RESEARCH REPORT

Eurofound

Living conditions and quality of life

COVID-19 and older people: Impact on their lives, support and care

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Eurofound

European Foundation for the Improvement of Living and Working Conditions

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Authors: Hans Dubois, Sanna Nivakoski, Klára Fóti, Valentina Patrini and Massimiliano Mascherini

Research manager: Hans Dubois

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European Foundation for the Improvement of Living and Working Conditions

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

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Abbreviations

EQLS	European Quality of Life Survey
ESF	European Social Fund
EU-LFS	EU Labour Force Survey
GP	general practitioner
ICT	information and communications technology
NGO	non-governmental organisation
NMW	national minimum wage
SHARE	Survey of Health, Ageing and Retirement in Europe
WHO-5	five-item World Health Organization well-being index

Executive summary

Introduction

This report focuses on older people's lives during the COVID-19 pandemic and how they were impacted by governments' and societies' responses in terms of their physical and mental well-being, social interactions, work, finances, and their need for and use of support services, healthcare and long-term care. The report analyses EU survey data and draws on information provided by the Network of Eurofound Correspondents, including national survey results and information on policy measures and initiatives.

Policy context

Europe's population is ageing. In 2021, the European Commission's Green Paper on ageing launched a debate on this defining demographic transformation. This report aims to contribute to that debate and includes a discussion on the rights highlighted in the European Pillar of Social Rights, such as the rights to access to healthcare and long-term care services and resources that ensure living in dignity in old age.

Key findings

- In the EU, people of all ages became more at risk of mental health issues and loneliness during the pandemic, but the impact was particularly severe among young people and people aged 80+. In summer 2020, 23% of people aged 80+ felt sad or depressed more often than before the pandemic.
- Social contacts decreased across the board, including for people aged 50+. Remote contacts substituted for face-to-face contacts, especially with relatives other than children. Among older people, particularly worrying trends were seen among people aged 80+: in summer 2020, 18% of this cohort felt lonelier than before the pandemic and one-third never left their home.
- Reduced physical activity during the pandemic increased with age. In summer 2020, 41% of people aged 50–79 and 46% aged 80+ went out for walks less often than before the pandemic. Smoking, unhealthy eating and alcohol intake increased for some and decreased for others, with healthier trends among the oldest age groups.
- Older people took up telework less frequently during the pandemic and were less likely to have teleworked before, increasing the telework age gap. Older people were less likely than younger people to report that their work negatively impacted their home life.
- The pre-pandemic trend of increased employment among older people continued, and older people were less frequently affected by unemployment than younger people. However, groups of older workers became unemployed and faced difficulties finding new employment; some also retired earlier than planned.
- Working hours decreased more often for older workers than for younger workers, mainly among self-employed people, who are overrepresented among older workers, especially those aged 65+.
- Older people faced decreases in income less often than younger people, but also saw their financial situation improve less often. Pensions were a stable income source. Expenditure increases, such as those related to private transport and care needs, caused problems for low-income groups in particular, and feelings of income insecurity were widespread.
- Older people's support needs were often addressed by partners and children during the pandemic, posing challenges for older people without an informal support network.
- Many private and public support initiatives emerged, focusing on older people, including phone lines addressing loneliness and mental health problems, and grocery and medicine delivery services.
- Most financial support measures aimed to maintain employment. However, the pandemic also triggered pension top-ups and other financial and in-kind support measures for people not in employment.
- Early in the pandemic, the unavailability of services and fear of catching the virus were dominant reasons for unmet healthcare needs. Subsequently, reasons already common before the pandemic, such as waiting lists, lack of reachability and unaffordability, increased.
- There was a shift from formal to informal long-term care and from residential care to home care. There was an increase among men aged 50–64 providing informal care, but it remains particularly common for older women to provide such care. Many informal carers provided more care, with additional pandemic-related challenges.
- Low-tech (phone) e-healthcare facilitated access to healthcare, but 56% of people aged 50+ who needed a consultation had a face-to-face consultation because they preferred it to the available e-healthcare options. An e-healthcare consultation did not fully meet the needs of 49% of people aged 50+ who used one. In long-term care, the role of e-care seems limited.

