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Public services

Access to care services: Early childhood education and care, healthcare and long-term care

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Authors: Hans Dubois (healthcare), Tadas Leončikas (long-term care), Daniel Molinuevo (early childhood education and care) and Martina Campajola (convergence)

Research manager: Hans Dubois

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European Foundation for the Improvement of Living and Working Conditions

Telephone: (+353 1) 204 31 00
Email: information@eurofound.europa.eu
Web: www.eurofound.europa.eu

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Country codes

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Executive summary

Introduction

This report investigates the issue of access to three types of care services that are essential for social protection and inclusion: early childhood education and care (ECEC), healthcare and long-term care. It develops a theoretical framework for access to such care services, and outlines barriers to the take-up of care services and differences in access issues between population groups in the EU.

The report then focuses on three areas that have the potential to improve access to services: ECEC for children with disabilities and special educational needs, e-healthcare and respite care. It presents an overview of the current situation in various Member States, Norway and the UK.

Policy context

The European Pillar of Social Rights states that people in the EU should have access to good-quality ECEC, healthcare and long-term care. It emphasises that children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities. For healthcare, it emphasises that access should be timely and comprise both preventive and curative healthcare. For long-term care, the emphasis is on home care and community-based services.

Access to these services contributes to reducing inequalities throughout the life cycle and achieving equality for women and persons with disabilities. By reducing deprivation and inequalities, guaranteeing access to these services can further contribute to achieving the UN's Sustainable Development Goals.

Key findings

Access problems can emerge throughout the process, from perceiving care needs to meeting those needs. They are caused by a combination of household, organisational and societal-level factors.

ECEC

Many people with children report no unmet needs due to informal care arrangements, but many who use ECEC have difficulty affording it. Continuing professional development (CPD) can improve the quality and inclusiveness of ECEC.

Healthcare

Unmet needs spiked around 2013, suggesting a delayed impact of the 2007–2008 global financial crisis and the austerity measures which followed. Employment, especially under a permanent contract, protects people from the insecurity of being unable to pay for healthcare. Besides the income from employment, supplementary private insurance, often provided by employers, acts as an additional buffer.

E-consultations and e-prescriptions were already offered in some countries, such as Lithuania, to prevent viruses from spreading – even before the outbreak of the COVID-19 pandemic. Other countries have followed suit with ad-hoc measures during the pandemic, albeit often temporary ones without proper structures. Some countries have more experience with national telephone lines (Austria, Estonia and Latvia) and electronic reimbursement structures (Denmark, the Netherlands and Norway). Experiences with screen-to-screen consultations are limited, but larger scale examples can be found in France, Germany and Sweden. E-prescriptions that only require patients to identify themselves at the pharmacist are fast gaining ground.

Long-term care

Rises in quality ratings and expenditure are mainly found in countries which already had relatively well-developed care systems, reinforcing a previous finding that access needs to be developed in Member States with lower-income levels in particular. Respite care has been a marginal or unfamiliar concept in many countries but now features in policy discourse in nearly all countries.

Policy pointers

General

- Policymakers should pay attention to the various outcomes across the spectrum of access problems, not just unmet needs. People may eventually meet their care needs but face difficulties throughout the process. Furthermore, people may anticipate access problems if they were to need care, leading to feelings of insecurity.
- Voluntary non-use of services should not be taken at face value. People may be more likely to use services if they were cheaper, better-tailored or of higher quality.

- A narrow view of access problems risks ineffectiveness. For instance, lowering the cost of care services may not address unaffordability if household income and expenditure, under-the-table payments and transport costs are not considered.
- To effectively enforce the right to access, it is important to focus on the multiple dimensions in this report's framework, along the whole process from identifying and meeting needs, to addressing household, organisational and societal factors.

ECEC

- Access to ECEC needs to be improved, particularly in some countries, to reduce inequalities among children and facilitate employment for informal child carers (the majority of whom are women).
- Unaffordability is a key barrier, but subsidising ECEC may not remove other barriers such as reachability, lack of trust or the inclusion of children with special educational needs.
- Updated EU targets for ECEC use could incorporate reasons for unmet needs, rather than just focusing on the proportion of children in ECEC. Furthermore, a wider age group than children under three could be taken into account to monitor progress on the European Pillar of Social Rights.

Inclusive ECEC

- More assessment of the effectiveness of training programmes is needed, and useful aspects of training should be better disseminated and applied.
- Staff and programme costs are important barriers for CPD.

Healthcare

- To become more resistant to economic shocks, access to healthcare should rely less on income and employment.
- To ensure the right to healthcare, inequalities associated with (often employer-provided) supplementary insurance should be monitored.
- Investing in healthcare infrastructure has limited potential to improve access if other factors, such as affordability and staff availability, are not addressed simultaneously.

E-healthcare

- The EU can help Member States learn from the wide range of (often small-scale) e-consultation practices across the EU.
- Financial incentives for doctors, hospitals and health insurers to apply e-consultations need to be appropriate. Legal frameworks often need to be properly adjusted.

Long-term care

- Formal long-term care provision needs to be expanded and made more flexible in most Member States. This can help to provide more adequate care, free up beds in hospitals, facilitate employment and reduce social exclusion and healthcare needs for informal carers.
- To provide flexible, tailored care and to support both early identification of increasing long-term care needs and prevention, it is important to facilitate access to some level of long-term care early on.

Respite care

- Diversifying the forms of respite care, to include alternatives to hospitals or residential facilities, can improve its use and usefulness.
- Better engagement with care recipients and their carers is needed for effective take-up of respite care. This can help to establish formal care contact earlier, making informal care more sustainable and improving carers' quality of life.

Introduction

Under the heading ‘social protection and inclusion’, the European Pillar of Social Rights emphasises everyone’s right to have access to various care services (European Commission, 2017a). This report focuses on three services explicitly referred to in the European Pillar of Social Rights: early childhood education and care (ECEC),[1] healthcare and long-term care. This range of services also reflects the idea of social protection and inclusion throughout the life cycle and ties in with Eurofound’s research experience.

The report begins by outlining the EU policy context concerning access to these ‘care services for social protection and inclusion’. It then develops a general framework for understanding access to care services. This framework encompasses the broad array of factors to be considered in order to enforce the right of access to ECEC, healthcare and long-term care.

Next, the report discusses access problems in relation to each of the three services, drawing on the literature and analysis of EU-level survey data. It analyses differences between countries and particular population groups, and discusses patterns in convergence and divergence, following an earlier research approach by Eurofound (2018a). While the focus is on convergence and divergence between Member States, it should be acknowledged that the dynamics can differ greatly between regions and municipalities within countries (Eurofound, 2018b).

For each of the three services, the report examines in closer detail one particular measure that may contribute to improving access:

- ECEC: **inclusive practices**, particularly those that improve the inclusion of children with disabilities and special educational needs.
- Healthcare: **e-consultations and e-prescriptions**, which eliminate the need for patients – particularly those in remote and rural areas – to travel to receive healthcare.
- Long-term care: **respite care**, which improves access to formal care for informal care recipients and provides relief for informal carers.

Drawing on input from the Network of Eurofound Correspondents (collected between November 2019 and March 2020) and Eurofound’s own research, the report presents an overview of the current situation in various Member States, Norway and the UK, outlining barriers to the take-up of care services and including specific examples.[2]

Based on this research, the report concludes by drawing up lessons for policymakers and service providers aimed at improving access to care services to support social protection and inclusion.

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[1] The term ‘early childhood education and care’ refers to ‘any regulated arrangement that provides education and care for children from birth to the compulsory primary school age – regardless of the setting, funding, opening hours or programme content – and includes centre and family day-care; privately and publicly funded provision; pre-school and pre-primary provision’ (Council of the European Union, 2019). Some of the information presented in the report may take a different perspective. For instance, some statistics concern all educational or care services for children up to the age of 15, and some surveys may only ask about ‘childcare’ (leaving the interpretation to their respondents).

[2] More detailed information for the 27 EU Member States, Norway and the UK remains unpublished, but can be requested from Eurofound.

1 EU policy context

Access to care services as a right

The European Pillar of Social Rights includes a section on social protection and inclusion, where it underlines the right of access to various care services, including good-quality early childhood education and care (ECEC), healthcare and long-term care (Figure 1). The EU monitors progress on the European Pillar of Social Rights through its Social Scoreboard.

The 2012 Charter of Fundamental Rights of the European Union states that 'the Union recognises and respects access to services of general economic interest as provided for in national laws and the Union'. It specifically highlights the right to access healthcare, and rights for specific population groups: children, the elderly, women, and persons with disabilities (Box 1).

The EU and all its Member States have subscribed to the UN Convention on the Rights of Persons with Disabilities, adopted in 2006. The convention stipulates, for instance, that persons with disabilities should have access to a range of 'in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community'. It also states that persons with disabilities should be provided 'with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons', adding that these services are to be provided 'as close as possible to people's own communities, including in rural areas'.

All EU Member States have also subscribed to the UN Convention on the Rights of the Child, which established specific provisions for education, care, healthcare, children with disabilities, and alternative care.

Figure 1: ECEC, healthcare and long-term care in the European Pillar of Social Rights

Social protection and inclusion

'Children have the right to affordable early childhood education and care of good quality. Children have the right to protection from poverty. Children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities.'

'Everyone has the right to timely access to affordable, preventative and curative health care of good quality.'

'Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services.'

Social protection, access to essential services, unemployment benefits, minimum income, old age income and pensions, inclusion of people with disabilities, housing and assistance for the homeless.

Source: *Figure compiled by Eurofound; text taken from the European Pillar of Social Rights*

Box 1: Care services in the Charter of Fundamental Rights of the European Union

The charter states that '**children** shall have the right to such protection and care as is necessary for their well-being', and that 'in all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration'. These extracts are particularly relevant for the section on **ECEC** in this report.

The charter also 'recognises and respects the rights of the **elderly** to lead a life of dignity and independence and to participate in social and cultural life'. This is especially relevant for the section on **long-term care**.

As **women** currently play a larger role in informal childcare and **long-term care**, it is relevant for the sections focusing on these aspects that 'equality between women and men must be ensured in all areas, including employment, work and pay'.

For the section on **long-term care** as well as the sections on **ECEC** and **healthcare**, it is relevant that 'the Union recognises and respects the right of **persons with disabilities** to benefit from measures designed to ensure their independence, social and occupational integration and participation in the life of the community'.

The following extract of the charter is also relevant for this report's section on **healthcare**:

'Everyone has the right of **access to preventive healthcare** and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.'

Access to care services as a policy priority

The EU's 'GDP and beyond' initiative emphasises that progress should be measured not only by income, but also more broadly by the quality of life of citizens (European Commission, 2009). From this perspective, access problems can impede progress, insofar as if people's care needs are not met effectively, this is likely to negatively affect their well-being or quality of life.

Access to long-term care and healthcare is key to addressing the needs of the EU's ageing populations. The Commission's 2018 ageing report highlighted the lack of availability of long-term care in many Member States, as well as the expected increase and changes in long-term care and healthcare needs (European Commission, 2018a). In its Green Paper on ageing, expected in late 2020, the European Commission will assess whether social protection systems are fit to deal with the needs of an ageing population. The European Commission is also in the process of measuring the impact of demographic change on different societal groups and on disproportionately affected areas and regions (European Commission, 2020a; 2020b). More specifically, it is examining how best to support EU regions most in need of targeted reforms or investment, notably to improve infrastructure and access to services.

Access to ECEC, healthcare and long-term care can facilitate employment for people with children, as well as people who have health problems and long-term care commitments. This can lead to higher employment rates, as envisioned by the EU's European Employment Strategy. Out of the total number of people aged 15–74 in the EU who had resigned from their job during the past eight years and remained out of employment, 5% did so in order to look after children or adults with care needs (Eurostat, 2018). According to Eurostat, the proportion of the EU's economically inactive population (among those aged 20–64) not seeking work due to looking after children or adults with care needs has been between 9% and 11% over the last decade.

Access to formal long-term care and ECEC is key for gender equality, as the European Commission argued in its recent communication on *A strong social Europe for just transitions*, in the context of its European Gender Equality Strategy 2020–2025 (European Commission, 2020a). As part of the implementation of the European Pillar of Social Rights, the Commission is coordinating efforts to improve work–life balance and support people throughout their careers. In this context, the 2019 directive on work–life balance for parents and carers points to the 'provision of accessible and affordable childcare and long-term care services, which are crucial for the purpose of allowing parents, and other persons with caring responsibilities to enter, remain in, or return to the labour market'.

Good access to ECEC and healthcare can bolster the personal and cognitive development of children and help to reduce inequalities. For instance, the Commission recommendation on investing in children and breaking the cycle of disadvantage urges Member States to 'intensify efforts to ensure that all families, including those in vulnerable situations and living in disadvantaged areas, have effective access to affordable, quality ECEC' (European Commission, 2013a). It also encourages them to 'address the obstacles to accessing healthcare faced by children and families in vulnerable situations, including costs, cultural and linguistic barriers, lack of information' and to 'improve the training of health care providers in this respect'. The Council of the European Union (2019) also recommends that Member States improve access to high-quality ECEC systems in line with the statements set out in its 'Quality framework for early childhood education and care'. Ensuring that children have access to the services they need and are supported right up to their adult lives is also relevant in the context of the European Commission's work on a Child Guarantee (Frazer et al, 2020).

Guaranteeing access to these three care services of social protection and inclusion further helps to reduce deprivation and inequalities, and thus to achieve the UN's Sustainable Development Goals, including 'no poverty' (Goal 1) and 'reduced inequalities' (Goal 10).

While investment in care services to support social protection and inclusion comes at a cost, there can, however, also be public financial returns on these investments, in terms of social contributions and taxes (EESC, 2014). In the case of healthcare, access problems can prolong or exacerbate health problems – which can result in longer absences from work, reduced productivity and increased healthcare costs (FRA, 2015). Insufficient access to long-term care leads to a greater reliance on informal care, with associated impacts in terms of ensuing health problems and loss of workforce (European Commission, forthcoming). These costs go beyond the period in which informal long-term care is provided, for instance, through the carer having difficulties reintegrating into the labour market after care breaks (Eurofound, 2019a). Problems in accessing long-term care services can also lead to people with long-term care needs occupying hospital beds, which tends to come at a larger cost to society. This can also result in suboptimal care, whereby the care needs are not sufficiently met or are even exacerbated by additional problems such as hospital-incurred infections.

The costs to society, too, are not only financial. Problems in accessing care services can affect the well-being of individuals. People's living situations depend not only on their basic material needs and purchasing power, but also on whether, and to what extent, they can call on personal assistance from others in times of need and emergency, when they are unable to cope with their problems alone (Bäcker et al, 2020). Access problems may also affect societal well-being and lead to lower levels of trust in institutions and government. Based on their own past experiences, the experiences of people close to them or reports in the media, people may also anticipate access problems in the event that they need care in the future. This can lead to feelings of social insecurity and discontent (Eurofound, 2018c). While this may only marginally translate into financial costs, it can have negative consequences for social cohesion.

EU policy tools to improve access

The EU's Social Protection Committee (SPC)'s voluntary European Quality Framework for social services aimed to develop a common understanding on the quality of social services and provide a reference point for defining, assuring, evaluating and improving the quality of these services (SPC, 2010). Its overarching principles include ensuring that services are available, accessible and affordable.

An important policy tool to improve access is funding. The EU's cohesion policy aims to reduce economic and social inequalities between regions in Europe – mainly through the European Structural and Investment Funds. In many of its Member States, these funds are already used to strengthen care services. For instance, in the 2014–2020 funding period, improving access to and quality of healthcare was a common area of support for Greece and most of the Member States that joined the EU after 2004. For other countries, smaller investments in specific projects have focused on elderly care. This has also been a major source of funding for care deinstitutionalisation and e-healthcare in countries such as Cyprus, Greece, Italy, Slovakia and Spain. This research contributes to understanding where the problems lie, how access can be improved, and how EU funding could be allocated to improve access.

The EU's Open Method of Coordination has also served as an important policy tool, stimulating countries to learn from each other and providing benchmarks. ECEC, healthcare and long-term care initiatives in specific Member States have all featured as best practices in the Open Method of Coordination. In the aftermath of the global financial crisis, its softer process has increasingly been overshadowed by the European Semester, leading to annual recommendations to the Member States. ECEC, healthcare and long-term care have featured in these country-specific recommendations (CSRs).

Country-specific recommendations

Specific mention of access to these three care services in the 2019 CSRs and accompanying texts is detailed below. They frequently cite long-term care along with healthcare, in the context of challenges to fiscal sustainability in ageing societies. Although CRSs tend to refer to the term 'childcare', ECEC is also sometimes mentioned, mainly in relation to the gender employment gap, as is long-term care.

ECEC

Seven Member States received a CSR regarding ECEC (Austria, Cyprus, Czechia , Ireland, Italy, Poland and Slovakia). This reverses the trend of decreasing numbers of Member States receiving CSRs in the area of ECEC in the last few years (10 Member States in 2014, 7 in 2015, and 4 in 2017 and 2018) (Eurofound, 2019b). All these 2019 CSRs are linked to the gender gap in employment, usually recommending increased access to affordable ECEC as a solution to closing the gap. Affordability is mentioned in five countries (Austria, Cyprus, Czechia, Ireland and Slovakia), while availability is mentioned in Austria, Czechia, Ireland and Italy, low enrolment is mentioned in Poland and Slovakia, and inclusiveness is also mentioned in Slovakia.

ECEC was also cited in the national policy reviews of some countries that did not receive a CSR (Bulgaria, Estonia, Hungary and Romania). In these cases, the reviews established a link between access to services and female participation in the labour market. In Bulgaria, for example, the review noted the low participation in good-quality ECEC, in particular for the Roma and children from other disadvantaged groups. In Estonia, the review also mentioned the need for continued investment in ECEC to reduce the gender gap in employment. The lack of good-quality ECEC facilities in Hungary and the low take-up of services in Romania also have implications for female participation in the labour market.

The rationale in the 2019 CSRs, therefore, seems to reflect the notion of childcare that presents it as a tool that only fosters female labour market participation, which has underpinned EU policymaking in this area in the past according to Radulova (2009).

Healthcare

For 17 of the EU Member States, access to healthcare is discussed in the accompanying text. Seven of the CSRs refer to access to healthcare in the recommendations themselves. This represents an important shift. Healthcare used to be almost exclusively referred to in the context of increasing efficiency and reducing public expenses, and rarely in relation to access (Eurofound, 2014). The recommendations on access to healthcare still include elements of efficiency and effectiveness – particularly in relation to costs – and sustainability, but these are accompanied by remarks on access, which is covered even more widely in the accompanying texts.

Common causes of access problems listed by the CSRs include low levels of funding (Bulgaria, Lithuania and Poland), low insurance coverage (Bulgaria and Cyprus), shortages of medical staff (doctors/general practitioners (GPs) and nurses in Bulgaria, Poland and Romania; nurses in Latvia; GPs in Slovakia), high out-of-pocket expenses (Bulgaria, Cyprus and Latvia) and informal payments (Lithuania and Romania). Unmet needs (Estonia, Finland and Latvia), long waiting times (Finland and Malta) and unaffordability (Estonia) are also referred to as key access problems.

The CSRs also highlight geographical disparities within countries, indicating more access problems in certain regions (France and Italy), and in poor areas (Hungary), scarcely populated and dwindling areas (Latvia), and rural areas (Romania). Some recommendations refer to population groups, generally to those in vulnerable situations (Latvia and Romania) or those outside the labour force (Finland). Some CSRs highlight limited access to specific services, such as waiting lists for certain procedures (Poland) or limited access to e-healthcare (Germany). The recommendations also warn against planned reforms that could increase access problems (Latvia) and highlight the absence of reforms to improve access (Slovenia). Where plans to improve access are in place, the CSRs encourage the proper implementation of these plans (Cyprus, Greece and Ireland). For Finland, they also express regret that a plan to reduce waiting times and ensure equal access was not approved by the national parliament in 2017. The issue of increasing and changing needs due to ageing is mentioned in Finland also, as well as in Ireland too.

Where there is no explicit reference to access in the CSRs, other types of recommendations can have implications for access. For instance, in Croatia an increase in health insurance premiums has resulted in a rise in healthcare payments, and pressure on disposable incomes has risen in Luxembourg due to the rise in workers’ healthcare contributions. The Commission also calls upon several countries to shift from hospital care to (underdeveloped) primary care – usually in order to improve efficiency (Croatia, Czechia, Hungary, Poland and Slovakia), and to reduce unnecessary referrals to specialists and inappropriate use of emergency care (Malta). Such measures may also contribute to improving access by freeing up capacity. Other measures mentioned in the CSRs that could improve access by reducing demand include the excise duties on tobacco introduced in Croatia in 2018, the call for investment in sustainable transport in Czechia to ‘reduce air and noise pollution, alleviating its impact on public health, especially in urban areas’, and Slovakia’s focus on prevention more generally.

Long-term care

For 10 Member States, access to long-term care is discussed, usually only in the accompanying text, but for four countries (Italy, Poland, Slovakia and Slovenia) it is also included in the recommendations. It is striking that some of the CSRs do discuss access to long-term care along with access to healthcare in their accompanying text, but only make reference to healthcare – not long-term care – in the recommendations (Hungary, Ireland, Latvia, Lithuania and Romania). Where long-term care does appear in the recommendations, it is mentioned alongside healthcare and/or ECEC, rather than by itself. Two of the four recommendations relating to long-term care focus on increasing labour market participation by improving access to good-quality ECEC and long-term care (Poland generally and Italy specifically for women). The other two call for better access to long-term care in general, mentioning this alongside ECEC (Slovakia) and healthcare (Slovenia).

The CSRs make frequent reference to the lack of long-term care or of expenditure on long-term care (Cyprus, Czechia, Estonia, Latvia, Poland, Romania and Slovenia), sometimes in relation to increased demand due to ageing populations (Cyprus, Romania and Slovenia). The link between poor access to long-term care and low labour market participation is also highlighted (Czechia), as is the lack of support for informal carers (Estonia and Poland), sometimes explicitly in the context of the gender employment gap (Finland and Italy). The CSRs for Croatia underline care responsibilities generally as a problem for employment, without making explicit reference to long-term care. Similarly, the CSRs for Greece do not reference long-term care specifically but note that investments should focus on enhancing access to inclusive, affordable and high-quality ‘social services’, as well as on developing day care centres. For some countries, the CSRs highlight the need to develop non-residential and non-institutional care, such as home care, day care and community care services (Italy, Latvia and Romania). For Romania, it is also noted that these services are concentrated in high-income areas.

The CSRs highlight groups in vulnerable situations, such as persons with disabilities (Bulgaria, Italy and Slovakia) and the elderly (Bulgaria). Some CSRs also highlight other groups, such as the Roma population, but it is not always clear in the context of which services they are mentioned (Bulgaria and Slovakia). Geographical disparities in the availability of long-term care services are highlighted in Italy.

* * *

Overall, this report confirms many of the access problems for these services highlighted in the CSRs. However, it also highlights problems in countries where they do not feature in the CSRs for the three services, and it reports particular types of problems that do not feature in the CSRs. Furthermore, while access to ECEC and long-term care services is discussed in the CSRs in the context of increased female labour market participation, the perspective of this report is wider, with the broader EU policy context also emphasising the importance of access to these services for well-being – for instance, acknowledging that ECEC can play a role in reducing inequalities and improving educational outcomes – and as a right.

2

Access to care services: An illustrated framework

In the present report, access to care services is defined as ‘obtaining care services that meet needs’. The focus is on formal services, provided by paid professionals.

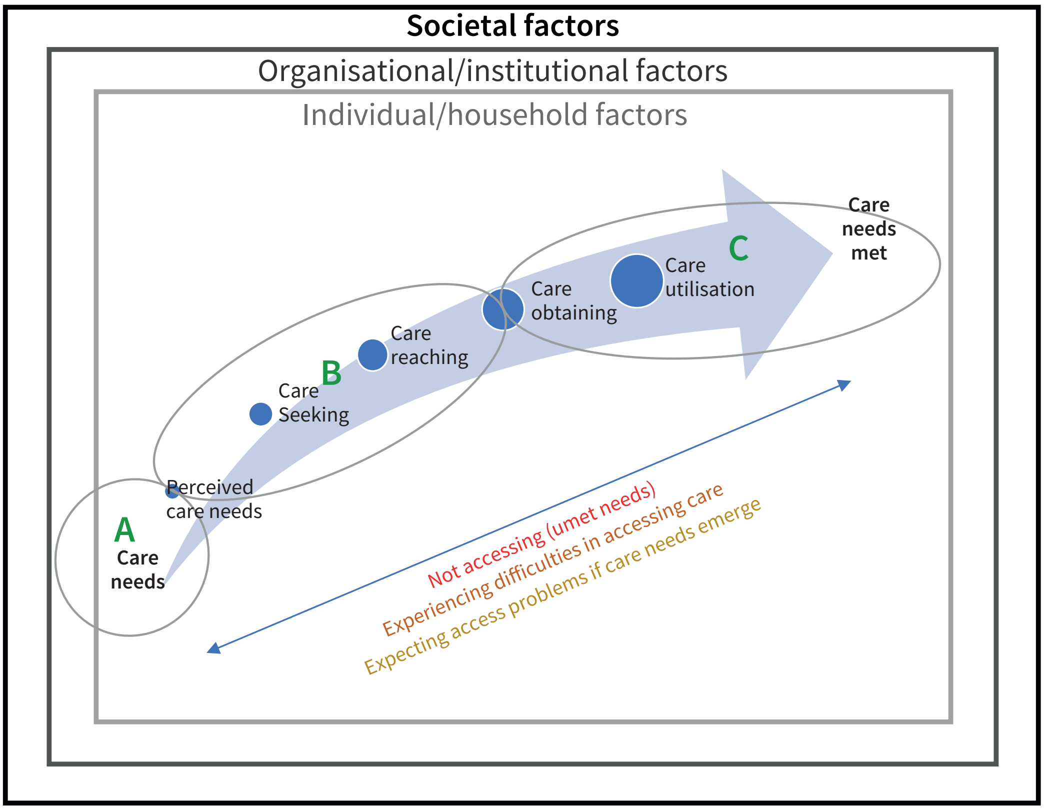
This chapter develops a framework to take into account the multiple aspects of access to care services (Figure 2). It follows the series of steps to be taken when accessing a care service. The framework begins with care needs. While the prevention of initial needs is outside the scope of this framework, raising awareness of needs and providing prompt access can forestall the escalation of needs.

In the context of early childhood education and care (ECEC), the care seeker is usually a parent or guardian of the child requiring care. In healthcare, the care seeker is usually the potential care user, but can also be a parent or child of the person in need of care. In long-term care, the care seeker may be a relative or partner of the person with care needs.

The framework should be considered continuously, as care needs may last over a certain period. The framework further differentiates between:

- individual, organisational and societal factors affecting access (Eurofound, 2015a)
- unmet needs, experiencing (but overcoming) difficulties in accessing care, and expecting access problems when care services are needed in the future (Eurofound, 2019b)

Figure 2: General framework for access to care services



Source: *Adapted from Levesque et al (2013) and Eurofound (2013, 2015a)*

The text below outlines various types of access problems, following the different steps when such problems can emerge, from perceiving care needs to meeting them adequately. In discussing these problems, the steps outlined in the framework are condensed into three stages (A, B and C in Figure 2).

A) Care needs → Perceived care needs

Needs for formal care services do not always translate into *perceived* needs. For the different services and situations, varying mechanisms dominate in this stage of the process.

First, people with care needs may fail to identify them. For instance, health literacy plays a role in perceiving healthcare and long-term care needs (Levesque et al, 2013). For ECEC, parents or guardians may insufficiently consider ECEC needs for the development of a child. Second, while care needs may be identified, formal care may not be deemed necessary. Alternative forms of non-formal care may be available, accepted by society and acknowledged by the institutional context. For instance, people may not perceive the need for ECEC or long-term care if a relative is able to provide care.

Such failure to perceive formal care needs tends to be framed as an individual factor, i.e. an inability of the individual to identify the needs. However, organisations can facilitate the identification of needs, and may for instance have failed in doing so through outreach activities. The Council of the European Union (2019) recommends that Member States establish ‘contact and cooperation with families and especially those in a vulnerable or disadvantaged situation’ to inform them about the possibilities and benefits of ECEC participation and, ‘where relevant, about available support, and build trust in the services and encourage participation from an early age’. Broader societal factors are also important in enabling people to identify care needs, such as the role of education in society, the importance assigned to various related elements in school curricula and media interest in relevant topics.

B) Perceived care needs → Care obtaining

Different access problems are more likely to emerge at different stages between perceiving care needs and obtaining care. Before care seeking: stigma and assuming non-availability or non-entitlement can form a barrier to access. After an initial search has started: reachability problems and waiting lists. After care has been reached but not yet obtained: physical barriers and waiting time at the venue. However, these problems can also form a barrier to access during other stages. For instance, if people expect long waiting times or physical barriers at the venue, they may not even begin to seek care. Alternatively, they may find out about waiting times and physical barriers after beginning an initial search and then refrain from reaching the service. Key access problems encountered during any of these stages are described in further detail below.

Informed access: Perceived needs may not translate into care seeking if people are unaware of financial support or free-of-charge care, or do not know how to apply for access. People may identify their needs but not approach the most appropriate service provider. Whether their care needs are then met depends on effective referral to other care services. Factors at all three levels can contribute to access problems. At an individual level, households may have limited ability to understand the relevant regulations. An example of an organisational/institutional factor is the complexity and lack of proactivity of care or support systems. Societal factors may include low internet penetration, which if increased could contribute to better dissemination, and legal restrictions preventing proactive approaches (Eurofound, 2015a).

Affordability: People may not fulfil the conditions entitling them to access the service for free, at reduced rates or with tax advantages, or to access the full package of services that they need. Affordability also depends on household income. On the cost side, affordability is further impacted by under-the-table payments, transport costs and expenditure needs on other items, such as housing. Opportunity cost also plays a role. In the case of ECEC and long-term care, this may involve loss of income from employment by an informal carer, taking into account benefit and tax impacts. In the case of healthcare, it may mean opportunity costs for the person in need of healthcare, or for a parent accompanying a child with healthcare needs (Frazer et al, 2020). The impact of this opportunity cost varies across the different types of care services: high opportunity cost (high loss of income when accessing healthcare) is a barrier to healthcare access, but low opportunity cost (low loss of income if providing informal care) constitutes a barrier for accessing ECEC and long-term care.

