labour market. Altogether, the share of adults with tertiary-level education is, however, highest in countries with differentiated branches.
- Low education achievement is highest in countries with common core education. The vocational content of education is highest in countries with differentiated branches with the practice of dual apprenticeships, followed by countries with single-structure education. Vocational content in education is lowest in countries with common core education, where vocational schools are traditionally considered second best and seem to signal a failure in the education career and where employers' expectations favour the more academically oriented tracks.
- Regarding satisfaction with one's own education, the highest levels are found in countries with single-structure education, followed by countries where education is organised in differentiated branches. Satisfaction is lowest in countries with common core or mixed types of education.
- Training provision is highest in countries that provide a high level of vocational skills to those arriving at the end of their secondary education via dual apprenticeships: countries with differentiated branches. This could also be due to the high level of tertiary-educated people.

Policy pointers

- For some countries (e.g. high-tech economies), it is preferable to achieve the highest possible general level of education for the majority of the population. State-sponsored single-structure education that brings most people to the highest general educational achievement and provides free tertiary-level education – in particular, vocationally oriented tertiary-level education – guarantees a highly skilled and adaptable workforce. This is the way skill formation is organised in all Nordic countries.
- Another possibility is to combine general education with on-the-job training or learning at secondary level. This is implemented in central Europe with early tracking and dual apprenticeships. The standardisation and specialisation of those leaving school is very high, and employers know what to expect from every graduate. This form of education suits the type of economy found in Germanic countries.
- Avoiding early school drop-out is another issue that needs to be tackled, particularly in countries with a common core education system where the share of students that drop out of school early is highest. This is possibly due to a lack of opportunities for pupils in common core school systems who are not following academic curricula. Education outcomes are not very standardised, and further tertiary education is limited.

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6 Young people: Inequalities in access to health and social services

Introduction

Social policy must always pay attention to young people as a social group, now and into the future. This is despite their being a diverse group with very different issues depending on their location and economic and social circumstances. The need for attention is due to their vulnerability during transition to adulthood and their particular needs at this time.

For a long time after 2008, policymaking at EU and national levels concentrated on the impact of the economic crisis on the well-being of young people (in this chapter, defined as people aged 12–24). The economic crisis is over in Europe; young people affected by it have grown up and many have returned to work. However, not everybody is benefiting from the improved economic situation. While young people are not a disadvantaged group overall, there are significant inequalities between groups of young people in terms of quality of life. Many current policy initiatives, such as the Youth Guarantee, target young people not included in the labour market or in education. However, inequalities between young people are prominent in other areas too, the most important being social inclusion, health and mental well-being and access to services.

Eurofound's report *Inequalities in the access of young people to information and support services* (2019) looks in detail at the most common social and health issues for young people before providing evidence on which groups face the most difficulties in accessing social and health services, what the main barriers to access are and how service providers prove successful in overcoming these barriers.

The most important findings of that report are outlined in this chapter, starting with a short summary of the main social and health issues affecting young people in Europe, as well as an outline of findings and trends surrounding young people's mental health in EU countries. The main focus of the chapter is access to services for young people. First, a summary of the types of services available and the problems they address is provided. Then new analysis is included on young people's access to health services, with particular attention to inequalities in access by different groups, based on results from the EQLS 2016. The final section, based on case studies and consultation with service providers, outlines strategies for policymakers to address these inequalities and provide better access to support and health services for all groups of young people.

Social and health issues affecting young people

The number of young people in Europe is on the decline, both in absolute and relative terms, affected both by birth rates and migration flows. Due to the latter, some receiving countries (e.g. Denmark, the Netherlands, Sweden and the UK) have been able to maintain their youth populations, while many others (e.g. Poland, Romania and Slovakia) have lost over 5% in the past 15 years.

Nearly one-third of young people (29% of those aged 12–17 and 31% of those aged 18–24) are at risk of poverty and social exclusion, while around 9% of both these age groups experience severe material deprivation (Eurostat [ilc_peps01], [ilc_mddd11]). A small proportion of young people experience the most severe economic hardship: homelessness. Worryingly, youth homelessness has increased in recent years in some countries that provide statistics on this issue, such as Denmark, Ireland and the Netherlands (Feantsa, 2018). Young people who lack strong family ties and those with mental health issues are most at risk of becoming homeless.

Despite the perceived importance of friendship networks for young people, family is the most important source of support. According to data from the EQLS 2016, even over the age of 18, 72% of young people (aged 18–24) turn to a family member when seeking advice or when feeling down and needing someone to talk to – this is well above the proportion who would ask a friend (52%). The rate of young people feeling socially excluded has declined in the past five years but remains high in some countries, notably Belgium, Bulgaria and Cyprus.

Economic hardship and inadequate support networks may contribute to mental disorders, which typically start at a young age (Kessler et al, 2007). Anxiety and personality disorders can begin as early as age 11, and half of mental disorders begin by age 14 (Kessler et al, 2007; OECD, 2012). Certain mental health problems, such as anorexia, bulimia and self-harm, are most commonly seen in young people. Chronic depression is especially common for young people in some countries, including Ireland and Finland (Eurofound, 2019).

Young people's physical health is often related to their mental well-being and health behaviours. Obesity is common among young people – especially in Bulgaria, Greece, Malta and the UK – with large gender gaps observed in many countries, boys having higher obesity rates (Eurofound, 2019). Anorexia and bulimia are more common among teenage girls than boys, but boys are also increasingly affected by eating disorders. Teenage pregnancy is declining in most European countries thanks to better access to contraception and tertiary-level education, but in many eastern European countries no decline is observed.

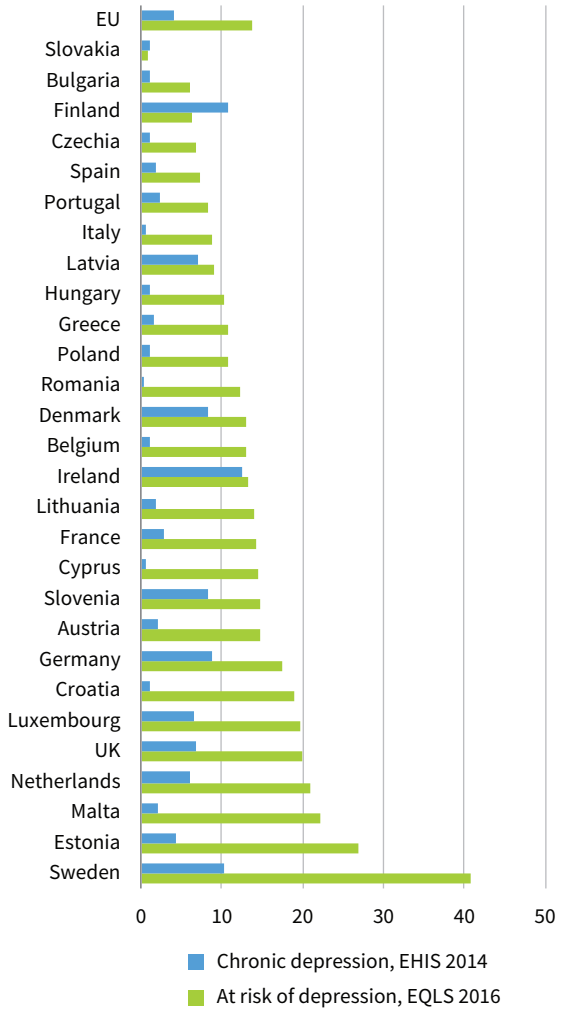
Some negative behaviours are strongly associated with young age and can be both the result of mental health problems and a cause of them. Bullying and cyberbullying others correlate strongly with having been bullied in the past. Being bullied is associated with having a younger age and poorer background. Both children who are bullied and those who bully others, and especially those who are both victims and bullies, are at increased risk of mental health problems and risky behaviours.

Some young people experience multiple and complex issues and are especially in need of support services. Substance abuse and other risky behaviours such as youth crime and unsafe sexual practices often occur together, have lifelong effects and are interrelated with material deprivation and mental health.

Many of these issues are gradually improving, with encouraging youth trends in tobacco smoking and alcohol consumption. However, new issues – like cyberbullying – are emerging, and many young people are still suffering the longer-term social impacts of the economic downturn. Access to services – especially health services but other support services as well – has been suggested as having a role in decreasing social exclusion through several channels, such as providing a sense of control and improving physical and mental health, depending on the nature of the service (O'Donnell et al, 2018).

This chapter focuses on inequality in access to high-quality services by young people – especially physical and mental health services – and how these inequalities can be overcome. As the mental health of young people can be affected by inequalities and be a cause of inequality itself, recent findings regarding young people's mental health are discussed first.

Figure 21: Young people at risk of depression based on WHO-5 index (age 18–24), 2016, and reported chronic depression (age 15–24), 2014 (%)



Source: *EQLS 2016; Eurostat – Persons reporting a chronic disease, by disease, sex, age and educational attainment level [hlth__cd1e].*

Mental health of young people

Young people's mental health has been the focus of research and policy related to youth issues, with most sources suggesting a worrying trend of increasing mental health issues for teenagers and young adults, and some researchers even suggesting a crisis in adolescent mental health in recent years (e.g. Gunnell et al, 2018).

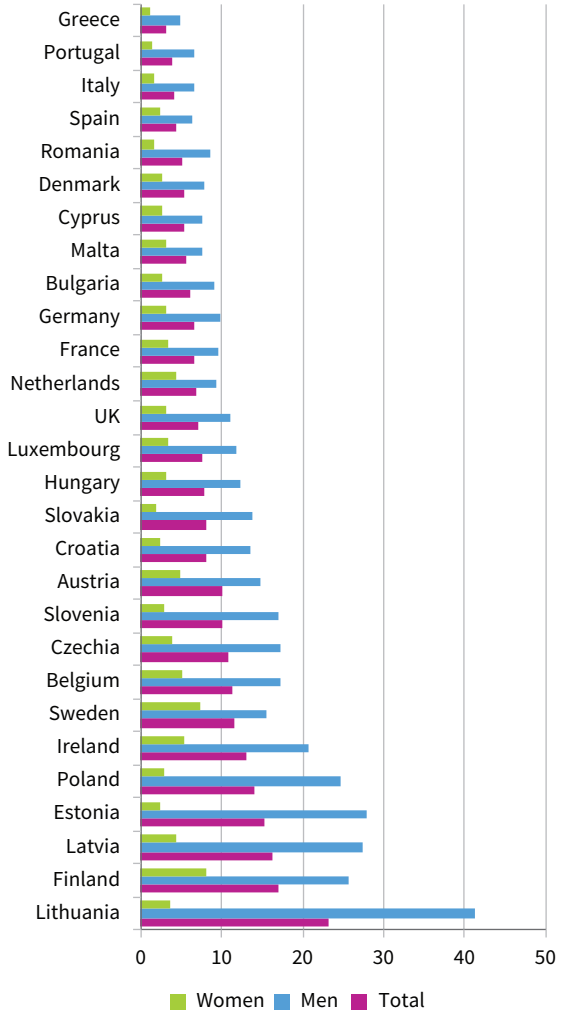
While most mental disorders begin at a young age, children are less likely than adults to receive treatment (Kessler et al, 2007). This affects young people's development, resulting in poorer educational attainment, higher risk of unemployment and worse physical health (OECD, 2018).

The EQLS measures general mental well-being using the WHO-5 scale, which asks people how they felt over the last two weeks. This measure, while not a diagnostic tool, can be used to estimate the proportion of young people potentially at risk of depression (see Figure 21).

The number of young people diagnosed with depression is much lower than those at risk of depression and, according to data from the EHIS 2014, was most common in Finland, Ireland and Sweden. While higher frequency of diagnosis can be a sign of high prevalence of a problem, it can also signal an effective primary diagnostic healthcare system and possibly a de-stigmatisation of mental health problems. In some other countries, low rates of diagnosis might hide the scale of the problem. High suicide rates among young people in the Baltic countries, for example, suggests that mental health issues are more common in these countries than is suggested by other statistics. Finland, Ireland and Sweden all have relatively high suicide rates, but this is also reflected in the data on depression in these countries.

Overall, there is a lack of comparative data over time and across countries on youth mental health, as diagnosis data miss undiagnosed mental health problems, of which children are at increased risk, while survey data are not available for the youngest group and include bias due to young people with mental health issues being less likely to answer surveys.

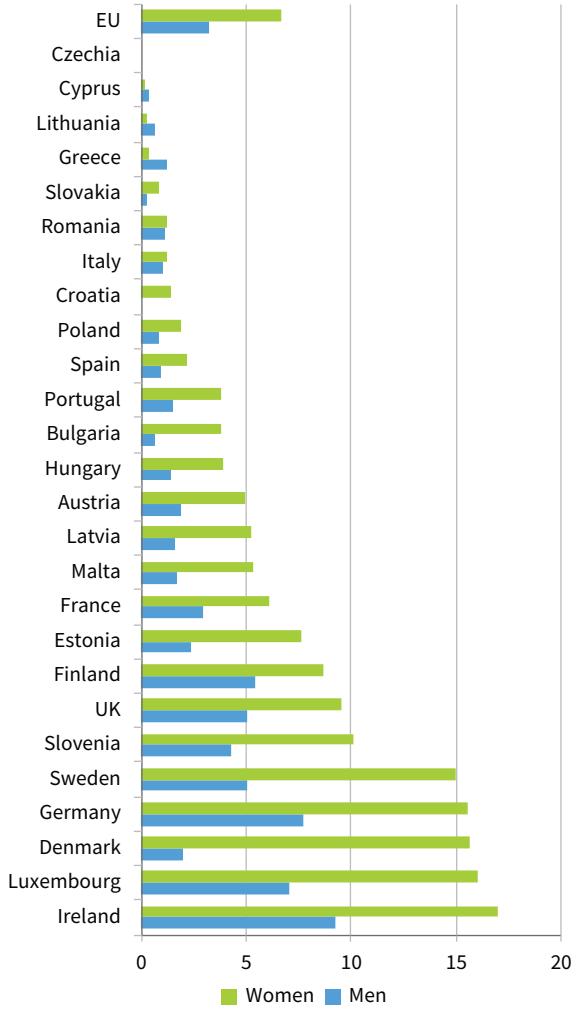
Figure 22: Suicide rate among 15–30-year-olds per 100,000 of total population, 2016 (%)



Source: *WHO Global Health Observatory data repository*

Suicide is more common among young men (see Figure 22), whereas young women are more likely to have moderate to severe depressive symptoms (see Figure 23). Young women are more likely to self-harm (22% vs 9%) (Children's Society, 2018), and they are also more likely to suffer from eating disorders than young men (2–3% vs 0.3–0.7%) (Keski-Rahkonen and Mustelin, 2016).

Figure 23: Young people with moderate to severe depressive symptoms (age 15–24) by sex, 2014 (%)



Source: *Eurostat – Severity of current depressive symptoms by sex, age and income quintile [hlth_ehis_mh2i]*

Disability and long-term illness are related to mental health. Depression is the leading cause of disability worldwide (United Nations University, 2015). In addition, physical disability is a risk factor for depression (Noh et al, 2016). In the EQLS 2016, 43% of young people with chronic illness or disabilities were at risk of depression, compared with 10% of young people without chronic illness (although depression itself is included among chronic illnesses). Among those young people who are limited in their daily activities by their condition (which is the WHO's definition of disability), 56% are at risk of depression. The reason behind this risk is often that society is not well adjusted to young people with disabilities, resulting in potential exclusion and discrimination.

