

Public services

# Quality of health and care services in the EU





# Quality of health and care services in the EU



**When citing this report, please use the following wording:**

Eurofound (2019), *Quality of health and care services in the EU*, Publications Office of the European Union, Luxembourg.

---

**Authors:** Hans Dubois (Healthcare chapter), Tadas Leončikas (Introduction and Conclusions) and Daniel Molinuevo (Long-term care and Childcare chapters)

**Research manager:** Tadas Leončikas

**Eurofound project:** 170801

**Acknowledgements:** Claus Wendt (healthcare), Jose-Luis Fernandez (long-term care), Nada Stropnik and Maria Vaalavuo (childcare), Anton Hemerijck, Nevena Kulic and Carlos Gil Hernández for providing feedback during drafting.

---

**Luxembourg:** Publications Office of the European Union

**Print:** ISBN 978-92-897-1885-1      doi:10.2806/918008      TJ-04-19-471-EN-C

**PDF:** ISBN 978-92-897-1886-8      doi:10.2806/5643      TJ-04-19-471-EN-N

This report and any associated materials are available online at <http://eurofound.link/ef18034>

© European Foundation for the Improvement of Living and Working Conditions, 2019

Reproduction is authorised provided the source is acknowledged.

For any use or reproduction of photos or other material that is not under the Eurofound copyright, permission must be sought directly from the copyright holders.

Cover image: © Robert Kneschke/Shutterstock

Any queries on copyright must be addressed in writing to: [copyright@eurofound.europa.eu](mailto:copyright@eurofound.europa.eu)

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.

**European Foundation for the Improvement of Living and Working Conditions**

**Telephone:** (+353 1) 204 31 00

**Email:** [information@eurofound.europa.eu](mailto:information@eurofound.europa.eu)

**Web:** [www.eurofound.europa.eu](http://www.eurofound.europa.eu)

# Contents

	<b>Executive summary</b>	<b>1</b>
	<b>Introduction</b>	<b>3</b>
<b>1.</b>	<b>Healthcare</b>	<b>7</b>
	Introduction	7
	Use of healthcare services	9
	Quality of healthcare services	12
	Access to healthcare	17
	Perceived fairness – equal treatment and corruption	18
	User satisfaction with aspects of care provision	21
	Country patterns	23
	Conclusions	25
<b>2.</b>	<b>Long-term care</b>	<b>29</b>
	Introduction	29
	Use of long-term care services	31
	Access to long-term care services	32
	Quality of formal long-term care services	36
	Conclusions	41
<b>3.</b>	<b>Childcare</b>	<b>43</b>
	Introduction	43
	Use of childcare services	45
	Access to childcare services	49
	Quality of formal childcare services	52
	Conclusions	58
<b>4.</b>	<b>Conclusions</b>	<b>61</b>
	<b>Bibliography</b>	<b>65</b>

## 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		

### Non-EU countries

CH	Switzerland	NO	Norway
IS	Iceland	RS	Serbia
MK	North Macedonia	TR	Turkey

# Executive summary

## Introduction

The report examines the use, access to and perceptions of quality in relation to health services (primary care and hospital services), long-term care and childcare across the European Union. These public services are important for managing care responsibilities, enabling participation in employment and social life and overall quality of life. The findings are based on data drawn from the European Quality of Life Survey (EQLS) 2016 carried out in 28 EU Member States.

Public services are understood as services for the public, regardless of whether they are provided by the public sector, private initiative or a mixed partnership. In the report, public services are considered to be of high quality if the following criteria are met: they are easily accessible, the quality of care received is high, people are treated equally by the services and the services are free of corruption. This follows the approach of the EU Social Protection Committee (SPC)'s 2010 voluntary European Quality Framework for social services, which suggests monitoring input, output and process-related dimensions and considers access as part of quality.

## Policy context

At both Member State and EU level, policymakers and stakeholders are developing concepts and frameworks for addressing the issue of quality in services. A milestone is the European Pillar of Social Rights 2017, whose principles reference different public services and, in addition to access, stipulate that services must be of good quality. Monitoring and assessing the quality of services will be essential for assessing implementation of the Pillar and developing country-specific recommendations in the European Semester.

## Key findings

### Healthcare

- Primary care services are used by a majority of people during a year. However, there are large differences in the use of e-healthcare (in more than half of the Member States, more than 90% do not encounter e-healthcare), and there are markedly varying levels of using emergency healthcare which suggests that access to more regular healthcare is not optimal in some countries.

- Healthcare has favourable overall scores compared to other services. However, 27% of people in the EU give low (lower than mid-point) ratings to health services in their country, ranging from one-tenth to about two-thirds of the population across Member States. Even in the best-performing Member States there are significant groups in the population who describe quality as low.
- Primary care is generally rated more favourably than hospital or specialist care. However, there are exceptions (a reverse pattern in Finland and Sweden).

### Long-term care

- User satisfaction with specific quality aspects in long-term care is lower than all other social and health services included in EQLS.
- Long-term care quality ratings are not as differentiated by socioeconomic background within countries as for other services, but country differences in both use and perceived quality are notable.
- Differences between countries concerning receipt of nursing care at home and of home help are considerable. However, they seem to reflect differences in the availability of and access to these services.

### Childcare

- User satisfaction tends to be higher in the case of services for young children and specifically for those using formal childminding rather than centre-based childcare. User satisfaction was lower in the case of after-school care (for children under 12).
- Proportionally more people in lower income groups benefit from free or subsidised childcare than in higher income groups; nevertheless, the take-up of formal childcare remains lower, and affordability issues are more frequent among people in the lowest income quartile compared to others.
- Preventing corruption and providing equal treatment in childcare were the dimensions ranked lowest compared to other aspects, indicating there could be issues around accessing and benefiting from childcare services.

With regard to inequalities in access to and quality of services, the income gradient is uneven and differs between types of services.

- The quality ratings for health services overall have improved for every income quartile from 2007–2011 to 2016. However, compared to other services discussed, income differentiates perception of quality most in the case of healthcare; the ratings of quality by the bottom income quartile remain the lowest and the gap between it and the higher-income groups has increased. Access difficulties, perceived corruption and unequal treatment explain part of the negative quality perception. The third income quartile enjoyed the greatest improvement and gave the highest overall healthcare quality rating in 2016 (6.9), more than the top income quartile (6.8).
- In the case of long-term care, middle income quartiles have somewhat better perception of quality (6.2) than the low- and high-income groups (6.1). In the case of childcare, the bottom income quartile (with a quality rating of 6.5) lags behind the others.
- In the case of childcare services, specific quality dimensions related to facilities and staff are high across countries and groups in society. However, affordability difficulties in relation to childcare were reported by approximately a third (36%) of Europeans with children under the age of 12 using these services; this proportion is higher for low-income groups.

## Policy pointers

- Paying attention, devoting time to and keeping users consulted about their care are ways to improve user satisfaction with services. Soft skills should not be underrated: if attention to and informing the service users is rated low, the otherwise highly rated professionalism and expertise of staff also tend to be considered low by the users.
- Improving *fairness* (equal treatment and preventing corruption) is relevant for all services discussed since the reported issues are at tangible levels in all of them, and are not confined to a small number of countries.
- Assessment of financial barriers to accessing services should consider not only the groups with the lowest income, but also the ‘twilight zones’ in which people have incomes too high to benefit from public funding but too low to afford services without difficulties. In the case of health and long-term care services, a substantial proportion of people in the third-highest income quartile reported difficulties in accessing services due to cost.
- Measuring equity via the gap between the highest and lowest income groups is insufficient, and should be complemented with measures capturing the middle-income groups to reflect evidence of an increasing gap between the low- and (upper-) middle-income groups.
- Measurement of poor access to services would benefit from going beyond ‘unmet need’ to include delaying care (‘economising’) and accessing but experiencing difficulties while doing so. This is relevant to countries where the entirely unmet need for care is rare, but barriers nevertheless may have less direct consequences.



# Introduction

## Role and potential of health and care services

There are several perspectives that inform an increasing interest in health and care services in Europe today: the manifestation of old and new challenges to welfare states, Member States' experiences of the great recession and recent austerity policies. An interest in the role the services could play is also sustained by a continued commitment to inclusive growth, reflected in the principles of the 2017 European Pillar of Social Rights.

In the EU context, there is a commitment to promoting social cohesion and social inclusion that cuts across policy strategies and specific European initiatives. In terms of the broad goals of encouraging economic growth, promoting employment and preventing poverty, a range of public service categories have been invoked that focus on human capital and tackle social risks, including services provided as part of active labour market policies (ALMP), education and lifelong learning, early childhood education and care (ECEC), work-life balance policies for parents and carers, promotion of healthy living and active ageing and long-term care services. Understanding the role and potential of services is important in recognising that employment alone does not always prevent poverty (Eurofound, 2017a), and therefore it is worth looking in tandem at both the world of work and the services that can facilitate labour market transitions, give support to families and prevent intergenerational poverty transmission.

The relevance of health and care services is high, given the policy initiatives in work-life balance, the challenges of ageing societies, pressure on social security systems, the need for long-term care and the economic potential of creating employment in the health and care services sector. The growth of jobs in health and care is anticipated, due not only to demographic ageing and the growing demand for such services, but also as the outcome of a general trend in productivity enhancement (including from new technologies) and affordability of services that improve quality of life (Pissarides, 2018).

Many of the aforementioned service types are emphasised in the developing approaches to social investment (Hemerijck, 2017) and it is argued that enabling the services and a life-course perspective are what particularly matter in trying to overcome static approaches to compensatory welfare policies. By improving the 'stock' (or human capital, skills, health of population), 'buffering' against social risks and life hazards (unemployment, sickness) and facilitating 'flows' between various life stages, public services can strive to achieve a positive multiplier effect (Hemerijck, 2017, pp. 26–28) that helps societies to be resilient. On the one hand, good services help to nurture 'high-quality human capital inputs' on which economic actors rely; on the other hand, there is an intrinsic value in the improvements to quality of life in which high-quality services are a factor. An illustrative example at an individual level is provided by Atkinson: when surgery is needed, timely intervention allows an incapacitated worker to return to work sooner, thereby creating extra output and saving costs over the long term – even if surgery is covered by public funds (Atkinson, 2015, p. 121, cited in Hemerijck, 2017, p. 29). However, this presupposes timely access to a good-quality service.

In releasing the Social Investment Package in 2013, the European Commission emphasised the role of social services, highlighting that they not only enable people to cope better with challenges and crises, but also help to improve future opportunities for people.

The reasons for focusing on health and care services in this report include the above, but it is also worth pointing to other service-specific features: healthcare, for example, is an area of near universal relevance (most people are in fact 'users' of some health services, either preventive or curative) and has been the object of substantial public spending in most countries. Hence, quality shortcomings or quality improvements in health services are likely to have a broad impact in terms of population affected. Care provision, on the other hand, may affect specific groups of people in particular life phases; however, the life circumstances in which care services are needed (whether childcare or long-term care) tend to profoundly affect daily routines, opportunities for economic and social life and health and mental well-being.

## Quality of public services in the EU policy agenda

The point of departure for this research is a growing interest in developing monitoring and establishing indicators on access to quality social services in EU policy circles.<sup>1</sup> References to ‘quality of public services’ have grown and spread across EU-level policy documents and the grey literature for more than a decade; however, a particular milestone has been the European Pillar of Social Rights, ratified in 2017. Many of its principles refer to specific public services and, in addition to access, explicitly state that the services have to be of good quality. Monitoring and assessing quality are likely to be important in assessing the implementation of the Pillar.

However, the quality of public services is already being addressed via established processes of EU policymaking, such as the Annual Growth Survey, the first step in the European Semester process which leads to country-specific recommendations (CSRs) by the European Commission to the Member States. Apart from some exceptions, the CSRs have focused mainly on the aspect of ‘cost-effectiveness’ in the past, with an emphasis on efficiency. However, the issue of access to high-quality services may be moving more to the fore in the policy agenda.

The political and practical relevance of addressing the quality of services from an EU perspective may have to do with an increasing recognition of the ‘social dimension’ (in addition to economic growth) and debates around convergence. Differences in the perceived quality and cost of services between Member States can be further relevant, as they may encourage people (who can afford it) to cross borders to obtain services such as healthcare or education, and also to work providing care services in other Member States, reducing the capabilities in the sending countries and in sectors that stagnate.

While research has been carried out on the quality of public services in different sectors or countries, the extent of comparable EU-wide data is limited. This report sets out to explore the results from Eurofound’s European Quality of Life Survey (EQLS) – covering all EU Member States – and to prepare the ground for empirically informed discussion on the extent and kinds of differences in service quality across the EU countries.

With regard to the development of concepts and dimensions of service quality in Europe, networks related to EU social policy have provided a particular impetus for involving stakeholders in the relevant

debates. For example, the EU SPC’s 2010 voluntary European Quality Framework for social services has become a useful reference point. Among its overarching quality principles are that social services (including healthcare services) should be accessible and affordable, as well as person-centred, comprehensive, continuous and outcome-oriented. Quality principles regarding the relationships between service providers and users include respect for users’ rights and participation and empowerment. Quality principles for the relationship between service providers, public authorities, social partners and other stakeholders include partnership and good governance.

## Measuring quality of services in the EQLS

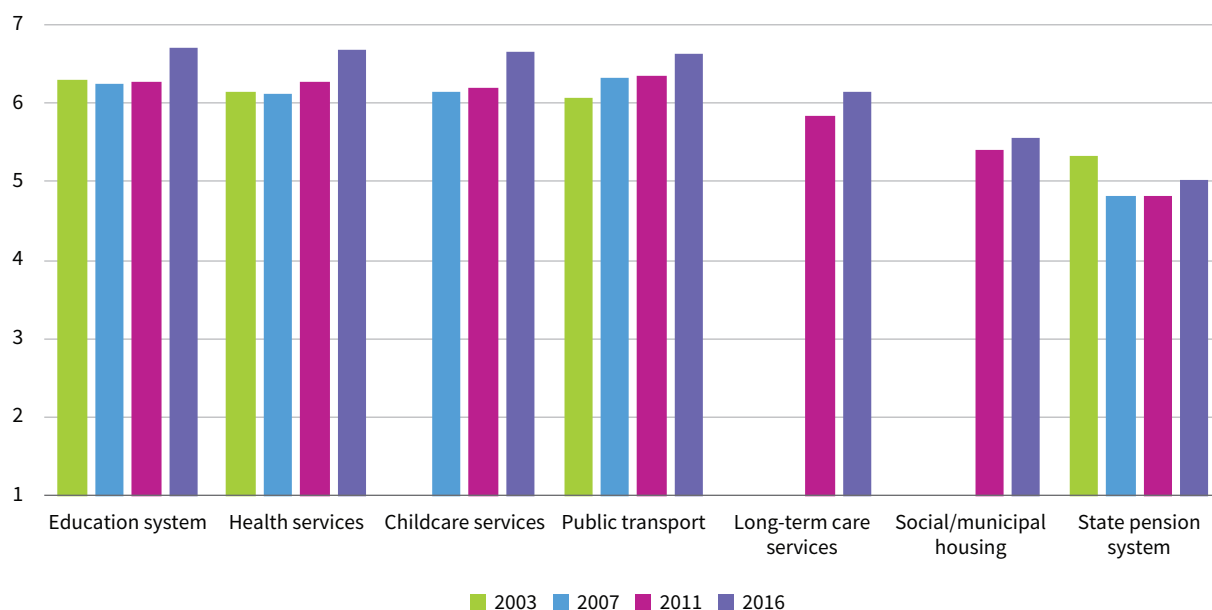
The quality of public services has been defined in many different ways, with varying dimensions. In the present research, services are considered to be of high quality if the following conditions are met: they are easily accessible, the quality of care received is high, people are treated equally by the services and the services are free of corruption. This follows the approach of the EU SPC’s 2010 voluntary European Quality Framework for social services, which recommends monitoring input, output and process-related dimensions and considers access as part of quality in relation to ‘inputs’. In this report, ‘public services’ are understood as services for the public, regardless of whether they are provided by the public sector, private initiative or a mixed partnership.

The report focuses on findings from the EQLS, a survey that has a time series for the seven public services monitored (Figure 1) and has added to its latest round – 2016 – a set of variables to rate the satisfaction of health and care service users with specific quality dimensions of those services (Table 1). The data concern self-reported experiences and perceptions of quality, and respond to a growing recognition that the preferences and views of the public are an important element in policy planning and delivery.

As seen in Figure 1, the quality ratings in the EU on average have increased notably since 2007 and 2011 for health and care services (and for education). However, it is important to acknowledge that in 2011 in some countries perceptions of quality may have been affected by the measures applied to public service provision in the period of the financial crisis, and that in some cases the increase may reflect recovery rather than long-term improvement.

<sup>1</sup> For an overview, see SPC (2018a).

Figure 1: Quality ratings for key public services, EU28



**Note:** Ratings on a scale of 1–10.

**Source:** EQLS 2016 (Q58).<sup>2</sup>

In this report, the results of the EQLS 2016 are used to examine the most recent evidence on perceived quality of health and care services, with the following objectives: to establish the extent of differences in reported service quality across the EU Member States, to identify social groups reporting access and quality problems, and to explore various indicators on access to and quality of the services.<sup>3</sup>

With regard to user satisfaction with various aspects of service quality, a set of dimensions was drawn up based on the aforementioned SPC's voluntary European Quality Framework for social services (Table 1), as well as drawing on debates around the specific services in health and care sectors. It aimed to capture both provider-focused features (facilities and

professionalism) and user-focused experiences; to this end, harmonisation of the questions was carried out when preparing the EQLS 2016 so that they could apply to the relevant services – and be comparable. Questions about fairness (equal treatment and perceived corruption) were addressed to all respondents regardless of whether they were service users; this was based on the presumption that people's opinion about fairness in a particular services sector can influence their decision on whether to choose such services or to look for alternatives – for example, making informal childcare arrangements (such as with a member of the family or a childminder without a contract), seeking health services abroad or – in the case of citizens of other Member States – in their country of origin instead of locally.

<sup>2</sup> The full text of all EQLS questions may be consulted online at <https://eurofound.link/eqlsq>

<sup>3</sup> Detailed tables and figures are available in a working paper published on the same web page as this report, at <http://eurofound.link/ef18034>

**Table 1: Ratings for specific quality dimensions of health and care services, EU28**

	Dimension	Primary healthcare	Hospitals	Long-term care	Childcare	Schools
<b>Ratings by service users</b>	Quality of the facilities	7.9	7.8	7.4	8.1	7.7
	Expertise and professionalism of staff	8.0	7.9	7.5	8.2	7.7
	Personal attention given	7.9	7.6	7.4	8.2	7.6
	Being informed or consulted about care	7.8	7.6	7.3	8.1	7.6
<b>Ratings by all respondents</b>	Equal treatment	7.6	7.3	7.1	7.7	7.6
	Absence of corruption	8.1	7.8	7.8	8.2	8.3

**Notes:** The scores for the first four dimensions are the average ratings given by respondents who reported using the service in the last 12 months. The scores for the last two items (Equal treatment, Absence of corruption) are based on answers given by all the respondents (both users and non-users of the services in question). Ratings are based on a 1–10 scale, where 1 means ‘completely disagree’ and 10 means ‘completely agree’.

**Source:** EQLS 2016 (Q62, Q63, Q64, Q66, Q73, Q75, Q81, Q83, Q85, Q86)

# 1 Healthcare

## Introduction

### EU policy context

Principle 16 of the European Pillar of Social Rights (in Chapter III: Social protection and inclusion) states that ‘Everyone has the right to timely access to affordable, preventive and curative health care of good quality’. This reaffirms the right ‘of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices’, set out in Article 35 of the EU Charter of Fundamental Rights (European Union, 2000). The European Commission’s Annual Growth Survey 2018, the first step in the European Semester process which leads to country-specific recommendations (CSRs) for all Member States, echoes this aspiration (European Commission, 2017a). It calls for policy actions to ‘enable people to stay healthy for longer, by making health systems and long-term care more cost-effective and ensuring timely access to affordable preventive and curative healthcare of good quality’.

In 2013, the EU’s Social Protection Committee (SPC) adopted a report by its Indicators Sub-Group (ISG) on developing an assessment framework – based on the Joint Assessment Framework methodology which was adopted in 2010 covering a broader range of topics – specifically in the area of health (hereafter ‘JAF Health’). This is used to identify key challenges experienced by Member States and to help establish their priorities in policymaking. JAF Health is particularly important for its cross-country comparability, which helps the Member States to evaluate their challenges in relation to each other. In 2017, the SPC completed the methodological work related to JAF Health and undertook a review of Member States’ health systems along the 93 agreed indicators on outcome, access, quality, non-healthcare health determinants, resource context and socioeconomic context (European Commission, 2015a; SPC, 2018b). The work of the Organisation for Economic Co-operation and Development (OECD) and regional office for Europe of

the World Health Organization (WHO) – including that of the European Observatory on Health Systems and Policies – has also contributed to the assessment of overall quality of healthcare services in different countries.

### Scope of research

This chapter presents an overview of quality in healthcare services in the EU – from the data regarding use of the services to perceptions of quality – and follows the chain from accessing to experiencing the services, as well as covering expectations of accessing them in the near future.

The most frequently used dimensions for assessing quality of healthcare are in descending order of frequency: effectiveness, efficiency, access, safety, equity, appropriateness, timeliness, acceptability, patient responsiveness or patient-centredness, satisfaction, health improvement and continuity of care (Legido-Quigley et al, 2008). While the European Quality of Life Survey (EQLS) does not cover all these quality dimensions, it includes several.

It is important from the onset to point out that the data from the EQLS – which are the focus of this report – concern self-reported perceptions. There is a growing recognition that the preferences and views of patients and the public are to be taken into account for achieving high-performing healthcare systems (Legido-Quigley et al, 2008). Of course, self-reported perceptions represent only one of many approaches to assessing quality of healthcare services. Another approach is, for instance, taken by the Healthcare Access and Quality Index which investigates deaths which should not have occurred if effective care has been ensured (GBD, 2018). Other approaches to assess healthcare quality combine various dimensions, including a wide range of domains such as population health, health outcomes from treatment, clinical quality and the appropriateness of care, responsiveness, equity and productivity (Smith et al, 2009).

## Box 1: Assessing the views on healthcare of service users and non-users

In the EQLS, regardless of having used the services or not, all respondents are asked about *access problems, economising on use of health and dental care, impressions of corruption or unequal treatment, general quality ratings of healthcare services, and expectations of being able to access healthcare services if needed in the near future*. A focus on users would overlook those who may not, for various reasons, have used healthcare, for instance due to access problems, economising or doubts about quality. Moreover, people may have used the services earlier, but not in the year prior to the survey, as the EQLS specified. For quality ratings of healthcare services in the country more generally, all respondents are included because they may have used other services than those covered in the EQLS or, again, they may have used them in the recent past but not in the previous 12 months. Also, non-users' general impressions of quality of healthcare services are important in terms of what they expect if they need them, as are their expectations about being able to cover future healthcare needs – both factors matter for quality of life. However, the question about satisfaction with detailed aspects of care was only asked of users, since they are likely to be best informed, and interpretation of their answer in this regard is deemed most meaningful.

The EQLS not only collects data on whether someone used a healthcare service, but also whether someone else in the household used it. In analysing the results, there are arguments for not only focusing on people who say they used the services themselves, but also those who say someone in their household did – they are both likely to have an informed opinion about the quality of these services. Also, even if the respondents have not used the service themselves, the quality of these services matters for their quality of life if people close to them benefit from these services. In this section, usage by household members is discussed where deemed relevant, but the focus is on usage by the respondents themselves.

It is also important to acknowledge that healthcare systems differ largely between countries, and even between regions. This report does not provide an overview of these systems, nor does it intend to appreciate the full complexity of these systems; there are other sources for this, in particular the European Observatory on Healthcare Systems and Policies' 'Health Systems in Transition' series and its 2017 'Country Health Profiles', prepared jointly with the OECD for the European Commission (2017b). In trying to interpret the EQLS results, the chapter does refer to differences in the systems, but the main focus is on complementary new information from the EQLS.

To provide context, some results on usage of healthcare services are reported, in particular to highlight different usage patterns between countries and population groups. Again, other data sources are better suited than the EQLS for studying healthcare use from the point of view of resources, such as data on hospital discharges and expenditure on various healthcare services (see the OECD's 'Health Statistics', the WHO's 'European Health for All database' and Eurostat's statistics on health and healthcare). The EQLS does not capture the number of times people have used these services, nor what the services were used for: such information is better captured by administrative data.<sup>4</sup> However, EQLS data are helpful where there are fewer EU-wide comparable

data available on usage of different types of healthcare, and to identify patterns of usage by different population groups.

The EQLS further seems unique in asking not only about respondents' use of healthcare but also about other persons in the household. Lastly, in the EQLS, usage refers to that occurring in the entire year preceding the interview, compared to the previous four weeks in the European Health Interview Survey (EHIS) (Eurostat, 2015). However, in this report, analysis of healthcare usage mainly serves to introduce the topic, to get a sense of how central these services are to people's lives, and to relate it to access problems.

Health status is treated in this report as a background variable rather than as a key variable of interest. The EQLS does include homogeneously collected information for all Member States on subjective health, mental health and chronic illness (Eurofound, 2014, 2017b). There are other sources of subjective reports on health status, such as the 2014 module of the European Social Survey focusing on the social determinants of health and health inequalities (Eikemo et al, 2017), the EHIS and the EU statistics on income and living conditions (EU-SILC). Comparisons with these other sources are of particular interest due to the EQLS's consistent coverage of all EU Member States, its standardised questionnaire and the opportunity

<sup>4</sup> Except in cases when, for instance, healthcare services help people in vulnerable situations 'outside the books', as was reported in particular in the context of the crisis (Eurofound, 2014).



afforded to analyse health status along with other data on quality of life collected in the EQLS. This report uses health as a background variable for analysing more unique data on quality of healthcare services.

## Use of healthcare services

The EQLS asks people whether they – or someone in their household – used various types of healthcare in the 12 months preceding the interview (see Box 1).<sup>5</sup> The types of healthcare included are: 1. General practitioner (GP), family doctor or health centre services; 2. emergency healthcare; and 3. other hospital or medical specialist services. The survey also asks respondents about their use of online or telephone prescriptions and consultations (here referred to as ‘e-healthcare’). This will be discussed in the section on ‘E-healthcare – prescriptions and consultations’ below as it may concern primary, hospital or specialist care, or other types of healthcare services. E-healthcare is of specific relevance for the EU policy discussion in the context of the European Commission’s Digital Single Market strategy.

It should be acknowledged that various types of healthcare play different roles across the Member States. For example, primary care in some countries covers medical procedures that in other countries would be in the realm of hospital care. Furthermore, interpretation of what the different services entail may differ somewhat across respondents (for instance, ‘emergency care’). While acknowledging these limitations, analysis of the data does, however, reveal some interesting patterns in service usage.

### Primary, hospital or specialist and emergency care

In the EU, **primary care**<sup>6</sup> services are used more often than hospital or specialist, and emergency care services (Figure 2). Overall, about two-thirds (67%) of people in the EU reported using primary care in 2016.<sup>7</sup> In the majority of Member States (21), at least 60% of people reported using it. Proportions are highest in Austria, Denmark, Germany, Lithuania and the United Kingdom (UK) (all 75%). In Cyprus and Romania (both 44%) and Greece (41%), the proportions are lowest. Where respondents themselves had not used primary care but

another person in the household had, the overall figure for the EU rises to 83% of people living in households where at least one person had used primary care services.

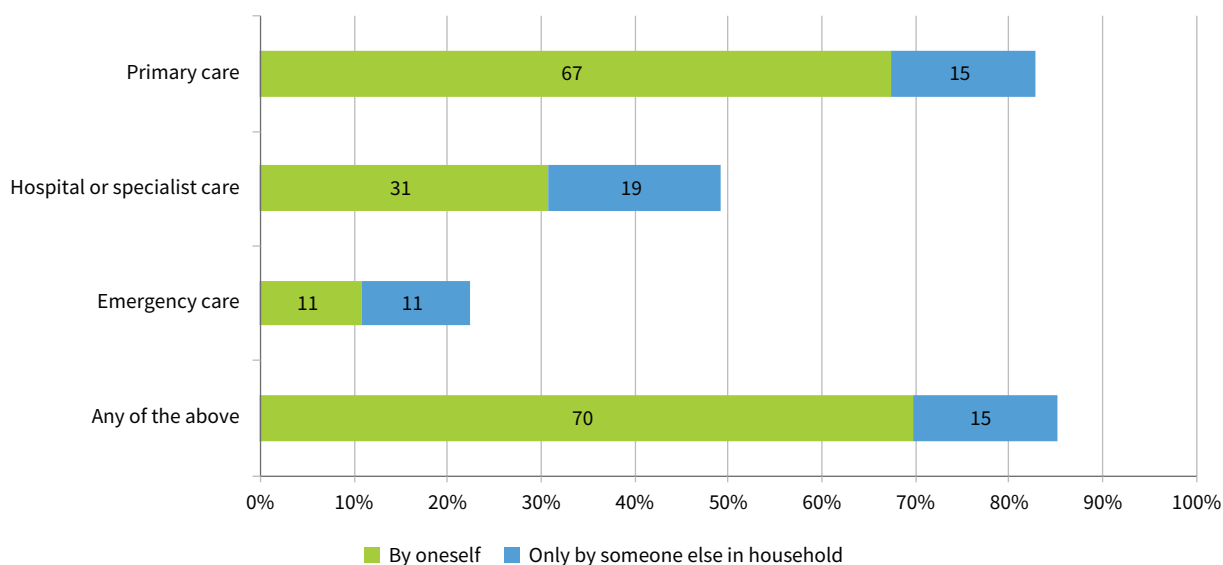
It is less than half as common for people to report they had used **hospital or specialist care** than primary care (31% versus 67%). Hospital or specialist care is most commonly used in Austria (most likely outpatient specialist care) and the Netherlands (both 43%), Slovakia (42%), and is least used in France and Greece (both 19%), and Romania (15%). While these results differ somewhat from data that take the institutional (hospital discharges) rather than the user perspective, it is notable that Austria also comes out on top in that regard (OECD, 2017). In none of the Member States is specialist and hospital more commonly used than primary care. For all countries, the difference is 22 percentage points (Greece) or above, except for Cyprus, where usage of primary care comes closest to that of specialist and hospital care, but still is used more often (44% versus 34%). Almost half (49%) of people in the EU live in households where at least one person used hospital or specialist care services in the previous 12 months.