Availability: Services may be unavailable in a country. However, services may also be perceived as unavailable because they are unaffordable or hard to reach. For instance, in the case of long-term care, it may only be possible to obtain professional care by a private provider which is expensive, as cheaper alternatives are unavailable. Some people may also perceive services as being unavailable if they are located far away and/or public transport links are not sufficient to access them, even if the services do have availability in reality. Poor working conditions in the relevant care sector can act as a societal-level contributor, leading to a shortage of care workers and thus a lack of available services and long waiting lists or waiting times.

Reachability: Geographical spread and access to high-quality public or private transport play a key role. Such barriers in accessibility affect some people more than others, not only based on where they live, but also for instance on whether they can afford transport. Also, for persons with a disability, there is a particular need for service providers and society more broadly to ensure reachability, including by appropriate transport links (in line with the European Accessibility Act, and SPC, 2010).

Timely/flexible access: Barriers to timely/flexible access can be caused by waiting lists, waiting times at the location of the service provider, or limited opening hours. Waiting lists can vary across different regions and specific services. They may be caused by difficulties in recruiting staff, staff cuts or a lack of funding for their service provision. Legal requirements may also play a role, such as the maximum number of children permitted per ECEC provider. Another organisational/institutional factor is that ECEC and primary healthcare services may only be accessible during regular office hours (e.g. Ünver et al, 2018). This can be a problem for single parents who work early-morning or afternoon shifts – an example of individual/household circumstances playing a role. These factors are shaped by societal norms and are reflected in legislation and the notion of ‘normal’ office hours. Similarly, home-based long-term care may not be available at short notice, at night, or at specific regular intervals.

Trust/quality: People may not seek care if they do not trust the available services, are afraid of engaging with them, or perceive their quality to be too low. For instance, people may fear long-term care because of accounts of abuse in residential care. Such access problems can lead to apparent discrepancies. For example, people may report access problems due to distance or waiting lists, although objective data show that services without waiting lists are available nearby; in this case, it may be that they do not trust these nearby services or perceive them to be of low quality (Eurofound, 2018a). Low levels of trust in ECEC facilities can be due to cultural reasons (European Commission/EACEA/Eurydice, 2019).

Stigma: Stigma is particularly likely to play a role in relation to mental healthcare, but can also be a factor in other types of care. For instance, there may be a stigma attached to residential long-term care in societies where there is a strong social norm of elderly parents living with their children. Stigma may also relate to the social benefits system. For instance, parents may be reluctant to request support for ECEC if it is narrowly targeted at the poorest members of society and organised in a way that means benefit recipients can be easily recognised (Eurofound, 2015a).

C) Care obtaining → Care needs met

Obtained care may not meet care needs. At an individual or household level, people may not engage effectively with the services. At an organisational level, the services offered may be inappropriate or there may be a lack of opportunities to engage, for instance due to discrimination (SPC, 2010). Broader societal factors include the quality of training for care providers, or stereotypes promoted by the media in the case of discrimination.

* * *

The following chapters focus only on some types of access problems for each of the services discussed. It is, however, important to keep the broader framework in mind, be aware that access problems go beyond those discussed, and avoid a narrow, data-driven perspective of access.

3 Access to early childhood education and care

This chapter focuses on issues around access to ECEC in the EU. The data available at the European level cover different types of ECEC.

In the EU Statistics on Income and Living Conditions (EU-SILC), the data encompass the following services provided in public or private structures (Flisi and Blasko, 2019):

- pre-school or equivalent
- compulsory education
- centre-based services outside school hours
- organised day care centres, including family day care, and professional certified childminders

Formal childminding provided without any structure between the carer and the parents is not included in the formal arrangements category in the EU-SILC. According to Eurostat, this is in order 'to take into account only childcare recognised as fulfilling certain quality patterns' (Eurostat, undated-a). Therefore, formal childminding is included in the 'other types of care' category, together with care by grandparents, other household members (other than parents), other relatives, friends or neighbours (Eurostat, undated-b).

The EU's Social Scoreboard monitors access to ECEC by looking at the uptake of services by children under the age of three. The indicator for use of services comes from the EU-SILC. It shows the percentage of children aged under three who are cared for by formal arrangements other than by their family for an average of at least one hour per week.

This chapter discusses this key indicator, but also looks beyond it by examining the use of ECEC for children between the age of three and the minimum compulsory school age. Furthermore, it looks into the volume of services received, in terms of number of hours. It also presents the available EU-level data on reported unmet needs. Besides discussing the different access problems that are particularly pertinent to ECEC and identifying groups at risk of access problems, it investigates how Member States have diverged or converged in terms of access to ECEC.

Common access problems and country differences

In 2018, 35.1% of children in the EU27 and UK under the age of three received ECEC for an average of at least one hour per week. Participation rates have risen steadily since 2010, apart from a decline between 2011 and 2012 from 29% to 27.3%. The average number of weekly hours of formal care increased. At the national level, all but five EU Member States experienced an increase in the average number of hours during this period. For children under three years old, the average rose from 7 to 10 hours between 2010 and 2018.

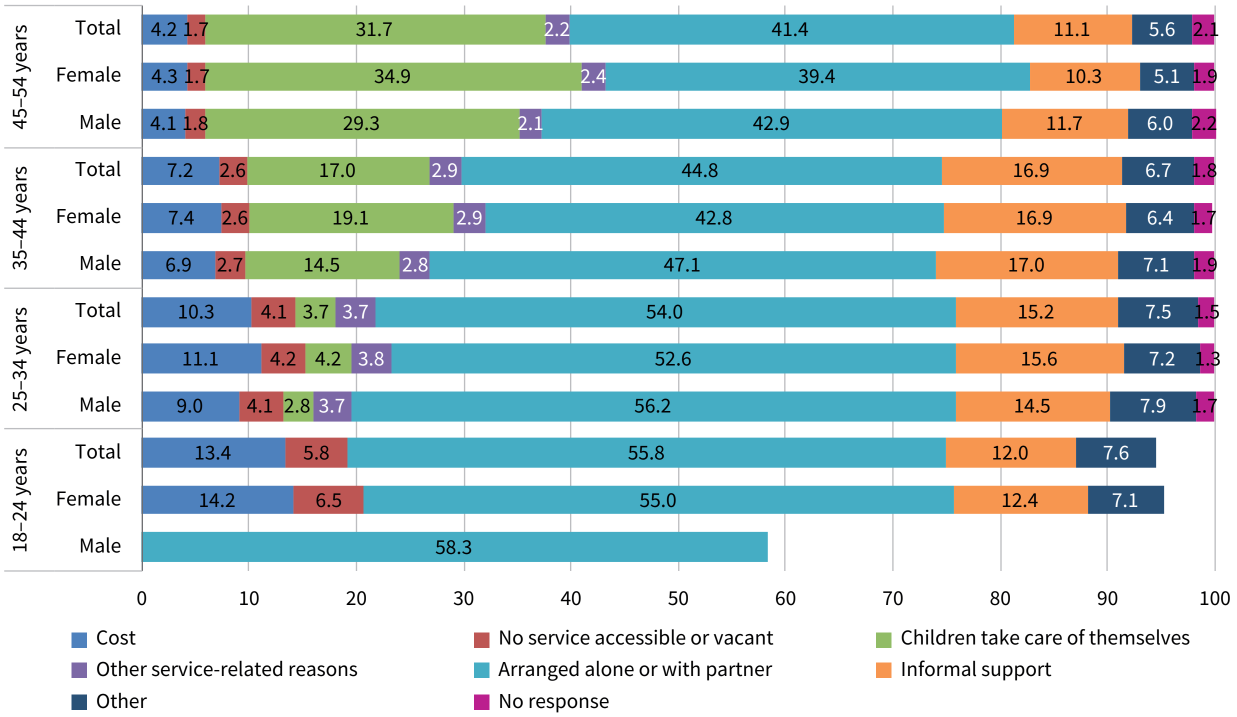
Further information about the use of services by different social groups and barriers to access is provided in ad-hoc modules in the EU-SILC and the European Labour Force Survey (EU LFS). The EU LFS 2018 ad-hoc module on 'Reconciliation between work and family life' provides data on the main reasons for not using ECEC services (referred to in the survey module as 'childcare services'), either for one's own or one's partner's children. It should be noted that the children using these services can be up to 15 years old. Data extractions for children up to the age of five (which would be more in line with ECEC services) are not publishable due to their sample size.

Profile of the population groups

Gender and age

There are almost no gender differences in terms of access to ECEC reported by parents when examining the entire 18–54 age group of parents (Figure 3). Some differences between the genders appear more prevalent between the ages of 25 and 44, with more women than men in that age group reporting cost as an issue. However, interpretation is a challenge and explanations would need to be explored further. There may, for instance, be significant differences in perspectives between women and men in two-adult households with at least one child. For example, one adult in the household may feel that their child's care is handled adequately by their partner, but the partner may report that they would rather have access to formal ECEC if cost was not an issue.

Figure 3: Main reasons for not using professional ECEC, EU27 and the UK, 2018 (%)



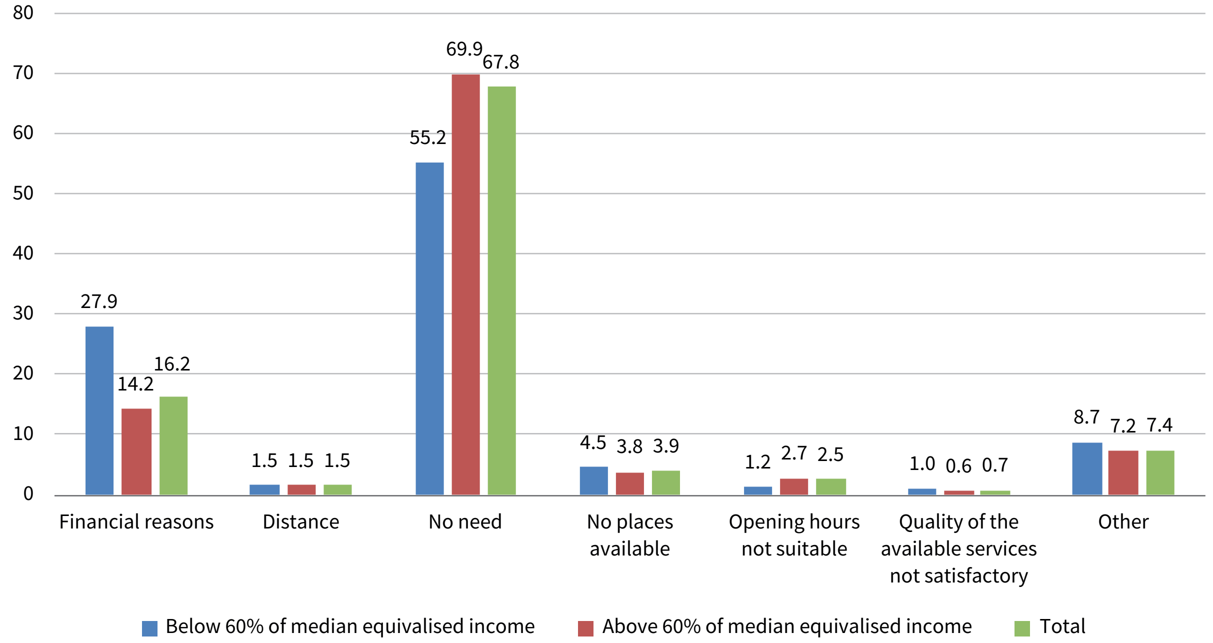
Note: *Respondents aged 18–54 with children up to 15 years of age who used services only for some children or did not use them at all.*
Source: *EU LFS 2018 ad-hoc module*

In the case of younger parents, informal care provided by the parents themselves is the main source of support. This decreases as the parents' age increases, with care by the children themselves also increasing with the age of the parents. A plausible explanation for this is that children of older parents are generally older themselves, and thus more capable of taking care of themselves. All service-related issues decrease with the age of the respondents. This could be in part due to the different nature of the ECEC services used. Most EU countries (25 of the Member States) offer free ECEC to children in the last year before school starts (i.e. at the age of 4, 5 or 6, depending on the country). Free-of-charge ECEC is available to children aged three in 15 Member States. Only Latvia, Lithuania, Luxembourg and Romania offer this for children under the age of two (European Commission/EACEA/Eurydice, 2019).

Income groups

The differences observed in cost as a barrier are probably linked to household income, which is likely to be higher for older age groups. This contributes to explaining the decrease in cost as a barrier according to the parents' age, as illustrated in Figure 3. The EU LFS ad-hoc module provides information about employment, but not about household income. This information is available in the EU-SILC 2016 ad-hoc module.

Figure 4: Main reasons for not meeting needs for formal ECEC services, EU27 and the UK, 2016 (%)



Source: *EU-SILC 2016 ad-hoc module. Data for the EU aggregated average are estimated.*

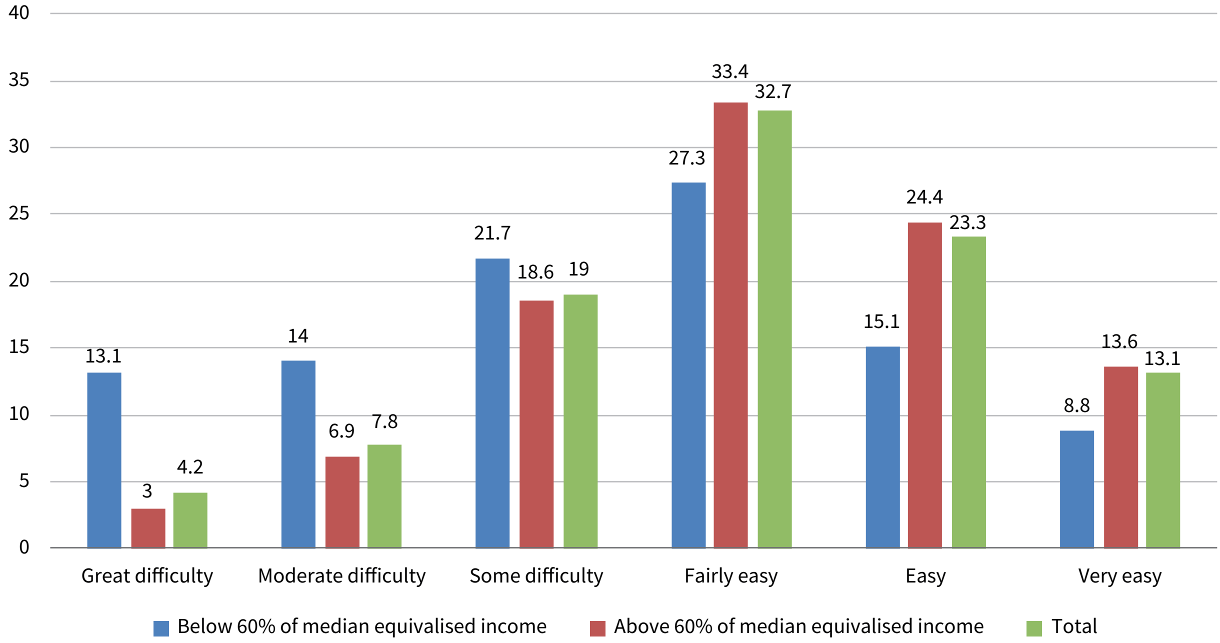
The largest differences between income groups can be found in the level of need and the extent to which cost (shown in Figure 4 as 'financial reasons') constitutes a barrier. Over two-thirds of respondents (67.8%) report having no need for ECEC, with households with a higher income having less need of ECEC. This was particularly the case in Finland, the Netherlands and Czechia, which had the largest gap in needs (over 30 percentage points) between the high- and low-income groups. Estonia was the only country in the EU where more low-income households than high-income ones declared no need for ECEC (a difference of 23 percentage points). It is important to note that childcare needs may not always translate into perceived childcare needs, as people are not always aware of the benefits ECEC can have for their children (see discussion around Figure 2 in the previous chapter).

With an overall difference of 13.7 percentage points, cost is the other area in which differences between the two income groups stand out. The widest gaps (over 30 percentage points) can be found in Romania and Slovakia. In Romania, about half (51.3%) of households with a lower income mentioned financial reasons for unmet needs, compared to only about one-fifth (20.2%) of households with a higher income. The gap was wider in Slovakia: 60.6% of low-income households, compared to just 17.5% of high-income households.

Furthermore, the EU-SILC provides information on how the cost of ECEC poses difficulties for different income groups. The biggest gaps between income groups can be found in the extent to which the cost causes them great difficulties, and the extent to which they find it easy to afford formal ECEC (Figure 5).

Research looking at net costs shows that costs as a percentage of disposable income are higher for low-income families than for medium-income and high-income families in most EU Member States (all except Belgium, Croatia, France, Italy, Luxembourg, the Netherlands and Portugal) (European Commission, 2019a). Net costs in this case are calculated as the difference between gross fees minus benefits/rebates and tax deductions, plus changes in other benefits. This research shows the need to complement perceived affordability with other data, such as on ECEC fees. Fees for children under the age of three are higher in the countries where they are not regulated and where ECEC providers have autonomy in establishing their prices (Ireland, the Netherlands and the UK) (European Commission/EACEA/Eurydice, 2019). As explained in the discussion around Figure 2, access problems due to affordability stem from an interplay of factors, including household income and expenditure (such as on housing), and various costs related to the use of the service.

Figure 5: Level of difficulty in affording ECEC services by income group, EU27 and the UK, 2016 (%)



Source: *EU-SILC 2016 ad-hoc module. Data for the EU aggregated average are flagged as estimated.*

Convergence/divergence between Member States

This section focuses on the question of whether countries have converged in terms of access to ECEC. Although there is no perfect indicator regarding all Member States over a period of multiple years, there are several relevant indicators. First, there is the Social Scoreboard indicator on the proportion of children in ECEC (previously analysed in Eurofound, 2019c). Most countries are below the Barcelona objective of 33% of children in ECEC, so an upward trend in practice means closer alignment with the policy objective. This section also analyses convergence and divergence in relation to the proportion of children between the age of three and school-going age who are in ECEC. For this indicator, the policy target is significantly higher, at 90%. Both these indicators mask any diversity in the intensity of this care. This section looks at an important aspect of such diversity: average number of hours in ECEC for all children up to primary school age. The analysis also examines convergence among two other age groups: children below the age of three, and children aged between three and primary school age.

The proportion of children under three who are in ECEC has converged between 2008 and 2018, but the pattern has not been consistent. The data show intermittent upward and downward changes in the standard deviation, resulting in only a slightly lower standard deviation in 2018 than in 2008. However, there has been a very clear and constant increase in the average proportion among all Member States, and only three countries (Denmark, Italy and Slovakia) have shown a decrease. Modest convergence can be explained by Member States with relatively low rates not increasing at a significantly faster rate than those that already have high rates. A relatively high number of ‘overperformers’ stand out – these countries were already above the average in 2008 and found themselves even further above average in 2018: Belgium, Finland, France, Ireland, Luxembourg, Portugal, Slovenia and Spain.

The trend of convergence has been stronger in terms of the proportion of children aged between three and primary school age in ECEC. Here, too, the average increased consistently. While more countries showed decreases (Belgium, Denmark, France, Germany, the Netherlands, Spain and the UK), most of these already had high rates. This occurred slightly earlier for children aged three to primary school age (in 2013) than for those aged under three (in 2014). Many Member States caught up from a lower-than-average position in 2008, resulting in their approaching the average in 2018 (Austria, Bulgaria, Czechia, Lithuania, Malta, Poland, Romania and Slovakia).

The average number of hours in ECEC for all children up to primary school age across all Member States has steadily increased each year, with one exception (2016–2017). The sharpest rise was during the period from 2009 to 2013. Overall, the process during this time was one of divergence. However, a more detailed look at the data reveals that in the past three years (2015–2018), countries have begun to converge following this longer period of divergence. Looking separately at the average hours for children under the age of three and those aged between three and primary school age, there has been a similar shift from divergence to convergence. This occurred slightly earlier for children aged three to primary school age (in 2014) than for those aged under three (in 2015). However, there is an important difference: overall, countries diverged during the period 2008–2018 in terms of children under three, but converged for those aged between three and primary school age.

The countries that have driven the divergence in average hours overall are those below the EU average that have fallen further away from the mean (Finland, Romania and Slovakia), as well as those already above the average that showed larger-than-average growth (Denmark, Latvia and Portugal). However, this observation masks the different dynamics for the two age groups. For children under three, the main drivers of divergence were those with below-average hours in 2008 that drifted even further away from the average in 2018 (Croatia and Slovakia), as well as those with above-average hours in 2008 that showed larger-than-average increases (France, Luxembourg, Portugal and Slovenia). However, for children aged between three and primary school age, convergence was mainly driven by countries below the average moving closer towards it (Croatia, Czechia, Germany, Greece, Ireland and Poland) and countries above the average moving closer towards it. In two cases, countries above the average that moved closer to the average showed decreases during this period compared to the average (Denmark and Italy), but in most cases convergence was due to lower-than-average rates of increase (Belgium, Estonia, Finland, France and Sweden).

Overall, there has been a trend of upward divergence in the number of hours of ECEC. However, this mostly seems to stem from divergence in ECEC arrangements for children aged three and below. Furthermore, a drive towards upward convergence can be observed from around 2014–2015 onwards, among all the examined age groups. As mentioned in Chapters 5 and 7, the delayed impact of the global financial crisis and the austerity measures that followed may have played a role in access to long-term care and healthcare. In some countries, access was reduced in the aftermath of the crisis and only picked up long after it ended, with one of the possible drivers for upward convergence being the desire to integrate parents into the labour market. Last, while average hours for children under three diverged between 2008 and 2018, they converged for children between three and primary school age. The different patterns for these age groups may reflect broader agreement in society as a whole – that is, among parents and policymakers – on the desirability of longer average hours for children aged between three and primary school age than for those under the age of three.

4 Access to early childhood education and care in focus: Inclusive practices

Spotlight on inclusive practices

The UN Sustainable Development Goal for quality education is to 'ensure inclusive and equitable quality education and promote lifelong learning opportunities for all'. One of the 2030 targets for this goal is to 'build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all' (UN, 2018, p. 5). Similarly, the Council recommendation on high-quality early childhood education and care (ECEC) systems recommends that Member States work towards ensuring that ECEC services are accessible, affordable and inclusive (Council of the European Union, 2019). The recommendation also states that inclusive ECEC should be:

> *… for all children, including children with diverse backgrounds and special educational needs, including disabilities, avoiding segregation and incentivising their participation, regardless of the labour market status of their parents or carers.*
>
> (Council of the European Union, 2019).

Principle 11b in the European Pillar of Social Rights states that 'children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities'. The accompanying Commission Staff Working Document lists the groups of children it addresses, which includes children with special needs or disabilities (European Commission, 2017b). The Commission recommendation on investing in children and breaking the cycle of disadvantage asks Member States to 'provide for the inclusion of all learners, where necessary by targeting resources and opportunities towards the more disadvantaged, and adequately monitor results' (European Commission, 2013a).

This chapter provides an overview of some of the policies and resources in place in EU Member States, Norway and the UK to promote inclusion in ECEC. The United Nations Educational, Scientific and Cultural Organization (Unesco) has defined inclusion as 'a dynamic approach of responding positively to pupil diversity and of seeing individual differences not as problems, but as opportunities for enriching learning' (Unesco, 2005, p. 12). In particular, this chapter focuses on children with special educational needs, as there is less information available for this group of children than for children with a socioeconomic disadvantage (see section on 'Evidence of inclusive practices in Europe' below). Children with special educational needs have been defined as 'children whose learning difficulties hinder their ability to benefit from the general education system without support or accommodation to their needs' (European Commission, 2013b, p.3, based on Unesco Institute for Statistics, 2012). In particular, the children considered here are those in the following categories established by the Organisation for Economic Co-operation and Development (OECD, 2007):

- Students with disabilities or impairments viewed in medical terms as organic disorders attributable to organic pathologies (for instance, in relation to sensory, motor or neurological defects). The educational need is considered to arise primarily from problems attributable to these disabilities (cross-national category 'A/Disabilities').
- Students with behavioural or emotional disorders, or specific difficulties in learning. The educational need is considered to arise primarily from problems in the interaction between the student and the educational context (cross-national category 'B/Difficulties').

Even when these children attend ECEC services, this might be in special schools or special classes within mainstream settings. It may be the case that they do not fully take part, are discriminated against, or have worse outcomes in mainstream classes. In order to achieve political commitments to inclusive education, it is necessary to have an adequately trained workforce. For example, in Spain, the National Disability Observatory identified difficulties in establishing an inclusive educational framework (at all educational levels) due to a lack of resources and, in particular, specialists (Observatorio Estatal de la Discapacidad, 2018). The reform of the national education system, which was presented in March 2020 and includes ECEC from zero to three years of age, put the emphasis on inclusion.

This chapter builds on and complements the information previously gathered by Eurofound. In the area of continuing professional development (CPD), Eurofound has provided evidence on effective measures to increase the overall quality of ECEC and make it more inclusive (Eurofound, 2015b; 2015c). CPD is the most consistent predictor of high-quality staff–child interaction and links directly to the development and learning of children (OECD, 2018).

This section puts the spotlight on one specific example of a service that aims to increase take-up: the Access and Inclusion Model (AIM) implemented in Ireland since 2016. This model is described in boxes in the different subsections to illustrate the various topics being discussed using practical examples (Boxes 2–5).

Box 2: AIM, Ireland – Overview

In September 2016, the Irish government established AIM to increase the uptake of ECEC services by children with disabilities. This group was still behind in terms of take-up, despite the introduction of the free pre-school year in 2010. Children with disabilities who accessed ECEC experienced issues regarding their inclusion in activities. The objective of AIM is to enable both access to and full participation in mainstream ECEC settings in Ireland. It sets out a tiered system of support, with seven levels of support available, ranging from universal support (available to everyone) to more targeted support. The first level of support (named 'An inclusive culture') includes training on diversity, equality and inclusion for practitioners. The third level of support (entitled 'Qualified and confident workforce') involves a multi-annual programme of formal and informal CPD training on disability and inclusion for pre-school practitioners (Department of Children and Youth Affairs, 2019a). The Leadership for INClusion in the Early Years (LINC) Programme was also developed as part of this third level of AIM (https://lincprogramme.ie/).

Evidence of inclusive practices in Europe

Even when the use of ECEC at the national level is in line with the Barcelona objectives and/or the benchmark[3] for ECEC set by the EU's Strategic framework for European cooperation in education and training (known as ET 2020), the take-up of services varies across different groups of children. For some groups of children, there are no data available in the EU-SILC or other international and national sources. Some studies may not record specific characteristics of children, and the sample size or sampling method may exclude some groups of children. In the case of children coming from disadvantaged socioeconomic backgrounds, there is information available in the EU-SILC about the use of ECEC, disaggregated by the level of household income and the risk of poverty or social exclusion (for an overview see Flisi and Blasko, 2019). As for information about ethnic groups, the Second European Union Minorities and Discrimination Survey (EU-MIDIS II) in 2016 showed that the proportion of Roma children who received ECEC regularly in many countries was less than half the proportion of children from the general population (FRA, 2016).

In the case of children with disabilities, there are fewer data available. Data about special needs are dependent on diagnosis and/or identification by parents, with definitions and classifications differing across countries (Eurofound, 2015b). The data from the OECD cover only 11 EU Member States and date back to the mid-2000s (OECD, 2007). The data show that the percentages of children with disabilities or learning difficulties who receive additional resources at pre-primary level are typically lower than the corresponding percentages in compulsory education. This can be due to difficulties in detecting disabilities and learning difficulties at a young age (Deluca, 2012). The number of children identified is linked to the proportion of staff trained to detect disabilities, the policies put in place to include these children, and parental views about these policies (OECD, 2019; see Box 3).

In 2018, a survey carried out in ECEC centres in nine OECD member countries (including only Denmark and Germany from the EU) gathered information about children with special needs. These children are defined as children for whom a special learning need has been formally identified because they are cognitively, physically or emotionally disadvantaged. This survey showed that in Denmark, more than 20% of staff report working with groups in which more than 11% of the children have special needs. This was the highest proportion in any of the participating countries, apart from Chile (OECD, 2019). It should be noted, however, that the response rate in Denmark was low.

In other European countries, the information available regarding the number of children who require additional support or the additional resources available includes the following:

- A survey of childcare providers in Belgium (Kind en Gezin, 2019) showed that 82% of the respondents make use of specialised assistance (mostly paramedics, parents and family counselling services). Specialists mainly give advice on developmental stimulation or support children in their development. In 63% of the ECEC and after-school care centres that participated in the survey, all or part of the staff had undertaken training on inclusive childcare or on dealing with diversity and specific care needs positively.

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[3] The benchmark set for ECEC was that at least 95% of children aged between four years and the compulsory age for starting primary education should participate in ECEC by 2020. This benchmark was achieved in 2016, and will most likely be replaced with a more ambitious benchmark target.

Box 3: AIM, Ireland – Data about children receiving support

The proportion of children with a diagnosed disability attending mainstream pre-schools ranged between 45% and 48% in the period from 2011 to 2016. Since the introduction of AIM, this increased to 57% in 2016–2017 and to 65% in 2017–2018. In 2018–2019, more than 5,000 children with disabilities received targeted support and most children aged three to five years also benefited from the universal support available through AIM. This may increase further, however, which leads to concerns about AIM funding (Department of Children and Youth Affairs, 2019b).

- In Norway, a report from 2015 stated that 2.6% of all children in kindergartens receive some form of support. The number of children with special needs receiving support had increased from 76% in 2009 to 83% in 2015 (Wendelborg et al, 2015).
- In Slovakia, children with special needs make up about 1.4% of all children enrolled in pre-primary education (either in special or mainstream ECEC centres). In September 2018, there were 2,221 children with special needs enrolled in ECEC. Two-thirds (1,667) of these children attended special pre-schools. Between 2014 and 2018, there was a decrease in the number of children with intellectual and/or physical disabilities attending mainstream pre-primary education. The number of children with autism attending mainstream pre-primary education increased during that period (CVTI SR, 2019).
- Kolnes and Konstabel (2018) looked at the number of children with special needs and the number of specialists in Estonia in 2015–2016. The data were gathered from national databases, schools, kindergartens and local governments. They concluded that an additional 88% of speech therapists, 126% of special educational needs teachers, 187% of psychologists, and 69% of social educators are needed to cover the workload in schools and pre-schools.
- In Czechia, 461 teachers participated in a 16-hour training session on inclusive education and education of children with special educational needs (described in further detail in the next subsection on ‘Continuing professional development’) in 2018. Two years earlier, in 2016, there had been 800 participants. A possible explanation of the decline in participation is that a new system of support measures for children with special educational needs in schools and kindergartens came into force in 2016.