Policy pointers

- Ensure well-developed, flexible welfare systems, health and social services and civil society to enable rapid responses when needs emerge. The pandemic has shown that most support is built on pre-existing structures.
- Governments should consider scaling up initiatives introduced during the pandemic to better understand older people's care needs and the support needs of their carers (also among non-service users), making such initiatives permanent and learning from those carried out elsewhere.
- Continue analysing the range of support measures implemented during the pandemic and encourage Member States to learn from others' experiences.
- Conduct further research with older people in vulnerable situations (for example, people living alone) and those often excluded from survey research (notably residential care users) to inform policy.
- Facilitate use of information and communications technology, including in primary care and to support carers, but acknowledge its limitations, especially for the provision of more demanding forms of care.
- Ensure access to mental health services, and address causes of mental health problems, such as social isolation and income insecurity.
- Enhance social interaction, which is key to well-being, by including older people in meaningful activities, designing public spaces that facilitate interaction and investing in home and community care.
- Improve the balance between caring and non-caring activities, including for informal carers not in employment, by increasing access to respite care and other support.
- Acknowledge the role that volunteers, many of them older people, played in responding quickly to emerging needs. Provide training and reduce administrative hurdles for volunteers. However, filling care staff gaps with volunteers poses risks, including for continuity and quality of care.
- Improve working conditions for care workers to enable sustainable staffing and provide reliable and high-quality services.
- Devote more attention to workers who wish to work more hours, the economically inactive who would like to work and long-term unemployed people.
- Facilitate the positive individual habits taken up during the pandemic, such as healthy behaviours, and ensure affordable internet connections for those who want to continue their social life online. Encourage active modes of transport, addressing obesity and contributing to the green transition.
- Improve people's living environments. Older people spend more time at home and in their neighbourhoods than younger people; lockdown measures have shown the importance of these living environments for quality of life in an ageing Europe.
- Improve fairness and prevent stereotyping by targeting needs rather than age groups. Avoid overemphasising employment and active ageing, acknowledging that progress relates more broadly to quality of life.

Introduction

The pandemic has impacted people of all ages in many aspects of their lives. This report focuses on the pandemic's impacts on older people. By early December 2021, there had been almost 850,000 registered COVID-19 deaths in the EU. In the wider European region, by the first week of November 2021, 77.1% of deaths were among those aged 65+, with higher rates early on in the pandemic (e.g. 89.3% by the first week of 2021) (ECDC and WHO, 2021). Many more suffered from severe illness, were hospitalised or needed rehabilitation care. Residential care users were disproportionally affected (Rocard et al, 2021).

This report maps the impact of the pandemic, and governments' and societies' responses to it, in terms of older people's physical and mental well-being, social interactions, finances and deprivation, employment, and involvement in volunteering and caring. It also explores the use of and need for support services, long-term care and healthcare. Furthermore, the report provides examples of policies and initiatives that were adopted or adjusted in response to the COVID-19 crisis, or that have seen increases in activity as a result of the pandemic situation, mitigating its negative impact on older people's lives. Assessments of these measures are mainly (still) unavailable, and therefore conclusions are not drawn about their effectiveness. Furthermore, discussing the broader country context is largely beyond the scope of this report. However, where possible, take-up data and challenges encountered are presented.

The report draws on an analysis of EU-level surveys, mainly Eurofound's *Living, working and COVID-19* e-survey (Eurofound, 2020a, 2021a) and the Survey of Health, Ageing and Retirement in Europe (SHARE) COVID-19 (Box 1). Some indicators are compared with the pre-pandemic situation, mainly through comparisons with results from the 2016 European Quality of Life Survey (EQLS). The analysis was complemented by data from national surveys (listed in Annex 1), reports and administrative data.[1] These were identified by the Network of Eurofound Correspondents (Annex 2), complemented by Eurofound's literature review, desk research and consultation with experts. This report captures information identified up to roughly mid-2021, when the report was prepared for publication.