Use of **emergency care** is rarer than use of primary or specialist and hospital care: just over one-tenth (11%) of people in the EU reported using it in 2016. It is lowest in Bulgaria (5%), Poland (6%) and in Italy, Croatia and Romania (7%). However, it is particularly high in Luxembourg (21%), Spain (20%) and Estonia and Sweden (18%). Low percentages may be indicative of problems in accessing this type of care. Conversely, high percentages may suggest that emergency services are being used for non-emergencies, for instance when other services are hard to access, which has for instance been cited as a consequence of the financial crisis in Spain (Gené-Badia et al, 2012). This is a concern, because emergency care tends to involve more costs than non-emergency care provision, it may not always be the most appropriate type of service for non-emergencies, and it risks becoming less accessible if overused (e.g. Durand et al, 2012). Despite use of emergency care being rarer than the other two types of care, over one-fifth (22%) of people in the EU live in a household where at least one person used it in 2016.

5 For readability, the text refers to reported usage in 2016, instead of ‘between the date of the interview (between September 2016 and February 2017) and one year earlier (September 2015 and February 2016)’.

6 In the report, ‘GP, family doctor or health centre services’ is abbreviated as ‘primary care’, and ‘hospital or medical specialist services’ as ‘hospital or specialist care’.

7 This is almost double the proportion found for the 23 Member States (36%) included in the EHIS 2014. The difference can largely be explained by the EQLS including use of care in the previous 12 months, compared to only the previous four weeks in the EHIS.

**Figure 2: Use of healthcare services in the EU**

Source: EQLS 2016 (Q60)

Overall, 70% of people in the EU reported that they used at least one of these three types of healthcare services themselves. Reported use of all three types of care is lower for men than for women: 62% versus 73% for primary care – the EHIS 2015 finds a similar difference: 31% versus 40% (Eurostat, 2015) – 27% versus 34% for specialist and hospital care and 10% versus 12% for emergency care. A closer look at the data reveals an exception: among people who did not use primary care, men who reported using hospital or specialist care in the past year are more likely to have also used emergency care (20%) than women (16%). Among people with self-reported bad health, the differences in usage fade almost entirely, with men even using hospital or specialist care more often: 92% of men and 93% of women with bad (or very bad) health used primary care, 68% versus 66% respectively for hospital or specialist care and 28% versus 31% respectively for emergency care. However, it should be noted that underreporting may be systematically higher for men (Hunt et al, 2003).

For all three services, people in the top two income quartiles are least likely to have used them: 9% used emergency services, 31% used hospital services and 67% used primary care services. In contrast, the second-lowest income quartile group is most likely to have used healthcare services: 33% used primary and 71% hospital or specialist care services. However, it is the lowest income quartile group which most often used emergency services (13%). Emergency services in the EU are thus relatively often used by people with the lowest incomes. However, patterns differ between

countries. In some countries, primary care services are used more often by the bottom income half (e.g. Bulgaria, Croatia, Poland); in others this is true in particular for emergency care (e.g. Latvia, Slovakia, Sweden); while in others this is true for specialist or hospital or specialist care (e.g. Cyprus, Lithuania, the Netherlands).

These patterns are interesting when considering which type of services seem particularly important for which population groups. However, naturally, some instances of high use among certain groups can be explained by greater healthcare needs in those groups – healthcare needs are greater in low-income groups where average levels of health are lower.

Among the 30% of people who did not use primary, specialist or emergency healthcare in 2016, 6% chose not to go to the doctor to save money and an additional 7% delayed going to the doctor in order to economise.

Further reporting shifts from income quartiles to income halves to allow for breakdowns by health status with limited sample sizes (except for primary care where usage is high enough to allow for reporting by quartile). When considering people who report having bad (or very bad) health, those in the lower income half have lower rates of usage of emergency healthcare than those in the upper half of incomes: 27% versus 29%. The difference is even more marked for hospital or specialist care, with 64% of the bottom income half with bad health having used it, compared to 69% of the top income half with bad health. The proportion is equally high for both income halves only for primary care.



## Box 2: Socioeconomic inequalities in health service use

After differences in need are taken into account, evidence from analysis of 2009 data including 12 EU Member States suggests that the most deprived are as likely to attend primary care as people who are in a better situation and, once they engage with primary care, they use it more often (Devaux and De Looper, 2012). The same research confirms earlier findings that, among the 12 Member States, income inequality in usage of (private) specialist services is greatest in France and Spain. Analysis from Spain confirms that people with lower socioeconomic status (measured by a classification based on previous or current occupation) are more likely to use primary care and less likely to use specialist care (Mortieruel et al, 2018). The authors suggest this can be explained largely by differences between services in terms of the charges applied. Across health services which are not provided free of charge, inequalities between groups with the highest and lowest socioeconomic classes were greatest for men's use of physiotherapists and podiatrists. A study in France revealed that patients often used emergency care as an alternative to primary care due to long waiting times for appointments and difficult access to primary care in evenings and at weekends (Durand et al, 2012). Another study revealed that use of emergency care services because 'a primary care physician was not available' was particularly common in Slovakia, a country where emergency services are also relatively often used by low-income groups (see above). The research also noted this to be a more common reason for emergency care use than on average in the EU, even if much below the proportion in Bulgaria, Czechia, England (no data for the UK as a whole), Estonia, Germany, the Netherlands (also above, but closest to the EU average), Portugal, Slovakia, Slovenia and Sweden (Van den Berg et al, 2016). In some of the countries, this may also reflect little use of emergency care overall (and thus easier to obtain a large proportion reporting this as a reason) or it may concern higher-income groups as well.

These differences in usage by income could reflect the need for different types of healthcare. However, they could also be caused by access problems for lower-income groups. Overall, access problems not only lead to postponement of care needs, but also seem to affect the usage balance between the various services. This can result in unanticipated demand for certain healthcare services, with suboptimal results in terms of cost-efficiency and appropriate care provision.

Qualitative evidence suggests that emergency care in particular provides an entrance point into the healthcare system for groups in vulnerable situations in some countries, because their own financial contributions are relatively low or do not apply (Karanikolos et al, 2013), or because in practice they are not strictly implemented (Eurofound, 2014). It should be acknowledged, though, that there are country differences in terms of such barriers and conditions (see Box 2). In some countries, emergency services represent a relatively easy way into the system, while for other countries primary care services play this role; elsewhere, lower-income groups may revert to hospital services (sometimes getting medication for free, for instance, in contrast to this being prescribed by a GP).

### E-healthcare – prescriptions and consultations

When it comes to actual e-contact between patients and medical staff in terms of consultations or prescriptions (rather than obtaining general health information), the EQLS findings suggest the role of information and communications technology (ICT) is limited in many Member States. In over half (16) of the Member States,

10% or fewer people reported using medical consultation online or by telephone; with regard to ordering prescriptions, this is true for 17 Member States (see Table 2). When comparing the proportions of people using these two types of 'e-healthcare' in the various Member States, three distinct country clusters emerge:

- 'highest use' e-healthcare countries: in five EU Member States, over half of the population report using at least one of these two types of e-healthcare in 2016 (Denmark, Estonia, Finland, the Netherlands and Sweden)
- 'medium use' e-healthcare countries: in seven countries, neither of the two forms of e-medicine is used by over one-third of the population, but at least a quarter of the population had used at least one of the two in 2016
- 'lowest use' e-healthcare countries: in 16 countries, one-tenth or fewer people used one of the two types of e-medicine.

In most countries, it is more common for people to have had an e-prescription than an e-consultation. This concurs with the findings for a subset of EU Member States from about a decade ago (Kummervold et al, 2008). For some countries, this difference is particularly marked, with e-prescriptions being relatively common but e-consultations lagging behind (Estonia, Germany, Luxembourg, the Netherlands).

Among people who had not used any of the three healthcare services in 2016, only 5% said they, or someone in their household, had ordered a prescription online and 3% had sought medical consultation online

or by phone (7% using at least one of the two methods). This suggests that e-prescriptions and e-consultations may mostly be used in relation to visits to the doctor rather than substituting a visit.

Use of e-healthcare is certainly not restricted to the young. As with the use of healthcare in general, the proportion of people in the EU who used either of the two types of e-healthcare increases with age, from 16% among 18–24-year-olds to 24% among those aged 50+. Among people with bad health, though, it is highest among 25–34-year-olds (56%) and 35–49-year-olds (44%) and lowest among those aged 65+ (23%). Possible explanations for this higher usage among younger people with bad health include being unable to find time to go to the doctor due to work commitments and different habits or abilities with regard to internet and phone versus face-to-face contacts. Age-related differences in patterns of internet and phone use versus face-to-face contacts may decrease as younger generations age, as they are more likely to have used e-tools throughout more of their lives.

Besides efficiency, in terms of patients' and doctors' time and administrative burden, a policy rationale for e-healthcare is to make healthcare more accessible, especially in rural areas (Eurofound, 2014). However, the EQLS data suggest that e-healthcare is not used more often in rural settings in any of the country groups (Table 1). Use of e-healthcare in rural versus urban areas<sup>8</sup> was 58% versus 57% respectively in the group of highest-use countries, 31% versus 32% in medium-use countries and 7% versus 9% in lowest-use countries.<sup>9</sup> However, there are some exceptions where these two types of e-healthcare are clearly used more in rural than in urban areas, in particular in the high- and medium-use countries: most notably, Germany (34% versus 29%), Luxembourg (30% versus 25%), the Netherlands (55% versus 48%) and the UK (42% versus 34%).

On average, in the high-use e-healthcare countries, e-healthcare is relatively often used by the lowest income half (61% versus 55%), while in the medium- (32% versus 33%) and lowest- (8% versus 9%) use countries, this is not the case.

It is interesting to note that users of at least one of the two types of e-healthcare in the top three countries where such services are used most often do not clearly report fewer difficulties in accessing healthcare, regardless of income. There is an exception though: e-healthcare users in the highest income quartile report difficulties finding time because of work, care for children or for others (23%) less often than non-users of these types of e-healthcare in these countries (26%).

## Quality of healthcare services

The general ratings of healthcare are discussed here first. The discussion goes on to look at the chain of service usage by patients: from accessing and experiencing the services to expectations of being able to access them in the near future. Access issues are reviewed as part of quality dimensions.

While access is often seen as a component of quality, it has also been argued that access can influence quality. People who experience access problems due to financial barriers have less confidence in receiving safe and quality medical care (Wendt et al, 2012). In this report, difficulties in accessing a service – for instance due to restricted opening hours, waiting times, architectural design or cost – are considered to be elements of poor quality care.

This approach to quality of healthcare services is in line with the EU SPC's 2010 voluntary European Quality Framework for social services. Among its 'overarching quality principles' is the requirement that social services (including healthcare services) should be accessible and affordable, besides being person-centred, comprehensive, continuous and outcome-oriented. Quality principles regarding the relationships between service providers and users include respect for users' rights and participation and empowerment. Quality principles for the relationship between service providers, public authorities, social partners and other stakeholders include 'partnership' and 'good governance' – the latter point relates to the fairness dimension (equal treatment and absence of corruption) considered in this report. Overall, several of the principles in this report are comparable with the criterion used in the periodic reviews of users' satisfaction with the services provided.

<sup>8</sup> Unless otherwise mentioned, 'rural' in this report refers to answering categories 1 and 2 in the following EQLS question, and 'urban' to categories 3 and 4: Q53 Would you consider the area in which you live to be...? 1. The open countryside; 2. A village/small town; 3. A medium to large town; 4. A city or city suburb; 98. (Don't know); 99. (Refusal).

<sup>9</sup> The proportions for these country groups are population-weighted.

Table 2: Use of e-healthcare – prescriptions and consultations, EU28 (%)

	E-prescriptions	E-consultations	Either of the two or both
Highest use			
Finland	48	46	64
Sweden	47	40	63
Denmark	48	42	61
Estonia	49	30	55
Netherlands	46	21	51
Medium use			
Croatia	33	26	38
United Kingdom	29	22	38
Latvia	23	23	33
Germany	29	12	32
Luxembourg	24	9	28
Slovenia	20	15	27
Italy	21	14	25
EU28	18	11	22
Lowest use			
Belgium	8	8	14
Czechia	8	7	14
Hungary	9	9	14
Austria	9	7	13
Ireland	10	5	12
Slovakia	10	4	11
Lithuania	2	8	9
Cyprus	2	8	9
Spain	4	6	8
France	6	2	8
Greece	2	7	8
Bulgaria	3	5	6
Poland	4	2	5
Portugal	3	2	4
Romania	4	2	4
Malta	1	2	2

Note: Sorted by 'Either of the two or both'. Only includes those who responded that they have used these services themselves.

Source: EQLS 2016 (Q60)

### Overall quality ratings<sup>10</sup>

As is the case with other services, overall, users of **healthcare services** tend to be more positive about these services than non-users. This appears to be the case for the overall quality ratings of healthcare services in general, but also for primary care services and

hospital services specifically (Eurofound, 2012, 2017b). Previous analyses of quality ratings of healthcare have further underlined the high satisfaction of people with healthcare services. Ratings are even higher when people are asked specifically about hospital services in general and primary care services in particular (Eurofound, 2017b).

<sup>10</sup> It should be noted that in this section, and throughout the report, apparent slight differences between percentages (after the decimal) cited in the text and shown in the figures and tables are due to rounding.

In the EU, people on average rate health services in their country at 6.7 on a scale of 1–10 – a considerable increase since 2011 (6.3) following a smaller increase from 2007 (when the average rating was 6.1) to 2011. Ratings of healthcare services lie well above the average rating of any of the other services the EQLS asks respondents to rate (education system, public transport, childcare services, long-term care services, social/municipal housing and state pension system). However, still one-quarter (27%) of respondents in the EU rate health services in their country at a 5 or below, even if this proportion has declined from 37% in 2007 and 35% in 2011. Even in the countries where this proportion is lowest, one-tenth or more of respondents rate healthcare services at 5 or below: 10% in Belgium and Malta and 11% in Finland, Luxembourg and the Netherlands. In the countries where the proportion is highest, at least half of the population give healthcare services a low rating: Greece (65%), Latvia (63%), Cyprus (58%), Poland (54%) and Slovakia (51%).

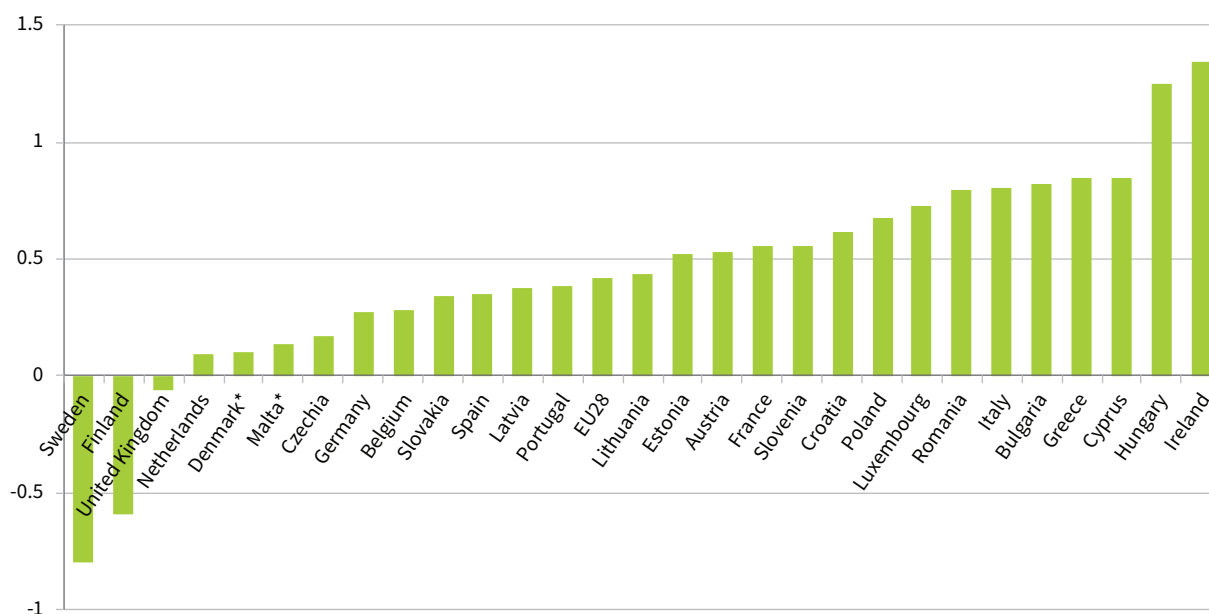
On average, people rate **primary care** and **hospital services** higher than healthcare services in general, by 0.7 (at 7.4) and 0.2 (at 6.9) respectively. In almost all Member States, primary care services are rated higher than hospital services (Figure 3). The difference is

greatest in Ireland (7.9 versus 6.6, or 1.3) and Hungary (7.1 versus 5.8, or 1.3). Finland and Sweden are the exceptions, with hospital or specialist care receiving considerably higher quality ratings than primary care. Denmark and Malta also stand out, in that quality ratings of primary care are not significantly higher than those of hospital or specialist care. However, there are also more subtle differences within the group of 24 Member States where quality of primary care services is rated higher than that of hospital or specialist services. In particular, Luxembourg, Romania and Italy rank higher compared to the other Member States for primary care (2nd, 16th, 18th) than for hospital or specialist care (7th, 21st, 23rd). For the UK, Portugal and Slovakia in particular, the opposite is true: they rank considerably better for hospital or specialist care (12th, 18th, 19th) than they do for primary care (17th, 24th, 25th).

### Quality ratings by income

People in the two highest income quartiles tend to rate **healthcare services** more highly than people in the two lowest income groups – this contrast is possibly related to the real quality of services available to them (Eurofound, 2017b). It is particularly the bottom income quartile which rates services low. On average, people in

**Figure 3: Difference in quality ratings between primary care and hospital or specialist care, by Member State**



**Notes:** Positive numbers indicate that primary care has a higher overall quality rating than hospital or specialist care. Rating on a scale of 1–10, where 1 means very poor quality and 10 means very high quality. Country order is based on value scale from highest to lowest for health services in 2016. \*Difference is not significant at 5% significance level.

**Source:** EQLS 2016 (Q59)

the third income quartile give better ratings than people in the top income quartile do. People in the top quartile, on average, almost rate the services at the same level as people in the second-lowest income quartile. It is possible that people in the top income quartile have higher expectations that lead them to give a more critical rating than people in the third income quartile. Other reasons could be the extent of positive change experienced by the third income quartile across the range of quality-of-life indicators (Eurofound, 2017b). Low ratings among bottom income groups may be due to poor access to good-quality care, which could be related to financial barriers stemming from co-payments, from a need for additional insurance to circumvent waiting lists or to get better hospital rooms or from under-the-table payments. Another reason for poor access could be a concentration of low-income groups in geographical areas within the country where services are worse.

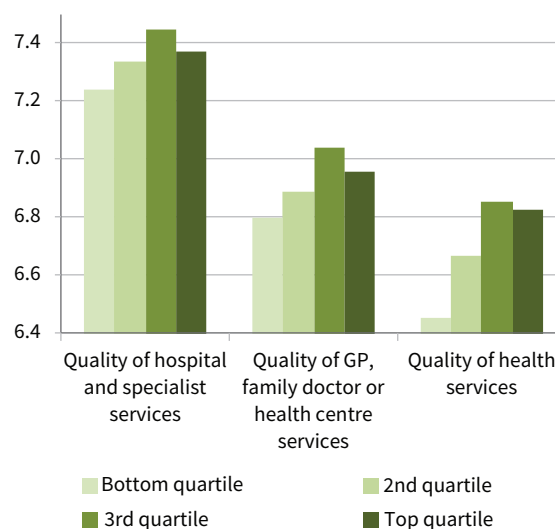
People in the bottom income quartile consistently rated quality of health services lower than any of the other income groups in 2007, 2011 and 2016. While ratings increased in every edition for this bottom income group, it did so at a slower pace than for the other income quartiles. In 2007–2016, the bottom income quartile ratings of health services increased by 0.4 from 6.1 to 6.5, while other income groups increased by 0.5 (second and top income quartiles) or 0.6 (third income quartile). In 2016, the ratings had become highest for the third income group (6.9) with the top income group close behind (6.8).

In 2016, the difference in ratings between the top and bottom income halves was highest in Italy (6.2 versus 5.4, a difference of 0.8) and was similarly high in 2011 (5.9 versus 5.2, or 0.7). Next come the Netherlands (7.5 versus 7.0, with a difference of 0.5) and Estonia (6.3 versus 5.8, a difference of 0.5). In both the Netherlands and Estonia, these differences in healthcare service rating between top and bottom income half increased compared to 2011, from a difference of 0.2 in both countries. Income differences in quality ratings for the overall healthcare system (and satisfaction with primary care and hospital or specialist care) are absent or relatively small in Austria, Denmark, France, Ireland, Luxembourg and Malta. However, income differences in access to or quality of healthcare do exist in these countries for specific types of services or aspects of quality, as will appear from the analysis in this chapter.

The patterns of quality ratings by income quartile hold for quality ratings of healthcare services overall, as well as for primary and hospital services (Figure 4).

The income gradient is steeper for quality ratings of healthcare services in general than for hospital or primary care services in particular. While the top two income quartiles give similar ratings to healthcare

**Figure 4: Quality ratings of healthcare services by income quartile, EU28**



**Note:** Rating on a scale of 1–10, where 1 means very poor quality and 10 means very high quality.

**Source:** EQLS 2016 (Q59)

services on average, the bottom two quartiles rate them considerably lower, in particular the bottom income quartile. Among people in the bottom income quartile who give a low (5 or below) rating to healthcare services, 54% still give a high (6 or above) rating to primary care and 41% to hospital or specialist care. Conversely, among people in the bottom income quartile who give a high rating to healthcare services in general, 8% rate primary care as low and 12% rate hospital or specialist care as low. Meanwhile, among people in the bottom income quartile who rate healthcare services as low, 38% rate both primary and hospital or specialist care services as low, while 33% rate both these services as high. It is rarer for people in this bottom income group to rate healthcare services as high but to rate both primary and hospital or specialist care services as low (4%). All these proportions are similar (at most, 4 percentage points higher or lower) to those of the other income groups.

The indicator of quality of healthcare services in general thus does not seem to be entirely explained by ratings of these two commonly used types of healthcare and further investigation would seem to be required. People may think of other healthcare services than primary, hospital or specialist care of which they have either a more positive or more negative impression. People may also think of the primary, hospital or specialist care services in their local area when asked to rate these services, but for healthcare services in general they may think of the country as a whole. It may also be that people rate the broader notion of ‘healthcare services’ differently than more specific services, possibly reflecting approval of the healthcare system, perceived

quality of social protection or even satisfaction with the government more generally. Most people in the EU (83%) who give a low rating to healthcare services (5 or below) also rank trust in the government as low (5 or below). This compares to 59% among those who do not rank quality of healthcare services as low. The percentage is lower when we reverse the relationship: only 34% of people who have low trust in the government also give low ratings to healthcare services. A large proportion of people who give low ratings to healthcare services overall and also give low ratings to primary care and hospital or specialist care (86%), or to one of the two (82%), also rate trust in the government as low. However, many people who do not give low rankings to either of the two services but who give low quality ratings to healthcare services also have low trust in the government (79%), compared to 57% of those who do not give low ratings to healthcare services (nor to primary care and hospital or specialist services).

### Factors affecting perceived quality

Next, the focus will be on various aspects of the healthcare services which are likely to explain perceived quality, such as satisfaction with specific aspects of healthcare services, access problems and perceptions of unequal treatment and corruption. The usage data presented in Figure 2 (p. 10) demonstrate that primary care and specialist or hospital care are rather commonly used services. Much of the ratings of the healthcare

services overall may thus be informed by experiences with these services. The analysis focuses on these types of often used care.

People seem to take access problems into account when rating the quality of healthcare services. Evidence comes from a model which tries to explain general quality ratings of primary healthcare services (for which the EQLS has data along the widest range of access problems) by access and fairness indicators.

Difficulties in accessing due to cost, distance, waiting times at the venue and, in particular, waiting times to get an appointment all seem to have a negative influence on perceived quality of primary care (see Table 3). The same holds true for difficulties in affording primary care if needed urgently, for example tomorrow. Absence of corruption and, in particular, equal treatment in primary care have a positive impact on its overall perceived quality. While the analysis is not shown in Table 3, the patterns are not just a reflection of Member State differences, but hold more generally in the EU. An exception is access problems due to cost, which loses its explanatory power after controlling for Member States. The impact of access problems due to cost seems to be largely captured by unequal treatment and fear of not being able to afford future needs. The variable 'access problems due to distance' also loses some of its explanatory power, but is still significant. The model controls for usage by respondents

**Table 3: Quality of primary healthcare services – explanatory power of access and fairness indicators, EU28**

	Standardised Beta coefficients	t statistic	Significance
(Constant)		82.758	0.000
Cost made it difficult to see a GP	-0.016	-2.383	0.017
Distance made it difficult to see a GP	-0.014	-2.229	0.026
Delay in getting an appointment made it difficult to see a GP	-0.115	-15.808	0.000
Waiting time on day on appointment made it difficult to see a GP	-0.041	-5.692	0.000
Finding time due to work or care responsibilities made it difficult to see a GP	-0.048	-7.384	0.000
It would be difficult to cover expenses for GP if needed tomorrow	-0.06	-9.966	0.000
All people are treated equally in these services in my area	0.344	52.566	0.000
Absence of corruption in these services in my area	0.098	14.897	0.000
Someone in the household used GP services in the last 12 months (but not the respondent)	0.001	0.176	Not significant
Respondent used GP services in the last 12 months	0.031	4.106	0.000

OLS regression analysis, dependent variable: Quality of primary healthcare (Q59a)  
 $R^2 = 0.237$ , adjusted  $R^2 = 0.236$ , model significant at  $p < 0.001$

**Notes:** Only variables were included for which information on primary care was available (not on 'economising') and which were asked to all respondents. However, in the process of generating this table, various regressions have been run (also with satisfaction on various quality dimensions), and the results reported above and discussed in the text seem robust. The larger the standardised Beta coefficient, the stronger the effect of the listed independent variables in predicting the dependent variable (perceived quality of primary healthcare). The t statistic indicates the precision with which the regression coefficient is measured by showing whether the coefficient is large compared to its standard error.

**Source:** EQLS 2016 (Q59a, Q60d,e, Q61, Q63, Q67a)



themselves which indeed has a positive impact on perceived quality even after controlling for access problems. Depending on the variables included in the model, ‘usage only by someone else in the household’ sometimes is positively significant (that is, people whose household members used primary care give it higher ratings) even if the coefficient is always smaller than usage by respondents themselves.

More detailed reference to the results in the table will be made in the relevant sections below on access to and fairness in primary care; here it mainly serves to support the more general argument to include ‘access’ and ‘fairness’ dimensions as elements of quality, as well as to point out that access issues may include more than cost, distance and waiting time.

## Access to healthcare

The *use of healthcare services* is not the same as the *need for healthcare services* (Eurofound, 2014). On the one hand, this is due to problems in accessing healthcare, not only due to cost, but because of a wide spectrum of other types of access problems (Eurofound, 2013a). On the other hand, there may be some overuse with, for instance, people attending primary, specialist or hospital care where other types of services – such as social services or long-term care – could better suit their needs, if such services were available (Eurofound, 2014). Access problems can lead to not attending care, to delaying it (both captured under ‘economising’), to accessing but experiencing difficulties while doing so and to low expectations about future access problems. The EQLS provides information along this whole spectrum of access problems. However, it does so neither for all types of access problems, nor for all types of healthcare. A subset of access problems beyond financial barriers is captured only for primary care (in previous editions of the EQLS it included specialist care) and for financial barriers it covers primary and specialist or hospital care for difficulties in accessing, and care by a dentist or doctor for reasons of economising. Only for expectations about being able to afford future healthcare needs, are more types of healthcare included (mental, dental and emergency care). So, for primary care, the EQLS provides most information along the spectrum and for different types of access.

### Barriers to accessing primary care

The EQLS asks respondents to what extent five different factors made it difficult for them to see (or be treated by) a primary care provider the last time they needed to. These factors are: distance to the provider, cost, waiting time on the day of the appointment, delay in getting an appointment and finding time (because of work, care for children or for other reasons). In the EU, waiting time at the healthcare venue (38%) and waiting lists to get an

appointment (42%) are the most commonly reported factors in making access to primary care difficult (Eurofound, 2017b).

Comparison over time is challenging as, previously, the question referred to the last occasion the respondent needed general medical (doctor) or specialist care, while in 2016 it asked for primary care more specifically. However, as it is clear from the above analysis that primary care is the most commonly used type of care, it is likely most people referred to primary care anyway in the previous editions as well. The proportions of people reporting difficulties in accessing healthcare services due to the different factors were similar in 2016 to those in the previous edition (2011), ranging from a drop of 3 percentage points (distance) to no significant difference (waiting time). However, problems due to cost were considerably lower: 30% in 2011 and 16% in 2016. It is likely that this is a reflection of access problems due to cost being generally lower for primary care than it is for care by a medical specialist.

Overall, cost is the least likely of all five factors to make it difficult to access healthcare, with 4% reporting that cost makes it very difficult and 13% difficult, totalling 16% reporting difficulties. However, countries do show larger variations with regard to the role of cost than with any of the other barriers, and it is a significant issue in several Member States, especially in south-east Europe, even for primary care services (Eurofound, 2017b). Cost as a factor that makes access difficult ranges from 3% of the population in Denmark (and 5% in Spain and the UK) to 62% of the population in Cyprus and Greece (and 51% in Malta). Such financial barriers are particularly likely to depend on how universal public coverage is, as well as on the degree of private co-payment. Cyprus and Greece are indeed among the countries (with Bulgaria) where the out-of-pocket share of healthcare financing is larger than the share financed through taxes or (compulsory) insurance (SPC, 2018b, p. 56). However, there are also factors of importance for financial barriers beyond the formal healthcare system, such as the prevalence of under-the-table payments, high travel costs (large distance to services and/or costly transport) and personal financial circumstances.

A few countries rank among the top 10 (Denmark, Finland, the Netherlands, Spain, Sweden) or among the bottom 10 (Greece, Romania) for all five types of access problems. Most countries, though, score relatively well on some aspects but relatively badly on others, hence confirming the importance of exploring multiple dimensions of access.

Examples include the UK where cost is rarely a problem for access to primary care, but delays in getting an appointment are more often reported than in any other Member State. A similar (but less pronounced) observation holds for Denmark, Germany, Hungary,

Slovenia and Sweden. Other countries show a contrary pattern: in Ireland, cost in particular often makes it difficult to access primary care but, on average, getting an appointment seems less of a problem. A similar (but less pronounced) trend can be found in Belgium, Bulgaria, Cyprus, Italy, Luxembourg and Slovakia. While spanning a different time period (2011–2013), applying different questions and only covering subsets of EU Member States, the data broadly match evidence summarised by the EU Expert Panel on effective ways of investing in health in their report ‘Tools and methodologies for assessing the performance of primary care’ (EXPH, 2018b). In its report, for instance, Lithuania scores unfavourably on waiting time to get an appointment and Slovakia scores unfavourably with regard to distance to the practice.