Family environment is one of the most important influences on a young person's mental well-being. The main risk factors are abuse or mistreatment, relationship difficulties between the child and the parent, and events such as the death of a family member, serious illness and the sudden separation of parents. On the other hand, mild dysfunctions in family life – such as unhappy marriages, parents working away from home, low income, living in poor housing or in a deprived neighbourhood – by themselves are not strongly associated with clinical depression in young people (NCCMH, 2005). However, low income may be associated with other risk factors and may affect young people's access to services.

Young people with care responsibilities (either for a child or a relative/friend with an illness or disability) are more likely to be at risk of depression, as measured by the EQLS (18% vs 13%).

Relationships with peers are also important for young people's mental well-being. Children with few friends and infrequent social contacts are more likely to develop depression and get involved in risky behaviours, often resulting in even more social isolation (NCCMH, 2005).

Social media and its relationship to mental health has increasingly been a subject of research. One large study concluded that social media use is associated with sleep issues, lower self-esteem and experience of online harassment for both girls and boys, and that this is partly why social media is associated with depressive symptoms (Kelly et al, 2019). This association is stronger in girls than in boys. In a large-scale study on the subject, Viner et al (2019) found that mental health problems related to social media in girls are likely to be due to 'exposure to cyber bullying and displacement of sleep or physical activity', while for boys, other mechanisms are behind the negative outcomes. It was also found that teenagers in lower-income households use more social media than others.

However, young people's increasing online presence also provides enormous benefits in terms of access to information and to social circles that are otherwise hard to reach. It can provide a sense of inclusion for those who feel excluded or unwilling to connect to others in other ways, such as those with autism or depression (OECD, 2018; Carras et al, 2018).

The OECD recommends educating parents and children on the risks of social media use while empowering children to be responsible online participants. At the same time, children and young people must get help early if they show signs of mental illness, and this

should be facilitated through attention to and education about mental illness in schools (OECD, 2018).

The internet and social media also have the potential to play a large role in access to social and health services (see Chapter 8). Both positive and negative aspects of young people's online activity must be considered in designing pathways of service provision for them.

Inequality in access to physical and mental health services

While most of the around 72 million Europeans aged 12–24 are healthy and socially well connected, many (alongside their families and environments) need support services that can have an impact on their ability to grow and develop.

Data from the EQLS 2016 for young people aged 18–24 shows that this is a diverse group: 78% were living with their parents, while 8% lived alone and 7% lived with a partner. Fifty-four per cent of young people lived in urban areas. Over one-third (35%) were working, while the majority (56%) were still in education at this age. Young adults were well connected, with 95% using the internet every day and 38% participating in volunteering activities. Sixteen per cent of young people had care responsibilities, either for their child or a relative/friend with an illness or disability.

Young people's health was generally good: only 2% rate their health as 'bad' or 'very bad'. At the same time, 11% of young people had a chronic mental or physical illness or disability, of which 62% said that this condition limits them in their daily activities. Fourteen per cent of young people were at risk of depression, as defined by the WHO-5 Mental Well-Being Index, as described above.

There is a wide range of advice and support services available in Europe, with diverse characteristics, financing and access. Some services target the individual, while others address the collective infrastructure available to young people. Preventive services are important at young ages: many address healthy behaviours, and others aim to improve family circumstances. Some services are compensatory, such as services for young people with disabilities or treatment of substance abuse. A third type includes services aimed at acute problems and involves crisis support (Eurofound, 2019). Informal support may be provided by parents, teachers or peers, while formal social services are often delivered in public–private partnerships. Table 5 categorises some of the main types of needs addressed by health and social services; however, these services and the issues they are trying to address are often interrelated.

Before looking at some evidence regarding differences in access to health services between different groups of young people, it is worth looking at the main barriers in accessing services. Eurofound's 2019 report categorises barriers that may prevent young people from using a service into four groups (although these are interrelated and multiple barriers can be present at once).

The first group includes personal barriers that are issues on the young person's side. Examples are reluctance to access a service due to perceived stigma associated with it (e.g. services for addiction or mental health issues), lack of information about services or rights, family issues such as parental intrusion and mental well-being problems such as anxiety.

Table 5: Needs addressed by various types of social and health services aimed at young people

Type of service	Needs addressed
Social support services (living conditions, social exclusion): Housing, legal assistance, financial assistance, compensatory services, information services, mediation	Poverty, social exclusion, risk of homelessness, abuse, extreme vulnerability/multiple disadvantage, family problems, problems settling into school
Health support services (physical and psychological well-being): Psychiatry, emotional and psychological support services, sexual health services, care for young mothers, health services for young people with disabilities	Mental illness, suicide risk, eating disorders, sexually transmitted diseases, teen pregnancy, chronic disease/disability
Services addressing adverse social and health outcomes: Counselling, school psychosocial support, helplines, online support services, support to young offenders, rehabilitation, treatment of addiction and substance abuse	Bullying, cyberbullying, antisocial behaviour, substance abuse, social media, gaming and gambling
Services for particular groups: Homeless intervention and support, support for LGBT youth, support services for young people with disabilities, aftercare, specific services for refugees or marginalised communities	Homelessness, disability, issues specific to LGBT young people, young people in care, unaccompanied refugee minors, marginalised communities

Source: *Eurofound, 2019*

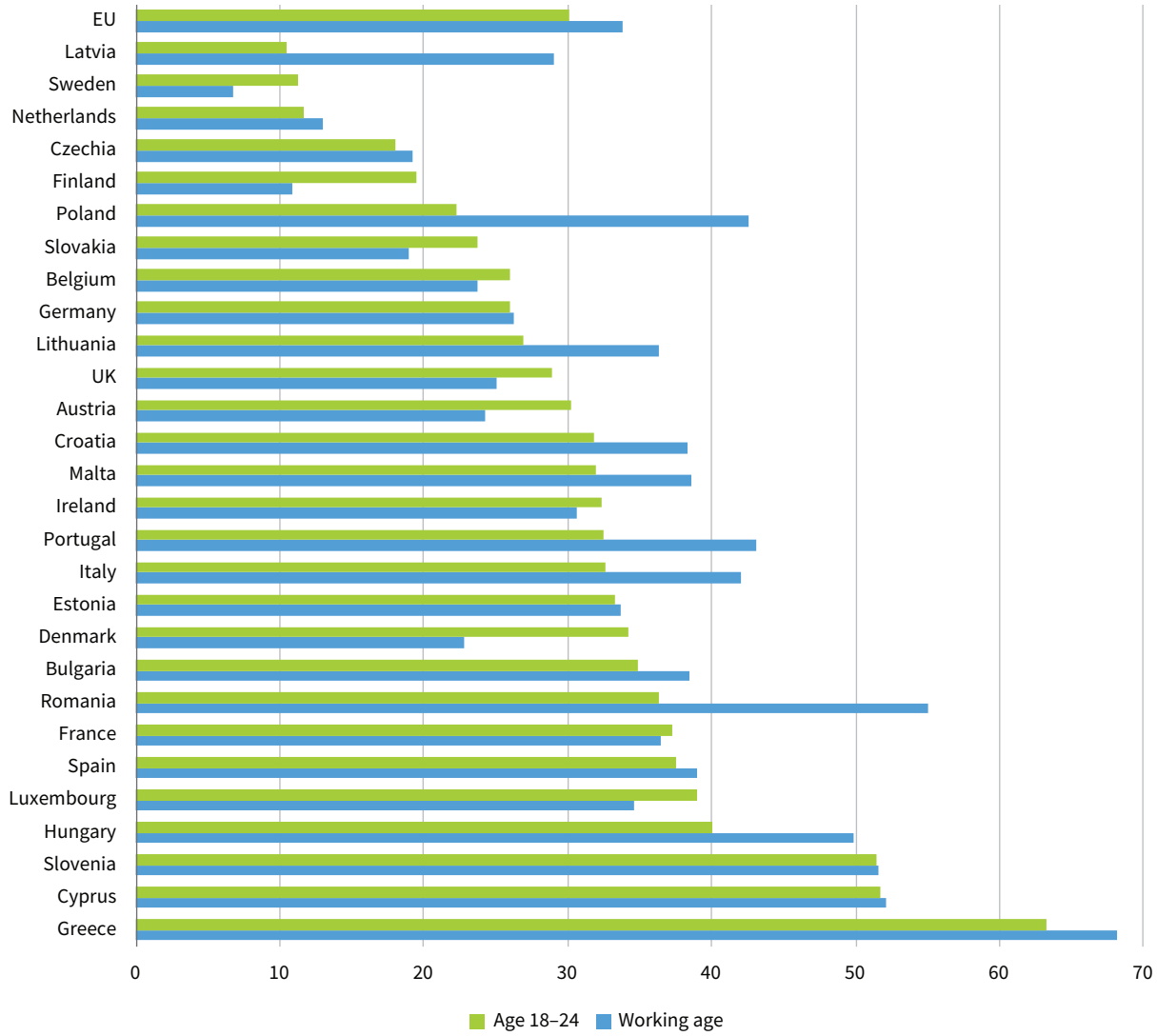
Cultural and societal barriers appear in the young person's environment. These include religious rules that prevent use of a service, specific communities that are remote or not reached by service provision, discrimination or prejudice that excludes groups from services and language issues that interfere with service use.

Structural and institutional barriers are present on the service provider's side. Some services include extensive paperwork, might need referrals and might involve issues related to privacy. Others have legal restrictions (e.g. on age or citizenship) or have a cost to the user. Some services are either not available in particular areas or have insufficient places due to lack of (qualified) staff or funding. Yet others have issues with physical access.

Finally, adequacy and quality can be barriers to access, even if a service is available. Quality issues may relate to service design, inadequate targeting, problems with delivery methods, staff competence and lack of good-quality facilities and equipment. Issues might also arise from inadequate assessment of needs. In terms of the latter, service outcomes and impacts should ideally be measurable and regularly evaluated. Involvement of users in evaluation can help provide better-quality services.

Access to mental health services is one of the main difficulties for young people in Europe, as many of the barriers are present. Waiting lists for public mental health services are often long, while psychology and psychiatry services in the private sector are expensive: 30% of young Europeans say they would not be able to afford mental health services if they needed them (see Figure 24). This proportion is lower than that reported for people of average working age in the EU (34%), as in many eastern European countries, especially in Poland and Romania, young people have higher expectations for affordability.

Figure 24: Repondents who would find it difficult to cover expenses for medical health services if needed (age 18–24), 2016 (%)

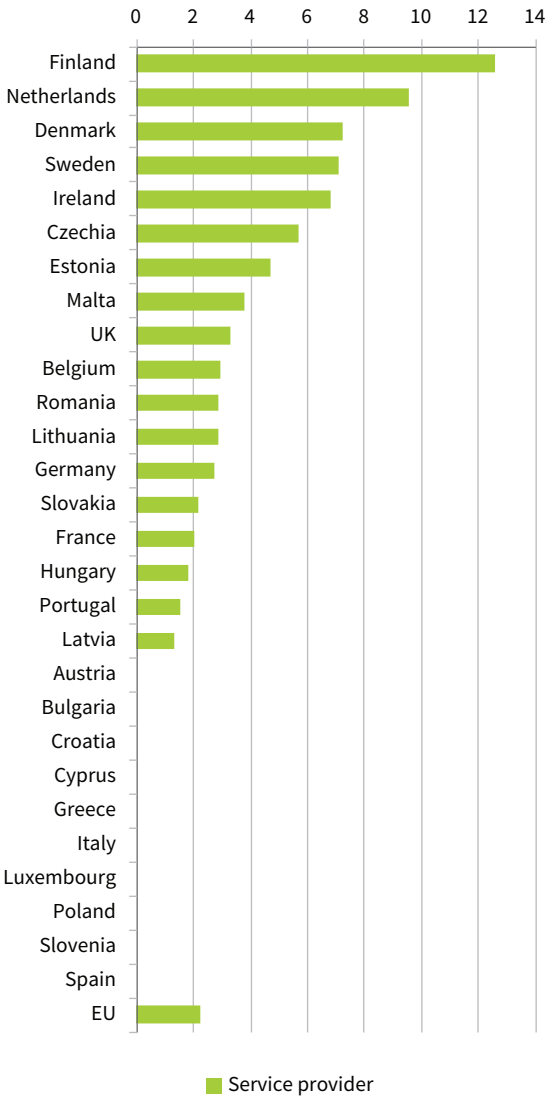


Source: *EQLS 2016*

However, in Austria, Denmark and Finland, young people are more likely than others to expect problems in relation to affordability.

Students or young people in employment are slightly less likely to foresee difficulties with affording mental health services (28% and 29%, respectively). It is a bigger issue for those who are unemployed (39%). This is due to availability of health coverage for students in most countries as well as coverage associated with employment contracts. It is also a problem for young parents (34%) and those in the lowest and second lowest income quartiles (34% and 33%, respectively).

Figure 25: Respondents who would turn to a service provider when faced with a serious problem or feeling depressed (age 18–24), 2016 (%)



Source: *EQLS 2016*

As described above, mental health issues still carry a social stigma that may affect relationships and often results in discrimination, especially in the job market. This can lead to reluctance in asking for help for fear of being diagnosed.

When asked who they are most likely to turn to for support (family, friends, a service provider or nobody), only 2% of young people say that they would turn to a service provider when feeling depressed or when facing a serious personal problem, compared with the average of 6% for people of working age. This difference is largest in France (2% vs 11%) and in the UK (4% vs 11%). While the decision to turn to a service provider is often dependent on the seriousness of the problem, the large differences between countries in terms of the proportion that would turn to a service provider are noteworthy. Low likelihood of turning to a service provider can be related to the cultural importance of family as the primary source of support – seen in many countries in southern Europe (Cyprus, Greece, Italy and Spain) – while greater willingness to turn to a provider may signal better availability of support services (e.g. in Finland) as well as higher trust in these services.

Access to health and social services

There are few data sources available on access to specific services such as mental health. In the EQLS, young people aged 18–24 were asked whether they had problems accessing general health services in terms of distance to the service, delay in getting an appointment, waiting time on the day, cost, and being able to find time. These access problems are summarised below, with only statistically significant differences between groups highlighted.

This information is supplemented by Eurofound's consultation with 151 youth service providers in Europe, which, while not a representative survey, can provide some qualitative and anecdotal information, and more detailed case studies conducted with 15 service providers in Bulgaria, Estonia, Finland, France and the UK. (More details on these can be found in Eurofound's 2019 report.)

Overall, young people are more likely than people of working age on average to experience difficulties in terms of delay in getting an appointment, waiting time on the day and the cost of healthcare, while issues related to distance and finding time to make it to an appointment are of similar frequency in the two age groups (see Table 6).

Table 6: Problems accessing health services by age group, 2016 (%)

	Ages 18–24	Average working age
Distance	18	18
Delay	44	39
Waiting time	49	43
Cost	20	17
Finding time	32	33

Source: *EQLS 2016*

Young people living with parents

Young people living with their parents (78%) had better access to health services and were less likely to have issues with delay in getting an appointment and waiting time (Table 7), possibly due to parents being involved in organising appointments. They are also less likely to work, making it easier to attend appointments.

Table 7: Problems accessing health services by living situation (age 18–24), 2016 (%)

	Not living with parents	Living with parents
Delay	54	43
Waiting time	53	47
Finding time	37	30

Source: *EQLS 2016*

On the other hand, living with and depending on parents can also prove to be a barrier. In Eurofound's consultation, mental health service providers indicated that teenagers aged 12–17 are more likely to have difficulties accessing these services. One organisation gave the explanation that parents can be very protective of young people with mental health issues, even keeping them from some helpful experiences. Often parents themselves are not very well educated about mental health and are unaware of some health risks young people may be exposed to. For example, lack of awareness of eating disorders can result in neglect of symptoms.

