Council of the
European Union

Brussels, 24 February 2020
(OR. en)

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ADD 1 COR 1

SOC 54
EMPL 41
GENDER 9
ANTIDISCRIM 4
SAN 44

COVER NOTE

From:	General Secretariat of the Council
To:	Delegations
Subject:	EIGE Note: Home-based formal long-term care for adults and children with disabilities and older persons

Delegations will find attached a research note entitled "**Home-based formal long-term care for adults and children with disabilities and older persons**" that has been prepared by the European Institute for Gender Equality (EIGE) at the request of the Croatian Presidency.

Home-based formal long-term care for adults and children with disabilities and older persons

Research note

2020

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Country abbreviations

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czechia
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HR	Croatia
HU	Hungary
IE	Ireland
IT	Italy
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	Netherlands
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
UK	United Kingdom
EU-28	28 EU Member States

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Introduction

The EU is currently experiencing unprecedented demographic changes. The share of population above 65 years in the EU is expected to increase from 19 % in 2016 to 29 % by 2080 and the percentage of people above 80 years will more than double to 13 %[1] in that time. Rapidly ageing population leads to an ever-growing need for long-term formal and informal care. In 2017, one in four people in the EU had a long-term disability, women (27 %) more than men (22 %)[2]. Another group of the population who is in need for long-term care (LTC) are families with children who have a disability. In 2017, about 5% of families with children had a child or children with disabilities (i.e. some or severe long-standing limitations in usual activities due to health problems)[3]. Given this context, the EU will face a major challenge in meeting long-term care needs in a financially sustainable way, ensuring that care is affordable without endangering the quality of services or the lives of care providers and the cared-for (Commission, 2017a).

Challenges related to LTC are highly gendered. Due to longer life expectancy, more women than men are in need of LTC services, therefore, they are more affected by the availability and quality of services. In the EU, an absolute majority of professional employees in the care sector are women. Women are also more likely to provide informal care to their family members when formal services do not suffice. Informal care is one of the main reasons behind a lower employment rate and higher inactivity of women in the labour market. It has also been proven to have negative effects on informal care givers' quality of life and their work-life balance (Riedel & Kraus, 2011; Szebehely & Meagher, 2017; Women).

The European Pillar of Social Rights and its New Start initiative on work-life balance endorses everyone's right to accessible, good-quality and affordable LTC services and, in particular, home care and community-based services. Although deinstitutionalisation and prioritization of formal home-based LTC is high on the political agenda, homecare services remain underdeveloped and difficult to access in many of the EU Member States (Spasova et al., 2018). Across the EU, nearly every third household lives without adequate professional home care services. LTC relies heavily on informal care with evidence indicating that the number of informal carers is twice that of formal caregivers (Commission, 2014). Certain groups of the population experience greater difficulty in accessing formal LTC services, including people with low income, poorly educated people, migrants and ethnic minority women (Commission, 2009). As a result, households are forced to provide care themselves or, in some Member States, to outsource care to domestic workers who are very often migrant women or even to stay without adequate care at all.

This research note focuses on formal home-based care across the EU. From care recipients' perspective, it looks at different aspects of LTC that determine women's and men's opportunities to access LTC services. Children with disabilities, adults with disabilities, and older people are the three

[1] Eurostat, Population projections, 2015, (proj_15ndbims).
[2] Eurostat, Health variables of EU-SILC, 2017, (hlth_silc_06).
[3] Eurostat, ilc_hch13

groups of (potential) care recipients covered in this study. From the perspective of care givers, this study focuses on the quality of employment in the formal home-based care sector.

1 Formal home-based long-term care: what and why?

1.1 What is formal home-based long-term care?

Long-term care (LTC) is 'a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or [are] in need of some permanent care' (Commission, 2014). LTC services can be formally performed by paid professionals in institutions (e.g. nursing home or residential care homes) or at home, or informally by family members, relatives, friends or others. The majority of countries heavily rely on informal care, although the need to develop formal long-term care services is recognized (Spasova et al., 2018).

Formal institutional or residential care is provided for LTC recipients who are staying in congregate institutions, such as nursing and care homes, or long-stay hospitals (Galik, 2013; OECD, 2019). The residents at such institutions are usually isolated from the broader community, they lack control over their lives and over decisions which affect them, and the requirements of the organisation itself tend to take precedence over the residents' individual needs (EPR, 2018). It is also a more expensive option of care, particularly for recipients with lower level of disability (Genet et al., 2011; Rostgaard et al., 2011). In case of children, institutionalised care may also mean institutions such as orphanages or children's homes where children with disabilities are likely to be placed to a larger extent than other children.

To improve quality of life and the efficiency of social care systems, the EU is moving towards the deinstitutionalisation of long-term care and supporting instead independent living at home through formal home-based or community based care. Independent living refers to people being able to make choices and decisions as to where they live, who they live with and how they organise their daily life[4].

Formal home-based care is usually provided by licenced providers (employees or self-employed) in the home of the care dependent person. It is regarded to be a more cost-effective solution providing better care outcomes for the recipients compared to institutionalised care and, most importantly, reflecting people's preference for home-based care. Home-based care may include assistance with tasks such as house-keeping, shopping, getting dressed, bathing, preparing and eating meals, psychological support and helping to participate in social activities (Rostgaard et al., 2011). It may include nursing services provided by medical professionals. These services make it possible for older people to remain independent for a longer period.

In addition to formal home-based care services, independent living may also require accessibility of the built environment; accessible transport; availability of technical aids; accessibility of information and communication; as well as life and job coaching; and access to other community-based services. It implies recognition of, and support for, family carers, including the need to help maintain or improve their quality of life[5].

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[4] The European Expert Group on the transition from institutional to community-based support (EEG) https://deinstitutionalisation.com/terminology/

[5] Ibid.

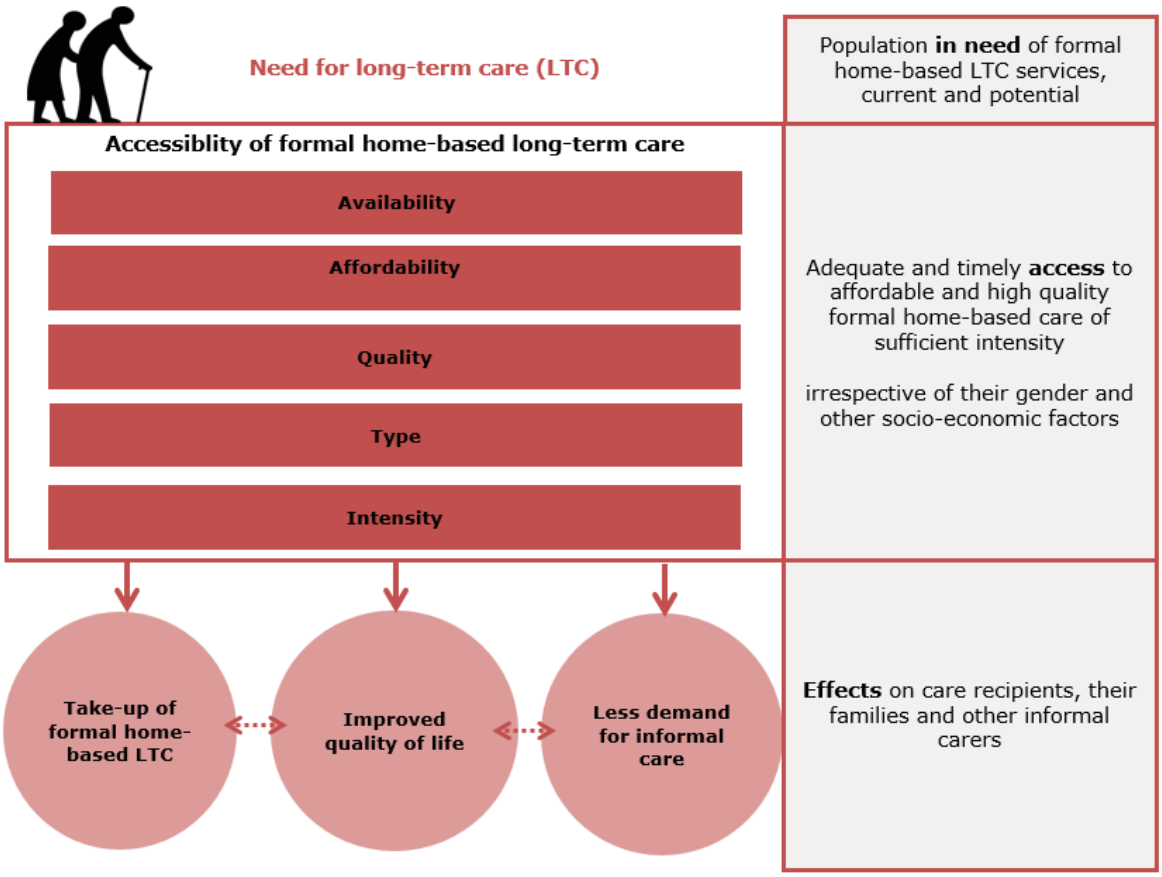
1.2 Accessibility of home-based LTC and its impact

The accessibility to services, i.e. whether individuals in need of and willing to receive formal home-based LTC can actually access adequate services, is crucial for the well-being and dignified life of the people in need. The accessibility to formal home-based care depends on how many and what kinds of services are available, how affordable they are, what is the quality of the services and if the intensity of services is adequate (see Figure 1). If the formal home-based long-term care is not adequate in any of these aspects, people and families need to opt for other solutions, i.e. to look for institutionalised care (e.g. hospitals, mental health care facilities, orphanages) or informal care provided by family, friends, neighbours or other people.

The European Commission distinguishes three main objectives for long-term care services (EPR, 2018) :

- Universal access: access to services should be affordable for all citizens and not related to the income or wealth situation.
- High quality: focusing on more comprehensive quality assurance involving issues such as patients' rights.
- Long-term sustainability: where the likely increase in LTC demand could be mitigated by preventive approaches and technological developments.

Figure 1: Accessibility of formal home-based LTC services



Low accessibility to formal home-based care has a particularly strong impact on women as potential recipients of care as well as informal carers. More women than men assume long-term informal care responsibilities at least several days a week or every day. Overall, women represent 62 % of all people providing informal LTC to older people or people with disabilities in the EU (EIGE, 2019).

Women of pre-retirement age (50-64) are most likely to be engaged in LTC. In 2016 in the EU, 21 % of women and 11 % of men of this age provided informal long-term care every day or several days a week (compared to 13 % of women and 9 % of men aged 25-49). The unequal distribution of informal care between women and men greatly impacts women's opportunities in the labour market, especially in pre-retirement age, leading to gender inequalities in pay and pension and increasing risks of poverty and ill health (EIGE, 2019).

Provision of informal long-term care is a significant aspect of work-life balance, which may lead to withdrawal from the labour market, and have impact on the health and wellbeing of the carers. Informal carers can be under considerable stress as they try to balance work and family duties, especially when most have received no training in caring for the people with disabilities or elderly (Commission, 2013c).This may have consequences to the health and wellbeing of those in need for care. In case of high-level care needs the informal carers need external support (Dorin, Krupa, Metzing, & Büscher, 2016).

Unpaid care work and gaps in the provision, affordability and quality of care services are key factors in determining whether women enter into and stay in employment and the quality of jobs they perform. Care responsibilities are keeping 7.7 million women (aged 20-64) compared to 450 000 men out of the labour market in the EU[6]. The contribution to economic growth of unpaid care work, carried out mostly by women, remains largely invisible.

Not all people in need for care have families living close enough to provide them with regular care. This means that shortage of care will lead to situation where the care and support might fall below the minimum care level. A survey of German care recipients showed that the care-receiving men are most often cared for by their wives while women – very often widows – are living alone and need a wider social network and need more often professional care (Dorin et al., 2016).

Children are also involved in care to family members who are elderly and/or with disabilities, girls more often than boys. Although the comparative data on young carers is very scarce, evidence from national sources shows that in European countries an estimated 2-8 % of children aged 5-17 are carers to family members who are ill or with disabilities (Chikhradze, Knecht, & Metzing, 2017). For instance, in Ireland, the 2016 Census showed that 3.800 children under 15 years engaged in providing care to others, accounting for 1,9 % of all carers. Half of these children providing unpaid care were under 10 years old (ME-WE, 2019). In such cases, children are involved in all areas of care – the same way as adult informal carers and their responsibilities increase with age (Chikhradze et al., 2017). Girls are more often involved in long-term care than boys. A study carried out in Austria showed that the share of girls among young caregivers is higher than the share of women among adult caregivers (Nagl-Cupal, Daniel, Koller, & Mayer, 2014).

Regular and intense responsibilities of caring for their adult family members have a strong impact on the lives of children. They are missing out on participating in society and spend most of their time at home. Young carers are often invisible, partially out of fear of being taken away from their home and fear of stigmatization by their peers and teachers (ME-WE, 2019). Service providers tend to focus on the persons who need care, rather than supporting carers, including children.

[6] Eurostat, LFS 2018 (lfsa_igar).

2 How is long-term care approached in public policy?

In light of demographic changes across EU Member States, addressing the challenges posed by an ageing population has become a necessity for the European Union. The increasing need for LTC also represents a significant challenge for achieving gender equality, given that women continue to be the main providers of informal and formal care and that LTC services remain insufficient across many Member States (EIGE, 2020). In the broader context of EU policies towards building a strong social Europe, gender equality features among the key principles of the European Pillar of Social Rights and work-life balance has become a key EU policy priority, most recently marked by the Directive on work-life balance for parents and carers.