Generally, cost is the most commonly cited factor in making it difficult to see a doctor for the bottom income half. However, there are some exceptions. Most notably, in Ireland the proportion of people reporting difficulties is higher among the top income half than among the bottom income half (a 9-percentage-point difference). This concurs with the observation that during the crisis just under half of the population had become entitled to an income-tested medical card, facilitating medical care at little cost for low-income groups. This has left a group in the ‘twilight zone’ (earning too much to be entitled to exemptions, but too little to comfortably pay for additional insurance or fee-for-service care) at particular risk of struggling to access healthcare (Eurofound, 2014). While a similar observation can be made for Poland and Romania (6 and 3 percentage-point differences respectively), a closer look at the data reveals that the difference is caused by more people in the higher income half reporting that cost makes it ‘a little’ difficult, while more people in the lower income half find it ‘very’ difficult. In several countries, inequalities by income half regarding access to healthcare due to cost are small or insignificant. For most of these countries, problems are relatively rare for both income groups (Austria, Czechia, Denmark, Germany, Spain, the UK – below 20%), while for some others it is particularly (but similarly) high for both income groups (Cyprus, Latvia – 28% or above).

## Perceived fairness – equal treatment and corruption

The EQLS asks respondents about their perception of two types of ‘unfairness’ in healthcare in their area: unequal treatment and corruption. Specifically, on a scale from 1 (completely disagree) to 10 (completely agree), it asks to what extent people agree with the following two statements: ‘All people are treated equally in these services in my area’ and ‘Corruption is common in these services in my area’.<sup>11</sup> Separate analyses are carried out for primary care and for hospital or specialist care.

A more detailed look at these two measures of fairness reveals that in the EU overall, absence of corruption scores higher than equal treatment. Furthermore, just as with other self-reported quality ratings, primary care scores better on both aspects of fairness than hospital or specialist care does.

While equity measures are frequently included in the measurement of healthcare quality, often under the heading of ‘fairness’ (WHO, 2000; Legido-Quigley et al, 2008; Smith et al, 2009), corruption is included less often. Perceptions of corruption may, for instance, be influenced by experiences with, or reports of, under-the-table payments, but may also relate to perceptions of bribery in medical service delivery, lobbies of pharmaceutical companies in getting doctors to recommend specific medicines, tax fraud and physicians in public hospitals suggesting that patients attend private clinics where they have a ‘double practice’.

Perceptions of equal treatment may partly be influenced by some of the same factors. Such perceptions of unequal treatment among the wider population may also relate to access to better facilities or privileged treatment for people who have better insurance (privately purchased, or as an employee benefit) or pay additional fees, or generally to financial barriers to accessing basic healthcare. However, they may also concern perceptions of discrimination by healthcare providers. For instance, a study by the EU Agency for Fundamental Rights reported that 17% of the Roma population surveyed felt healthcare personnel (medical or other) discriminated against them (FRA, 2013).

<sup>11</sup> In this report, the scale of the second question is reversed and interpreted as ‘absence of corruption’, so that a higher score can be interpreted as positive both for ‘equal treatment’ and ‘absence of corruption’.



The results discussed below show in what countries, for which services and among which groups perceptions of unfairness can be found. However, these perceptions may stem from diverse factors in the various countries. The EQLS does not allow for the identification of the type of corruption or unequal treatment respondents have in mind, beyond whether it concerns primary or hospital care. Only some inferences can be made by cross-checking the data with other variables and with other sources. While this is a limitation, it also has an advantage: the EQLS questions capture various types of unequal treatment and corruption which the respondents have in mind when assessing their specific regional context and individual situation.

When asked to what degree they agree that ‘all people are treated equally in these services in my area’, people who used primary care services themselves gave a score of 8.0 (on a scale of 1–10) compared to 7.0 among non-users.

The score for absence of corruption is also higher for users than for non-users (8.4 versus 7.7). For hospital care, the difference between users and non-users for these fairness dimensions is smaller (8.0 versus 7.8 for corruption) or even absent (7.0 for equal treatment for both users and non-users).

Among people who did not go to the doctor or who delayed a visit to save money, scores for fairness are worse both for primary and for specialist or hospital care than for people who did not economise on healthcare. For instance, the score for absence of corruption is 8.3 and 8.0 for primary and specialist or hospital care respectively among people who report not having to economise on care, while it is 6.9 both for those who delayed a visit or did not go to primary care, and 6.4 and 6.7 respectively for those who delayed and did not go to specialist or hospital care.

These average scores mask large differences within the population. In the EU overall, 22% and 18% of people disagree (give a score of 1–5 out of 10) with the statement ‘All people are treated equally in these services in my area’ for hospital and primary care respectively (hereafter, ‘report people are not treated equally’), and 20% and 17% of people agree (give a score of 6–10 out of 10) with the statement ‘Corruption is common in these services in my area’ for hospital and primary care respectively (hereafter, ‘report corruption to be common’). Overall, using these measures, about two of every five (39%) people in the EU report that people are not treated equally and/or corruption is common in primary and/or hospital and specialist care. However, it should be emphasised that these include various degrees of perceived inequalities and corruption. The picture changes when only the extremes are counted, where people ‘completely disagree’ with the statement that people are treated equally, or ‘completely agree’ with corruption being prevalent – then the figure drops to 7%. One in a

hundred (1%) people in the EU feel this strongly about the degree of inequality and corruption for both primary and hospital or specialist care.

Do people who report difficulties in accessing primary care also find these services more often unfair? Among people who do not experience difficulties accessing primary care due to cost, the majority (55%) ‘completely disagree’ with corruption being common in their area. This compares to 29% among people who do experience such access problems. Similarly, the proportion of people who completely agree that people are treated equally is 29% for those who report no difficulties in accessing primary care due to cost, compared to 18% for those who do report difficulties. Conversely, among people who ‘completely agree’ (give a score of 10) with the statement that all people are treated equally in the EU as a whole, 11% report that cost made it (very or a little) difficult for them to see a doctor the last time they needed to. In contrast, among people who ‘completely disagree’ with this statement (a score of 1), the proportion is more than three times greater (35%).

In the EU overall, among people who do not report access problems, 25% either report at least one of the two types of unfairness in primary care, compared to 51% among people who do report access problems due to cost. This may be explained by countries that have higher proportions of people experiencing such difficulties also having more people reporting unfairness. However, the difference holds for every single Member State, except for the UK. In percentage points, the difference is greatest in Estonia and Czechia where, respectively, 13% and 44% of people who do not report access difficulties due to cost report one of the two fairness problems, compared to 49% and 78% among people who do report access difficulties due to cost, that is, 36 and 34 percentage points more respectively.

There are large country differences in perceptions of unfairness. In Denmark, Finland, the Netherlands, Spain and Sweden, perceptions of at least one of these types of unfairness are high among a quarter of the population or less. At the other end of the scale, for Croatia, Cyprus, Greece, Hungary and Romania, the proportions are 65% or above. While many of the EU Member States where unfairness is perceived to be high are former communist countries, Austria, Cyprus, Greece and Italy also appear in the bottom half of countries.

The bottom-scoring countries do show different patterns though. For example, in Austria and Hungary, unequal treatment is similar to or below the EU average for primary care, but the problem lies in unequal treatment (Austria) or corruption (Hungary) in hospital and specialist care. This concurs with some high-profile cases of corruption that emerged in Hungary (related to hospitals) and a 2016 protest by healthcare workers

against corruption in hospitals. For Austria an explanation may be that it appears to be among the countries where it is most common for patients to be asked to go for a private consultation in order to be treated in a public hospital (European Commission, 2017c). For Bulgaria and Italy, proportions with regard to unequal treatment, both for primary and hospital or specialist care, lie below or at the EU average. However, larger than average proportions of people perceive corruption to be a problem, for both types of services.

Overall, some countries rank considerably better on the fairness dimensions considered here for primary care than for hospital or specialist care, or vice versa. For instance, Bulgaria, Denmark, Estonia, France and Latvia rank considerably better for primary care than for specialist or hospital care regarding equal treatment in terms of average national scores. In contrast, on equal treatment, Czechia, Finland, Lithuania, Slovakia and Slovenia rank considerably better for specialist or hospital care than for primary care.

On corruption, the differences are less marked. In other words, if a country ranks well or badly for corruption in primary care, it also tends to do so for specialist or hospital care. So, here, the value added from asking about corruption in the two specific services seems less apparent than for equal treatment. However, there are also some differences here: some countries rank considerably worse on corruption for specialist or hospital care (Latvia 17th, Germany 16th) than for primary care (respectively 10th, 9th). Other countries score worse for primary care (Malta 16th, Bulgaria 18th) than for specialist or hospital care (3rd, 11th).

Under-the-table payments are likely to contribute to higher corruption ratings for some countries, whether payments are monetary or in the form of a present, before or after treatment, and implicit or explicit. In a 2017 Eurobarometer survey (European Commission, 2017d), respondents who had visited a public healthcare practitioner or institution in the last year were asked if they had given an extra payment or gift to the practitioner, or had made a hospital donation in addition to the official fees. The five countries where this was most common were Romania (19%), Hungary (17%), Greece (13%), Lithuania (12%) and Austria (9%). Also, according to the EQLS data, it is notable that the first four countries score relatively low on absence of corruption ratings both for primary and hospital or specialist care.

In other countries inequality may be explained by people with additional insurance having better access to hospital rooms and circumventing waiting lists (Ireland), or to cover co-payments (France, Luxembourg). In some countries, such insurance covers co-payments. However, such complementary insurance coverage is more likely to be perceived as unequal treatment in some cases than others. For instance, in Luxembourg, more than half of the population has

complementary health insurance offsetting co-payments, possibly contributing to feelings of unequal treatment by people who note that such insurance lowers financial barriers to healthcare. In France, while such coverage of co-payments is also a feature of additional insurance, almost 100% of the population has such insurance, thus it is less likely to be widely perceived as a source of inequality.

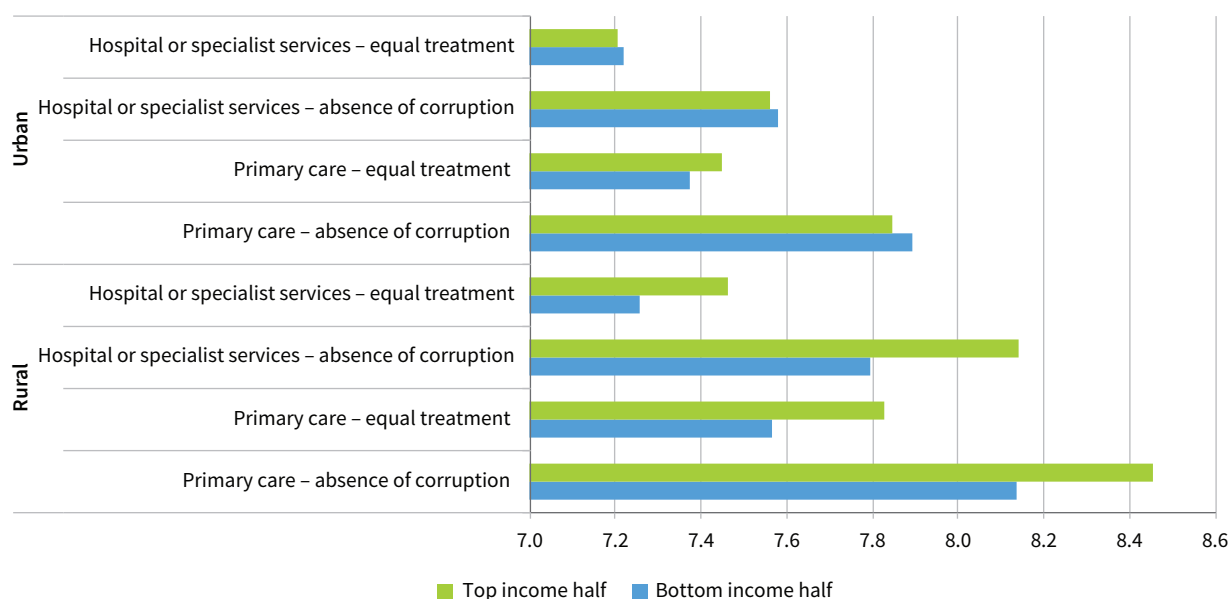
The four countries with the lowest proportions of people reporting either of the two types of unfairness (Denmark, Finland, the Netherlands and Sweden) are also the top-scoring four EU countries in Transparency International's general 'Corruption Perceptions Index 2016' (CPI). Many countries with the highest proportions of people reporting either of the two types of unfairness are also at the bottom of the CPI. However, there are some discrepancies. For instance, Spain ranks 17th of 28 Member States in the CPI, while it ranks better on all dimensions in the EQLS analysis, ranking fifth overall. An explanation may lie in the CPI covering more sectors than healthcare alone. People in Spain may associate healthcare less with corruption than other aspects of society. Bulgaria, Italy and Malta also seem to score a bit better on healthcare fairness than on the CPI. This is, however, mostly explained by scoring relatively well on 'unequal treatment' indicators, while worse on 'corruption' indicators in both hospital and primary care. Austria and Ireland seem to do a bit worse on their ranking in the EQLS analysis than on the CPI. This discrepancy also seems to relate mainly to their relatively low ranking on unequal treatment in hospital or specialist care, rather than on corruption.

Perceptions of absence of corruption and equal treatment are higher in rural than in urban areas. However, income differences matter more in rural than urban areas (Figure 5). People in the top income half who live in rural areas on average score absence of corruption 0.3 higher, both for hospital and primary care. For equal treatment, people in the top income half who live in rural areas also rate equal treatment higher on average by 0.2 for hospital or specialist care and 0.3 for primary care. In urban areas there is a 0.1 difference for equal treatment in primary care, but in all other instances perception of corruption and equal treatment shows a negligible difference between income halves.

### Could e-healthcare improve transparency and access?

Addressing perceptions of fairness in healthcare can be complex, and corruption and unequal treatment need to be addressed by multidimensional measures. In this section, some comments are made on the possible role of only one tool: e-healthcare. Previous qualitative evidence has suggested e-healthcare may contribute to reducing under-the-table payments (Eurofound, 2014). More generally, the argument could be made that e-healthcare can make healthcare more transparent.

Figure 5: Fairness in primary and hospital or specialist services by income and urbanisation, EU28



**Note:** The scale for Q63b and Q66b regarding corruption is reversed.  
**Source:** EQLS 2016 (Q63 and Q66)

Is use of e-healthcare associated with higher perceptions of fairness, according to the indicators of absence of corruption and equal treatment included in the EQLS? One challenge is that countries where e-healthcare is used often also tend to score better on the fairness dimensions. To address this, it is interesting first to look at the three countries with highest e-healthcare use, as they score similarly on fairness indicators. For these countries, there seems to be little difference in reported fairness by people who had used at least one of the types of healthcare and those who do not. For instance, on a scale of 1–10, most users and non-users (both 87%) gave a score of 6 or above when asked to what extent they agreed with this statement about primary care: ‘All people are treated equally in these services in my area’.

And what about the group of countries where e-healthcare is least often used? Out of these countries, five rank 20th or above on both absence of corruption and equal treatment for specialist and primary care services, and two rank 20th or above on all dimensions except for equal treatment in primary care. Differences between users and non-users may appear minor, but they are consistent for all dimensions of fairness measured. For instance, 55% of users have an absence of corruption score for hospital or specialist care of 6 or above, compared to 53% among non-users (63% versus 62% for primary care) and 66% of users score equal treatment in hospital or specialist care at 6 or above, compared to 64% among non-users (74% versus 72% for primary care).

## User satisfaction with aspects of care provision

For both primary and hospital or specialist care, the EQLS includes information on satisfaction regarding four quality aspects:

- the quality of the facilities (building, room, equipment)
- the expertise and professionalism of staff
- the personal attention given, including staff attitude and time
- being informed or consulted about their care

These aspects capture a broad spectrum of service quality dimensions. Quality of the facilities seeks to assess an important aspect of the ‘tangibles’, identified as a key dimension of service quality in a healthcare setting (Babakus and Mangold, 1992). Perceived expertise and professionalism would broadly concur with the ‘assurance’ dimension of service quality identified in the healthcare setting, receiving personal attention with the ‘empathy’ dimension, and being informed with the ‘responsiveness’ dimension. The aspects dealt with here also cover various principles of the voluntary European Quality Framework for social services discussed above (SPC, 2010). The aspects in the EQLS are not comprehensive, for example they do not capture the ‘reliability’ dimension of service quality in healthcare (such as ‘services are provided at the promised time’) separately from staff attitude and attention given.

## Primary care

The perceived quality of primary care is relatively high on all dimensions for the EU as a whole. Expertise and professionalism of staff get the highest ratings. Even in the Member States with the lowest scores, ratings are 7.1 out of 10 or above. While personal attention given and quality of the facilities are both rated at 7.9 on average, there is more country variation for the latter, with the lowest ratings at 6.5 (Greece) and 6.8 (Italy). In terms of personal attention, people on average give scores at 7.0 or above in all countries.

All four aspects of satisfaction with primary care are highly significantly positively correlated with each other. The correlation between perceived expertise of staff and personal attention given is particularly high, which means that people ranking one of these two aspects highly also give a high ranking to the other (Pearson's  $r = 0.83$ ). There is also a clear correlation between perceived personal attention given and being informed about care (Pearson's  $r = 0.83$ ). The correlation between quality of the facilities and being informed about care is lowest (Pearson's  $r = 0.62$ ). Overall, if any of these indicators were to be dropped, it should be 'personal attention given' as it seems to add relatively little differentiating power to 'being informed about care' and 'expertise of staff'.

Given these strong correlations, it is not surprising that several countries score either relatively well on all four quality dimensions of primary care (Austria, Germany, Ireland, Luxembourg) or relatively badly on all of them (Bulgaria, Greece, Italy, Portugal). However, even within these countries there are some differences between the dimensions. In particular, while Ireland scores in the top three for the other dimensions, it does somewhat worse for quality of the facilities. In contrast, while Portugal is among the worst-scoring countries for the other dimensions, it scores better for quality of the facilities.

For other countries there is more diversity among these four dimensions of quality of primary care services. In particular, Denmark is among the top three for the other dimensions, but comes 20th of all 28 Member States for 'being informed or consulted about care'. To some extent, this may be related to high expectations which cannot always be fulfilled, with work intensity in the healthcare sector being relatively high; according to analysis of the European Working Conditions Survey 2015 for this report, only 8 of the 27 other Member States rank higher in terms of work intensity in healthcare than Denmark. In Sweden and the UK, quality of the facilities come out considerably better than any of the other three dimensions, while in Croatia and Malta the reverse is true, with quality of the facilities ranking relatively low.

## Hospital or specialist care

The perceived quality of hospital or specialist care is lower on all dimensions than primary care for the EU as a whole. However, here the ratings are also generally positive. Again, expertise and professionalism of staff gets the highest ratings, not only for the EU as a whole, but even in the Member States with the lowest scores, where ratings are 7.0 out of 10 or above.

Similar to primary care, all four aspects of satisfaction with hospital or specialist care are highly significantly positively correlated. However, the correlation between expertise of staff and personal attention given (Pearson's  $r = 0.823$ ) comes out a bit weaker than that between personal attention and information provision (Pearson's  $r = 0.843$ ).

Finland and Sweden are in the top three for all four dimensions of hospital or specialist care. This is in sharp contrast to primary care, and tallies with the earlier observation (Eurofound, 2017b, p. 53) that these countries are exceptional in the EU in having lower overall quality ratings for primary care than for hospital or specialist care.

Just as for primary care, Denmark is in the top three for three dimensions of quality, but not for 'being informed or consulted about your care', even if it has a higher ranking (ninth) than it has for primary care. Ireland again scores relatively badly on 'quality of the facilities', considerably more so than for primary care and, in contrast to primary care, Ireland does not reach the top three for any of the other three quality dimensions for specialist and hospital care.

In the EU overall, income seems to matter more for satisfaction with hospital or specialist care than with primary care. The greatest income differences in satisfaction for specialist or hospital care can be found for 'being informed or consulted' with, on average, a difference of 0.3 points between the top and bottom income half. Income differences are also considerable for perceived 'expertise and professionalism of staff' and 'personal attention given' (a difference of 0.2 points for both). There are country differences. For Italy, the big income difference in general healthcare system ratings seems to come largely from hospital service, and less so from primary care services. In Estonia and the Netherlands this is not the case, and differences in hospital or specialist and primary care ratings by income seem related to the large income differences in overall rating of healthcare services.



## Country patterns

### Clustering countries by healthcare system characteristics

Often, countries are clustered in terms of healthcare, based on characteristics of the financing system. A typical distinction would be between the ‘Beveridge’ (predominantly tax-funded) and ‘Bismarck’ (predominantly social health insurance-funded) systems. It appears that the situation is more ‘complicated and complex’ than typologies suggest. For instance, social health insurance countries ‘vary considerably along organizational and structural dimensions, reflecting differing histories and, often, different national norms and values that underpin these organizational arrangements’ (Saltman et al, 2004, p. 141). It may come as no surprise that there are great variations for multiple dimensions of quality of healthcare, not only between these groups, but also within these groups. Such typologies map features of the historical background and financing system, but do not necessarily relate to quality of care.

Clusters have also been developed using a more bottom-up approach, driven by the similarity of specific data. A notable recent example is based on available macro indicators on healthcare system financing (such as per capita health expenditure, and shares of public financing and out-of-pocket expenditure) and other characteristics of healthcare systems (such as proportions of inpatient and outpatient care, whether GPs are salaried or fee-for-service, and whether there is a GP gatekeeping system) (Wendt, 2014). As the exercise is based on cluster analysis, it should be acknowledged that not all countries necessarily fulfil each of the characteristics of the group. The study limited itself to OECD countries, for which data is standardised to some extent, so it has not clustered all EU countries.

### Overall country patterns in perceived quality of healthcare services

The objective of this section is more modest than to create such overarching typologies; it seeks to identify countries that are similar in terms of the variables measured in the EQLS, and make use of the harmonised information on all the EU Member States.

A heterogeneous picture emerges from the EQLS data, with no clear divisions along the lines of the healthcare system typologies outlined above. Some countries score worse or better on all aspects of quality covered in the EQLS. These countries broadly coincide with countries identified among the worst and best performers in other research on quality of healthcare (for example, GBD, 2018). However, there are countries that score well on almost all aspects of perceived quality of healthcare measured in the EQLS, but (relative) deficiencies and different patterns across population subgroups can still be highlighted. Similarly, countries that score generally

worse on all dimensions still seem to do a bit better on some quality dimensions than on others. Furthermore, poor rankings on one dimension can be explained in different ways depending on the countries. If a regional dimension were to be added, the picture can be expected to be even more heterogeneous.

The EQLS 2016 collected detailed data on perceived quality of primary care and specialist or hospital care in particular. General quality ratings for these services are relatively high, and so is satisfaction with detailed aspects of them. The weighting attached to the various aspects of quality determine whether a country ranks better or worse overall. Furthermore, for a true quality ranking, these subjective data should be combined with numerous other data available.

Taking these limitations into account, one should be careful in using these data to cluster countries by overall quality, and rather focus on clustering the countries by the type of problems that emerge. However, it would also be wrong to ignore the fact that some countries score clearly better or worse in almost all regards than others. So, a compromise was found by first identifying four clusters of countries that clearly are in different leagues in terms of most quality indicators in this report. Next, within these broad groups, clusters are identified comprising countries with similar problems, as much as possible respecting the complexity unveiled by the EQLS data on primary and specialist or hospital care along the dimensions measured.

#### 1) Countries with generally high performance on all quality dimensions:

*Austria, Denmark, Finland, Luxembourg and Sweden*

While the countries in this group are rather homogeneous in their high performance on these subjective indicators, there are some subtle differences. Finland and Sweden score somewhat worse on primary care than on hospital or specialist care, while for Denmark and Luxembourg the opposite is true.

*Primary care:* Austria and Luxembourg do somewhat worse on feeling protected for future care needs and on distance-related access problems. Luxembourg does somewhat worse on waiting time on the day of the appointment, while in Finland and Sweden perceived delays in getting an appointment are relatively problematic. Both are relatively often a problem in Austria.

*Specialist or hospital care:* Austria (less so) and Luxembourg score somewhat worse on satisfaction with expertise and professionalism and personal attention given. Austria and Luxembourg (less so) also score somewhat worse in terms of equal treatment and absence of corruption in hospital or specialist care. Denmark, Finland and Sweden rather consistently rank highest in terms of hospital

or specialist care, except that Denmark scores worst of the five countries in this group in terms of satisfaction with being informed or consulted about care.

2) **Countries with generally high performance on most dimensions but low performance on others:**

*Belgium, Czechia, Estonia, France, Germany, Ireland, Lithuania, Malta, the Netherlands, Slovenia, Spain and the UK*

Belgium and the Netherlands do better on primary care than specialist or hospital care, while for Malta and the UK the opposite holds true.

*Primary care:* the Netherlands and Spain rank considerably worse than the others in this group on 'personal factors of care', including on expertise and professionalism of staff, personal attention given and, in Spain in particular, being informed or consulted about care. Czechia and Slovenia rank worst in this group on perceptions of equal treatment and, together with Lithuania, on corruption. With regard to access, distance most often makes access difficult in Czechia and Estonia, delay in obtaining an appointment makes access difficult in the UK in particular (but also in Estonia, Lithuania and Malta) and waiting time at the venue makes access difficult particularly in Czechia and Malta (but also in Germany and Lithuania). Ireland and Malta stand out in this group in terms of the proportion of people who report that cost makes access difficult. Finding time is most often an issue in Belgium, France and the UK. Feeling protected for future primary care needs is most often an issue in Slovenia.

*Hospital or specialist care:* here the Netherlands ranks poorly for 'personal factors of care', but Belgium and France stand out more with their negative rankings in this respect. For hospital or specialist care, Spain joins these relatively low rankings on the personal factors of care, but only on being informed or consulted about care. Czechia, Lithuania and Slovenia stand out with their particularly low rankings on both fairness dimensions and, to a lesser degree, Malta and Spain (only for absence of corruption), Belgium and Germany (for equal treatment) and Ireland (for both indicators).

3) **Countries with generally low performance on most dimensions but high performance on others:**

*Bulgaria, Hungary, Italy, Latvia, Poland, Portugal and Slovakia*

In this group, Hungary generally ranks more favourably on primary care quality indicators than on those for hospital or specialist care, while for Portugal the reverse is true.

*Primary care:* Italy and Portugal rank lowest on satisfaction with the personal factors of care, as do Bulgaria, Poland and Slovakia, although to a lesser extent. Bulgaria and Italy rank particularly low with regard to satisfaction with quality of the facilities. In terms of the two fairness dimensions, Slovakia stands out, ranking lowest among the countries in this group on both dimensions. With regard to the proportion of people reporting access problems, some stand out in terms of difficulties related to distance (Portugal, Slovakia), some on delay in getting an appointment (Hungary, Latvia, Portugal), some on waiting time at the venue (Bulgaria, Portugal), some on cost (Bulgaria, Latvia) and Bulgaria scores worst on access problems due to difficulties finding time. Hungary and Poland stand out for their low ranking with regard to feeling protected if primary care needs emerge in the near future.

*Hospital or specialist care:* Hungary and Slovakia stand out within this group with regard to their low rankings on both fairness dimensions. Bulgaria, Portugal and, in particular, Italy have the lowest rankings in this group on satisfaction with the three personal factors and with quality of the facilities.

4) **Countries with generally low performance on all quality dimensions:**

*Croatia, Cyprus, Greece and Romania*

While the countries in this group are rather homogeneous in their low performance on these subjective indicators, there are some subtle differences.

Croatia and Romania (less so) score somewhat better on primary care than on hospital care. Cyprus and Greece have similarly low rankings for both types of care.

*Primary care:* Croatia scores a bit better than the others with regard to satisfaction with being informed or consulted, personal attention given and expertise and professionalism of staff. The same holds true, albeit to lesser extent, for Romania. Cyprus does better on perceived difficulties in accessing primary care due to waiting times, but worse on cost. Greece stands out for being among the bottom three countries for all dimensions measured.

*Hospital or specialist care:* Croatia does somewhat better than the others in terms of satisfaction with the three personal factors, and Romania on being informed and consulted and on equal treatment. However, most apparent is that none of these four countries rank better than 20th of the 28 Member States on any of the aspects of perceived quality of specialist or hospital care.

Overall, these country groups differ from those identified in the typologies discussed above (Saltman et al, 2004; Wendt, 2014). For instance, Denmark and Slovakia are grouped together in the typology developed by Wendt (2014), but they clearly emerge as rather different cases in terms of the results of the EQLS analysis. The same holds true for Portugal and Sweden, Italy and the Netherlands, and Austria and Belgium. They differ from each other not only with regard to overall performance, but also by specific indicator, raising the question of how well the indicators – upon which the typologies discussed above are based – can explain such differences. Also, each of the four groups identified above includes countries with predominantly tax-funded systems and countries with predominantly social health insurance-funded systems. For instance, an updated version of this typology (SPC, 2018b) groups Croatia with Luxembourg as mainly social health insurance contribution-financed countries, and Portugal with Sweden. These countries clearly fall into different groups when categorised along the quality indicators in the EQLS. Several countries with reportedly higher shares of out-of-pocket expenditure fall in the bottom two EQLS groups (Bulgaria, Cyprus, Greece, Latvia), but some with lower shares of out-of-pocket expenditure do so as well (Croatia, Italy, Romania, Slovakia).

## Conclusions

### Use of healthcare services

The fact that, in a single year, about 9 out of 10 people in the EU had experience of at least one of the healthcare services covered in the EQLS (either themselves or someone in their household) or refrained from using a healthcare service that they thought necessary in order to economise highlights the central role healthcare services play in society. Their perceived quality is thus relevant for the vast majority of people in the EU, affecting people's expectations, uptake and actual experiences – both the experiences of service recipients and of other household members. Therefore, improving healthcare quality could positively affect the vast majority of the population.

Among the 30% of people who themselves did not use primary, specialist or emergency healthcare in 2016, 6% did not go to the doctor in order to economise and an additional 7% delayed going to the doctor for the same reason. Emergency services are relatively often used by people in the bottom income quartile, suggesting that in some countries emergency services represent a point of access into a healthcare system for people who otherwise find it hard to get the care they need. Both the postponement of healthcare and seeking shortcuts in accessing care (such as using emergency care for non-emergencies) can lead to worse health outcomes and ultimately to higher public expenditure.