In this report, older people are broadly defined as people aged 50+, including people of working age, young retirees and the oldest old (those aged 80+). The report acknowledges the heterogeneity in older people's situations, across Member States and within countries. The report is principally written for EU- and national-level policymakers.

Box 1: Main EU-wide surveys drawn upon

Living, working and COVID-19

Eurofound's online survey investigated the pandemic's impacts on well-being, health and safety, work and telework, work–life balance and financial situation. This report draws on data collected in three rounds, with surveys starting in April 2020 (round 1), June 2020 (round 2) and February 2021 (round 3). The e-survey was open to anyone aged 18+. Responses: nearly 190,000.

SHARE COVID-19

This was a survey of the COVID-19 living situation of people aged 50+ by the Survey of Health, Ageing and Retirement in Europe (SHARE). Ireland and Austria were excluded. Data were collected between June and August 2020 by computer-assisted telephone interview (CATI). Responses: nearly 50,000, including care home residents.

1 Detailed unpublished input from the 27 Member States can be requested; where references are lacking on national evidence in this report, it comes from these national contributions.

EU policy context

In 2020, the European Commission presented a report on the impact of demographic change (European Commission, 2020a). This was followed in 2021 by a Green Paper on ageing, launching a debate on one of Europe's defining demographic transformations. This report aims to inform that debate by pointing to where problems have occurred for the growing older population during the pandemic, providing examples of how these have been addressed, and drawing lessons for the long term. The following aspects of life are considered.

Health and well-being

The pandemic situation has negatively impacted health and well-being, key indicators of societal progress (Council of the European Union, 2019). Deaths have occurred mainly among those with underlying health conditions (EESC, 2021). Health inequalities have contributed to the increased vulnerability of lower socioeconomic groups to the virus, partly caused by preventable environmental factors (such as air pollution) and individual-level factors (unhealthy behaviours). Individual-level factors are influenced by working and living conditions, with, for instance, low-quality local areas discouraging physical activity (Eurofound, 2019). The 2021 European Pillar of Social Rights Action Plan called for the EU's strategic framework on occupational health and safety to be updated, arguing that increased psychosocial and organisational risk factors may increase work-related stress and poor mental health. By 2022, a non-legislative EU-level initiative on mental health at work is anticipated. In addition, from 2021 to 2027, the EU will invest €5.1 billion in the health programme EU4Health, which will also cover health promotion in an ageing population. Finally, the United Nations has proclaimed 2021–2030 the Decade of Healthy Ageing, and its Sustainable Development Goals include ensuring health and well-being for all.

Social interactions

Physical distancing requirements during the pandemic have posed challenges for many, including older people who live alone, have faced visitor restrictions in care homes, or lack access to digital tools to maintain social contact (FRA, 2020). The European Commission's 2020 strategic foresight report emphasises the increase in loneliness, with accompanying mental health challenges. The Green Paper on ageing raises questions regarding loneliness, its impacts and policy responses.

Employment

The pandemic situation has led to job losses. Older people who lose their jobs generally face more challenges in finding a new job. Informal workers, migrants and women have been hit particularly hard (ILO, 2021). The European Pillar of Social Rights Action Plan set an employment rate target of 78% for people aged 20–64 and emphasises the need for more older people to participate in the labour market. The Green Paper on ageing argues that, to compensate for the shrinking working age population and ensure adequate sustainable pensions, the EU and its Member States should promote policies that enable longer working lives, including lifelong learning and adjustments to pension systems (see also Eurofound, 2016a). The 2017 EU social partners' framework agreement on active ageing calls for fostering healthy and productive working lives in a life course perspective. Many older people do unpaid work, including caring and volunteering. Informal care fulfils many care needs but carers face health problems and social and employment exclusion (European Commission, 2021a). Improved access to long-term care and early childhood education and care addresses unmet care needs, can improve quality of care and reduces informal care burdens. As most carers are women, this fits with the goals of the European Commission's Gender Equality Strategy (2020–2025). The EU's 2019 Work–Life Balance Directive aims to improve work–life balance through the introduction of carers' leave. The Green Paper on ageing questions how volunteering can be better supported, acknowledging that it benefits young and old alike in terms of knowledge, experience and self-esteem, and has an important economic value.