Continuing professional development

In-service training has been shown to improve the quality of ECEC services and the outcomes of children (Eurofound, 2015c; OECD, 2018). Only five European countries (Luxembourg, Romania, Serbia, Slovenia and the UK) make CPD courses mandatory for all staff, specifying the minimum amount of time to be spent. Ten other European countries refer to CPD in regulations or make it compulsory, but without specifying the amount of time to be spent on it (European Commission/EACEA/Eurydice, 2019). As part of the Teaching and Learning International Survey (TALIS) Starting Strong Survey in 2018, ECEC staff identified a number of barriers to participation in CPD (in general, not only in terms of inclusion). The main barriers identified were not having enough staff to cover absences, followed by CPD being too expensive and CPD clashing with the work schedule (OECD, 2019).

The 2018 TALIS Starting Strong Survey also showed that training in special needs was the main professional development need of ECEC staff (OECD, 2019). Similar needs have been identified in several European countries. In Croatia, many university courses on autism have been available to special needs teachers since the country’s reforms as part of the Bologna Process. However, staff who finished their studies before the start of the Bologna Process could only avail of one course on this topic and hence further training and education is needed. In Lithuania, several studies and surveys point out the lack of training opportunities in inclusive education. A survey showed that 45% of special needs teachers (*Socialinių pedagogų*) working in pre-school, pre-primary, primary, general and vocational training schools lack methodological guidance or support measures (SPPC, 2019). A study found that the main problems faced by education professionals when seeking to improve their qualifications in special educational needs are the lack of specialised workshops and training in some parts of the country, lack of training capacity, the high cost of seminars, and insufficient funding (Diržytė et al, 2018). According to the findings of another survey, the education of children with special educational needs is problematic for 22% of primary and nursery schools in Vilnius (VPPT, 2018).

Initial education and CPD

There is a link between the extent to which inclusion is part of initial education and whether it is offered in CPD training courses. In countries where inclusion is a compulsory component of initial education, there is less CPD training on the topic. In Estonia, the 1999 Preschool Child Care Institutions Act requires pre-school teachers to observe how the child develops and copes and then adjust their teaching and learning according to the child's special needs. Special needs education is a voluntary competence that may be undertaken by those studying pre-school teaching. Teachers of special or mixed groups need to acquire special educational qualifications through university or other courses that cover the topic of children with special needs. Several CPD training courses on inclusion were identified in Estonia (see 'Duration' subsection below).

On the other hand, training and skills development in how to make ECEC services more accessible and inclusive are part of the general education of teachers in Latvia, where the present study found no CPD courses on inclusion. No CPD courses on inclusion were found in Finland, either, based on the list of courses provided by the Regional State Administrative Agencies. As in Latvia, this may be because it is already integrated in the basic education of ECEC staff. For example, the bachelor's degree programme for ECEC teachers at the University of Helsinki includes courses on critical special pedagogy, disability studies and inclusive education. In addition, it is possible to take special needs education as a major and specialise as a kindergarten special educational needs teacher. This study only identified one CPD course provided by a private company, Aikopa. This course is six days long and focuses on improving tools to identify children's needs. It consists of six workshops that focus on different areas of ECEC, such as language, emotions, and psychological and neurological challenges (Aikopa, 2019). The course is financed by the Finnish National Agency for Education.

Some countries have introduced CPD in inclusion as a requirement. In Lithuania, teaching staff must have completed a CPD programme in special education and special psychology. This must be completed within one year of starting work as a teacher. The requirement does not apply to teachers who have completed courses in special education and/or special psychology as part of their university studies. The aim of the programme is to develop a positive approach towards inclusive education, the diversity of children's educational needs and the abilities and needs of children with special educational needs, and to develop teachers' ability to provide education to these children.

In the Netherlands, staff working in ECEC for children aged two to three years with a language deficiency or disadvantage are required to have an upper-secondary vocational education (*middelbaar beroepsonderwijs*) level 3 degree covering certain topics relevant to the development of a child. If these topics are not covered, staff must undertake additional training. It is common for teachers to receive training from the Netherlands Youth Institute, even if they meet the minimum education requirements. This is because the methods and approaches specific to language deficiencies or disadvantages are often taught only in specific training and not as part of initial education. Moreover, language deficiency or disadvantage programmes subsidised by municipalities almost always require that the participating ECEC centres train their staff in these methods.

Nursery schools funded by local authorities in the UK must follow the requirements set out in the special educational needs code of practice (UK Department for Education, 2015). These requirements include providing appropriate training and development for relevant staff to meet the special educational needs of children and young people. They also require the designation of a teacher as a special educational needs coordinator, who would be responsible among other things for the coordination of training. The governing bodies must publish information about the implementation of the policy for pupils with special educational needs on their websites. This includes information about the expertise and training of staff to support children and young people with special educational needs, including how specialist expertise will be secured.

In other countries, CPD inclusion is not specifically addressed in training policies. For example, in Cyprus, the 2015 scheme for the professional education of teachers does not define areas of training and educational activities (Cyprus Ministry of Education, Culture, Sports and Youth, 2015).

Working with groups of children

A previous review of inclusive practices in ECEC was able to find only two examples of CPD that had been evaluated as successful (Eurofound, 2015b). The two examples relate to working with children with autism and other emotional disorders and children with speech and language difficulties. The examples identified by the Network of Eurofound Correspondents were as follows:

- In Slovenia, private company Center Motus provides day courses focusing on attention deficit hyperactivity disorder (ADHD), autism and emotional disorders for teachers, assistants and counsellors. Participants learn about gender differences, how to adapt their educational methods and how to collaborate with parents. Courses accept teachers working in pre-school, primary, and secondary education, but there are no specific courses for assistants. The course 'Working with pre-school children with autism' offers an in-depth understanding of the behavioural and developmental principles for working with autistic pre-school children on a daily basis. Another private company, Zatis, offers a seminar on anxiety and panic disorders. Participants from all educational levels are eligible and the seminar involves practical exercises. The National Education Institute also organises a 16-hour course for all educational levels focusing on autism and the adaptation of pre-school education to children with special needs (Vršnik Perše et al, 2016).

- In Slovakia, the CPD course 'How to educate children at pre-school age with speech difficulties in pre-schools' focuses on the identification of speech disorders, their prevention, and speech development. It is provided as a 25-hour course lasting up to 10 months and the target group comprises pre-school teachers with at least six months of experience. The programme covers the whole country and is financed using EU funding and co-financing from the national budget.

Children can be eligible for these forms of support with a medical diagnosis or at the request of their parent or ECEC centre. In the Netherlands, in order to attend an ECEC centre for children with a language deficiency or disadvantage, children must obtain an official assessment or 'indication' (*VVE indicatie*). This is obtained at the municipal level via a designated department or consultation office (Government of the Netherlands, undated) and the assessment is often carried out at a youth and family centre (*Centrum voor Jeugd en Gezin*) or a similar organisation (BOINK, undated).

In addition to these CPD courses, several countries (for example, Belgium, Denmark, Hungary, Norway and Poland) have centres specialised in providing support to staff working with children with special educational needs and training is provided as part of the support provided by specialists. In some cases, these centres do not, strictly speaking, provide training, but rather ad-hoc advice. In Poland, for instance, ECEC staff working with children with disabilities receive support from public and private guidance and counselling centres. The support specialists in these centres are psychologists, teachers and speech therapists who help the ECEC staff to choose appropriate working methods. In Flanders (Belgium), inclusion coaches from 16 centres for inclusive childcare provide tailored support to ECEC centres through looking at the needs of each child. The Danish Ministry of Children and Education allocated DKK 23 million (€3.1 million as at 11 June 2020) to teams of educational practice consultants in the day care sector for the 2016–2019 period. These consultants train staff in day care centres by providing supervision and educational tools. The consultants have also carried out educational sessions for municipalities. In Hungary, since 2014 the Unified special educational, conductive educational methodological institutions (EGYMI) provide expert services to education providers, including kindergartens. They offer so-called 'mobile educators', and other types of professional support, including consultations and lectures. Some also organise training courses about inclusive education at integrated kindergartens.

Target groups

Very few training courses on inclusion target ECEC specifically. In some cases, the target audience spans several levels of education. For example, in Romania and Spain, most of the accredited courses target teachers in pre-university education. The courses provided by the Bavarian Academy for Teacher Training and Development, ALP Dilligen, mainly target primary education but may also be available at other levels. Several of the CPD training courses found in Eastern Europe gave their target audience as those working in 'early childhood intervention', which is defined by the European Agency for Development in Special Needs Education as:

> *… a composite of services/provision for very young children and their families, provided at their request at a certain time in a child's life, covering any action undertaken when a child needs special support to: ensure and enhance her/his personal development; strengthen the family's own competences; and promote the social inclusion of the family and the child.*
>
> (European Agency for Development in Special Needs Education, 2010, p. 7).

In Hungary, the Family Friendly Country (*Családbarát Ország*) courses target ECEC staff, as well as health and social professionals such as physiotherapists, speech therapists and visiting nurses involved in screening, detection, evaluation and intervention. The bulk of the target group is made up of professionals who are involved in the early childhood intervention system. To a lesser degree, some of the courses target staff in mainstream nurseries and kindergartens.

Naturally, this type of training also targets the above-mentioned specialists providing support to ECEC centres. In Poland, the Centre for Education Development (*Ośrodek Rozwoju Edukacji*) delivered training in 2011 and 2012 as part of the 'Early support of child development in a family environment' project. The training was aimed at directors of ECEC facilities and specialists such as special educational needs teachers, psychologists, speech therapists, therapists and physiotherapists. Another example is the CPD course provided by the Slovak Research Institute of Child Psychology and Pathopsychology (*Výskumný ústav detskej psychológie a patopsychológi*) on psychodiagnostics of children and youth in the context of school and social inclusion. The target group of this course comprises psychologists, including school-based psychologists, with a minimum of six months of experience. This CPD training course started in January 2020 and aims to develop and maintain the professional competencies of psychologists who provide interventions to children in an educational environment, including in pre-primary education. The participants learn about inclusion and inclusive education and update their knowledge and skills using psychodiagnostics.

The present study identified courses in Ireland and Luxembourg aimed at training staff to become the key person in charge of inclusion in their organisation. The course in Luxembourg prepares a member of staff to coordinate and support their colleagues in the implementation of an inclusion plan. Its five modules deal with the responsibilities of the role and the behaviours of children with special needs and disabilities (UFEP, 2020).

Format

Not all CPD training is equally effective. A review of studies analysing the relationship between CPD and the quality of ECEC found that CPD that is integrated into a centre's practice, focuses on reflection and leads to changes in practice and curricula is more effective. For training courses shorter than six months, video feedback has been found to be effective in improving staff competencies. Longer forms of training interventions that are integrated in daily practice, such as pedagogical guidance and coaching in reflection groups, are effective in improving interactions between staff and children (Eurofound, 2015b).

Some of these elements were found in CPD training on inclusion. In Luxembourg, the CPD course 'Inclusion for everyone!' targets the observational skills of ECEC staff and their implementation of adequate support strategies. The course is six hours long and includes work on child observation and documentation, as well as practical exercises and questions. The course 'Towards an inclusive, non-formal educational structure' includes group work, reflection and exchange of experience (FEDAS Luxembourg, undated). In Romania, the Ministry of National Education recommends the following allocation of time in training: 10% assessment/evaluation, 30% course or theoretical activity and 60% practical application. Family Friendly Country courses in Hungary also include lectures, discussions and practical exercises.

Many of the identified training courses featured an online component. In Poland, both public providers (for example, the Centre for Education Development and the Higher School of Social Sciences in Lublin) and private providers (for example, the company MrM Soft Marek Maroszek) offer online training for pre-school teachers, special educational needs teachers, psychologists and parents to support children with disabilities. These courses cover legal issues and the theoretical and practical aspects of supporting children in pre-school. In Romania, the European Centre for the Rights of Children with Disabilities has launched an online course for teachers, made up of five online presentations lasting one hour. Although it is not an interactive course, participants must complete an evaluation questionnaire in order to obtain a certificate of graduation.

Duration

Most of the identified CPD courses on inclusion lasted between one and a few days. In Denmark, a 2014 survey among managers of day care institutions, early childhood teachers and day care workers showed that most of the staff had participated in training activities on inclusion lasting less than one day. Roughly half of the staff had participated in training activities with a duration of one to three days, and approximately one-third had participated in training activities with a longer duration (EVA, 2014).

- In the special education and special psychology in-service training programme in Lithuania, teachers learn how to identify children's special educational needs and individual abilities, how to adapt curricula to children with special educational needs, and so on. The programme lasts 60 academic hours (32 hours of theory, 16 hours of practical work and 12 hours of independent work). Those who complete all the topics covered by the programme are awarded a certificate of completion.
- Several one-day courses are available in Estonia. There are also seminars and information days, which do not constitute training as such but do provide insights and new information. The seminars usually last for a couple of hours and take place in the relevant pre-school institution, or in regional centres in the case of longer seminars. There is no national curriculum in place for these seminars; topics are based on everyday practice and specific requests made by pre-school institutions and local governments. These seminars cover many aspects of special needs education, such as identifying and responding to different needs, supporting children and their parents, and organising additional support. During the past five years, there have been 306 seminars attended by 4,668 pre-school teachers.
- In Czechia, the National Institute for Further Education, managed by the Ministry of Education, Youth and Sports, provides a 16-hour training course for teachers in kindergartens. The training focuses on inclusive education and the education of children with special educational needs, including children with disabilities. The first part of the training focuses on basic theoretical knowledge and practical skills. The second part then focuses on the development of individualised educational support plans, which include modifications of teaching methods, adjustments in evaluation criteria and changes in learning strategies.

Cost

As stated in the previous chapter, cost constitutes one of the main barriers to accessing CPD training (OECD, 2019). In some countries, CPD training is delivered by public providers or subsidised by the public sector. In Finland, training is often organised by Regional State Administrative Agencies, and municipalities also purchase services from private companies. In some cases, universities or other higher education institutes organise staff training. The providers of the above-mentioned special education and special psychology training programme in Lithuania are mainly public institutions funded from municipal budgets. These include education centres for youth and adults, educational assistance services and education centres for teachers. In Romania, teachers must pay to take part in CPD training. The training fee is paid by the teacher or by the school to which the teacher is affiliated, provided funds are available in the school budget. The non-profit European Centre for the Rights of Children with Disabilities provides online training for free (see ‘Format’ subsection above).

In cases where courses are delivered free of charge, sustainability can become an issue. The ‘Early support of child development in a family environment’ project in Poland organised training sessions for groups of specialists from all over the country. The sessions had 40–45 participants and consisted of lectures and workshops, as well as meetings to exchange experiences. A lack of funding led the project to abandon this format and instead follow a snowball approach, whereby training participants are expected to deliver the training themselves. The ‘Leaders of early support of child development’ project follows a similar approach. Participants receive free training focused on developing the competencies of teachers, therapists and psychologists. Leaders are subsequently tasked with supporting those interested in the subject in their regions.

The training to become an inclusion representative in Luxembourg is funded by the Ministry of Education, Children and Youth and is free for participants. Other courses charge a fee. For example, the 21-hour course ‘Challenging children: Children who are different – Understand children’s specific behaviour’ costs €420. In Estonia, funding from the European Social Fund has contributed towards making some training courses free of charge. These include seminars in ECEC centres and university courses promoting the inclusion of children with delayed speech development and the development of children with special needs in kindergartens. Similarly, in Czechia, training of pre-school (kindergarten) staff on inclusive education, including of children with disabilities, is supported through European Social Fund funding. Kindergartens do not need to write elaborate project proposals to apply for these funds: the Ministry of Education announces areas of investment and the schools simply select their area to request funding.

Box 4: AIM, Ireland – Continuing professional development

A survey among early years professionals in Ireland showed that more than 80% of respondents undertook training in their own time (SIPTU, 2019). A previous survey identified working with children with additional needs as an issue that had to be dealt with in CPD (Duignan, 2018). Over the first two years of the LINC CPD training programme, 1,699 early childhood teachers graduated from the programme and a further 941 were enrolled in the 2018–2019 programme (LINC Consortium, 2019).

The LINC CPD training takes place over three semesters in one year. Participants are teachers from centres that nominate them for the course. The course combines online courses with face-to-face meetings with tutors at the end of each module. The programme consists of six modules, comprising topics such as concepts and strategies, child development, collaboration to achieve inclusion, curriculum and leadership, and a final module that requires reflection on practices. There are also on-site mentoring visits. Throughout the course, there are quizzes to test participants’ knowledge, as well as video clips, reading and case studies to prompt reflection on the practice (LINC Consortium, 2019).

Box 5: AIM, Ireland – Evaluation

The review of the first year of the AIM rollout in 2019 involved desk research, an online survey of pre-school settings, another survey for parents and guardians, interviews with stakeholder groups and five case studies focusing on children. The review found that the quality of teaching had increased as a result of extra training. It suggested developing this further by providing more training to staff and parents, improving the content, structure and delivery, and ensuring coverage in all parts of the country. This first-year review will be followed by a more in-depth review in 2020 (Department of Children and Youth Affairs, 2019a).

Summary of main issues

Cost has been identified as a barrier to the take-up of CPD training in many countries. This chapter provided some examples of the use of the European Social Fund to overcome this barrier. The Erasmus+ programme has also been used to promote the integration of ECEC services and to support multilingualism. The EU Semester policy framework is designed to align closely with the UN's Sustainable Development Goals, which include inclusive education. In turn, EU funding is meant to be more closely aligned with the European Semester, which opens up the opportunity to increase the financing available to funds such as the European Social Fund.

Only a few of the training courses identified so far have featured the components found to be effective in previous research by Eurofound. To ensure their effectiveness, the funding of programmes could prioritise aspects such as reflection, coaching and exchanges of experiences of day-to-day practices. In order to avoid shorter and less-effective formats, more countries could be encouraged to indicate a minimum length of CPD training courses and perhaps include requirements regarding the delivery format. This would be more effective than asking Member States to make CPD compulsory, which could lead to the rapid growth of CPD courses that do not improve current practices. Explicit policy guidance in relation to the content and format of CPD would represent a step in the right direction.

Most of the evaluations of inclusive practices previously compiled by Eurofound (2015b) included some sort of pre- and post-intervention measurement, but no follow-up measurement to analyse long-term impacts. Only half of the evaluations were carried out by an independent contractor. Almost none gathered the perspectives of children in ECEC. As many of the initiatives were pilot projects, they were not suitable for conducting randomised controlled trials, due to their sample sizes and funding constraints (Eurofound, 2015b).

Many of the CPD training courses found in this research – those in Czechia, Denmark, Hungary and Slovenia – were only assessed by asking for the views of training participants. For example, a survey of providers, teachers, managers and educational consultants in Denmark's day care system found that the more training the staff participated in, the more systematic their work on inclusion was. For example, they dealt with inclusion in staff meetings or used tools to assess the day care centre's work on inclusion. Respondents also demanded more opportunities for competency development and supervision, and teachers and providers also requested more feedback (EVA, 2014). The training course of the multifunctional centre in Liopetri (Cyprus) underwent an interim evaluation aimed at reviewing children's progress. The final assessment involved recounting discussions between teachers and interviews with children and parents.

The evidence base underpinning effective CPD and the evaluation methods to assess inclusive practices could also benefit from action at the EU level. Examples of evaluated practices have been gathered on the European Platform for Investing in Children and in the inclusion toolkit of the European Commission's working group on ECEC of the Strategic framework for European cooperation in education and training (ET 2020). These two repositories could provide more information relating specifically to CPD courses on inclusion, which could then be further expanded on the School Education Gateway website. Similarly, the evaluation of ECEC services could also be supported by the Horizon 2020 programme.

5 Access to healthcare

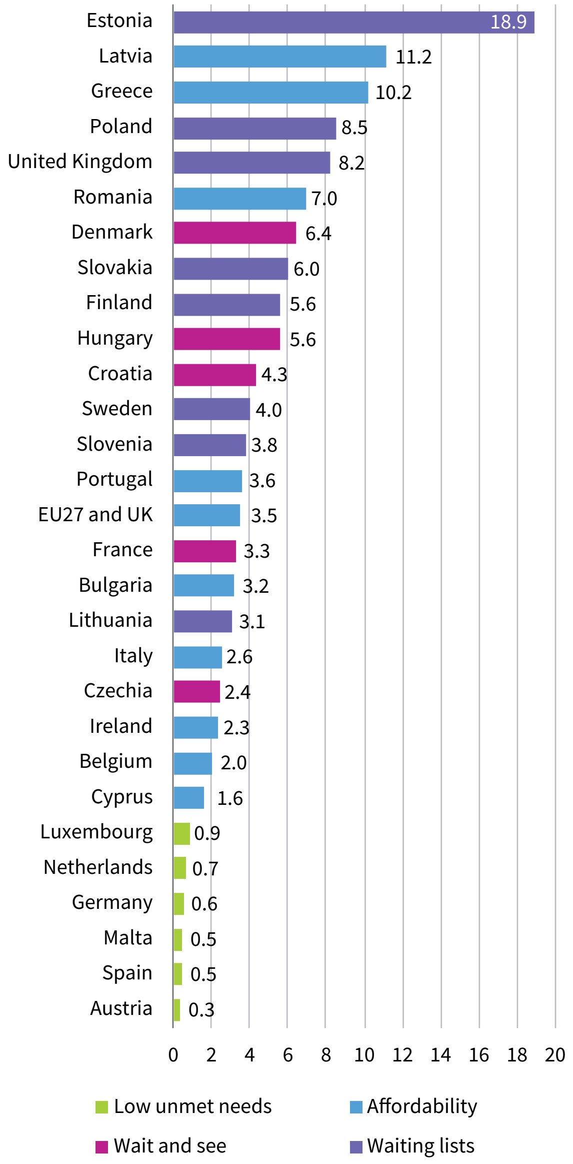
This chapter presents an overview of differences between the 27 EU Member States and the UK in terms of unmet medical needs, reasons for unmet needs, difficulties in accessing healthcare, and expected difficulties if needs emerge. It also examines differences between people in employment and those who are unemployed or economically inactive. Trends are discussed throughout, with a specific section discussing convergence between countries. It should be noted that the data presented do not yet capture the economic and health-related impacts of the coronavirus (COVID-19) crisis.

Common access problems and country differences

The EU's Social Scoreboard includes three indicators in relation to healthcare: self-reported unmet need for medical care (due to waiting times, cost or distance), out-of-pocket expenditure on healthcare, and life expectancy. The first captures acute access problems – in other words, people not receiving the care they need, the second captures a snapshot of social protection in healthcare, and the third reflects health status – specifically, the number of years for which people are expected to live healthily beyond the age of 65 – and hence relates more to prevention than to access to healthcare. As the focus of this report is on access to healthcare rather than prevention or health in general, life expectancy is not discussed. Out-of-pocket expenditure is an important factor, but it is not a focus here. Access problems due to affordability depend on the complex interplay of various factors (see earlier discussion around Figure 2 in Chapter 2). This section focuses on unmet needs and the insecurity people feel around their ability to afford healthcare if they need to. The fear of being unable to access healthcare when necessary is an important component of social insecurity, potentially causing discontent and negatively affecting a person's quality of life (Eurofound, 2018c).

People may report unmet medical needs for many reasons. These could include voluntarily waiting to see if their condition improves. As discussed around the framework presented in this report (Figure 2), such waiting may be explained by factors such as unaffordability, stigma, waiting lists, physical barriers, expected waiting times at the venue, or lack of trust. As demonstrated in the next chapter on e-healthcare, people who would otherwise wait and see if things get better might be willing to have a consultation if a low-barrier option were available, such as a telephone line or a mobile application (app). Another example of the difficulties in interpreting reported reasons for unmet needs concerns people who give waiting times as the main reason for their unmet needs. There may be another factor at play in this case: for example, there may be alternative care options available without waiting times, but at a higher cost. In such situations, the person may arbitrarily attribute unmet needs either to waiting times or to cost.

Figure 6: Proportion of people reporting unmet medical needs and main reason, EU27 and the UK, 2018 (%)



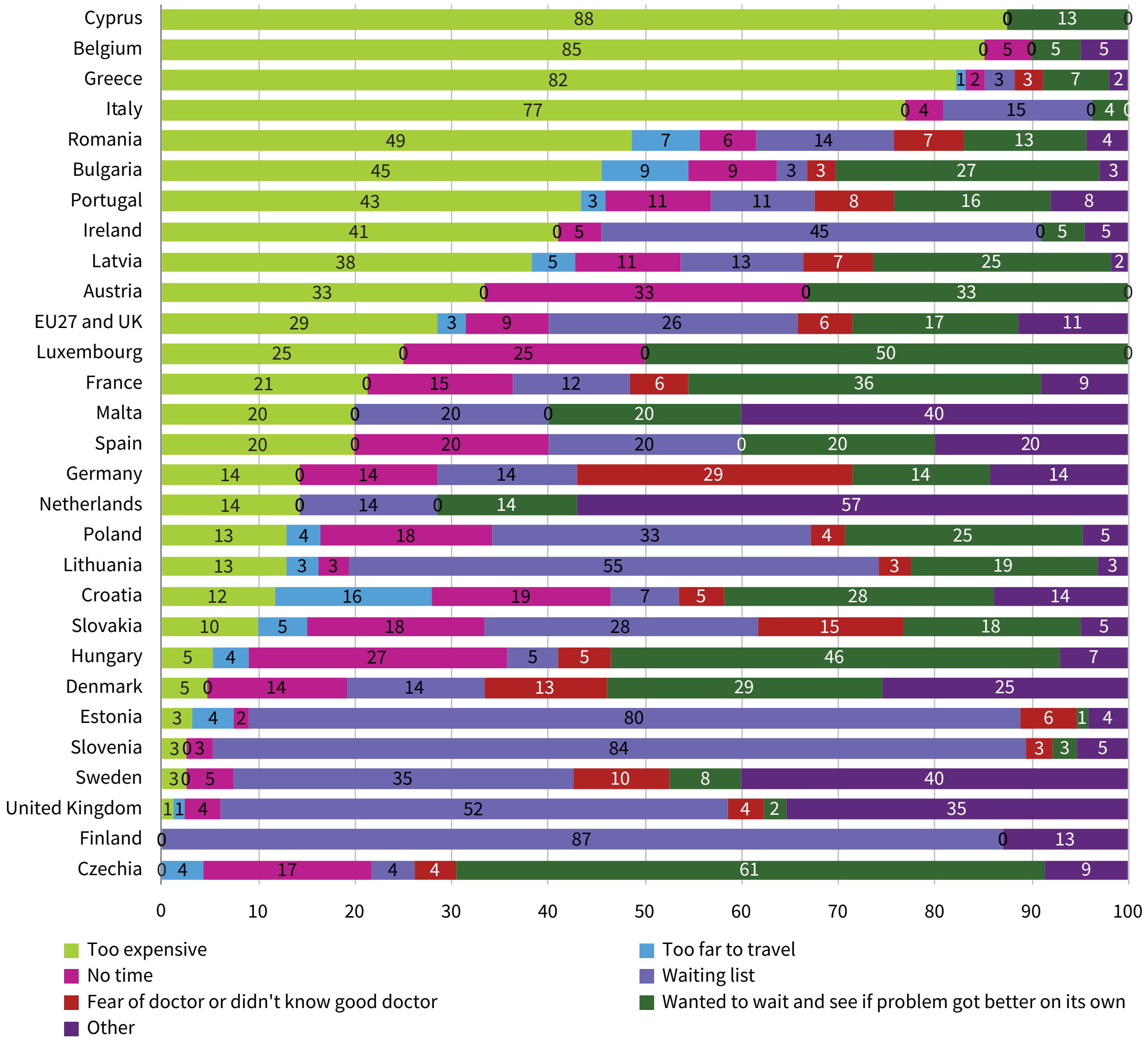
Source: *Compiled by Eurofound from Eurostat's online database (from EU-SILC 2018)*

This section begins by taking a comprehensive approach, including unmet medical needs for any reason. In the EU and the UK (as of 2018), 3.5% of people report unmet medical needs. In 19 of the countries studied, 4.3% or fewer report such problems. Three Member States stand out with proportions above 10%: Estonia (18.9%), Latvia (11.2%) and Greece (10.2%). The lowest levels of unmet needs (below 1.0%) are found in Austria, Spain, Malta, Germany, the Netherlands and Luxembourg. The main reported reason for unmet needs is waiting lists, as highlighted in Figure 6, which shows the percentages by country and the main reported reason for countries where more than 1% of the population reports unmet needs.

Figure 7 presents more detailed data about the reasons for unmet medical needs. In eight countries, over 40% of people with unmet medical needs report cost as the main reason: Belgium, Bulgaria, Cyprus, Greece, Ireland, Italy, Portugal and Romania. For one of these countries (Ireland) and for five others (Finland, Estonia, Lithuania, Slovenia and the UK), waiting lists are the main reason for over 40% of people with unmet medical needs.