ICT has become a common way for people to get information on their health and on healthcare. It has also become mainstream in healthcare administration and patient records. However, in more than half of the Member States, when it concerns actual service delivery – that is, where patients use ICT to communicate with healthcare providers – ICT falls far behind the levels of those countries in which its use is most common. In particular, in countries where e-healthcare is rarely used, its use is more often restricted to urban areas and higher-income groups. It seems that only when e-healthcare becomes more widely used will people in the lowest income quartile and in rural areas start accessing, and potentially benefiting from, e-healthcare. In the EU as a whole, it seems rare for e-healthcare to replace visits to the doctor: it seems rather to complement such visits, for instance by supplying prescriptions for medicines. E-healthcare is certainly not restricted to younger people, with many older people using it.

### Overall quality ratings

Quality ratings of the healthcare system overall have improved for every income quartile, in 2007–2011 and 2011–2016. However, they remain lowest for the bottom income quartile and the gap separating this quartile from the higher-income groups seems to be increasing.

The comparison of change in perceived quality over time reveals that it is the third income quartile that enjoyed the greatest improvement as well as giving the highest overall healthcare quality rating in 2016. This suggests that an approach (seen, for example, in JAF Health) that aims to capture equity by measuring the gap between the highest and lowest income groups may not suffice for comprehensive monitoring.

Even with favourable overall scores compared to other services, 27% of people in the EU give low (lower than mid-point) ratings to health services in their country, ranging from 10–66% of the population across Member States. So, while the situation in the worst-performing countries is particularly worrying, even in the best-performing Member States there are significant parts of the population who describe quality as low.

Quality ratings for primary care and for hospital or specialist care provide insights into the overall quality ratings of healthcare services. For instance, in Hungary and Ireland perceptions of hospital or specialist care quality seem to bring overall healthcare ratings down, while in Finland and Sweden primary care is lagging behind relatively. Quality ratings for primary and for hospital or specialist care can to some extent be explained by the specific aspects of quality of these types of care (such as differences in levels of personal attention). This chapter shows that looking only at the overall quality of healthcare indicators may mask the fact that problems may be concentrated in a certain

type of healthcare service and aspect of this. It is important, therefore, to take into account the type of healthcare service and more detailed aspects of quality (including access, fairness and fear of not being able to pay for healthcare when needed).

Nevertheless, there are good reasons to continue monitoring the general healthcare service rating as well: such overall ratings capture other services and quality aspects since, inevitably, the set of selected indicators can only cover some of them.

## Barriers – beyond cost

### Waiting times

Although assessment of barriers to accessing healthcare often tend to focus on cost as an issue, in the EU, waiting time to get an appointment (42%) and waiting time at the healthcare venue (38%) are by far the most common factors in making access to primary care difficult. Solutions can be sought in capacity (allocation of resources) and organisational improvements. E-healthcare has the potential to contribute to addressing the most common access problems in the EU, such as waiting times; however, there still seems to be little evidence that it does in practice. Waiting times may largely be explained by structural mismatches between resources and demand for healthcare, raising the question of how effective a solution e-healthcare will prove to be in this respect.

### Financial issues

To ensure access to healthcare, then, policymakers are advised to look beyond ‘unmet needs’. It has been suggested that countries set ‘relative’ objectives rather than absolute ones with regard to access to healthcare, as it may be unrealistic for the worst-performing Member States to reach the level of the best (EXPH, 2018a). Following similar reasoning, it may also make sense to set objectives for access indicators beyond unmet needs. This is particularly true for the best-performing countries, where people rarely have unmet needs, but can find it difficult to access healthcare (or postpone using it) due to cost.

In reporting, the focus is often on the bottom income groups. While proportions are generally higher among this group, access problems due to financial reasons are not restricted to the bottom income groups. In some countries, middle-income groups fare similarly badly or worse than lower-income groups in accessing certain types of care, often because they are too well-off to be entitled to be exempted from co-payments or to avail of publicly funded insurance, while they are too poor to afford healthcare services and insurance without such support. This ‘twilight zone’ group was identified in a previous report as a group in a vulnerable situation (Eurofound, 2014), along with other ‘new’ and more commonly identified groups in vulnerable situations with regard to access to healthcare. Now the data

confirm this group’s existence in a more quantifiable way.

Furthermore, EU-SILC distinguishes between medical care and dental care. While this distinction is important, it can be revealing to look at different types of ‘medical care’. For instance, the EQLS confirms that cost generally seems less of an issue for access to primary care than for other forms of healthcare. Thus, generalisations for unmet needs due to cost based on EU-SILC data overall may refer less to primary care than to other types of ‘medical care’.

When addressing cost-related access problems, discussions tend to focus on co-payments, own risk and insurance coverage. Such healthcare system financing features are key (including the role and take-up of private insurance), but the access problems people experience due to cost may also relate to under-the-table payments, travel costs and personal financial circumstances, which can be adversely affected, for instance, by low income, household debt problems or housing costs.

### Perceptions of unequal treatment and corruption

Perceptions of unequal treatment and of corruption in healthcare appear to be important elements of perceived quality of care and are widespread in a number of countries. However, in some countries, healthcare comes out favourably in particular with regard to corruption compared to broader measures of corruption in society. Unequal treatment is perceived to be an issue by many people, in particular in relation to hospital or specialist care. Patterns and likely causes differ between countries, but dual practices and under-the-table payments probably play a role.

Levels of perceived unfairness are higher in urban than in rural areas, but income seems to matter more in rural than urban areas. In rural areas, people with low incomes report more unequal treatment and corruption in particular than people with high incomes, both in primary and specialist or hospital care.

Perceptions of unequal treatment in primary care correlate with difficulties in accessing primary care due to cost, but affordability seems to explain only part of these perceptions.

A lesson can also be learned from the new ‘fairness indicators’ in the EQLS 2016, where unequal treatment and corruption were measured separately for primary care and specialist or hospital care. The need to differentiate between these two sectors of healthcare seems greater for unequal treatment than for corruption; countries that rank low (or high) for absence of corruption in specialist or hospital care generally do so for primary care too. However, overall absence of corruption gets better ratings in primary care than in specialist or hospital care. Furthermore, when analysing results, it is important to look at the proportions of



people reporting low scores along with averages. For instance, Austria has a higher score on equal treatment in specialist or hospital care than the EU average. However, the proportion of people giving equal treatment in specialist or hospital care a low score is actually also higher than in the EU on average. Austria's high average scores on equal treatment can mostly be explained by more than a third of people giving equal treatment the highest rating possible (10), compared with about a quarter in the EU as a whole.

Addressing perceptions of fairness in healthcare can be complex, and corruption and unequal treatment need to be addressed by multidimensional measures. E-healthcare may be one tool among many with the potential to increase transparency, for instance by reducing under-the-table payments (Eurofound, 2014), making it more than just a shift in the means of providing healthcare.

### User satisfaction with quality aspects

Professionalism and expertise of staff in healthcare gets particularly high ratings. Even the country with the lowest average rating for professionalism and expertise of staff has a rating of 7.0 for hospital or specialist care (Italy) and 7.1 for primary care (Portugal). However, when people give lower ratings to professionalism and expertise of staff, they also tend to rate the other 'personal factors of care' lower: attention given (including staff attitude and time devoted) and being informed or consulted about care. This suggests that low ratings of professionalism and expertise may reflect such 'softer' aspects of professionalism rather than the technical abilities of staff. In the EU overall, there seems to be most room for improvement in these 'softer' quality aspects such as better informing or consulting people about their care.

In terms of legal aspects, it is interesting to note that countries that do well on user satisfaction with patients' rights – such as access to own medical records (HCP, 2018) – do worse on user satisfaction with being informed and consulted about care. This is particularly the case in Denmark and the Netherlands. On the one hand this may have to do with higher expectations in countries with more patients' rights, but there may also be a difference between legal and procedural warranties of patients' rights and actual provision of information by healthcare providers when spending time with the patient. For instance, providing information to patients can be challenging for medical personnel if work pressure is high. Overall, in the EU, the health sector scores more favourably on other aspects of quality of work (such as social environment), but it has the highest levels of work intensity compared to nine other sectors (Eurofound, 2017c). Other research suggests that, when asked to assess the hospital where they were treated, patients in hospitals with a better

work environment give higher quality ratings. Nurses in these hospitals give higher ratings for quality of care and patient safety. Improvement of hospital work environments might be a relatively low-cost strategy to improve safety and quality in hospital or specialist care and to increase patient satisfaction (Aiken et al, 2012).

People with lower incomes give lower quality scores to healthcare. Access difficulties and perceived corruption and unequal treatment seem to explain some of this. Overall, perceived problems are more common for hospital or specialist care than for primary care.

## Policy pointers – healthcare

### Impacting positively on everyone's life

- Improving the quality of healthcare services can positively affect the majority of members of society, not only service users themselves but also people who share households with service users, and for those with postponed or unmet healthcare needs. In 2016, about 9 in 10 people in the EU could be accounted for by one of these groups.
- There is a large gap between countries in the extent of e-healthcare use: those where e-prescriptions and consultations are common, and those where they are not. In particular, in those countries where e-healthcare is uncommon, it seems more of a privilege, available to higher-income groups and urban areas. Investment in effective e-healthcare is needed if these countries are to reap its potential benefits. E-consultations are rarer than e-prescriptions, and much e-healthcare seems to be complementary to physical visits to the doctor, rather than replacing such visits.

### Extending access and addressing barriers

- Some differences in service use seem related to certain services being easier to access rather than being the most appropriate point of access. For instance, in some countries, emergency services are relatively more often used by people in the bottom income quartile, possibly because these services are easier to access after working hours or at weekends, or because they do not charge or implement co-payments. Policymakers should seek to steer people to the most appropriate type of care and prevent the possible overuse of relatively expensive services, for instance by further improving access to primary care on all dimensions.
- Healthcare systems in the EU are often described as 'universal'. However, many people face barriers in accessing healthcare. By addressing them, policymakers can prevent postponement of care and unmet needs, which can result in health inequalities and greater healthcare needs in the future.

- It is important to consider groups not captured (well) by population surveys, such as the homeless or people with very low incomes; these groups can find access to healthcare the most challenging, but they are often overlooked.
- Policy documents often focus on data concerning ‘unmet medical needs’. However, such a narrow focus risks underestimating the barriers faced by people in the EU in accessing healthcare. Access problems can not only lead to unmet needs (by not attending care at all), but also to delaying, to accessing but experiencing difficulties while doing so and to expecting access problems when healthcare needs emerge. Indicators that go beyond unmet needs in particular provide indications for policymakers from countries where unmet needs are rare.
- The often used measure of ‘unmet needs due to financial reasons’ may not adequately reflect the fact that many people in the EU postpone care rather than not using it at all. Furthermore, patients often access healthcare services despite financial difficulties (due to the importance of health) but with the consequence of higher economic burdens and lower quality of life in other areas.

#### **Tackling unequal access and corruption**

- It is important for policymakers not to underestimate perceptions of unequal treatment and corruption in healthcare, which are clearly not confined to a small number of Member States. While they have country-specific forms and causes, such perceptions do negatively impact on perceived quality of primary care and hospital or specialist care.

- Appropriate use of e-healthcare has the potential to make healthcare systems more transparent and to improve perceptions of fairness, including via reducing the incidence of under-the-table payments. However, the e-healthcare has to be rolled out to reach a critical mass of the population in a number of Member States.

#### **Creating synergies between primary care and hospital/specialist care**

- Primary care services are used by the vast majority of people in the EU, and they also receive high quality ratings. These services therefore are an asset policymakers may want to cherish, and lessons may be learnt for other public services, for instance, in terms of proximity and personal contact.
- Comparison of quality ratings of primary care and hospital or specialist care suggests that in some countries improvements are to be sought in specialist or hospital services (Hungary, Ireland) while, elsewhere, perceptions of primary care lag behind the high quality perceptions of specialist and hospital care (Finland, Sweden).
- Both in primary and in hospital or specialist care, there seems to be most room for improvement in ‘softer’ quality aspects such as better informing or consulting people about their care. Improving work environments in health provider organisations can contribute to achieving this goal.

## 2 Long-term care

### Introduction

#### EU policy context

The ongoing demographic change and the increase in demand for long-term care services associated with it have led the European institutions to repeatedly remind Member States of the need to be more cost-conscious. The European Commission's 2018 *Ageing in Europe* report estimates that the old-age dependency ratio (people aged 65 and above relative to those aged 15–64) will increase from 30% in 2016 to 51% in 2070 (European Commission, 2018a). In the next four decades, public expenditure on long-term care is foreseen to increase by 1.2 percentage points of GDP, which is more than the growth expected in spending on healthcare or pensions. Cost-efficiency has thus featured strongly over the years in the CSRs issued by the European Commission in the framework of the European Semester (see Box 3).

The quality of long-term care services is also part of the EU policy agenda. Several recent peer reviews of social protection and social inclusion (which are part of the social open method of coordination promoting mutual learning) have discussed different aspects of long-term care provision, including service quality. This is the case, for example, in the two peer reviews 'Germany's latest reforms of the long-term care system' and 'Improving reconciliation of work and long-term care' (European Commission, 2018b).

Quality is also mentioned in the European Commission's Annual Growth Survey, which sets general economic goals and recommendations for the euro zone. The 2018 Annual Growth Survey states that 'Europeans need affordable, accessible and quality services. Services such as childcare, out-of-school care, education, training, housing, health services and long-term care are essential for ensuring equal opportunities for all' (European Commission, 2017a, p. 6). Similarly, the European Pillar of Social Rights states that everyone has the right to affordable long-term care services of good quality.

#### EU initiatives in data collection and indicators

Since 2017, the Social Protection Committee Indicators Sub-Group (SPC-ISG) has been developing the definitions and components for a common framework of long-term care indicators. It is envisaged that this framework will include indicators on long-term care quality, access and sustainability (SPC, 2018b).

Past research carried out by Eurofound showed that differences in the quality of services provided in public and private care homes referred to the likelihood of having a single room and staff ratios (Eurofound, 2017d). Staff ratios, as well as information on waiting times, are the indicators monitored in most countries – see Table 4 (Spasova et al, 2018).

#### Box 3: Country-specific recommendations in 2018 from the European Commission about long-term care

Austria: 'Ensure the sustainability of the health and long-term care and the pension systems, including by increasing the statutory retirement age and by restricting early retirement'

Belgium: 'Pursue the envisaged pension reforms and contain the projected increase in long-term care expenditure'

Slovenia: 'Adopt and implement the healthcare and health insurance act and the planned reform of long-term care'

**Table 4: National-level indicators for measuring quality in long-term care**

	Quality indicators		Countries
Outcomes	Effectiveness of care and user safety	Clinical aspects, injuries, falls, etc.	BE, CH, DE, DK, FI, FR, IS, LT, LU, LV, NO, PT, SE
	Patient-centredness and responsiveness	User satisfaction/user experience	CY, DE, DK, IS, LT, NL, SE, SI, UK
	Care coordination		FI
Structural factors	Workforce	Staff ratio	AT, BE, DE, DK, EL, LT, LU, LV, MK, NO, PL, RS, SI
		Continuity of staff	SE
		Rate of sickness	NO
		Skills/level of education	LV, NO
	Care environment	Infrastructure	FR, IS, LV, NO
	ICT	Safety technologies	FI
Other indicators	User complaints		LV, RS
	Unmet needs		IT, SI, UK
	Timeliness of services	Waiting time/waiting lists	DK, LV, NO, PT, SI, SK, TR
	Well-being of staff/working conditions		FI, LT, SI
	% of compliance with inspected outcomes		IE

**Note:** See p. iv at the beginning of the report for a list of the country codes.

**Source:** Spasova et al (2018)

The interest in the provision of quality long-term care services reinforces the need for data and indicators to monitor reforms and inform policymakers. The EU-SILC 2016 ad hoc module on access to services included questions about professional home care. ‘Professional’ means that home care is a work or paid activity, thus excluding home care provided on an unpaid basis by friends, relatives, neighbours, etc. Home care services included healthcare (e.g. medical treatment, wound care, pain management and therapy) and/or assistance with activities of daily living (for instance, help with daily tasks such as meal preparation, medication reminders, laundry, light housekeeping, shopping, transportation and companionship). This ad hoc module included questions about the services received, as well as voluntary assistance (that is, unpaid care) provided by respondents to other adults.

### Definitions of the main indicators

Long-term care in the EQLS is defined as services for dependent people because of old age, chronic illness or disability. Formal long-term care (referred to in this chapter sometimes simply as ‘long-term care’) can be public, private for-profit, or non-profit. It encompasses the following three types of formal care services:

- nursing care services at home
- home help or personal care services at home
- residential care or nursing home (also referred to in this report as ‘care homes’)

The information gathered in the EQLS concerns the use of long-term care services by the person interviewed and/or by someone close to this person (either living in the same household as the respondent or elsewhere), with multiple answers being possible. The EQLS does not include people residing in hospitals or care homes at the time of the interview. The information about the use of care homes in the EQLS thus only includes previous use in the past year by respondents themselves (for instance, in cases of being admitted temporarily following hospital discharge) or by someone close to them.

The questions about use, overall quality of services, perceived fairness of services in the area, cost as a barrier and user satisfaction are common to all services dealt with in this report. Information gathered in other surveys, such as the number of hours services are used (included in SHARE – the survey of health, ageing and retirement in Europe – and the EU-SILC 2016 ad hoc module) is not part of the EQLS questionnaire in order to keep the focus on user satisfaction. The aspects of user satisfaction included in the EQLS reflect several dimensions of the European Quality Framework for long-term care services (WeDO, 2012).

**Table 5: Proportion of people using long-term care services during previous 12 months, EU28 (%)**

	Respondent using service	Someone close using service	No one
Nursing care at home	3	7	90
Home help or personal care services at home	3	5	92
Residential care or nursing home	1	5	95

**Notes:** Percentage of each type of service used by type of service user. 'Someone close' is reported by respondents. Multiple answers were possible.

**Source:** EQLS 2016 (Q68) (Eurofound, 2017b, p. 57)

## Use of long-term care services

Over one-quarter (28%) of the respondents to the EQLS 2016 were aged 65 or over and 6% were over 80. In addition to that, 31% of respondents reported having a chronic or long-standing (that is, lasting or expected to last for six months or more) physical or mental health problem, illness or disability. Within this group, 25% reported that they were severely limited in their daily activities by this physical or mental health problem, illness or disability and 50% were limited to some extent.

According to the EQLS 2016, 14% of the respondents reported using formal long-term care (either themselves and/or someone close to them). In most cases, the use of formal long-term care refers to use by someone close, especially in the case of residential care and nursing homes (Eurofound, 2017b, p. 57). This is mainly because the EQLS interviews are carried out in private households and respondents can only report about their own use if they are no longer in a care home. The fact that we are dealing with a small subgroup of respondents limits the analysis of the EQLS that can be carried out at national level.

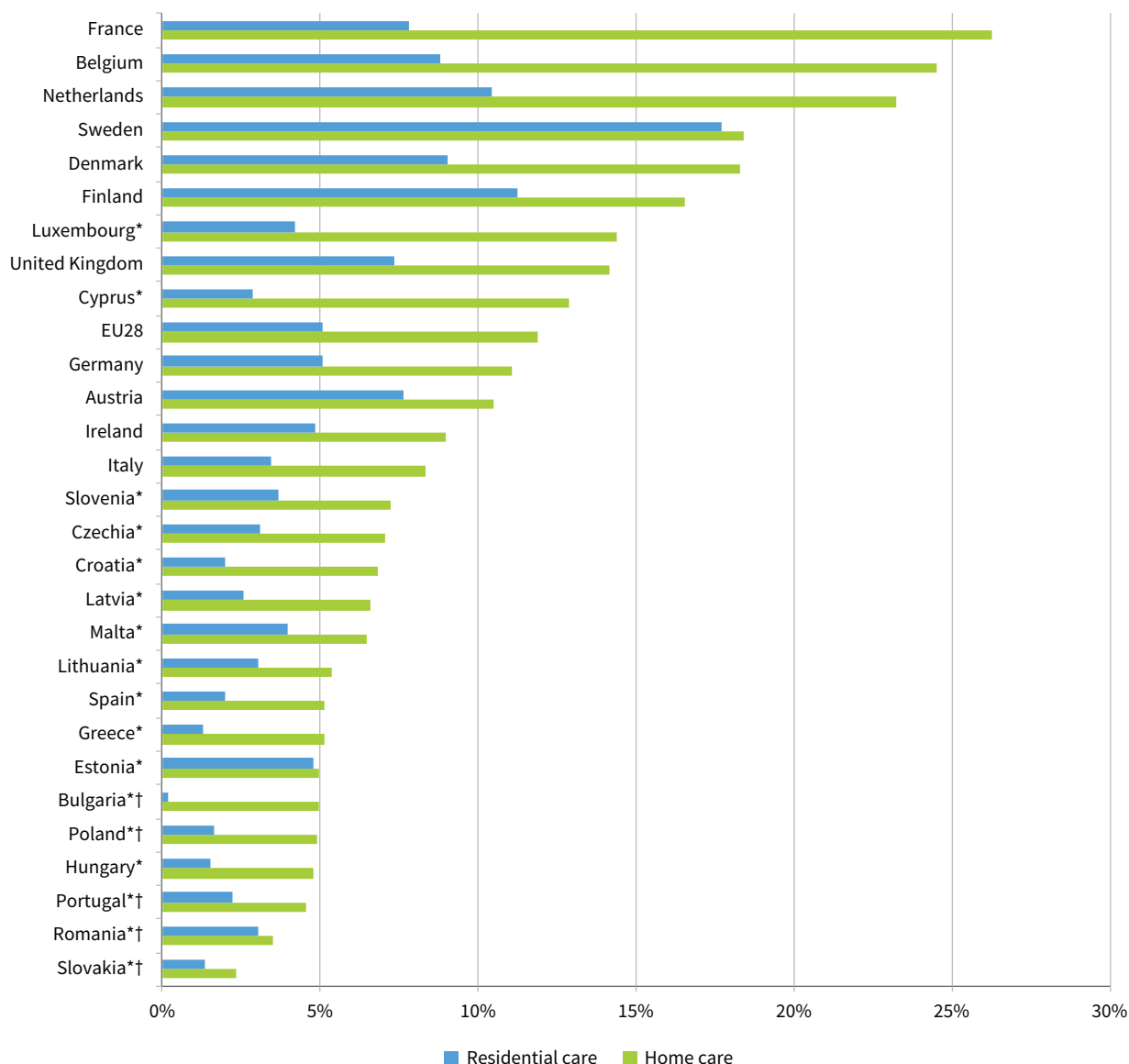
Only 10% of those that had some type of chronic (that is lasting, or expected to last, six months or more) physical or mental health problem, illness or disability made use of long-term care services themselves. The share of users among those with severe limitation of daily activities by physical or mental health problem, illness or disability is higher (22%). Among users, the proportion of women (61%) was higher than men (39%). The differences between genders were bigger in the use of home help and personal care services at home (64% women and 36% men respectively). The fact that most service users are aged over 65 and that there are more women in that age group largely explains these gender differences. More than half (57%) of those using formal long-term care directly were aged 65 or over and

27% of the users were aged over 80. Nearly two-thirds (63%) of those aged 65 and over who used services themselves were women. Among direct users aged over 80, 72% were women.

Differences in use are associated with income to some extent. Among interviewees making use of formal long-term care themselves directly, the lowest income quartile made more use (over 30% of the total number of users in all types of services) than any other income group. Those in the top income quartile made use to a lesser extent than others of any type of long-term care services except nursing care services at home, which were used the least by the third income quartile (19% of the total number of users). The use of residential care services was much lower among the top income quartile than the other income quartiles when it was the respondents themselves using the service.

Figure 6 shows the take-up of each type of long-term care service by Member State. On average, 8% of respondents in the EU28 stated that in 2016 they and/or someone close to them had used home care services in the last 12 months. In the case of both types of home care services (home help or nursing care at home) respondents are mostly reporting their use by someone close (on a ratio of 2 to 1). More than 20% of respondents in Belgium, France and the Netherlands reported that they and/or someone close to them had used home care services. Conversely, less than 5% of respondents in Bulgaria, Hungary, Poland, Portugal, Romania and Slovakia reported making use of these services.

Finland, Sweden and the Netherlands reported the highest (more than 10% of the total number of respondents) proportion of users of nursing homes/residential care. The lowest use (less than 2%) was reported in Poland, Hungary, Slovakia and Greece. In most cases, the use reported is by someone close to the interviewee, at a ratio of 5 to 1.

**Figure 6: Use of long-term care services (either by respondents themselves and/or by someone close to them), EU28**

**Notes:** Percentage of each type of service used by type of service user. 'Someone close' is reported by respondents. Countries marked with an asterisk have an unweighted count for residential care users below 50. Countries marked with a cross have an unweighted count for home care users below 50. Regarding rates of informal care provision, see the EQLS results in European Commission (2018c).

**Source:** EQLS 2016 (Q68)

## Access to long-term care services

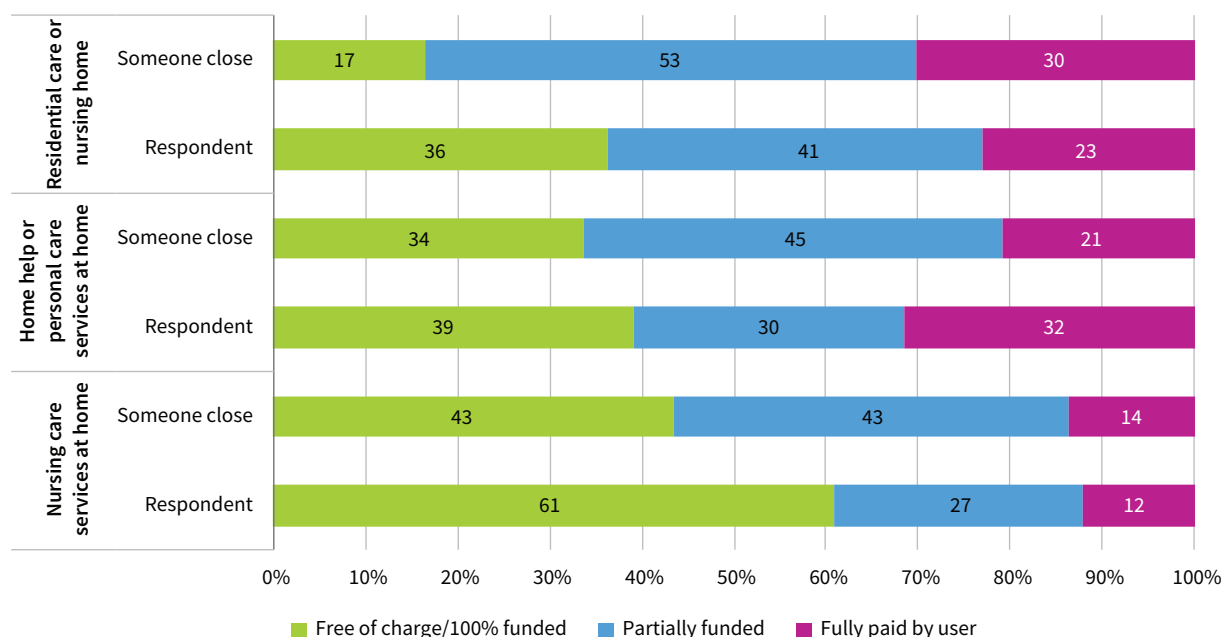
### Funding and affordability

In the EU, nearly one-third (32%) of users (both direct and indirect) of formal long-term care used services free of charge, with the remaining 68% either making full or partial payment. In the case of home care services, 41% of people reported that the services were free of charge or 100% funded and the remaining 59% paid fully or partially for services. A higher percentage of users of

nursing care services at home used them free of charge than in the case of home help or personal care services at home. In the case of residential care homes, the majority of users paid for services. Figure 7 shows that the percentage of services used free of charge is higher when the respondents themselves use the services directly. For example, 36% of those that had used residential/nursing home services themselves used them free of charge, whereas in the case of someone close only 17% did. A similar difference can be found in the case of nursing care services at home.



Figure 7: Funding of formal long-term care services, by type of service and service user, EU28

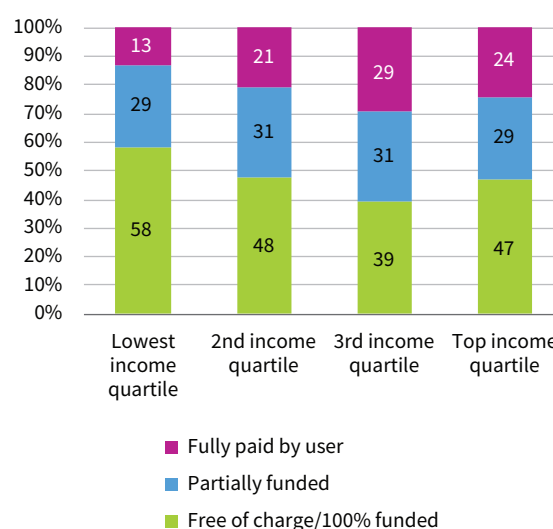


Source: EQLS 2016 (Q69, Q70)

Services that are free of charge (100% funded) are used to the greatest extent by those in the lowest income quartile (see Figure 8). Although services funded 100% were the most common funding type in all income groups, they constituted less than half of the total in all the other income groups. The third income quartile reported the lowest use of free of charge services and the highest share of users making full payment. The low number of respondents does not allow for a breakdown of the participation in free of charge services by each income group at the Member State level, but it is important to acknowledge that the availability of such services varies greatly from country to country.