Parental involvement is especially an issue when sexuality and crime are concerned. Service providers highlight that fear and embarrassment about discussing sexuality with parents and teachers is still widespread. This has repercussions for accessing services that are often mediated by parents; for example, visits to a family doctor or a gynaecologist.

Young victims of crime are often afraid or ashamed to discuss this with their parents, especially if, for example, the incident took place while the young person was doing something illegal. They are also reluctant to speak to the police, teachers or service providers if their parents commit a crime. Ensuring anonymity and privacy is a primary concern for victim support services, but it is not always possible if registration of personal data and involvement of parents and teachers is required for access.

Sex and sexual orientation

Young women use health services more frequently than young men in the 18–24 age group, with 63% having visited the GP in the past year compared to 47% of young men. Young women were more likely to have issues in terms of distance to a healthcare provider. This could be explained by access to a car, which has improved for young women but is still lower than for young men (Tilley and Houston, 2016). Waiting time is also mentioned more frequently by women. This, as well as issues with distance, might be related to young women's greater use of specialist services: 25% of young women and 15% of young men reported they had used hospital or specialist services in the past 12 months. On the other hand, cost was more frequently mentioned as an issue by young men than women (see Table 8).

Table 8: Problems accessing health services by sex (age 18–24), 2016 (%)

	Young men	Young women
Distance	16	20
Waiting time	46	52
Cost	21	18

Source: *EQLS 2016*

Young men are less likely to turn to service providers concerning personal problems. A case study from Estonia indicated that young men prefer online counselling compared to visiting clinics, with men representing 20% of users of internet counselling but just 5% of users of youth clinics (Eurofound, 2019).

Young people in the LGBT community can often feel isolated, marginalised and powerless, especially in countries where discrimination against them is more common. They are often not aware of their right not to be discriminated against, as indicated by some service providers. While non-discrimination and acceptance in society should be a priority, some targeted services can help in the shorter term.

Worries about family doctors potentially talking to parents are particularly prevalent among LGBT young people. Conflicts with families related to the young person coming out can lead to physical harm, low self-esteem, mental health problems and increased risk of homelessness, with LGBT youth significantly overrepresented among the homeless population (Feantsa, 2017).

Availability of services specifically for LGBT young people can be a concern in many eastern European countries and in rural areas, which is where these services are most needed.

Disability and mental and physical illness

Young people with a chronic physical or mental illness or disability (11% of all young people in Europe) are more likely to have issues in terms of delay in getting an appointment and waiting time on the day (see Table 9). This is particularly concerning as young people in this group have a higher need for regular access to healthcare and are more frequent users of specialist and hospital services (49% vs 16% of young people without these conditions).

Table 9: Problems accessing health services by chronic illness/disability status (age 18–24), 2016 (%)

	Young people with no chronic illness or disability	Young people with chronic illness or disability
Delay	43	53
Waiting time	48	54
Finding time	31	41

Source: *EQLS 2016*

Young people with chronic illness or disability also have issues finding time for appointments due to their work or care responsibilities. This could also be due in part to their need for more frequent appointments. Those who are limited in their daily activities by their chronic condition were also more likely to say that distance (30%) was an issue.

Young people with disabilities were among groups most often highlighted by service providers as having difficulties accessing services, especially by those organising events or activities, possibly due to some disabilities limiting mobility. Some young people with disabilities have very specific needs in terms of accessibility, which are not always covered by initiatives.

While online services offer an effective form of provision for people with limited mobility, over a third of organisations that use web- or app-based services say that they have problems reaching young people with disabilities.

Young people at risk of depression (14%) are more likely to have issues on all access dimensions except for cost (see Table 10). They are also heavier users of health services. In line with this, access problems for younger teenagers were mentioned most frequently by organisations targeting young people with mental health issues.

Table 10: Problems accessing health services by risk of depression (age 18–24), 2016 (%)

	No risk of depression	Young people at risk of depression
Distance	16	29
Delay	42	58
Waiting time	48	58
Finding time	31	41

Note: *Based on WHO-5 score.*
Source: *EQLS 2016*

Poor mental health can be a barrier in itself: problems such as anxiety, depression and severe introversion often result in young people being reluctant to ask for help even if it is available. This affects their access to not only mental health services but many other general health and social services as well, especially given the interrelationship between mental health problems and other issues such as family background.

Low income

Income is one of the main determinants of inequality in many areas of young people's lives, and this is also true for access to health services. While the difference between the top three income quartiles is relatively small, people in the lowest quartile were significantly more likely to report problems with all five dimensions of access. The biggest difference was in waiting time on the day and finding time due to work or care responsibilities (see Table 11).

Table 11: Problems accessing health services by income (age 18–24), 2016 (%)

	Top three income quartiles	Lowest income quartile
Distance	16	22
Delay	43	49
Waiting time	47	56
Cost	18	25
Finding time	30	40

Source: *EQLS 2016*

Certain services have costs associated for the young person and, even if these are relatively small, young people without their own incomes may not be able to meet them. Income is especially a problem regarding dental costs, with 32% of young people saying it would be difficult to cover them. Access to psychology and psychiatry services is also affected by affordability, with 30% of young people saying they would have difficulties

paying for these. For young people in the lowest income quartile, this increases to 38% for dental services and 34% for psychology and psychiatry services.

While many services are specifically targeted at young people with low incomes, in some cases eligibility criteria can penalise young people with a lack of demonstrable income or those who are homeless or unemployed; for example, preventing them accessing rental housing programmes.

Rural areas

A simple rural–urban distinction of an area based on respondents' own classifications reveals significant disparities in access to healthcare. Young people in rural areas (46% of the total) more commonly have issues regarding distance, but they are less likely than young people in urban environments to have cost issues with health services (see Table 12).

Table 12: Problems accessing health services by urban/rural area (age 18–24), 2016 (%)

	Rural	Urban
Distance	24	13
Cost	16	23
Finding time	34	31

Source: *EQLS 2016*

Many service providers rely on young people attending their events or visiting their premises. Nearly a quarter of service providers consulted by Eurofound said that young people in rural areas had problems accessing the services they provided. This problem was most frequently reported by organisations providing education on sexual health and other information services as well as those providing emotional and psychological support. Rural access issues were most often found in eastern European countries and were most common among organisations that targeted young people with an ethnic minority background and those at risk of leaving school early. Case studies also highlight access problems in relation to street teams reaching out to addicted young people and services targeting LGBT young people in rural areas.

Internet access

People without internet access were most frequently identified as 'hard to reach' by organisations, especially those that used web- or app-based services or social media, those that provided information on social issues, those that targeted LGBT young people and those targeting young people with an ethnic minority background.

Regular and private internet access is important, as online services have a significant role for young people who otherwise would not want to turn to a service provider; for example, because of a mental health problem such as anxiety or depression, which leaves them unable to reach out, or due to fear of being found out and facing discrimination.

Internet access is especially important for young people with disabilities. Those with a chronic illness or disability were the most common users of online prescriptions (28%) and consultations (27%). Online services are also an option to replace at least some services in rural areas.

Strategies to address inequalities

Service providers for young people across Europe are actively trying to address the barriers and inequalities highlighted in the previous section. Some strategies that have been successful in overcoming these are outlined below. This information is based on Eurofound's consultation with service providers as well as the 15 case studies conducted in 5 countries (Bulgaria, Estonia, Finland, France and the UK) with youth service providers that have actively addressed, with some success, one or more of the barriers. (Further examples can be found in Eurofound's 2019 report.)

Confidential services

One of the main barriers to accessing services for young people is lack of privacy and fear of problems being shared; therefore, one of the most important strategies is to provide anonymous support. Being able to access services without parents is key for certain topics, as intrusion of parents and fear of punishment is one of the key personal barriers to accessing services. The provision of support through anonymous online chats has increased extensively, successfully reaching young people. Even for face-to-face services, guaranteeing anonymity without the need to submit documents or complete any paperwork can result in reaching more young people at initial contact; this is an important point as this contact can provide a pathway to more structured services should the young person want to take advantage of them. Some services make it explicit that they do not respond to parents' queries.

Ensuring anonymity is especially useful for:

- initial contact with psychology/psychiatry services
- sexual health, contraception, crisis pregnancy
- victim support

The issue of crime is an example where confidentiality must be balanced by the need to ensure safety. It is important that young people are informed in advance if serious issues must be reported to the police. Overall, providing a confidential, safe environment to access services over the long term can increase trust in services in general for young people and have an important preventive role.

Examples of confidentiality used in service provision

Inkoo contraceptive care, Finland

Inkoo municipality provides free contraceptives and consultation on sexual health to young people under 25. While young people attending school have good access to these services in Finland, the municipality recognised that a lot of this support disappears once the individual leaves school. The issues of unwanted pregnancy and sexually transmitted diseases still carry a stigma in some rural communities, so emphasis is placed on confidentiality. Importantly, names and social security numbers are not required to register, even in face-to-face appointments (online consultation is also available). This provides complete anonymity, unusual in public healthcare. Contraceptive services are available in all municipalities, but confidentiality rules are not uniform.

RIKU, Finland

This organisation provides anonymous support to victims and witnesses of crime via online chat. The confidentiality and safety aspects are balanced: no personal information is collected during the chat, but in cases of serious crime the young person is asked to talk to a professional by phone, at which point more personal information is collected. Parents are not informed, but where very serious crime is involved RIKU is required to inform the police.

Improving online service provision

Throughout Europe, many organisations have made significant efforts to make their services available online or by telephone. Over half of the organisations consulted by Eurofound said they provide services online. As noted above, one potential advantage of online provision is confidentiality – the young person being able to receive support more easily and to get in touch with the organisations without involving parents or teachers. This is why it is especially common among those who provide support in pregnancy or crisis pregnancy, with nearly 90% providing online support. Online provision is also often offered by organisations providing mental health services to 12–17-year-olds.

Another advantage of online provision relates to young people's high online presence. As the internet and social media is their main source of information, development of these channels could contribute to greater awareness

Examples of online service provision

Fil Santé Jeunes, France

This organisation provides prevention and support on health matters, dedicated to 12–25-year-olds, especially in rural areas. It includes a hotline and an online chat service with physicians and psychologists who answer young people's health-related questions daily from 9:00 to 23:00. They also have an informative website and a (moderated) virtual community where young people can interact with each other. Anonymous chats are available without the need to register a profile. The need for this type of service shows in its widespread use: the service processes 90,000 calls and 25,000 individual chats annually.

Albert Kennedy Trust, UK

While this organisation primarily provides an emergency safe house for young people in the LGBT community, it also launched an online support service that allows young people to speak directly to trained mentors. One of the main areas of support is help in coming out to friends and family and preparing for housing issues and prevention of homelessness if the young person expects their family to send them away from home. The service helps young people locate local services and groups specifically targeted to LGBT youth, which are often less available or well known in rural areas. While online mentors are not available 24/7, an emergency contact number is provided for urgent support.

Single Step, Bulgaria

A similar online chat service is available for LGBT youth in Bulgaria. Importantly, Bulgaria has one of the lowest levels of acceptance of LGBT youth in the EU, with lack of awareness of rights and widespread prejudice. Single Step provides help in coming out, and it also provides family counselling and mediation services helping parents with acceptance.

Examples of peer-to-peer support

TORE, Estonia

The youth association TORE is a non-governmental organisation that specialises in promoting a safe, supportive and tolerant school environment. TORE trains young people aged 12+ who then provide support to schoolmates suffering from bullying or exclusion. They intervene to stop conflicts at school and conduct seminars and activities to prevent bullying and other problems. This programme is a response to the issue that teachers in school are not always trusted by young people when it comes to bullying, and that adults are less likely than peers to notice students that are excluded or at risk of bullying. The success of the peer-to-peer support system led to it becoming a widely used initiative in Estonia with more than 60 secondary schools and more than 600 support students participating.

Coram's Young Parenthood programme, UK

In this London-based initiative, young parents who have participated in the programme visit schools to talk about their experiences of being pregnant at a young age, how it impacted their lives and how they dealt with related financial, housing and relationship issues. A survey by Coram found that nearly three-quarters of young people preferred to talk about personal, sexual and health topics with other young people rather than adults. This initiative provides teenagers the opportunity to hear personal stories first-hand and the chance to ask questions about the issues around having children at a young age.

of services and social issues. In addition, online services have potential to provide access for groups that are unable to attend face-to-face services, such as:

- young people living in rural areas with lack of services
- young people with physical disabilities
- young people with mental health issues unwilling to meet someone face-to-face

Therefore, online support addresses the 'lack of privacy' barrier, and it overcomes the problem of physical distance, reducing inequality in access to services.

There are some limitations associated with online-only support. Some young people do not have internet access (or private internet access). In addition, the type of data one would collect face-to-face is not available to providers – only what the young person discloses online. In addition, lack of knowledge of the seriousness of a problem can be important; for example, when a social worker tries to talk to a child online. Additional issues are involved when the online platform provides an interactive space that works as social media; here, moderation is required to prevent bullying and other issues.

Peer-to-peer mentoring and support and service user involvement

Peer-to-peer support and service provision is an increasingly popular method used by service providers. This can be especially helpful for those young people who find the attitude of parents, teachers and health professionals patronising; they are more likely to trust other young people who have been through the same circumstances they are experiencing.

A particularly successful strategy for improving access is to involve those young people who are or have been users of the service. Over a third of organisations consulted by Eurofound had existing users reaching out to other young people. This strategy was more common in organisations providing services related to mental health, physical or sexual abuse and substance abuse, especially to reach young people aged 18–24. Having left secondary school, this age group may rely more on their peers when dealing with (mental) health-related issues. Young parents are among those that can benefit from peer-to-peer support.

Involving users could be useful for increasing awareness without the need for increased staff or budget. Furthermore, users can be involved in aspects of service provision; the most common involvement is in needs assessment, as organisations aim to match their services to young people's demands. Other common areas of user involvement are monitoring/evaluation and promotion/outreach.

Conclusions

- Research suggests that mental health issues are increasing for adolescents, though more comparative data is needed to measure the extent of the problem in Europe. Mental health is closely related to all other youth issues and can both be an outcome of inequalities and a source of inequality itself. Risk factors for mental health issues include disability and long-term illness, family problems, relationship problems with peers (such as social exclusion or bullying) as well as heavy social media use.
- There is a wide range of support services available for young people in Europe, but considerable inequality exists in terms of access. Access to services addressing mental health issues is especially difficult for some young people, as these are often expensive, not available everywhere, carry a social stigma and may need parental involvement.
- While young people living with parents have, on average, better access to health services in general, dependence on parents can be a barrier to accessing services, especially when sensitive topics like sexuality or crime are involved.
- Young women have more access problems related to distance and waiting time, but young men are more reluctant to turn to service providers face-to-face. Young people with physical disabilities commonly have issues accessing health and support services due to distance, while young people with mental health problems often have personal access issues as well as those arising from parental involvement.
- Young people in the lowest income quartile have problems accessing health services not only due to cost, but also on all other access dimensions, such as distance, waiting time and finding time to attend an appointment. Young people in rural areas have problems due to lack of services nearby, and this can be especially the case for young people in the LGBT community.
- One of the most commonly used solutions to inequalities is the introduction of online or telephone services. This type of provision especially benefits young people with mental health issues and those with distance and physical access problems; it is also useful in situations where sensitive topics are being discussed. Regular and private internet access is crucial for those young people who rely on these services; thus, internet access is another dimension of inequality for some young people.
- Confidential service provision, sometimes without parental involvement and guaranteeing anonymity, is important to gain young people's trust when they are afraid to reach out. Public services often require paperwork that involves provision of personal details, which can be the reason why young people do not ask for help in a crisis. For victims of crime, it is important that they are notified in advance if police must be notified.
- Peer-to-peer service provision and user involvement has also been used successfully in gaining young people's trust, reducing the effects of stigma and discrimination and increasing awareness. User involvement is especially important in assessing demand for services and for better targeting.