EU policies in the areas of social protection, health and LTC aim at ensuring access to adequate and affordable LTC provided by qualified professionals in a sustainable manner[7] . Forward-looking policy and the development of sustainable models of LTC delivery are crucial instruments to remove barriers keeping informal carers, especially women, away from the labour market. In this respect, the Social Protection Committee, together with the European Commission, introduces new ways to provide more adequate and sustainable LTC services in ageing societies, by investing, for instance, in preventive care, rehabilitation and age-friendly environments (Commission, 2014).

The European Commission has identified achieving active and healthy ageing as a major societal challenge common to all EU countries, but also as an opportunity for Europe to establish itself as a global leader in providing innovative solutions. Active ageing, is considered by the European Commission as "helping people stay in charge of their own lives for as long as possible as they age and, where possible, to contribute to the economy and society"[8]. In 2011, the Commission launched the European Innovation Partnership in Active and Healthy Ageing, which promotes greater autonomy and participation in paid employment of older persons as a way to decrease demand for LTC. By bringing together all relevant actors across different policy areas and through the involvement of all levels of the innovation chain, it is expected to foster innovation and digital transformation in the field of active and healthy aging. For example, this initiative highlights the potential of digitalisation of health and care, although in a gender-neutral way, in helping informal carers to reconcile employment with caring for their dependent relatives. To tap into the potentially transformative effect on the division of informal care, digitalisation and smart home technologies should be more broadly investigated from a gender perspective (Wilson, Hargreaves, & Hauxwell-Baldwin, 2015).

To support EU countries in monitoring active ageing outcomes, the European Commission, jointly with UNECE, has developed the Active Ageing Index, measuring the realisation of older people's potential in terms of employment, participation in social and cultural life and independent living as well as the enabling environment. The Commission also publishes the Ageing Report triennially, which looks at the long-run economic and fiscal implications of Europe's ageing population, including a section on long-term care, determinants of expenditure and long-term projections.

[7] European Network of National Human Rights Institutions (ENNHRI). http://ennhri.org/news-and-blog/overview-long-term-care-in-europe/

[8] European Commission on Active Aging. https://ec.europa.eu/social/main.jsp?langId=en&catId=1062

However, those tools do not integrate a gender analysis of the specific challenges experienced by women and men nor the cost analysis of gender inequalities in informal care in an aging society.

The European Pillar of Social Rights[9] specifically underlines the importance of access to good quality and affordable LTC services across all EU Member States, in particular home-care and community-based services. Deinstitutionalisation and prioritization of formal home-based LTC is high on the political agenda across the EU. For example, the European Disability Strategy 2010-2020 encourages the transition from institutional to formal home-based services, although it does not consider the specific challenges and long-term care needs of women and men with disabilities. The 2017 Progress Report on the European Disability Strategy (Commission, 2017c) has no gender focus, nor is there any indication that a gender mainstreaming approach was applied when collecting evidence on the EU situation (EIGE, 2020).

The need for deinstitutionalisation reforms has also been recognised in the European Semester. The European Commission had convened the European Experts Group on the Transition from institutional to community-based care (EEG), a coalition of stakeholders representing people with care or support needs. They published 'Common European guidelines on the transition from institutional to community-based care' (EEG, 2012) and 'Toolkit on the use of EU funds for the transition from institutional to community-based care' (EEG, 2014). In 2017, two-thirds of EU Member States have either adopted a dedicated strategy on deinstitutionalisation or included measures for deinstitutionalisation in a broader disability strategy (FRA, 2018).

The deinstitutionalisation process, even if not explicitly mentioned, and the push for independent living has its corner stone in the Convention on the Rights of Persons with Disabilities (CRPD) ratified by the European Union and its Member States in a mixed agreement. Article 19 of the CRPD addresses the right of people with disabilities to "live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community" and "ensuring access to in-home, residential and other community-based support services, particularly to personal assistance" (FRA, 2017; UN, 2006)

The CRPD addresses children with disabilities, specifically in Article 7 and 23, stating that their best interest comes first and that "States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting." (UN, 2006). The European Commission has recognised the importance of supporting families and of promoting alternative care opportunities as a part of the 2013 EU Recommendation on "Investing in Children: Breaking the Cycle of Disadvantage" (Commission, 2013a). Furthermore, those issues were included as a key element of its Social Investment Package, reaffirmed in 2017 by a Staff Working Document "Taking Stock of the 2013 Recommendation on Investing in Children: breaking the cycle of disadvantage" (Commission, 2017d) and a progress report. Importantly, this recommendation makes explicit reference to the fact that fighting child poverty and exclusion must be underpinned by gender mainstreaming. In the same year, the Council revised and adopted the "EU Guidelines for the Promotion and Protection of the Child – Leave no Child Behind" (Council, 2017) recognizing that by implementing a systems-approach the most vulnerable children, including children with disabilities,

[9] European Pillar of Social Rights https://ec.europa.eu/commission/sites/beta-political/files/social-summit-european-pillar-social-rights-booklet_en.pdf

will have their rights protected. It highlights the importance of promoting alternative care for children and providing them with appropriate support to participate in community life and to access mainstream services across all Member States in line with the UN Guidelines for the Alternative Care for Children (UN, 2010).

Long–term care cuts across different policy areas, such as social protection and inclusion or health care. The gender mainstreaming across different areas of EU policy, including the implementation of Europe 2020 and the European Semester is fragmented and lacks a systematic approach. Even where gender equality objectives are included, a cross-cutting gender mainstreaming approach is often insufficient. For instance, while the European Pillar of Social Rights includes a gender-specific principle, it lacks a gender dimension across some of its key principles, such us long-term care (EIGE, 2020).

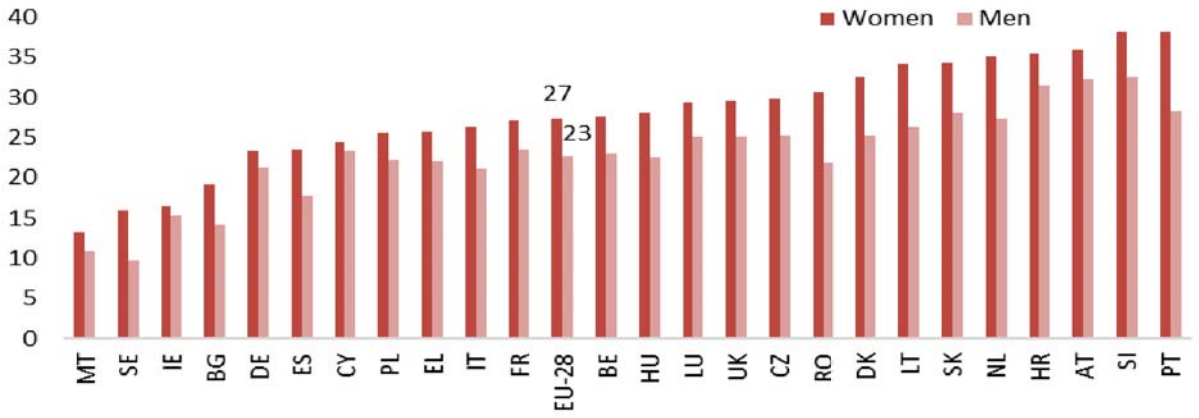
3 Who needs home-based LTC?

Understanding who in society is most in need of long-term care, especially home-based, is essential to ensure not only that adequate services are designed and developed but also to evaluate into what extent needs are met. The underlying assumption in this study is that people who have some kind of disabilities are (potentially) in need for help and for long-term care. Disability is a complex, evolving and multi-dimensional concept which can be defined and measured in various ways[10]. The following sections highlight the segments of the EU population who 'experience limitations in their daily activities due to health problems', as is measured by EU-SILC, the main survey providing information on the home-based long-term care.

3.1 Older persons and adults with disabilities

In the EU, one in four adults reports being limited or very limited in their daily activities as a result of a health problem. While such limitations affect 12% of the population in Malta, the highest burden of disability is observed in Latvia with 40% of adults reporting limitations[11]. As shown in Figure 2**, in every EU country, women are more likely than men to experience limitations in daily activities due to health problems (**27% of women compared to 23% of men). At the national level, the largest gender differences are seen in Portugal (10 p.p.), Romania (9 p.p.), Finland (9 p.p,), Lithuania, Latvia and Netherlands (8 p.p.).

Figure 2: People with long-standing limitations in their usual activities due to health problems, by gender (%, 16+), 2018[12]



Source: Eurostat, Health variables of EU-SILC, 2018 (hlth_silc_06). Countries ordered in the ascending order of the percentage of women reporting limitations.

[10] See for instance https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability_statistics_introduced
[11] Eurostat, Health variables of EU-SILC, 2018 (hlth_silc_06)
[12] Note: The question asked: For at least the past six months, to what extent have you been limited because of a health problem in activities people usually do? An activity is defined as: 'the performance of a task or action by an individual' and thus activity limitations are defined as 'the difficulties the individual experience in performing an activity'. Answers 'Yes, strongly limited', 'Yes, limited', and 'Not, not limited' were used. Answers 'Yes, strongly limited' and 'Yes, limited' were grouped.

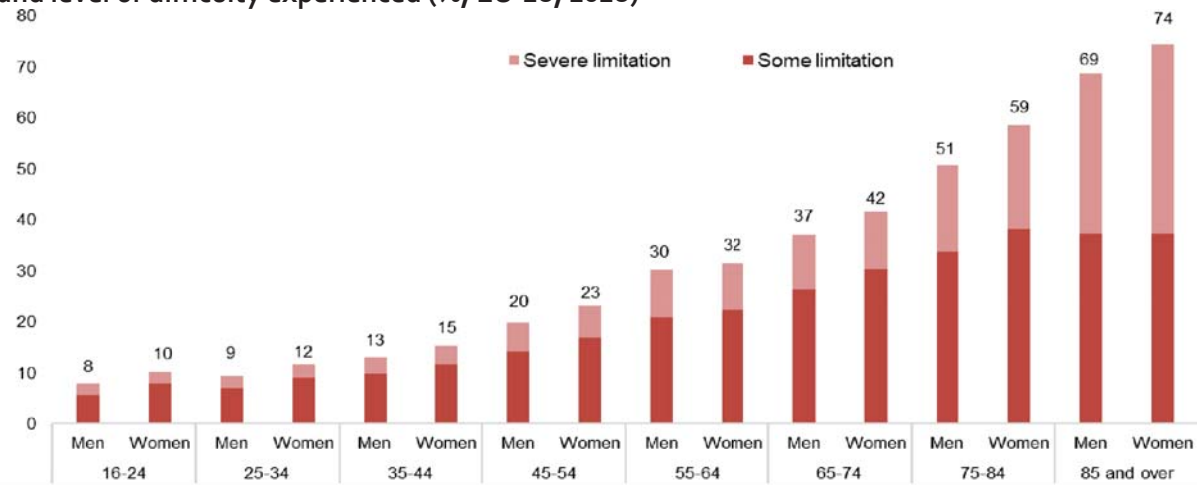
In the majority of EU countries the share of people with long-standing limitations has increased since 2008[13]. Only seven countries (SE, IE, ES, DE, IT, HU and SK) have seen the share of people experiencing limitations decrease.

Such trends reflect the fact that gains made in life expectancy in the past decades have been accompanied by an increase in the occurrence of chronic diseases that can limit the ability to handle some daily activities and lead to an increasing need for LTC (Commission, 2013c)

In the EU, **while women enjoy a higher life expectancy**, 83.5 years compared 78.3 years for men (a difference of 5.2 years in 2017), this advantage is partially offset by the fact that **women spend more years in ill health**. In 2016, for example, women in the EU spent approximately 20 years of their lives in poor health when compared to 16 years for men (EIGE, 2019).

An analysis of the burden of disability by gender and age shows that if one in four adults is affected by limitations at the EU level[14], this situation affects only 9% of people under 25 compared to 40 % of people aged 65 to 74 (Table 1 in Annex). Within a context of the prevalence of limitations increasing with age and affecting women and men differently, any analysis of the needs for LTC must consider not only age and gender but also the severity of the limitations (Figure 3).

Figure 3: Women and men limited in their usual activities due to health problems, by age group and level of difficulty experienced (%, EU-28, 2018)



Source: Eurostat, EU-SILC, 2018 (hlth_silc_06). Data labels refer to the total percentage of women and men of each group reporting some or severe health limitations.

Women are likely to be over-represented among people in need of LTC due to two main reasons. First, due to their higher life expectancy, women comprise a larger share of older population. Second, research shows that women are more likely to report symptoms of ill health than men. In addition, they are affected by disabilities at a younger age than men on average and by chronic conditions to a greater degree than men (WHO, 2011). This is due to a whole host of reasons including unmet need for medical examination, poor working conditions and low socio economic status, or gender-based violence (Garcia-Moreno & Watts, 2011). The reported gender-based differences in disability can be determined not only by objective differences in health condition, but

[13] Bulgaria, Malta,France,Belgium,Poland,Portugal,Lithuania,Denmark,Greece,Netherlands,Finland,Cyprus, Austria,Czechia,Luxembourg,Latvia,Romania,United Kingdom, Estonia, Slovenia. Eurostat, 2018, [hlth_silc_06]
[14]Eurostat, Health variables of EU-SILC, 2018 (hlth_silc_06)

also by gender norms. Normative masculinity is closely associated with physical strength, rational thinking, and independence while admitting and reporting illnesses, seeking treatment and discussing symptoms is often found to be more socially acceptable for women (Caroli & Weber-Baghdiguian, 2016; Emslie, Hunt, & Macintyre, 1999; Swain, Finkelstein, French, & Oliver, 1994).