Figure 9 shows the share of funding by Member State. The low number of users of formal long-term care services does not allow for the disaggregation of funding of services by user (that is whether it is the respondents themselves using services or it is someone close to them). The highest take-up of formal long-term care free at the point of use (that is over 50% of the total use by interviewees and/or someone close to them) was reported in France (52%), Slovenia (56%), Denmark (58%), Spain (65%) and Poland (78%). The lowest (below 20%) was reported in Austria (18%), Finland (13%), Greece (10%) and Cyprus (6%). It must be noted that in several of these countries (marked with asterisks in Figure 9), the number of respondents using

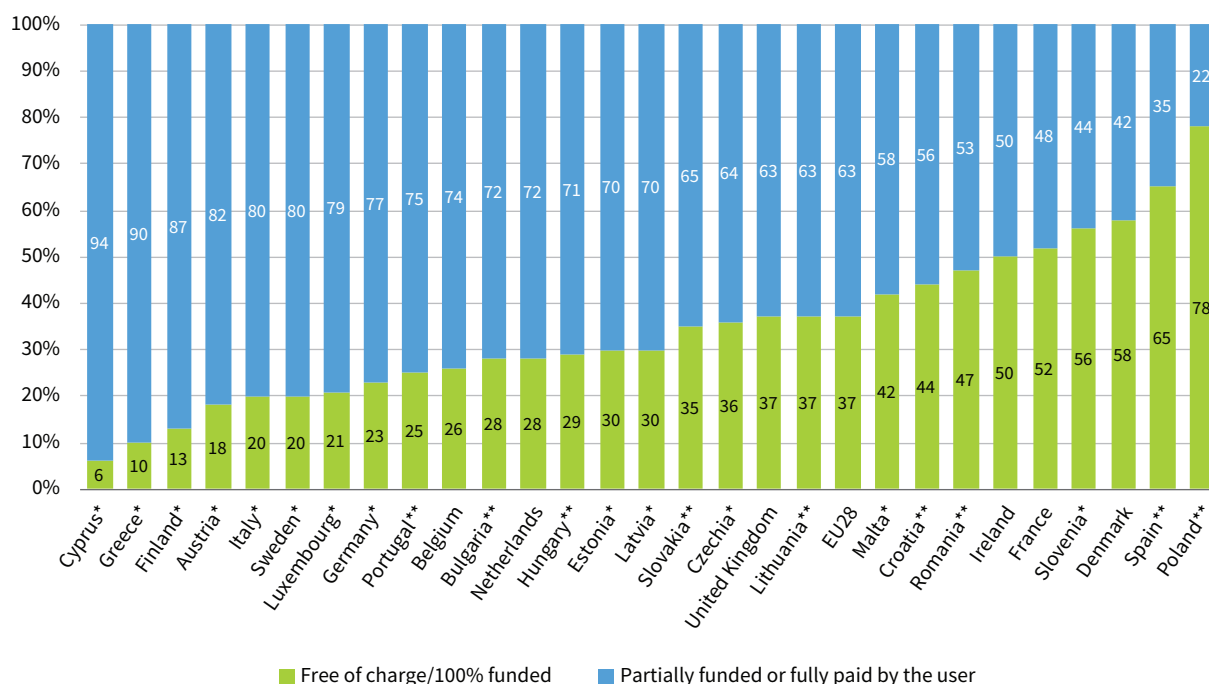
Figure 8: Funding of formal long-term care services, by income quartile, EU28



Note: Only the services used by respondents themselves are included in the calculations.

Source: EQLS 2016 (Q69)

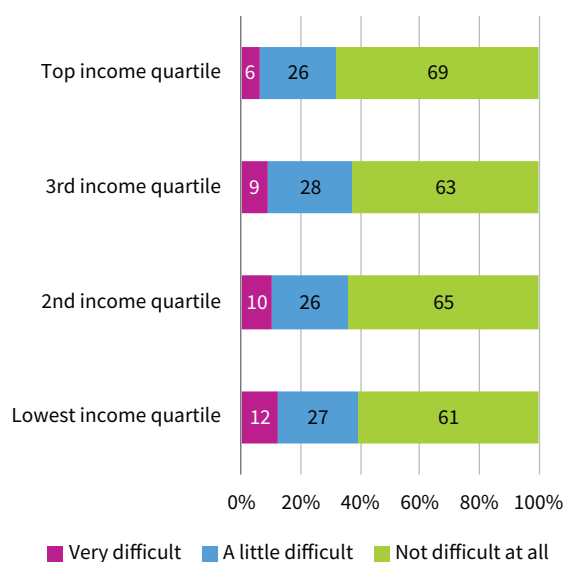
services free of charge is low and therefore these findings need to be complemented with other sources of information.

**Figure 9: Funding of formal long-term care services, by Member State, EU28**

**Notes:** Includes use by respondents and by someone close to them. Countries with one asterisk have an unweighted count of users of services free of charge/100% funded below 50. Countries with two asterisks also have an unweighted count of users of services partially funded or fully paid by the user below 50. An exception to this is Slovenia, which has an unweighted count of users of services partially funded or fully paid by the user below 50.

**Source:** EQLS 2016 (Q69, Q70)

In the EU28, on average, 63% of users did not find it difficult at all to access long-term care services because of cost, with 28% finding it a little difficult and 9% finding it very difficult. Cost was more of an issue in nursing/residential care centres than home care. About half of those using care homes had no difficulties at all because of cost, whereas this was the case for 65% of the users of home care services. Significant differences in affordability emerge between urban and rural areas, with those in urban areas experiencing fewer affordability issues than those in rural areas. The higher take-up of services free of charge by those in the lowest income quartile (see Figure 8) may be one of the reasons why there is a similar share of users in all income quartiles reporting that cost did not constitute a difficulty at all (over 60% of the users in each income quartile group, Figure 10). The fact that a higher percentage of respondents in the third income quartile (37%) experienced difficulties due to cost than in the second income quartile (35%) reflects the differences in the take-up of services free of charge between these two income groups (see Figure 8). These differences, probably caused by differences in eligibility for public funding of services (earning too much to be entitled to exemptions but too little to be able to pay for services without difficulty), have also been detected in the case of healthcare services.

**Figure 10: Extent to which cost made it difficult to use long-term care services, by income quartile, EU28**

**Note:** Includes replies by those using the services directly or someone close to them using the services.

**Source:** EQLS 2016 (Q74)



The low number of users of long-term care in the EQLS does not allow for the breakdown of results at the Member State level. Table 6 shows the level of difficulty in affording professional home care services as reported in the EU-SILC 2016 ad hoc module. The lowest percentage (less than 35%) of home care users finding it difficult – to a great, moderate or some extent – to afford services was found in the Nordic countries

and Luxembourg, with around one-fifth (21%) of home care users in Denmark stating that affording home care was very easy. Conversely, more than 90% of home care users in Cyprus, Greece, Lithuania and Slovakia experienced some level of difficulty affording home care services, with more than half (55%) of users in Greece experiencing great difficulty.

**Table 6: Level of difficulty in affording professional home care services, EU28 (%)**

	Great	Moderate	Some	Fairly easy	Easy	Very easy
Austria	8.1	21.9	28.6	18.8	17.5	5.2
Belgium	8.7	17.8	24.1	25.7	17.8	5.9
Bulgaria	36.7	23.8	17.7	21.9	0.0	0.0
Croatia	15.8	25.3	41.4	15.3	2.2	0.0
Cyprus	45.8	28.3	18.2	5.8	1.9	0.0
Czechia	14.6	26.3	43.4	10.5	4.4	0.9
Denmark	16.3	7.0	8.1	27.7	19.8	21.0
Estonia	0.0	17.6	51.0	24.1	1.3	6.0
Finland	1.6	6.2	17.0	37.9	18.4	18.9
France	3.0	17.5	21.9	33.4	19.7	4.5
Germany	8.3	11.8	19.0	45.1	14.1	1.6
Greece	55.0	32.7	5.6	6.5	0.3	0.0
Hungary	12.7	34.0	34.1	19.2	0.0	0.0
Ireland	27.2	6.7	13.3	22.0	30.8	0.0
Italy	26.6	25.2	29.2	11.7	7.2	0.0
Latvia	40.4	22.2	14.2	23.2	0.0	0.0
Lithuania	1.2	33.1	59.8	0.0	5.9	0.0
Luxembourg	12.8	4.3	17.0	53.6	8.5	3.8
Malta	17.1	17.5	4.9	41.6	13.1	5.8
Netherlands	3.9	16.6	16.4	18.3	39.8	5.0
Poland	22.7	20.1	39.4	8.2	9.6	0.0
Portugal	20.2	30.9	29.3	13.4	6.2	0.0
Romania	:	:	:	:	:	:
Slovakia	17.3	24.9	52.3	5.3	0.0	0.2
Slovenia	16.4	29.7	20.4	21.9	7.9	3.6
Spain	22.5	22.4	26.0	19.4	9.2	0.5
Sweden	3.5	9.2	14.2	31.5	19.0	22.7
United Kingdom	12.7	5.5	27.0	26.1	23.2	5.5
EU28	12.1	17.6	23.1	24.6	18.0	4.5

**Note:** HC230: Affordability of professional home care services. 1. With great difficulty, 2. With difficulty, 3. With some difficulty, 4. Fairly easily, 5. Easily, 6. Very easily. Level of difficulty experienced by households in covering professional home care services costs. Costs other than for professional home care, such as costs of equipment used for physiotherapy for example, are excluded. Only users who pay for home care services were asked about affordability.

**Source:** EU-SILC 2016 Module on Access to Services

## Quality of formal long-term care services

### Overall quality ratings

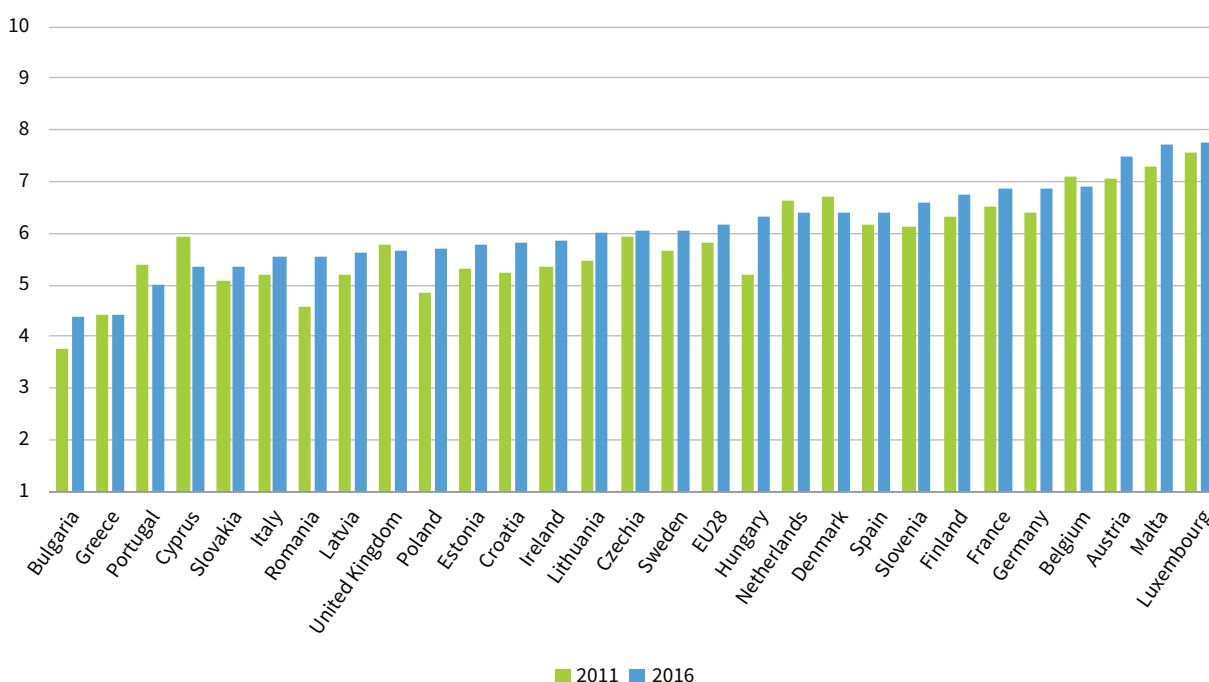
All EQLS respondents have been asked to rate the quality of long-term care services in their Member State from 1 (very poor quality) to 10 (very high quality). The EU28 average of the overall quality ratings given to long-term care services was 6.2 in 2016. This is a higher rating than those given to, for example, social housing (5.6) and the state pension system (5.0), but lower than, childcare, the education system and health services (all three rated 6.7). Service users tend to give higher overall ratings to the quality of services in the country than the rest of the population (Eurofound, 2017b). Therefore, one reason for the differences in the overall ratings of these services is the percentage of the population that use each service.

If we compare the ratings given to these seven services within each country, long-term care services received the lowest rating in Finland and the second-lowest rating in Denmark, Estonia, the Netherlands and Portugal. As shown in Figure 11, the highest (all above 7.0) overall scores for long-term care in 2016 were in Austria, Malta and Luxembourg (7.7, the highest in the EU). The lowest ratings (all below 5.0) were found in Portugal, Greece and Bulgaria (4.3, the lowest in

the EU). The difference between the highest and lowest rating of long-term care services (that is the range) in the EU in 2016 was 3.4 points, on a scale of 1–10. This is a wider range than for other services, similar to the differences in the ratings of healthcare; the variability of ratings is higher only in the case of views on quality of the state pension system (5.3 points). The difference between the ratings of the highest and lowest scoring Member State for long-term care services has nevertheless decreased since 2011 (3.8 points).

The EU average rating of long-term care quality has increased from 5.8 in 2011 to 6.2 in 2016. While the EU average of overall ratings has increased for all services during this period, the increases were higher in the case of the education system and childcare services. At Member State level, the biggest increases (that is over 15%) in overall ratings between 2016 and 2011 were in Bulgaria, Poland, Romania and Hungary (21%). These increases were reflected in the ranking of Member State, with Hungary experiencing the biggest climb in the ranking of countries by its overall quality ratings (from 21st in 2012 to 12th in 2016). Only six countries experienced a decrease in the overall ratings in 2016 compared with 2011, with the most prominent decrease taking place in Cyprus (-10%), which went from being the 13th country in the EU in the overall quality ranking to the 25th in 2016.

Figure 11: Overall quality ratings of long-term care services, EU28



**Note:** Ratings are given by all respondents, not just service users.  
**Source:** EQLS 2016 (Q58e)

**Table 7: Quality ratings by type of service used and funding, EU28**

	Free of charge /100% funded	Partially funded	Fully paid by the user	Total (all types of funding)
Respondent – nursing care services at your home	7.0	6.6	5.6	6.6
Someone close to you – nursing care services at this person's home	6.5	6.2	5.3	6.7
Respondent – home help or personal care services at your home	7.1	6.6	6.4	6.9
Someone close to you – home help or personal care services in this person's home	6.5	5.9	5.6	5.8
Respondent – residential care or nursing home	6.8	6.5	6.6	6.8
Someone close to you – residential care or nursing home	6.7	6.1	5.8	6.2

**Note:** Ratings are on a scale of 1–10, where 1 indicates lowest quality and 10 indicates highest quality. The ratings refer to the type of long-term care service that has been used most in the last 12 months (Q71, Q72). The 'total' column refers all respondents regardless of the type of funding.

**Source:** EQLS 2016 (Q58e, Q69, Q70)

Those who used the services themselves or someone close to them did give an overall rating of long-term care of 6.4. Non-users gave an overall rating of 6.1. Those who used the services themselves directly gave a rating of 6.8. Those who had someone close use the services gave a rating of 6.2. At the EU level, the analysis of variance shows that the differences in the general quality ratings given by the use or non-use of specific long-term care services is significant only in the case of home help and personal care services, with only non-use or direct use making a difference in this case.

If we look at the overall quality ratings given by those who used the services themselves directly or by those who had someone close use them, we can see a significant difference between people using services with different types of funding. Those who used services free of charge or 100% funded gave higher overall ratings (6.7) than those paying partially (6.3) for

services, with those having to pay in full giving the lowest overall quality ratings (5.9). This difference takes place for all types of long-term care services and for both types of users (that is, respondents using the services directly themselves or someone close to them using the services), except in the case of respondents using nursing homes themselves (see Table 7).

The overall quality ratings differ very little by gender, age, income group, employment status or education level of respondents. Table 8 charts the characteristics of service users where some differences were found (not controlled for by other factors). Some differences in the overall ratings can be seen between those employed and retired, those severely limited in their daily activities and according to level of deprivation. People in small and medium towns give somewhat higher ratings than those in cities or countryside (these differences are statistically significant).

Table 8: Long-term care quality ratings by respondent characteristics, EU28

		Quality of long-term care services (overall rating)	Long-term care: All people are treated equally in these services in my area	Long-term care: Absence of corruption in these services in my area
Area where respondent lives	Open countryside	5.9	7.2	8.2
	Village/small town	6.0	7.3	7.9
	Medium or large town	6.0	7.2	7.7
	City or city suburb	5.9	6.9	7.6
Limitation in daily activities by a physical or mental health problem, illness or disability	Yes, severely	5.8	6.9	7.6
	No	6.0	7.2	8.2
Employment status	Employed	5.9	7.1	7.7
	Retired	6.2	7.3	8.0
Deprivation (number of items not afforded) *	0	6.3	7.3	8.1
	1	5.9	7.1	7.7
	2	5.7	6.9	7.2
	3	5.5	6.7	7.3
	4	5.5	6.6	7.0
	5	5.1	6.5	6.5
	6	5.1	6.6	6.8

**Note:** \* The items included in the deprivation section are the following: keeping your home adequately warm; paying for a week's annual holiday away from home (not staying with relatives); replacing any worn-out furniture; a meal with meat, chicken or fish every second day if you want it; buying new, rather than second-hand, clothes; having friends or family for a drink or meal at least once a month (Q89).  
**Source:** EQLS 2016 (Q58e, Q75a,b)

## Perceived fairness – equal treatment and corruption

On average in the EU28, long-term care services were rated 7.1 in terms of equal treatment, which is the lowest score of all services for which this information is requested. Absence of corruption scored 7.8, which indicates that corruption is also perceived to be more widespread than in the other five services (see Table 1 in Introduction). Non-users gave equal treatment a score of 7.1, whereas users gave a rating of 7.3. Those who used the services themselves gave a rating of 7.6, whereas indirect users gave a lower rating (7.1) than non-users. The same is the case with the perception of corruption, with non-users giving a rating of 6.7 and direct and indirect users giving a score of 7.1. It is clear that, both in home and residential care, those using the services free of charge believe that services treat people more fairly than users who need to make some type of payment.

Patterns are more diverse at country level, with users in several countries perceiving less equal treatment and more corruption in long-term care services in their area than non-users (see Table 9). In Estonia and Italy,

for example, users report less equal treatment than non-users. In Italy, service users perceived more corruption than non-users. Finland, Denmark and Sweden were the countries in which corruption was perceived to be less widespread in terms of average scores as well as regarding the share of respondents who completely disagreed with the statement 'Corruption is common in these services in my area'.

Services were perceived to be fairer and less corrupt in rural than in urban areas (see Table 8). Retired people perceive less corruption and more equal treatment than people in employment. Those experiencing more material deprivation find services in the area less equal and more corrupt than those who are better off.

Equal treatment has a weak positive linear relationship with general quality ratings and also with the quality of the facilities and the personal attention given (Pearson's  $r = 0.4$ ). There is also a weak negative linear relationship with perceived corruption (Pearson's  $r = -0.4$ ). Lastly, there is a moderate linear relationship (Pearson's  $r = 0.5$ ) with being informed and consulted about care and with the expertise and professionalism of staff.

Table 9: Perceptions of fairness in long-term care services, by Member State, EU28

	Equal treatment			Absence of corruption		
	Non-user	User	Total	Non-user	User	Total
Austria	7.5	7.7	7.5	8.0	7.8	8.0
Belgium	7.2	7.5	7.3	8.0	8.3	8.0
Bulgaria*	7.5	7.6	7.5	7.4	6.6	7.3
Croatia	6.3	6.6	6.3	6.5	7.0	6.5
Cyprus	6.1	5.7	6.0	6.2	6.1	6.2
Czechia	6.5	7.0	6.5	6.3	5.9	6.3
Denmark	8.6	8.4	8.5	9.7	9.7	9.7
Estonia	7.8	6.8	7.7	8.2	7.8	8.1
Finland	7.3	7.6	7.4	9.0	9.0	9.0
France	7.8	7.8	7.8	8.7	9.0	8.8
Germany	7.2	7.2	7.2	8.2	8.3	8.2
Greece	6.3	5.9	6.3	6.1	6.1	6.1
Hungary	7.0	7.0	7.0	6.0	5.5	6.0
Ireland	7.5	7.5	7.5	7.9	7.7	7.9
Italy	6.8	5.8	6.7	7.6	6.2	7.4
Latvia*	7.2	7.5	7.2	8.1	8.4	8.1
Lithuania**	6.6	6.2	6.6	6.0	5.9	6.0
Luxembourg	7.3	8.0	7.5	8.5	8.9	8.6
Malta	8.2	8.1	8.2	7.7	7.9	7.7
Netherlands	7.3	7.5	7.4	8.9	8.6	8.8
Poland**	7.1	7.7	7.2	6.9	7.5	6.9
Portugal**	6.9	6.6	6.9	7.4	7.0	7.4
Romania**	6.5	7.9	6.6	5.4	5.7	5.5
Slovakia**	6.6	6.0	6.6	6.7	6.0	6.6
Slovenia	6.9	7.0	6.9	7.1	7.2	7.1
Spain*	7.5	8.2	7.6	8.0	8.5	8.0
Sweden	8.0	8.3	8.1	9.5	9.6	9.6
United Kingdom	6.6	6.2	6.6	8.1	7.6	8.0
EU28	7.1	7.3	7.1	7.7	8.1	7.8

**Note:** Countries with one asterisk had an unweighted count for service users below 50 in one aspect of perceived fairness. Countries with two asterisks had an unweighted count for service users below 50 in both aspects. Users comprise both respondents themselves as well as someone close to them.

**Source:** EQLS 2016 (Q75)

### User satisfaction with specific quality aspects

Direct and indirect users were asked to express their satisfaction with the main type of long-term care use in the last 12 months. Users of long-term care services in the EU28 were less satisfied with all aspects of structural and process quality included in the EQLS than users of other services (Table 1 in Introduction). The lowest level of user satisfaction was with being informed or consulted about long-term care (7.3). Overall, those who used home care services were more satisfied than residential care users.

Respondents who used home help or personal care services at home themselves as the main type of long-term care in the last 12 months rated the specific quality aspects higher (an average of 7.7 in the four dimensions of user satisfaction) compared to users of nursing services at home (7.6) or residential care/nursing homes (6.6). However, when it was someone close making use of home help or personal care services at home, satisfaction was actually lower (6.6) than in the case of nursing care services at home (7.5) or residential care/nursing homes (7.0). When it comes to funding, those who used services free of

charge were more satisfied than those who had to pay partially or fully for services. This can be explained by different expectations of the service received, but also by differences in the type of service provider and/or having quality criteria and monitoring associated with funding. Even though full payment is likely to be linked to private for-profit service provision, it is important to acknowledge the differences in eligibility criteria for funding across countries and that findings about the differences in quality between public and private providers are inconclusive (Eurofound, 2017d).

The aspects of user satisfaction that are related to staff (that is expertise and professionalism of staff, personal

attention given and being informed or consulted about care) correlate strongly with one another (Pearson's  $r > 0.8$ ). Regarding the quality of the facilities, the linear relationship with the other aspects of user satisfaction is weaker. This close relation between the different aspects of user satisfaction is reflected in the ratings at Member State level. Table 10 shows the user satisfaction ratings in all Member States, ranked by the average of all four aspects included in the EQLS. The highest user satisfaction across quality dimensions on average was in Malta, Romania and Ireland, whereas Cyprus had the lowest user satisfaction ratings in all dimensions.

**Table 10: User satisfaction with aspects of care provision in long-term care services, by Member State, EU28**

	Quality of the facilities	Expertise and professionalism of staff	Personal attention given	Being informed or consulted about care	Average user satisfaction
Malta	8.4	8.4	8.6	8.7	8.5
Romania	8.7	8.5	8.2	8.7	8.5
Ireland	8.7	8.5	8.2	8.2	8.4
Poland	8.3	8.2	8.2	8.2	8.2
Slovenia	8.2	8.3	8.1	8.1	8.2
Spain	7.7	8.2	8.3	8.2	8.1
Finland	8.2	8.1	7.9	8.0	8.1
Estonia	7.9	7.8	7.9	8.4	8.0
France	7.6	7.8	7.9	7.5	7.7
Denmark	8.7	7.7	7.5	6.8	7.7
Belgium	7.7	7.7	7.7	7.6	7.7
Germany	7.9	7.7	7.6	7.5	7.7
Hungary	7.5	7.7	7.4	8.0	7.7
Sweden	8.0	7.5	7.4	7.5	7.6
Luxembourg	8.2	7.5	7.3	7.3	7.6
Austria	7.5	7.7	7.4	7.6	7.6
Slovakia	7.8	7.4	7.3	7.7	7.5
Netherlands	7.5	7.4	7.4	7.3	7.4
Latvia	7.5	7.5	7.2	7.3	7.4
Croatia	6.9	7.4	7.5	7.3	7.3
Lithuania	7.8	7.1	7.1	7.2	7.3
Portugal	6.6	7.4	7.3	6.8	7.0
United Kingdom	6.7	6.9	6.9	7.0	6.9
Czechia	7.2	6.5	6.2	6.7	6.6
Greece	6.1	6.6	6.7	6.7	6.5
Bulgaria	6.4	6.0	7.1	6.4	6.5
Italy	6.1	6.5	6.4	6.2	6.3
Cyprus	5.3	5.6	5.7	5.6	5.5
EU28	7.4	7.5	7.4	7.3	7.4

**Notes:** Users comprise both respondents themselves as well as someone close to them. Average of four quality dimensions has been calculated at an individual level.

**Source:** EQLS 2016 (Q73)



While the overall quality ratings of long-term care services in each country vary little across socioeconomic groups, these differences are more marked in the case of user satisfaction. As stated in the EQLS 2016 overview report, users aged 65 and over are more satisfied than younger users (Eurofound, 2017b). This could possibly be due to the fact that these two age groups receive different types of long-term care services, but also to differences between generations in their expectations. The EQLS overview report also indicates that users in the highest income quartile are less satisfied than users with lower income, possibly due to higher expectations. In addition to these differences, those with lower secondary education or below were more satisfied (7.8 on average of the four dimensions) than those with upper secondary or post-secondary education (7.2) or tertiary education (7.3).

## Conclusions

### Use of long-term care services

The proportion of service users who do not experience any difficulties at all in accessing long-term care services due to cost is 63%, which is fairly high in comparison with other services. The differences across income quartiles in the extent to which cost constituted a difficulty is smaller than in the case of other services analysed in this report. Approximately 40% of those in the lowest income quartile experienced some level of difficulty in accessing long-term care services due to cost, whereas for the top income quartile the percentage is approximately 30%. It is also worthwhile noting that the share of respondents in the third income quartile experiencing difficulties is higher than in the case of those in the second-lowest income quartile. The differences in the take-up of 100%-funded or free-of-charge services by each income group largely explains these findings. Given the context of increased private provision (Eurofound, 2017d; Spasova et al, 2018) and the fact that the foreseen increases in public expenditure in long-term care will most likely lead to further cost containment measures, it is important to acknowledge the impact that cuts in public funding could have on equal access to services by different income groups. This is critical for those in the lowest income quartile, but is also an issue for the third income quartile, some of whom may have too high an income to be eligible for free services but are not affluent enough to afford services without difficulties. The fact that this group seems to be caught in a 'twilight zone' when it comes to accessing health and long-term care services is something that could be taken into account in future CSRs dealing with the accessibility of these services.

Whereas most sources of quantitative information do not disaggregate different types of home care, the EQLS provides data about nursing care services at home and about home help or personal care services at home. As these two services are managed by different providers and/or departments in many Member States, this differentiation potentially allows for improving the monitoring and detection of issues worth pursuing in policy reforms. However, the small number of users in many Member States as captured by this survey makes it necessary either to combine both types of services when analysing data or to study countries with more users. Some of the issues that emerge at the EU28 level are the differences in the share of services that are free of charge and the differences in the quality ratings given by users and non-users of home help. As in the case of other services included in this report, there is a difference in the overall quality ratings given by those who use the service (either themselves directly or indirectly through someone close to them) and those who do not. These differences are significant in the case of use of home help and personal care services by respondents themselves, who give a higher overall rating to long-term care (6.9) than other service users and those that do not use any type of long-term care service (6.1).

### Access

A particular source of concern is the fact that long-term care services are perceived to be more corrupt and treat people less equally than in the case of other services. The lack of perceived fairness is more widespread than in the case of healthcare services overall. Whereas corruption in healthcare is an area that has been researched extensively, there is less information about this problem in the case of long-term care. The Joint report on health care and long-term care systems and fiscal sustainability (European Commission, 2016) makes reference to corruption in healthcare systems, but it does not deal with it in the case of long-term care – something that could perhaps be addressed in the future. The data about corruption gathered in the EQLS goes beyond bribery to include other forms of abuse of position, power or authority in services. Further research could explore which unfair practices are most prevalent. For example, the updated study on corruption in the healthcare sector (European Commission, 2017c) includes one case of misuse of funds allocated for the establishment and operation of a nursing home in Romania. Given that transparency is one of the key principles of the voluntary European Quality Framework for long-term care services, any monitoring of its implementation could provide further information about the most problematic issues for ensuring fair and transparent access to long-term care.

## Quality

The increase in the overall quality ratings of long-term care services since 2011 is greater than in the case of other public services included in the EQLS. However, caution is advised in interpreting what it means: there appears to have been a general post-crisis rise in ratings given to health, care, and education services which includes the views of the general population (both users and non-users). Also, in 2011, 44% of the EQLS respondents reported that poor quality of care made it difficult for them or someone close to them to use long-term care services (Eurofound, 2013b). This survey question has subsequently been replaced with questions to service users about specific quality dimensions in 2016, and the responses show that ratings given by the users to specific quality aspects are in fact lower than in the case of all other health, education and social services included in the EQLS.

The fact that those using services free of charge were more satisfied than users making some type of payment deserves further research at the national level to identify whether this is caused by having different service providers. Research into differences in the quality of services provided in public and private care homes so far was inconclusive (Eurofound, 2017d). However, given that there is a long-standing trend towards the marketisation of long-term care services (Eurofound, 2017d; European Commission, 2018a), the findings from the EQLS suggest that this could have implications for the perceived quality of services.

User satisfaction is higher for home care than for nursing homes or residential care centres, especially when it comes to the personal attention given and being informed or consulted about care. This finding supports the emphasis in the European Pillar of Social Rights on home care service provision. It seems to indicate that home care services provide better opportunities for the co-production of user-centred services, but could also

be explained by the fact that users of nursing homes may be in poorer general health and, being older, user satisfaction is thus influenced by the level of need. Most of the aspects of user satisfaction included in the survey are related to interactions between staff and service users. Even though it is difficult to establish a clear link between the working conditions of staff and user satisfaction, any shortages in qualified staff are likely to decrease the quality of care.

The 2017 *European Jobs Monitor* shows that jobs in health and social care in care homes were among the top 10 fastest growing in 2016, with an average annual growth rate of 4.5% in the case of healthcare and 3.1% per annum in the case of personal care. In terms of employment composition, in both types of jobs, over 80% of the workforce are women and around one-fifth of workers are aged over 55. The wages of both types of health and care jobs are on the second-lowest quintile for pay. This shows that the rising demand for long-term care services is being met in the residential care sector by an ageing workforce almost exclusively comprising women in jobs that are badly paid (Eurofound, 2017e). A similar situation can be seen in the case of home care services, with some Member States mitigating the situation by recruiting more men and young people to this sector, and improving the situation of current employees to optimise their potential and to retain them in the sector (Genet et al, 2012; Eurofound, 2013c). Nevertheless, jobs in the long-term care sector are still perceived negatively and as offering precarious working conditions (Spasova et al, 2018). In Germany and Sweden for example, 40–55% of long-term care workers perceive a worsening of the conditions in which they can meet the care needs of service users (Theobald, 2018). Even if the impact of working conditions of carers on user satisfaction of care recipients still needs more research, it is important to recognise that poor quality of services represents a barrier for take-up and effective use of long-term services.