Finances and deprivation

The European Pillar of Social Rights states that '[e]veryone in old age has the right to resources that ensure living in dignity'. The risk of income poverty among older people, which was decreasing until 2016, has risen again (SPC and EC, 2021a). The pandemic situation has added to this challenge because of reduced income and increased expenditure for some groups of older people. For future cohorts of older people, possible long-lasting employment scarring from the pandemic may hinder the accumulation of pensions. More generally, many people are unable to work until the (increasing) official pension age because of health problems, disability and care commitments. They often depend on social assistance and disability and unemployment benefits, and may fall into pre-pension poverty (Eurofound, 2016a). The European Commission's Gender Equality Strategy seeks to reduce the gender pension gap, and the European Pillar of

Social Rights calls for equal opportunities in the accumulation of pension rights. The European Pillar of Social Rights Action Plan aims to have at least 15 million fewer people at risk of poverty or social exclusion in the EU by 2030 and proposes that a Council recommendation on minimum income be adopted in 2022.

Care and support services

During the pandemic, healthcare services have been overburdened, and access to treatment, including for chronically ill people, has been reduced (EESC, 2021). Access to and quality of long-term care have also been negatively affected (SPC and EC, 2021b). It has been argued that a key lesson of the pandemic is the need to better recognise and value social services' contribution to the well-being of millions of Europeans, and to consider investment in them to be investment in the future rather than a mere cost (EPSU and Federation of Social Employers, 2021). The European Pillar of Social Rights states that everyone has the right to affordable long-term care services of good quality, in particular home care and community-based services, and to timely access to affordable, preventive and curative healthcare of good quality. In September 2021, the European Commission announced a forthcoming European Care Strategy to support people in finding the best care and life balance for them. According to the European Pillar of Social Rights Action Plan, the European Commission will also propose an initiative on long-term care (2022) to set out a framework for policy reforms to guide the development of sustainable long-term care that ensures better access to high-quality services. It will also propose tools to better measure healthcare access problems (2021–2022), encourage Member States to invest in the health and social care workforce, and boost the digitalisation of health systems. The EU's Strategy for the Rights of Persons with Disabilities for 2021–2030 includes the theme 'Independent living and autonomy', which will involve the launch of an initiative to improve supporting services. The 2021–2027 EU4Health programme supports actions on digital transformation and on improving access to healthcare for groups in vulnerable situations. The Green Paper on ageing highlights problems with access to care services in rural areas and questions how older people can reap the benefits of digitalisation. It also emphasises the importance of ensuring the autonomy, independence and rights of older people, and enabling their participation in society. It further asks how to reconcile adequate and affordable healthcare and long-term care with financial sustainability.

1 Health and well-being

Self-reported health

After only a few months of the pandemic, many older people, in particular those aged 80+, reported that their health was worse than before the pandemic. Worsening health was reported by 7% of people aged 50–64, 9% of 65- to 79-year-olds, and 16% of people aged 80+; 2–3% in each age group reported improved health. Among all older age groups, women reported more often than men that their health had worsened (Figure 1). The proportion of people aged 50+ reporting worse health was highest in Lithuania and Portugal (both 14%). In all countries, larger proportions reported worsened health than improved health. The gap was smallest in Sweden and Finland, with 8% and 10% reporting worse health and 7% and 9% reporting improved health, respectively.