Those factors account for the fact that gender differences in limitations in everyday activities are higher between the older age groups as highlighted in Figure 3. For instance, among individuals aged between 55 and 64 years, the share of women limited in everyday activities is only 2 p.p. higher than the share of men (32% of women limited in activities when compared to 30% of men). Among individuals aged between 75 and 84 years, the difference between women and men limited in everyday activities rises to 8 p.p. (59% of women limited in everyday activities compared to 51% of men.

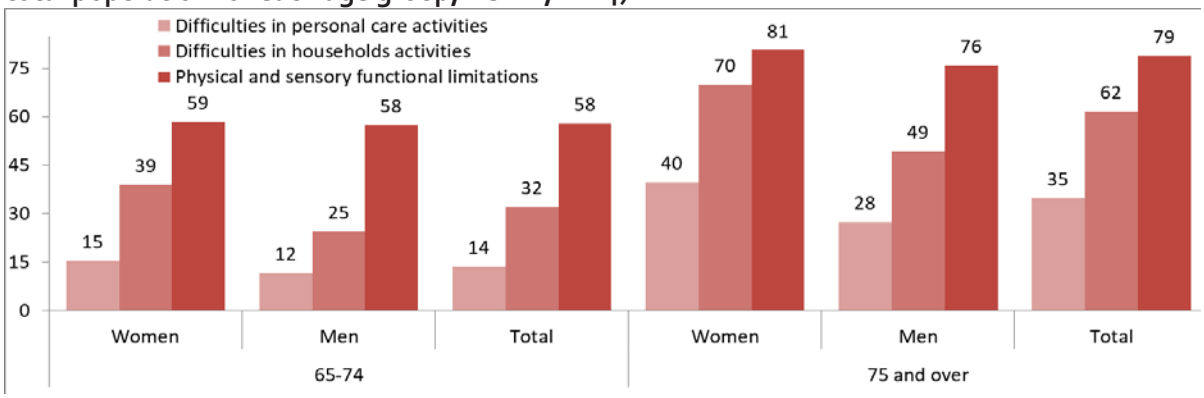
Figure 4 presents the share of women and men aged 65 and over experiencing some limitations or severe limitations in their everyday activities due to a health problem. **In nearly all Member States, except of Ireland, more women than men aged 65 and over experience limitations in their daily activities due to health problems** ranging from 25% in Sweden to 75% in Latvia. In 19 MS, the majority of women of this age group suffer these limitations. Men's experience of limitations ranges from 17% in Sweden to 71% in Latvia.

Figure 4: Women and men aged 65 and over limited in their usual activities, (%, EU countries, 2018)

Source: Eurostat, Health variables of EU-SILC, 2018

Women and men differ not only in the overall probability of experiencing limitations in everyday activities but also in the type of such limitations. The European health interview survey distinguishes three general types of limitations: physical and sensory functional limitations (seeing, hearing, and walking), difficulties in personal care activities (e.g. feeding oneself, bathing), and difficulties with household activities (e.g. preparing meals, shopping, housework) (Figure 5). Many more women than men indicated having difficulties in household activities, in particular in the age group 75 and over.

Figure 5: Women and men with moderate or severe limitations in activities, by age group (% of total population for each age group, EU-28, 2014)[15]



Source: Eurostat, (hlth_ehis_ha1e; hlth_ehis_pc1e; hlth_ehis_pl1e).

The above section has highlighted that the prevalence of long-standing health limitations among adults is high in most EU countries and on the rise compared to previous decades. Both **prevalence and severity of health limitations increase with age and tend to affect women disproportionately.** The steadily growing care needs represent an important long-term challenge for the national health and social protection systems.

While the data presented above refer to people who are living at home, large numbers of people fall outside of the scope of such statistics because they reside in different types of institutions, such as elderly homes or medical facilities. A study published in 2007, estimated that 1.2 million people with disabilities lived in institutions across the EU. One of the key reasons for the high numbers of people being placed in institutions is the paucity of community-based services and support (Mansell, Knapp, Beadle-Brown, & Beecham, 2007). Therefore, it is fair to assume that more people would use home-based services if they were available. However, there is no evidence on how many people receiving care in institutions would be able to live independently if adequate home-based formal long-term care were available.

3.2 Children with disabilities

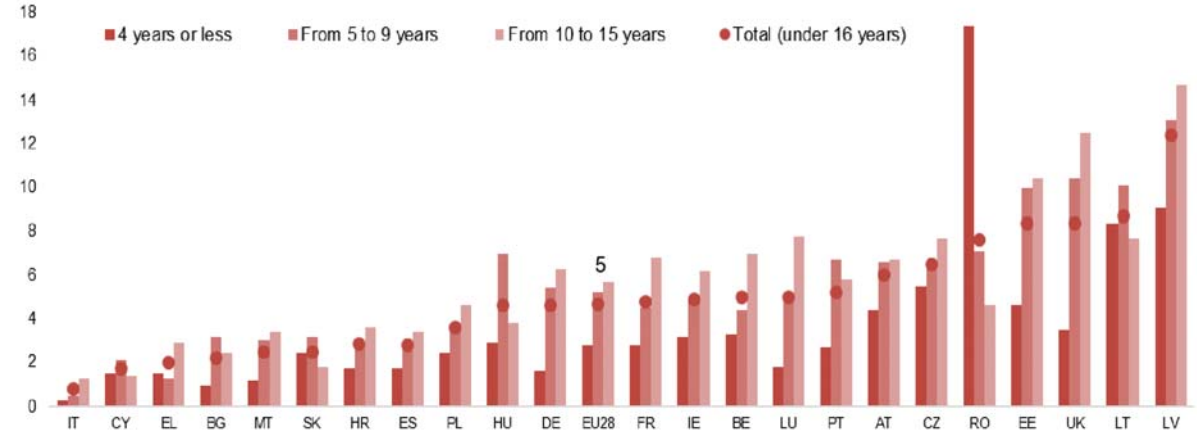
Another group of the population who is in need of long-term care are families with children with disabilities. The number of children with long-term conditions across the EU has been rapidly increasing in the last decade (Nightingale, McHugh, Kirk, & Swallow, 2019). This trend can be

[15] Notes: a) Limitations in personal care activities show the severity of difficulties in at least one personal care activity covering feeding, getting in and out of a bed or a chair, dressing and undressing, using a toilet, bathing or showering based on the self-reports of the population aged 65 and over. b) Limitations in household activities show the severity of difficulties in at least one household activity covering preparing meals, using the telephone, shopping, managing medication, carrying out light housework, carrying out occasional heavy housework, taking care of finances and everyday administrative tasks based on the self-reports of the population aged 65 and over. It should be noted that there may be other than health reasons behind difficulties doing household activities. c) Physical and sensory functional limitations refer to the extent of the severity of at least one limitation self-reported by the population aged 15 in what concerns vision, hearing and walking. Respondents evaluated the extent of their difficulties on the following scale: no difficulty, some difficulty (in this article referred to as moderate difficulties), a lot of difficulty and cannot do at all (both referred to as severe difficulties).

explained by advances in medical knowledge and technologies which enable to identify children's chronic illnesses with more accuracy, and which in turn have improved survival rates of children with disabilities (Isaacs & Sewell, 2003). Besides, children's health status can be more accurately assessed by monitoring them for a longer time period and it can lead to a higher number of reported disabilities in their age group (Nightingale et al., 2019).

In 2017, about 5% of EU families with children had a child or children with disabilities (i.e. some or severe long-standing limitations in usual activities due to health problems)[16]. The average masks a wide diversity among EU countries ranging from less than 1% of households in Italy to 12% of households in Latvia, 9 % in Lithuania and 8% in Estonia and the UK indicating having children with moderate or severe limitations[17].

Figure 6: Households with children who have moderate or severe limitations in activities due to health problems by age and country (% out of all households with dependent children), 2017



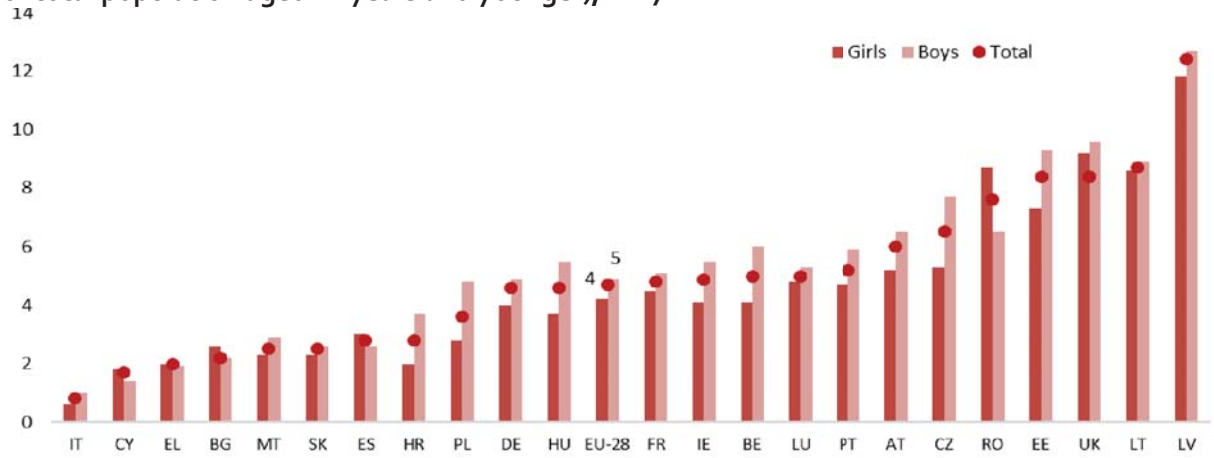
Source: Eurostat (ilc_hch13).
Note: Data from Denmark, Netherlands, Slovenia, Finland and Sweden are missing.

As shown in Figure 6, many children are born with disabilities with 3 % of families with children younger than 4 years indicate experiencing moderate or severe limitations[18]. The number of households with children with disabilities increases, as children get older. In the EU, disabilities in children affect 5% of families with children aged 5 to 9 and 6% of families with children aged 10-15.

By the age of 16 -24 already 9.4 % of adolescent girls and 7.4% of adolescent boys had a disability in the EU in 2017[19].

[16] Eurostat, ilc_hch13, relates to children aged 16 years and younger.
[17] Eurostat, ilc_hch13, relates to children aged 16 years and younger.
[18] Eurostat, ilc_hch13
[19] Eurostat, Health variables of EU-SILC, 2017, hlth_silc_12

Figure 7. Boys and girls with limitations in activities due to health problems by countries (% out of total population aged 16 years and younger), 2017



Source: EIGE calculations based on EU-SILC, 2017.
Note: Variable: RC020T: Limitation in activities because of health problems (child): 1. Severely limited; 2. Limited but not severely; 3.Not limited at all. Countries are sorted by the total level of disabilities among girls and boys.

As seen in Figure 7, there are slight gender differences in prevalence of disabilities among children, with boys being more likely to be affected in 19 Member States[20]. About 4% of girls under 16 and 5% of boys experience health limitations in the EU. The largest gender differences are seen in Czechia, Estonia, Poland, Belgium and Hungary with 2p.p. to the detriment of boys.

Children limited in everyday activities are more likely to live in a single-parent household (Di Giulio, Philipov, & Jaschinski, 2014; Loft, 2011). In 2017 across the EU, 4% of all children who had a disability lived with two parents and 7% - with one parent[21]. This is mostly due to higher separation rates among parents of children with disabilities (Di Giulio et al., 2014; Hogan, 2012) **meaning that daily care responsibilities fall entirely on the shoulders of one parent, mostly mothers** (Di Giulio et al., 2014; Levine, 2009).

Lone parents raising children with disabilities have especially high needs of formal LTC services. If they are unavailable, parents might need to withdraw from the labour market to become full-time carer of their children (Di Giulio et al., 2014) with negative, often long-term financial implications. Women are at a greater disadvantage considering the fact that they make up for almost 85 % of all one-parent households in the EU.[22] In many countries, children with disabilities continue to be institutionalised (Crowther, 2019).

In addition, the level of poverty is known to be higher among lone parents. Almost half (35 %) of lone mothers and a third (28 %) of lone fathers are at risk of poverty or social exclusion[23]. **The lack of financial resources is one of the main reasons behind unmet needs for LTC**.[24]

[20] SK,LT, IT, UK, LU, FR,MT, LV,DE,PT,AT, IE, HR,HU,BE,PL,EE,CZ.

[21] Eurostat, ilc_hch13

[22] EIGE (2016) Poverty, gender and intersecting inequalities in the EU: Report https://eige.europa.eu/publications/poverty-gender-and-intersecting-inequalities-in-the-eu

[23] EIGE's calculation, EU-SILC.

[24] Ibid.

4 Accessibility to long-term care services and gender impact

4.1 Use and users of formal home-based long-term care services

Although a quarter of the adult population in the EU has reported having long-standing limitations in their day to day activities due to health problems (Figure 4), the use of professional home-care is not very high. Across the EU, only 2% of people say someone in their household has used such services (Figure 8). The overall use of services varies from 5.5% in Netherlands to less than 1% in Romania, Bulgaria, Latvia, Germany, Estonia and Poland. The fact that these percentages are well below the share of people with disabilities in the society, is the first indication of a shortage of homecare services.