Policy pointers

The main success factors in reducing inequality in access to services for young people can be summarised as follows.

- Systematic consultation of young people on their needs and experiences with mental health and other social and health services is important to improve access. Data must remain confidential and the young person must be fully aware what data are collected and who they are disclosed to.
- Support is required for hard-to-reach groups and groups with limited access. It is important to specifically target young people in rural areas, young people with disabilities or with chronic mental or physical conditions, young people with an immigrant background, young people in the LGBT community and young people not in education or employment.
- Online and telephone service provision has enormous potential to provide a confidential space in which to discuss problems as well as to improve access to hard-to-reach groups. This form of provision is important for mental health support, sensitive issues and when dealing with victims or witnesses of crime.
- In relation to protecting children online, parents and children should be educated about safety and responsibility in online communications.
- Peer-to-peer support and user involvement in service provision, wherever appropriate and possible, has been successful in improving access by reducing stigma and building trust with young people.
- School-based interventions are important in reducing stigma and preventing future discrimination. These should be used regarding mental health issues to promote understanding of mental health literacy, sexual health, LGBT issues and gender diversity.
- Young people are still dependent on their families and their schools, which have an important role in preparing them for adult life but can introduce additional barriers in terms of parental intrusion and lack of trust in adults. Active support should be given to organisations that engage with schools, families and the communities.
- For researchers, better comparative data are needed on youth mental health in order to be able to correctly assess the scale of the issue over time and to better see which countries and regions need policies specifically targeting youth mental health.

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7 Public services for the social and economic integration of refugees

Introduction

Between 2014 and 2016, over three million asylum-seekers arrived in the EU. This posed serious immediate and continuing challenges for both the Member States and the EU. It also prompted EU-level responses (there is an ongoing review of the relevant legislative framework and rules – this has to be agreed by the Member States). Initially, in 2015 and 2016, the average duration of asylum procedures in the most affected countries increased considerably due to the high inflow. At the same time, the need for quick integration and early intervention was recognised and moved higher on the agenda.

This chapter considers the key role played by public services – individually and in more coordinated efforts – in the integration of refugees primarily, but in some cases asylum-seekers as well (while reception could be more relevant for the latter, some measures may include services relevant to them, especially for those who have a high chance of staying). The chapter highlights challenges and lessons learnt which can inform policy decisions for the future.

The number of first-time asylum applicants in the EU increased substantially from 562,680 in 2014 to 1.26 million in 2015 – a rise of more than 100%. In 2016, despite efforts to contain the high inflow (such as the closure of the 'Balkan route' and the Turkey–EU Statement), the number of new asylum applicants still amounted to 1.21 million. At present, more than two million recognised refugees and almost one million asylum-seekers with pending applications for asylum are present in the EU, most of whom arrived in 2015–2016. While the inflow decreased in both 2017 and 2018 (the number of asylum applications in the EU more or less halved, at 654,610 and 581,775, respectively), EU countries granted protection to close to half a million (437,555) asylum-seekers in 2017 and almost a quarter of a million (217,400) in 2018 (first-instance decisions; the figures do not necessarily include those who came in 2017 or 2018).[16]

The greatest challenge was posed not only by the size of the inflow but also by the varied nature of integration measures that were needed. For example, initiatives had to be designed to meet the specific needs of refugees with mental health issues following their traumatic experiences. Therefore, substantial capacity building was required.

From the perspective of public services specifically, the most visible difficulty was to increase resources. While EU funding (e.g. the Asylum, Migration and Integration Fund) could help, this provided complementary resources only. Increasing budgets was more difficult given the increase in negative public attitudes and the rise in the anti-immigration rhetoric of populist parties that were gaining ground.

Integration of migrants (not only refugees) is defined at EU level as a 'dynamic, long-term, and continuous two-way process of mutual accommodation …. It demands the participation not only of immigrants and their descendants but of every resident.'[17] Within the context of the process, the EU's Common Basic Principles for Immigrant Integration Policy also emphasises rights and responsibilities which the immigrants should adopt in relation to the host country (Council of the European Union, 2004, p. 19). Whether or not this process is successful can hardly be decided without the voice of the specific target group being heard – be they migrants, refugees or asylum-seekers (Pace and Simsek, 2019).

A lot of attention is given to the role of integration for entry to the labour market. Refugees and asylum-seekers do not have a job arranged prior to their arrival (unlike many labour migrants). Moreover, in terms of employment, experiences have shown that it could take 20 years for them to catch up with the natives of the host country (OECD, 2019). In order to be ready to enter the labour market, refugees and asylum-seekers first require access to services. They rely on certain preparatory measures (language training, orientation courses) and, mainly, public services (e.g. housing, health, education – the importance of these services in this phase was also emphasised by the European Migration Network, 2019). Moreover, they often have suffered trauma, lose time in the asylum stage, become demotivated when staying for months in reception facilities without much to do and face uncertainties over the prospect of residing legally and permanently, even after asylum is granted. All these circumstances underline the importance of social

16 Eurostat [migr_asydcfsta]

17 The theoretical framework underlying immigrants' adaptation to the host society, however, includes three other strategies as well as integration: assimilation, separation and marginalisation. Integration is regarded as the best approach, since it implies that immigrants maintain their identity 'while engaging in daily interactions with other groups' (see Robila, 2018, p. 2, which refers to Berry's study on immigration, acculturation and adaptation).

integration, aside from its role in entering the labour market, in terms of gaining access to services.

Although the chapter title refers to refugees, integration could also be relevant for asylum-seekers and other groups that receive short-term protection, such as beneficiaries of subsidiary protection, or so-called 'tolerated' persons (who are not given asylum but, due to humanitarian considerations, are not expelled from the country). In their number, asylum-seekers still constitute an important group, since many of the applications are still pending (according to the latest data available from Eurostat their number, that is, first-time applicants, in the EU stood at almost 100,000 at the end of 2018). In order that they can start their integration early, they are eligible for certain measures (especially those with a high chance of getting protection status – this practice features mainly in Germany and Austria). The groups receiving short-term protection now may eventually reside in the host country for long periods (or longer than initially expected).

As the 1951 Geneva Convention defines the status, a refugee is someone who has a

> *fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.*
>
> (UNHCR, 2016)

Under the term refugee, this chapter covers those third-country nationals who have applied for asylum, as detailed in the Recast Qualification Directive 2011/95/EU, and who were subsequently granted international protection, meaning the Geneva Convention refugee status (defined above) or subsidiary protection, or who were granted a national (humanitarian) status should they not qualify for harmonised EU status. It may also cover those third-country nationals who arrive as part of a resettlement or (intra-EU) relocation programme. Asylum-seekers are third-country (non-EU) nationals who 'left their country of origin, have sought international protection, have applied to be recognised as a refugee and are awaiting a decision from the host government' (UNHCR, 2016).

The Eurofound research sought to identify the challenges faced and lessons learned by Member States in approaching integration. This was achieved through exploration of a selection of measures (see Eurofound, 2019, for a detailed report). The research covered five countries: Austria, Finland, Germany, the Netherlands and Sweden. These countries vary in terms of the scale of the inflow as well as the traditions of receiving refugees, labour market conditions, social assistance systems and presence of other migrant groups.

They also vary in terms of citizens' attitudes towards migrants, in particular towards refugees, as recent research has shown. While there was a decline in public support for generous policies for treating asylum requests in the selected countries between 2014/2015 and 2016/2017, in Sweden, for example, where there had been a more positive attitude towards migrants in the past, public support has remained relatively high (though with some decline during the same period). Based on a European-wide overview, the research concluded that the

> *changes, then, did not greatly impact the longstanding overall pattern of cross-national differences in support for or opposition to immigration. Compared to the enduring national differences, these short-term changes as a result of the refugee crisis were relatively modest.*
>
> (Heath and Lindsay, 2019, p. 19)

A total of 16 integration measures were identified as case studies in the 5 selected Member States, based on several criteria, for example: the case studies should cover the five key integration areas (employment, education, housing, health and social integration); national and regional/local measures should also be examined; the measure had preferably been evaluated; and the measure could potentially be replicated in other contexts and/or countries.

The case studies were conducted primarily through desk research and interviews with stakeholders (a total of 44 interviews were conducted, mainly with representatives of service providers, government authorities and employers, due to the focus of the study on public services; while refugees were not included, their situations were reflected by those interviewed). Three case studies were carried out in each country except for Germany, where four were completed.

This chapter focuses on the case study findings from a comparative perspective, examining the role of public services in each integration area: labour market, education, housing, health and social integration. The last section outlines conclusions and policy messages.

Findings from the case studies by area of integration

Overview of the case studies

The case studies are presented in the Annex in Tables A1 and A2. In most cases, the case study measures focus on one main area of integration, although some focus on two areas. It is understandable that overlaps are found in labour market integration and education, which is the case with three of the selected initiatives: Jugendcollege in Austria, Supporting Immigrants in Higher Education – SIMHE in Finland and The Short Way in Sweden. Other initiatives relate to various integration areas too.

The key features of the case studies are as follows.

Main integration areas

- Labour market integration: 7 in focus, 2 related
- Education: 4 in focus, 3 related
- Housing: 2 in focus, 2 related
- Health: 2 in focus, 1 related
- Social integration: 4 in focus

Geographical scope

- National: 12
- Regional: 3
- Municipal: 1

Role of public service/other public entity involved

- Regulator/supervisor: 2
- Regulator and funder: 6
- Regulator, funder and service provider: 8

Table A1 in the Annex shows the category of the public service/other public entity (e.g. local authorities or government departments) involved. As can be seen, which public service/public entity is involved often depends on the area of integration. For example, in the area of labour market integration, it is usually the public employment services (PES) that play an important role, whereas in the areas of housing and societal integration, municipalities and other local authorities are the main actors.

With regard to the scope of the case studies, most initiatives have been scaled up since their inception as pilot projects – hence the high number of measures which are national in scope. It is important to underline also that even though some services target all migrants, not just refugees (e.g. SIMHE, Sweden Together), most started as a response to the refugee crisis – that is, after the summer of 2015 (there is one exception, The Short Way, which was set up in 2008).

Public services for labour market integration

Public employment services are active at the local or national levels (see good practice examples from the PES network – European Commission (undated) – some of which are the same or similar to those detailed in this study), and they are also involved with almost all the selected labour market integration measures. In a couple of cases, the local PES founded the initiative (MySkills and Jugendcollege). In others, it played a significant role during implementation – for example, in mediating between its local offices and companies (as is the case with Sweden Together and the 100 Club). Accordingly, in this measure, and in MySkills, the PES is responsible not only for regulating and funding, but also for implementing. In two cases – The Short Way (Sweden) and Jugendcollege (Austria) – although the PES is a leading organisation (responsible for design, oversight and procurement), other service providers are responsible for implementing the measure (in The Short Way, these are universities, or folk high schools [18] and private education providers). In three other cases – social impact bonds (SIB), SIMHE (both in Finland) and Welcome Guides (Germany) – public authorities, such as ministries (rather than public services), were responsible for commissioning and overseeing the measures.

The role of public services as funder is not always entirely straightforward. For example, the SIB measure, launched by the Finnish Ministry of Employment and Economy, is based on inviting institutional and private investors to finance projects in order to improve the integration of refugees. This is a results-based approach, meaning that if the expected social benefits (in this case, employment of refugees) are achieved, investors receive their capital back with interest. The advantage of this type of funding is that less public money is needed, since companies invest in the fund (Eurofound, 2019). At the same time, the aim of the measure is ambitious: to facilitate the employment of 2,500 refugees in the period 2016–2019.

Social partners are actively involved not only in policymaking through information provision, but also in support for getting apprenticeships (Eurofound, 2016). This too is illustrated in the case studies, specifically by Sweden Together/the 100 Club, where the government initiated collaboration between the social partners and various actors, acknowledging that public institutions such as the PES, the Migration Board and the government could not deal with the problems on their own. Due to the nature of the initiative and the need for on-the-job training, employers play a particularly important role. In this nationwide initiative, large companies are involved: they commit to employing at least 100 new arrivals within 3 years via internships or work practice. The PES enters into direct contact with the specific member company, consulting with them on their needs and helping with the match. In addition, employer organisations act as intermediaries between companies and the PES to help companies with supervision and language development (Eurofound, 2019). When refugees are placed in a company, it can avail of special placement services and receive wage subsidies from the state.

18 Most commonly found in the Nordic countries and in Austria, Germany and Switzerland, folk high schools are non-formal residential schools that offer learning opportunities in almost any subject, mainly to students aged 18–24.

Some challenges of cooperation were highlighted, mainly by the employers, who found it difficult to make the right contact within local public services. Companies often lost their contacts at local PES offices due to frequent personnel changes. This poses a problem as these are the officials in charge of assigning the candidates within the scheme. Moreover, there is no internal ranking at the PES even though, in principle, priority should be given to measures for direct job entry. Therefore, internships are often not prioritised, and the risk is that they are overlooked by PES officials.

The importance of regular communication between the PES and the other actors was emphasised in different case studies. For example, in Jugendcollege, good cooperation (and an understanding from the PES) was needed so that service providers (mainly education institutions) could react quickly to the need for changes in the programme.

MySkills was designed precisely for facilitating efficient communication and cooperation: it provides test results, based on assessment of refugees' skills, which can be attached to job applications as an additional document. In this way, it is possible to give the employer a quick overview of the candidate's professional knowledge. Large employers have particularly appreciated the precise and objective information provided by this tool. With regard to the PES, it could improve matching, both on supply and demand sides, guided by jobseekers' potential (their skills and qualifications) or a job-oriented approach, in which a PES looks for suitable candidates based on employers' specific needs.

The administrative burden, which employers and public administrations have to shoulder during their work together, is often identified as a recurring challenge. Cooperation of this sort can be particularly burdensome in small and medium enterprises (SMEs), which make up a large share of employers across the EU. They often face skills shortages but have limited capacity to deal with the administrative requirements regarding asylum-seeker and refugee employment. The Welcome Guides in Germany is one measure designed to provide support for these companies, to encourage their efforts. Since early 2016, about 150 Welcome Guides have supported SMEs in filling open training and work places with refugees (Eurofound, 2019).

Public services for education

Related largely to their age composition (i.e. their young age), many asylum-seekers or refugees have only primary and lower secondary school attainment. In addition, these young people often lack a school-leaving certificate and/or do not have basic knowledge, and they often have literacy problems – meaning that most of them are barely employable.

In response, Finland introduced legislative amendments that included a renewal of basic education for migrants above the age of compulsory education (ICF, 2018b, p. 5). Similarly, in Austria, the National Assembly of Austria passed a Law on Compulsory Training in June 2016 (European Social Policy Network, 2016), which entered into force in July 2017, making school or vocational education compulsory for minors. The law stipulates that parents must ensure that young people between the ages of 15 and 18 participate in further education and training in order to prevent interruptions in their formal education (ICF, 2018a, p. 5). Jugendcollege in Austria is a special programme for asylum-seekers and refugees aged 15–25 (mostly beyond compulsory school age). The aim is to enable the newly arrived young people to attend basic education that qualifies them either for further education or entry into vocational dual training or employment. In accordance with this, the initiative not only provides participants with lessons (language classes equip them with numeracy and soft skills), but there is also emphasis on giving them practical experience in companies. The young refugees receive an education programme which is dependent on their level of prior knowledge.