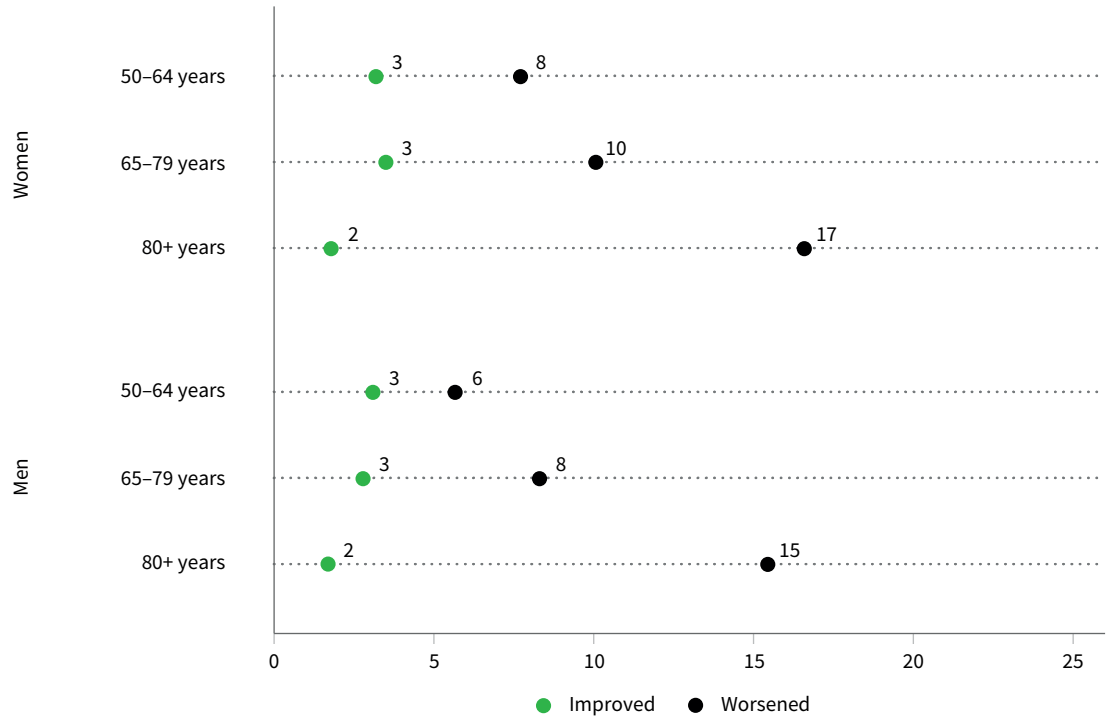
During the pandemic, up until spring 2021, the proportion of people reporting being in (very) bad health increased further in all age groups (*Living, working and COVID-19* e-survey).