Figure 8. Proportion of persons using homecare services (16+)

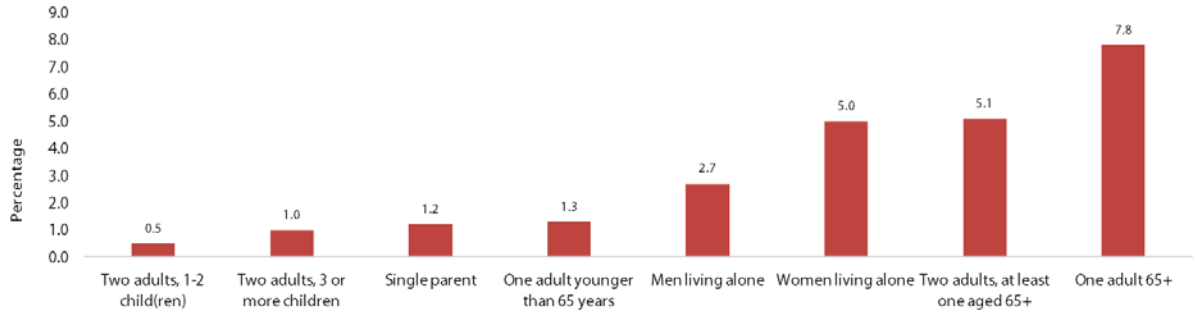
Source: Eurostat, EU-SILC (ilc_ats13).

The statistics on the use of homecare services lacks a gender perspective. Care needs are assessed at household level and therefore it is not known how many women and men use such services.

Different types of households use home-based long-term care differently. In 2016, in the EU-28, 1.2% of all lone parent families in the EU used home-based long-term care compared to 1% of two-parent families with three or more children and 0.5% of families with one or two children (Figure 9). This also reflects the fact that children with disabilities are more likely to live with one parent when compared to children without disabilities.

The highest use of professional homecare services is observed among people who are above 65 and live alone. Although 52% of women and 45% of men of this age have limitations in their usual activities (Figure 4), only 7.8% of adults aged above 65 and living alone indicated using homecare services (Figure 9). People in this age group are most in need of formal care, as they are most likely to have a disability and with no one in the household who could provide them with help and informal care. Due to a longer average life expectancy, this situation is more common for women than men - at a later stage of their lives.

Figure 9. Proportion of persons using homecare services by type of household EU-28, 2016 (16+)



Source: Eurostat, EU-SILC (ilc_ats13).

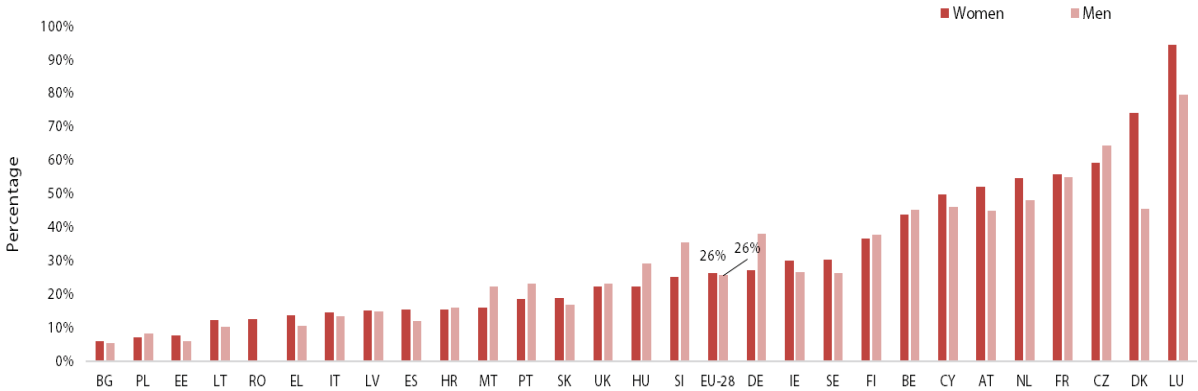
Note: household types include both those who have someone with disabilities as well as those who do not.

The evidence of gender difference of care recipients is available only for households of people living alone. In the EU, 2.7% of men and 5% of women (age 16+) who live alone are users of formal home-based long-term care.

A quarter of both women and men (26%) who live with someone with disabilities indicate that their household receives formal home-based LTC services. The remaining 74% of households therefore rely on informal care, either provided by the family and friends or by individuals such as migrant workers who are paid unofficially and have no formal status of a care giver.

The country differences vary between 94% of women and 80% of men in Luxembourg to less than 10% of women and men in Bulgaria, Poland and Estonia who report receiving formal home-based LTC services. The gender of the person with disabilities is not known and thus this indicator only describes the need for informal care in these households.

Figure 10. Percentage of women and men living in the households with individuals limited in everyday activities who report that their household receives formal home-based LTC services (16+), 2016

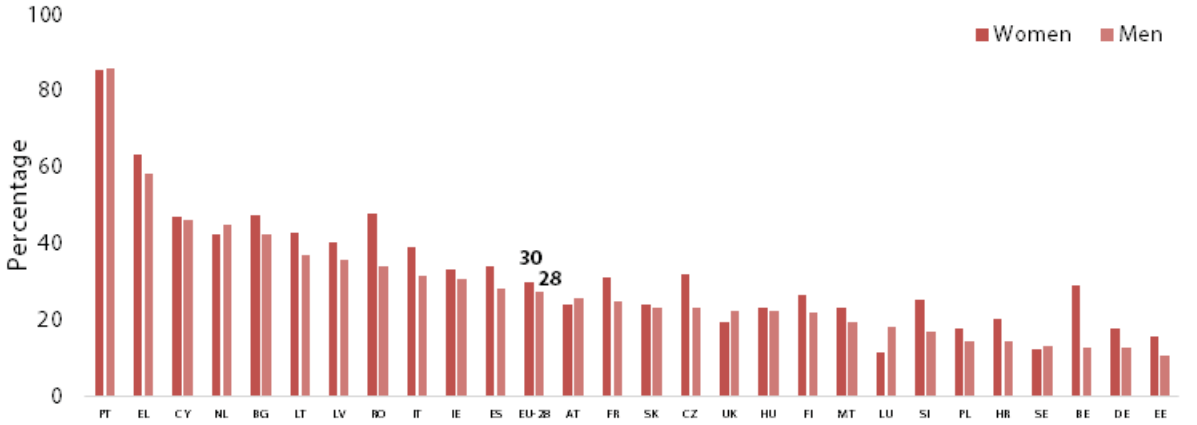


Source: Author's calculations EU-SILC, ad hoc module 2016

Not everyone who has some limitations in their everyday activities need or want formal care. They are either independently living in an environment adjusted to their needs or they receive sufficient informal care from their family. Some evidence suggests that women and men prefer different kinds of LTC. For instance, men more than women favour home-based LTC provided by the spouse while women prefer professional support or institutional LTC. Overall, little is known about what older citizens consider appropriate LTC (Carvalho et al., 2019).

In the EU, about 29% of households reported unmet need for professional home-care services in 2016 (EIGE, 2019). The reporting of unmet needs was slightly higher in the households where a woman responded to the survey (30 %) compared to a man (28 %). **Women are more likely than men to report an unmet need for professional home-care services** in all but six Member States (LU, NL, AT, PT, SE, UK). Nearly a quarter of women and men live in households which rely on informal care which may either be insufficient or not suitable/preferred arrangement for either the carer or the one cared for.

Figure 11: Percentage of women and men reporting unmet household need for professional home-based care services (households with at least one individuals having limitations with everyday activities) (EU-28, 16+), 2016



Source: EIGE (2019) based on EU-SILC, 2016 (HC240).
Note: The question asked: Whether there are household members who require professional home care, but are not provided any or are provided less professional home care then they require? Answers 'yes' were used.

The share of people with unmet needs is linked to the overall level of gender equality in the society. The highest levels of gender inequalities in the use of time, as measured by the Gender Equality Index, are noted in the Member States (e.g. EL, PT) with higher unmet needs for professional home-care services. Member States with the best gender-equality achievements in the use of time (e.g. SE) have fewer households with unmet needs for professional home care (EIGE, 2019).

4.2 Availability of formal home-based LTC

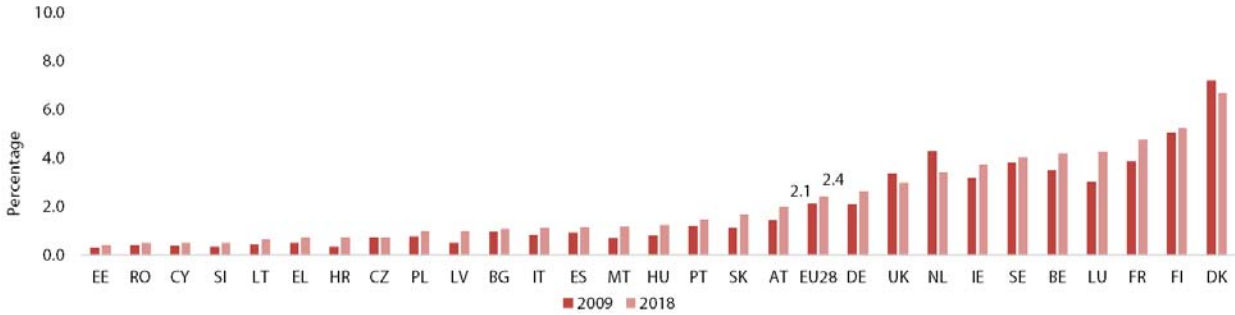
The presence of formal home-based LTC services is an obvious necessary condition to enable accessibility to the potential recipients. For full availability, demand should be met by an adequate supply by either public, private, or other kind of entities in a timely manner (Riedel & Kraus, 2011). The supply of formal LTC services (both home-based and residential) does not meet the needs in most EU countries and the availability of formal home-based services is lower when compared to residential care (Spasova et al., 2018).

Home-based long-term care services often fall within both social and health care services, offered by a mix of state, local and private providers. This adversely affects the quality of available comparable data on the provision of the services or the number of service providers.

In 2018, social workers comprised 2.4% of the work force in the EU (over 5.5 million people) providing services without accommodation (i.e. at home or in the community) compared to 2.1% in 2009 (Figure 12). Comparative 2018 figures vary across Member States, from 0.4% in Estonia and 0.5% in Cyprus and Romania up to 6.7% in Denmark, 5.2% in Finland and 4.7% in France in 2018. In

all Member States, except for the Netherlands, Denmark and the UK, the number of social workers has increased over past ten years.

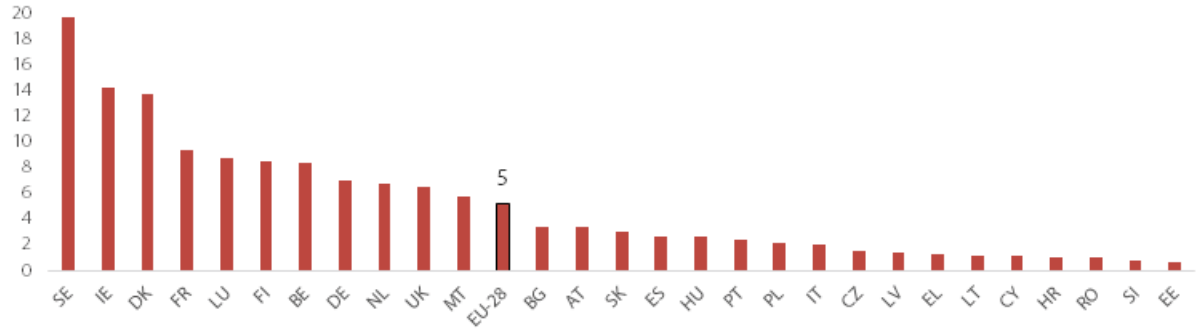
Figure 12 Social workers providing services without accommodation out of total workforce 2009 and 2018



Source: Eurostat, lfsa_egan22d

On average in the EU there are five social workers per 100 persons with disabilities, who provide some kind of social work services outside of residential care (Figure 13). There are about 20 adult persons with disabilities per social worker. The highest potential recipient/social worker ratio is found in Sweden, Ireland and Denmark while the lowest ratio emerges in Estonia, Slovenia and Romania. However, this number needs to be interpreted cautiously because these social workers are not only addressing the home-based or community care needs of people with disabilities, they also provide support to other groups of people (e.g. migrants, youth, homeless people).

Figure 13. Number of employees providing social work activities without accommodation care per 100 persons with disabilities, age 16+ (EU-28), 2018



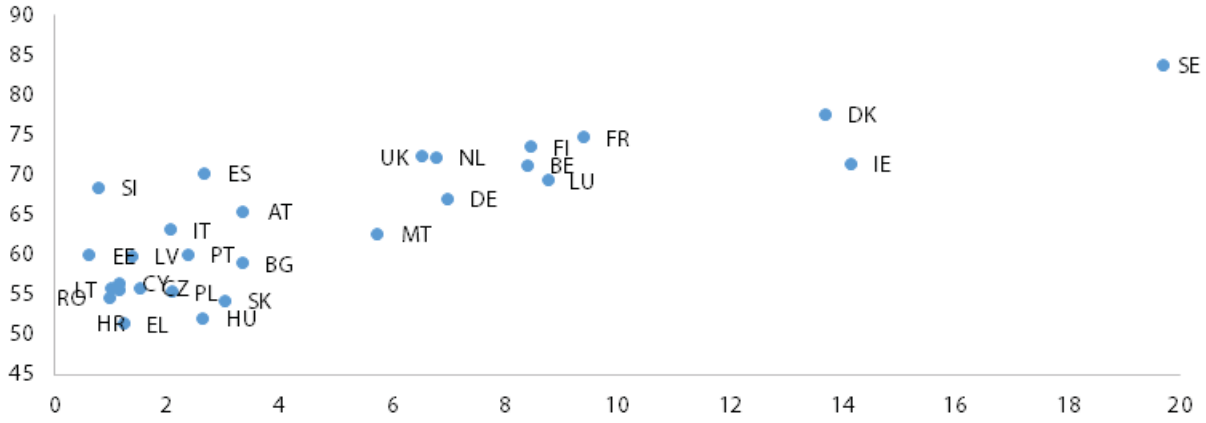
Authors' calculations based on Eurostat data, 2018 (hlth_silc_06; demo_pjan; lfsa_egan22d
Note: Calculated as a ratio between 1) employees providing social work activities without accommodation (i.e. not in institutions, but at home or in community), identified by NACE rev.2 code 88) by the number of population with disabilities, defined as limited in everyday activities (hlth_silc_06, demo_pjan).