# 3 | Childcare

## Introduction

### EU policy context

Childcare services have been on the EU policy agenda for a long time. In the past, a focus on labour market outcomes prevailed and availability of childcare places was a primary concern. For example, the Council Recommendation of 31 March 1992 on childcare emphasises the importance of these services for the reconciliation of work and family life. The importance of childcare for the improvement of work–life balance for working parents continues to be highlighted in recent policy documents (for example, the 2017 Employment Guideline no.6 and several of the CSRs issued in 2018). In addition, over the last decade, there has also been an increasing emphasis on the quality of the services in order to reap the benefits of what early childhood education and care (ECEC) can provide to society in the long term. Social policy initiatives in line with the social investment approach make reference to positive impacts of high-quality ECEC. This includes an equitable distribution of welfare (SPC, 2017), as well as a way to promote the social inclusion of disadvantaged children (European Commission, 2013). As EU targets and benchmarks regarding enrolment are being met slowly over time, there have been recent calls to focus more on other aspects of service provision, including quality (European Commission, 2018b).

This focus on quality is also reflected in the European Pillar of Social Rights signed in 2017. The first principle in the chapter on social protection and inclusion deals with childcare and support to children and includes the statement ‘Children have the right to affordable early childhood education and care of good quality’. Several activities in the framework of the social open method of coordination have also dealt with the quality of services. This includes, for example, the peer reviews in social protection and social inclusion on ‘Provision of quality early childcare services’ (European Commission, 2015c) or ‘Furthering quality and flexibility of Early Childhood Education and Care’ (European Commission, 2018g), which were intended to promote the exchange of experiences between Member States.

The growing emphasis on quality is also reflected in the European Semester process. The 2018 Annual Growth Survey mentions childcare as one of the services that should be ‘affordable, accessible and [of] quality [...] to promote work–life balance’ (European Commission, 2017a, p. 6). As in other areas dealt with in the European Semester, the number of countries that have received CSRs about childcare has markedly declined over the last few years: in 2014, 10 Member States received CSRs dealing with or mentioning ECEC/childcare; 7 did in 2015, 6 in 2016, 4 in 2017 and 4 in 2018 (see Box 4). This decrease in the number of recommendations over time reflects the improvements in service provision achieved through policy reforms, as well as the Commission’s decision to prioritise those areas where action is needed the most (European Commission, 2017e).

### Box 4: Country-specific recommendations in 2018 from the European Commission about ECEC/childcare

Ireland: ‘Ensure the timely and effective implementation of the National Development Plan, including in terms of [...] affordable quality childcare’

Italy: ‘Encourage labour market participation of women through a comprehensive strategy, rationalising family support policies and increasing the coverage of childcare facilities’

Poland: ‘Take steps to increase labour market participation, including by improving access to childcare’

Slovakia: ‘Foster women’s employment, especially by extending affordable, quality childcare. Improve the quality and inclusiveness of education, including by increasing the participation of Roma children in mainstream education from early childhood onwards’

An important milestone in the promotion of quality is the Council Recommendation on high quality early childhood education and care systems (European Commission, 2018e). It aims to support Member States in improving accessibility and quality and developing a shared understanding of quality and further cooperation. This proposal builds on the Quality Framework for early childhood education and care developed in 2014. The Council Recommendation emphasises that ‘policy measures and reforms need to give priority to quality considerations’ (Council of the European Union, 2019). The recommendation puts particular emphasis on workforce issues, curriculum development, monitoring and evaluation mechanisms. As part of the suggested measures, it proposes having updated European benchmarks or targets on ECEC service provision.

The staff working document accompanying the proposal lists the following benefits of participating in quality ECEC:

- early child development that has a positive impact on individuals’ future prospects
  - social and labour market outcomes
  - female labour market participation and gender equality
  - tackling child poverty and disadvantage and fostering social inclusion
- (European Commission, 2018e).

## EU initiatives in data collection and indicators

Until recently, most of the indicators used to monitor and inform EU policy initiatives focused on the availability of childcare places. This has been done primarily in relation to the Barcelona targets, agreed in 2002 and set for 2010, with the goal of providing childcare for at least 90% of children aged between 3 years and the mandatory school age and at least 33% for children aged younger than 3. The commitment was extended beyond 2010 in the European Pact for Gender Equality (2011–2020). The targets have been monitored since 2004 through EU-SILC. The EU-SILC data on access to formal childcare for children below the age of 3 also comprise part of the European Social Pillar Scoreboard used to compare Member States’ performance. The data regularly collected in EU-SILC were complemented in 2016 with an ad hoc module on access to services that includes several indicators about formal childcare services.<sup>12</sup>

In addition to these targets, the Education Council adopted in 2009 benchmarks as part of the Education and Training 2020 Strategic Framework for cooperation in education and training (ET 2020). The benchmark set for ECEC was that at least 95% of children aged between 4 years and the compulsory age for starting primary education should participate in ECEC by 2020. While the Barcelona targets refer to formal childcare and include care at day centres without educational content, the ET 2020 ECEC benchmark deals with programmes officially classified in formal education (Flisa et al, 2016). This benchmark is monitored through administrative data from the UNESCO OECD Eurostat joint data collection (UOE) (Eurostat, undated). The ET 2020 benchmark was achieved in 2016.

Ongoing work on EU-wide indicators reflects the increasing interest in quality. As part of the preparatory work leading to the proposal for the 2018 Council Recommendation, the Commission asked experts to complement the ECEC Quality Framework developed in 2014 with a set of indicators that can be used to monitor quality (European Commission, 2018e). Furthermore, one of the objectives of the SPC-ISG in 2018 was to develop a common methodology and policy indicators for measuring the quality of social services building on the voluntary European Quality Framework for social services (SPC, 2018c). The aim of this methodology is to help public authorities in Member States to develop quality assessments. Their preliminary mapping of existing monitoring frameworks and related indicators showed that ‘While there is generally information on expenditure and participation [...] indicators on access and quality are more limited in number’ (SPC, 2018d, p. 10).

## Definitions of the main indicators

‘Formal’ childcare in the EU-SILC 2016 ad hoc module comprises childcare at centre-based services and childcare at day-care centres. Childcare by a professional childminder at the child’s home or at the childminder’s home is considered to be ‘informal’ childcare. The EQLS aims to complement the activities and support the policy initiatives described in the previous subsections by providing information about the perceived quality of formal childcare services.

<sup>12</sup> For the list of variables in the 2016 ad hoc module, see European Commission (2015b).

In this chapter, the term ‘childcare’ is used to make reference to both formal and informal care provided by anyone other than the child’s parents or guardians. The following types of childcare arrangements were asked about in the EQLS:

1. childminding by child’s grandparent(s)
2. childminding by other household members or relatives, friends, neighbours or other informal arrangements, such as childminder without a contract
3. childminding with a formal agreement or contract
4. childcare facility (e.g. kindergarten, crèche, nursery, playgroup, day-care centre) or after-school care
5. other

Of the above, the first two items are considered to be informal childcare. Even though ‘other’ can refer both to formal and informal services, only items 3 and 4 are referred to in this chapter as formal childcare. Item 4 encompasses centre-based services for children below school age and after-school care, which is mostly used by children of school age. The term ‘early childhood education and care’ (ECEC) is used in this chapter to refer to the services in items 3 and 4 for children below school age (thus excluding after-school care).

Most studies and research on the quality of childcare are carried out from the perspective of researchers, with less attention being given to the viewpoint of children, their parents or childcare staff (Ceglowski and Bacigalupa, 2002). All respondents in the EQLS with children aged 12 or less were asked about childcare arrangements. The direct recipients of the care are children, but the available data analysed in this report are provided by adults in households with children aged 12 or under. Therefore, in the discussions that follow, ‘users’ refers to adults. In addition, perceptions about formal childcare services from non-users are also reported.

The aspects of quality included in the EQLS questionnaire cover structural and process quality and are based on quality frameworks such as the Key Principles of a Quality Framework for early childhood education and care, the voluntary European Quality

Framework for social services and the OECD Starting Strong Quality Toolbox. In addition, they also include new questions about equal treatment and corruption. Given that the user satisfaction questions are only answered by those whose youngest child has used childcare services in the last 12 months, the number of respondents in several Member States is low. This is not only a reflection of the actual use of services, but could also be due to underreporting caused by the stigma associated with some services (for example, out-of-school services in some countries; see Plantenga and Remery, 2013). The small subsample of respondents who used childcare represents a limitation for analysis that does not allow for breakdown by country in many aspects and therefore makes it difficult to go beyond descriptive analysis. Nevertheless, the results provide an overview of the perceived quality that is not available from other sources.

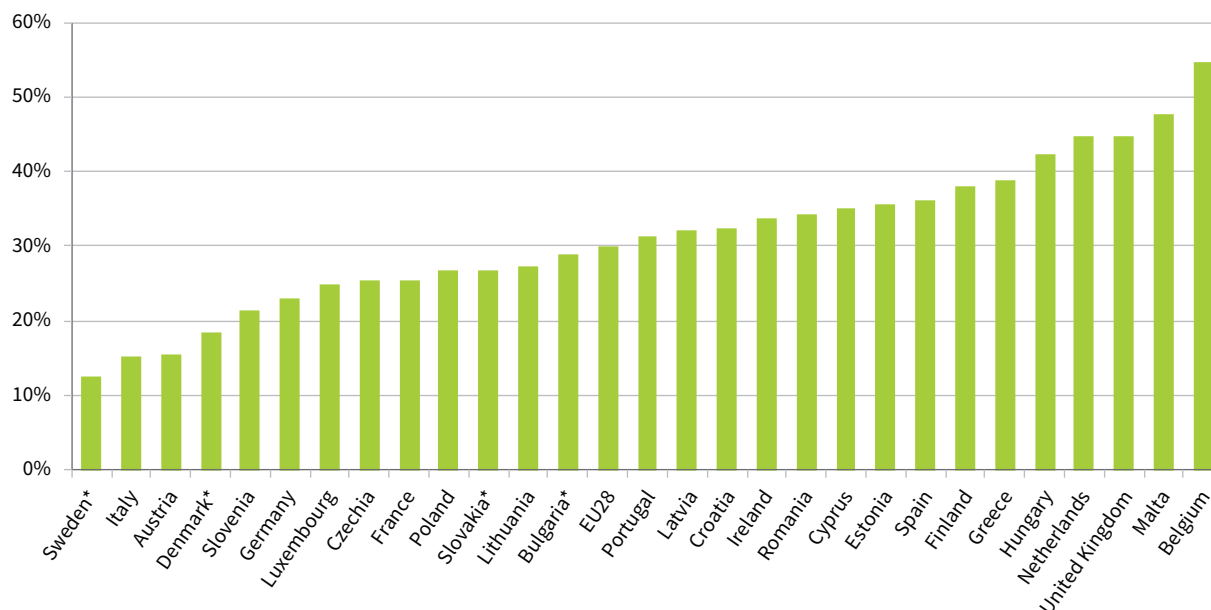
This chapter will first describe the use of childcare services, the barriers to use and the characteristics of services users. Subsequent sections will focus on general quality ratings given by all respondents to childcare services in their Member State and the perceived fairness of childcare services in their area. The final section deals with the satisfaction of users of formal childcare services with different aspects of service provision.

## Use of childcare services

This section describes the types of childcare services used across Member States. Approximately one-quarter (27%) of the EU28 respondents reported that there was at least one child aged 12 or under living in the same household.

In the EU as a whole, 70% of households with at least one child aged 12 or under used some type of childcare in the previous 12 months. This ranges from 88% of respondents with children of that age in Sweden to 45% in Belgium (see Figure 12). Conversely, in the EU28 overall, 30% of households with children aged 12 or under did not use any childcare services, which may mean that full care is provided by children’s parents or guardians.



**Figure 12: Proportion of respondents with at least one child aged 12 or under not using childcare, EU28**

**Notes:** Respondents not using any type of childcare other than provided by the child's parents or guardians as a proportion of the total number of people with at least one child aged 12 or under. Countries with an asterisk have a low number of unweighted counts (below 50).

**Source:** EQLS 2016 (Q77)

To gauge the prevailing types of childcare, interviewees were asked about the 'main type of childcare' – defined as the one in which the child spent most time – received by the youngest child outside of regular school hours (see Figure 13). In cases where a child was not receiving care at the time of interview but had received it in the previous 12 months, the last care type received was considered to be the main type. Although these data do not represent the entire range of care and only refer to the youngest child in the household, they give an idea of the types most widely used. On average, over half (58%) of households with a child aged 12 or under that used some type of childcare for the youngest child had an informal arrangement, with 36% of respondents getting help from the child's grandparents. Approximately one-fifth (22%) used childminding by other household members or relatives. Regarding formal childcare services, 29% of households with at least one child aged 12 or under used childcare facilities (kindergarten, crèche, nursery, playgroup, day-care centre or after-school care) and 5% reported using childminding with a formal agreement or contract.

The EQLS shows that, on average, care provided by grandparents was the main form of informal childcare in Europe. Only in Austria, Denmark and Ireland did more people report using childminding by household members or relatives other than grandparents. The share of users of these two types of informal care was more or less even in Finland, France, Germany, Lithuania, the Netherlands, Spain and the United Kingdom. Care provided by grandparents can give more opportunities for mothers to enter the labour market,

particularly in countries where formal childcare is less developed (Herlofson and Hagestad, 2012). However, a study by Aassve et al (2012) showed that care by grandparents played a role in the mother's decision to enter the labour market only in some countries. Similarly, demographic changes and increasing mobility across Europe suggest that this and some other types of informal care arrangements may be less available in the near future (European Commission, 2018a). There is also the issue of the care skills and parenting style of grandparents, with some countries offering grandparenting training courses (for example 'The adventure of being grandparents' in Austria; see Eurofound, 2012).

The EU-SILC indicator monitoring the Barcelona targets is split into 'use up to 30 hours' in a usual week and '30 hours or more' in a usual week as proportions of all children of the same age group. The data from the EQLS show that, in the EU28 on average, 16% of children under 3 used ECEC services (that is formal childminding or childcare centres) less than 30 hours a week (24% in the case of children aged 3 or over but not yet attending school) and 17% did so 30 hours a week or more (25% in the case of children aged 3 or over but not yet attending school).

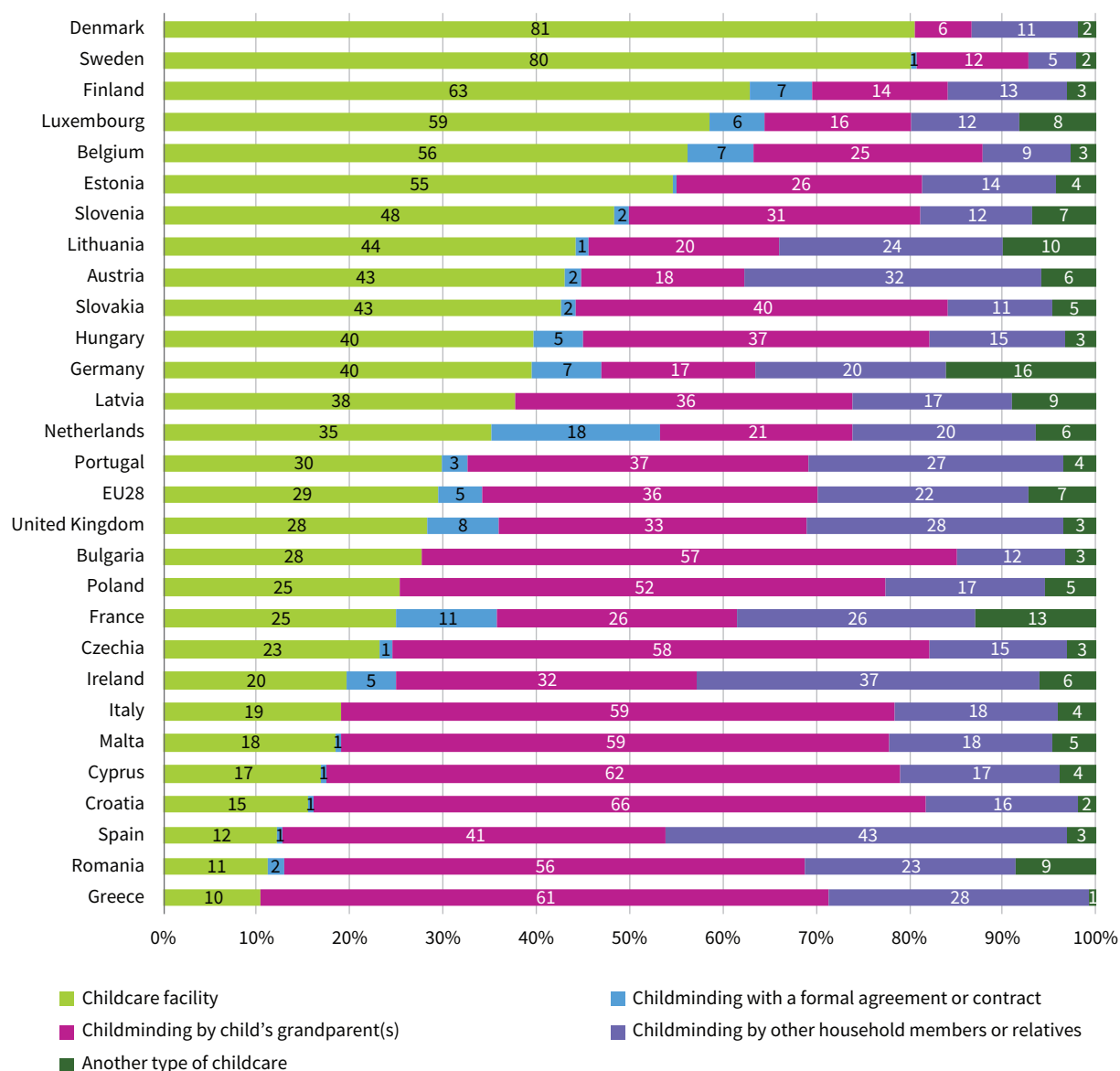
The highest use of formal childcare for the youngest child aged 12 or under was found in the Nordic countries, Benelux and Estonia. The highest share of users of formal childcare (over 60%) was found in Denmark and Sweden (both 81%), Finland (70%) and Luxembourg (64%). Conversely, less than one-fifth of



respondents in seven countries in southern Europe made use of ECEC, and the lowest rates of use of formal childcare for the youngest child aged 12 or under were in Romania and Spain (both 13%) and Greece (10%). These differences in use of formal childcare are mainly determined by the use of centre-based services such as kindergartens, crèches, nurseries, playgroups, day-care centres or after-school care. The use of formal

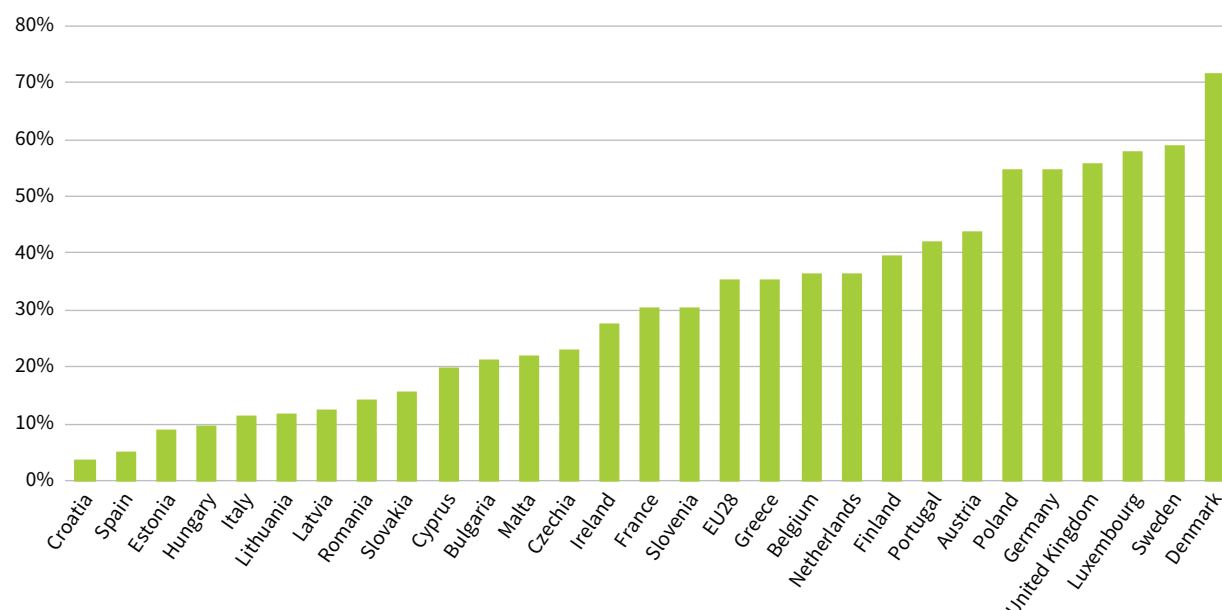
childminding with a formal agreement and contract was 5% or less in 21 Member States, with only the Netherlands (18%) and France (11%) reporting use over 10%. In the case of France the data at the national level show that formal childminders (*assistantes maternelles*) mainly care for children under 3 and that the use of these services is decreasing due to declining birth rates (CNAF, 2017).

**Figure 13: Main type of childcare received by youngest child, EU28**



**Note:** The data show prevailing types of care as reported for the youngest child in the household by those who use some type of childcare (provided by anyone other than the child's parents or guardians) for children aged 12 or under. It is not representative for all children and does not capture those who do not use any childcare beyond parents/guardians.

**Source:** EQLS 2016 (Q78)

**Figure 14: Proportion of children aged 12 or under in formal childcare, EU28**

Source: EU-SILC 2016 ad hoc module

### Formal childcare statistics in EU-SILC

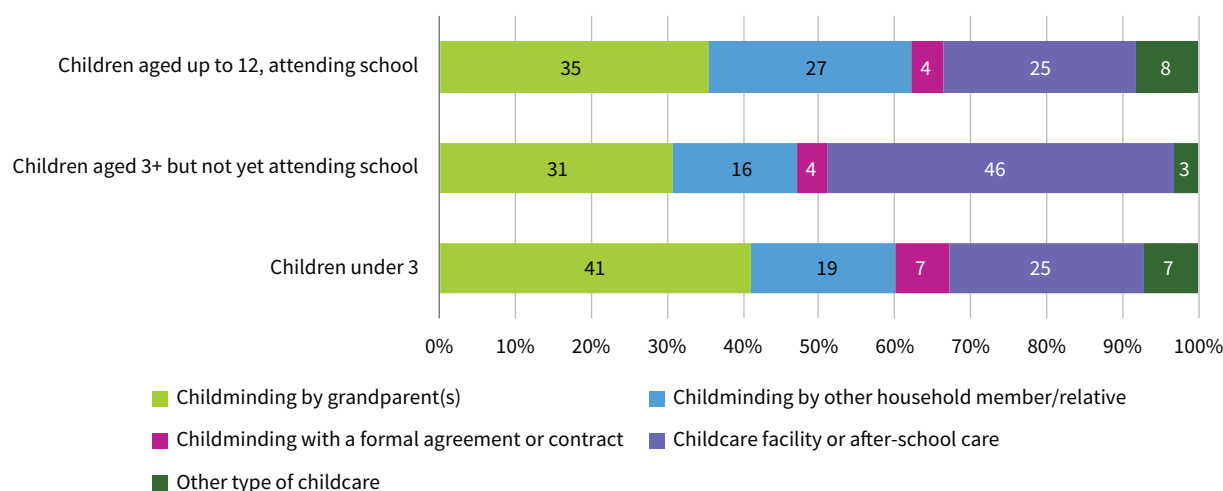
Figure 14 shows data on the use of formal childcare available from the EU-SILC. The differences in how the share of service users is calculated explain to some extent the discrepancies between the use of these services reported in the EQLS and the data from the EU-SILC 2016 ad hoc module. The data from the EU-SILC 2016 ad hoc module show the percentage of children usually cared for by formal arrangements in a usual week as a proportion of all children in the same age group. The data from the EQLS show the proportion of respondents using childcare facilities or after-school care for their youngest child in the last 12 months as a proportion of those making use of some type of formal or informal childcare (other than the child's parents or guardians). The differences can also be due to the definitions and specific services in each country that are included in the national questionnaires, in particular regarding the compulsory school category included in EU-SILC. Differences can also be due to the low number of counts in some countries.

### Use of childcare services by children of different age groups

The targets set at the EU level regarding the share of children using formal childcare focus both on children under 3 and children aged 3 up to school age. The European Commission's assessment of progress on the so-called Barcelona objectives using EU-SILC data states that the target of 33% of children under 3 in formal childcare was reached for the first time in 2016, with an EU average of 32.9% (European Commission, 2018f). However, the target of 90% of children from age 3 until mandatory school age has not been met yet; in 2016, 86.3% of children in that age group participated in formal childcare or attended preschool.

The EQLS provides additional information about the type of services used by different age groups (see Figure 15) and a striking difference emerges from the data regarding the use of grandparent care and childcare facilities between age groups. In the case of children aged 3 or over but not yet attending school, the use of formal childcare is higher. Slightly less than half of the respondents using some type of childcare for their youngest child aged 12 or under were at a childcare facility (kindergarten, crèche, nursery). In the two other age groups, childcare facilities were used by a quarter of respondents.

Figure 15: Main type of childcare received by age group, EU28



**Notes:** The data show prevailing types of care as reported for the youngest child aged 12 or under in households that use some type of childcare. Childcare facility includes kindergartens, crèches, nurseries, playgroups and day-care centres. Not all children are represented and the data do not capture households that do not use any childcare beyond that provided by parents/guardians.

**Source:** EQLS 2016 (Q78)

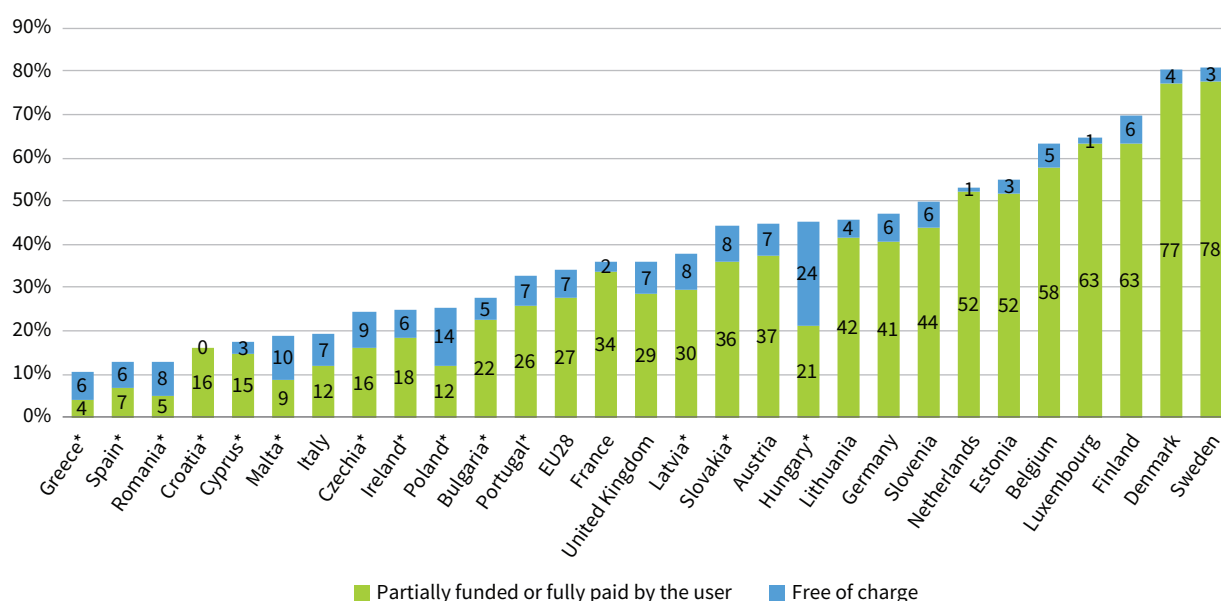
## Access to childcare services

### Funding and affordability

In the EU, on average, nearly three-quarters (74%) of EQLS respondents using formal childcare for their youngest child paid for this service: 39% paid fully and 35% paid partially, with the remaining 26% using the service free of charge or being 100% funded. The data from the EU-SILC 2016 ad hoc module shows a similar

split between funding types (respectively, 68% making a full or partial payment and 32% using services free at point of use for children aged 12 or under). Figure 16 shows the share of households with children aged 12 or under by type of funding for the formal childcare services received by the youngest child. The low number of responses due to the sensitive nature of the question and the sample size make it necessary to interpret the results for the countries with an asterisk with caution.

Figure 16: Proportion of childcare service users and type of funding, EU28



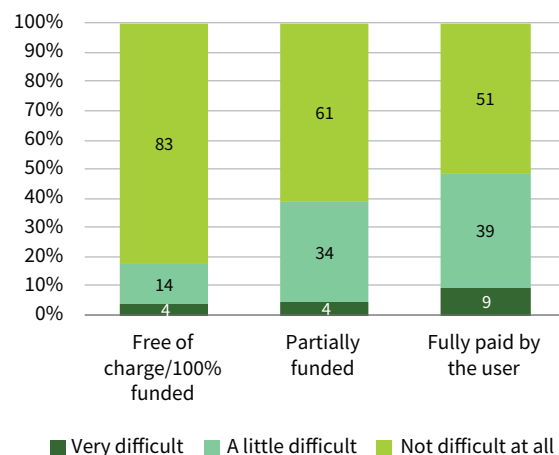
**Notes:** The data show the different types of funding for formal childcare (childminding and childcare facilities) expressed as a proportion of households with at least one child aged 12 or less that use childcare provided by someone other than the child's parents or guardians. Countries with an asterisk have a low number of unweighted counts (fewer than 50).

**Source:** EQLS 2016 (Q80)

These funding arrangements have implications for the affordability of services. The data from the EQLS in Figure 17 show that almost 40% of childcare users making partial payment and almost half (49%) of users paying fully for childcare experienced some level of difficulty affording services. The fact that some users of services that are free still reported difficulties due to cost could be on account of payments associated with certain activities: for example, trips for which parents are supposed to provide food and a small payment or the need to provide meals, clothing and activity materials; and so-called 'voluntary' contributions that are expected in some contexts.