The framework for access to care services (outlined in Figure 2) points to an important limitation of the unmet medical needs indicator: it only captures one outcome of problems in accessing healthcare. This means, for instance, that it fails to capture people who enter into poverty by paying for healthcare (referred to as

Figure 7: Main reason for unmet medical needs, EU27 and the UK, 2018 (%)

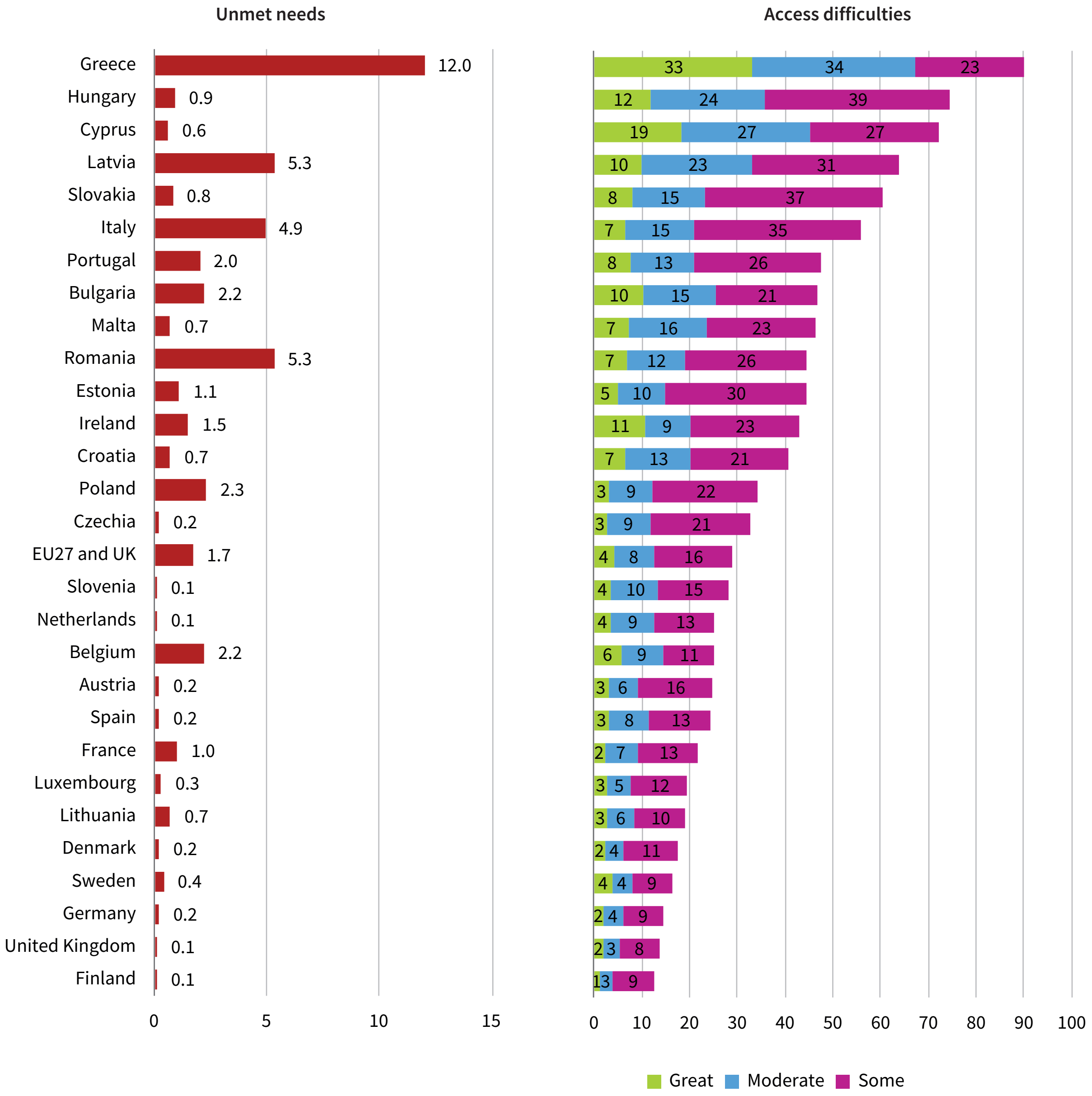


Source: *Eurostat online database (from EU-SILC 2018)*

'catastrophic healthcare expenditure' by WHO, 2010), or who experience great difficulties due to waiting times or distance, even if they manage to access healthcare eventually. Focusing too heavily on unmet needs risks underestimating problems. Figure 8 depicts financial barriers to access, comparing for each country the proportion of people reporting 'unmet needs' to those reporting (various levels of) 'difficulties in accessing healthcare'. Hungary, Cyprus and Slovakia stand out in showing a particularly large difference between these indicators, with few people (below 1.0%) reporting unmet medical needs, but many people reporting difficulties accessing healthcare (above 60%) .
Among the six countries with the largest proportions of people reporting 'great' difficulties in accessing healthcare (10% or more), Ireland also stands out as having below-average levels of unmet needs (1.5%). The unmet needs indicator alone would fail to highlight these access problems.

There are differences in access difficulties between types of healthcare services. For instance, the European Quality of Life Survey (EQLS) 2016 asked people about difficulties in accessing primary care specifically. Cost generally appears to be less problematic for this healthcare service. Access problems in primary care mainly stem from waiting times and delays in getting an appointment (Eurofound, 2017). Eurostat data from 2014 showed that 14.8% of people in the EU reported unmet needs with regard to at least one of the following: dental care (12.3%), medical care (5.9%),

Figure 8: Financial barriers to accessing healthcare: 'unmet needs' versus 'access difficulties', EU27 and the UK, 2016 (%)



Unmet needs

Access difficulties

Source: *Eurostat online macroeconomic database (from EU-SILC 2018)* prescribed medicine (4.6%) and mental healthcare (2.7%). EQLS 2016 data identify considerable shares of the EU population who would expect it to be 'very or rather difficult' to cover expenses if they needed to immediately access any of the following services: dental care (36%), psychologist, psychiatrist or other mental health services (34%), (other) hospital or medical specialist services (29%), emergency healthcare (23%) and GP, family doctor or health centre services (17%). While dental care scores badly for both indicators, the difference for mental healthcare deserves attention. The low rate of unmet needs according to the first indicator probably reflects the fact that fewer people need mental healthcare than medical care overall, rather than that there are fewer access barriers for mental healthcare. Furthermore, due to the stigma attached, people with unmet mental healthcare needs may be more inclined to report on what they might expect if – hypothetically – they were to need mental healthcare, rather than to report that they have actually needed the service.

Population groups: income and employment

There has been much discussion on health inequalities and on the access to and quality of healthcare. This section seeks to add to this discussion by analysing survey data on access problems, focusing on differences between countries and highlighting differences between certain population groups. In terms of the latter, this section concentrates on differences by income group and by activity status, acknowledging that there are many other dimensions of the population and numerous specific vulnerable groups that could also be considered.

In the EU, there is a difference of 3.2 percentage points between the bottom income quintile and the top income quintile in terms of unmet healthcare needs (5.4% versus 2.2% in 2018) (EU-SILC data). The countries with the largest difference include those with the largest proportion of unmet needs due to unaffordability (Greece and Latvia). Unmet needs due to unaffordability are not necessarily higher for lower income groups, however. This may be due to targeted measures to improve income and reduce the cost of accessing healthcare (and transport), or broader facilitation of access for everyone. The difference in unmet medical needs between the top and bottom income quintiles is absent or very small in Austria, Slovenia and Spain. Austria and Spain have the lowest level of unmet needs overall, while Slovenia is a country where unmet needs are higher, but unaffordability plays a minor role.

There are several countries where people with the highest incomes report few access problems, but people in middle incomes groups report more (or similar) access problems than those with the lowest incomes. These people find themselves in the so-called 'twilight zone' group: earning too much to be entitled to support, but too little to be able to afford care (Eurofound, 2014; 2019a). A clear example of this comes from Ireland, where in 2018, 32.4% of people with low income were able to access medical care for free or at reduced rates (through so-called 'medical cards'). Others must pay full fees, unless they have supplementary insurance to partially cover these fees.[4] As a result of this, people in the second and third income quintile in Ireland have in recent years reported similar or more frequent access difficulties due to cost than those in the bottom (first) income quintile. This worked as an 'automatic stabiliser' in the recession following the global financial crisis, when people whose income dropped below the income threshold became entitled to support (Eurofound, 2014). During this period, Ireland introduced co-payments for medical card holders, which may contribute to explaining negative developments in access for the lowest income groups (see the 'Convergence/divergence between countries' section below).

In the EU, access problems peaked not at the height of the global financial crisis, but rather in its aftermath, around 2013–2014. The crisis had an immediate impact on access through loss of employment, loss of income and over-indebtedness. However, many of the public-sector cuts in healthcare coverage and provision came later, around 2012, and probably had their greatest impact in 2013–2014. This 'delayed impact of the crisis' has been described previously but can now be observed clearly in the data (Eurofound, 2014). Different types of cuts have affected different population groups, depending on their needs. For example, staff cuts have led to longer waiting lists for those awaiting certain medical procedures. In the context of the crisis, people not in employment emerged as a large population group at risk of access problems (Eurofound, 2014). The remainder of this section focuses on this group.

Unemployed people are most likely to report unmet needs, while employees are least likely to do so (Figure 9a). The gap between these groups peaked in 2014, when the proportion of people with unmet needs among the unemployed group was 4.8 percentage points higher than that of employees, meaning that unemployed people were around 60% more likely to report unmet needs. The gap has decreased, but in 2018 it was still considerable at 1.6 percentage points.

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[4] Supplementary insurance is here defined as 'insurance in addition to the basic package'. Often this is referred to as 'voluntary private insurance'. 'Voluntary' suggests the individual has a choice, which may be limited for someone with difficulties making ends meet, and 'private' suggests providers cannot be public, while theoretically (and depending on the definition used) this may be the case.

Figure 9a: Unmet needs due to any reason, by employment status, EU27 and the UK, 2010–2018 (%)

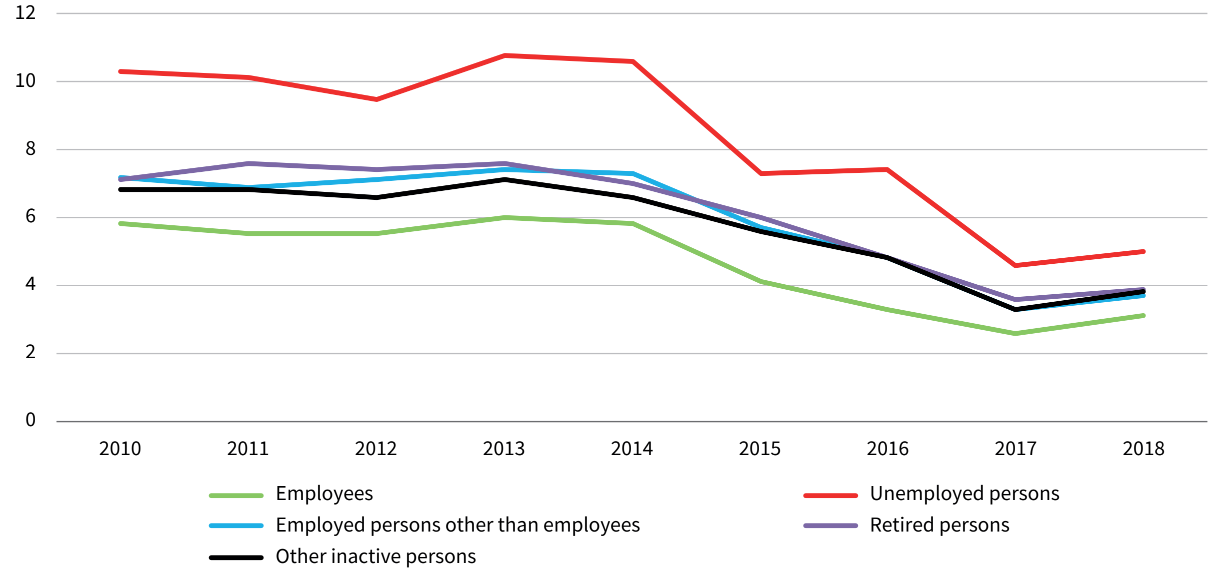
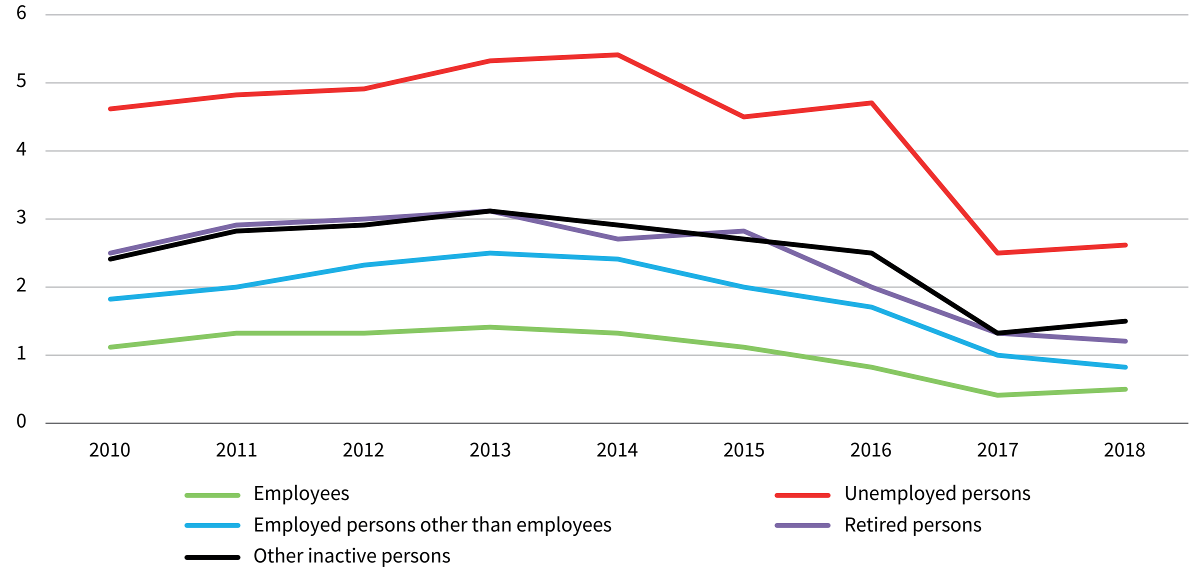


Figure 9b: Unmet needs due to affordability, by employment status, EU27 and the UK, 2010–2018 (%)



Source: *Eurostat online database (from EU-SILC, hlth_silc_13)*

However, in relative terms, unemployed people remain roughly 60% more likely than employees to report unmet needs. Unmet needs among ‘employed persons other than employees’ are also higher than among employees.

Reasons for unmet needs differ somewhat according to employment status. The explanations go beyond income differences alone. Waiting lists are relatively common for retirees, for example. This may be explained by the types of healthcare needs experienced by this group. Employees are the least likely to report unmet needs for any of the reasons. The gap between employees and other people is largest for unmet needs due to affordability (Figure 9b). In 2018, unemployed people were five times more likely to report unmet needs due to unaffordability than employees (2.1 percentage point difference).

Supplementary insurance plays an important role in many EU Member States. It may help to circumvent waiting lists, reduce co-payments, access better rooms in public hospitals with private sections, access care outside office hours, obtain e-healthcare (see next chapter) or cover healthcare services that are not included in the basic packages. It has been argued that supplementary insurance has increasingly played a role in access to healthcare since the start of this century in Denmark, Finland, Norway and Sweden, for instance (Tynkkynen et al, 2018). During the financial crisis, a complex combination of factors shaped demand for such insurance. People becoming unemployed lost their employer-provided insurance, while people with reduced incomes (many self-employed) may have voluntarily terminated their insurance. At the same time, however, increased problems in the public sector – for example, longer waiting times and higher fees – may have caused others to purchase supplementary insurance (Eurofound, 2014).

It is possible that the impact of supplementary insurance on differences in access will increase further. In Spain, for instance, ‘rising supplemental private coverage (of an “occupational-mutualist” type) adversely impacts access’ (Petmesidou et al, 2020). An EU-level study in 2018 also warned that the growth in voluntary and corporate health insurance may exacerbate inequalities in access, particularly when being used to ‘jump the queue’. It argued that these practices come with access to healthcare being based on an ability to pay, and can reduce the availability of public healthcare if doctors leave the publicly funded sector to work in the private sector (Baeten et al, 2018).

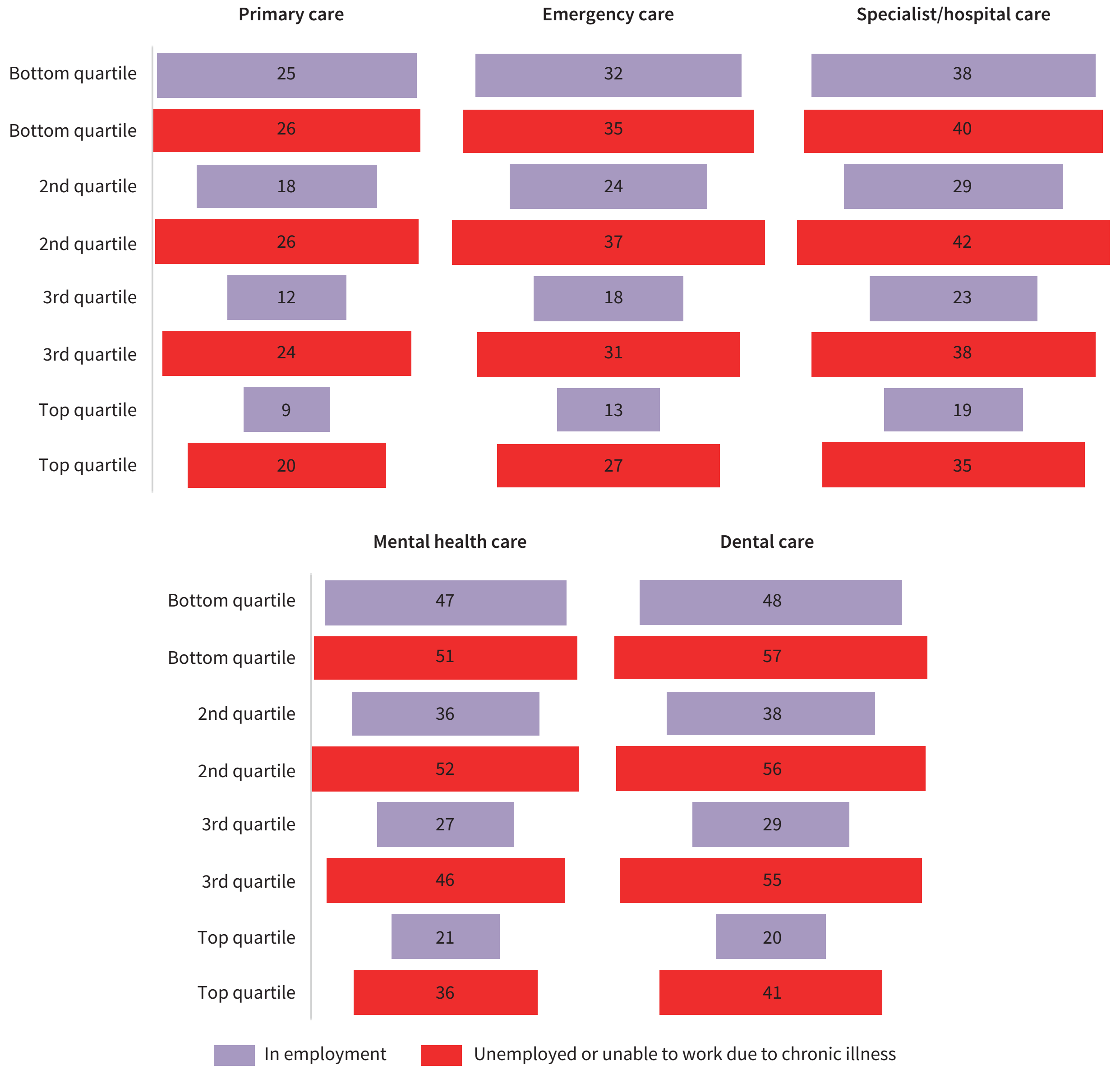
People can buy supplementary insurance individually or as a group – for example, through trade unions. However, such insurance is often part of corporate benefit packages for employees. This may contribute to explaining the finding that ‘employed persons other than employees’ are more likely to experience unmet needs than employees. In some cases, employers also provide supplementary insurance to cut down on absenteeism among their employees due to long waiting times. Some countries also offer tax incentives. In Sweden, employer-provided supplementary insurance is excluded when calculating employees’ income tax. In Denmark and Finland, tax exemptions for employer-provided supplementary insurance were in place during 2002–2012 and 2003–2006 respectively. These exemptions were later abolished due to equity concerns, but had a longer-lasting impact. Insurance provision has become a symbol of being a good employer and is used to attract and retain skilled employees by showing them that they are valued. It has also been described as ‘a fringe benefit that is expected’ (Tynkkynen et al, 2018).

People without such supplementary insurance who do not experience unmet needs may still experience more difficulties in accessing care, receive less satisfactory care, or expect more difficulties or less satisfactory care in the event that they do need to access care. So, arguably, not only current access problems should be considered, but also expected difficulties in the event that healthcare were needed.

Based on data from the EQLS 2016, people in employment in any income group are less likely to anticipate difficulties affording healthcare if they happen to need it – for any of the healthcare services mentioned – than people who are unemployed or not in employment due to a chronic illness or disability (Figure 10).

This suggests that employment may not only provide protection through income, but also through employee benefits, such as supplementary insurance. People with permanent contracts are particularly likely to feel protected in the event that healthcare needs emerge. Employment seems to protect high earners more than those with lower incomes. Furthermore, among people who are unemployed or unable to work, those in the second income quartile face healthcare insecurity to a similar extent to those in the bottom income quartile. This corresponds to the above-mentioned ‘twilight zone’ theory: while high, the proportion of people who anticipate difficulties accessing healthcare is no higher for those in the bottom quartile than for those in the second quartile, presumably because the lower income group are more likely to be in receipt of support.

Figure 10: Proportion of people anticipating difficulties paying for particular types of healthcare, by income quartile and employment status, EU27 and the UK, 2016 (%)



Source: *Eurofound's analysis of EQLS 2016 microdata*

Convergence/divergence between countries

This section investigates patterns of convergence or divergence in unmet needs. It focuses on unmet needs for any reason, although analysis was also conducted for unmet needs due to waiting lists, distance and cost only (the indicator used for the Social Scoreboard, as previously analysed in Eurofound, 2019c), as well as for unmet needs for any reason among the bottom two income quintiles. The section ends with a discussion on how trends differ between cities (densely populated areas), towns and suburbs (medium-density areas), and rural areas (sparsely populated areas).

While arguably the best indicator available, it is important to re-emphasise that unmet needs are only part of a spectrum of access problems (as highlighted in Figure 2 in Chapter 2). Another limitation is that countries collect the data on unmet needs through questionnaires, which vary widely. Even the question itself varies: for instance, the question applied in the Netherlands explicitly refers to primary care, while that in other countries does not (Box 6).

Box 6: Differences in national survey questions on unmet medical needs

Examples from Italy, the Netherlands and Spain have been used to illustrate differences in the questions on unmet medical needs in the 2018 EU-SILC questionnaire. The questionnaires first ask whether respondents have experienced a medical need:

- Italy: 'Besides the dentist, in the last 12 months have you really needed to **visit a medical specialist or a therapeutic treatment?**' ['*A parte il dentista, negli ultimi 12 mesi [testo] di avere avuto effettivamente bisogno di una visita medica specialistica o di un trattamento terapeutico?*']
- Netherlands: 'Did you, in the past 12 months, at any time urgently need a **check, examination or treatment by a GP, specialist or other medical doctor?**' ['*Heeft u de afgelopen 12 maanden weleens dringend een controle, conderzoek of behandeling nodig gehad van een huisarts, specialist of andere arts?*']
- Spain: 'During the last 12 months, did you at any time really **need medical care (except dental care) for yourself?**' ['*Durante los últimos 12 meses, ¿alguna vez realmente ha necesitado asistencia médica (excepto dentista) para usted mismo?*']

If this need was unmet (a question also asked in somewhat different ways across the questionnaires), the questionnaires then ask for the reasons for this. For instance, 'unaffordability' is worded as follows:

- Italy: 'I could not pay for it, it was too expensive' ['*Non potevo pagarla, costava troppo*']
- Netherlands: 'It was too expensive' ['*Het was te duur*']
- Spain: 'I could not afford it (too expensive or not covered by the insurance)' ['*No me lo podia permitir (demasiado caro o no cubierto por el Seguro)*']

Source: *Eurofound's compilation from national questionnaires*

Prior to the coronavirus (COVID-19) crisis, unmet needs for any reason had decreased rather steadily across the EU Member States, from an average of 6.8% in 2008 to 4.6% in 2018. This EU Member States average is calculated as the average unmet needs for each Member State, regardless of population size, in contrast to the EU average reported in Figure 9, in which more populous countries have a higher weighting. The decrease mainly occurred between 2013, when the figure was still 6.9%, and 2017, by which time it had fallen to 4.2%. The figure then increased again from 2017 to 2018, so even prior to the coronavirus (COVID-19) crisis.

Countries converged in this generally positive development of reduced unmet needs for any reason, with a decreasing standard deviation during the 10-year period from 2008 to 2018. This pattern of upward convergence is also true for unmet needs due to waiting lists, distance or cost only (the Social Scoreboard indicator). However, the overall trend of convergence is stronger for unmet needs for any reason than for the Social Scoreboard indicator.

The countries that drove this upward convergence include Hungary, Latvia, Poland and Romania. These countries caught up with others, moving closer to the average from their previously high levels of unmet needs. Other strong performers in this regard had higher-than-average unmet needs in 2008, but lower-than-average unmet needs in 2018: Bulgaria, Croatia, Italy, Lithuania and Sweden. Some countries did not follow this trend, however. Estonia and Greece already had higher-than-average unmet needs, and moved further away from the average during this period. Other countries went from having lower-than-average unmet needs to higher-than-average levels (Denmark, Finland, Slovakia and the UK), while others maintained lower-than-average levels but moved towards the average figure (Belgium, Portugal and Slovenia).

Country patterns for the bottom two income quintiles are generally similar to those for the population as a whole. However, Germany and Ireland show a different trend, with a more negative pattern for unmet needs among the bottom income 40% than for the population overall. This suggests that income has remained similarly important for access to healthcare in most countries and has become more important in Germany and Ireland.

Patterns for some Member States differ between those with unmet needs for any reason and those with unmet needs due to waiting lists, distance or cost only (the Social Scoreboard indicator). Countries show a flattening pattern in terms of the latter, but clearly managed to reduce unmet needs due to other reasons (Austria, Luxembourg and Spain). Unmet needs in other countries rose towards the average for the Social Scoreboard indicator, but even reached above-average levels for the overall unmet needs indicator (Denmark and Slovakia). Some showed more improvement in terms of unmet needs for any reason (Ireland and Slovenia), while others improved more with respect to the Social Scoreboard indicator (France, Hungary and Sweden).

The pattern of upward convergence also applies to the three levels of urbanisation. However, here also this overall trend masks varying country patterns. Cities have generally fared better than the other levels of urbanisation in terms of improving levels of unmet needs. A notable exception is Slovenia, where unmet needs in all three levels of urbanisation increased from their below-average levels in 2008, but of the three levels of urbanisation, only cities had reached an above average level by 2018. Rural areas show worrying trends in some Member States. In Ireland, the Netherlands and Slovakia, unmet needs in rural areas were below average in 2008. They have since increased while the EU average has decreased, meaning that unmet needs in rural areas have converged negatively towards (Ireland and the Netherlands) or even beyond (Slovakia) the average. Unmet needs in cities in these three countries have continued to decrease, albeit at a slower pace than the EU average, meaning they have also converged towards it. While in Ireland and the Netherlands, towns and city suburbs showed the same trend as cities, in Slovakia their trend was similar to that of rural areas. In France, towns and city suburbs demonstrate more worrying trends than rural areas or cities. Unmet needs in France were below the average in 2008 and 2018 for all three levels of urbanisation. However, there has been an increase in unmet needs in areas in the suburbs group, while those in cities and rural areas have decreased (albeit at a below-average pace).

6 Access to healthcare in focus: E-healthcare

Spotlight on e-healthcare

Healthcare features in the EU's Digital Single Market policy, which emphasises access to and exchange of data, rather than the role e-healthcare can play in improving access to healthcare (European Commission, 2015). However, in its 2018 communication on digital transformation of health and care in the Digital Single Market, the European Commission states that 'health and care systems require reforms and innovative solutions to become more resilient, accessible and effective in providing quality care to European citizens' (2018b). The accompanying working paper mentions that digital tools 'can assist in addressing shortages in health and care staff in rural areas and certain specialties' and 'connect the various actors across the health and social care sectors'. The 2020 communication, *A strong social Europe for just transitions*, raises increasing rural–urban inequalities in the context of ageing populations, and highlights the potential of technology.

Both electronic consultations and electronic prescriptions have the potential to improve access to healthcare by overcoming barriers such as lack of time and reachability (in terms of distance, lack of transport or mobility limitations, and accessibility limitations of the buildings of healthcare providers). However, these forms of e-healthcare can only do so for people who have access to it. And, if they replace rather than complement non-e-healthcare models, access to others may be reduced.

The EU has stimulated e-healthcare by allocating funding through its European Structural and Investment Funds and urging countries to improve e-healthcare in the CSRs (see Chapter 1, 'EU policy context'). However, while the internet has become an important source of health information for people in the EU and information and communication technologies (ICT) are being applied widely in healthcare equipment and administration, e-consultations were shown to be relatively rare and mainly used as follow-ups to face-to-face meetings (Eurofound, 2019a). Especially in countries where e-healthcare is uncommon, e-consultations were even rarer in rural areas. This seems to provide empirical evidence for the 2018 communication's argument that only when new care models are fully developed will it 'allow equitable and inclusive access to better health services for all segments of the population' (European Commission, 2018b).

In the 2016 EQLS, basically in all Member States significant (albeit often small) proportions of people reported using e-consultations and, in particular, e-prescriptions (Eurofound, 2019a). However, it is unclear what types of e-consultations and e-prescriptions the respondents had in mind. This section sheds light on this by presenting information from the Network of Eurofound Correspondents, complemented by Eurofound's own research and literature review, on the use of e-consultations and e-prescriptions. It also investigates the financial implications for doctors using e-consultations (especially in terms of remuneration).

The research took an open approach, avoiding giving strict definitions of the terms 'e-consultation' and 'e-prescription' in advance, hence allowing a broad range of types of these forms of e-healthcare to emerge from the Network of Eurofound Correspondents' input. In the case of e-consultations, the focus was primarily on consultations between patients and GPs or specialists via telephone, email or video (known as 'screen-to-screen' consultations). However, messages sent by SMS, WhatsApp and even social media were also cited as examples. Consultations between GPs and specialists were also of interest as tools to improve access to specialist care in more remote parts of Europe. Different types of e-prescription also came up, albeit with the common feature that they facilitate the issuing of prescriptions – particularly repeat prescriptions – without the need for a physical visit to a doctor.

E-consultations

Between patients and GPs or specialists

Incidence across countries

Prior to the coronavirus (COVID-19) crisis, even in countries that are in the forefront for their strong ICT sectors or application of technologies in other services, e-consultations in healthcare have been relatively rare (Finland and Ireland) or largely limited to follow-ups by phone (Estonia). Some of the most affluent countries in the EU lag behind greatly in this regard (Belgium and Ireland). Only in a couple of countries (Denmark and Sweden) have e-consultations become mainstream, mainly in primary care, as detailed here:

- In Denmark, 27% of the remunerated services provided by GPs in 2018 (just under 41 million services in total) were consultations by telephone and 17% were screen-to-screen or email consultations. In comparison, 52% were regular face-to-face consultations. Since 2015, telephone consultations have declined by 1.2 million, but screen-to-screen and email consultations have increased by 1.5 million.