The educational attainment of the newly arrived refugees varies, depending often on their nationality, so tailor-made measures are needed. The problems of limited prior education and illiteracy (for persons above compulsory school age) require courses targeted to these groups. In Finland, a national programme called 'The educational tracks and integration of migrants – problematic areas and proposals for actions' was launched in 2016. The programme contains 56 actions including basic education for adult migrants as well as refugees and asylum-seekers above the age of compulsory education. With regard to the education of minors, Sweden has introduced preparatory classes on a part-time basis, where children can study for a maximum of two years while at the same time holding a place in a mainstream class. This enables pupils to improve their literacy and adapt to the new environment while also attending mainstream school (Eurofound, 2019).

Education is closely related to broader societal integration as well as to the labour market. It could play a decisive role not only for young refugees (and asylum-seekers if they attend any education measure) but also for their children. Education measures are of crucial importance for specifically vulnerable groups – illiterate adults, people with learning difficulties and those with concentration problems due to trauma or other mental health issues.

Public services for housing

The importance of housing in integration is shown by the fact that following the large inflow, in many countries affected, the systems that had been in place underwent significant changes. Even in those countries where dispersal policies (aiming at distributing refugees to various parts of the country) were already in place, the systems were often transformed. In Sweden, for example, the previous policy had been based on voluntary agreements between the state and the municipalities. Due to the high inflow, however, the voluntary system could not be sustained. According to the Resettlement Act of 2016, the municipalities are obliged to settle newly arrived refugees staying at the Migration Board's reception centres; but due to lack of sufficient suitable social housing options in the Netherlands, municipalities were struggling to meet their targets for housing refugees. This meant that the refugees often had to stay in reception centres for longer than intended which, in turn, meant having to restrict the provision of temporary shelter to new asylum-seekers.

In response to tight housing markets, it was a common thread across countries to develop more coordinated approaches between central governments and local municipalities – even though housing is usually the remit of local or regional governments (Eurofound, 2019). Provision of adequate accommodation is clearly an important prerequisite for any kind of integration of individuals and families. In addition, it plays a crucial role in allowing refugees to settle (including their integration into local communities). The challenge of providing housing is more acute in cities, where housing shortages are often severe and prices are high. Indeed, a housing shortage in specific areas is one of the reasons for policies of dispersal. Dispersal, however, may also prevent the creation of a critical mass of users for support services and keep refugees away from areas rich in job opportunities (OECD, 2019).

The Resettlement Programme in Sweden aims to resettle refugees from all over the world, a practice in which the country has a long tradition. The Swedish Migration Agency plays a prominent role since it is responsible for selecting, instructing and transferring the resettled refugees after having assessed their protection needs. Every municipality in Sweden is obliged to receive a fixed number of resettled refugees. The municipalities are responsible for the integration of the refugees, starting by providing accommodation upon their arrival and following with measures concerning other areas of integration (labour market and societal integration). As elsewhere, a lack of adequate accommodation poses the greatest challenge for the Resettlement Programme. There is a general housing shortage in Sweden, even in areas of the country where this has not previously been the case (ICF, 2018c).

In the Netherlands, Platform Home Again (*Opnieuw Thuis*) sought to find innovative means to address a lack of housing by involving various stakeholders in creating housing opportunities. The innovative solutions included using empty office buildings for social housing purposes. A guide on house-sharing was published. This practice targets single refugees and, at the same time, provides local authorities with information on the types of contracts that exist for housesharing; it also allows for monitoring of the impact on refugees' allowances, etc.

In each of these housing measures, public services faced serious challenges, mainly concerning negative public opinion and attitudes of local communities towards housing for refugees. For example, in Sweden, one municipality faced resistance from the local community when attempting to create smaller cottages. In the Netherlands, conflicts arose from conflicting interests as local authorities had to organise emergency or flexible housing for vulnerable groups other than refugees. With regard to Platform Home Again, its activities were hindered by the fact there were local municipalities which did not wish to provide refugees with social housing – they argued that for them it would have been politically difficult to justify to local inhabitants that refugees were given priority over citizens who had been on the waiting list for social housing for many years.

Platform Home Again's activities included identifying the reasons for bottlenecks in the process of housing provision. There was a general problem concerning the delay incurred when refugees tried to acquire a citizen service number and be registered in the Basisregistratie Personen (BRP) – the personal records database. Due to this delay, refugees were unable to access certain government services or open a bank account, which also meant that their access to housing was delayed. The registration process caused difficulties even among those who had managed to secure accommodation: these involved delays in the payment of benefits, resulting in some refugees accumulating large debts. In response, accelerated procedures were introduced for BRP registration and for benefit applications. This new system made it possible for both processes to take place as soon as the refugee received a positive response.

Public services for health issues

In general, public health services are the cornerstone of healthcare provision. Public services play a prominent role in two of the case study measures: in Germany, the Hesse Ministry for Social Affairs and Integration initiated the Step-by-Step measure and was responsible for overseeing its implementation; in Finland, the role of public services was crucial in all phases of the Paloma project. Both measures have a specific focus on mental health – an important area, mentioned earlier, that can not only hinder labour market integration, but also prevent newcomers being able to participate in local community life.

Step-by-Step was initiated because the Hesse government recognised that a high share of newly arrived refugees display significant signs of trauma. Consequently, it was decided that a systematic form of psychotherapeutic care was needed to treat traumatised refugees, and the pilot initiative was launched. According to data, 80% of refugees accommodated in the reception facility[19] during the project period regularly participated in Step-by-Step activities. A total of 70 staff members and 140 volunteers were involved in implementing the project. The Step-by-Step initiative was based on five key concepts: providing safe, reliable structures; being aware of the 'unimaginable' – what people can do to one another; enabling alternative relationship experiences to strengthen resilience; useful activity over passivity; and the need to regain human dignity. The implementation of these five concepts was process led, thereby ensuring sufficient flexibility to adapt activities to the specific needs of target groups.

The Paloma project made efforts to tackle mental health issues in Finland through provision of a reference book, *PALOMA*, for different professionals who work with refugees, to help them to recognise, prevent, treat and/or guide refugees and asylum-seekers' mental health. The handbook covers the whole field of mental health work from preventive work outside of health and social services to primary and specialised care by health and social services. Accordingly, many different public service providers have been involved in writing the handbook, such as social and health professionals from the district and central hospitals, professionals from non-governmental organisations, representatives from ministries and researchers from several institutes. The handbook will be distributed nationally.

Mental health ties in with all other areas of integration, influencing take-up and success in, for example, education and employment. Traumatised refugees benefit from being encouraged, immediately upon arrival, to remain active and avoid passivity. Providing clear information to refugees upon arrival (regarding legal issues, social assistance, etc.) is crucial to counter the likelihood of re-traumatisation. Education opportunities for refugees of all ages were also seen as key to promoting proactive attitudes and preventing refugees from succumbing to 'psychological retreat'.

Public services for social integration

Social integration involves dynamic interaction between refugees and existing residents. In fact, according to experiences in the Member States, it often proved challenging not only to engage the refugees, but also to overcome negative public perceptions towards the newly arrived refugees and asylum-seekers.

Civic orientation courses are measures aimed specifically at social integration. Values and Orientation courses in Austria were launched by the Austrian government in 2015, initially as a pilot project in Vienna. The courses were scaled up to national level in 2016 and 2017. They help asylum-seekers and refugees to navigate Austrian society by providing information about everyday life and basic values. The courses consist of modules on history, language, education, labour market, economy, healthcare and housing. The Integration Act of 2017 made the course compulsory for refugees as part of their Integration Plans. Each course lasts 8 hours, which is the subject of some criticism (e.g. in Germany, courses like this last 100 hours). For those who are interested, more in-depth courses are organised on certain topics, but participation in these is voluntary.

Social integration occurs mainly at the local community level. The aim of the Zeist WegwijZ initiative in the Netherlands is to provide holistic and comprehensive support for those refugees who moved to settle in the Zeist local area.[20] The Zeist municipality brought together local public service organisations and designed the project, which was initiated as a pilot in December 2016. The pilot phase was closed with an evaluation in 2017 – which concluded that the project helped to accelerate integration – and the project is ongoing. It includes general and tailored services. One central point of contact, the so-called 'social matchmaker', gathers the needs of refugees with the help of interviews. On the basis of this information, the social matchmaker refers refugees to the relevant local services. In addition, a mobile app was introduced for refugees to be able to navigate public services (this also allows public services to communicate with each other so that they can provide an integrated service). Besides the interviews and the app, refugees and local service providers are invited to meetings. As of July 2019, improvements are being made to the app, and more focus is being placed on the two other pillars, 'Establishing and maintaining a social network' and 'Knowing the way around' – feedback has shown that progress in these two pillars is rather slow.

19 The reception centre had a maximum capacity of 1,000.

20 When designing the measure, the following four key elements of integration were identified: speaking, reading and writing Dutch; establishing and maintaining a social network; participating in society, according to ability (i.e. in relation to work); knowing the way around (e.g. being able to locate sport activities, libraries, etc.).

Unlike Zeist WegwijZ, the Integration of Asylum Seekers and Refugees (IvAF) programme in Germany is a nationwide initiative, funded, managed and implemented by the Federal Ministry for Labour and Social Affairs (BMAS). It has around 200 individual People in the programme receive support, information, orientation and advice, including on language learning, school and work, labour and social law, claiming of benefits, family and parenting as well as health. A large number of organisations (about 40 including municipalities and non-governmental organisations) participate in the initiative; they are also supported by BMAS. Although the ultimate aim of the programme is providing access to employment, it also builds up networking between organisations, focusing directly on employment (e.g. jobcentres, training providers, education institutions) and other public services in the areas of healthcare, housing and education as well as non-governmental organisations (also at local level). A holistic approach is adopted in which other aspects of integration, such as orientation in the host society, are also considered, since these services also help prepare people for entering the labour market. Besides the holistic approach, the other key value added by the programme is that many of its projects focus on small groups at local level, providing support tailored to specific needs (so the heterogeneity of refugees is recognised). However, it is challenging to establish and maintain coordination and collaboration between the different authorities and various stakeholders.

Although OTAV in the Netherlands is a nationwide measure, it was set up to assist local authorities in providing housing and integration support in the wake of the increased inflow of asylum-seekers. With regard to integration support, a wide range of areas is covered, including education, health, social assistance and participation in society. The initiative was launched in October 2015 and is managed by the Ministry of Internal Affairs and Kingdom Relations in collaboration with the Association of Dutch Local Authorities. These two institutions are responsible for overseeing and implementing the measure. The tools to assist local authorities include a help desk and an expert network to which municipalities can turn with their requests (including also emergency shelter and asylum-seeker centres). During implementation, it proved particularly challenging to strike the right balance between meeting the refugees' basic needs and at the same time not going 'above and beyond expectations that other Dutch citizens on social assistance would have from the government'; that is, avoiding friction within the local community (Eurofound, 2019).

Conclusions

- This chapter explored the role of public services in integrating refugees and asylum-seekers through measures addressing various areas of integration.
- One of the main lessons was that tailor-made integration measures should be designed so that they accommodate people of different cultural backgrounds and legal status. The measures also need to meet the specific needs of refugees who have had traumatic experiences or who are experiencing mental health issues. Language learning is especially challenging for those who have low skills levels and those with low levels of literacy or none at all.
- The attitudes of the receiving society are crucial during the integration process. There are examples of positive attitudes (e.g. in Germany, at least 10% of the population were active in helping the refugees in different ways). Negative public perceptions, however, seem to have become more widespread, adversely affecting societal integration in general but also the employment of asylum-seekers and refugees. Aside from the impact of negative public perceptions, employers are sometimes reluctant to hire refugees because integration is a resource-intensive process.
- Although most of the 16 measures included in this study cover more than one area of integration, almost half focus mainly on labour market integration. The prominence of employment is understandable; not only is labour market integration high on the policy agenda in all five countries (and at EU level), but participation in the labour market is also regarded as a significant step to wider societal integration. A relatively large number of cases address social integration, which may include civic education. Access to social services plays an important role in social integration, and four of the measures focused on education, three on housing and two on mental health issues.

- The role of public services varies across the selected measures: in some cases their regulatory role was prominent, while in others they were the main providers; in yet other cases public services were either primarily financing the measure or the three roles of regulator, service provider and funder were combined (see Table A2 in the Annex).
- The case study evidence reveals that in those measures where the target group had not been pre-registered and/or attendance was not legally binding, outreach proved challenging. One reason was lack of communication and coordination on the part of the service providers. This was a factor when reaching out to target groups based on referrals by case handlers and other intermediaries. Those who were expected to refer potential beneficiaries were often not aware of the measure (e.g. in Sweden's The Short Way and Finland's SIB). On the other hand, target groups were often not aware of the existence of initiatives that could support them.
- As of July 2019, the share of women among the newcomers is low. Rather few of the selected measures in this study focused on attracting women – exceptions were IvAF in Germany and the SIB measure in Finland. However, even when it was claimed that particular attention was being paid to gender, this was not always visible in specific activities and outputs. In some cases, the issue has been recognised during implementation. For example, the Welcome Guides initiative in Germany, recognising the low number of female participants, intends to hire more female guides in future to improve outreach to women refugees.
- Some of the measures have been innovative. For example, MySkills in Germany helps to overcome major obstacles in skills assessment through use of new technology. The MySkills app has proved to be a pragmatic and easy-to-implement tool for carrying out skills assessment. Similarly, the SIB measure in Finland has shown strong innovative potential in relation to funding: the measure is initially funded by institutional and private investors who are reimbursed from the public purse, but only if the expected social benefits (in this case, employment of refugees) are achieved.
- Ongoing coordination and cooperation among stakeholders was found to be highly important and a key to success, especially in complex projects which adopted a holistic approach. When a particularly high number of actors from a wide variety of stakeholders were involved, however, coordination and cooperation was sometimes difficult.
- Sweden Together – the 100 Club provides an example of successful cooperation. Here, companies cooperate with the Swedish PES to organise provision in each company of internships or work practice for at least 100 new refugees within three years. The companies can make use of special placement services, and they receive wage subsidies from the state. In addition, employer organisations act as intermediaries between companies and the PES.
- The incidence of poor mental health among asylum-seekers and refugees was an issue in all the selected countries. As the Eurofound study points out, many refugees experience psychological and emotional traumas in their country of origin, during their journey or in the host communities, which increases the risk of mental illness including psychological trauma, post-traumatic stress disorder, depression, panic attacks and anxiety disorders (Eurofound, 2019). In addition, cultural barriers and difficulties in communication, coupled with the cost of treatment, create difficulties for refugees in accessing appropriate care once they have arrived in the host communities.
- Step-by-Step, in Germany, focuses specifically on provision of psychological and mental health support. The experience of this initiative underlines the importance of identifying trauma in a timely manner and assessing the specific needs of different groups of refugees with respect to mental health. Very few other measures paid particular attention to these issues – they were mostly preoccupied with fast labour market integration or fast language acquisition. A notable exception is the IvAF network, which cooperates with another initiative that supports traumatised persons specifically. That service provider is supported by a trained psychologist who can identify traumatised refugees and initiate clinical treatment.
- Even with the decline in the number of asylum-seekers there is a continuing, long-term need for effective integration measures. The key messages from the evidence presented in this chapter are summarised next.