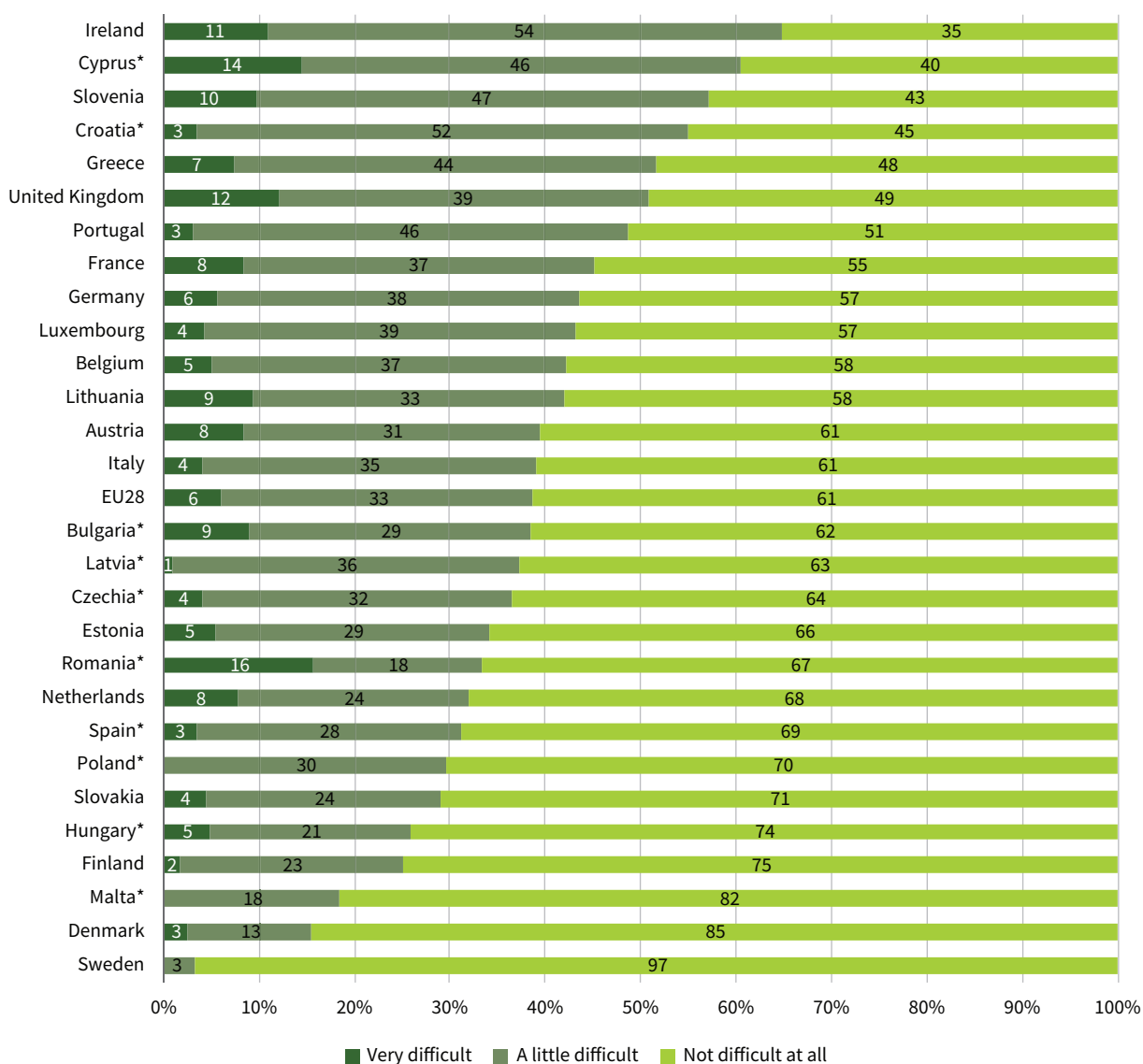
Figure 18 shows the extent to which the cost of formal childcare services made use of such services difficult. In the EU, on average, one-third of households that used formal childcare (formal childminding or childcare

**Figure 17: Cost as a difficulty in using formal childcare services by funding type, EU28**



Source: EQLS 2016 (Q82)

**Figure 18: Extent to which cost made it difficult to use formal childcare services, by Member State**



**Notes:** Percentage of users of formal childcare services (for their youngest child aged 12 or under). Countries with an asterisk have an unweighted count below 50.

**Source:** EQLS 2016 (Q82)

facilities) for the youngest child declared that cost made it 'a little difficult' to access. Cost did not make use difficult at all for 75% or more of service users in northern Europe and Malta (although the low number of counts in the latter means that findings should be interpreted with caution). In contrast, in Ireland, just one-third (35%) of respondents did not experience difficulties regarding costs, compared to 65% of service users finding the childcare services difficult to access due to cost – the highest percentage in Europe.

In general, the proportion of people with children using formal childcare services tends to be higher in those

countries where users reported less difficulties in using the services due to cost.

### Other access barriers

Given that the EU-SILC 2016 ad hoc module focuses on accessibility, the EQLS discontinued the accessibility questions used in 2011 in order to include more questions about perceived fairness and quality dimensions (covered in more detail below). Table 11 lists the main reasons for not making greater use of formal childcare according to the EU-SILC 2016 ad hoc module. On average in the EU, cost was the main barrier

**Table 11: Main reasons for not meeting needs for formal childcare services, EU28 (%)**

	Financial reasons	No places available	Opening hours not suitable	Distance	Quality of the services available not satisfactory	Other	No need
Austria	11.7	3.9	1.1	0.5	1.1	6.1	75.6
Belgium	7.9	2.1	1.1	0.0	0.4	6.9	81.6
Bulgaria	6.3	2.3	0.3	0.3	0.3	1.2	89.3
Croatia	4.4	1.7	0.0	0.0	0.0	1.6	92.3
Cyprus	39.9	0.7	0.8	2.4	2.0	1.1	53.1
Czechia	6.3	4.6	1.1	0.5	0.4	6.5	80.7
Denmark	0.7	0.4	1.6	0.4	0.2	2.9	93.9
Estonia	20.4	7.4	0.3	2.1	1.2	20.7	47.9
Finland	6.6	8.6	4.3	2.1	0.2	8.8	69.4
France	13.6	8.7	5.3	2.0	0.6	8.5	61.4
Germany	4.9	3.2	2.5	0.2	1.1	2.3	85.8
Greece	23.7	6.8	3.7	2.4	1.9	0.1	61.3
Hungary	18.7	1.7	2.0	1.4	0.7	7.1	68.3
Ireland	37.6	1.4	0.2	2.1	0.1	5.6	53.0
Italy	22.8	3.4	4.2	4.4	1.9	14.9	48.4
Latvia	24.8	15.6	2.9	5.4	2.9	9.0	39.4
Lithuania	29.6	2.3	0.9	9.0	0.4	12.6	45.1
Luxembourg	9.1	4.7	1.7	1.7	0.9	4.3	77.7
Malta	10.6	3.5	2.2	0.4	0.7	36.6	45.9
Netherlands	18.5	0.7	1.6	0.0	0.5	9.2	69.4
Poland	4.6	4.7	2.5	4.2	1.1	9.1	73.8
Portugal	14.2	2.5	1.9	1.8	0.4	3.4	75.8
Romania	30.9	2.6	0.3	6.7	0.0	7.8	51.7
Slovakia	29.5	3.7	3.4	6.2	1.3	14.8	41.1
Slovenia	7.7	4.7	1.3	1.8	0.3	6.8	77.3
Spain	51.8	2.1	3.9	1.3	0.2	28.4	12.3
Sweden	0.7	1.2	1.8	0.3	0.1	6.8	89.1
United Kingdom	25.9	2.6	1.3	0.6	0.4	5.7	63.5
EU28	16.2	3.9	2.5	1.5	0.7	7.4	67.8

**Note:** Figures represent the percentage of households with children aged 12 or under.

**Source:** EU-SILC 2016 ad hoc module (ilc\_ats04).

to access for 16% of households with children aged 12 or under, followed by lack of places available (4%), unsuitable opening hours (3%), distance (2%) and poor quality of the services available (1%) (Eurostat, 2018).

### Characteristics of service users

The EQLS asks about care provided by grandparents, which in some cases completely replaces informal care by other members of the family. Half of those declaring that they spend no time caring for or educating their children report using care by grandparents instead of other types of non-parental childcare, compared to approximately one-third of those who do spend time caring for or educating their children. The use of childcare facilities by those who spend no time caring for or educating their children was also much lower (16%), with at least 30% of those who do spend time caring for and educating their children making use of childcare centres. Those never caring for their children also faced more difficulties due to cost when it comes to using formal care services. A particularly interesting finding is that nearly half (45%) of the long-term unemployed (more than 12 months) who made use of childcare services resorted to childcare by grandparents, whereas only one-third of those employed (33%) or unemployed for less than 12 months (31%) used childcare by grandparents.

Past studies have led to different conclusions regarding the use and accessibility of services in urban and rural areas (European Commission et al, 2014; Ünver et al, 2018). The EQLS 2016 data, for example, show no clear urban–rural divide in the extent to which formal childcare is used, and whether cost constitutes a barrier. However, there is a clear difference between respondents with tertiary education and those with lower levels of education in the use of formal childcare: respondents with tertiary education made more use of formal childcare services than those with lower levels of education and made less use of informal care arrangements with grandparents or other relatives/household members. They constituted approximately half of the users of formal childcare services (45% in the case of childcare facilities and 52% in the case of childminding with a formal agreement or contract). They were also around one-third of the total users of childminding by grandparents (34% of the users of this type of arrangement) or by other household members/relatives (35%). Those with tertiary education were also more likely not to face any difficulties in use due to cost.

Regarding different income groups, the EQLS data show no clear difference in the use of childcare provided by grandparents, whereas in the case of childminding by other household members or relatives, higher-income groups made less use. Conversely, those with higher incomes made more use of both types of formal childcare services. Higher-income groups also faced fewer difficulties in use due to cost. Slightly over half of

those in the bottom income quartile did not have any difficulties in access due to cost, whereas two-thirds of respondents in the top income quartile said that they had no difficulties at all in accessing services due to cost. The low number of counts does not allow the characteristics of service users at the national level to be identified. Past research has shown that higher income households with children under 3 are more likely to use formal ECEC, but with no significant differences between income groups in Denmark, Iceland and Sweden (OECD, 2016).

## Quality of formal childcare services

This section looks at how Europeans perceive the quality of formal childcare services. All respondents were asked to rate the quality of several services (including childcare services) in their country on a scale of 1–10. Due to the general nature of phrasing ('childcare services'), the question may capture answers about all types of childcare services (this rating is also referred to below as 'overall quality rating'). The EQLS 2016 also included two questions about the fairness (in terms of equal treatment and corruption) of formal childcare services in the area and asked those using some type of formal childcare about their satisfaction with different quality aspects. The choice of quality dimensions included in the EQLS questionnaire was informed by the quality frameworks mentioned at the beginning of this chapter. The questions have been adapted from questionnaires in other surveys, such as the US NIH Office of Research Services (ORS) Child Care Survey and the Dutch Quality of Public Service 2010 survey (*SCP Kwaliteit publieke dienstverlening*).

The findings about general quality, user satisfaction and perceived fairness are described in the subsections below, analysing the links between them and with the findings about use and accessibility.

### Overall quality ratings

The overall ratings given by respondents to the quality of childcare in their Member State in 2016 were similar to those given to health, education and public transport and higher than ratings of long-term care, social housing and pensions (Eurofound, 2017b). Childcare receives the highest rating of all the services listed in the previous sentence in Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Malta, the Netherlands, Slovakia, Slovenia and Sweden. As in the case of healthcare, 33% of respondents in the EU28 gave a rating of 5 or below to childcare services in their country. The range (that is the difference between the maximum and minimum overall quality rating in EU Member States) has decreased since 2007. The five countries with the highest average ratings for childcare (Austria, Finland, Luxembourg, Malta and Sweden) have a score at least one point above the EU average (6.7). On the other



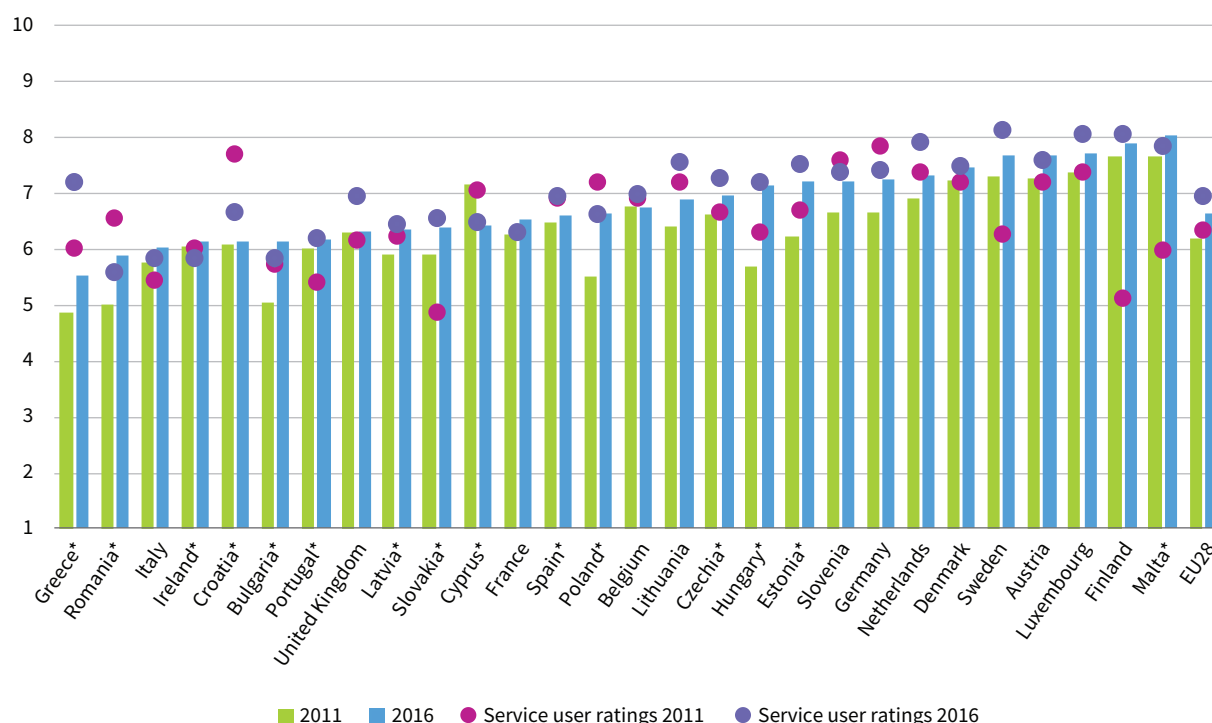
hand, the difference between the EU average and the five countries with the lowest ratings (Croatia, Greece, Ireland, Italy and Romania) is less than half a point, with no country having an average rating of 5 or below. The overall quality rating of childcare has increased almost half a point from the EU average in 2011 (6.2), with the highest increases in perceived quality in this period taking place in Bulgaria, Hungary and Poland. Only two countries (Belgium and Cyprus) experienced a decline in the ratings of general quality from 2011 to 2016.

The analysis of the EQLS 2011 showed that there is a correlation (with the exception of some outliers) between overall quality ratings and the intensity of service use, both when it comes to public services in general as well as in the specific case of childcare services (Eurofound, 2013b). This is likely to be because people using the services rate them on the basis of their own experience and relationship with the care provider rather than on general assumptions. Conversely, services that are generally perceived as being of poor quality may be used less (Eurofound, 2013b). Given that service users tend to give higher general ratings, the differences in the overall quality ratings across

countries can be affected to a certain extent by differences in the share of service users. In 2016, the EU average quality rating given only by service users is 7.0, compared to the 6.7 average for all respondents (Figure 19). The user rating is higher than the national average in many Member States (19), with Sweden having the highest user rating (8.1) and Romania the lowest (5.6) in 2016. The general quality rating by service users has also increased since 2011, from 6.4 to 7.0 on average in the EU. Increases during that period were largest (more than one point) in Greece, Slovakia, Sweden, Malta and Poland. It must also be noted that in several countries (those marked with asterisks in Figure 19) the number of respondents was low and therefore it is important to interpret the findings in combination with other sources of information.

There is a moderate positive linear relationship between the 2016 overall quality ratings with expenditure on ECEC services in kind (Eurofound, 2019, forthcoming), which is in line with the findings of the analysis of the EQLS 2011 (Eurofound, 2013b). The following sections describe some of the characteristics of services and respondents that influence the general quality ratings.

**Figure 19: Perceived general quality ratings for childcare services and ratings given by service users, 2011 and 2016, EU28**



**Notes:** Countries with an asterisk have an unweighted count of less than 50 for 2016 service user ratings. Service user ratings in 2016 are based on the answers of respondents using formal childcare services (Q78, 3, 4 or 5). User ratings for 2011 are based on a broader definition of users: respondents or someone else in the household who used or would have liked to use childcare services in the last 12 months (Q54a, 1).

**Source:** EQLS 2016 (Q58d)

## Quality ratings by income

The quality ratings given by all income groups in 2016 have increased in comparison with 2011 and 2007 (see Figure 20). Those in the bottom income quartile gave the lowest rating in 2016, and the gap between the bottom income quartile and other income groups has increased – with the difference becoming statistically significant.

People in the highest income quartile gave a slightly lower rating (6.6) than the middle income quartiles (6.7). This is in line with the pattern found in the EQLS 2011 (Eurofound, 2013b) and 2016 with regard to healthcare ratings, possibly reflecting higher expectations of services in the top income group.

**Figure 20: Childcare quality ratings by income quartile, EU28**



**Note:** Rating on a scale of 1–10, where 1 means very poor quality and 10 means very high quality.

**Source:** EQLS 2016 (Q58d)

## Accessibility, user satisfaction and general quality ratings

Quality frameworks such as the SPC's voluntary European Quality Framework for social services, the Key Principles of a Quality Framework for Early Childhood Education and Care and the OECD's Starting Strong Quality Toolbox consider accessibility as part of service quality. The evidence from the previous edition of the EQLS shows that general quality ratings indeed correlate with the accessibility of childcare services. In countries with lower levels of reported difficulties for using childcare, the overall quality ratings were higher

(Eurofound, 2013b). The EQLS 2016 data confirm that the overall quality rating of childcare services in countries is related to the affordability of services (both in the case of ratings by all respondents or those given by service users only). Higher overall quality ratings are associated with fewer difficulties in access due to cost. For example, Ireland – where cost makes accessing services difficult ('a little difficult' and 'very difficult') for the highest share of users in Europe – also ranks very low in the general quality of services (a rating of 5.9, 22nd in the EU). At the other end, Swedes report fewer difficulties due to cost than any other country and have the third-highest overall quality rating. It must be noted, though, that there is a very weak linear relationship at country level between the general quality ratings in the EQLS and the share of respondents from the EU-SILC 2016 that report affordability as the main reason for not making more use of formal childcare services (however, the limitations to comparability of the EQLS and EU-SILC measures of formal childcare must be kept in mind, as pointed out earlier). The same applies to all other barriers to use included in the EU-SILC ad hoc module; however, the access problems, namely the lack of available places and distance, have a weak negative linear relationship ( $r = -0.3$  in both cases). This is slightly different from the findings in the EQLS 2011, where the accessibility index comprising similar items<sup>13</sup> was strongly correlated to the general quality rating. The linear relationship between general quality and user satisfaction is significant, albeit weak (Pearson's  $r < 0.3$ ,  $p < 0.001$ ). The case is the same regarding perceived fairness, with equal treatment having a stronger positive linear relationship than all other quality aspects included in the EQLS ( $r = 0.39$ ,  $p < 0.001$ ).

## Perceived fairness – equal treatment and corruption

The discrimination of certain groups in accessing services has been covered in other surveys. For example, the UNDP/WB/EC regional Roma survey carried out in central and eastern Europe in 2011 included a question about whether Roma children are welcome in their kindergarten/preschool. The question in the EQLS deals with the perception of equal treatment of all people by the childcare services in the area. Corruption encompasses not only bribes, but also other forms of misuse of position or authority in services, such as favouring some families in the enrolment over others. While corruption in childcare services may not be perceived to be as widespread as in other services, this can be due to the fact it has not yet

<sup>13</sup> Cost, availability (for example, waiting lists, lack of services), access (for example because of distance or opening hours) and quality of care.

been researched extensively. All interviewees are asked to what extent they agree with the statements 'All people are treated equally in these services in my area' and 'Corruption is common in these services in my area'. Interviewees are asked to what extent they agree or disagree with these statements on a scale of 1–10. In this report, the scale of the second question has been reversed and interpreted as 'absence of corruption'. Higher scores thus indicate more equal treatment and absence of corruption.

Table 12 shows the perceived level of fairness of formal childcare services in the EU. The Nordic and Baltic countries and the Netherlands have the highest levels of perceived fairness. At the other end of the spectrum are countries from southern, central and eastern Europe. There is a wider gap between top and bottom countries in the level of perceived corruption (a difference of 3.7 points) than in the case of equal treatment. On average, there is a higher perception of absence of corruption than that of equal treatment.

**Table 12: Perceived fairness of formal childcare services, EU28**

	Users of formal care services		Users of informal care		No use of childcare services other than by parents or guardians		All respondents	
	Equal treatment	Absence of corruption	Equal treatment	Absence of corruption	Equal treatment	Absence of corruption	Equal treatment	Absence of corruption
Austria	8.9	8.7	8.1	8.6	8.2	9.3	8.2	8.5
Belgium	7.4	8.5	7.7	8.8	7.4	8.1	7.3	8.2
Bulgaria*	8.3	8.0	8.2	8.3	8.7	8.8	8.1	8.0
Croatia*	7.7	8.8	7.5	7.9	7.1	7.0	7.1	7.4
Cyprus*	8.7	7.8	7.7	7.0	7.8	6.8	7.4	7.1
Czechia*	8.1	9.0	8.6	8.4	8.6	9.5	8.0	8.8
Denmark	9.0	9.9	9.0	9.6	9.5	9.4	9.0	9.7
Estonia*	8.4	9.5	8.2	8.8	8.6	7.8	8.3	8.7
Finland*	8.0	7.7	7.0	7.5	6.8	6.9	7.0	7.2
France	7.9	7.8	7.6	8.0	7.7	8.4	7.6	8.2
Germany	8.7	9.4	8.4	9.6	8.6	9.5	8.3	9.4
Greece*	8.2	8.6	8.2	9.4	7.8	8.9	8.0	8.8
Hungary*	7.3	6.9	7.0	6.5	7.1	7.7	6.7	6.7
Ireland*	7.4	7.4	8.1	7.0	7.6	8.1	7.7	6.8
Italy	8.4	9.3	8.0	8.3	8.1	8.5	7.9	8.4
Latvia*	6.7	7.4	7.1	7.7	7.6	8.3	7.0	7.7
Lithuania*	8.2	8.3	7.3	7.1	8.6	7.4	7.9	7.1
Luxembourg*	8.3	9.1	7.5	8.6	7.7	8.6	7.6	8.8
Malta*	8.9	9.5	8.6	9.2	8.9	9.0	8.2	8.9
Netherlands	8.8	8.1	8.3	6.9	8.8	9.4	8.5	8.3
Poland	8.7	9.6	8.2	8.7	8.1	8.8	8.0	9.1
Portugal*	8.7	8.0	8.1	7.3	7.4	7.9	7.9	7.7
Romania*	8.1	7.8	8.0	8.1	5.9	7.0	7.5	8.0
Slovakia*	8.1	8.1	7.0	6.5	8.0	6.3	7.2	6.0
Slovenia*	9.0	9.8	9.1	9.8	8.7	9.4	8.8	9.7
Spain	8.1	8.0	7.9	8.0	7.7	7.9	7.8	7.8
Sweden	8.2	8.5	7.3	7.2	7.2	7.4	7.2	7.4
United Kingdom	7.9	9.0	7.3	8.8	7.3	8.5	7.2	8.6
EU28	8.2	8.7	7.7	8.1	7.7	8.4	7.7	8.2

**Notes:** Higher scores mean higher perception of equal treatment and absence of corruption. 'Formal' childcare comprises formal childminding and childcare facilities (Q78 3 and 4). 'Informal' childcare comprises childminding by child's grandparents and childminding by other household members or relatives, friends, neighbours or other informal arrangements, such as childminders without a contract (Q78 1 and 2). An asterisk means that the number of unweighted counts of formal childcare users is below 50.

**Source:** EQLS 2016 (Q83)

The fact that there is a significant moderate linear relationship between perceived equal treatment and corruption explains the small differences between the perceptions of equal treatment and corruption in Member States, which is less than 1 point in almost all countries.

The correlation between user satisfaction with the aspects of care provision and equal treatment is weak, and very weak in the case of corruption. There is a stronger (albeit still weak) correlation between equal treatment and perceived general quality. Furthermore, interviewees are not asked about the specific service that they are using, but about the perceived fairness of services in the area.

There are significant differences in how people using different childcare services perceive fairness. Those using informal childcare (whether parental or other informal childcare) are more likely than formal service users to perceive formal childcare services in their area as not treating people equally and being more corrupt, with those using informal care by grandparents having the lowest perception of equal treatment (7.7) and the lowest perception of lack of corruption (7.9). At the other end of the spectrum were respondents with children in childcare facilities, who gave the highest rating of equal treatment (8.4) and the highest rating for absence of corruption (8.8). One reason for these differences could be that those using informal childcare do so as a consequence of their perceived lack of fairness in formal childcare services (either experiencing its negative consequences or refraining from use). The fact that they are not in direct contact with formal childcare services means that these respondents judge fairness using other criteria; they may or may not have suffered directly from unfair treatment; however, they report what they consider to be characteristics of the service provision in their area generally.

## User satisfaction with aspects of care provision

Interviewees who used some type of formal childcare for their youngest child in the last 12 months were asked to rate on a scale of 1–10 (where 1 means very dissatisfied and 10 means very satisfied) how satisfied or dissatisfied they were with each of the following aspects:

- quality of the facilities (building, room, equipment)
- expertise and professionalism of staff/carers
- personal attention the child was given, including staff/carers' attitude and time devoted
- being informed or consulted about their child's care
- the curriculum and activities

## User satisfaction and characteristics of services

The aspects of quality included in the EQLS 2016 are the same across all services to allow for comparability. Users of formal childcare were more satisfied with all aspects than users of the health, education and care services included in the EQLS 2016 (see Table 13). Formal childminding services are considered to be more satisfactory than childcare centres, possibly reflecting more choice over the service provider. The high satisfaction with the personal attention given in formal childminding could reflect smaller group sizes in this care setting (European Commission, 2009). The large gap between users of formal childminding and users of childcare centres for children up to 12 years old in satisfaction with the curriculum and activities perhaps denotes the possibility of adapting activities to the specific needs of children.

As with other services analysed in this report, there is a highly significant positive correlation between all aspects of user satisfaction. The highest correlation can be found between being informed or consulted about

**Table 13: User satisfaction with health, education and care and education services, EU28**

Quality dimensions of respective public services	GP	Hospital	Long-term care	School	Formal childcare (all services)	Formal childminding	Childcare centres
Quality of the facilities	7.9	7.8	7.4	7.7	8.1	8.4	8.1
Expertise and professionalism of staff	8.0	7.9	7.5	7.7	8.2	8.4	8.2
Personal attention given	7.9	7.6	7.4	7.6	8.2	8.5	8.2
Being informed or consulted about care	7.8	7.6	7.3	7.6	8.1	8.4	8.0
The curriculum and activities				7.5	8.1	8.4	8.1

Source: EQLS 2016 (Q62, Q64, Q73, Q81, Q85)

the child's care and the personal attention the child was given (including staff/carers' attitude and time devoted) (Pearson's  $r = 0.834$ ). There is also a high correlation between being informed or consulted about the child's care and the satisfaction with the curriculum and activities (Pearson's  $r = 0.826$ ). The lowest correlation is between the satisfaction with the quality of the facilities and the satisfaction with the curriculum and activities (Pearson's  $r = 0.706$ ). The high correlation between different quality aspects is reflected in the similarity of ratings across dimensions in each Member State. However, Denmark is an exception to this, with one of the highest levels of satisfaction with the expertise and professionalism of staff/carers (8.6, 5th in the EU), but a very low level of satisfaction with being informed or consulted about childcare (7.0, 27th in the EU).

As noted in the previous section, there is a significant but weak correlation between user satisfaction and the general quality ratings (either rated by all respondents or only by service users). The average rating for the five dimensions of user satisfaction is displayed in Figure 21. While in Ireland the overall quality rating of childcare services in the country is one of the lowest in Europe, service users are the most satisfied in Europe in all aspects. Italy scores last in all five dimensions of user satisfaction, with the general quality rating also being very low in this case.

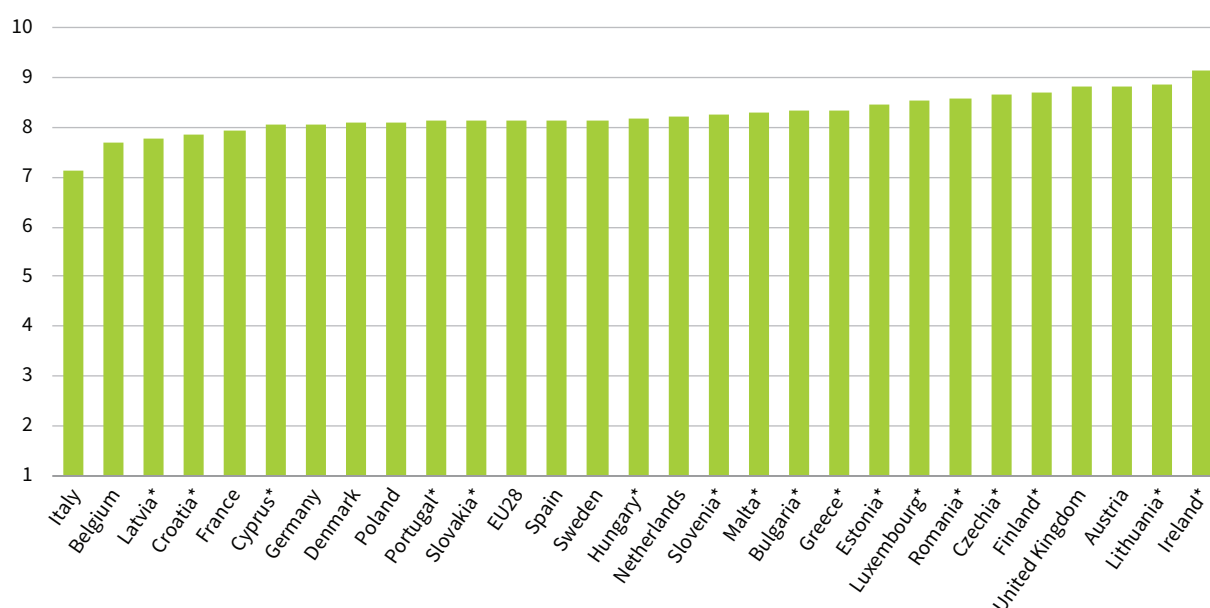
There is a significant but fairly weak ( $r \leq 0.4$ ) positive linear relationship between user satisfaction and the extent to which people are perceived to be treated equally in childcare services in the area. In several countries where user satisfaction is high, people are

perceived to be treated equally by the services in the area. Given that there is a weak relationship between both variables, we can also see that several countries deviate from this pattern. For example, the UK has high levels of user satisfaction but ranks very low (23rd in the EU) when it comes to equal treatment. There is also a significant but very weak ( $r \geq -0.75$ ) negative linear relationship between corruption and the different aspects of user satisfaction, meaning that higher user satisfaction correlates to a limited extent with less perceived corruption. Again, given the weak relationship between both variables, there are several countries deviating from this pattern. For example, Czechia and Lithuania are among the top six countries in the EU in terms of user satisfaction, but are among the top five countries where corruption is perceived to be more common.