- In Sweden, applications (apps) produced by private companies such as Kry, Doctor.se and Min doctor have played an increasingly large role since 2015. Users initially identify themselves and describe their symptoms. They are then connected to a doctor (for 15 minutes) or a psychologist (25 minutes) who can provide e-prescriptions, issues documentation, or set appointments for face-to-face GP or hospital care. The doctors usually work part time both for the app and at a GP practice or hospital. They have received training in how to support patients in virtual meetings. These apps are used relatively often by people aged under 20, who do not have to pay user charges, and by people in larger cities. They are particularly often used by people with temporary illnesses such as influenza who are seeking an initial assessment. Consultations are paid for using public funding, and there is concern that the apps generate demand for care for less-serious needs. Regions are now building their own e-consultation systems, allowing them to access some of this funding. The region Västra Götaland is a forerunner, offering services similar to those provided by the private companies (Breakit, 2018).

In other countries, e-consultations also played an important role even prior to the coronavirus (COVID-19) crisis, albeit to a lesser extent. In Norway, for instance, e-consultations went up from just over 92,000 in 2017 to over 333,000 in 2019 (from 0.6% to 2.7% of all consultations), while other consultations decreased, from 14.4 million to 12.0 million. These e-consultations include both text and screen-to-screen consultations, but in practice they are likely to be mainly by text. As in Sweden, the public sector has followed private initiatives that include video consultations (such as those of KRY.no, EYR.no and Hjemmelegene.no). The Norwegian Directorate for eHealth has recently rolled out a video service to the Foundation for Student Life in Oslo and Akershus, envisioned to be available to hospitals in 2020.

Sometimes there are differences between regions in some countries in terms of how common e-consultations are. In Spain, the number of regions that have started initiatives in dermatology (13 regions), ophthalmology (12 regions) and cardiology (11 regions) stand out, although many of these are in pilot projects (for example the TeleDerma pilot project in Andalusia). Only four regions have implemented e-consultations in primary care (García et al, 2019). One example concerns the Galician Healthcare Service (SERGAS), which implemented an e-consultation service in 2015. In 2018, e-consultations amounted to 2.9 million of a total of 15.8 million consultations (18%) in primary care. While e-consultations have increased steadily, face-to-face consultations have also increased slightly. Most e-consultations were telephone consultations (2.8 million), while some (just over 200,000) were part of Conecta 72, a programme to monitor patients having undergone hospital procedures during a 72-hour period after discharge. In Catalonia, 30% of consultations and treatments between 2015 and 2017 were developed at least initially through an e-consultation.

Conditional and legally restricted

In some countries, e-consultations have only recently became a legal option, having previously been prohibited or highly restricted. In France, e-consultations have been a legitimate way to provide healthcare since September 2018, as stipulated by the National Medical Convention for Private Doctors, following an initial pilot phase that began in 2014. In Poland, the relevant law for doctors and dentists was amended in 2015 to permit the use of ICT for consultations. In Germany, a ban on remote treatment remains in place, although this has been relaxed in some cases since 2018. In Belgium, e-consultations were not reimbursed until March 2020, at which point GPs started to be reimbursed, albeit only for triage and for caring for COVID-19 patients. In contrast, in some countries, for example Lithuania, it is mandatory for healthcare providers to have an e-healthcare option. In Denmark, email consultations have been an option for GPs since 2003, and email and telephone consultations have been mandatory options since 2009.

Even when e-consultations are allowed, they tend to only be permitted under certain conditions. For instance, it may be that they can only be used after an initial face-to-face consultation, as was the rule for specialists in Estonia and the Netherlands until 2020. In some cases, this also needs to have been within a certain period prior to the e-consultation, for example a one-year period for GPs in France. This rule does not necessarily apply to e-consultations for specialist patients, provided the referring GP has already met the patient. Lithuania not only requires that a new diagnosis or prescription be provided face to face, but also stipulates that an e-consultation must be followed by a face-to-face consultation if the second consultation relates to the same issue. E-consultations (by phone) are also applied in municipalities with influenza epidemics (that is, 100 cases per 10,000 members of the population per week), allowing patients to obtain the necessary doctor's note to justify absence from work while preventing the virus from spreading. France is exceptional in stipulating that e-consultations be carried out by video in order to ensure high-quality interaction.

Box 7: National telephone healthcare consultation lines

Estonia’s national medical consultation line has been in place since 2005. Since its establishment, 12–14% of callers to the line have required a follow-up consultation or been redirected to the emergency services. A reason for this relatively low rate may be that experienced GPs and nurses are answering the calls. The first five minutes are free, then callers are charged standard call rates. Users remain anonymous, but as of 2020 they can identify themselves through the national digital authentication system. This allows the doctor to access the caller’s digital health records and provide more personalised advice. The service is mostly used during evenings and weekends, when primary care centres are closed. Between 92% and 97% of calls are answered within 1–2 minutes. Since its establishment, 2.8 million calls have been received – a rate of around 680 calls per day. Calls mainly relate to fever and viral diseases, medicines and blood pressure.

Latvia’s national line has been offering advice from experienced GPs and assistant doctors on weekdays from 17:00 until 8:00, and on weekends and holidays, since 2011. It mainly serves to relieve the burden on emergency services and hospitals’ outpatient departments when primary care centres are closed. Consultations are available via phone, email or Skype, and the service receives an average of 5,000 calls per month.

Austria’s telephone line, which is available around the clock at normal call rates, was rolled out in 2019 after a pilot in 2017–2018. It is staffed by trained nurses. In the first year, there were around 74,000 calls, of which 20,000 just requested information about opening hours of healthcare providers and 11,000 ended prematurely. Of the 43,000 remaining consultations (discounting 11,000 calls that ended prematurely), about two-thirds of callers were referred to a nearby doctor. A national survey showed that around half the population had heard of the telephone service and 5% had used it. The line helps to guide people to the most appropriate care, and arguably has contributed to preventing visits to more expensive outpatient hospital departments. In Vienna, for instance, 18% of the callers said they would otherwise have visited a hospital or called an ambulance.

First-contact phone lines

Overall, e-consultations by telephone or email are most common, usually between GPs and their patients. Often, they are conducted informally as an ad-hoc service. This may be considered as a favour to the patient, typically to deal with follow-up questions after a face-to-face consultation or to renew a prescription (Cyprus and Estonia). Some countries where other e-consultations are uncommon have a national telephone line that people can contact when in need of medical care. These lines may serve largely to guide people through the healthcare system (Austria), to provide basic services outside office hours (Latvia) or to provide a relatively comprehensive primary health consultation service (Estonia) – see Box 7.

ICT plays an important role in medical appointment systems in the EU. Sometimes these include some form of pre-consultation to facilitate appropriate and quicker care, sometimes by preventing an initial diagnostic visit. An example from the private sector comes from Slovakia. Since 2016, three private neurology clinics have been providing e-consultations with a doctor online, by phone or by email before the first face-to-face visit, with about 3,500 e-consultations annually. Czechia has two clinics in the same network.

Screen-to-screen consultations

While screen-to-screen consultations are rare, examples can be found across Europe, even in countries where e-consultations are infrequent overall.

As mentioned earlier in this section, France is also exceptional in having rolled out screen-to-screen consultations nationally with GPs and specialists. The country’s national health insurance provides doctors with up to €525 to purchase the necessary equipment. Most users are young (56% are under 40), but many older people (12% over 70) also participate. Women make up the majority of users (65%). More than one-quarter of users (27%) have chronic conditions. Since 2019, France has also offered screen-to-screen consultations at pharmacies, with appointments arranged between the doctor and the patient in advance. Pharmacies receive €1,225 to enable them to purchase suitable equipment for the e-consultations (including a connected stethoscope, otoscope, oximeter and blood pressure monitor) and a fixed contribution of €350 in each subsequent year. (For information on reimbursements to pharmacists for consultations, see the ‘e-prescriptions’ section below). In its first year, from September 2018 to September 2019, 60,000 e-consultations were reimbursed. In September 2019, there were about 3,300 e-consultations per week, and in February 2020 about 10,000.

Sometimes screen-to-screen options consist of facilities organised to provide services in remote locations. These are generally publicly funded, elaborate structural services, with solid infrastructure. They aim to bring reasonable access to medical care, without investing in large physical and human infrastructure, for small pockets of the population. Examples include:

- Denmark: The island Ærø, in the Southern Denmark region, and the Zealand region both have small hospitals from which virtual consultations can be conducted, avoiding the need for patients to travel. The first focuses on haematological patients and is part of a wider increase in the role of technology, which includes access to healthcare data and a mobile app for patients. The latter is for a broader group of patients and is often used by diabetics, people with high blood pressure and patients with chronic kidney disease.
- Greece: As part of a network of e-healthcare stations (known as 'EDiT') implemented by the Attica and Aegean regions and partly financed by the EU, a range of e-consultation facilities began operating in 2016. In 30 remote locations across the country, there are stations equipped with video conferencing and digital sensor-based medical equipment, which help patients (and GPs) to consult specialists in 12 large hospitals.
- Sweden: In 2013, in the small village of Slussfors in Västerbotten County, a first 'virtual room' was established to connect patients in remote areas with doctors in other locations. EU funding was later made available to create such rooms elsewhere as well. As travel to healthcare is reimbursed by the regions, this form of remote care represents a saving on public funds.

Finland's South Karelia Social and Health Care District (Eksote) has implemented several pilot projects featuring e-consultations, including in its health centres (since 2015) and in a bus (through several projects since 2010), where nurses provide services including screen-to-screen consultations with doctors in other locations.

Private sector initiatives

In many countries in Europe, e-consultation initiatives come from the private sector (for example, in Estonia, Finland, Germany, Ireland, Latvia, Norway, Poland, Slovakia, Spain and Sweden). Usually the services are offered by private healthcare providers, private health insurers, or companies which both provide healthcare services and sell supplementary health insurances. For instance, in Poland, private healthcare provider Medicover provides e-consultations by internal medicine doctors, paediatricians, endocrinologists, dermatologists, allergists, midwives and travel medicine doctors. Medicover's e-consultations have been found to facilitate access, above all, for chronically ill people, pregnant women and young mothers. The company increases the availability of its e-consultations during peaks of seasonal infections. Finland's biggest private healthcare company, Terveystalo, estimates that it carries out 10,000 e-consultations per month (Nordic Health Forum, 2019). In this case, investment in ICT infrastructure tends to be small, with consultations undertaken through mobile apps, phones or tablets. In Spain, private company Sanitas registered roughly 2,000 e-consultations per month in 2018, about five times more than in 2017. These are screen-to-screen e-consultations with GPs or specialists and constitute 8% of all consultations through Sanitas. MediQuo, another e-consultation app in Spain, has reported that the 220,000 e-consultations in 2018 covered the following areas: general medicine (46%), gynaecology (15%), paediatrics (11.5%), psychology (11%), nutrition (8%), sexology (5.5%), training and nutrition (2.5%) and cardiology (0.5%). Usually these private initiatives include a screen-to-screen option along with other modes.

These services are offered as part of supplementary insurance packages. In the UK, specific GPs may offer this service to patients registered with them (including a screen-to-screen option). In some countries, the service may also be offered at a fee. For instance, the company Minudoc in Estonia, which was established in 2018, charges €10–50 for a video consultation. It offers same-day appointments, engages international doctors to offer particular services, deals with minor emergency cases out of hours and at weekends, and offers on-demand prescription renewals. In Finland, since 2018, a private company called DoctorOnline has been offering video consultations for a fee.

Use of these services may still be funded by national public insurance (for example, in Sweden – where the patient's home region contributes SEK 650 per e-consultation) or social health insurance (Germany) – or this may be the aim in the future (Belgium). In Germany, Patientus has been providing e-consultations (including screen-to-screen) since 2014. At first, the service was only available to fee-paying patients and via some pilot projects of health insurance providers. Since 2017, however, these e-consultations have been part of health insurers' standard benefit packages, and its current owner, jameda, states that over 6 million patients use its platform every month. The consultations are provided by 25 doctors, including GPs, dermatologists, nutrition specialists, immunologists and physiotherapists. In Belgium, about half a million people with complementary health insurance with AXA Partners have had access to e-consultations since November 2019, but there is no evidence of take-up as yet. An earlier initiative, launched in 2017, concerns ViViDoctor, which provides video consultations in partnership with hospitals. While the idea is to reduce hospital admissions, ViViDoctor's model relies on reimbursement by social health insurance in Belgium, which has not been implemented so far. Its status and future, therefore, remain unclear.

Between GPs and other healthcare providers

Across the EU, e-consultations between GPs and other healthcare providers (usually specialists) seem more common than between patients and doctors. In 2018, about one-fifth of GPs in the EU (excluding the Netherlands) and UK reported that they used broadband-based technology platforms for this purpose regularly (9%) or occasionally (10%), compared to 5% and 6% for consultations with patients (European Commission, 2018d). The consultations may involve screen-to-screen sessions with the patient present, but usually concern queries by GPs, sometimes with an exchange of digital images. In Portugal, since 2018, it has been compulsory for primary care providers to send a photo when referring patients to a dermatologist: the dermatologist can then respond and carry out an e-consultation later if deemed appropriate. Preliminary analysis suggests that this happens in over 40% of cases. GP-specialist e-consultations are sometimes carried out with groups of GPs or specialists, such as the bi-weekly ‘lunchtime clinics’ to which GPs in Ireland’s Carlow and Kilkenny regions can sign up. These sessions involve a video link with a team of cardiologists in St Vincent’s University Hospital in Dublin to discuss medication requirements, monitoring, primary care or, if necessary, an appointment at an outpatient clinic.

Sometimes consultations between GPs in remote locations and specialists in hospitals are part of established structures. Examples are documented here:

- In Ireland, two initiatives (to reduce waiting times) include the following. First, GPs are paid a fee for participating in weekly virtual consultations with cardiologists to discuss patients with heart failure. The aim is to reduce the number of patient appointments in acute hospitals, thereby shortening waiting lists. This will apply in four pilot areas, the objective being to have 17,500 virtual clinics established by 2022. Second, a new primary care centre has been established from which GPs can send images to radiologists. This complements the existing off-site general x-ray services at Belmullet Community Hospital and Ballina District Hospital in County Mayo.
- In Estonia, a platform for GPs to connect with specialists was established in 2013. This was initially only set up for urologists and endocrinologists, but other specialist areas have been added each year. The specialist can reply with advice within four working days – avoiding the need for a face-to-face visit, or recommend a face-to-face consultation if appropriate. Consultations have more than doubled every year, increasing from 990 in 2014 to nearly 13,000 in 2017. Most consultations with specialists concern diseases of the musculoskeletal system and connective tissue (15.5% of all consultations until 2018) or the circulatory (11.3%) and respiratory (10.8%) systems.
- In Poland, GPs and their patients have been able to engage with cardiologists or geriatric doctors in an e-consultation since 2015. This can involve remote interviews, analysis of test results and discussions about treatments. This approach helps to increase the availability of specialised services for patients from small and/or remote towns and villages. As of 2019, a total of 828 patients had received cardiological e-consultations, and 30 patients had received geriatric e-consultations.
- In Slovenia, as part of the TeleKap programme, specialists in 12 hospitals support GPs in local health centres to assist stroke patients. This allows the GPs to respond quickly to their needs, which is particularly important for the recovery of these patients.

E-prescriptions

While e-prescriptions are more common than e-consultations, many Member States also lag behind in this respect, despite numerous e-healthcare strategies and pilots. In Bulgaria, for example, although e-prescriptions have been issued through a pilot project in Plovdiv as early as 1996–1997, they have still not been implemented nationally. The findings of the EQLS 2016, however, indicated high e-prescription usage in countries where other sources have shown this to be low. Eurofound (2019a) hypothesised that respondents may have included their own online purchases of medicine in their responses to the survey. The results from the survey suggest that this may be part of the explanation. For instance, Luxembourg has long required that patients present paper prescriptions at pharmacies and only started to shift to using e-prescriptions in 2019, despite having had a national e-healthcare strategy since 2006. However, two pharmacies in Luxembourg are licensed to sell non-prescription medicines online. An additional explanation for this higher than expected reported use of e-prescriptions may be that there are different types of e-prescriptions.

Most e-prescriptions can improve access to healthcare by reducing the need to travel and the time required to visit a doctor and preventing mistakes due to misunderstandings. This even applies to systems where a printed version still needs to be taken to the pharmacy, such as in Belgium. Entering e-prescriptions into an electronic system has further potential in terms of improving data collection. If the pharmacist has access to such a system, it can help to prevent mistakes with prescriptions. Electronic systems can also send reminders to patients, as they do in Italy, for example. In Austria, pharmacists have access to historical prescription data, which enables them to double check the suitability of prescriptions.

Many countries are moving, though, towards systems in which prescriptions are entered by doctors into an electronic system that can be accessed by pharmacists. Several countries already have this in place (Croatia, Cyprus, Denmark, Estonia, Finland, Lithuania, Norway, Portugal, Slovakia and Slovenia). In the UK, this system is also in place in England, although e-prescriptions are unavailable in Wales, Scotland and Northern Ireland (Camrose, Gillies and Hackwood Partnership, 2019). Patient identification at the pharmacy using a medical (insurance) card or identification is usually sufficient. In other cases, as in Czechia and tested in pilot projects in Germany, it may be that pharmacies have access to information to some extent, but patients need to show a prescription-specific identification number or barcode, rather than just their identification or health insurance card.

In Finland, e-prescriptions have been mandatory since 2014. They are also mandatory in Latvia, albeit only for reimbursable medicines. However, it is usually the case that multiple systems operate alongside each other, meaning patients are still able to use the paper prescriptions system. In some countries, paper prescriptions may only be issued in specific situations. In Estonia, for example, they may only be issued during home visits or where technical issues prevent the use of e-prescriptions. In Poland, e-prescriptions had the status of ‘prescriptions in absence’ until 2018, but they now hold the same status as those issued during face-to-face consultations. In fact, as of 2020, e-prescriptions are required as standard in Poland, with the exception that doctors may issue paper prescriptions for themselves or their family members. In Portugal, both paper and e-prescriptions can be issued, according to the preferences of the doctor and patient. In England, the circumstances in which electronic prescriptions can be issued were broadened in 2018. Belgium made e-prescriptions compulsory from 1 January 2020, unless the prescription is issued by a doctor who is over the age of 64 on that date, or issued outside a consultation room or in extraordinary circumstances. Croatia and Estonia were in the forefront of introducing e-prescriptions early. In a 2014 survey among e-prescription users in Croatia, 81% judged the system to be ‘excellent’.

In Hungary, about 70% of prescriptions are entered into the e-healthcare system during consultations. Around 20% of patients use the paperless feature whereby prescribed medicines can be collected simply by presenting identification at a pharmacy. About 20% of GPs are not connected to the e-healthcare system, but their prescriptions are often later entered into the system at pharmacies. Paper prescriptions issued during home visits are also entered into the system later. As of 2018, about 1,100 of Croatia’s 1,200 pharmacies had access to the country’s electronic system, which was implemented in 2011. In the UK, the use and availability of e-prescriptions by general practices increased from less than 1% in June 2010 to 63% in June 2018. In Malta, about 30% of ‘Pharmacy of your choice’ prescriptions – meaning prescriptions issued through the government’s national pharmaceutical service – are issued electronically, with 284 doctors using the system as of January 2020. In Slovenia, most but not all prescriptions (92%) were issued electronically in 2018 (Rant and Stanimirović, 2019). In Slovakia, almost 4.3 million e-prescriptions were issued in 2018, and in Greece about 6 million per month were issued in 2019. In Estonia, paper prescriptions made up 34.5% of prescriptions when e-prescriptions were introduced in 2010, but this number had dropped to 0.25% by 2018. In Belgium, nearly 16,000 doctors wrote almost 4.4 million e-prescriptions – approximately half of all prescriptions – in November 2018. In Norway, 91% of medicines sold in 2019 were based on e-prescriptions. In Spain, e-prescriptions represented 90.9% of the total prescriptions delivered via the national health system in 2018 (MSCBS, 2019). In Lithuania, although 93% of reimbursable medicines were prescribed electronically in June 2019, just half of all doctors in the country use e-prescriptions. In general, e-prescription systems are used primarily for reimbursable medicines.

Often e-prescription systems were at first restricted to the public sector, certain regions, or pilot schemes. In 2016, Portugal implemented e-prescriptions first in public sector healthcare facilities and later in the private sector (SPMS, 2017). In Malta, e-prescriptions were also first adopted in public primary care systems in 2016, before being adopted by private practices. Although elsewhere in Italy similar projects were introduced, e-prescriptions were first implemented in Trento in December 2013, meaning pharmacies would have access to prescriptions via an electronic system. By 2016, some 85% of prescriptions were being issued through the electronic system. A study by Dalle Fratte et al (2017) suggested this change had saved money, mainly by preventing the need to process prescription pads. In Germany, a law adopted in summer 2019 envisaged the rollout of e-prescriptions by mid-2020, but this has so far been restricted largely to pilot projects. One such project has been implemented by the health insurer Technische Krankenkasse in the Wandsbeck district of Hamburg, and another by the federal state of Baden-Württemberg (known as the ‘Gerda’ project). In Austria, two e-prescription pilot projects began in 2020, both in the region of Carinthia. As part of these projects, which Austria plans to roll out nationwide in 2022, prescriptions are entered into an electronic system and patients only need to show their healthcare card at the pharmacy. Paper prescriptions are still required elsewhere, but since 2018 pharmacists across Austria have been able to see records of previously issued medicines on the electronic system in order to check the suitability of prescriptions.

Financial incentives for healthcare providers

If doctors are reimbursed for face-to-face consultations but not for e-consultations, there is a financial disincentive to provide e-consultations. This has been the case in Austria, Belgium, Latvia, Romania and Slovakia, for instance. Many GPs and specialists working in the public sector in the EU are salaried, for example in Greece, Lithuania and Spain. The financial rewards for these salaried doctors remain the same, regardless of how they use their time. Financial incentives – and disincentives – due to differences in reimbursement are also less relevant in systems where GPs are paid based on the number of patients registered with them (usually adjusted according to demographics). Such systems are in place in Cyprus (since 2019), Estonia, Hungary, Italy and the UK. However, in such systems, there may still be a financial incentive to offer e-consultations if they may help to attract new patients or reduce the amount of time needed for consultations. One example identified in Finland even showed that e-consultations can reduce rental costs for doctors operating privately, as no space is needed for patients. However, there are still costs associated with installing the necessary ICT infrastructure. The number of consultations may also rise, as people may request an e-consultation in cases where they would not have sought a face-to-face consultation.

Several countries with reimbursement systems had until recently systems that did not facilitate e-consultations. In some countries, such as Belgium, consultations required a physical meeting. In other countries, doctors have sought reimbursement for e-consultations under general reimbursement codes for consultations. In Cyprus, for instance, e-consultations were until recently provided free of charge – without reimbursement – or by doctors being paid fixed salaries. However, there were reports of such services being categorised as consultations, in the absence of a clear category for e-consultations. In Austria, doctors are not reimbursed for e-consultations. However, a one-year pilot project began in Vienna in July 2019. Through the project, GPs, gynaecologists and paediatricians who have contracts with the largest Vienna branch of the regional health insurance company (Wiener Gebietskrankenkasse) are reimbursed for telephone consultations.

Overall, payment/reimbursement rules have been increasingly explicit about e-consultations, using various terms. Usually this has only occurred in the past two or three years (for example, France started in 2018). However, Norway introduced its rules as early as 2013. Finland equated e-consultations (except by chat) to face-to-face consultations in 2016, allowing for reimbursement. Such payment/reimbursement rules may involve either payment to the patient who then pays the medical doctor (in health insurance systems), or direct payment to the medical doctor. Some countries clearly categorise e-consultations as a service that must be reimbursed, for example Czechia, Denmark, Norway and Sweden, as well as Hungary for specialist consultations. Sometimes reimbursement rules only explicitly mention certain modes of e-consultation. In Estonia, for example, telephone and email consultations are specifically included for GPs, but only email is used for specialists, and screen-to-screen consultations are not explicitly mentioned in either case. In the context of the COVID-19 outbreak in 2020, Estonia’s national health insurance fund added remote specialist care to their list of reimbursable services. In Germany, video calls were added to the list of reimbursable services in 2017, albeit with restrictions on follow-ups. These reimbursable services include privately provided options, such as those provided by jameda (as mentioned in the ‘E-consultations’ section above). Sometimes reimbursement/payment only concerns specific medical conditions. For instance, Czechia has included specific telephone consultations since 2008. Poland reimburses geriatric e-consultations – used by 30 patients between 2015 and 2019 – and cardiological e-consultations – used by 828 patients between 2015 and 2019 – in primary care centres. It also reimburses e-consultations to support remote rehabilitation for those recovering from heart attacks.

In countries where the reimbursement/payment of e-consultations is explicitly included in the rules, their reimbursement rates are usually equal to or lower than face-to-face consultations.

In France and Sweden, e-consultations are reimbursed at the same rate as face-to-face consultations. This is also the case for e-consultations provided by GPs in Norway and, in a more specific context, for e-consultations provided in Luxembourg during the COVID-19 crisis. Furthermore, in Norway, consultations by text are reimbursed at the same rate as longer face-to-face meetings, even though e-consultations are generally quicker and more flexible in terms of time allocation for the doctor. In France, where only screen-to-screen e-consultations are reimbursed, charges are paid initially by the patient to the doctor. As mentioned above, the charges are equal to those for face-to-face consultations – between €23 and €58.50, depending on the doctor’s speciality and area of practice. Patients are then reimbursed at the same rate as for face-to-face consultations (70%), although they may be reimbursed more in certain circumstances, for example if the consultation concerns long-term care or is provided in the context of a maternity ward. In the Netherlands, e-consultations by GPs have been reimbursed at the same rate as face-to-face consultations since 2019, but some e-consultations, particularly those carried out by email, may qualify more often as ‘short consultations’ rather than ‘consultations’ or ‘long consultations’. For specialists, screen-to-screen consultations, telephone consultations and written consultations (including by email) are all pre-defined actions that are reimbursed.

Other countries reimburse e-consultations at a lower rate than face-to-face consultations, regardless of their duration. In Cyprus, ‘distance consultation’ was added as a reimbursable category for specialists in December 2019, reimbursed at a rate of €7.50. This is considerably lower than the various rates for face-to-face consultations, which range between €18.75 and €87.75 depending on their nature and duration. In practice, such distance consultations are often provided to patients abroad by phone or email. In Denmark, GP reimbursement rates are considerably lower for e-consultations – DKK 28.08 (€3.77) for telephone consultations and DKK 45.08 (€6.05) for screen-to-screen consultations – than the rate of DKK 143.44 (€19.24) for face-to-face consultations. Since 2019, e-consultations in Germany (permitted once per treatment course) are charged at a rate of €9.27, with a surcharge of €4.21 for screen-to-screen consultations. Video calls with a nurse, which are allowed three times per treatment course, are charged at a rate of €6.92. The reimbursement of e-consultations was initially introduced in 2017 and these surcharge options were added in 2019.

When GPs consult a specialist, this is not always reimbursed, as in Norway for example. In Estonia, specialists are reimbursed as a ‘recurring appointment’, at a lower rate than for a ‘first appointment’. In France, the payment is made by the patient, who will then be reimbursed at the same rate as for a face-to-face consultation with the specialist. As part of a 2016–2017 pilot scheme in the Gorenjska region of Slovenia, both GPs and specialists were paid for e-consultations between GPs and specialists. The stated intention of the scheme was to shorten waiting lists. GPs consulted internal medicine doctors most often and neurologists and surgeons less frequently. Since 2018, online e-consultations between GPs and specialists concerning patients with non-urgent conditions have been reimbursed by the national health insurance. The specialist has between one and two weeks to answer the query. Both the GP and the specialist receive a fee of €11.32 (this fee can vary from €2.45 to €18.9 for face-to-face consultations, depending on the speciality). Between September 2018 and September 2019, 8,124 e-consultations were reimbursed in Slovenia. Most consultations concerned abnormal activity of the thyroid. GPs seem to have a larger financial incentive in this case, given that they are reimbursed at the same rate as the specialist, who would usually receive higher fees. Similarly, in France, both the GP and the specialist are reimbursed. Assuming no in-depth study of the patient’s medical situation is required (e.g. reading a retinography, spirometry or photo of a skin lesion) the specialist receives €12 and the GP receives €5. If further investigation of the patient’s situation is required – for example, monitoring the development of a chronic inflammatory disease, adapting an anti-epileptic treatment or conducting a pre-chemotherapy check-up – the specialist receives €20 and the GP €10. For the GP, an annual maximum reimbursement of €500 applies. If patient consultations are carried out directly at a pharmacy, the pharmacist receives a fee depending on the number of e-consultations a year: €200 if between 1 and 20 consultations, €300 if between 21 and 30, and €400 if more than 30.

Financial incentives and disincentives are not only important at the level of the doctor. Sometimes they are relevant at an organisational level. For instance, in the Portuguese public system, doctors receive fixed salaries, but organisations providing healthcare receive 10% more for an e-consultation than for a face-to-face consultation. Another incentive for e-healthcare comes from hospitals receiving fixed budgets, where they are incentivised to provide the most efficient type of care. However, budgets may also require face-to-face consultations as part of standard treatment patterns. Face-to-face consultations are also simpler for accountancy purposes, with procedures in place to verify whether e-consultations have occurred. For health insurers, multiple incentives and disincentives can apply. For instance, if healthcare insurers pay healthcare providers a fixed amount agreed in advance, regardless of the volumes of care actually provided, insurers may not benefit from possible cost reductions due to e-healthcare (see Box 8). The fees paid by patients to the public system may differ for e-consultations, even though the medical professionals providing these consultations are on fixed salaries and do not receive these fees. In Portugal, for instance, fees for e-consultations are lower than for face-to-face consultations.

Impact of the COVID-19 crisis

E-consultations

The COVID-19 crisis has forced the rapid implementation of e-consultations, sometimes as a short-term solution. For instance, in Luxembourg, the National Health Fund announced on Thursday 26 March 2020 that an e-consultation option had been activated on a dedicated website. It offers patients the possibility to organise online consultations with their doctor, dentist or midwife. People who do not have internet access can also contact their doctor by phone. The main objective is to reduce the risk of infection for patients and doctors by enabling them to speak to each other remotely via a video consultation. It is then up to the doctor to decide whether the patient can stay at home or should go to an advanced care centre. In Ireland, e-consultations have also replaced face-to-face consultations where judged possible (*Irish Times*, 2020).