The availability of social services such as social work has clear gender equality implications. The better the availability of formal services, the less burden falls on families to provide care and support to their family members with disabilities. Since care in the family is still stereotypically taken on by women – starting already with girls from a young age – the need for informal care limits the opportunities for women in other areas of life.

At the country level, there is a clear link between the overall level of gender equality, measured by the Gender Equality Index and the number of social workers (providing care without accommodation) per people with disabilities (Figure 15).Countries such as Sweden, Denmark and Ireland have the highest availability of social work services as well as high Gender Equality Index scores. In East European countries scores are relatively lower on both aspects.

Figure 14Countries such as Sweden, Denmark and Ireland have the highest availability of social work services as well as high Gender Equality Index scores. In East European countries scores are relatively lower on both aspects.

Figure 14. Correlation between number of social workers per 100 persons with disabilities and Gender Equality Index scores



Source: EIGE's calculations.

Even with sufficient services in place, certain groups of people still face many barriers that potentially limit the actual accessibility for the home-based LTC. First, geographically services may not be equally available, in particular to the disadvantage of rural and low-populated areas (Corsi, Crepaldi, & Samek, 2009). When considering older women and men (65 years and older) who are living alone, at the EU level, there are no notable differences in the use of services in cities (2%), towns and suburbs (1.9%) and rural areas (2.1%). However, important differences in service availability may be present inside countries. There are some countries where rural areas have significantly more care users (e.g. Belgium, Luxembourg, Slovakia and Finland) when compared to cities, but also countries where cities have lowest availability of services for single older women and men (e.g. Portugal, Finland) (Eurostat, ilc_ats13).

All Member States can and do set criteria and eligibility rules for their social services. Eligibility to publicly funded LTC services can be subject to the care needs of the person, his or her income and assets and the availability of family carers. Publicly funded services may be available only through insurance schemes and therefore to those who are or have been active in the labour market, thus excluding those in precarious jobs from access to the public service provision. Women are more likely to be inactive or in precarious jobs and therefore they are more likely to be ineligible for publicly funded services. Eligibility criteria may also exclude people without residency or citizenship, the long-term unemployed and the homeless. In recent years, several EU Member States have tightened their eligibility criteria by restricting services to those individuals with severe care needs (e.g. EL, HU, IE, SE, UK) (Spasova et al., 2018, p. 14).

Public formal long-term care in several EU Member States is reserved for citizens who do not have family support (e.g. BG, EL, LV, PL, UK) (Spasova et al., 2018). Although it is crucial to improve the quality of life of these people (e.g. elderly women and men living alone), this policy approach disadvantages informal carers – most often female family members – who often have no other option than to carry the care burden. Families often have legal responsibility to provide care to their adult members. In some countries, e.g. in Sweden, families do not have a legal responsibility to provide care to their adult members (Meagher & Szebehely, 2013). Nevertheless, a Swedish

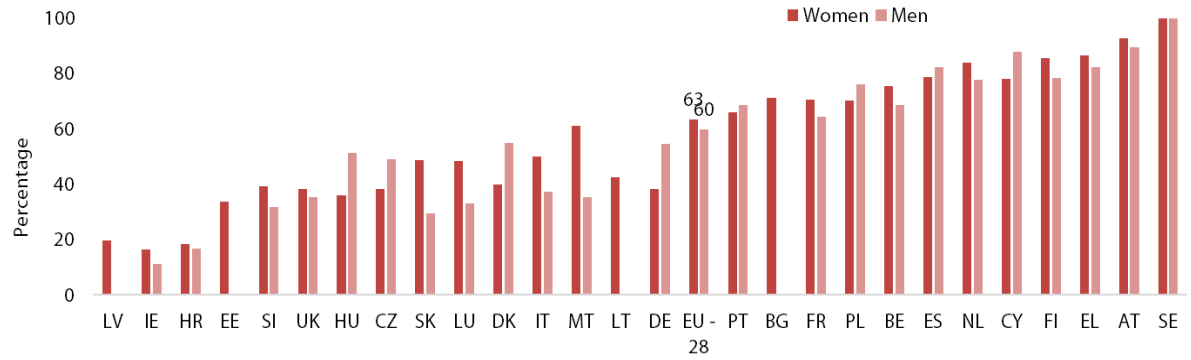
study showed, the likelihood of receiving formal home help was lower for those living with their spouse and/or with children (Larsson, Kåreholt, & Thorslund, 2014).

To adequately assess care needs of a person, a standardised procedure can prevent favouritism in the allocation of care, which may be crucial in a context of supply shortage. Formal assessment tools, also need to be neutral and inclusive, for instance in terms of different kinds of disabilities and special needs (e.g. mental health issues). Evidence exists on the presence of gender bias in such assessment procedures. For instance, in certain circumstances women have to "exhibit greater levels of disability" than men before formal LTC services are granted (Gruneir, Forrester, Camacho, Gill, & Bronskill, 2013). Another study revealed that care managers were more likely to grant less care if the requests were sent by women in comparison to men (Jakobsson, Kotsadam, Syse, & Øien, 2016). Gender biases in the provision of formal LTC clearly require more research.

4.3 Affordability of formal home-based LTC

The availability of such services does not ensure that these are universally affordable. Affordability depends on the cost of the services, available public funding or subsidies and individual or household income. **In 2016, in most EU countries, over half of the care recipients needed to pay for the formal home-based LTC services**. Nursing care is more likely to be free of charge than home help or personal care services in the EU (Eurofound, 2019).

Figure 15. Percentage of women and men who report that their household needed to pay for received formal home-based LTC services (2016, EU-28)



Source: Authors calculations based on EU-SILC data 2016 module. Measured by variable HC220:
Note: Data for Romania for women and men; for Estonia, Lithuania and Bulgaria for men is missing due to small sample sizes.

In some countries, such as Latvia, Ireland and Croatia, less than 20% of the households pay for home-based LTC services. In other countries, such as Sweden, all care recipients make a financial contribution for the service. In Austria, Greece, Finland, Cyprus and Netherlands receiving service free of charge is rather exceptional, as over 80% of households need to pay for such services.

Although payment applies in nearly all countries, it is not clear how expensive and affordable such services are for the recipients. Quite often, the services are highly subsidised and the fees for the households are not very high or are means-tested, i.e. free of charge for those with the lowest levels of income. Long-term care services (including both home-based and institutionalised) in the EU are more likely to be free of charge for those in the lowest income quartile (58%) (Eurofound, 2019). In some Member States, this benefit is reserved for people with severe disabilities (e.g. CY, EL, HR, HU, MK, RO, SK,). The eligibility for (e.g. CY, HR, MK, PT) and the amount of the benefit (e.g. ES, FR, SK) can also depend on the income of the beneficiary (Spasova et al., 2018).

Figure 16. Women and men living in households where inability to afford services was the main reason of the unmet household needs for professional home care services

Source: Authors calculations based on EU-SILC data 2016 module. Measured by variable HC250: Main reason for not receiving (more) professional home care services. Answers: "1. Cannot afford it" were counted. Alternative answers' options included "2. Refused by person needing such services"; "3. No such care services available"; "4. Quality of the services available not satisfactory"; "5. Other reasons".
Note: data for Luxembourg and Denmark is not available due to small sample size.

The link between the availability of free of charge service and the overall availability of the LTC services is not straightforward. In 2016, **over half (52%) of households indicated unmet professional home-based service needs due to inability to afford such services** (see Figure 14 below). The lowest share of people who were not able to afford the services was in Sweden where no free service is available (see Figure 15). Concurrently in Austria, Greece and Cyprus where also a majority of recipients pays for LTC service, a large share of households with unmet needs for professional home care service reported being unable to afford it.

Available statistics on the affordability of the service does not provide a good overview of gender differences. While the data reveals how many women and men are living in the households which cannot afford such services due to financial reasons, it does not show the gender differences of those left without professional home care services. It is also unknown how much of the formal home-based LTC services are financed by the recipients themselves and how much by their families. One could assume that due to the gender pay gap, gender pension gap and a limited economic independence, women are more likely to encounter financial obstacles.

4.4 Quality of formal home-based LTC

The quality of care is multidimensional. It may include factors affecting the context in which the care is delivered (e.g. training of professionals), the process of care provision (e.g. individual approach, timely and adequate service delivery), the outcomes (e.g. changes in care recipients' physical or mental health status, independence, behaviour, or knowledge, as well as their overall quality of life) (Donabedian, 1988). In 2010, the Social Protection Committee (SPC) released a voluntary European Quality Framework for social services and defined services to be of high quality if they meet the following conditions: wide range of services available, easily accessible, affordable to the individual, provided continuously for the duration of the need and primarily focused on the benefits of the user (Social Protection Committee, 2010). The World Health Organisation (WHO) connects quality of care services directly with the achievement of desired care outcomes. High quality care must be safe, effective, timely, efficient, equitable and people-centred (WHO, 2016). Given that an increasing share of population is in need of formal LTC services, all EU countries are facing challenges in finding sustainable ways of ensuring the affordability and coverage of formal home-based LTC services without compromising the quality of care.

The quality of formal home-based care services remains one of the key challenges in LTC (Spasova et al., 2018). **Home-based care sector is mostly unregulated and unmonitored in a majority of the Member States in contrast with residential care services** where some of measures are applied across the EU (on-site inspections, requirements and standards, licencing etc.) (Spasova et al., 2018; Szebehely & Meagher, 2017). **Formal home-care service quality might also be negatively affected by poor working conditions of professional care givers**, as due to high workload, tired care givers are not always able to provide services which meet the highest standards (Leichsenring, Billings, Nies, & eds., 2013) (see Chapter 5 for more information on professional carers working conditions).

At the policy level, **insufficient coordination between the social and health care sectors** is another challenge that might contribute to low quality of formal home-based services. In most EU countries, responsibilities are shared between the health and social care sectors in terms of regulation, funding and service provision with powers attributed at different institutional levels, namely national, regional, or local, These two policy areas often lack sufficient integration and coordination, which might have a negative impact on overall accessibility and quality of services (Spasova et al., 2018).

Data about the quality of formal home-based care is scarce. From all reviewed EU level surveys[25], only Eurofound's EQLS has a question specifically designed to measure the quality of home-based care services, but the sample of respondents is too small to carry out reliable and comparative analysis across all EU Member States. Alternatively, EQLS includes a broader question about direct and indirect users[26] of residential and/or home-based care to evaluate the quality of LTC services in several dimensions (see Table 1). On average, across all four LTC quality dimensions, the highest user satisfaction is found in Malta, Romania and Ireland, whereas Cyprus has the lowest (Eurofound, 2019). It is likely that the quality rating of the overall long-term care system in the country (both residential and home care) also well reflects the quality trends of home-based care services.

Table 1: User satisfaction with aspects of care provision in long-term care services, by Member State, EU28

	Quality of the facilities and equipment	Expertise and professionalism of staff	Personal attention given	Being informed or consulted about care	Average user satisfaction
MT	8.4	8.4	8.6	8.7	8.5
RO	8.7	8.5	8.2	8.7	8.5
IE	8.7	8.5	8.2	8.2	8.4
PL	8.3	8.2	8.2	8.2	8.2
SI	8.2	8.3	8.1	8.1	8.2
ES	7.7	8.2	8.3	8.2	8.1
FI	8.2	8.1	7.9	8.0	8.1
EE	7.9	7.8	7.9	8.4	8.0
FR	7.6	7.8	7.9	7.5	7.7
DK	8.7	7.7	7.5	6.8	7.7
BE	7.7	7.7	7.7	7.6	7.7
DE	7.9	7.7	7.6	7.5	7.7

[25] EU-SILC, EU-LFS, EHIS, EWCS, EQLS, EHIS, SHARE, OECD health statistics.
[26] Including both persons who personally received LTC services and persons who stated that someone close to them had received such services in the last 12 months.

HU	7.5	7.7	7.4	8.0	7.7
SE	8.0	7.5	7.4	7.5	7.6
LU	8.2	7.5	7.3	7.3	7.6
AT	7.5	7.7	7.4	7.6	7.6
SK	7.8	7.4	7.3	7.7	7.5
NL	7.5	7.4	7.4	7.3	7.4
LV	7.5	7.5	7.2	7.3	7.4
HR	6.9	7.4	7.5	7.3	7.3
LT	7.8	7.1	7.1	7.2	7.3
PT	6.6	7.4	7.3	6.8	7.0
UK	6.7	6.9	6.9	7.0	6.9
CZ	7.2	6.5	6.2	6.7	6.6
EL	6.1	6.6	6.7	6.7	6.5
BG	6.4	6.0	7.1	6.4	6.5
IT	6.1	6.5	6.4	6.2	6.3
CY	5.3	5.6	5.7	5.6	5.5
EU28	7.4	7.5	7.4	7.3	7.4

Notes: Users comprise both respondents themselves and someone close to them. An average of four quality dimensions was calculated by Eurofound at an individual level (EQLS 2016 (Q73)).
Source: (Eurofound, 2019).