Mental well-being

Depression, anxiety and sleep problems

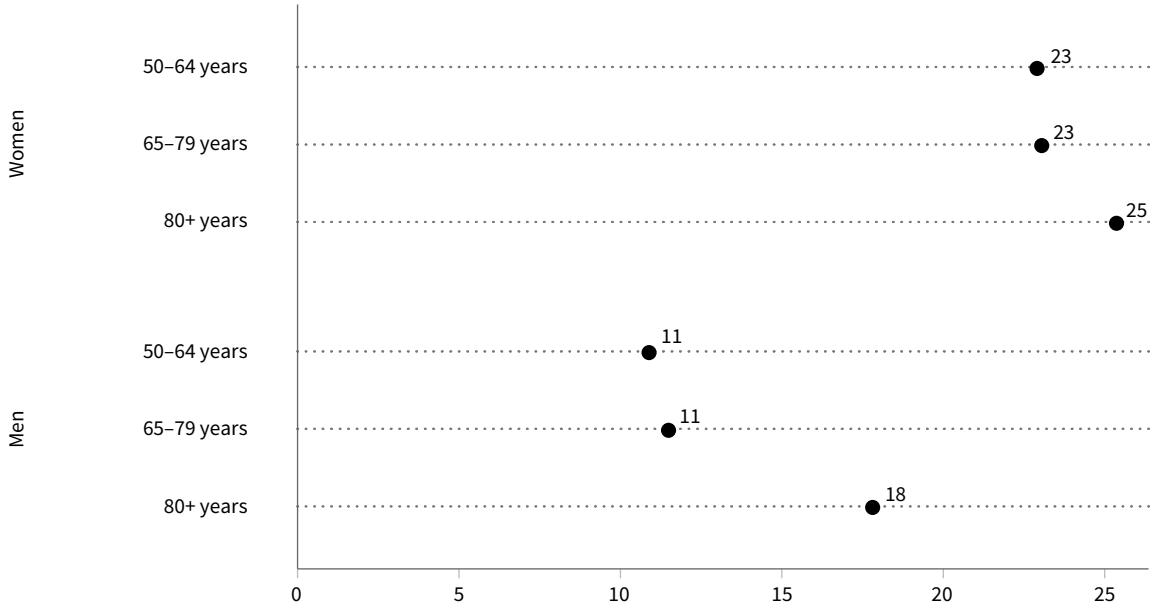
Even more older people reported a deterioration in their mental well-being than in their general health. In the summer of 2020, 18% of people aged 50+ reported feeling sad and depressed more often than before the pandemic. Again, the oldest old (those aged 80+) were particularly likely to report such an increase, albeit the difference was less pronounced than in the case of general health (Figure 2). Women appear to have suffered more than men. The proportions of people aged 50+ feeling depressed more often than before the pandemic were highest in Portugal (29%), Italy (25%), Spain (24%) and Malta (23%), and lowest in Denmark (8%), Slovenia and Latvia (both 9%) and Czechia (10%).

Figure 1: Changes to health since the start of the pandemic, by age group and gender, summer 2020, EU (%)



Note: *Austria and Ireland are not included. It should be noted that in all figures, numbers have been rounded to the nearest whole number.*
Source: *SHARE COVID-19 (June–August 2020)*

Figure 2: Feeling sad or depressed more often than before the pandemic, by age group and gender, summer 2020, EU (%)



Note: *Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

People's living situation had an impact on the results: 21% of those aged 50+ living alone reported feeling sad or depressed more often than before the pandemic, compared with 16% of people living with a spouse or partner. These differences become smaller but persist when age, gender and country effects are taken into account. There was no significant difference between nursing home residents and others in reports of feeling sad or depressed more often than before the pandemic, but mental well-being issues may already be more common among this group.

In summer 2020, about 30% of people aged 50+ in the EU reported experiencing a mental health problem: depressed mood, anxiety symptoms or sleep problems (Santini and Koyanagi, 2021). Of those experiencing these problems, 64% reported a worsening of a depressed mood, 73% experienced a worsening of anxiety symptoms and 35% experienced a worsening of sleep problems since the start of the pandemic.

National surveys provide additional insights into the types of problems experienced and the groups of older people most affected. Among people aged 70+ in Sweden, 50% reported feeling bad, 39% feeling depressed, 23% having difficulties concentrating and 23.5% having trouble sleeping because of the pandemic (SE8[2]). Evidence from Finland suggests that 20% of people aged 80+ had more problems sleeping because of the pandemic, more than in the other age groups (10% among people aged 20–69) (FI7). Retirees in Slovenia cited sleep problems, fatigue, lack of energy and lack of interest/joy as the most common symptoms of depression (SI2). In a Cypriot survey, one in five respondents aged 50+ indicated that they had slept less since the pandemic began (CY1). In Barcelona, among those aged 65+, 76% experienced a negative impact on cognitive functions; rates were higher for women, those aged 80+ and those with a low level of education (ES7). Most often affected were cognitive functions of orientation (48%), executive functions (42%), processing speed (42%) and attention (41%). In Latvia, compared with before the pandemic, 27% of people aged 50+ were more likely to feel nervous or anxious, 15% were more likely to feel sad or depressed, and 12% were more likely to have sleeping problems, with higher rates among women, people aged 75+ and residents of large cities (LV1). In Ireland, among people aged 60+, 21% reported potentially clinically significant levels of depressive symptoms, double the proportion before the pandemic (IE1). In Poland, 14% of those aged 60+ reported needing psychological support because of the pandemic (PL3).