In France, two decrees of 9 March and 19 March 2020 (valid until 31 May 2020) temporarily allowed people affected or potentially infected by COVID-19 to have an e-consultation with a doctor or nurse, even if the doctor had not previously seen them, with full reimbursement by the state insurance scheme. Furthermore, all e-consultations were temporarily fully covered by health insurance, while previously they were reimbursed at 70% (or more if part of a long-term care procedure or maternity care, for instance). From 23 to 29 March, over 486,000 billing requests were received, a figure equating to 11% of consultations, compared to 1% previously. In Cyprus, from 8 April 2020, telephone consultations with GPs became temporarily mandatory, with face-to-face meetings only allowed in non-COVID-19 cases deemed urgent by the GP. E-consultations have also increased in Belgium, although it is unclear whether these changes will remain in the long term or even permanently.

E-prescriptions

The Austrian government implemented e-prescriptions nationwide in mid-March 2020. In order to reduce face-to-face visits to doctors, prescriptions by telephone, fax and email were introduced. Prescriptions are entered into an electronic system. Medicines can then be collected by the patient or by someone on their behalf at a pharmacy, which also has access to the electronic system. In early April 2020, Italy facilitated the implementation of prescriptions by email or text message across its regions. Prescription codes still need to be shown at the pharmacies, which do not have access to the system. In late March 2020, Luxembourg also made it possible to prescribe medicines by email following an e-consultation. The prescription is sent immediately after the e-consultation to the desired pharmacy, where patients, who also receive a copy, can then collect their medicines. In Greece, as a result of the COVID-19 crisis, patients are now allowed to present their prescriptions to pharmacists on an electronic device or simply give them the relevant code. In Ireland, e-prescriptions have also increased, for instance through GPs and pharmacists signing up to a previously small-scale private initiative.

Summary of main issues

Digital strategies for healthcare have multiplied at a fast rate across the EU since the turn of the century. This chapter looked beyond such government strategies by mapping what is happening in practice in terms of e-consultations and e-prescriptions. It investigated whether electronic options are being facilitated, for instance through rules on reimbursement/payment, and whether they are being taken up. Such take-up is considered a good indicator of access. E-consultations and monitoring generally do not require the complex approval processes that are customary in the pharmaceutical industry for the approval of medicines, for example, so one may expect innovation in healthcare to be booming in this area. However, it appears that most of the e-healthcare options discussed have only been developed in the past five years or are currently in the process of being established. The COVID-19 crisis has pushed countries to implement ad-hoc e-healthcare options, but often on a temporary basis and without solid legal and technical frameworks.

In the countries that offered e-consultations before the COVID-19 crisis, user numbers have been increasing rapidly. However, in most countries, initiatives involving public money have usually been restricted to small-scale pilots and specific facilities, for instance to connect a particularly remote area to a hospital elsewhere. Screen-to-screen consultations are particularly rare. Apart from a few examples in the private sector, e-consultations have tended to be restricted in terms of their usage. Some countries only use them in exceptional circumstances, such as during influenza epidemics, while others only allow e-consultations to be used after an initial face-to-face consultation or for specific purposes, for instance to obtain sick leave notices for work.

Many initiatives come from private health insurance companies or private healthcare providers, and their services are rarely covered by the public system. In these models, e-healthcare reduces barriers to access due to distance and transport costs mainly for those who have supplementary insurance, which may cover these private services, or for those who can afford to pay the required fees. E-healthcare covered by insurance can also reduce the cost of access to healthcare directly. For instance, in Ireland, some private providers offer e-consultations for e-prescriptions at between €25 and €30 per consultation – around half the cost of obtaining a prescription by visiting a GP. Generally, such private services are more accessible for higher-income groups and often form part of employee benefit packages, making them more accessible for people in employment. As incomes and employment rates are generally higher in urban areas, such services are usually more accessible in urban areas, and marketing and coverage often focus on areas with high population density. Also, insurance providers can use e-consultations to attract younger people who have fewer healthcare needs on average (as has been observed in Czechia). Similar methods may be used by GP practices that are paid based on the number of people registered with them (as found in the UK).

Some of the recent broader, nationwide e-healthcare systems described in this chapter are being implemented by governments. France is a trailblazer with its nationwide screen-to-screen consultations. Government initiatives may incorporate private providers too. For instance, as of 2020, private providers must be included in Hungary's nationwide e-healthcare system. In the case of e-prescriptions, systems have tended to be either rolled out homogeneously across the country or absent altogether. There are still some notable differences, however, especially where e-prescriptions co-exist with paper prescriptions and the paper prescriptions are not only reserved for exceptional circumstances. In this case, GP practices and pharmacies in urban areas, which tend to have better internet coverage, are more likely to make use of ICT. For instance, in Hungary, e-prescription rates are higher in Budapest than in rural areas, and in Croatia some isolated mountain regions and small islands are not yet included in the country's system. A similar observation can be made for e-consultations. In France, 44% of e-consultations are provided in Paris and the surrounding region. In Sweden, private e-healthcare – mainly involving e-consultations through mobile apps – is relatively widely accessible, mainly to people under 20 years old as the state pays their user fees in full. Still, it tends to be used more in Stockholm than in other areas.

E-consultations do not necessarily improve access. If it is the only option, it can be a barrier for people unfamiliar with ICT, especially if they are required to engage with it without support. Other patients may feel they would benefit from a face-to-face consultation but do not have this option available to them. If user fees for an e-consultation equal those for a face-to-face consultation, cost barriers are likely to be lower for e-consultations for patients with access to ICT, as they save on transport and time (opportunity cost – see discussion around Figure 2). There are also examples where e-healthcare has actually increased waiting times due to system failures, for example in Lithuania (Valstybės kontrolė, 2018) and the bus-based health centres used in pilot projects in Finland. Technical problems have also prevented some e-healthcare systems from being used at all. For example, e-consultations between the island of Gozo and the mainland in Malta were hardly used. Doctors reported that they found the system inconvenient, as only a few facilities were set up with the necessary equipment, and these were located at a distance from where many doctors usually worked (Telecommunication Development Bureau, 2000). Doctors also reported that they found such appointments time consuming to arrange and the equipment laborious to use. Technical problems were also cited as a negative point in a largely positive assessment of the pilot scheme in Slovenia's Gorenjska region.

Another key barrier is the lack of a clear legislative framework, such as in relation to accounting – for example, how e-consultations are recorded to confirm that they took place – and liability issues. In 2013, an EU-funded pilot project that used an electronic system to connect GPs in rural areas of Romania with specialists was discontinued due to the lack of a legislative framework. Similar issues have been experienced in Latvia, where the requirement that reimbursement be arranged in person has also posed an issue. E-consultations may also reduce the preventive impact of GP visits, as patients are typically exposed to a range of informational materials in GP waiting rooms. However, there is also potential to carry out online information campaigns or, for example, have informational banners on GPs' emails. Possible litigation can also act as a barrier in rolling out e-consultations. Interestingly, in practice, litigation has not emerged as a major issue in the e-consultation experiences documented in this research, even in instances where patients are able to record their consultations with GPs using apps, such as in the UK. However, it should be acknowledged that this was not the focus of the current study.

E-consultations do not always decrease public healthcare expenditure, due to the fixed cost structure of the healthcare system. Costs may also be increased by the need for a nurse or specialist to join in a doctor–patient e-consultation, as in the case of the bus health centres in Finland and several of the GP–specialist e-consultation examples described above. Access to e-healthcare can also increase demand for healthcare by facilitating access for people who would otherwise not have sought care for a specific need. However, the escalation of healthcare needs can be prevented by timely access – hence forestalling the need for costly emergency care use for non-emergency needs. E-consultations can also be more time-efficient than face-to-face visits, as well as preventing infectious diseases from spreading, and acting as an initial step to direct people to the most appropriate service (Boxes 7 and 8). Assessment of the overall cost–benefit picture is complex and situation/priority-specific. This goes beyond the focus of this report, which is limited to access. It is nevertheless important to be aware of such considerations in order to understand the barriers in rolling out e-healthcare options.

Box 8: E-monitoring and consultation for COPD and heart failure

COPD InBeeld (which translates as ‘COPD In the picture’) is a joint initiative by a health insurer and mobile application developer in the Netherlands. Following their discharge from hospital, patients with chronic obstructive pulmonary disease (COPD) are given an iPad with a specialised app, via which they fill out a monitoring survey twice per week. If their results are beyond a certain threshold, online consultations can be arranged 24/7 with a nurse and – if the nurse judges it necessary – with a doctor. The nurse or doctor provides advice to the patient to help control the disease, for example through breathing exercises, helping to prevent escalation and the need for emergency care. A similar initiative was adopted for heart failure, which in contrast to COPD (for which subjective measures seem most reliable) includes physical measurements. A particularly innovative aspect of the initiative was that the insurer included community care nursing needs in the contract with the participating hospital, so that if the initiative led to reduced hospital care needs but increased community care needs, this would be taken into account in the overall cost.

For heart failure patients, the frequency and length of hospital visits clearly went down. For COPD patients, however, this was not the case (Van der Burg et al, 2020). However, costs did decrease in this case, probably due to fewer tests (spirometry, x-rays) and less dual diagnosis (a similarly positive cost–benefit was identified in a COPD monitoring exercise in Portugal – see Filipe, 2019). E-monitoring and consultation seems to help patients to better manage their conditions and leads to earlier detection of deterioration, thereby reducing the incidence of acute symptoms that necessitate emergency admission. Moreover, this practice may alter people’s perceptions of when they need to seek additional support, as well as professionals’ decisions about whether to refer or admit patients. Furthermore, the increased comfort provided to patients may itself contribute to controlling the disease and improving quality of life. The latter was also noted as a positive experience of a 2011 evaluation of COPD and heart failure monitoring in the Italian region of Piedmont, which focused on people in particularly remote areas. It was also tentatively highlighted in an overview of 41 COPD e-healthcare apps in the Netherlands (Hallensleben et al, 2019). Reduced hospital visits can also be of particular benefit to this group of patients, who are generally more susceptible to infections.

However, participants must be carefully selected and convinced to make sure people engage with the COPD e-monitoring tool effectively, which is based on subjective questions. In order to scale up the tool, barriers should be removed in incentive systems for health insurers, healthcare providing organisations and medical staff. Furthermore, a positive impact on quality of life is not always considered in the cost–benefit analyses. To improve the preventive impact, it could also be beneficial to scale up e-monitoring among patients with milder forms of COPD by involving GPs. A key driver may come from increased pressures on human resources in healthcare, as illustrated by an experience at Leiden University Medical Center. Guidelines say that patients with heart failure should have four follow-up visits, but in this initiative the second and third visits were replaced by e-monitoring. One factor contributing to this approach was the difficulty experienced by cardiologists to cope with the high demand for their services. Follow-up consultations also have relatively low reimbursement rates as compared to other medical interventions by cardiologists. However, the first and last consultation is still conducted face to face, which provides quality assurance from both the doctor’s and patient’s perspective.

From the doctor’s perspective, there is an advantage in using e-consultation tools that do not require the doctor and patient to be engaged at the same time. This allows doctors to respond to queries when time slots emerge (for instance because of no-shows). This is the case with chat-based mobile apps such as *Beter Dichtbij* in the Netherlands, which allow patients to share pictures and ask questions, as well as for email consultations. In Norway, GPs are reimbursed equally for consultations by text and screen to screen, although for text consultations they only need to respond within five working days. It comes as no surprise, therefore, that screen-to-screen consultations are rare, while consultations by text are rather common. Doctors may allocate time slots for e-consultations that require simultaneous engagement, as GPs in Estonia and Latvia have done. Generally, countries and insurers are still fine-tuning their rules and reimbursement systems. There can be confusion about which types of e-consultations fall under which rule or reimbursement category, and when they are permitted. Furthermore, it proves difficult to achieve fair reimbursement rates that reflect the time invested and any necessary simultaneous interaction appropriately, for both patient–doctor and GP–specialist interactions.

Sometimes e-consultations and e-prescriptions were implemented as part of wider agreements, and as elements of broader e-healthcare systems. In April 2019, the Irish Department of Health reached an agreement with GPs on a new contract to provide medical care to those who hold a medical card. Part of the agreement requires GPs’ cooperation with the deployment of e-prescriptions from 2021. E-prescriptions have often been implemented as part of nationwide e-healthcare systems, such as in the EU-funded National eHealth Infrastructure (EESZT) that has been operational in Hungary since 2017. In Cyprus, a mandatory health insurance system has been in place to cover primary care since June 2019 and is expected to be introduced for secondary care in June 2020. It includes an electronic information system, which also incorporates e-prescriptions that can be accessed by pharmacies. In Latvia, an e-healthcare system was rolled out in 2018. This already includes health data and e-prescriptions, and the country plans to use it for e-consultations in the future.

E-prescriptions of a less-integrated nature – whereby pharmacies do not have access to a fully integrated electronic system so patients still need to bring a paper copy or prescription-specific code with them – can be a stepping stone towards systems to which pharmacies also have access. Malta, for example, has stated its intention to transition completely to e-prescriptions. Austria has been storing the e-prescription histories of patients since 2018 and is planning the full implementation of e-prescriptions by 2020, with pharmacies having direct access to prescriptions and patients needing only to show their identification. Overall, the developments in this area are relatively recent, with the countries that have implemented fully fledged e-prescription systems having only done so in the past five years, such as Portugal in 2016. Other countries' systems are still in development, but European countries are clearly moving towards systems in which patients only need to show their identification or health insurance card at a pharmacy. This is not the case for many of the e-prescription systems applied during the COVID-19 crisis, which have tended to be temporary and ad hoc, usually with a unique number replacing paper prescriptions.

7 Access to long-term care

EU-wide data on access to long-term care are relatively scarce. The initial version of the EU's Social Scoreboard did not contain direct indicators for long-term care. The EU's Social Protection Committee (SPC) has since carried out preparatory work on indicators and an eventual review of long-term care in the EU. As part of this work, it is exploring indicators in the areas of access, sustainability and quality of long-term care.

Arguably, the development of comprehensive care policies must consider both formal and informal care. The main forms of formal care include residential facilities, day centres and home care. Formal care services are services provided by professional, paid carers. However, even those who receive formal care services receive considerable inputs from informal carers such as household members, family or friends. Based on data covering the EU27 and the UK, this chapter points to access problems to support the policy debate, which seeks to determine the focus of the long-term development of care services.

In order to understand where care services require long-term investment, it is first important to understand unmet needs and the particular features of care that people with care needs and their households are willing to use. This chapter recognises the extensive contribution that informal carers make to the overall provision of long-term care and considers the care services broadly, as they relate to both those with the care needs and their households and informal carers. It investigates the area where formal home care services and informal care provided by relatives or friends intersect, on the basis that there is great untapped potential to draw lessons on the design and delivery of long-term care in this area. After mapping access problems and highlighting country differences, the chapter briefly discusses groups in vulnerable situations in terms of access to long-term care. Finally, it explores convergence and divergence trends in access to long-term care.

Access problems and country differences

In order to examine access to long-term care services, it is essential to clearly categorise the people who potentially need to access those services. The capacity and availability of formal care services is dependent on several key factors:

- the proportion of older people (who tend to be more likely to need support due to poorer health, although this varies greatly between countries)
- overall population health in terms of the proportion of people with chronic illnesses and disabilities (including those related to old age) and success in preventing them
- the prevalence of informal care and preferences to give and receive care of a certain type

In terms of the available data on long-term care across Europe, EU policy has used people with self-reported, long-standing limitations in activity due to health problems as a basic reference category for its data on long-term care. This was the case in the 2018 ageing report, for example (European Commission, 2018a).[5] As this rate is higher among older age groups (see Figure 11), older people are one of the groups in focus later in this chapter. However, there is also a severe lack of support available to other groups and their carers, such as parents of children with illnesses or disabilities in some countries. For example, protests in Croatia, Hungary and Poland have demanded increased support and benefits for caring parents in recent years.

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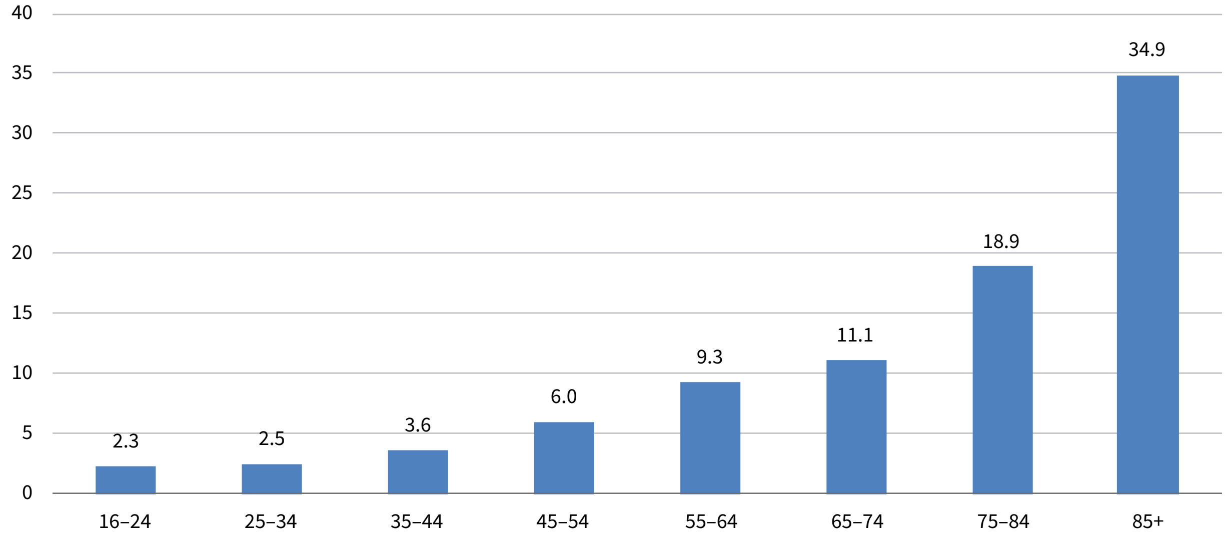
[5] The joint European Commission/SPC report on long-term care, planned for 2021, considers data on severe difficulties with main or instrumental activities of daily life from the 2019 European Health Interview Survey.

Figure 11: Proportion of people with severe long-standing limitations due to health problems, by age group, EU27 and the UK, 2018 (%)



Note: *Data on 'self-perceived long-standing severe limitation in activities because of health problems [for at least the last 6 months]'. These data are in relation to the population living in private households, not people with care needs who are in medical or residential care facilities. Thus, the figures are likely to underestimate the number of people that have care needs, but could be seen as a proxy for how many have potential needs for home care.*
Source: *Eurostat online database (from EU-SILC 2018, hlth_silc_06)*

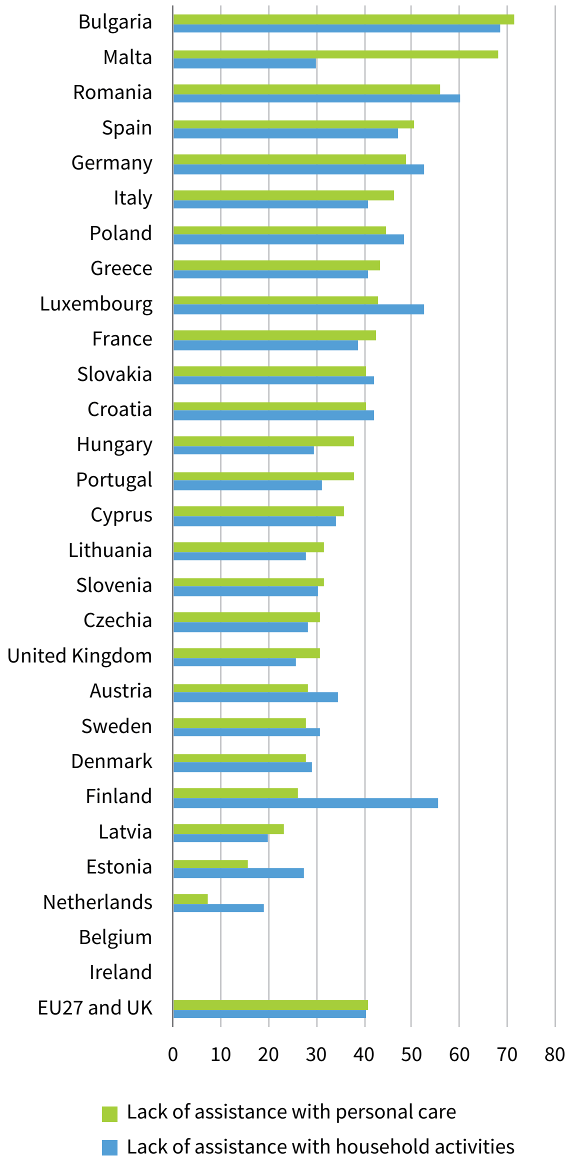
The use of particular care services is sometimes presented as a proxy for access (Spasova et al, 2018). Countries differ in terms of the proportions of people who use any type of formal long-term care service, including residential care, nursing care delivered at home, and home help or personal care. The figures range from 3% in Slovakia to over 25% in Belgium, France, the Netherlands and Sweden (Figure 12). Apart from barriers to use of existing services, the supply/availability of formal care services differs across countries (Eurofound, 2019a).

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

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

Notes: *Proportion of people responding 'yes, I have' or 'yes, someone close to me has' in relation to use of at least one of three formal long-term care services: nursing home care, home help or personal care, or home nursing care.*
Different data sources cover different groups or different services: for instance, the Survey of Health, Ageing and Retirement in Europe provides some information about care needs of the population aged 50+ (but not younger dependent persons); the European Health Interview Survey covers home care needs; EU-SILC 2016 provides information on users of professional home care (but not other types of long-term care); the European Commission (2018a, p. 134) provides figures of recipients of long-term care services or benefits from administrative sources. For an overview of country differences, the EQLS 2016 has been chosen, since this survey asks about use of both informal care and the three main types of formal services. It does not capture the use of day care facilities.
Source: *Eurofound (2019a, p. 33), based on EQLS*

Figure 13: Proportion of people aged 65+ with some or severe activity limitations who lack assistance, 2014 (%)



Source: *Eurostat online database (from European Health Interview Survey 2014). Personal care data taken from dataset hlth_ehis_pchlpd; household activities data from dataset hlth_ehis_hahlpd. No data available for Belgium and Ireland.*

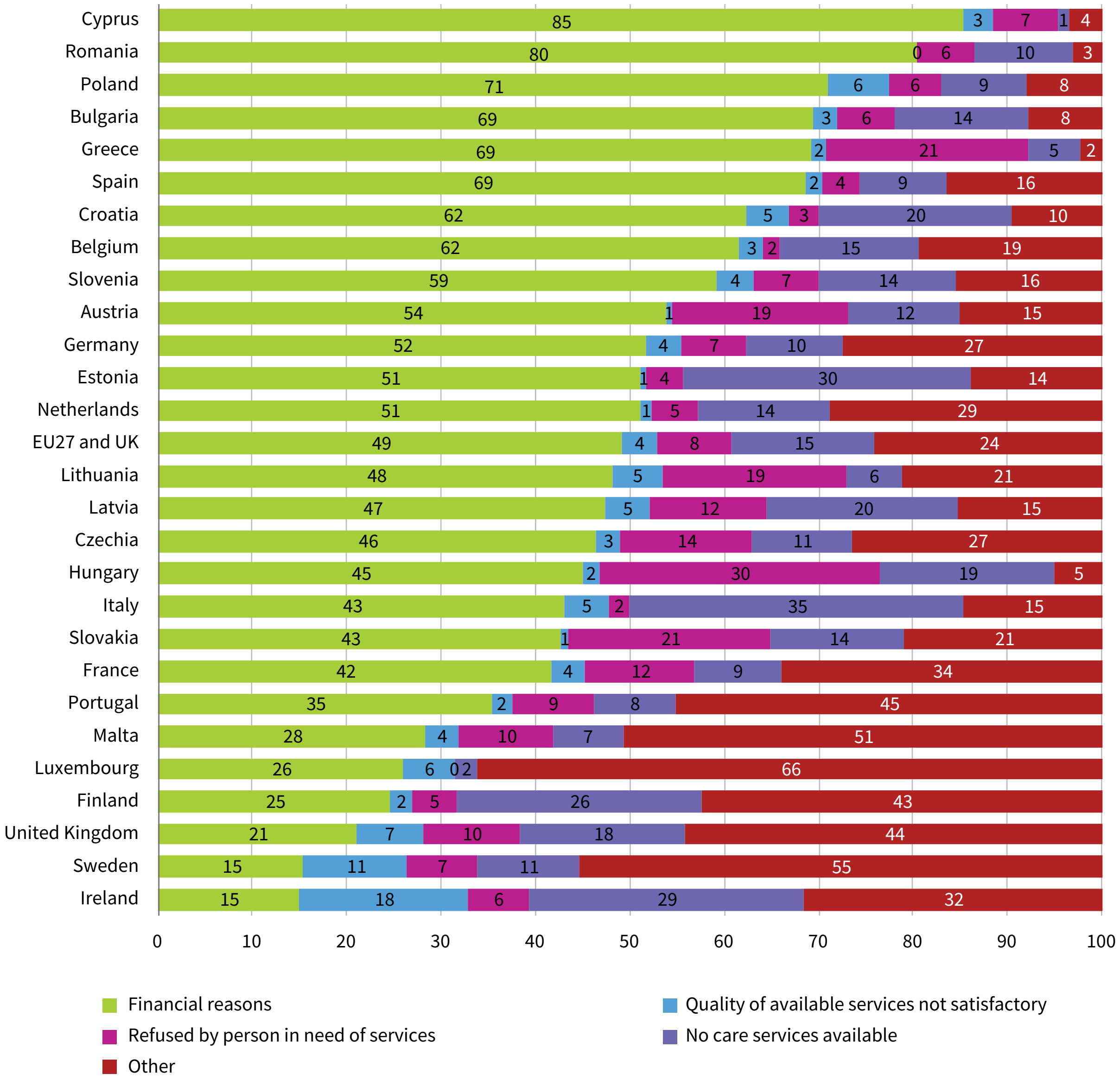
Differences in the availability of services may affect the types of access issues that prevail (see Figure 2, Chapter 2). For example, eligibility for long-term care being limited to people with the most severe dependencies is a basic access problem faced by those who may not be eligible but nevertheless experience substantial care needs (or represent a substantial burden, in the case of carers). Where services are more widely available, access problems could relate to, for example, the amount of care support provided or the quality of the available services.

The levels of unmet care needs reported by people living in private households vary across countries (Figure 13). Over 40% of people aged 65 or older with activity limitations reported a lack of assistance with personal care and household activities in the 2014 European Health Interview Survey (data from the 2019 wave are not yet available). Countries with well-developed long-term care service systems (for example, Austria, Denmark, Finland, the Netherlands and Sweden) report lower levels of lack of assistance. Levels are also low in countries without extensive services for people at home (at least as of 2014), for example in Estonia and Latvia, which may indicate a high frequency and intensity of informal care. While this informal care may indeed meet many people's care needs, it may also suggest a heavy reliance on this form of care. Informal care also appears to have a similar impact on later data, such as from the EU-SILC 2016. Needs for formal long-term care are not always translated into perceived needs (see discussion around Figure 2 in Chapter 2).

Among people who report a need for home care in their household and do not use formal home care services, over one-third (34.5%) say they do not need professional home care services. This may be because informal care is the preferred or accepted form. Societal norms and expectations play an important role here. There may be an expectation that people give up their own paid work to provide informal care for others. Some people may consider long-term care to be of low quality or find the available options inflexible. There may also be a perception that people do not really need formal long-term care services.

Among those who lack or need more professional home care, costs are the prevailing reason for unmet needs – for 49% in the EU on average (Figure 14). However, this figure varies widely between individual countries, from 85% in Cyprus to 15% in Ireland and Sweden. This is similar to the trend observed for healthcare.

Figure 14: Professional home care: main reason for unmet needs, 2016 (%)



Note: *Proportion of respondents who have someone in their household who needs help due to long-term illness, infirmity or old age (excluding those who reported 'no need' to use – or use more – home care).*
Source: *Compiled by Eurofound from Eurostat online database (ilc_ats15)*

The finding regarding the proportion of people who find their ability to access services or use more services is limited by cost should probably be interpreted cautiously, with consideration of how severe that limitation is. Access to long-term care services may be substantially affected by other factors. The intensity of the need is also unknown in this case.

However, the present report emphasises that alongside unmet needs for services, policymakers should also analyse other access problems and take-up in order to design measures that can be preventive and effective if available early on. This would help to support independent living and improve quality of life. It should be noted, however, that the availability of other nearby services is also key to ensuring independent living (Eurofound, 2018a).

The non-availability of services for 15% of those with care needs in their household in the EU is a substantial issue. Large geographical disparities within countries – for example between rural and urban areas or between specific regions – are not reflected in country averages.

The 4% who find the quality of services unsatisfactory and the 8% who report that the people in need of care are unwilling to accept the professional home care services on offer demonstrate that the acceptability and adequacy of services must be addressed when designing and delivering them (see discussion on learning from informal carers in the next chapter).

Finally, one in four people with care needs in their household – potential users of home care services, in other words – report ‘other’ reasons for non-take-up. This shows that there is room to improve the existing instruments to reflect people’s needs and preferences, but that designing the services represents a significant challenge given the potential diversity of these needs and preferences. There may be reasons behind the ‘other’ category that are not possible to identify specifically through the EU-SILC methodology. These reasons could, however, relate to factors illustrated in other research, such as the conditions for receiving benefits and the flexibility of informal carers’ employment situations. They may also link to issues around perceived fairness and equal treatment (Eurofound, 2019a).

In the context of reforms that are projected or already taking place in the long-term care sector, awareness about entitlements and how to navigate service systems and providers is becoming increasingly important. In some countries, this issue is traditionally approached through so-called ‘case management’, whereby service providers appoint professional assistants to make sure care recipients are supported to access services. Institutionalised professional long-term care advice in Germany is one recent example of good practice in providing ‘navigation aid’ to recipients. It is also often important to have an ‘advocate’ – usually a household member or a guide representing a public service provider – who can help the person with care needs to access the appropriate services. In particular, this may be critical for those with care needs related to frailty and cognitive impairments, including dementia for example. As argued earlier in this report, by ensuring the effective flow of information and timely access to services, formal carers could play a role in preventing or delaying dependency on more intensive care (Eurofound, 2019a).