Policy pointers

- There is certainly scope for transfer of innovative measures such as MySkills in Germany (which had strong positive feedback from users) to other countries, even though contexts differ. Being an interactive, computer-based and easy-to-use tool, MySkills is a good example of how to exploit the potential of digital technology, making it possible to develop and apply a standardised but versatile approach to assessing the skills of a large number of people.
- Experiences from SIB in Finland could be useful, especially amidst growing budget cuts, for initiatives seeking external sources to cover the cost of programmes requiring long-term investment. The 'payment by results' method removes certain risks which could otherwise cause controversy. For SIB, however, meaningful results depend on the clear definition of criteria for a successful outcome and benchmarks (Benton and Embiricos, 2019, p. 10).
- The case studies suggest that continuous monitoring of mental health issues and provision of psychological support are needed. Mental health issues, and traumatic experiences, should be considered even during the planning and design phase of an integration project. Moreover, the integration process in general could be more sustainable if mental health problems are identified and addressed promptly.
- Outreach to target groups proved challenging in several initiatives. Cultural differences may also hinder outreach; involving migrants who have ample experience in the given country could help address interpersonal and interculturaldifferences.
- Some of the integration measures are compulsory (e.g. the Values and Orientation courses in Austria). It remains to be seen to what extent compulsory measures work well, but incentives to participate and easy access to the measures play an important role.
- It is important to remove bottlenecks caused by long and complicated bureaucratic procedures. These lead not only to confusion among refugees, but also to serious delays in meeting basic needs which are prerequisites for integration.
- In some Member States, budget cuts have recently been made in relation to integration measures, which will likely impact the future implementation of initiatives. For public services, it is increasingly challenging to try to improve integration with fewer resources. Although innovative methods and new tools could help, a more collaborative approach is needed, 'drawing on relationships with the private sector and civil partners, as well as the whole of government' (Benton and Embiricos, 2019, p. 2.). In fact, such an approach could help make savings by improving efficiency and combining resources across different government departments, which in turn can result in more coherence across the various integration areas, reduce waste and avoid duplication of work.
- Budget cuts can be related to an increasingly negative anti-immigration rhetoric and to 'integration pessimism' (Bevelander and Emilsson, 2019). In some measures, the prevalence of negative attitudes even affected the willingness of other organisations to cooperate in the initiative. It can also be challenging to make the case for refugees in local communities with other vulnerable groups. Addressing this successfully, BMAS has started to actively promote those activities it offers in support of other disadvantaged groups; for example, the long-term unemployed, single mothers and people at risk of poverty. The idea is to prevent hostile feelings over the allocation of public money between newly arrived refugees (also asylum-seekers) and other vulnerable groups. In the case of the Swedish Resettlement Programme, it became clear that a committed, strong municipal leadership was needed in order to counteract a negative shift in public perception.
- Some Member States have recently introduced restrictions on family reunification, and this process has even become more difficult in those countries where the rules have not changed: the practice of granting subsidiary protection instead of Geneva Convention status has become more widespread, and people with this status have to wait longer for their families to join them. However, higher inflows of women can be expected in the near future, so specific attention is needed to boost participation of women in integration measures. In this context, good practice is illustrated by those initiatives which have provided accompanying activities, such as childcare facilities, in order to stimulate women's participation.
- Low-skilled refugees require activities targeted to them that focus on individual needs (e.g. provision of information tailored to the participant). Support for this group should incorporate flexibility and continuous adaptation to newly emerging needs.
- Recent research has shown that the long-term cost of non-integration could be considerably higher than the current levels of investment made at the time of arrival (Kancs and Lecca, 2017, pp. 38–39). Moreover, the cost of non-integration or failure could be further increased by constraining the available policy options in the case of high inflow in the future (OECD, 2019).

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Annex to Chapter 7

Table A1: Overview of the selected measures by area of integration

Member State	Title of measure	Employment/ labour market	Education	Housing	Social integration	Health
Austria	Jugendcollege	✓	✓			
	Values and Orientation courses	✓	✓	✓	✓	
	Language courses		✓			
Finland	Social impact bonds (SIB)	✓				
	Supporting Immigrants in Higher Education (SIMHE)	✓	✓			
	Paloma					✓
Germany	MySkills – Identifying professional skills and competencies	✓				
	Step-by-Step					✓
	Integration of Asylum Seekers and Refugees (IvAF)	✓	✓		✓	
	Welcome Guides	✓				
Netherlands	Platform Home Again (*Opnieuw Thuis*)			✓		
	OTAV		✓	✓	✓	✓
	Zeist WegwijZ				✓	
Sweden	Sweden Together – the 100 Club	✓				
	The Short Way	✓	✓			
	The Swedish Resettlement Programme			✓		

✓ *Predominant integration area(s) of the measure*

✓ *The integration area is addressed by the measure, but is not the main focus*

Source: *Eurofound, 2019*

Table A2: Overview of the categories and the role of public services/public entities in the selected measures

Member State	Integration measure	Category of public service/other public entity involved	Role of public service/other public entity involved	Geographical scope of measure
Austria	Jugendcollege	PES (regional)		Regional
	Values and Orientation courses	Integration fund (national)		National
	Language courses	Integration fund (national)		National
Finland	Social impact bonds (SIB)	Ministry		National
	Supporting Immigrants in Higher Education (SIMHE)	Public universities; ministry		National
	Paloma	Government research institute; hospitals		National
Germany	MySkills – Identifying professional skills and competencies	PES (national)		National
	Step-by-Step	Ministry		Regional
	Integration of Asylum Seekers and Refugees (IvAF)	Ministry		Regional
	Welcome Guides	Ministry; chamber of commerce		National
Netherlands	Platform Home Again (*Opnieuw Thuis*)	Ministries; government agencies		National
	OTAV	Ministry; government agency; health service providers		National
	Zeist WegwijZ	Local authority		Municipal
Sweden	Sweden Together – the 100 Club	PES (national)		National
	The Short Way	PES (national)		National
	The Swedish Resettlement Programme	Government agency; PES		National

Responsible for regulating and overseeing the implementation of the measure

Responsible for financing the measure

Responsible for implementing the measure as a service provider

Source: *Eurofound, 2019*

8 Impact of digitalisation on health and social care

Introduction

Context

The transformational impact that the increased use of digital technologies has had in the economy and in society has led some authors to hail these changes as being as significant as the Industrial Revolution. Eurofound has defined the current state of technological change as the digital age, 'an historical period marked by the widespread use of digital technologies in different aspects of human activity' (Eurofound, 2018a, p. 1). Far from being confined to industry, the digital age has already had a profound impact on public services, with a wave of change that will continue and strengthen as time goes on.

The magnitude of the potential impact of digitalisation is reflected in the EU policy debate. The AGS 2019 makes extensive reference to digitalisation and technological change, as challenges as well as opportunities for future growth (European Commission, 2018a). Digitalisation (together with the ageing of the population and climate change) is considered to 'put mounting pressure on our workforce, social welfare systems and industry, compelling us to innovate and reform to sustain high living standards' (European Commission 2018a, p. 5). Its impact on work is among the long-term challenges for Europe, whereas the slow diffusion of digital technologies is considered a challenge in the short term. The AGS also shows that there are significant investment gaps in intangible assets (e.g. copyright) and infrastructure (e.g. broadband) as well as in the digitalisation of SMEs. The AGS indicates that some regions and sectors have struggled to make the most of technological innovation and warns about the risk of widening disparities. Consequently, Member States are invited to carry out reforms prompting the broader and faster uptake of productivity-enhancing technologies. Some types of reform mentioned in the AGS are investment, skills development and stronger links between education and training systems and businesses.

The AGS findings point to the need for upskilling due to technological change and the importance of investments in education and training. The AGS also highlights the importance of the adaptability of the workforce, especially the low skilled, to ensure optimal application of technological progress. The need for digital skills is also mentioned in the *Draft joint employment report* accompanying the AGS 2019 (European Commission, 2018d). The report notes the slow improvement over the last year regarding the share of populations with basic digital skills or better, showing that there is a 'two-speed digital Europe'. This is one of the headline indicators of the Social Scoreboard, which ranks EU Member States according to their performance in various domains.

Scope and objectives

The purpose of this chapter is to provide examples of the use of digital technologies in public services. Furthermore, it presents some of the impacts and main issues associated with the use of these technologies.

Digital technologies have been classified and conceptualised in very different ways. Given the policy relevance of this topic, it is important to establish a clear conceptual framework and definitions. Eurofound has clustered digital technologies into three categories: automation, digitalisation and platforms (see Box 7).

Box 7: Three categories of digital technologies

Automation of work: the replacement of (human) labour input by machine input for some types of tasks within production and distribution processes (Eurofound, 2018a, p. iv). This includes technologies such as advanced robotics, artificial intelligence (AI) and machine learning.

Digitalisation of processes: the use of sensors and rendering devices to translate (parts of) the physical production process into digital information (and vice versa) in order to process, store and communicate information (Eurofound, 2018a). This includes technologies such as the Internet of Things and virtual/augmented reality.

Coordination by platforms: platforms mediate any activity that 'uses digital networks to coordinate transactions and interactions in an algorithmic way' (Eurofound, 2018a, p. 4). Platforms mediate for-profit or not-for-profit economic activities by bringing together service users and providers with the aim of conducting specific tasks or solving specific problems (Eurofound, 2018b). Some examples of platforms in the care sector included in Eurofound's platform repository are care.com and sittercity.com (Eurofound, undated-b). Blockchain technology is included in this category.

ICT per se is not the main focus of research. Nevertheless, given that ICTs are often bundled together with the digital technologies listed in Box 7, they are sometimes referred to in this chapter. For example, telepresence can combine video calls and virtual meeting spaces. Apps and websites are often used to access platforms. Smart homes for older people combine the use of ICT with a range of digital technologies. Although Big Data is technically not a digital technology, it is included in this chapter as it is often used together with digital technologies. Thus, the examples presented here include information about ICT in those cases where it is combined with the digital technologies listed in Box 7.

The research focuses on health and social services listed in the European System of Integrated Social Protection Statistics, which provides a framework for comparison of benefits across countries (Eurostat, 2012). These benefits can be in cash or in kind and can be public, private for-profit and/or private not-for-profit. There is a focus on the services listed in the 'Social protection and inclusion' chapter of the European Pillar of Social Rights (European Commission, 2017a), as seen below:

- childcare and support to children (e.g. parenting support, child benefits)
- social assistance welfare and benefits
- unemployment benefits
- old-age income and pensions
- healthcare
- inclusion of people with disabilities (including incapacity and disability benefits)
- long-term care
- housing and assistance for the homeless

Methodology

Most of the data were gathered via semi-structured questionnaires completed by the Network of Eurofound Correspondents (NEC) (Eurofound, undated-a). In early 2018, the NEC provided information about the role of digital technologies in the delivery of social services. Initiatives included public policies such as changes in regulation and new legislation/programmes. On the basis of this information and desk research, a further contribution was requested from the NEC at the end of 2018 in 11 countries[21] where there are relevant developments regarding the use of digital technologies in the design of social services. This chapter is largely based on these two contributions from the NEC. This is complemented with five country case studies (Austria, Estonia, Finland, Italy and the UK) that provide information about how digitalisation strategies have been implemented. These five case studies also include examples of how digital technologies have changed the accessibility of different social services.

Use of digital technologies in social services

This section presents examples illustrating the use of digital technologies in the design and delivery of social services. The section is organised by type of technology, although in practice technologies often overlap with each other. For example, Internet of Things applications and wearable devices are both enabled by Big Data. Furthermore, these digital technologies can also be used in combination with ICT and/or assistive/adaptive technologies (e.g. prostheses).

Advanced robotics

There are numerous ways to categorise or define robots. In Eurofound's report on game-changing technologies in the service sector (Eurofound, 2019, p. 11), the following definition is used:

> *While there is no common definition of what constitutes an 'advanced' robot, the term is often used to refer to a new generation of robots in which improvements in machine dexterity and the machine's ability to interact with its environment mean that the robot is able to perform tasks which go beyond repetitive, discrete motions*
>
> (based on Grant, 2012)

Socially assistive robotics are defined as those robots that provide support carrying out social rather than physical tasks, usually providing assistance in convalescence, rehabilitation or teaching (Feils-Seifer and Mataric, 2005). They are similar to socially interactive robots (also referred to as social robots), which interact with humans for the sake of interaction itself rather than as a means to assist in rehabilitation or convalescence.

21 Austria, Belgium, Czechia, Denmark, Estonia, Finland, France, Germany, Slovenia, Spain and Sweden.

Hobbit robot (Austria)

The overall aim of this project is to create a low-cost robot that would help older people live independently at home for longer (Bajones et al, 2018). The project received funding from the European Community's Seventh Framework Programme (FP7/2007–2013). In the process of designing the Hobbit, end users were involved and consulted in special workshops to give their opinions and ideas about the robot and what it should be able to do and how it should look. Through the use of sensors, the robot is able to detect emergency situations such as falls and communicate this to relevant parties. The robot can interact with users (e.g. giving reminders) and communicate a set of emotions (such as happiness, concern and sadness). It can also play games and help to look for objects.

PARO robotic seal (Netherlands)

PARO is a robot designed by a Japanese company that can help care for patients with dementia or people who suffer from depression. The aim of the robot is to stimulate interaction and communication. PARO has five types of sensors: tactile, auditory, light, temperature and posture. These sensors work to perceive and interact with people. PARO is able to adapt to user preferences and gives the impression of truly interacting with users by recognising the direction of voice as well as darkness, light and other sounds (Paro Robots, undated). In 2017, around 230 units were sold to care organisations in the Netherlands (Vendrig et al, 2017). A Japanese study about PARO compared the responses of elderly people with varying degrees of dementia to the robot PARO and to a robot lion found that users were generally more positive towards PARO, and that PARO was largely seen as a positive tool and as an icebreaker in the care home setting (Takayanagi et al, 2014). Šabanović et al (2013) studied the use of PARO by 10 nursing home residents with different levels of dementia and concluded that PARO motivated them to interact more with each other as part of group therapy.

Artificial intelligence

The European Commission gives the following definition: 'Artificial intelligence (AI) refers to systems that display intelligent behaviour by analysing their environment and taking actions – with some degree of autonomy – to achieve specific goals' (European Commission, 2018b, p. 1).

Robotic process automation

Robotic process automation is sometimes referred to as a software robot. Despite the adjective 'robotic', AI is the digital technology that primarily enables robotic process automation.

> *Robotic process automation (RPA) is a 'software robot', being 'automation that interacts with a computer-centric process through the user interface of the software' in order to conduct software-based business processes as a human would (for example, to automate the transfer of data between spreadsheets) (Wilcocks and Lacity, 2016).*
>
> (Eurofound, 2019, p. 13)

City of Espoo together with Tieto (Finland)

The city of Espoo in Finland, in collaboration with IT software and service provider Tieto, developed an AI project that identifies service patterns and risk factors for users of social services. The analysis identifies patterns in families that have been in contact with child protection agencies or received a referral for child/youth psychiatry services. Although multiple factors are at play in predicting the need for services, families that meet a combination of risk factors are three to five times more likely to use child protection services. Tieto is hoping to expand the project in the future when the number of people participating (and the volume of data available) increases (Espoo, undated).

Case handling automation in Trelleborg (Sweden)

The Swedish municipality of Trelleborg has used 'case handling automation' in the administration of social assistance applications. Applicants fill in an application online and an advanced program assesses the information provided and decides if the applicant has met the criteria for receiving social assistance (Voister, 2017). The benefits for the municipality included a 60% reduction in administration costs and a reduction of 22% in the cost of financial aid as well as the introduction of robust processes; in addition, 12% more citizens began employment or study (Valcon, undated).