2 Codes in the text refer to the national surveys consulted. Further details of these national surveys are provided in Annex 1.

The risk of depression has risen dramatically for all age groups compared with before the pandemic (Figure 3). However, mental health problems have increased most for younger people (see also Helliwell et al, 2021). National surveys among adults of all ages that explicitly ask respondents about the impact of the pandemic have confirmed this. For instance, a survey in Luxembourg found that 22% of people aged 65+ reported a decline in their mental health, with higher rates among people aged 18–44 (37%) and 45–64 (33%) (LU2).

By summer 2020, there had been some easing of the initial lockdowns implemented in the spring. This easing may have contributed to the decrease seen in the risk of depression. The prolonged duration of the pandemic situation and further waves of infections coincided with pronounced rises in the risk of depression by spring 2021 (Figure 3).

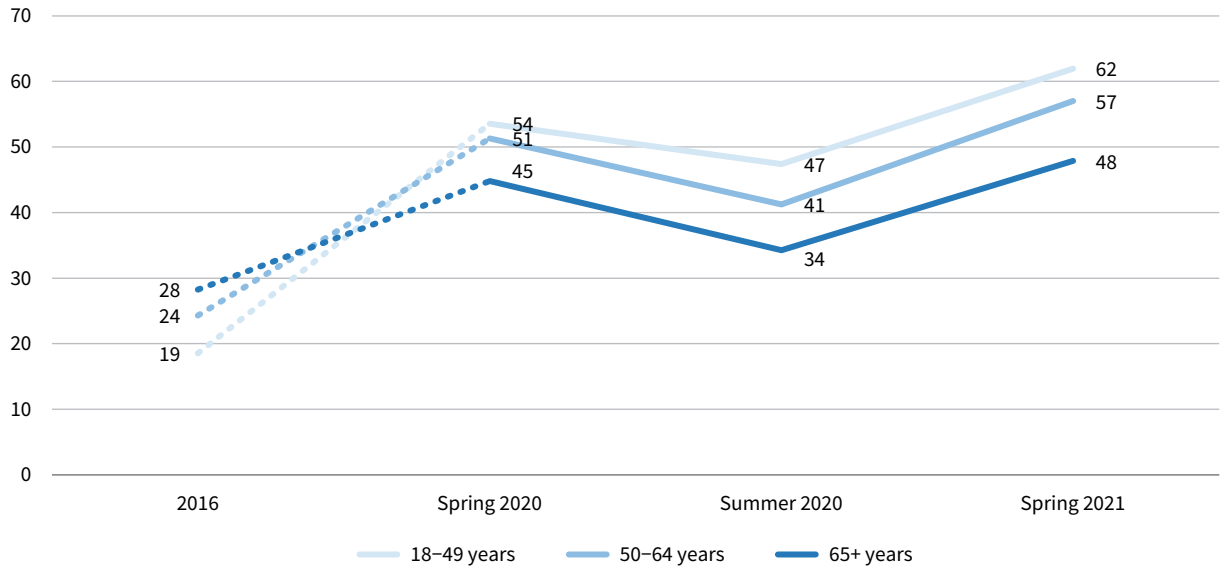
In 2016, people aged 65+ were most at risk of depression (and those aged 18–49 were least at risk), whereas this age pattern was reversed during the pandemic (Figure 3). Some national evidence, using different mental health scales, supports this observation. Research in Austria found that, during the lockdown of spring 2020, on average people aged 18–34 had the worst mental health and people aged 65+ the best mental health, reversing the pre-pandemic situation (Pieh et al, 2020). Older people (along with men), however, seem less likely to report depressive symptoms (Balsamo et al, 2018). Older people with mental health problems may also be underrepresented in the *Living, working and COVID-19* e-survey.