Despite the diversity of Europe’s long-term care systems, one thing most countries have in common is the need to rethink the provision of care due to demographic and financial challenges and emerging knowledge about coverage and access. Both piecemeal changes and reflection on overall policy approaches help with this. Keeping in mind the limitations on resources, gradual expansion of the long-term care system could be considered even in countries where long-term care is presently limited, by applying the principles of preventing or delaying dependence on intensive care, for example (European Commission/SPC, 2014). Such approaches could involve implementing measures to improve public health and rehabilitation, and providing support to care mechanisms that help to extend autonomous living. Interestingly, in the countries where the proportion of the population with care needs who receive professional home care services is higher, the intensity of the services delivered to most recipients tends to be lower (under 10 hours per week, as illustrated in Figure 15). Countries with limited resources – where care provision is generally focused on the most demanding cases – could develop their services sustainably by gradually extending measures to broader groups, including for example by offering limited low-intensity care. Such measures help to sustain quality of life in households with care needs and, in some cases, strengthen their capacity to deal with manageable amounts of care (for example through respite care).

Population groups at risk of access problems

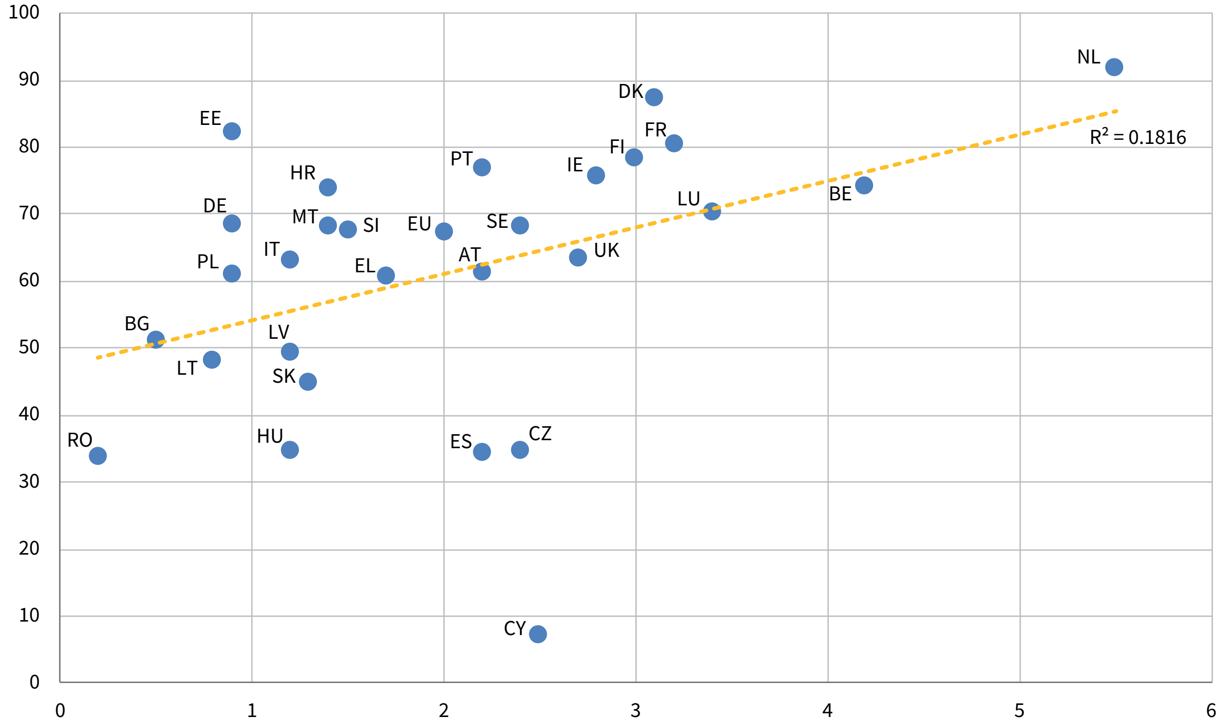
Given the differences in long-term care and its availability across the EU Member States (Schulmann et al, 2014), the groups most affected by access problems also differ accordingly. While ageing populations are a factor raising awareness about the elderly population, parents of children with disabilities have also raised concerns about the increasing socioeconomic vulnerability of their households in countries where long-term care services are less extensive, such as Croatia, Hungary and Poland. Diminishing access to long-term care for part of the population has been an outcome of reduced public funding in the aftermath of the global financial crisis, for example in Ireland and Spain (Eurofound, 2019a).

While there are large differences between countries in terms of availability and use of long-term care services, socioeconomic differences in access to some care services within countries are relatively small, according to analysis focusing on differences between income groups (Eurofound, 2019a) or social risk groups (Privalko et al, 2019 – a study of 11 Member States). National-level analysis may not capture geographical differences due to varying budgets or approaches between regions or municipalities. Nevertheless, the risk of unmet need for home care is higher in poorer households, especially those experiencing material deprivation. According to Privalko et al (2019), when the likelihood of unmet need for home care is compared for people over the age of 65 and those of working age, the risk is considerably higher both for working-age adults and single parents and working-age families with a disability (1.9 and 2.6 times higher respectively).

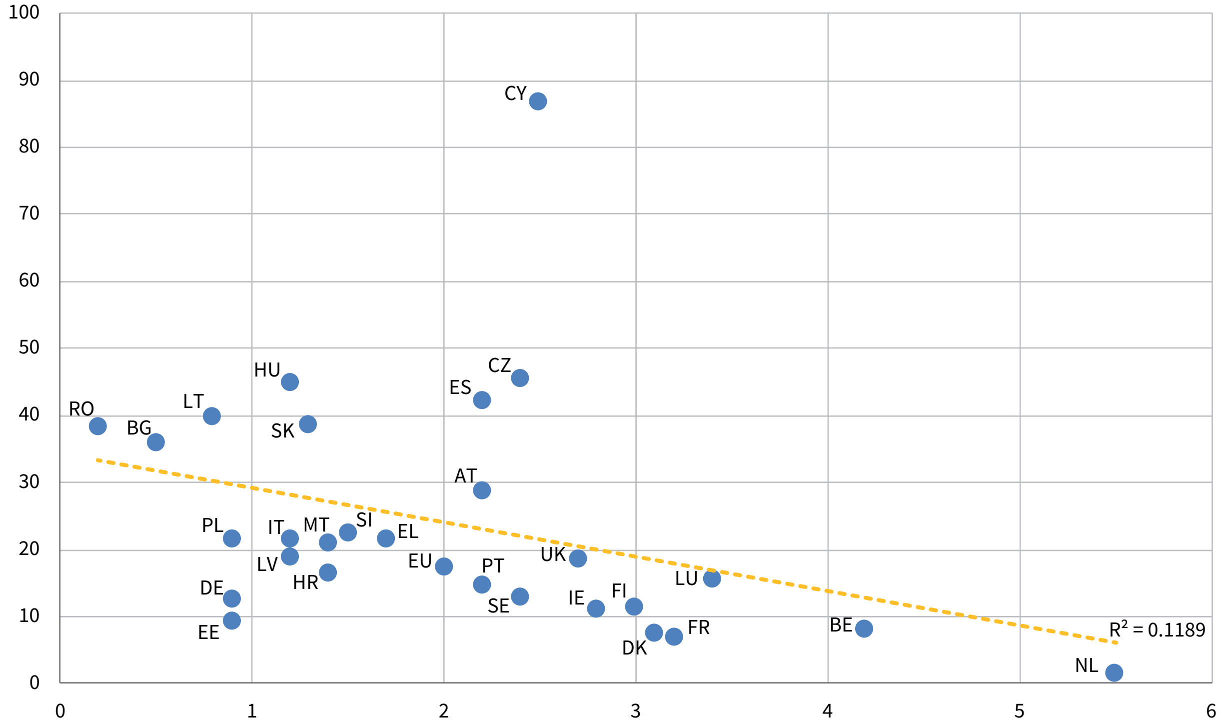
It is also instructive to understand access to care from the perspective of time – sometimes referred to as a ‘care trajectory’ – and to consider different types of care. First, health outcomes and care needs may differ between socioeconomic groups, as the more advantaged groups tend to live longer lives and have greater resources to choose their preferred services. It is important to note that health affects care needs, but the extent to which people access and use care services may differ depending on their resources. This means that poorer people with poorer health may not actually

Figure 15: Proportion of people using professional home care services by hours used, EU27 and the UK, 2016 (%)

% using home care/ % using less than 10 hours per week



% using home care/ % using 20+ hours per week



Source: *Compiled by Eurofound from Eurostat online database (EU-SILC 2016, ilc_ats14). Horizontal axis: percentage of people (with care needs) using professional home care services. Vertical axis: percentage of users that use up to 10 hours of care per week (top panel) and more than 20 hours per week (bottom panel). Includes data for the 27 EU Member States and the UK* be the most likely long-term care service users (Ilinca et al, 2017). Second, the need for long-term care may be affected by factors beyond health, such as quality of housing and the local area (Eurofound, 2019a). As a result, poorer people may need care sooner and end up in residential care earlier if their home care options are limited. People with lower incomes or assets also rely more on informal care (European Commission, 2019a).

Care responsibilities have a distinct gender dimension, whereby more women provide care and women are more likely than men to reduce their participation in paid work in order to provide care. The gender gap in employment is smaller in households where needs for formal home care are met (Privalko et al, 2019).

Convergence/divergence between Member States

In terms of comparisons between Member States, policy discourses on long-term care seem to have converged. There has been an emphasis on deinstitutionalisation in countries where long-term care often used to be provided through residential and institutional care, focusing on keeping people in the community as long as possible, with home and community care to support them. Also, there seems to have been some convergence in policy instruments – one example being the introduction of so-called 'respite care' into the policy discourse (see next chapter).

Meaningful quantitative measurement of convergence in access to long-term care is hindered by the lack of indicators with more than one year of data for all Member States. For instance, the indicator on unmet home care needs analysed above is only available for 2016. Another challenge is that people living in residential care tend to be excluded from survey samples, thereby omitting an important group of long-term care users. This section therefore examines convergence in access to long-term care with respect to two indicators that must be considered suboptimal, but do nevertheless offer insights into convergence: public expenditure on long-term care and perceived quality of long-term care.

In terms of public expenditure, only 11 Member States have sufficient data to conduct any meaningful analysis of convergence (Austria, Belgium, Estonia, Finland, France, Germany, Hungary, Lithuania, the Netherlands, Portugal and Spain) – other countries lack data for the period prior to 2014 in particular. As the EU has mentioned in its CSRs, formal long-term care services – in contrast to healthcare, for instance – have been widely seen as underdeveloped in many Member States (European Commission, 2018a; Eurofound, 2019a). While an increase in funding of long-term care can act as a proxy of increased availability and access, increased expenditure does not necessarily imply improved access in reality. One should therefore be cautious in interpreting upward convergence in this indicator, as increases may for instance actually reflect increased needs or higher inefficiencies. Furthermore, the data concern health-related long-term care only.

For quality of long-term care, the focus is on data from the 2011 and 2016 waves of the EQLS, in which respondents were asked to rate the quality of long-term care in their country on a scale from 1 to 10. In its 2007 wave, the question concerned 'elderly care' rather than long-term care. Some remarks also make reference to that year, keeping in mind the challenges posed by this distinction in terms of comparability. Again, this is an imperfect proxy for access. However, it is plausible that people would rate long-term care badly if they have experienced, or expect to experience, any access problems in line with the framework presented in Figure 2. This indicator on perceived quality therefore seems to be a more readily interpretable indicator of convergence than the indicator on expenditure.

The perceived quality of long-term care has increased from an average of 5.8 points (out of 10) across the EU Member States in 2011 to 6.1 in 2016 (and from 5.6 in 2007). Overall, there has been a clear improvement during 2011–2016 (and during 2007–2011). Furthermore, this upward trend seems to have been one of convergence from 2011 to 2016, with a decreasing standard deviation (countries also converged during 2007–2011, albeit at a slower pace).

However, overall upward convergence notwithstanding, there were decreases in perceived quality in several Member States (Belgium, Cyprus, Denmark, Greece, the Netherlands and Portugal) and the UK. The drivers of convergence from 2011 to 2016 were the countries with quality ratings below the mean in 2011 that then showed a larger increase than the EU overall from 2011 to 2016, and thus moved closer towards the mean (Bulgaria, Croatia, Estonia, Ireland, Italy, Lithuania, Latvia, Poland, Romania and Sweden) or even surpassed it, in the case of Hungary.

The average of the 11 Member States' expenditure on long-term care for which sufficient data were available has also shown an upward trend: it increased in every single year from 2008 until 2017, at an almost constant rate. Expenditure, though, shows a pattern of divergence. At first sight, this seems at odds with the trend of convergence in quality ratings. However, when analysing only the 11 Member States for which expenditure data are available, perceived quality similarly reveals a trend of upward divergence during 2007–2011. There is also divergence in expenditure from 2011 to 2016, but on closer examination it is clear that divergence in expenditure is strongest in the period until 2012 and weakens thereafter. The sharp increases in the standard deviation for every year from 2008 until 2012 appeared to level off after 2012.

When comparing trends in the expenditure and quality indicators, some interesting findings emerge at the country level. For instance, Germany's expenditure increased at a higher-than-average rate every single year from 2008 until 2017, as did the perceived quality rating during 2007–2016 (including during 2011–2016). Hungary's expenditure also increased every single year, but at a lower-than-average rate, while its perceived quality rating also increased greatly. This does not necessarily indicate that funds were spent well: it may, for instance, also imply that relatively small improvements were particularly appreciated by the public.

Regarding expenditure, it is also interesting to note that divergence was driven by countries with already higher-than-average expenditure in 2008 that went on to show larger-than-average expenditure increases (Austria, Belgium, Finland, Germany and the Netherlands). The exceptions are France, whose expenditure increased at a lower-than-average rate but remained higher than average, and Spain, which became a below-average spender and was the only country to show a decrease. In Spain, expenditure flattened out during the financial crisis and fell away from the mean in its aftermath. Portugal also experienced such a fall in the aftermath of the global financial crisis. Again, these observations support the idea that the crisis had a delayed impact, not only for healthcare in general (see Chapter 5), but also for health-related long-term care. Estonia, Hungary, Lithuania and Portugal showed increases during 2008–2017, but were below average and fell away further from the mean.

8 Access to long-term care in focus: Respite care

Spotlight on respite care

In the 27 EU Member States, Norway and the UK, a large proportion of all the long-term care required is provided by informal carers. Many countries face the issue of ensuring the availability of affordable long-term care services. Where long-term care services are scarce, services tend to be prioritised for groups deemed to have the greatest care needs, such as children with disabilities or illnesses, or people with severe long-term dependency. However, this presents a significant challenge for those in need of care who are unable to access care services, as well as being a continuous burden for their carers. Overall, there is increasing understanding that access to care services affects not only the people with care needs, but also their carers, with wider implications for society as a whole (see section 'Access to care services as a policy priority' in Chapter 1).

Given the large dependence on informal care, it is important to ensure that those willing to provide care are able to maintain their own mental and physical well-being while doing so, so that they can continue to provide care of a good quality and avoid social and labour market exclusion (see Chapter 1, 'EU policy context').

Understanding the concepts

Policy measures to support informal care can be classified into three main types: compensation measures (mainly financial), supportive measures (mainly services, including respite care), and work and life reconciliation measures (flexible work arrangements or a right to carer's leave – as in the EU's 2019 directive on work–life balance) (Le Bihan et al, 2019).

In understanding the long-term care measures that affect informal carers, a useful distinction to make is that between direct and indirect support to carers. All EU Member States have some form of care services and measures to support people with acute care needs (such as those due to disabilities and severe illness). Through such measures, for example disability or care allowances or personal budgets, some amount of compensation can reach their carers. Similarly, if a person with care needs is granted access to home care, day care or a stay in care facility, this may provide an opportunity for their carers to take a break. However, it is hard to know the extent of such 'spill-over' support, or indeed its adequacy in terms of meeting the needs of specific carers. Therefore, measures that are aimed directly at carers – such as respite care – are highly important. In this context, it is useful to define respite care as services that enable a planned, structured break from care responsibilities.

Finally, in debating care services, it is useful to reflect on how formal and informal care interact. There are arguments suggesting that these are not two alternative options for achieving the same result, but rather complementary services (Eurofound, 2019a). Using formal long-term care services does not mean relatives or friends should stop spending time with and caring for the person in need; in fact, this may help them to do so in ways that are rewarding to both the carers and the people they care for. For example, the combination of formal and informal care may help to maintain a strong personal relationship in which the carer continues caring for the person in need to some extent, while being enabled to continue participating in employment and society themselves.

Role of respite care

The notion of respite care has until recently been somewhat on the fringes of the wider domain of care services. In fact, it used to be an entirely unfamiliar concept in a number of EU Member States, in spite of the fact that some of them relied predominantly on informal carers to meet their care needs. By the end of 2019, respite care featured in the policy discourse in nearly all Member States, and an increasing number of countries have recently adopted new legislation that formally recognises the status of informal carers and outlines their rights and access to services such as respite care. For example, the relevant legislation was updated in Belgium in 2019, and adopted in Lithuania in 2019 and Portugal in 2020. In several Member States, such as Estonia and Italy, the reforms are still taking shape through the development of legislation and implementing regulations. Some of these countries are explicitly addressing both the purpose of the services offered as respite for carers and their supervision, as Italy has done in its draft legislation.

Despite the growing recognition of the concept of respite care, it is not yet evident to what extent the existing long-term care systems are transforming to address carers as the target group for services. In most Member States, care services are centred around the person in need of care and are based on assessing their health and needs, while support to informal carers is provided only indirectly. While it is clear that the development of respite care supports informal carers, it remains somewhat difficult to evaluate its adequacy and impact if the services are not assessed by taking into account the carer's individual situation and needs.

Many countries have declared an interest in developing home and/or community care in addition to residential care – often in the context of the deinstitutionalisation of care – as a policy objective that will lead to the development of respite care services. The role and importance of this policy trend may be different in countries where a large part of the long-term care burden is carried by privately hired care workers, for example Austria, Cyprus, Italy and Spain. In this case, the privately hired care workers help share the burden of care with household members, family and friends, and therefore residential care is not as prevalent, or at least is not considered as such.

Specific respite care services aimed directly at informal carers are present in several countries, and in some cases have been established for a long time (for example, in Denmark, Ireland, Norway, Sweden and the UK). More recently, carer-focused services have been introduced in Luxembourg (night care and holiday rooms), Malta, Portugal and Slovakia. However, national differences in the scale of respite care provision remain large, despite apparently similar policy concepts (see Table 1). In several countries where respite services have been introduced recently, user numbers are not readily available.

Table 1: Number of respite care recipients, selected countries

Country	Country population*	Number of respite care recipients (per year unless otherwise stated)	Year	Limitation on amount of respite services per recipient	Notes and source
Belgium	11,311,117	2–6% of non-resident carers, 4–14% of resident carers	2016	n.a.	Estimate from the national survey of vulnerable people aged 65 or over (and their carers) who use day care centres and residential care (KBS, 2016).
Czechia	10,610,055	12,800	2018	n.a.	In relation to the 278,000 people in receipt of a care allowance who also have an informal carer, the figure suggests that 5% received respite care. This includes, indirectly, their informal carers. In relation to 135,000 with the third or fourth 'degree of dependence' – i.e. those who require more intensive daily care – the figure is around 9% (though not all of the 135,000 are cared for by informal carers). The number of recipients of respite care increased from 10,000 in 2013 to 12,800 in 2018 (Czech Ministry of Labour and Social Affairs, 2019).
Finland	5,503,297	25,650	2017	3 days per month	Respite care figure is an estimate. The number of informal carers who are committed to providing regular care through a contract with a municipality is around 47,500, of which 54% have used at least one day of annual leave in 2017 (compared to 50% in 2012). As a proportion of the estimated 350,000 informal carers in the country, the figure is 13.6%, but there are some additional respite care recipients among the non-contracted carers (Sotkanet, 2018).
Malta	475,701	224	2018	Twice a week for up to 7 weeks	Respite care provided as replacement care in private homes has been available since 2016. The figure does not cover other respite care services (annual reports of the Ministry of Family, Rights of Children and Social Solidarity).

Country	Country population*	Number of respite care recipients (per year unless otherwise stated)	Year	Limitation on amount of respite services per recipient	Notes and source
Netherlands	16,979,120	Estimated 0.4–0.88 million (20% of informal carers)	2016	n.a.	According to estimates from Statistics Netherlands (2016), 14.2% (about 2 million) of the population aged over 16 are informal carers. The survey-based estimate from De Klerk et al (2017) is higher at 32%, or 4.4 million, hence the range in estimates. One in five informal carers reported having used respite care services.
Norway	5,295,619	18,166	2018	n.a.	The figure is the number of people with care needs who received services on the grounds of respite (5% of the total 366,495 people having received care services). The overall number of respite care recipients decreased somewhat between 2011 and 2018 (based on data from Statistics Norway).
Slovenia	2,066,880	7,783	2018	20 hours per week	Applies to care recipients aged 65 and above only. Figure has increased by 18% since it was first reported in 2013 (Social Protection Institute of the Republic of Slovenia, 2019).
Sweden	10,120,242	7,400	2018	10–20 hours per week	Annual statistical reports of the National Board of Health and Welfare.
United Kingdom (England only)	55,977,200	42,300	2018–2019	n.a.	The number of people who received respite or other forms of carer support. This figure is 12.2% of the total 345,850 carers (among people aged 18 and over) that were either supported or assessed by the local authorities that year (NHS Digital, 2019). The estimated total number of carers taken from the 2011 Census in England was 5.4 million (6.5 million for the UK overall).

Notes: *This table provides a selection of somewhat comparable data that have been identified. The figures are provided for illustrative purposes to help appreciate the scale and differences in respite care. However, caution should be applied due to potential differences in definitions and therefore counting of service cases. *The population figures are based on Eurostat data for the same year as the reference figure for number of care recipients. n.a. = not available.*
Source: *National figures of carers based on inputs by the Network of Eurofound Correspondents, compiled from national-level sources (identified where a single main source was used)*

There are also alternative forms of respite care emerging. Services combining hospitality and care support (also known as ‘respitality’) have been identified in Luxembourg and the UK, with a similar private initiative found in France. In Belgium, some health insurance funds, informal care associations and the Red Cross offer customised holidays. There are also initiatives to extend access to a range of leisure and arts activities to allow carers and those they care for to participate together. Although some such services emerge as civil society initiatives and may appear to be niche activities, they help to diversify services and their personalised approach has great potential. Developing respitality options may prove relevant in contexts such as the recent COVID-19 pandemic by creating care arrangements whereby the person receiving care and their carer can limit their contact with other people if needed, but also benefit from support through certain daily activities and catering, for example.

Regarding specific issues or groups of carers, policy considerations in countries such as Denmark, France and Norway pay specific attention to young carers, aiming to alleviate the burden of care and ensure that their future prospects are not compromised. For example, France pledged to adjust the pace of study for student carers and raise awareness among national teaching staff in its recent strategy on carers (Secrétariat d’État chargé des Personnes handicapées, 2019). According to the EDY-CARE project, which examined the circumstances of carers aged 16–19 in Italy, Portugal, Slovenia and Sweden, small changes in schools such as adjustments to educational strategies and teaching methods can result in big changes in the lives of young carers. These changes can help them to reach their full potential and achieve their goals in life.

Although few specific figures are available, national estimates indicate that carers make up around 8% of the population aged 11–18 in the UK, 7% of 14–16-year-olds in Sweden, and 2.8% of 15–24-year-olds in Italy (Eurocarers, undated). According to the EQLS 2016, 7% of carers in the 18–24 age group provide care at least several times a week, compared to 8–9% on average among all people aged over 18 across the EU. According to the EU-SILC 2016, 4.9% of people in the 16–24 age group (4.3% of men and 5.5% of women) provide care or assistance to someone, compared to 10.2% of those aged over 16. Of those young carers, 10.1% provide care for 20 or more hours per week. While this proportion is usually higher for other age groups, it is interesting to note that the proportion of young carers caring for 20 hours or more per week is at least 20% in six countries: Bulgaria, Cyprus, Italy, Latvia, Spain and the UK. The levels are highest in Bulgaria (33%), Cyprus (26.2%) and the UK (29.9%).

Main issues

A challenge commonly reported in many Member States relates to differences in the availability of care services in various parts of the country. Indeed, this is somewhat similar to the situation reported for other types of public services. For example, ‘the coverage of residential and home care services in Southern Italy is (at least) half that registered in Centre-Northern Italy’ (Spasova et al, 2018, p. 24). In Lithuania, where respite care remains in the early stages of development, only EU-supported, project-based funding has been made available to support trials of respite care services in a limited number of municipalities. In the absence of this co-funding, both the provision of services and their affordability for individual care recipients remains uncertain.

Since the provision of care services is often organised at the local or regional level, disparities related to differences in economic performance between regions are common. However, solutions can be found by optimising the scale on which the services are organised, as part of efforts to deal with the general challenges of regional development. Both clustering (grouping together administrative units) and centralisation have been noted as possible solutions. For instance, Finland has approached the uneven availability and quality of health and care services in different areas by providing government support to municipalities willing to cooperate between themselves in setting up a shared mechanism for administering and providing certain services. A number of ‘regional’ bodies – written in inverted commas here as they do not necessarily correspond to the larger administrative regions – have emerged as a result. Meanwhile, other municipalities have been allowed to either carry on by themselves or continue searching for collaborative arrangements that work for them (Tynkkynen et al, 2019).

A more specific challenge concerns the acceptability and adequacy of services from the recipient’s perspective. For instance, it was noted in Latvia that although respite care is offered to help parents of children with disabilities (in some municipalities), some parents have reservations about entrusting their children to these services. The potential feeling of guilt experienced by carers when passing the responsibility of care over to others has been acknowledged in other contexts, for example in the case of carers of dementia patients. Providers are potentially challenged with organising and administering a variety of support types for a wide range of situations. The 2018 reform of the long-term care insurance in Luxembourg introduced a flat rate charge for the costs of essential support services (IGSS, 2019), thereby potentially enabling more flexibility and facilitating the administration of services.

An example of noting and responding to the user’s perspectives comes, again, from Finland. The country has rather extensive data about carers, not least because a considerable proportion of informal carers enter into contracts with municipalities and are paid for the care they provide (usually to members of their own households). In this way, the authorities obtain a commitment from the carer to provide regular care to the person in need. The carer then receives financial support as well as an entitlement to health check-ups or other support services, including up to three days off per month and the offer of respite care. However, only a third of the informal carers who have a contract with a municipality use the leave available to them, and another third use fewer days off than they are entitled to (Kalliomaa-Puha and Kangas, 2018). A survey of these informal carers found three key reasons behind the non-take-up of leave (and, by association, the respite care they are offered): first – in nearly half the cases – the carers were not willing to let others provide care to the person they looked after; second, in some cases, the care recipients were unwilling to accept a change of carer; and third, some carers indicated that suitable forms of respite care were not available (Linnosmaa et al, 2014). Experts believe that some carers do not think that the available respite care is good enough or that it is suitable for the care recipients. Others may also prefer not to make a dependent family member undergo the stress related to moving in and out of their home.

Out of the total number of informal carers who have contracts with municipalities in Finland, around 40% have opted to temporarily place the person they care for in healthcare facilities as a form of respite care in recent years. This figure also relates to the 47,500 informal carers who had a contract with a municipality in 2018. The overall number of informal carers is larger, at around 350,000. The proportion who choose placements in residential facilities has decreased, as has the use of informal arrangements with family members or volunteers. Meanwhile, the use of home care has increased. In about 5% of cases, foster carers or foster families take over from the regular informal carers when they opt to take a break. Recently, foster care is being strengthened as an additional measure in a suite of home care services that are improving the take-up of respite by informal carers (see Box 9). Overall, a potential message from the Finnish example is that in order to make access to and use of formal care services more effective, policymakers should find ways to better reflect the preferences of users (informal carers and those they care for) and to improve flexibility by catering for a range of needs.

Box 9: Foster care services in Finland[6]

Context: The legislation for foster care for elderly people (phrased in Finnish as ‘family care’) has been in place since the 1990s. It provides for the possibility to accept an elderly person to live and be cared for in the carer’s home or establish a formal foster care home (for up to seven people under the care of two carers). An additional option of a visiting foster carer was introduced in 2015, and this model was successfully promoted in subsequent years. Although it is not yet available nationwide, there are an increasing number of municipalities introducing it and uptake is growing among users. A boost to the development of foster care and its assessment was provided by government funding to support the set-up and training of local authorities as well as training to foster carers. The rollout of these services was first supported in the areas with the highest proportions of older people (such as South Karelia), with other regions following gradually. These developments took place in a broader context of creating new operational frameworks for home care services for elderly people and developing services to support living at home. The foster care is not meant as a mainstream care service. Rather, it is seen as filling in a niche within the long-term care services area (which ranges from informal care to specific services delivered at home and residential/institutional placements). So far, the main use of the foster carers is in enabling the primary informal carers to take their respite entitlement of up to three days per month (for those who have committed to looking after someone via an agreement with their municipality).

Organisation of services: As in the case of other long-term care services, the allocation of foster care is carried out by the local authorities. This involves an initial assessment of care needs to determine eligibility, cost and appropriateness of the service. Following the assessment, a formal service agreement is concluded. For care recipients, the costing of foster care is based on the same principles used in residential care (a maximum of 85% of the care recipient’s income can be charged). The Finnish Federation of Foster Care Associations is engaged in the recruitment, training and peer support of foster carers, while supervision is carried out by local authorities. Those delivering foster care as visiting carers are professionals from similar services and non-governmental organisations, as well as former informal carers. Sometimes, former recipients of foster care become carers themselves, for example those who have undergone successful rehabilitation supported by foster care.

Services in practice: Having a visiting foster carer or moving into a foster carer’s home is an option for older people who have care needs that cannot be met by home care services (or by an informal carer alone) but do not require continuous residential care. It is believed that foster care responds successfully to a preference that many households and people have: to continue living in a home environment, even if care needs increase. Foster carers complement the work of primary informal carers, enabling them to take respite without needing to change the routines of those they care for. The ‘fostering’ aspect of this lies in the fact that the visiting carer is not a relative or friend of the care recipient, but is nevertheless a substitute for the primary carer who is expected to provide care with the same attentiveness. In this sense, foster carers are often perceived as more acceptable than residential (institutional) care, which may be considered less personal. As an outcome, the foster care model provides an acceptable form of respite care compared to the previously available forms – for example temporary use of residential care – that were not widely taken up.