Quality of formal home-based services is somewhat less likely to be affected by gender of care provider or recipient and has a lower impact on gender equality when compared to inequalities in the affordability of such services. However, **due to isolated home environment, especially when care recipients live alone (more likely women than men, due to longer life expectancy), they are more likely to experience abuse or neglect of care**, which might involve care givers' aggressiveness, rough handling, threats, physical violence, sexual harassment or even abuse (Hawes, 2003; Post et al., 2010; WHO, 2011). **Home-based care recipients might also be subjected to economic violence**, especially when care work of family members is compensated by the state or local community.

4.5 LTC for children with disabilities

Children with disabilities represent a unique group of LTC recipients. Their care needs are specific and usually arise from congenital diseases, rather than from acquired illnesses. In most cases, children's health limitations are described as long-standing and requiring intensive LTC services, including continuous monitoring of their health status. This makes them reliant on LTC services for their whole life, while parents play an indispensable role in both the formal and informal care processes. Moreover, children with disabilities usually require specific types of care services, such as childminder, psychologist, educator or highly qualified healthcare worker. Complex care needs of children with disabilities pose great challenges to accessibility, affordability and quality of services for national LTC systems in the EU.

Informal care provided by parents remains the main type of care received by children with disabilities (Elias, Murphy, & the Council on Children with Disabilities, 2012; Knox & Bigby, 2007; Stein, 2001). This is mainly due to dominant societal expectation that parents of children with disabilities (and especially mothers) should be primarily responsible for childcare (Stein, 2001), especially when LTC services for children with disabilities are insufficient. Professional care services (including home-based care) are usually provided only in addition to intensive informal care already provided by family members (Yantzi, Rosenberg, & McKeever, 2007).

None of EU Member States provide fully funded LTC services, hence additional out-of-pocket contributions are often needed (Eurofound, 2019). Families with children with disabilities (and especially lone parents) face a higher risk of poverty or have financial difficulties to afford services more often compared to other families (Di Giulio et al., 2014). Access to such services is also challenging in rural areas, which often have limited nursing and social care resources (Elias et al., 2012).

In cases when a child has severe disability and limited access to home-based LTC services, parents might face a stark decision on whether to place a child into permanent institutional care or fully dedicate themselves to informal care with potentially negative consequences to economic well-being and overall quality of life. According to the Academic Network of European Disability Experts, in many European countries children with disabilities are significantly more often placed in institutional care than able-bodied children (ANED, 2019). Member States have progressed in reducing the number of children in institutional care settings; however, children with disabilities are often being left behind this process (ANED, 2019).

5 Providers of the formal home-based LTC

5.1 Who are the main providers of the formal home-based LTC?

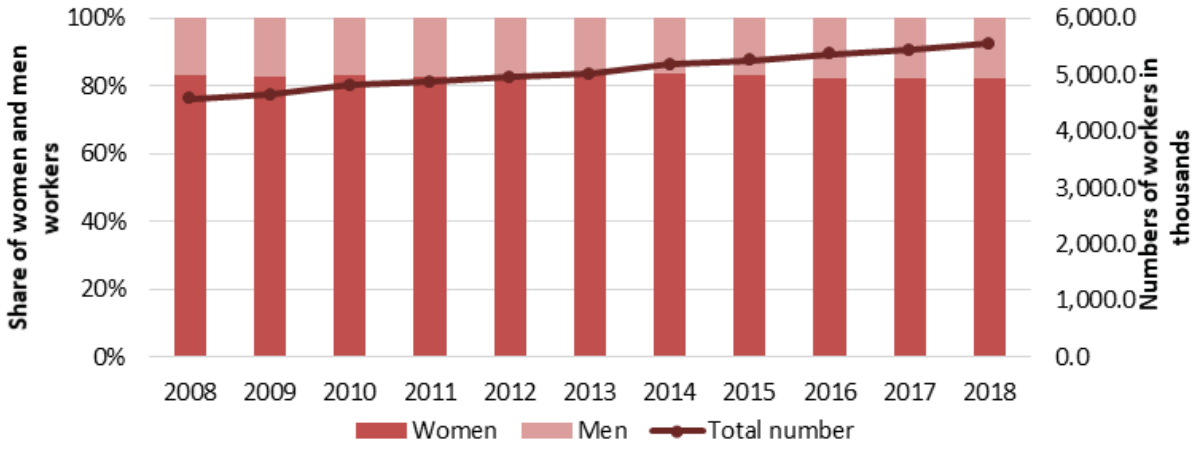
The actual social value of care work is high and is recognised as both an important aspect of economic activity and indispensable factor contributing to the well-being of individuals, their families and societies (Stiglitz, Sen, & Fitoussi, 2017) In reality, **the value of informal care to economic growth is invisible and not recognized and the formal care work usually belongs to the lowest paid and lowest valued professions**. Formal home-based care can significantly improve well-being of care recipients and reduce demand for residential care (ILO, 2018; Spasova et al., 2018). The overall aim of the home-based care givers' tasks is to increase the care recipients' quality of life and independence by providing help with everyday tasks (Commission, 2013b). However, formal care givers are not a homogenous group as they differ amongst each other based on work functions and care types they provide:

- Home-based care givers, often qualified **medicine nurses,** helping with medicine consumption, regular health monitoring and similar activities.
- Home-based **personal carers**, often without formal qualifications in the health sector, helping with everyday personal activities such as walking, eating, bathing, or dressing up, as well as help with domestic tasks (such as shopping, cleaning, cooking).
    - **Domestic workers**, who mostly assist with domestic tasks and who usually enter into direct employment relationship with care recipients, can be distinguished as an additional subgroup of home-based personal carers (ILO, 2018).

Women are heavily overrepresented among all types of home-based care providers (ILO, 2018). In 2018, 4.5 million out of 5.5 million EU workers in the economic sector of 'social work activities without accommodation'[27] were women[28]. They represented around 82% of all workforce in this sector, compared with only 46% of female workforce in the total economy[29]. **During the last ten years, the share of women in social work remained unchanged despite the overall increase of workers in this sector** (see Figure 17). Moreover, the same sector employed 4.3% of women from the total workforce, compared to only 0.8% of men[30]. Gender distribution among formal home-based care providers is unlikely to change unless major policy actions are taken (e.g. significant increase of care givers' salaries, effective social campaigns encouraging men's involvement in the sector) (Commission, 2012).

[27] NACE 88 category, for more information see statistical classification of economic activities in the European Community (https://ec.europa.eu/eurostat/documents/3859598/5902521/KS-RA-07-015-EN.PDF).
[28] Eurostat LFS 2018 (lfsa_egan22d).
[29] EIGE's calculations based on Eurostat LFS 2018 (lfsa_egan22d).
[30] EIGE's calculations based on Eurostat LFS 2018 (lfsa_egan22d).

Figure 17: Number of total workers and share of women and men workers in the economic sector of social work activities without accommodation (NACE 88) in the EU-28, (15+), 2018



Source: Eurostat LFS, (lfsa_egan22d).

Women with low or medium level education and migrant women are more likely to work in long-term care sector (especially as personal carers) (OECD, 2019). According to OECD, few EU countries require personal care workers to hold minimum education level or have licenses/ certifications, therefore personal care workers not always have sufficient knowledge or training to deliver high quality care services (OECD, 2019). In recent years, **the growing demand for LTC workers and significant differences in pay and working conditions amongst the different countries induced the inflow of mainly women migrant workers**. Foreign-born care givers play an especially important role in Southern European countries and Austria (Commission, 2012). The over-qualification is a rather common phenomena among skilled migrant women working in care sector (e.g. qualified medical nurses) (Commission, 2017b; ILO, 2018) as they find difficulties in validating their qualifications and therefore tend to face a higher risk of unfair recruitment practices (Cangiano, Shutes, Spencer, & Leeson, 2009).

5.2 Difficult employment conditions of formal carers

Employment in the formal care sector is often described as low quality and precarious (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011; ILO, 2018; Spasova et al., 2018). In many EU countries formal care work is characterised by:

- High intensity of work (determined by high emotional demands, and high workload)
- Adverse social environment (high risk of abuse, harassment, and under-appreciation)
- Atypical working time (working at night and/or on weekends, frequent changes to working time arrangements)
- Low income

High workload and high level of stress are prevalent in the formal care sector (ILO, 2018; Spasova et al., 2018). Home-based care workers often carry out complex tasks, which involves different roles and responsibilities such as social workers, household helpers, nurses and assistants in day to day activities. Many of the care tasks involve high physical exertion such as tiring or painful positions, lifting or moving other people, which might have negative effects on care givers' physical health in the long-term. For example, muscular pain and exhaustion are described as common health problems among many professional care givers (Elwér, Lena, & Hammarström, 2012).

Care givers and care recipients usually engage in healthy and satisfactory relationship; however, it can also become very demanding and emotionally fraught, especially with recipients having psychological or mental problems (Elwér et al., 2012; ILO, 2018). High emotional workload of care givers increases their risk of mental health problems such as mental fatigue or depression (Colombo et al., 2011). Moreover, **care workers report some of the highest levels of violence and harassment compared to other industries and sectors** (Eurofound, 2015; Lippel, 2016). In 2012 a German survey among care staff revealed that 56% of them experienced physical violence and 78% experienced verbal aggression in the 12 months preceding the survey (Schablon et al., 2012). Because of the isolated environment of care recipients' home, home-based care workers are likely to face a higher risk to experience adverse social behaviour of care recipients or their family members compared to the residential care givers working at institutions. Due to composition of the workforce, **abuse and violence disproportionately affect women, in particular migrant women working as domestic workers** (ILO, 2018).

Formal home-based care givers are highly likely to experience atypical working time, which is found to have negative effects on workers' work-life balance, overall health, and subjective well-being (Eurofound, 2017; ILO, 2018). A study in Sweden found that some care givers choose part-time employment as a strategy of creating possibility to accommodate work to family life despite high workload, atypical and irregular working hours in the sector (Elwér et al., 2012). Although part time employment might have positive effects by allowing care givers to rest and spend more time to family and social commitments, it also has a negative effect on current and future incomes (Elwér et al., 2012).

Care providers are generally low paid. In 2011, OECD analysis of home-based carers' wages in 16 European countries revealed that **low skilled carers were likely to earn less than national average wages** (Commission, 2012). Low payment not only negatively affects the attractiveness of the sector, but also has a negative impact on the economic independence and overall well-being of care givers. Migrant personal care workers in round-the-clock live-in arrangements are also particularly vulnerable to financial exploitation, as they are unable to exit the employment relationship (ILO, 2018).

Improvement of employment quality in the formal home-based care sector are likely to contribute to the overall gender equality levels in the Member states. Since women make up majority of professional care givers, improved working conditions in the care sector would benefit them more. It is also likely that **improved employed quality, especially higher wages, would attract more men to the sector**, make concentration of women and men in care sector more even, and would decrease shortage of professional care givers.

6 How to monitor progress in formal home-based LTC?

Monitoring of formal home-based LTC from gender equality perspective requires consistent comparable data. Available data sources on EU-28 provide fragmented information and does not allow to make strong conclusions on potential relationship between formal home-based care and gender equality. EIGE reviewed multiple EU-level surveys (i.e. EU-SILC, EU-LFS, EHIS, EWCS, EQLS, EHIS, SHARE, OECD health statistics) and, while all of them are relevant, they also have serious limitations. The key challenges concerning the data relevant for the monitoring of formal home-based services:

1. LTC of older people is monitored much more extensively compared to adults with disabilities. For instance, EHIS asks questions about limitations with everyday activities only if respondent is older than 65. SHARE data covers only population over 50. Data gaps are especially large in case of children with disabilities. While the provision of childcare is monitored by several surveys, it is not possible to identify whether care is provided to children with disabilities.
2. LTC is monitored more rarely compared to other heath or social services. For instance, EU-SILC includes questions about received health or dental care services in their primary surveys (implemented annually), but questions concerning LTC were asked only in the ad hoc module of 2016 (collected every five years or even less often).
3. As for data on care recipients, the three most suitable datasets are EU-SILC (especially ad-hoc module of 2016), EQLS, and SHARE. However, all of them have serious limitations and disadvantages. Information for the EU-SILC module 'Access to services' is collected only every five years and most of the relevant questions are collected on the household level. Therefore, the analysis of gender or age differences of care recipient is limited. SHARE survey covers only people older than 50 years old. EQLS has several very useful and suitable questions for the analysis of LTC, but the sample size of this survey is relatively low.
4. Difficulty to identify professional home-based care givers complicates the monitoring of their employment quality. Ideally, formal home-based care givers could be identified using ISCO profession code '5322 Home-based Personal Care Workers' or NACE profession code '88.1 Social work activities without accommodation for the elderly and disabled'. However, individual level surveys' data usually provide only one or two digits ISCO and NACE codes (that cover not only formal home-based care givers).

Taking into account the advantages and limitations of different EU level surveys, the mix of following surveys could be used to monitor different home-based long-term care aspects presented in this report (see Table 2). Filled-in data tables of the proposed indicators are included in Annexes.