As with the overall quality rating of childcare services in the country, there is no clear relationship between public expenditure and any of the aspects of user satisfaction. The low number of responses in several countries does not allow for further disaggregation of data by Member State.

The analysis at the EU28 level shows that service users with younger children are more satisfied with formal childcare. On average, parents with children under 3 in ECEC centres give user satisfaction ratings that are slightly higher on average (8.4) than those with children in centres aged 3 or over but not yet attending school (8.3). This is the case with all aspects of user satisfaction except the expertise and professionalism of staff/carers, where parents with older children are more satisfied.

**Figure 21: Average rating of the quality dimensions by users of formal childcare services, EU28**



**Note:** Average of the five dimensions of user satisfaction. Countries with an asterisk have a low number of respondents using the services (unweighted count below 50).

**Source:** EQLS 2016 (Q81)

It must be noted that in the EU group size is on average smaller for 0–3-year-olds and there is a higher staff–child ratio than for 4–6 year olds (European Commission, 2009). The low number of respondents does not allow for the breakdown of these age groups by Member State, which would allow satisfaction levels with centre-based services in ‘split’ and ‘unitary’ systems to be compared. In most Member States, centre-based services are provided in a split system, whereby younger children (usually up to 3 years old) are in a setting focused on care and older children are in early education services (European Commission et al, 2014). In unitary systems, all centre-based ECEC is organised and delivered in the same setting (European Commission et al, 2014). This system prevails in most Nordic and Baltic countries, Croatia and Slovenia. Satisfaction with centre-based services for children of school age up to 12 is slightly higher than the ratings of school services, but much lower than those given by parents with children below school age using childcare centres. While after-school care is grouped with other types of centre-based services, it is to be expected that children of school age will be using after-school care rather than kindergartens, crèches, nurseries, playgroups or day-care centres.

## Conclusions

### Use of childcare services

Even though the availability of formal childcare services has increased over the last decade (with the EU benchmark of at least 95% of children aged between 4 years and the compulsory age for starting primary education participating in ECEC being met for the first time in 2016), almost one-third of households with children aged 12 or under did not use any of the types of formal and informal childcare included in the EQLS. This would indicate that parents or guardians were the main care providers.

The EQLS shows that informal childcare is still the most prevalent arrangement for the care of young children: more than half of the households use care by grandparents or other relatives as the main type of non-parental childcare. Grandparents remain a key resource in the EU: 36% of households in which the youngest child receives childcare report that care by grandparents is the main type of childcare. This proportion increases to 60% in Greece, Croatia and Cyprus. Long-term unemployed respondents tend to use care provided by grandparents more frequently than others.

### Access

The EU-SILC (2016 ad hoc module) shows that cost of childcare is the main reason for an unmet need, with 16% of respondents stating they do not use (or do not use more) formal childcare services because they cannot afford it. This proportion increases to 52% in Spain and 40% in Cyprus. According to the EQLS, more users of formal childcare services experienced some level of difficulty (39%) in accessing services due to cost than users of a GP or long-term care services. Those with tertiary education or with higher income report cost as a barrier less often and make more use of formal childcare services. There is also a greater difference between income quartiles regarding the extent to which cost made it difficult to use childcare services. Even though 40% of the childcare services that are free of charge or are fully subsidised are used by people in the lowest income quartile, the fact that they use services less and experience more affordability difficulties indicates that it may still be necessary to increase support to the low-income groups. The EU-SILC 2016 ad hoc module confirms that single parents with dependent children are more likely to experience difficulties in affording formal childcare services than co-parents with children. Given that affordability is one of the aspects of ECEC provision highlighted in the European Pillar of Social Rights and that the EQLS has, unsurprisingly, identified it as a barrier, activities at the EU level (for example, in the framework of the European Platform of Investing in Children) could focus more on helping to tackle inequalities in access.

One new finding specific to the EQLS that can shed further light on access barriers is the information about corruption. Even though corruption in childcare is perceived to be less widespread than in other services asked about in the EQLS, it was reported at higher than EU28 average levels in countries in southern, central and eastern Europe and is perhaps an emerging issue to be considered in future research. The fact that users of informal care and those that do not use childcare perceive more corruption and less equal treatment than those using formal childcare suggests that the lack of perceived fairness can act as a barrier or a deterrent for the use of formal childcare. It could also indicate that the availability of formal childcare increases equal treatment. Lack of fairness was perceived to be more widespread in urban than in rural areas. Lack of equal treatment of specific groups has been explored in previous research (see Eurofound, 2015a for a summary of service provision of specific groups of children) but more information about the role of ECEC in fostering social inclusion in general would be welcome. The European Commission’s Education and Training 2020 (ET 2020) working group on ECEC includes social inclusion and professionalism of staff as part of its work programme and could therefore provide further examples of how to promote fairness and how it relates to the overall quality of ECEC systems.



## Quality

The overall quality ratings of childcare services have improved over time. These ratings vary little across different socioeconomic groups, the biggest difference being between users and the rest of the population, with the former giving higher ratings in all countries except Bulgaria, France, Ireland, Italy and Romania. The increased availability of childcare places and use over time is one of the reasons behind the increase in overall quality ratings. If we look at the general quality ratings given only by service users, the countries with higher ratings are Finland, the Netherlands and Sweden. The biggest gaps between the ratings given by the total population and users were found in Finland, Malta and Sweden.

Users of formal childcare services give higher average ratings to all aspects of service provision than users of the health and long-term care services included in the EQLS 2016. The highest intercorrelation can be found between being informed or consulted about the child's care and the personal attention the child was given (including staff/carers' attitude and time devoted).

User satisfaction with various dimensions of quality was lower for centre-based services for children in school aged 12 or under, which corresponds more or less to after-school care. User satisfaction was higher in the case of services for younger children and formal childminding services, perhaps because of the wider possibilities that this service offers in terms of choice of provider and the activities for children. It could also be associated with the smaller size of groups in formal childminding. Further research or a larger sample would be relevant for identifying whether there is more satisfaction in countries with unitary or split centre-based systems or vice versa.



## 4 Conclusions

### Extent of country differences in reported quality of services

Out of seven types of public services examined in the EQLS, health and care services have a broad range of difference between highest and lowest quality perceptions across the Member States. In 2016, the difference between top and bottom country rating (on a scale of 1–10) was 3.4 for health services and long-term care, 2.5 for childcare and 5.3 for state pension systems – the greatest difference of all.

Next to overall quality ratings, the current report has presented data on satisfaction with various dimensions of service quality, which show that deciding on quality advantages of a particular model or structural features of service provision is not straightforward. An exercise in grouping countries in terms of high, medium and low levels of perceived quality on most dimensions of healthcare revealed that country groups differ from the typologies based on types of funding systems (such as insurance-based, tax-funded or relying on out-of-pocket payments). The data on extended range of quality dimensions offer a way of including citizens' perspectives in assessing policy priorities.

Apart from quality perceptions, the differences in use of particular services are much greater across countries. Use of some health services is nearly universal in all countries; however, variation in use of e-healthcare (prescriptions or consultations) is considerable to the point that the majority of the population (over 90%) do not encounter it at all in more than half of the Member States.

Differences in use of certain types of long-term care are also considerable, especially given that long-term care needs prevail in a subset of the population (for potential care recipients as well as their carers). It is hard to relate this variation to differences in the health of the older population: it seems to point to differences in the availability of and access to services. A specific feature of long-term care ratings is that they are not as differentiated by socioeconomic background within countries as other services, but country differences in both use levels and perceived quality are notable.

With regard to childcare, there are large differences in the extent to which grandparents are used as an informal resource (by 36% of parents in the EU on average, reaching 60% in certain countries). This inevitably relates to the proportion of people having experience with formal childcare services, as well as their perspectives on access and, possibly, fairness in these services.

### Main social inequalities in access to and quality of health and care services

With regard to income differences, the survey results point to the necessity of paying closer attention to developments in the middle-income groups. In the case of both healthcare and long-term care, the income gradient is not even.

With regard to health services overall, the quality ratings have improved for every income quartile in 2007–2011 and 2011–2016. However, they remain lowest for the bottom income quartile and the gap separating this quartile from the higher-income groups seems to be increasing. Access difficulties, as well as perceived corruption and unequal treatment, explain part of the negative quality perception.

The third income quartile enjoyed the greatest improvement and gave the highest overall healthcare quality rating in 2016 (6.9). Income was a factor influencing the perception of quality most in the case of healthcare, compared to other services discussed.

In the case of long-term care, middle income quartiles have a somewhat better perception of quality (6.2) than the bottom and top income groups (6.1). In the case of childcare, the bottom income quartile lags behind the others (with a quality rating of 6.5).

In the case of childcare services, facilities and staff are rated highly across countries and groups in society, and differences in ratings of these dimensions of quality between income quartiles are relatively small. However, affordability difficulties in relation to childcare were reported by over a third (39%) of Europeans with children; this proportion is higher for low-income groups. The proportion of people in the bottom income quartile using formal childcare services is lower than in higher income groups, regardless of the fact that this income quartile has a higher proportion of people making use of the subsidised childcare.

However, being in a higher- or middle-income group is not necessarily an advantage: in the case of both health and long-term care services, there is a substantial proportion of people in the third income quartile who report difficulties in accessing services due to cost. Future monitoring should pay close attention to the those in the 'twilight zone' where people have an income too high to be eligible for public funding but too low to afford services without difficulties.

There seems to be a particular pattern of differences in quality of life between urban and rural areas that manifests itself in relation to services too. For example, levels of perceived unfairness are higher in urban than in rural areas, but income seems to matter more in rural than urban areas. In rural areas, people with low incomes report more unequal treatment and, in particular, corruption than people with high incomes, both in primary and hospital care. The challenges of balancing efficiency, cost and accessibility of services geographically are common across all countries; however, the data suggest that resolving them in ways that are seen as fair is also a challenge.

### Perceived lack of fairness in services

The perceptions of unequal treatment and corruption in health and care services are clearly not confined to a small number of Member States. Tangible levels of perceived corruption were registered across a range of countries and in relation to services including primary healthcare, long-term care and childcare, suggesting that the issue of fairness in services should not be underestimated.

While perceived lack of fairness, including perceptions of corruption, has country-specific forms and causes, such perceptions negatively influence perceived quality of services – in both primary healthcare and hospital services, in long-term care and in childcare.

Appropriate use of e-healthcare has the potential to make healthcare systems more transparent; however, processes for accessing and using long-term care and childcare merit further exploration.

### Strengthening evidence base on quality of health and care services

An approach that aims to capture equity by measuring the gap between the highest and lowest income groups (for example, used in JAF Health) may not suffice for comprehensive monitoring: in particular, it may not reflect improvement in the upper- and middle-income groups as well as an increasing gap between the lower- and the (upper) middle-income groups (or a potential polarisation in the middle).

Measurement of bad access to services would benefit from broadening the understanding of inadequate access from ‘unmet need’ to other consequences of poor access, and from recognising that financial barriers may manifest themselves in a range of ways. In the case of healthcare, they range from not attending care (due to cost or other reasons) and delaying (both captured under ‘economising’) to accessing but experiencing difficulties while doing so and expectations about future access problems. The practical value of the broader approach could apply to a number of Member States where levels of the entirely unmet need for care are low, but barriers nevertheless may have consequences, even if less directly.

With regard to satisfaction with quality and its specific aspects, fairness (equal treatment and corruption) seems to be relevant for all services discussed, since the reported issues are at tangible levels in all of them, and are not confined to a small number of countries.

Regarding healthcare in particular, differences in perceptions of corruption within countries are relatively small between primary care and hospital services, so that a single indicator of corruption in healthcare can be considered for general purposes, although differences in perception of unequal treatment persist, in which case distinguishing service types is still worthwhile. Any measures to replace an overall rating for health services should be taken with care since an overall rating still seems to capture more than separate assessments of primary care and hospital services.

### Potential for raising user satisfaction

As a general pattern seen across the data, service users give higher ratings for the quality of public services than non-users. However, in those rare instances when users are more critical than the general public or non-users, this should send a signal to providers and supervisors to investigate and identify the reasons why.

On the basis of reviewing assessments of specific quality dimensions by service users, it can be concluded that the professionalism of staff is regarded highly in most services across most countries when compared to other quality aspects of the service provision. There are some country exceptions with regard to the quality of facilities. However, overall in the EU, there seems to be room to develop the ‘soft’ skills of staff, such as attention to staff attitude and time devoted, as well as informing or consulting the users about the care provided. The importance of these soft aspects should not be underestimated, because when attention to and informing the service users is rated low, professionalism and expertise of staff also tends to be rated low.

Improving interaction with service users is a relatively realistic and, arguably, affordable strategy. However, it may be challenging in work environments where work intensity is high, as is the case in the healthcare sector. With regard to long-term care, specific quality dimensions receive relatively lower ratings than in the case of other social or health services asked about in the survey. Improving satisfaction with long-term care may be more challenging as the shortcomings appear across the board: in lack of equal treatment and corruption, quality of facilities (that may require structural solutions) and in staff behaviour-related dimensions. With regard to the latter, the known challenges are related to the fact that working conditions in long-term care centres tend to be poorer compared to other services.

Conversely, quality dimensions of childcare tend to have relatively higher ratings. User satisfaction tends to be higher with services for young children and specifically with childminding, more so than in centre-based childcare. User satisfaction was lower in the case of after-school care (for children under 12).

No obvious relationship was found between childcare quality perceptions and the structural features of childcare systems at a national level, suggesting that efforts to improve quality in childcare should assess such provision at a subnational level. It is notable that, overall, preventing corruption and unequal treatment in childcare were the dimensions ranked lowest compared to other aspects of childcare provision.





# Bibliography

All Eurofound publications are available at [www.eurofound.europa.eu](http://www.eurofound.europa.eu)

- Aassve, A., Arpino, B. and Goisis, A. (2012), 'Grandparenting and mothers' labour force participation: A comparative analysis using the generations and gender survey', *Demographic Research*, Vol. 27, No. 3, pp. 53–84.
- Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R., McKee, M. et al (2012), 'Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States', *BMJ*, Vol. 344, p. e1717.
- Babakus, E. and Mangold, W. G. (1992), 'Adapting the SERVQUAL scale to hospital services: An empirical investigation', *Health Services Research*, Vol. 26, No. 6, pp. 767–786.
- Ceglowski, D. and Bacigalupa, C. (2002), 'Four perspectives on child care quality', *Early Childhood Education Journal*, Vol. 30, No. 2, pp. 87–92.
- CNAF (Caisse nationale des allocations familiales) (2017), *L'accueil du jeune enfant en 2016: Données statistiques*, Paris.
- Council of the European Union (2019), 'Council Recommendation of 22 May 2019 on High-Quality Early Childhood Education and Care Systems', *Official Journal of the European Union* C189/4, 5 June.
- Devaux, M. and De Looper, M. (2012), *Income-related inequalities in health service utilisation in 19 OECD countries, 2008-2009*, OECD Health Working Papers, No. 58, OECD Publishing, Paris.
- Durand, A.-C., Palazzolo, S., Tanti-Hardouin, N., Gerbeaux, P., Sambuc, R. and Gentile, S. (2012), 'Nonurgent patients in emergency departments: Rational or irresponsible consumers? Perceptions of professionals and patients', *BMC Research Notes*, Vol. 5, p. 525.
- Eikemo, T. A., Bambra, C., Huijts, T. and Fitzgerald, R. (2017), 'The first pan-European sociological health inequalities survey of the general population: The European social survey rotating module on the social determinants of health', *European Sociological Review*, Vol. 33, No. 1, pp. 137–153.
- Eurofound (2012), *Third European quality of life survey: Quality of life in Europe: Impacts of the crisis*, Publications Office of the European Union, Luxembourg.
- Eurofound (2013a), *Impacts of the crisis on access to healthcare services in the EU*, Dublin.
- Eurofound (2013b), *More and better jobs in home-care services*, Publications Office of the European Union, Luxembourg.
- Eurofound (2013c), *Third European Quality of Life Survey: Quality of society and public services*, Publications Office of the European Union, Luxembourg.
- Eurofound (2014), *Access to healthcare in times of crisis*, Publications Office of the European Union, Luxembourg.
- Eurofound (2015a), *Early childhood care: Accessibility and quality of services*, Publications Office of the European Union, Luxembourg.
- Eurofound (2015b), *Early childhood care: Working conditions, training and quality of services: A systematic review*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017a), *In-work poverty in the EU*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017b), *European Quality of Life Survey 2016: Quality of life, quality of public services, and quality of society*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017c), *Sixth European Working Conditions Survey: Overview report (2017 update)*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017d), *Care homes for older Europeans: Public, for-profit and non-profit providers*, Publications Office of the European Union, Luxembourg.
- Eurofound (2017e), *Occupational change and wage inequality: European Jobs Monitor 2017*, Publications Office of the European Union, Luxembourg.
- Eurofound (2018a), *Local area aspects of quality of life: An illustrated framework*, Dublin.
- Eurofound (2018b), *Social insecurities and resilience*, Publications Office of the European Union, Luxembourg.
- Eurofound (2019, forthcoming), *Quality of society and public services in the EU*, Publications Office of the European Union, Luxembourg.
- European Commission (2008), *Quality in and equality of access to healthcare services*, Brussels.
- European Commission (2009), *The provision of childcare services: A comparative review of 30 European countries*, Publications Office of the European Union, Luxembourg.
- European Commission (2013), *Investing in children: Breaking the cycle of disadvantage*, C(2013)778 final, Brussels.

European Commission (2015a), *Towards a joint assessment framework in the area of health – Work in progress: 2015 update*, Brussels.

European Commission (2015b), 'Commission Regulation (EU) 2015/245 of 16 February 2015 implementing Regulation (EC) No 1177/2003 of the European Parliament and of the Council concerning Community statistics on income and living conditions (EU-SILC) as regards the 2016 list of target secondary variables on access to services', *Official Journal of the European Union*, L41/11, 17 February.

European Commission (2015c), *Peer Review in the Czech Republic: Provision of quality early childcare services*, Brussels.

European Commission (2016), *Joint report on health care and long-term care systems and fiscal sustainability*, Publications Office of the European Union, Luxembourg.

European Commission (2017a), *Annual growth survey 2018*, COM(2017)690 final, Brussels.

European Commission (2017b), *State of health in the EU: Companion Report 2017*, Publications Office of the European Union, Luxembourg.

European Commission (2017c), *Updated study on corruption in the healthcare sector*, Publications Office of the European Union, Luxembourg.

European Commission (2017d), *Special Eurobarometer 470: Corruption*, Brussels.

European Commission (2017e), *Taking stock of the 2013 Recommendation on "Investing in children: Breaking the cycle of disadvantage"*, SWD(2017)258 final, Brussels.

European Commission (2018a), *The 2018 ageing report: Economic and budgetary projections for the EU Member States (2016–2070)*, Publications Office of the European Union, Luxembourg.

European Commission (2018b), *Peer Review on Germany's latest reforms of the long-term care system, Berlin, Germany, 11-12 January 2018 and Peer Review on Improving reconciliation of work and long-term care' Berlin, Germany, 24-25 September 2018*, DG Employment, Social Affairs & Inclusion, Brussels.

European Commission (2018c), *Informal care in Europe: Exploring formalisation, availability and quality*, Publications Office of the European Union, Luxembourg.

European Commission (2018d), *European education and training monitor 2018: Country analysis*, Publications Office of the European Union, Luxembourg.

European Commission (2018e), *Complementing the 2014 ECEC quality framework proposal with indicators: Recommendations from ECEC experts*, Publications Office of the European Union, Luxembourg.

European Commission (2018f), *Report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the development of childcare facilities for young children with a view to increase female labour participation, strike a work-life balance for working parents and bring about sustainable and inclusive growth in Europe (the "Barcelona objectives")*, COM(2018)273 final, Brussels.

European Commission (2018g), *Peer Review on 'Furthering quality and flexibility of Early Childhood Education and Care'*, Copenhagen, Denmark, 13-14 December 2018, Brussels.

European Commission, EACEA, Eurydice and Eurostat (2014), *Key data on early childhood education and care in Europe: 2014 edition*, Publications Office of the European Union, Luxembourg.

European Union (2000), *Charter of Fundamental Rights of the European Union*, COM (2000) Official Journal of the European Communities C 364/3, Publications Office of the European Union, Luxembourg.

Eurostat (2015), [European Health Interview Survey 2](#), Luxembourg.

Eurostat (2018), *Access to social services: Almost 4 in 10 children in the EU receive formal childcare services*, news release 30/2018, Luxembourg, 20 February.

Eurostat (undated), *UNESCO OECD Eurostat (UOE) joint data collection: Methodology*, web page, accessed 19 November 2018.

EXPH (Expert Panel on effective ways of investing in health) (2018), *Opinion on tools and methodologies for assessing the performance of primary care*, European Commission, Publications Office of the European Union, Luxembourg.

EXPH (2018), *Opinion on benchmarking access to healthcare in the EU*, European Commission, Publications Office of the European Union, Luxembourg.

Flisa, S., Meroni, E. C. and Vera-Toscano, E. (2016), *Indicators for early childhood education and care*, Publications Office of the European Union, Luxembourg.

FRA (European Union Agency for Fundamental Rights) (2013), *Inequalities and multiple discrimination in access to and quality of healthcare*, Publications Office of the European Union, Luxembourg.

FRA (2015), *Cost of exclusion from healthcare: The case of migrants in an irregular situation*, Publications Office of the European Union, Luxembourg.

- GBD (Global Burden of Disease Study 2016 Healthcare Access and Quality Collaborators) (2018), 'Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: A systematic analysis from the Global Burden of Disease Study', *The Lancet*, Vol. 391, No. 10136, pp. 2236–2271.
- Gené-Badia, J., Gallo, P., Hernández-Quevedo, C. and García-Armesto, S. (2012), 'Spanish health care cuts: Penny wise and pound foolish?' *Health Policy*, Vol. 106, No. 1, pp. 23–28.
- Genet, N., Boerma, W., Kroneman, M., Hutchinson, A. and Saltman, R. B. (eds.) (2012), *Home care across Europe: Current structure and future challenges*, World Health Organization, Copenhagen.
- HCP (Health Consumer Powerhouse) (2018), *Euro Health Consumer Index*, Marseillan, France.
- Hemerijck, A. (ed.) (2017), *The uses of social investment*, Oxford University Press, Oxford.
- Herlofson, K. and Hagestad, G. O. (2012), 'Transformation in the role of grandparents across welfare states', in Arber, S. and Timonen, V. (eds.), *Contemporary grandparenting: Changing family relationships in global contexts*, The Policy Press, Bristol, pp. 27–49.
- Hunt, M., Auriemma, J. and Cashaw, A. C. A. (2003), 'Selfreport bias and underreporting of depression on the BDI-II', *Journal of Personality Assessment*, Vol. 80, No. 1, pp. 26–30.
- Karanikolos, M., Mladovsky, P., Cylus, J., Thomson, S., Basu, S., Stuckler, D. et al (2013), 'Financial crisis, austerity, and health in Europe', *The Lancet*, Vol. 381, No. 9874, pp. 1323–1331.
- Kummervold, P. E., Chronaki, C. E., Lausen, B., Prokosch, H. U., Rasmussen, J., Santana, S. et al (2008), 'eHealth trends in Europe 2005–2007: A population-based survey', *Journal of Medical Internet Research*, Vol. 10, No. 4, p. e42.
- Legido-Quigley, H., McKee, M., Nolte, E. and Glinos, I. A. (2008), *Assuring the quality of health care in the European Union: A case for action*, World Health Organization, Copenhagen.
- Leichsenring, K. (2018), "“EU Uniform Care”: The way ahead or a hazard?", 1st Joint E.D.E.–EAHSA Congress, 13 September, Prague.
- Mortieruel, M., Rodriguez-Alvarez, E., Martin, U. and Bacigalupe, A. (2018), 'Inequalities in health services usage in a national health system scheme: The case of a southern social European region', *Nursing Research*, Vol. 67, No. 1, pp. 26–34.
- OECD (2016), *Who uses childcare? Background brief on inequalities in the use of formal early childhood education and care (ECEC) among very young children*, OECD Publishing, Paris.
- OECD (2017), *Health at a glance 2017*, OECD Publishing, Paris.
- OECD (2018), *OECD Reviews of Health Systems: Lithuania 2018*, OECD Publishing, Paris.
- Pissarides, C. (2018), 'Labour market challenges in Europe: New technology, automation and allocative efficiency', presentation, Eurogroup informal meeting, Vienna, 7 September.
- Plantenga, J. and Remery, C. (2013), *Childcare services for school age children: A comparative review of 33 countries*, Publications Office of the European Union, Luxembourg.
- Ryan, M., Scott, D. A., Reeves, C., Bate, A., Van Teijlingen, E. R., Russell, E. M. et al (2001), 'Eliciting public preferences for healthcare: A systematic review of techniques', *Health Technology Assessment*, Vol. 5, No. 5, pp. 1–186.
- Saltman, R. B., Busse, R. and Figueras, J. (eds.) (2004), *Social health insurance systems in western Europe*, Open University Press, Maidenhead, UK.
- Smith, P. C., Mossialos, E., Papanicolas, I. and Leatherman, S. (eds.) (2009), *Performance measurement for health system improvement: Experiences, challenges and prospects*, Cambridge University Press, Cambridge.
- Spasova, S., Baeten, R., Coster, S., Ghailani, D., Peña-Casas, R. and Vanhercke, B. (2018), *Challenges in long-term care in Europe: A study of national policies*, European Social Policy Network (ESPN), European Commission, Brussels.
- SPC (Social Protection Committee) (2010), *A voluntary European quality framework for social services*, SPC/2010/10/8 final, Brussels.
- SPC (2017), *Annual report 2017*, Publications Office of the European Union, Luxembourg.
- SPC (2018a) *Discussion note for the SPC ISG: Review of the existing monitoring frameworks on the access to quality social services*, SPC/ISG/2018/1/9, Brussels.
- SPC (2018b), *Annual report 2018*, Publications Office of the European Union, Luxembourg.
- SPC (2018c), *2018 ISG Work Programme*, SPC/ISG/2018/1/2 FIN2, Brussels.
- SPC (2018d), *Discussion note for the SPC ISG: Monitoring access to quality of social services*, Brussels.
- Theobald, H. (2018), *Pflegearbeit in Deutschland, Japan und Schweden: Wie werden Pflegekräfte mit Migrationshintergrund und Männer in die Pflegearbeit einbezogen?* Hans-Böckler-Stiftung, Düsseldorf.

Thornicroft, G. (2018), 'Improving access to psychological therapies in England', *The Lancet*, Vol. 391, No. 10121, pp. 636–637.

Transparency International (2017), *Corruption Perceptions Index 2016*, web page, accessed 19 November 2018.

Ünver, O., Bircan, T. and Nicaise, I. (2018), 'Perceived accessibility of childcare in Europe: A cross-country multilevel study', *International Journal of Child Care and Education Policy*, Vol. 12, No. 5.

Van den Berg, M. J., Van Loenen, T. and Westert, G. P. (2016), 'Accessible and continuous primary care may help reduce rates of emergency department use: An international survey in 34 countries', *Family Practice*, Vol. 33, No. 1, pp. 42–50.

Wagstaff, A. (2009), 'Measuring financial protection in health', in Smith, P. C., Mossialos, E., Leatherman, S. and Papanicolas, I. (eds.) (2009), *Performance measurement for health system improvement: Experiences, challenges and prospects*, Cambridge University Press, Cambridge, pp. 114–137.

WeDO (2012), 'The European quality framework for long-term care: Principles and guidelines for the wellbeing and dignity of older people in need of care and assistance', AGE Platform Europe Conference, 14 November, Brussels.

Wendt, C. (2014), 'Changing healthcare system types', *Social Policy and Administration*, Vol. 48, No. 7, pp. 864–882.

Wendt, C., Mischke, M., Pfeifer, M. and Reibling, N. (2012), 'Confidence in receiving medical care when seriously ill: A seven-country comparison of the impact of cost barriers', *Health Expectations*, Vol. 15, No. 2, pp. 212–224.

WHO (World Health Organization) (2000), *The world health report 2000: Health systems: Improving performance*, Geneva.

WHO (2015), *The European health report 2015: Targets and beyond: reaching new frontiers in evidence*, Copenhagen.

## Getting in touch with the EU

### In person

All over the European Union there are hundreds of Europe Direct information centres. You can find the address of the centre nearest you at: <http://europa.eu/contact>

### On the phone or by email

Europe Direct is a service that answers your questions about the European Union. You can contact this service:

- by freephone: 00 800 6 7 8 9 10 11 (certain operators may charge for these calls)
- at the following standard number: +32 22999696
- by email via: <http://europa.eu/contact>

## Finding information about the EU

### Online

Information about the European Union in all the official languages of the EU is available on the Europa website at: <http://europa.eu>

### EU publications

You can download or order free and priced EU publications from the EU Bookshop at: <http://publications.europa.eu/eubookshop>. Multiple copies of free publications may be obtained by contacting Europe Direct or your local information centre (see <http://europa.eu/contact>).

### EU law and related documents

For access to legal information from the EU, including all EU law since 1951 in all the official language versions, go to EUR-Lex at: <http://eur-lex.europa.eu>

### Open data from the EU

The EU Open Data Portal (<http://data.europa.eu/euodp>) provides access to datasets from the EU. Data can be downloaded and reused for free, both for commercial and non-commercial purposes.

Public services are essential for achieving high levels of social protection, social cohesion and social inclusion. However, to be effective in this regard, services must be of good quality and they must be equally accessible to the broadest possible range of citizens. Care services in particular represent a key component of social protection for EU citizens, improving quality of life and access to education and employment. This report reveals citizens' perceptions of quality in healthcare, long-term care and childcare, and compares them between countries, groups in society and the receivers of care and indirect service users.

---

**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.**