Target groups/applicability: Foster care, as described above, applies well to care needs related to mild or moderate memory disorders, insecurity or depression, and frailty. Having a familiar carer and maintaining usual routines is beneficial for care recipients with dementia, Alzheimer’s disease or similar conditions. This may

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[6] Eurofound is grateful to Anja Noro, Sari Jokinen, Teija Hammar, Sari Jokinen (THL- Finnish Institute for Health and Wellbeing), Raija Leinonen (Federation of Finnish Foster Care Associations) and Minna Valtonen (carers’ facilitator, South Karelian regional authority for care) for their input.

explain why – without the option of foster care – informal carers may otherwise not choose to take their respite entitlement, as this would imply a break in the regular care routines of those they care for. According to experts, a visiting foster care service could also become a relevant means to assist older people with anxiety or loneliness, who sometimes turn to making repeated calls to emergency services. Having a visiting foster carer is practical in situations where the care recipient has been discharged from hospital or is undergoing rehabilitation. This gives the carer a respite following an intensive period of care, as well as helping to reduce the use of costly residential care services. Practitioners note that one example of a situation where foster care is often sought and keenly accepted is in family or household settings where care needs increase, but the household is looking for a way to stay together and cope with the care needs.

Future prospects: In order to improve the service model further, the optimal social security standards for foster carers could be examined, as they have not yet been systematically assessed. Currently, foster care services are commissioned by local authorities, but the carers do not have occupational healthcare and unemployment insurance. To keep foster care services relevant and attractive to users, language and communication skills should also be considered, especially when designing training for potential carers who are migrants or non-native Finnish speakers. There may also be a need for linguistic diversity, as carers may need to assist non-Finnish speakers with particular language needs. Prompted by the search for a response to the limited take-up of respite care, foster care seems to represent an enhancement of home care services. In effect, it engages more people in formal home care services by maintaining the positive features associated with informal care.

Spasova et al (2018, p. 10) have recommended that improving support to informal carers should include, alongside the option of respite care, ‘regular checks on the ability and willingness of informal carers to bear the burden of care as well as meeting their own needs’ and ‘improved ways of sharing care tasks among more than one informal carer’. Several countries already take note of the carer’s availability and willingness to commit to providing care during initial assessments of their eligibility and suitability to do so, for example Austria, Finland and Sweden, as well as the UK. However, checks on the carer’s performance and possible changes in the needs of the person being cared for are very rare, as noted in the UK. Alongside the ability and willingness of the carer from a health-related perspective, the social expectations and social bond with the care recipient are factors to take into account in the design of services. A carer’s reluctance to seek professional help may lead to requesting respite at a critical stage in the recipient’s care, while earlier care could have prevented the critical situation or have better anticipated it. It has been suggested that respite care, just like psychosocial support, must be offered proactively (Anthierens et al, 2014).

It is also important to monitor carers’ views and needs. Practices in this area vary across countries. In several countries, including Bulgaria and Croatia, no specific survey or research focusing on carers has been identified. In such cases, the EQLS is a helpful source for the estimates on informal care, as well as the use of long-term care services among the population. National surveys of informal carers were noted in Austria and Belgium (2016), Finland (2019), France (2015), the Netherlands (2014 and 2016) and the UK (England, in 2018–19). The survey sample approaches include using the administrative databases of the recipients of care benefits (people with an assessed/certified disability or dependence, for example in Austria), using the networks of non-governmental organisations to reach carers (as in Ireland), and carrying out national population surveys with a subsample of carers (as in Belgium, France and the Netherlands).

Regarding the information gathered, the UK is an example of where the defined framework of the Adult Social Care Outcomes Framework is used for regular official reporting on both adult carers and people receiving personal social care services (NHS Digital, 2019). For example, this includes questions on how easy it is to find information about support. In cases where at least some national surveys were carried out covering informal carers – whether smaller or larger scale, representative, self-selective or only project-based, as in Lithuania – the need for temporary respite came up as one of the most needed services for the surveyed carers. The need for respite may be more acute in situations of long-lasting care, such as in the case of specific health conditions. For example, an international survey of family members providing care for people with severe mental illness highlighted that almost half (47%) of carers never have a break, which must be related to high levels of reported stress and exhaustion (Vermeulen et al, 2015). It also relates to potential issues around the access to and suitability of the formal care services for this group, since less than one-quarter of such carers reported that communication with healthcare professionals was going well, and a large majority (around 80%) expressed the need for informational and emotional support and respite (higher than the 62% reporting the need for financial support).

Specific evaluations of respite care services are especially rare, although an example of good practice was noted in Finland.

The following have been noted as ways to obtain information on carer needs and needs for care services. These methods could be used where representative monitoring is not established:

- organising consultations with organisations of informal carers, or organising round tables or focus groups if there are no such organisations
- analysing types of queries via information and consultation services for carers
- analysing experiences of care agencies, especially those with web tools such as job- or service-search platforms, to identify common types of services searched for, found or not found

Of course, these measures do not preclude using carer surveys. They could, however, have specific purposes, for example when developing policies and preparing legislative changes.

In Austria, both a national-level forum – the government-supported interest group Pflege – and regular meetings and round tables with carers at local and regional levels have been organised. Even in instances where carer surveys and some consultative discussions have taken place, more structured carer representation is less common. For example, several Member States including Cyprus, Latvia and Lithuania are not represented in Eurocarers, the European network representing informal carers, even though a large amount of care in these countries is provided by informal carers. Even though carer representation should in principle help both carers and policymakers, the lack of carer organisations should not be an obstacle for developing respite care services; for example, respite care is defined in legal provisions in Cyprus, despite no carer organisations being established there. Greece is a contrasting example of a country where there are active, established organisations supporting carers and certain types of patients and their families, but respite care provisions are not in place. Nevertheless, these could be temporary, short-term differences, and carer representation would probably help policy development in the longer term. In some countries, such as Bulgaria and Greece, it was noted that dialogue between policymakers and informal carers was stimulated by the EU directive on work–life balance. The directive provides for a right to carer's leave of at least five days per year for people in employment. However, beginning a discussion with carers opens up the prospect of a broader consideration of carers' situations and measures that could improve overall access to long-term care services, including the co-design and possibly co-production of care services by carers themselves.

Regarding ease of contact, some countries have dedicated telephone services for answering queries from carers – for example Austria and Czechia – which also offer audio-visual support. In France, a new programme to support informal carers, starting in 2020, has planned informational support, including a telephone helpline and information points, as a top priority. Nevertheless, assessments of long-term care mention lack of awareness about respite care services even in countries where some informational support for engaged carers is available, such as Czechia. There is little evidence so far on the use and potential impact of these services, as well as the type of issues relating to them. In this area, it would be useful to consider the experience of setting up and using similar services in healthcare (specifically e-healthcare – see Chapter 6 'Access to healthcare in focus: E-healthcare').

A study by Yeandle and Wigfield (2011, cited in OECD, 2020) found that the health of carers without access to respite care deteriorated more rapidly than the health of those with access to respite care. However, overall, there seems to be little research and evidence on the impact of respite care. The policy approach that is currently gaining ground in Europe favours promoting community care and home care services. This is leading to increasing recognition of the need for respite for carers, followed by some growth in respite services. Against this background, identifying and evaluating the design and implementation of such services is likely to be of increasing relevance for policymaking. However, there are almost no reported evaluations of respite care services in the EU Member States, whether in terms of delivery, user satisfaction or other outcomes. Some new knowledge could, however, be expected from the ongoing work by Eurocarers on quantifying the value of care. One possible issue for evaluating the adequacy and impact of respite care is the dual purpose of existing care services or systems, whereby respite care is identified in policy programmes, but its actual delivery is centred around people with care needs, as are the related eligibility criteria. Such an approach to services has been referred to as 'indirect support' to carers. While this is by all means relevant in general, it remains challenging to assess the specific types and modes of respite, and their impact on carers and their households, without considering information specific to the carer.

The mapping exercises to date have not always been consistent in identifying what support measures are available or lacking in the EU Member States. Nevertheless, these exercises – including the present report – help to build knowledge on which service types are most common or emerging, and hence how the assessment techniques could be developed. Future evidence collection and assessments could be considered for the following respite care measures that appear to be applied or considered across several countries:

- engaging informal carers and their organisations in the co-design of care services
- using foster care or flexible home care arrangements to replace a regular informal carer at the care recipient's home
- establishing administrative and survey sources to capture the extent of informal care provision, as well as potential problems in accessing long-term care, including respite care services

Another role that could potentially be played by respite care relates to preventing or postponing dependency on intensive care – assuming there is a need for residential facilities or intensification of other health and formal care services – and improving quality of life by enabling ageing at home and in the community.

9 Summary of discussion

Access to care services to support social protection and inclusion

Access to care services is essential for the social protection and inclusion of people in need. It is important to guarantee such access, regardless of the financial situation of the household. Numerous access problems may exist, as outlined in the framework presented in this report (Figure 2). These problems are influenced by the complex interplay of a broad spectrum of individual and household-level, service-level and societal factors throughout the entire process, from initially identifying care needs to eventually satisfying these needs.

Access tends to be considered under broad categories, such as affordability, availability, accessibility and outreach. The framework is instrumental in breaking down the complexity behind such labels. One example concerns 'unaffordability'. The complexity lies in the fact that this is an outcome from the perspective of the potential user, which depends on specific service needs and a wide array of both real and perceived costs – including transport costs, opportunity cost and informal payments – in addition to income and expenditure patterns, and availability and awareness of the support measures. This complexity also applies to how access problems express themselves, in terms of non-use of services, difficulties using services, use of suboptimal services or untimely use of services, as well as expectations of access problems if care needs were to emerge. Furthermore, the unaffordability of prompt, nearby and high-quality service delivery via privately provided alternatives blurs the distinction between 'waiting list', 'reachability' and 'quality' problems and an 'unaffordability' problem.

This complexity of the concept of access has implications for the interpretation of access-related data. Data on service fees only capture part of the cost side of unaffordability, for example, but survey data on reported access problems encapsulate the income and cost picture more comprehensively. The framework also sheds light on the complexities of interpreting survey data on the reasons for unmet needs. For example, people may report that a service is 'too far away' as a main reason for unmet needs, while the real issue is that the transport options available to them are too expensive or inadequate. Public transport may be infrequent, slow or inaccessible to those travelling with a wheelchair or buggy. Alternative services that are easily reachable may be unaffordable, or not trusted. In this context, it is also highly relevant to note that all such problems are ignored by policymakers, who rely purely on objective geographical data on the location of service providers (Eurofound, 2018a).

This complexity also has implications for investment decisions that aim to improve access to services to support social protection and inclusion. Funding may be used to equip physical structures, such as primary care centres, hospitals, ECEC providers or nursing homes, in areas where access is lacking. However, such investment may have a limited impact on improving access if it is not accompanied by measures to attract and retain staff and improvements in the affordability of care based on the various individual, organisational and social factors. For instance, in the case of healthcare, the allocation of EU funding in some former communist Member States has arguably focused too heavily on infrastructure in previous funding cycles. This has left facilities underused and limited the impact of the funding in terms of improving access effectively (Eurofound, 2014). The European Commission (2016) has also acknowledged that these countries have focused too heavily on infrastructure development, albeit from the point of view of the limited impact on efficiency, rather than on access.

Overall, effective access to care services to support social protection and inclusion may be hindered if policy is focused on some dimensions, while ignoring others. For instance, policymakers may focus on guaranteeing free access to ECEC, healthcare or long-term care. However, people may still experience problems accessing these services, for example, because they are unaware of the entitlement, live far away from the nearest provider, face long waiting lists or times, or are unconvinced of the quality of the services.

Early childhood education and care

In 2010, the Barcelona objectives were renewed until 2020 in the European Pact for Gender Equality (2011–2020). Even though the European Commission's Gender Equality Strategy 2020–2024 does not refer to these targets, the use of ECEC by children under the age of three is monitored in the Social Scoreboard. Similarly, the Strategic framework for European cooperation in education and training (ET 2020) set as a benchmark that at least 95% of children aged between four and the compulsory age for starting primary education should participate in ECEC by 2020. This benchmark has been reached and there are ongoing discussions regarding its follow-up. There is, therefore, an opportunity to monitor access beyond take-up and affordability. Access barriers have been surveyed in the EU-SILC 2016 ad-hoc module and the EU LFS 2018 ad-hoc module. In order to better follow trends in access to ECEC across Europe, questions about access could be incorporated in the EU-SILC main questionnaire, as part of the questions about ECEC arrangements, or the ad-hoc module could be repeated in the future. Similarly, even though there have been several EU LFS ad-hoc modules regarding the reconciliation of work and family life, not all of them have included questions about unmet needs with regard to formal ECEC. The experience of the 2016 and 2018 ad-hoc modules could be used to refine and harmonise the services considered as ECEC, in particular regarding the age of children, which in the case of the EU LFS 2018 ad-hoc module includes children up to 15 years old. This would constitute a good basis for including an indicator of unmet need for formal ECEC in the Social Scoreboard, similar to the indicator ‘Self-reported unmet need for medical care’.

The renewal of targets for ECEC could also represent a good opportunity to gather more data regarding aspects of quality that affect the use of these services. Staff are crucial in ensuring the quality of services. Analysing their working conditions would enable a comparison of their situation with that of other sectors and help to identify which areas need improvement. Workforce issues have been included in the EQLS, the European Working Conditions Survey and the OECD Starting Strong Survey, and this possibility could be explored further in the context of an EU-wide study.

In 2021, the European Commission plans to introduce a Child Guarantee that would call for free or affordable ECEC for children with disabilities, children with a migrant background, children residing in institutions or alternative care and children living in precarious family situations due to economic fragility – in particular, income poverty or material deprivation – household composition, or other social risk factors. While acknowledging the importance of paying attention to material poverty, the current report also highlights that it is critical to go beyond income poverty and beyond cost as the only barriers to access. For instance, it is important to consider the situation of children with special educational needs, who may or may not be in a situation of poverty or at risk of poverty and face many barriers other than cost. In order to monitor the situation of these groups of children, the data available about them need to be improved. Given the lack of data and the multiple definitions used at the national level, at this stage it would be advisable to collate and bring together the sources of data and definitions used in each Member State, as has been done in the case of other groups at risk of social exclusion.

Healthcare

Three dimensions are key in moving towards universal healthcare coverage: population (who is covered), services (what is covered), and direct cost (the proportion of costs covered) (WHO, 2010). However, to achieve effective access to healthcare, as targeted by the European Pillar of Social Rights and the UN’s Sustainable Development Goals, it is important to look beyond these dimensions of formal coverage alone. Access should be ensured along the entire spectrum from perceiving care needs to satisfying them, by addressing individual, organisational and societal factors (see Figure 2, ‘General framework for access to care services’, p. 11).

Employment, especially with a permanent contract, seems to protect people from the insecurity of being unable to pay for healthcare if needed. It does so through the income (and income security) it provides, but also through factors beyond income. These additional factors may include supplementary insurance, which is often part of employee benefits. Coverage beyond the basic package is needed to prevent access problems in many Member States. For instance, additional coverage may help to circumvent waiting lists or reduce waiting times or consultation fees.

Even when people are covered for the services they need and fees are low, multiple access barriers may still prevent them from getting the care they need, make them postpone their care or anticipate difficulties in the event that they need care. In terms of unmet needs overall, countries have converged upward during 2008–2018, moving to lower levels of unmet needs. Drivers of this convergence include Hungary, Latvia, Poland and Romania catching up with the other countries overall. However, several countries have diverged negatively, and there have been interchanging periods of divergence and convergence in this period. For several Member States, including reported reasons for unmet needs beyond just waiting lists, cost and distance (the Social Scoreboard indicator) changes the observed pattern of convergence and divergence. Given the complexities in interpreting reasons for unmet needs reported by survey respondents, it could be argued that unmet needs should be considered comprehensively, regardless of reported reasons.

E-healthcare was highlighted due to its potential to improve access. National e-healthcare strategies have been present in the EU for two decades. In many countries, ICT has found its way into healthcare in the application of medical equipment and the use of some level of healthcare data. However, in terms of contacts between patients and healthcare providers, the role of ICT has often been limited to appointment systems or occasional, informal follow-up phone calls.

E-consultations between patients and doctors, in particular screen to screen (video), were until recently rare in the EU, except in a few countries such as Denmark and Sweden. They have, however, increased over the past few years and are now becoming common in some countries, such as the Netherlands and Norway. In many cases, e-consultations had not been formalised, for instance in relation to reimbursement rules in Belgium. In others, such as in Cyprus, France and Germany, they have only very recently started to become formalised, although this is often the case only for primary care. Countries apply multiple and differing criteria as to when e-consultations are permitted, such as during influenza epidemics or only after an initial face-to-face consultation. France stands out in having rolled out a national system in 2018 and requiring consultations to be conducted screen to screen. Sometimes reimbursement systems steer doctors towards certain modes of e-consultation. For example, in systems where text consultations are reimbursed equally to screen-to-screen consultations, such as in Norway, texting tends to be more popular, as it is quicker and gives the doctor more flexibility to reply at a time that suits them. In countries where doctors generally receive a fixed salary, there should be no financial disincentive to implement e-consultations. Nevertheless, few initiatives have emerged, which could be due to inertia, lack of investment and disincentives at the level of the organisation (typically the healthcare centre or hospital).

In contrast, in many Member States, smaller-scale e-consultations through mobile applications (apps) have become available in the private sector. Access is usually restricted to people with supplementary insurance coverage, or those who pay a fee. E-consultations can also be used as a marketing tool to attract relatively healthy people by insurers or by GP practices that are paid according to their number of registered patients. Usage is often concentrated in urban areas, thus neglecting to improve access in rural areas for which remote access is likely to be more beneficial. Consultations through such private sector apps have been reimbursed through the social health insurance or public system in Germany (since 2017) and Sweden. Low-barrier apps and telephone lines also seem to trigger access for many people who would otherwise have waited to see whether their health situation improved. However, e-consultations also seem to have contributed to reduced medical costs, such as through fewer emergency department visits or medical tests. Examples of this include e-consultations via national telephone lines (see example from Estonia) or as part of COPD and heart failure e-monitoring tools (see example from the Netherlands). In addition, they can provide reassurance for people and improve their quality of life.

The COVID-19 crisis has boosted the use of e-healthcare in many countries. However, many of these initiatives are ad hoc and temporary, outside a solid structural framework. In most cases, they are restricted to consultations by phone and e-prescription systems similar to the paper systems that preceded them, without the full electronic systems that are accessible to pharmacies. Furthermore, during the COVID-19 crisis, many people have postponed care needs, some of which could have been prevented by better access to well-established e-healthcare options. Reimbursement/payment rules have also not always been satisfactorily clarified, with potentially minor queries being billed as full consultations or healthcare providers not sufficiently compensated. In order to ensure the long-term benefits of e-consultations and e-prescriptions, it will be important to learn from the more established experiences described in this report.

Long-term care

The review of various sources of information about access to long-term care services suggests there are several issues that may not have received sufficient attention in both the planning and assessment of policies. One issue is the prevailing focus on data about the use of care services when assessing access. Long-term care coverage and availability of care services differ considerably between various countries and therefore usage data can indeed be instrumental in obtaining a broad, cross-country overview. However, in the context of this report, it is clear there is a need for more and better indicators to reflect access issues, especially from an in-country perspective. The limitations of the available data are further illustrated by the fact that almost one in four (24%) people who had an unmet need for professional home care did not receive care because of an unidentified reason (referred to as ‘other’ in data from the EU-SILC 2016).

Improving the understanding of different care needs shaped by factors other than health – for instance, household situations – could be a way to improve the suitability of care services and boost independent living. Understanding these needs, however, requires acknowledgement that care needs and care provision affect not only the persons in need of care, but also their households and their informal carers. This reinforces the view that formal and informal care should be seen as complementary services, rather than alternatives to each other. With the emphasis on community and home care in the European Pillar of Social Rights, this is particularly important. As in the area of healthcare, there is also a role to be played by new technologies, even if their use seems to have been limited so far.

This includes strengthening communication and information, such as through the establishment of dedicated telephone lines (Austria and France), increased self-medication (the Netherlands), and safety alerts (Estonia and Sweden).

Given the diversity of care policies across Europe and the fact that informal care plays a considerable role in many countries, there is room to improve the development of services by enhancing the co-design and co-production of care. Also, developing services that help both people with care needs and their carers opens up the possibility to gradually roll out new services that may be more easily sustainable, even in systems with limited resources. Moreover, promoting the development of early care assistance could help to improve preventive capacity, thereby reducing or postponing the need for more intensive, and therefore more expensive, care.

Respite care, whereby informal carers are supported by some form of formal care, is one way to initiate formal care contact with people with care needs early on, at a stage when they can still benefit from targeted support and informal care. Importantly, early contact with formal services can also facilitate social inclusion and even employment for informal carers. However, in several countries where respite services have been recently introduced, user numbers are not reported. This represents a basic obstacle to assessing the policies on the basis of organised evidence. While the development of temporary respite care has been noted in some Member States, it may or may not be achieving the intended objectives of respite, which must ensure a structured approach to planned breaks from caring.

Improving the involvement of carers in policy design and implementation can be instrumental in ensuring the effectiveness of these policies. Finding ways to gradually extend formal care services could be easier in conjunction with informal care, effectively enabling more people to access professional care. However, any eventual extension of measures to support informal carers, including with respite, should not divert attention away from stepping up professional services to meet specific care needs. Overall, the sustainability of care is an objective central to both the organisation of long-term care and the provision of respite services.

10 Conclusions and policy pointers

Conclusions

EU citizens have the right to social protection and inclusion through access to care services that are of good quality. As outlined in the European Pillar of Social Rights, these services include ECEC, healthcare and long-term care. The present report has detailed the multiple aspects of access to care services that need to be the focus of policymakers working towards enforcing this right.

This report has outlined current problems in accessing ECEC, healthcare and long-term care in the EU Member States, Norway and the UK, and differences between countries and population groups. It is necessary to effectively address these problems in order to ensure that the right to access these care services is enforced. The report has discussed how three specific measures can contribute to this and summarised the experiences of these measures in Europe. The first specific measure covered in this report concerned practices to make ECEC more inclusive, particularly for children with special educational needs and disabilities. The second was access to e-healthcare, including e-consultations and e-prescriptions, which can facilitate access to healthcare for people in remote and rural areas in particular. The third measure discussed was access to respite care, which can support informal carers and establish contact with formal services for people with long-term care needs.

Policy pointers

This report has resulted in a number of messages for policymakers and service providers. Some of these messages apply generally to care services in the context of social protection and inclusion. This section first presents these general policy pointers, before focusing on the three specific services discussed in the report.

General

- Unmet needs are only one end of the spectrum of access problems. Even people who eventually access care and meet their needs effectively may have experienced difficulties in doing so or initially postponed the process. Furthermore, irrespective of whether they currently have care needs, people may anticipate access problems if they were to require care services in the future. Such expectations can lead to feelings of insecurity and negatively affect their quality of life and trust in institutions. Focusing on unmet needs risks losing sight of the variety of problems present across the different countries.
- ‘Voluntary’ non-use or postponement of services – or reported lack of need – should not be taken at face value. In the case of healthcare, people who say they want to wait until their condition improves, for instance, may actually opt to use healthcare services if a low-barrier e-consultation via a mobile app or telephone were available to them. For long-term care or ECEC, people who report that they do not need the services may only be considering the inflexible or low-quality options available to them. Others may report that they no longer need care because informal care is being provided by someone, even though that person may have given up their job or be suffering from social exclusion or poor health as a result. Social norms in this regard can challenge the meaning of ‘volunteerism’.
- To address access problems due to unaffordability, one should not narrowly look at the cost of the service, but rather take into account all other cost and income aspects affecting affordability for specific needs.
- To effectively enforce the right to access, it is important to improve its multiple dimensions, throughout the whole process of access, from perceiving care needs to satisfying these needs.

More specific policy pointers for the three services discussed in this report are included below.

Access to ECEC

- Access to ECEC still needs to be improved, particularly in some countries, in order to reduce inequalities in the degree to which children benefit from ECEC and to facilitate employment for informal child carers (the majority of whom are female).
- Affordability is a key barrier, but subsidising ECEC does not remove all barriers to access for all children. For instance, policy measures should go beyond addressing material poverty and consider the situation of children with special educational needs. The issues of quality, distance and staff shortages also need a broader policy perspective.
- The renewal of EU targets in the use of ECEC could incorporate reasons for unmet needs, rather than only focusing on the proportion of children in ECEC. Furthermore, a wider age group than children under the age of three could be considered for monitoring progress on the European Pillar of Social Rights in terms of access to ECEC.

Inclusive ECEC

- Continuing professional development (CPD) can improve the quality and inclusiveness of ECEC, but more robust evidence and evaluations are needed to validate this. Aspects of training that have been found to be useful should be better disseminated and applied.
- Staff costs and financing of programmes have been identified as the main barriers to CPD in several countries. EU funding can play a role in tackling these issues.

Access to healthcare

- The global financial crisis has had a delayed negative impact on access to healthcare, with multiple money-saving measures having been implemented towards the end of the crisis. This resulted in a post-crisis peak in access problems.
- Although access problems have reduced since that post-crisis peak, some systemic factors that contributed to the peak, for example higher user costs (user fees, transport costs) or waiting lists in the public sector, may still be in place. The improvements in access since the peak may have been caused by higher incomes and employment, rather than by more accessible systems. This implies vulnerability to future economic shocks, with a more immediate and intense negative impact on access to healthcare to be expected. In order to be more resistant to economic shocks, access should rely less heavily on income and employment.
- The experiences of some richer and poorer Member States show that unmet medical needs do not have to vary by income. Countries seeking to reduce the impact of income inequalities may want to look at the practices in these Member States for guidance.
- It is important to monitor inequalities associated with the role of supplementary insurance, which is often provided by employers.
- Action is needed to achieve a more consistent trend of upward convergence in access to healthcare between Member States, focusing in particular on the countries diverging from this path. These include several Member States for which access to healthcare is not mentioned in the EU's country-specific recommendations (CSRs), such as Slovakia (in particular rural areas).
- Investing in establishing and modernising healthcare establishments has a limited potential to improve access if not accompanied by investment in other factors, such as affordability of healthcare and availability of staff.

E-healthcare

- The EU can facilitate knowledge exchange by drawing on a wide range of long-standing e-consultation practices across the EU, most of which have been implemented on a small scale. This could also help to transfer the ad-hoc facilitation of e-consultations and e-prescriptions due to the COVID-19 crisis into more permanent structures. In many cases, there is a need for clearer legal frameworks with regard to issues such as accountability, including monitoring whether consultations have taken place, reimbursement and liability. It is also important to gear funding towards scaling-up more systematic systems and ensuring population groups for whom e-healthcare has particular potential are reached more effectively. These groups include people who live in rural and remote areas, persons with disabilities, people who have no one to accompany them to visit a healthcare provider, people who have frequent healthcare needs due to chronic conditions, or those who suffer from conditions whereby travelling to a healthcare provider poses risks to their health.
- Financial incentives to provide e-consultations and e-prescriptions need to be appropriate for doctors, especially when they do not receive fixed salaries, as well as for insurers and hospitals. In some countries, doctors receive the same rate for e-consultations and face-to-face visits. In other systems doctors receive less for e-consultations or such e-consultations are categorised as 'short' consultations. The rules do not always differentiate between e-consultations by text or screen to screen, providing disincentives for the latter. In some countries, e-consultations have not been reimbursed (Austria, Belgium, Latvia, Romania and Slovakia). Most countries restrict the scope of e-consultations, often limiting them to follow-up consultations or to specific methods, such as screen-to-screen consultations in France. Investment in essential equipment is another financial barrier. In practice, such investment rarely seems to take off without government support, but some low-cost mobile apps for general consultations have emerged in the private sector.
- There may be particular potential to improve access for broader groups of people using lower-tech e-consultation options, such as national telephone lines (as in Austria and Latvia and especially Estonia).

Access to long-term care

- Formal long-term care provision needs to be expanded greatly in most countries, improving access to a range of flexible options. This can contribute to freeing up beds in hospitals, providing more adequate care, facilitating employment and reducing social exclusion for overburdened informal carers, as well as cutting down on the healthcare needs of informal carers.
- It is important to provide access to some level of long-term care in the early stages of needs. This helps to facilitate early identification of increasing long-term care needs and prevention, and provide flexible care tailored to specific needs and family contexts.

Respite care

- While many countries are developing or testing out respite services, the introduction of measures is rarely built on systematic and representative inputs from carers as a target group. It could be beneficial, therefore, to increase carers' involvement in the co-design and co-production of policy.
- Where certain respite care services exist, adjustments to home care services can help to address the risk of non-take-up due to the perceived unsuitability of services and the reluctance of carers to entrust those they care for to formal service providers. These adjustments to home care may involve addressing the training of staff, as well as the recruitment or engagement of former informal carers.
- Diversifying forms of respite care services, especially by providing alternatives to the placement of the people with care needs in hospitals or residential facilities, is a way to improve the access and take-up of respite care. Specifically, it is a way to respond to the reluctance of some care recipients and their carers to opt for formal residential care, which was identified in carer surveys in several countries.
- Involving informal carers in the organisation of respite care could prove productive. It would require policymakers to address areas of service organisation that are very relevant for the future of long-term care, including identifying the aspects that are most important for the quality of respite services and their acceptability for care recipients and their carers and families. It would also help to identify which aspects of care need to be formalised and supported, and to encourage care providers, including those who offer respite care, to adapt their services to the needs of the target groups in practice. Overall, better-organised respite care is needed to support informal carers, whose care responsibilities greatly impact on their own lives.

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The right of access to good-quality care services is highlighted in the European Pillar of Social Rights. This report focuses on three care services: early childhood education and care (ECEC), healthcare, and long-term care. Access to these services has been shown to contribute to reducing inequalities throughout the life cycle and achieving equality for women and persons with disabilities. Drawing on input from the Network of Eurofound Correspondents and Eurofound's own research, the report presents an overview of the current situation in various EU Member States, Norway and the UK, outlining barriers to the take-up of care services and differences in access issues between population groups. It pays particular attention to three areas that have the potential to improve access to services: ECEC for children with disabilities and special educational needs, e-healthcare and respite care.

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