Table 2. List of indicators to monitor home-based long-term care

LTC aspect	Title	Data source
Care recipients		
Care needs	**Indicator 1:** Percentage of women and men limited in usual activities by age group in EU countries (16+), 2018	EU-SILC
	Indicator 2: Percentage of children with limitation in activities due to health problems (younger than 16 years), 2017	EU-SILC
Prevalence of formal home-based care	**Indicator 3:** Percentage of women and men living in the households with individuals limited in everyday activities who report that their household receives formal home-based LTC services (16+), 2016.	EU-SILC
Availability of formal-home based LTC	**Indicator 4:** Number of employees providing social work activities without accommodation per 100 population (16+) limited in everyday activities, 2018	EU-SILC
Accessibility of formal home-based care services	**Indicator 5:** Percentage of women and men reporting unmet household needs for professional home-care services (16+), 2016	EU-SILC
	Indicator 6: Main reason of the unmet household needs for professional home care services by gender of the household respondent (16+), 2016	EU-SILC
Affordability of formal home-based LTC services	**Indicator 7:** Percentage of women and men who report that their household needed to pay for received formal home-based LTC services (16+), 2016	EU-SILC
	Indicator 8: Percentage of women and men who report that their household faced difficulties in paying for received formal home-based LTC services (16+), 2016	EU-SILC
Quality of formal home-based LTC services	**Indicator 9:** Care recipients' ratings of the quality of received formal home-based LTC services in the EU Member States (18+), 2016	EQLS
Care providers		
Individuals working as formal home-based care providers	**Indicator 10:** Proportion of women and men working as formal home-based care givers (15+), 2018 Home-based care providers identified with NACE 3 digits category 88.1 - Social work activities without accommodation for the elderly and disabled	EU-LFS (currently data not available, EIGE is expecting to receive relevant calculations from Eurostat in near future)
Employment quality of formal home-based care givers	**Indicator 11.1:** Working on weekends (15+), 2018 **Indicator 11.2:** Night work (15+), 2018 **Indicator 11.3:** Exposure to violence at work or threat of violence (15+), 2013 **Indicator 11.3:** Participation in education and training activities during the last 4 weeks (15+), 2018 **Indicator 11.4:** Monthly (take home) pay from main job (deciles) (15+), 2018 Home-based care providers identified with NACE 3 digits category 88.1 - Social work activities without accommodation for the elderly and disabled	EU-LFS (currently data not available, EIGE is expecting to receive relevant calculations from Eurostat in near future)

Conclusions

Long-term care needs are on rise and affect women disproportionately

Population ageing leads to fast increasing needs for long-term care and potentially adds to women's already disproportionate burden of unpaid care responsibilities, given that long-term care services are insufficient across the EU. Although long-term care related challenges have been on EU policy agenda for some time, the policies seldom contain gender equality perspective.

The prevalence of health limitations among adults is high in most EU countries, increases with age and **affects women disproportionately**. Due to a higher life expectancy, more women than men are dependent on long-term care. In addition, the vast majority of formal and informal carers are women. The **growing care needs represent an important long-term challenge for national health and social protection systems**, but also for the achievement of the overall aims of the EU to combat social exclusion and discrimination and to promote equality between women and men.

Nearly every tenth person, more men than women, enter adulthood with health limitations

Although the prevalence of disability is highest among older people, about **8% of young women and 10% of young men aged 16-24 start off their adulthood with some or severe limitations in their everyday life.** Due to specific and complex needs, their parents might need to forgo employment and engage in full time informal care. **Children with disabilities often live in one-parent families** – with lone mothers more often than lone fathers – **who are at greater risk of poverty and might have financial difficulties to access professional care services**.

The care needs of young women and men with disabilities differ significantly from the needs of older people. Young people with disabilities need life span support and care to acquire independence, attain education, integrate into the labour market and prevent possible deepening of their disabilities and dependence. The specific needs of girls and boys and young women and men in need of long-term care should be broader addressed in long-term care policies.

Shortage of formal long-term care puts economic independence of women at risk

The availability of formal long-term care services varies greatly in the EU Member States. Across the EU, only a quarter of households with persons with disabilities receive formal home-based LTC services. LTC relies heavily on the support provided by informal carers. **Nearly a third of women and men in the EU live in households with unmet needs for professional care.** Certain groups of women are particularly disadvantaged in accessing the services, e.g. if they are not covered by social insurance schemes, have lower income or due to gender biases in the need assessment process.

The shortage of adequate formal home-based care leads to several adverse consequences. It causes either extensive engagement in informal care by family members or friends, avoidable institutionalisation or insufficient care and poor quality of life for those in need of care. Most often, **women in the family take over the care responsibilities - starting already from a very young age - and this puts their economic independence at risk**. Care responsibilities is one of the main reasons keeping women out of the labour market or in part-time employment and leading to potentially severe economic and health consequences (gender pay gap, gender pension gap, risk of poverty, ill health etc.).

Informal carers need support and their contribution to economy needs to be recognized

The de-instutionalisation process in the EU moves care from institutions to home-based care. Providing care to severely ill or people with disabilities might have negative impact to carers health and well-being, particularly if they are lacking adequate training and support. Besides adult family members, **many children are involved in providing care to the family members who are ill or disabled** and it has a vast impact on their quality of life, education and mental health. Gender roles in care start operating at very early age –girls more often than boys take on the care of their chronically ill or disabled relatives and household tasks.

Developing **support structures and services to formal care at home needs to go hand in hand with supporting family members who provide informal care**. They should be designed and coordinated in a way which would allow family members freely choose how to arrange the care and to what extent family will use professional services to reach adequate work-life balance. The role of informal carers is vital, it needs to be acknowledged and valued.

Policy targets, actions and data collection needs to be extended to children with disabilities

With the development of medicine and technologies, the number of children with disabilities is on rise with about 5% of EU families having a child with disabilities. **Children need complex and integrated services, which would support their development**, prevent deepening of the disability and support future independent life. Such children grow up to be adults with disabilities and they are life- long dependent on LTC services.

Children with disabilities are mostly dependent on care by their parents although the evidence on the services provided to children with disabilities is very scarce. Care for children with disabilities is very demanding and may lead to intense work-life conflict, stress and low quality of life of informal careers. **Without adequate services, parents (mostly mothers) of children with severe disabilities may face a stark choice on whether to place a child into permanent institutional care or fully dedicate themselves to informal care** provided at home, risking falling out of the labour market and into poverty and social exclusion.

The same applies to adults with disabilities whose institutionalisation may sometimes be prevented with adequate support and home-based care services, a more cost-effective solution providing often better health outcomes and higher quality of life. Overall, over one million Europeans with disabilities live in institutions (FRA, 2018). People with intellectual disabilities as well as younger people with disabilities appear to face a higher degree of institutionalisation (ANED, 2010).

Better remuneration required for long-term care providers to account for difficult working conditions

Lack of service providers has been seen as one of the reasons behind the scarcity of home-based LTC services. Social workers who provide services outside of institutionalised care make up just over 2% of the workforce in the EU, covering not only the needs of home-based and community long-term care for older people and people with disabilities, but also other disadvantaged groups (e.g. youth, refugees).

Majority of people engaged in social work in the EU are women. In 2018, women comprised 4.5 million out of 5.5 million professional social workers providing care outside institutional settings in the EU. The actual value of both formal and informal care is not adequately recognized in the society. **Employment conditions in the formal care sector are often difficult and precarious**

characterised by high intensity work, atypical working hours, adverse social environment and low income. Currently information on the actual working conditions of the people providing home-based long-term care services in different Member States is scarce. In order to improve the working conditions and secure adequate pay, policies should recognize the precariousness of jobs in care sector in the majority of Member States and to acknowledge the need of good quality comparable data on working conditions in this sector.

Ambitious and gender-specific policy goals are needed

Targets should be set in order to effectively monitor progress in the provision of formal home-based long-term care – similar to the targets on the provision of childcare (Barcelona targets). The targets should cover not only long-term care provided to older persons and adults with disabilities, but also to children with disabilities. The study proposes a set of indicators that could be used to capture the complexity of the accessibility of care. In addition to measuring the overall level of need for care, Member States should also collect data and regularly map the situation regarding the availability, affordability and quality of the services. In order to achieve positive care outcomes, care must be safe, effective, timely, efficient, equitable and people-centred (WHO, 2016).

Since both formal and informal long-term care are highly gendered issues, a **gender perspective needs to be introduced when setting the targets and significantly strengthened in data collection.** Current high quality and comparable statistics on the use of home-based long-term care in the EU is lacking a gender perspective as most of the information is collected at a household level. This sets limitations to researching gender inequalities in the field of formal home-based long-term care, especially in terms of availability, affordability and quality of services.

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Annexes

Indicator 1: Percentage of women and men limited in usual activities by age group in EU countries (16+), 2018

	Total (16 years or over)			From 16 to 64 years			From 65 to 74 years			75 years or over		
	Total	Women	Men	Total	Women	Men	Total	Women	Men	Total	Women	Men
EU-28	**25.0**	**27.3**	**22.6**	**17.9**	**19.2**	**16.6**	**39.6**	**41.7**	**37.1**	**59.0**	**62.3**	**54.4**
BE	25.3	27.6	23.0	19.8	21.2	18.4	34.7	35.4	34.0	53.8	56.9	48.9
BG	16.8	19.1	14.3	9.2	9.6	8.8	31.2	32.6	29.3	51.2	55.3	44.2
CZ	28.0	29.8	25.2	18.6	19.8	17.0	42.7	44.0	40.7	66.4	69.2	61.0
DK	29.0	32.5	25.3	25.4	29.4	21.4	37.6	39.2	35.8	44.7	44.7	44.8
DE	22.3	23.3	21.2	17.7	18.4	17.0	31.1	31.7	30.4	42.4	44.8	39.9
EE	39.7	42.1	36.3	29.9	29.7	30.1	60.2	62.6	56.1	77.1	78.5	73.0
IE	15.8	16.4	15.3	11.9	12.4	11.4	27.3	26.6	28.1	42.4	42.6	42.2
EL	24.0	25.7	22.0	10.6	11.0	10.1	48.7	50.8	46.2	77.8	79.7	75.4
ES	20.7	23.4	17.8	13.5	14.5	12.4	33.4	36.9	29.5	58.8	63.8	51.4
FR	25.3	27.2	23.4	18.4	19.7	17.0	37.3	38.0	36.5	59.0	59.5	58.4
HR	33.5	35.5	31.4	22.0	21.5	22.4	62.2	63.4	60.8	81.6	84.4	76.6
IT	23.8	26.4	21.0	12.9	13.4	12.3	40.8	43.7	37.7	67.6	71.5	61.6
CY	24.0	24.5	23.3	16.0	15.4	16.7	51.2	52.7	49.5	73.0	80.2	64.0
LV	40.1	43.5	35.8	29.0	30.1	27.8	64.9	65.7	63.6	83.0	83.6	81.3
LT	30.6	34.1	26.3	19.4	20.2	18.6	57.0	58.2	54.9	74.2	75.9	70.0
LU	27.2	29.4	25.1	22.2	24.3	20.0	42.9	45.3	40.5	64.8	67.1	62.6
HU	25.4	28.1	22.5	16.7	17.6	15.7	46.9	48.7	44.3	68.1	71.1	63.1
MT	12.0	13.2	10.8	7.6	7.8	7.4	22.5	24.0	20.8	37.8	42.3	31.9
NL	31.3	35.1	27.3	26.1	29.7	22.6	43.7	46.9	40.3	56.4	59.5	52.3
AT	34.1	35.9	32.2	27.3	27.9	26.7	51.2	52.6	49.7	71.5	74.3	67.0
PL	24.0	25.5	22.2	16.3	16.1	16.6	41.1	42.8	38.8	64.5	67.5	58.5
PT	33.6	38.2	28.2	23.5	26.7	20.0	55.2	60.6	48.6	71.8	75.1	66.4
RO	26.5	30.7	21.9	16.5	18.7	14.4	55.2	60.2	48.6	72.6	75.0	68.4
SI	35.4	38.1	32.6	28.7	30.2	27.2	52.1	51.9	52.4	70.4	75.5	62.3
SK	31.3	34.3	28.1	22.0	23.6	20.4	65.1	65.5	64.6	84.8	84.8	84.6
FI	34.3	38.8	30.0	28.5	32.3	25.0	42.7	44.7	40.7	61.8	66.6	55.0
SE	12.8	15.9	9.7	10.1	12.6	7.8	16.9	20.1	13.4	26.5	30.3	21.3
UK	27.3	29.5	25.0	21.8	23.8	19.7	37.6	38.7	36.5	55.4	56.9	53.4

Source: Eurostat, EU-SILC (hlth_silc_06), 2018.
Notes: Flags are relevant for all the cells in the row. Available flags: provisional data for IE and UK.

Indicator 2: Percentage of children with limitation in activities due to health problems (younger than 16 years), 2017

	Total	Girls	Boys
EU-28	**4.7**	**4.2**	**4.9**
BE	5.0	4.1	6.0
BG	2.2	2.6	2.2
CZ	6.5	5.3	7.7
DK	:	:	:
DE	4.6	4.0	4.9
EE	8.4	7.3	9.3
IE	4.9	4.1	5.5
EL	2.0	2.0	1.9
ES	2.8	3.0	2.6
FR	4.8	4.5	5.1

HR	2.8	2.0	3.7
IT	0.8	0.6	1.00
CY	1.7	1.8	1.4
LV	12.4	11.8	12.7
LT	8.7	8.6	8.9
LU	5.0	4.8	5.3
HU	4.6	3.7	5.5
MT	2.5	2.3	2.9
NL	:	:	:
AT	6.0	5.2	6.5
PL	3.6	2.8	4.8
PT	5.2	4.7	5.9
RO	7.6	8.7	6.5
SI	:	:	:
SK	2.5	2.3	2.6
FI	:	:	:
SE	:	:	:
UK	8.4	9.2	9.6

Source: Eurostat, EU-SILC (ilc_hch13), 2017, and authors' calculations based on the EU-SILC micro data, 2017
Notes:: ":" - not available.