Internet of Things

The Internet of Things can be defined as

> *the next step towards digitisation where all objects and people can be interconnected through communication networks, in and across private, public and industrial spaces, and report about their status and/or about the status of the surrounding environment.*
>
> (European Commission, 2016, p. 5)

Smart homes with sensors, wearable devices and assistive technologies provide support for elderly or disabled people. 'Wearables' are technological devices comprising an ensemble of electronics, software and sensors, which are designed to be worn on the body (Billinghurst and Starner, 1999). This includes, for example, wearable video cameras, smart watches, wrist PCs or smart patches measuring heart and breathing rates.

Virtual and augmented reality

Virtual reality is a computer-generated scenario that simulates a real-world experience (Steuer, 1992). Augmented reality combines real-world experience with computer-generated content (Azuma, 1997).

Longer Together at Home (Denmark)

The project Longer Together at Home from the Danish company intelligentcare.com uses the Internet of Things and wearable devices. The project aims to support patients suffering from dementia and their spouses so that the patients can stay longer in their own homes instead of moving to residential care. The project developed a sensor-based warning system that is installed in the private homes of the target group. This project has been developed by five municipalities, the Danish Agency for Digitisation and intelligentcare.com.

Wildcare virtual reality game (Italy)

This project is aimed at children with neurodevelopmental disorders. The project uses a low-cost wearable virtual reality viewer by Google Cardboard. Although the viewer is relatively affordable for users, operation requires a smartphone. With the virtual reality viewer, children can choose from a number of games that complement their 'traditional' therapies (Locatelli, 2016).

Folkhälsan and Gonio virtual reality game (Finland)

Folkhälsan (a non-governmental organisation) and Gonio VR (a Danish company) have collaborated to create a virtual reality game to physically and mentally support elderly people. The virtual reality game encourages movement among patients, and the technology is meant to complement existing approaches and therapies in care of the elderly. The game was developed together with staff and patients of Folkhälsan's facilities in Espoo. Gonio VR has adjusted and reworked the game according to feedback from the staff and patients.

www.care.com

The platform www.care.com exists in 16 countries. The platform helps people find carers for different needs including childcare, au pairs or non-medical care for elderly people. It is estimated that the number of workers registered on this platform worldwide is over 6.5 million, the second largest in the world (Smith and Leberstein, 2015). In Vienna, more than 14,000 carers are registered for childcare on betreut.at.

StreetLink app (UK)

StreetLink is a digital platform commissioned by the Ministry of Housing, Communities and Local Government. It was launched in 2012 in England and Wales. StreetLink is administered by Homeless Link, the national membership charity for homelessness agencies, in partnership with St Mungo's, a major provider of homelessness services. If a member of the public sees someone sleeping rough, they can notify the local authority or outreach team through the StreetLink app. Furthermore, StreetLink contacts the local authority within 10 working days to follow up on the alert. StreetLink is a non-profit organisation with a total budget of around €570,000 per year.

Digital platforms

Digital platforms aim to conduct specific tasks or solve specific problems (Eurofound, 2018a). There are three parties involved in a digital platform: the online platform, the user and the provider. The platform acts as an intermediary, bringing together supply and demand and facilitating a match between them.

Blockchain

Blockchain is the technology that underlies cryptocurrencies. It is a group of 'blocks' of transactions and information stored cryptographically on a network of machines, with all participating devices sharing one record of data and being notified of changes in the blocks of data (Deshpande et al, 2017).

MyPCR (UK)

MyPCR is a personal care record platform powered by blockchain. MyPCR allows the continuous monitoring of patients with long-term conditions regarding their adherence to personalised treatment plans. It also allows patients to receive updates about their treatment, ensuring compliance with the General Data Protection Regulation for patient consent. It was not possible previously to do this in an electronic format due to issues around patient consent and data sharing. With this technology, users can access medication adherence support through their smartphones. Blockchain technology allows for a secure mechanism to deliver care data and information to users.

In addition to preventing treatment failure by improving medication adherence, the MyPCR platform can potentially achieve savings for both users and providers of healthcare. The aim is for MyPCR to provide 30 million National Health Service (NHS) patients in the UK with instant access to their primary healthcare data (Guardtime, undated).

Federal Labour Agency (Germany)

The German Federal Labour Agency analysed large sets of data on unemployed citizens to help create personalised interventions. This process, along with other initiatives, allowed the agency to reduce its spending by €10 billion annually, at the same time as cutting the amount of time that the unemployed took to find employment, and increased the satisfaction among users of its services (HM Government Horizon Scanning Programme, 2014, p. 5).

Data mining and profiling models in unemployment provision (Belgium)

The Flemish regional public employment service (VDAB) has tested Big Data analytics in two projects targeting unemployment. One initiative uses algorithms to develop more tailored job searches for jobseekers when they are using VDAB's jobs database. Another initiative aims to improve job recommendations for jobseekers using VDAB services. To achieve this, the project uses large-scale datasets and recommendation algorithms.

A second project developed by the VDAB utilises user information (i.e. jobseeker profiles) to monitor how they interact with the VDAB job website (click data). Consequently, a 'score' is created which helps VDAB prioritise it contacts and follow-ups with the jobseeker (OECD, 2018).

Big Data

Although Big Data is technically not a digital technology, it is often used together with digital technologies. The data company SAS Institute identifies five key components in its definition of Big Data (SAS, undated):

1. volume of data generated and stored
2. velocity at which data are generated and processed (often in real time)
3. variety in the type of data
4. variability in the flow of data (for instance, data trending in social media triggered by an event)
5. complexity in the data since it comes from different sources, which makes it difficult to match and to establish links

Impacts

Notwithstanding this being the early days of implementation and the corresponding lack of evaluation, several common themes can be discerned regarding the impacts of the use of digital technologies in social services.

Efficiency

There are different ways in which digital technologies can contribute to the efficiency of a service. According to a report by the Wessex Academic Health Network and the NHS (2018), AI has the potential to increase the accuracy of diagnostics. Furthermore, using data, AI can provide personalised medicine to patients and create more personalised services (Wessex Academic Health Network and NHS, 2018). In Sweden, the SAS Institute and Lifegene (an initiative run by Swedish university Karolinska Institutet) have developed a preventive analytical model for identifying individuals at high risk of developing type 2 diabetes. By analysing data from patients with diabetes, the model can identify which patients are at higher risk. One of the aims is to use the model with healthcare data provided by Stockholm County. Another study by AstraZeneca on type 2 diabetes concludes that preventive measures would reduce overall costs by identifying the disease sooner in patients or by even identifying the illness before it has progressed (Karolinska Institutet, undated; LIFe-time, 2016).

In some cases, digital technologies may have less accuracy than other options and/or commit errors that decrease efficiency. Profiling tools assessing the employability of jobseekers (which in some cases use Big Data and AI) can produce errors in assessment of the risk of unemployment. In some countries this has been mitigated by complementing these digital technologies with other sources of information in the decision-making process (OECD, 2018). In Slovenia, social workers using an information system that automatically calculates welfare benefits (IS CSD2) do not modify erroneous information about claimants because the system does not allow it (Kovač and Remic, cited in Pečarič et al, 2016). The evaluation of the Danish smart homes initiative Longer Together at Home found that the technology is harder to implement in private homes than in residential care homes. The technology is based on warnings through SMS text messages to family members. The family members have found that the text messages are often false alarms or contain invalid information. Many of the families have stopped using the technology because of these problems with text alerts. There have also been problems with cooperation

between the families, the care sector and the company behind the technology. It was unclear how the roles, tasks and responsibilities were divided (Bamberg Consult, 2017).

Accessibility and affordability

The use of digital technologies can make services more accessible in several ways. People with limited physical abilities or those living in remote locations will usually have an easier time accessing a digital service than an in-person one. The use of digital technologies decreases travel costs and time spent commuting for staff and service users. As one example, the digital platform care.com allows users to find home carers and childminders in their own geographic area (although the platform has more carers in urban areas, where the demand is higher). Digital technologies can increase the offer of services in remote areas. The platform Virtu.fi provides healthcare and social services in the sparsely populated Finnish Lapland region, connecting social service professionals with service users. The platform enables access to advice and assessments from specialists who do not practise in the region. Telecare is combined with home visits in some instances, allowing care workers to 'check in' with service users more frequently than before. However, there are still regional differences in the take-up of digital social services.

In 2015, the Italian National Institute of Social Security conducted a pilot study with 53,159 users simulating their future pension benefits online (Istituto Nazionale Previdenza Sociale, undated). Around 80% of the people participating in the study found the service to be 'very useful' or 'extremely useful'. The study also found a strong disparity and digital 'imbalance' between the north and south of Italy, with far more participation from the north in the project.

In the Wild Card project in Italy, keeping the cost low for service users was an important goal in the design of the service. The project involved development of a virtual reality game to supplement existing therapies (Garzotto et al, 2017). The virtual reality viewer that was chosen was the 'Google Cardboard' technology, which costs €5–10, thus ensuring an affordable service for users. In developing the Hobbit care robot in Austria, the aim was for it to cost less than €15,000 in order to be affordable for users. However, end users still found the Hobbit expensive, and although it met many of the users' expectations, the robot was still largely viewed as a toy rather than a rehabilitation tool (interview with a service provider) (Prifl et al, 2016). The lack of affordability was one of the reasons that the robot did not continue past the pilot phase (interview with a service provider).

Conclusions

Machine vs labour input: Impact on jobs and working conditions

- Experience as of 2019 shows that technological change rarely automates all the tasks within a job or occupation, and this will most likely be the case until AI reaches human level or advanced robotics reach the same level of dexterity as humans – neither of which are likely to happen in the near future. Technological change so far has led to the automation and alteration of selected tasks only. Technical change is more likely to affect routine tasks because these are easier to codify and automate (Fernández-Macías and Bisello, 2016).
- Studies see as a main determining factor of the substitutability of human labour either the level of skills required in a job or the prevalence of routine tasks (Eurofound, 2017a). A recent analysis of the potential long-term impact of automation identifies human health, social work and education as the sectors where jobs are at lowest risk of automation because the prevalence of creativity and the need for social and emotional skills makes it more difficult to replace human labour (PwC, 2018).
- Even if improvements in technology enable further automation of tasks in health and social care, the foreseen increase in demand for services will ensure that jobs are still created in these sectors. According to the 2017 European Jobs Monitor, personal care workers and allied healthcare professionals working in residential care activities are among the jobs with the fastest employment growth, with an average annual growth rate of 4.5% in the case of healthcare and 3.1% in social personal care (Eurofound, 2017b). This is likely to increase in the coming decades. According to the 2018 Ageing Report, by 2070 public expenditure in long-term care will increase by 1.2% percentage points of GDP (European Commission, 2018f).
- There is a higher risk of automation in the case of those jobs in health and social care which have a lower level of complex or social tasks. For example, the automation of processing of social benefit applications in Trelleborg (see p. 96: Case handling automation in Trelleborg (Sweden)) has led to job losses because of reduced need for officers handling applications. Other municipalities are expecting similar scenarios (Sveriges Radio, 2018). However, it is also the case that staff have been hired to handle the next steps in the application process, such as helping people to find a job. Similarly, the assistive technology care initiative in Norfolk County Council (UK) did not result in any staff reductions and led to the recruitment of more assistive technology service workers (Eurofound, 2013).

- The European Jobs Monitor shows that those working in long-term care have an average age of 55 and have earnings in the second-lowest quintile. This, coupled with difficulties in the retention and recruitment of staff, raises a question as to whether the workforce will be able to meet increased demand for services. It has been suggested that robots could mitigate workforce shortages by assisting carers in physically demanding tasks (e.g. lifting patients) while they focus on social tasks (Prescott et al, 2013).
- In terms of changes in tasks and working conditions, Swedish trade unions are concerned about the replacement of 'human time' with the use of robots, with fewer working hours for employees (interview with Anna Spånt Enbuske, researcher at Kommunal, 2018). In France, social workers feel that their jobs are being threatened by the automation of counselling tasks. Several French trade unions have expressed concern about the job losses caused by the digitalisation of public services.
- There are cases where the use of digital technologies has increased the amount of interaction between staff and service users. A study by Zechmann (2014) looked at the attitude of service providers towards assisted ambient living technologies in the Austrian smart homes projects ModuLAAr and Leichter Wohnen. In interviews with six staff members from Samariterbund Burgenland who were involved with the project, it emerged that the service providers observed increased interaction between users and service providers because of the project. Also, service users were glad that staff visited the homes to check in with them about the devices.
- The digitalisation of services affects both job content and job quality. A recent study by the European Social Observatory (Peña-Casas et al, 2018) analysed the impact of smartphone digital tools on the job quality and job content of home care workers in France, Italy, Spain and the UK. The study found improvements in the planning and organisation of work thanks to better centralisation of information, better interaction with colleagues and supervisors, improved management of working time and travel time and being more readily available to service users. Difficulties in correcting errors and rapid changes without sufficient warning were reported by the participants in the study as negative impacts on the planning of work. The recording of working time was also negatively affected (e.g. underestimation of time spent commuting). Other aspects of job quality that were negatively affected were the standardisation of time, less direct communication with colleagues and weak vocational training. The negative outcomes for workers reported were mental fatigue, stress due to consulting electronic planning and an increase in traffic accidents caused by using their smartphone while driving (Peña-Casas et al, 2018).

Acceptability and accessibility for service users

- The preferences of service users also play a role in the choice between machine or human input. Consequently, increasing the acceptability of digitalised social services has featured in pilot projects (e.g. a smart homes project financed by the Bavarian Federal Government). Service users sometimes feel their choice is restricted by decisions taken by AI and/or robots, and they experience loss of control, privacy and personal liberty (Sharkey and Sharkey, 2012). Monitoring systems can restrict people's freedom, privacy, autonomy and/or dignity (Caleb-Solly et al, 2018). For example, the use of cameras or GPS sensors in care for elderly people brings up issues around privacy and dignity.
- One factor influencing user preferences is whether they feel they have the skills necessary to use digital technologies. According to the Digital Skills Indicator, 17% of the EU population in 2017 did not have any digital skills (European Commission, 2018e). Lack of digital skills appears to have created an environment in some Member States or regions for limited uptake (identified by the NEC in Croatia, Cyprus and Malta). For example, a study by Vetrano and Vaccaro (2017) found that digital technologies are used very rarely in home care in Italy. Furthermore, according to a study by Ernst & Young (2017), 45% of Italians have not used online services offered by public administrations, preferring direct contact with public service employees. Furthermore, 25% indicated that they would not know how to access public services if they were exclusively offered online. In the Austrian ModuLAAr project, some of the users were unfamiliar with the digital technologies used in the project (i.e. sensors and apps). Training has been provided in digitalisation initiatives such as the Austrian Digital Roadmap. As part of the Roadmap, advisory centres such as the web-based initial contact and consulting service (TEWEB) and assistance systems have been established to help the elderly and those with special needs.
- The European Semester and national governments often point to technological developments as a way to increase cost efficiency in long-term care. There is a risk that when technology achieves savings, this factor overrides the preferences of service users and staff. French trade unions have targeted the digitalisation of labour as a cause of 'de-humanisation of the public service' (Labaune, 2017).