Indicator 3: Percentage of women and men living in the households with individuals limited in everyday activities who report that their household receives formal home-based LTC services (16+), 2016.

	Total	Women	Men	Gap
EU-28	26.0	26.1	25.6	0.5
BE	44.4	43.7	45.2	-1.5
BG	5.7	5.9	5.2	0.7
CZ	60.8	59.3	64.3	-5
DK	62.0	74.1	45.3	28.8
DE	32.5	26.9	37.8	-10.9
EE	7.1	7.6	6.0	1.6
IE	28.6	29.9	26.5	3.4
EL	12.1	13.7	10.5	3.2
ES	14.4	15.3	11.8	3.5
FR	55.4	55.6	54.9	0.7
HR	15.7	15.5	15.9	-0.4
IT	14.0	14.5	13.3	1.2
CY	47.8	49.7	45.9	3.8
LV	14.9	14.9	14.7	0.2
LT	11.7	12.2	10.2	2
LU	88.6	94.5	79.6	14.9
HU	24.3	22.2	29.1	-6.9
MT	19.2	15.9	22.2	-6.3
NL	52.0	54.5	48.0	6.5
AT	49.5	52.1	45.0	7.1
PL	7.2	6.9	8.1	-1.2
PT	20.5	18.5	23.1	-4.6
RO	8.8	12.5	-	-
SI	28.4	25.0	35.5	-10.5
SK	18.0	18.7	16.7	2
FI	37.0	36.7	37.6	-0.9
SE	28.8	30.4	26.4	4
UK	22.5	22.1	23.1	-1

Source: Authors' calculations based on the EU-SILC micro data, 2016
Notes: "-" – data not available because of the low reliability (number of answers in the group is lower than 20 cases.

Indicator 4: Number of employees providing social work activities without accommodation per 100 population (16+) limited in everyday activities, 2018

EU-28	5.2
BE	8.4
BG	3.4
CZ	1.5
DK	13.7
DE	7.0
EE	0.6
IE	14.2
EL	1.2
ES	2.7
FR	9.4
HR	1.0
IT	2.1
CY	1.2
LV	1.4
LT	1.2
LU	8.8
HU	2.7
MT	5.8
NL	6.8
AT	3.4
PL	2.1
PT	2.4
RO	1.0
SI	0.8
SK	3.1
FI	8.5
SE	19.7
UK	6.5

Source: Authors' calculations based on the Eurostat EU-SILC data, 2018. NACE 88 category 'Social work activities without accommodation' was used to identify employees providing social work activities without accommodation.

Indicator 5: Percentage of women and men reporting unmet household need for professional home-care services (16+), 2016

	Women	Men	Gap
	29.9	27.5	2.4
BE	29.0	12.8	16.2
BG	47.3	42.6	4.7
CZ	32.1	23	9.1
DK	-	-	-
DE	17.8	12.6	5.2
EE	15.5	10.8	4.7
IE	33.2	30.8	2.4
EL	63.5	58.4	5.1
ES	34.1	28.1	6.0
FR	31.0	25.0	6.0
HR	20.4	14.4	6.0
IT	39.1	31.4	7.7
CY	47.2	46	1.2
LV	40.3	35.6	4.7
LT	42.7	36.9	5.8
LU	11.5	18.2	-6.7
HU	23.1	22.2	0.9
MT	23	19.4	3.6
NL	42.6	44.9	-2.3
AT	24.1	25.5	-1.4
PL	17.7	14.6	3.1
PT	85.3	86	-0.7
RO	47.8	34	13.8

SI	25.1	17	8.1
SK	24.1	23.2	0.9
FI	26.7	22.1	4.6
SE	12.1	13	-0.9
UK	19.3	22.4	-3.1

Source: EU-SILC Ad hoc module on Access to services, 2016. EIGE's calculation with microdata.

Indicator 6: Main reason of the unmet household needs for professional home care services by gender of the household respondent (16+), 2016

	Cannot afford it			Refused by person needing such services			No such care services available			Quality of the services available not satisfactory			Other reasons		
	Wome	Men	Gap	Women	Men	Gap	Women	Men	Gap	Women	Men	Gap	Women	Men	Gap
EU-28	**51.2**	**47.3**	3.9	**7.6**	**8.3**	-0.6	**14.0**	**15.4**	-1.4	**3.3**	**3.5**	-0.2	**23.8**	**25.5**	-1.7
BE	66.2	50.0	16.2	2.9	3.2	-0.3	6.4	28.8	-22.4	5.0	0.0	5.0	19.6	18.1	1.5
BG	67.6	71.6	-4.0	6.4	5.1	1.3	14.1	13.7	0.4	2.4	3.4	-1.0	9.5	6.2	3.3
CZ	51.8	36.4	15.5	12.8	14.0	-1.1	11.4	5.5	5.9	1.6	5.0	-3.3	22.3	39.2	-16.9
DK	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
DE	43.1	50.0	-7.0	14.4	5.7	8.6	3.9	12.0	-8.1	0.0	2.3	-2.3	38.7	30.0	8.7
EE	49.5	53.2	-3.8	1.6	4.6	-3.0	32.2	26.8	5.4	0.6	0.0	0.6	16.1	15.4	0.8
IE	19.1	13.7	5.4	6.7	8.3	-1.6	26.7	31.6	-5.0	20.0	3.8	16.2	27.6	42.6	-15.0
EL	66.5	67.0	-0.4	25.1	23.2	1.9	5.0	4.9	0.1	1.8	1.7	0.0	1.6	3.3	-1.7
ES	72.4	66.7	5.8	3.9	2.8	1.1	9.4	10.0	-0.7	0.7	2.1	-1.4	13.6	18.4	-4.8
FR	50.6	34.7	15.9	9.7	13.6	-3.9	7.7	7.4	0.3	4.0	0.8	3.2	28.0	43.6	-15.6
HR	73.1	48.1	25.0	0.9	3.9	-3.0	14.2	23.7	-9.5	5.6	5.2	0.4	6.2	19.2	-13.1
IT	44.0	45.2	-1.1	2.1	2.7	-0.7	34.0	36.3	-2.3	4.6	5.1	-0.5	15.3	10.7	4.6
CY	88.8	77.8	11.0	6.3	10.5	-4.2	1.0	0.0	1.0	2.8	4.3	-1.5	1.1	7.4	-6.4
LV	51.2	40.7	10.4	16.4	12.3	4.1	16.7	22.4	-5.7	4.0	7.2	-3.2	11.7	17.4	-5.7
LT	44.4	29.1	15.3	17.4	13.9	3.5	8.0	4.4	3.6	3.8	9.3	-5.5	26.4	43.4	-16.9
LU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
HU	43.3	52.9	-9.5	25.0	33.1	-8.1	20.5	6.5	14.0	3.8	0.0	3.8	7.4	7.6	-0.1
MT	29.1	17.0	12.1	8.6	8.3	0.4	0.0	6.9	-6.9	2.4	4.9	-2.5	59.9	63.0	-3.1
NL	53.4	46.4	7.0	3.1	3.2	-0.1	15.3	13.4	1.9	1.1	2.1	-1.0	27.1	34.9	-7.8
AT	59.9	58.1	1.8	18.5	14.5	4.0	4.8	10.3	-5.5	1.9	0.0	1.9	14.9	17.1	-2.1
PL	73.2	68.0	5.2	5.9	11.1	-5.3	7.4	11.7	-4.3	6.1	2.3	3.8	7.5	7.0	0.5
PT	37.3	37.1	0.2	8.5	10.0	-1.4	6.1	10.0	-3.9	2.3	1.2	1.0	45.8	41.6	4.1
RO	80.2	72.6	7.6	4.5	7.2	-2.8	11.2	16.8	-5.6	0.0	0.0	0.0	4.1	3.4	0.7
SI	58.5	70.0	-11.5	8.1	4.7	3.4	11.4	11.0	0.4	3.2	1.0	2.2	18.8	13.3	5.5
SK	41.0	49.1	-8.1	17.7	27.1	-9.4	14.4	6.4	8.0	1.7	0.0	1.7	25.3	17.5	7.8
FI	29.7	24.0	5.7	3.4	2.8	0.6	22.6	28.2	-5.6	2.5	2.1	0.3	41.8	42.9	-1.0
SE	20.8	6.8	14.0	6.9	3.2	3.6	12.9	13.7	-0.8	0.0	22.3	-22.3	59.5	54.1	5.4
UK	26.7	23.7	3.0	8.8	10.7	-1.9	14.8	14.3	0.5	5.6	7.6	-2.0	44.1	43.8	0.3

Source: Authors' calculations based on the EU-SILC micro data, 2016.
Notes: "-" – data not available because of the low reliability (number of answers in the group is lower than 20 cases). "n.a." – data not available (no answers).

Indicator 7: Percentage of women and men who report that their household needed to pay for received formal home-based LTC services (16+), 2016

	Total	Women	Men	Gap
EU-28	62.0	63.4	59.9	3.5
BE	72.2	75.5	68.6	6.8
BG	68.1	71.2	-	-
CZ	41.7	38.3	49.0	-10.7
DK	44.6	40.0	54.8	-14.8
DE	48.1	38.3	54.8	-16.5
EE	31.3	33.6	23.4	10.2
IE	14.6	16.5	11.2	5.3
EL	84.9	86.8	82.3	4.4
ES	79.0	79.0	82.4	-3.4

FR	68.5	70.8	64.5	6.3
HR	17.5	18.4	16.8	1.6
IT	44.9	50.0	37.4	12.6
CY	82.7	78.1	88.0	-10.0
LV	14.5	19.8	0.0	19.8
LT	46.9	42.5	-	-
LU	43.1	48.5	33.2	15.3
HU	41.5	36.0	51.3	-15.4
MT	45.6	61.2	35.3	26.0
NL	81.8	83.9	77.8	6.1
AT	91.9	93.0	89.6	3.4
PL	71.8	70.2	76.1	-5.9
PT	67.4	66.2	68.8	-2.6
RO	-	-	-	-
SI	36.1	39.2	31.7	7.5
SK	41.9	48.8	29.5	19.3
FI	83.3	85.8	78.4	7.4
SE	100.0	100.0	100.0	0.0
UK	36.9	38.2	35.3	2.9

Source: Authors' calculations based on the EU-SILC micro data, 2016
Notes: "-" – data not available because of the low reliability (number of answers in the group is lower than 20 cases.

Indicator 8: Percentage of women and men who report that their household faced difficulties in paying for received formal home-based LTC services (16+), 2016

	Total	Women	Men	Gap
EU-28	52.8	53.5	46.3	7.2
BE	50.6	52.1	51.7	0.5
BG	78.2 n	80.1 n	-	-
CZ	84.3	83.2	85.6	-2.4
DK	31.4	31.8	40.1	-8.3
DE	39.1	33.2	37.7	-4.5
EE	68.6 u	-	-	-
IE	47.2	43.5	-	-
EL	93.3	93.1	95.8	-2.7
ES	70.9	74.9	64.5	10.5
FR	42.4	47.4	31.3	16.2
HR	82.5 u	-	-	-
IT	81	87.5	78.8	8.7
CY	92.3	92.4	92.4	0.0
LV	76.8 u	-	-	-
LT	94.1 u	-	-	-
LU	34.1	37.9	-	-
HU	80.8 n	95.5 n	-	-
MT	39.5	35.6	-	-
NL	36.9	38.8	35.1	3.7
AT	58.6	62.3	53.0	9.3
PL	82.2	84.8	-	-
PT	80.4	86.1	71.9	14.2
RO	:	-	-	-
SI	66.5	61.7	82.6	-20.9
SK	94.5 n	89.1 n	-	-
FI	24.8	27.9	26.4	1.6
SE	26.9	30.7	27.1	3.7
UK	45.2	45.2	41.7	3.5

Source: Eurostat data (ilc_ats16) and authors' calculations based on the EU-SILC micro data, 2016
Notes: "-" – data not available because of the low reliability (number of answers in the group is lower than 20 cases); ":" – not available. Flags and footnotes: u-low reliability; n- not significant.

Indicator 9: Care recipients' average ratings of the quality of received formal home-based LTC services in the EU Member States (18+), 2016

	Total	Women	Men	Gap
EU-28	7.8	7.7	7.9	-0.2
BE	8.1	8.0	8.2	-0.1
BG	-	-	-	-
CZ	7.2	-	-	-
DK	8.9	8.4	9.3	-0.9
DE	7.9	7.8	-	-
EE	-	-	-	-
IE	-	-	-	-
EL	-	-	-	-
ES	-	-	-	-
FR	7.9	7.8	8.0	-0.2
HR	-	-	-	-
IT	6.3	6.0	6.7	-0.7
CY	-	-	-	-
LV	7.6	7.3	-	-
LT	-	-	-	-
LU	8.5	8.7	-	-
HU	8.5	8.6	-	-
MT	8.7	8.7	-	-
NL	7.7	7.8	-	-
AT	-	-	-	-
PL	-	-	-	-
PT	-	-	-	-
RO	-	-	-	-
SI	8.1	8.1	-	-
SK	-	-	-	-
FI	8.6	-	-	-
SE	8.5	8.1	-	-
UK	-	-	-	-

Source: Authors' calculations based on the EQLS micro data, 2016.
Notes: "-" – data not available because of the low reliability (number of answers in the group is lower than 20 cases).