Data protection

- A survey about the attitudes of Europeans regarding the impact of digitalisation and automation on daily life found that 70% of respondents would be willing to give their health and personal well-being data to others (European Commission, 2017b). However, this was mainly to give access to doctors or healthcare professionals. Only 21% agreed to share this data (if anonymised) with public authorities or public sector companies for medical research purposes.
- Several recently implemented policy initiatives aim to improve the sharing of data. For example, the Finnish Innovation Fund Sitra and the Ministry of Social Affairs and Health are setting up a digital health hub that will centralise data about citizens' well-being. The hub allows the storage, sharing and analysis of data, which will contribute towards the improvement of health and social care services (Teknologian Tutkimuskeskus VTT, 2017, 2018). In Denmark, the Common Public Sector Strategy for Digital Welfare (2013–2020) includes a preliminary analysis of how best to share data between local authorities (Danish Agency for Digitisation, 2013).
- In some countries, a prerequisite for putting these types of initiative in place or developing them further is legislative change regarding requirements for personal data storage, sharing, privacy and security. In Sweden, the government commissioned a report in late 2016 analysing the legislation relevant for the use of digital technologies in public administration, indicating the legal reforms necessary to develop this area. A pilot project showed that personal data could be used for predictive healthcare analysis, but legislation in place when the study was published made this difficult because of the high level of protection of personal information (Statens Offentliga Utredningar, 2018).

Policy pointers

- Many Member States do not address digital technologies in health or social care services specifically, but have digital transformation strategies for the whole public sector. In other Member States, the digital transformation of social services is promoted as part of initiatives targeting mainly healthcare services. The same can be said about EU policy initiatives. For example, the Communication on enabling the digital transformation of health and care in the Digital Single Market includes in its priorities issues that are relevant for both health and social care systems (e.g. the development of EU-wide standards for data quality, reliability and cybersecurity) but mainly referring to healthcare systems (European Commission, 2018c). A similar situation can be found in the European Innovation Partnership on Active and Healthy Ageing and the Active and Assisted Living Joint Programme. All these initiatives address long-term care services, but mainly from a healthcare perspective.
- The digitalisation of other social services may deserve special attention when it comes to the implementation of the European Pillar of Social Rights or the allocation of funding in the follow-up to Horizon 2020. The evaluation of the impact of digital technologies in social services seems to be an underdeveloped area that could benefit from EU funding.
- Trade unions and service users raise the need to avoid the 'dehumanisation of care'. The Ethics guidelines for trustworthy AI issued by the High-Level Expert Group on Artificial Intelligence note that social interaction with AI in care and other areas can have both positive and negative impacts on social skills and mental and physical health. In their proposed assessment list to operationalise trustworthy AI, they ask for the monitoring of social impacts, including potential job losses or deskilling of the workforce (European Commission, 2019). This could be taken up in the development of AI strategies at the national level.
- Due to the sensitivity of the data involved in health and social care services, it seems that take-up and acceptability of digital technologies could be improved by offering safeguards. Accountability of decisions taken though AI or other digital technologies could be improved through an effective 'right to an explanation'.
- Investment in education and training is mentioned several times in the AGS 2019 as a necessity for successful transition to the digital economy and reducing inequalities in access to related services. Skills levels have also been identified in several countries as key to increasing take-up by both staff and service users. The newly established InvestEU Programme will group different EU financial instruments that can support training and lifelong learning. It is envisaged that the programme will support Member States in tackling challenges and addressing investment priorities identified in the European Semester's CSRs.
- In some Member States, local and regional authorities mainly drive the digitalisation of social services. Member States can support local authorities in their efforts to be become 'smart cities' through opportunities available at the EU level, such as the Digital Transition Partnership, which is part of the Urban Agenda for the EU.

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9 What next?

Introduction

The eight preceding chapters in this volume cover a wide range of themes, brought together under the umbrella concept of 'quality of society'. They are based on research conducted by Eurofound mostly in the period 2016–2018. The analyses presented represent not only a variety of subjects but also a range of research methods, although several chapters draw extensively on the EQLS 2016. Data from the EQLS are complemented in some chapters with recent EU-LFS, EU-SILC, Eurobarometer and European Social Survey analyses. In addition, measures to improve the situation of disadvantaged groups have been drawn from case studies in Member States, based on the work of external contractors as well as input from the Network of Eurofound Correspondents (NEC) and in-house studies. For instance, in the chapter on young people, a survey of service providers was developed with support from an external contractor.

Although the chapters examine services to groups across the whole population of the EU, there is, evidently, a focus on services to meet the needs of people with health and social problems. In particular, and in different ways, several of the chapters address the needs of younger people: of the very young for childcare services, of children for education, of teenagers and young adults for access to health and social care services and of young refugees and asylum-seekers. It is notable that Eurofound's research increasingly seeks to examine the situation of young people aged 12–18, whereas its focus in the past has largely been on those aged 18 and over.

Several of the services specifically address transitions across the life course, from school to vocational education, from teenage years to adulthood and from life in a troubled country to settlement in the EU. Clearly, what happens at an early age influences needs and demands later in life, and this applies to the population in general regarding needs for healthcare and long-term care, for example.

Demand for many public services is growing, with increasing needs across the spectrum of health and care. Of course, many needs in these sectors are met by family and neighbours or friends acting as informal carers. An awareness of the significance of unpaid informal care highlights the specific and greater involvement of women in these roles. However, it is also the case that an increasing number of workers – again, women in particular – are occupied in paid employment in these public services. For people in need, it is imperative to improve access to sources of support, both formal and informal, from personal or social networks as well as from public service providers.

The EQLS 2016 shows that in the EU as a whole, and contrary to some popular conceptions, trust and social cohesion have recovered to levels that existed before the financial crisis (Eurofound, 2017). However, there were still 12 Member States where average trust in national institutions in 2016 was lower than in 2007. The ranking of institutions in terms of trust is relatively stable over time and across countries. National political institutions (governments and parliaments) tend to be ranked lower in general than other institutions, and only 30–40% of people typically express trust in these national political institutions (the proportion expressing trust in the EU is usually somewhat higher). Perceiving the existence of certain societal tensions – between ethnic or racial groups, and between religious groups – is more common now than before the crisis, and this has a significant negative impact on trust in institutions. As the first chapter in this volume showed, civic participation, especially volunteering, has a positive impact on levels of trust, while feelings of insecurity result in lower expressed trust in institutions. The importance of insecurities is increasingly emphasised (Eurofound, 2018; OECD, 2018); the EQLS documents some declines in feeling certain about being able to retain accommodation and widespread concerns regarding income insecurity in old age. It appears that a certain sense of security is an essential factor for trust in institutions.

There are some indications of improvement in the quality of public services (particularly healthcare and childcare) between 2011 and 2016 – more so in countries where quality ratings were previously low. The ranking of the quality of long-term care remains relatively low compared with, for example, childcare, suggesting a need for greater attention to the quality (and also availability) of this service. On the whole, quality ratings of the public services examined are relatively uniform for the different services in individual Member States. The results also point to a marked continuity over the last decade in the countries where services are generally regarded as being of high or low quality – this is true of healthcare, long-term care, childcare and the education system – which suggests that the broader welfare systems in different countries are important determinants of perceived quality of individual services.

Access to quality services

Large differences between Member States in the proportions of people using formal services such as childcare and long-term care underline the major gaps in availability of services in some Member States. While the European Pillar of Social Rights (European Commission, 2017) calls for universal access to health and care services, this has evidently not been realised. Access is a multifaceted concept (Eurofound, 2014), but the existence or availability of the service is obviously fundamental. Long-term care, particularly home care services in the community, appear to be largely absent in half of EU countries. In primary healthcare, while services are generally available, there are widespread access problems associated with physical distance, cost of the service and waiting lists or opening hours. Regarding the spread of digitalisation in social services, it is clear that digital transformation strategies specifically for health and social services are lacking in most Member States and implementation is weak.

From a public policy perspective, the differences in access to and satisfaction with services within Member States presents a glaring challenge. The most evident inequalities are associated with income and are underlined, for example, in the greater difficulties facing people in the lowest income quartile in terms of accessing primary healthcare; the poorest quartile of the population also experiences services differently, with lower ratings of satisfaction with the quality of GP and hospital services. Among young people it appears that those in the lowest income quartile experience more problems in all aspects of access to health services. Young women appear to have more difficulties with distance to healthcare and with waiting times while, not surprisingly, young people in rural areas report more access difficulties due to distance from the service. The chapter on services for refugees points to a lack of attention to their specific needs and a lack of effort to attract them to available measures for integration; in particular this applies to women refugees, greater numbers of whom are expected to arrive in the EU in the near future.

In general, it appears that the greatest improvements in quality of life between 2011 and 2016 were experienced among the second-highest income quartile (Eurofound, 2017). The situation of people in the second-lowest income quartile is addressed specifically in the chapter on healthcare, with reference to people living in the twilight zone; these are people with too much income or wealth to receive financial support or benefits, but too little to pay directly for services, and who, consequently, experience more problems with access to care. The story of the 'middle classes' in Europe may need to distinguish the experiences of higher and lower income groups in that category. In the last decade of cutbacks and austerity in some services, it appears the impacts may have been more pronounced for disadvantaged groups – with closure of local health services, childcare centres and youth services.

Service improvements

Implementation of the European Pillar of Social Rights is underway, with initiatives focused on the reconciliation of work and care as well as working conditions and social security coordination. However, it is clear that recent experiences with the Social Investment Package or with digitalisation strategies have been uneven, both between and within Member States (European Commission, 2018). The reform of welfare systems, as well as the promotion of digitalisation in social services, has underlined the importance of non-governmental and private sectors working alongside public authorities. Likewise, regarding the introduction of services for refugees and asylum-seekers, there has been a need for collaboration between government and private sector and civil society partners; this is well illustrated in the chapter on refugees in relation to coordination between the PES and companies to promote labour market integration. The imperative for rapid integration of quite diverse groups of people from different cultural backgrounds and with different legal statuses has required tailor-made measures. The integration of refugees is complex, and most measures necessarily involve more than one area of integration. It appears the 'whole of government' approach, engaging different sectors or departments, can improve both effectiveness and efficiency for integration.

Measures to address the needs of young people with health and social problems commonly involve cooperation between schools and service providers. Schools can help increase awareness and understanding of sensitive issues, and they can be an especially good setting in which to develop peer-to-peer support. However, there may be constraints, as parents expect or demand involvement in school-based initiatives. Hence, the chapter on young people emphasises the value of organisations in the local community, away from home and school.

The provision of care, particularly long-term care, is largely based on the work of informal carers. However, these informal carers require support to both sustain and improve the quality of their efforts, and this must come from the network of community or institutional services. So, 'integrated delivery' of many services involves not only coordination between formal service providers but between formal and informal provision.

The implementation of many initiatives documented in this volume demonstrates learning and change over time. In some cases – for example, in many digitalisation projects – there is explicit development of services as 'pilots' with different strategies to increase the acceptability over time of digitalised social services to both workers and service users.

In several of the measures to integrate refugees, it is apparent that a major challenge exists to reach targeted groups; in several countries, attendance at language classes or civil education was made compulsory. More generally, the take-up of benefits and services requires systematic attention to effectively reach intended beneficiaries (Eurofound, 2015).

In services to young people, including healthcare, and in long-term care and refugee integration, there are many examples of innovation through ICT or digital technologies. E-healthcare has the potential to improve service quality, cut costs and promote sustainability, and there was relatively widespread use of e-prescriptions (though only rare instances of e-consultations) in 2016. Examples of the application of digital technologies in social services indicated a number of promising initiatives for long-term care services, but it seems that such developments are not yet widespread. The use of online and telephone services for young people assists in dealing with sensitive problems as well as overcoming distance as an issue. It appears such measures can promote a sense of security and confidentiality while also reducing the amount of paperwork or administration. In social security systems, similar advantages may accrue with digitalisation of benefit and tax administration: for example, to avail of graduated benefits (helping claimants in the twilight zone). Bottlenecks in complicated bureaucratic procedures are, evidently, also a problem for integration of refugees. For this group, several initiatives, notably MySkills in Germany, have facilitated the process of employment integration. Nevertheless, for all this potential of digitalisation, as the AGS underlines, successful incorporation into mainstream services is strikingly underdeveloped.

Emerging issues

There is a lack of data to inform the effective development of many health and social services and a lack of sound evaluation to establish the effectiveness of many policy initiatives. The various chapters in this volume highlight the limited availability of data on access and use of services, with even less information available from assessments of quality. It is noted, in addition, that most surveys exclude people in institutions or residential care. For young people, there is a strong indication that mental health is deteriorating, in northern and western Europe at least. However, results from the different surveys are not consistent, and there is clearly a need for much better comparative data – at regional as well as country levels. For the targeted development of appropriate support, experience with young people highlights the need for more systematic consultation on needs and preferences; this could be applied to most other groups in vulnerable situations.

At both EU and Member State levels, there is a call for evidence-based reforms. This requires the application of appropriate process and outcome indicators which are relevant not only to short-term but also to longer-term outcomes, as illustrated in the case of refugees. In our ageing societies there is much emphasis on the need for long-term care services, but ratings of long-term care by both users and non-users is low. The development of appropriate services demands both better data and more systematic efforts to conceptualise 'quality'. Even in the healthcare sector, where there has been significant advance in the context of the Joint Assessment Framework Exercise, there is little comparative information on quality. It appears especially relevant to acquire more data on the process of receiving a service – for example, with regard to healthcare, on 'being informed and consulted' – aspects with which many health service users are dissatisfied.

This report includes a number of positive experiences with the involvement of client groups in the design, and sometimes the delivery, of services. Those with experience of services, the users, tend in all cases to give higher ratings of the quality of the service than non-users do. Among young people explicitly involved in service design, it appeared this was instrumental in gaining their trust, increasing their awareness and reducing feelings of discrimination. Such involvement is also helpful in assessing demand for services and developing a targeted approach. The establishment of services for refugees highlighted the need to tailor to specific groups and, for example, to involve people with mental health problems more directly in design of their support. Involvement in the design and development of public services can, as indicated in the opening chapter, contribute not only to better services but to promoting trust in institutions. Likewise, the benefits of being involved, through active citizenship or civic participation, are evident in relation to higher levels of trust; but effective volunteering, for example, requires the development of an infrastructure to promote this as well as the strengthening of civic values and attitudes.

The contributions in this volume have highlighted a series of challenges and emerging issues for public services. The big differences between Member States in terms of availability of services are replicated also at regional and local levels; more structured and systematic mapping of both service presence and use is essential. In documenting the available services, there is clearly a need for more information on the characteristics of the service regarding facilities and staffing. As the chapter on childcare illustrates, the relationship between these characteristics and users' assessment of the quality of services requires much more elucidation. Among the different quality dimensions, the way in which services are delivered and how they are experienced has been highlighted for both health and care services.

Among other dimensions, the sense of fairness in the allocation of resources is a particular issue, with large numbers perceiving an unequal distribution of health and care services. This relates to the continuing major concern with social inequalities, primarily associated with income but also, as in the case of fairness, with the differences associated with the areas in which people live. Alongside inequalities, there appears to be a growing awareness that a sense of security (about income, housing, employment) matters for both quality of life and trust in institutions. The EQLS data indicate some important positive developments in ratings of the quality of public services and trust in institutions, but the absolute levels in many Member States allow no room for complacency. There appear to be increasing urgency around dealing with mental health problems among, for example, young people and refugees, as well as addressing care needs across the life course. While delivery of quality public services is a cornerstone of the European Pillar of Social Rights, there is a pressing need to translate the principles into action (European Commission, 2018).

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What have been the major developments in quality of life and public services in Europe in recent years, as captured by research into these areas in Eurofound's work programme for 2017–2020? This flagship publication provides a synthesis of the main findings on several key topics, based, in part, on European Quality of Life Survey data. It maps developments and perceptions regarding the following: trust in institutions and social cohesion; access to and quality of health and care services; the impact of digitalisation on social services; access to services for young people; and measures aimed at integrating refugees. While the report highlights many challenges and emerging issues for public services, it also showcases a number of positive experiences with the involvement of client groups in the design of services and take-up of new technologies.

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