Patterns of antidepressant use also shed light on mental health issues, although variations in drug prescriptions and usage between countries and population groups should be acknowledged. In Portugal, 34% of people aged 65+ reported using anti-anxiety/antidepressant drugs during the pandemic, compared with 23% of people aged 46–65, 14% of those aged 26–45, and 9% of those aged 16–25. Those aged 16–25 most often reported having started taking these medicines, while older people mostly increased their dosage (PT7). In France, antidepressant and anti-anxiety drug use peaked right after the lockdown measures were introduced, in March 2020, including among older people. However, among people aged 75+, use of these drugs fell less dramatically in early April 2020 than in other age groups (Weil et al, 2020). While not referring only to antidepressants, in Romania, 31% of people aged 65+ and 22% of those aged 51–65 mentioned taking more medication during the pandemic than before it (RO1).

Triggers

Along with loneliness (see Chapter 2), bereavement during the pandemic has been a key trigger of depression (Santini and Koyanagi, 2021; Wang et al, 2021). Experiencing the death of someone close has been more common among older people. Dealing with personal loss has been even more difficult because of restrictions on hospital visits, care home visits and funerals. Social interaction, which is particularly important for many people during the grieving process, has also been restricted. As an indication of the scale of the impact of the pandemic on bereavement, during the

Figure 3: Risk of depression, by age group, EU (%)



Notes: *Based on the five items in the World Health Organization well-being index (WHO-5). People with a WHO-5 score of 50 or lower are considered at risk of depression. The dotted lines indicate that 2016 and 2020/2021 data are not perfectly comparable, as they are from different surveys.*
Sources: *EQLS 2016 (EU27) and* Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

first 12 months of the pandemic, 37% of people aged 50+ had experienced the death (from any cause) of a close friend or relative (34% of all adults) and 12% had experienced a COVID-19-related death among people close to them (10% of all adults) (authors' calculations using data from the *Living, working and COVID-19* e-survey).

National survey data provide more insights into the causes of the worsening of mental well-being. A Portuguese survey found that restrictive measures (social distancing) introduced during the pandemic caused many people to feel agitated, anxious or sad, with the highest rate among those aged 46–65 (90%), and rates of 77% among those aged 16–25, 88% among those aged 26–45 and 74% among those aged 65+ (PT7). In Bulgaria, 43% of people aged 60–69 and 30% of those aged 70+ reported a negative impact of staying at home on their general physical and mental well-being (compared with 50% of people aged 18–29) (BG3). In Sweden, half of those aged 70+ who stayed at home all the time reported a deterioration in their mental health (SE8). In Lithuania, most people aged 50+ and living in one-person households indicated that their lives had changed during the pandemic: half reported slight changes and a quarter said that their lives had changed significantly. About half indicated that the pandemic had had a negative impact on their mood (51%) and/or physical health (46%) (LT1).

Fears and worries

Older people generally seemed to express fears and worries about the pandemic more often than younger age groups. A Danish survey found that 54% and 40% of people aged 60+ and 50–59, respectively, perceived COVID-19 as the biggest threat to Denmark in their lifetime, compared with 28% of people below 40 (DK5). In an Italian survey in December 2020, over 40% of people aged 65+ reported being very worried about COVID-19, while 28% overall made the same statement (IT2).

This may be explained in part by the fact that older people are at higher risk of suffering severe consequences of the virus. For instance, a Swedish survey found that people aged 60+ were more worried than average about contracting COVID-19 (SE2). In Italy, in late summer/early autumn 2020, 61% of those with chronic diseases and 74% of older people feared that they would suffer severe or very severe health consequences in the event of COVID-19 infection (IT1). Another explanation may be that older people with care needs are unable to self-isolate, as they rely on support for activities of daily living. According to a Spanish survey, 21% of people older than 50 years reported not having the appropriate quarantine resources to properly isolate themselves, probably due mainly to the presence of other adults or children in the home. In particular, being female, 70 years or older and unable to self-isolate seemed to elevate the chance of testing positive (ES6; Oliver et al, 2020). In Czechia, people aged 60+ (74%) and 45–59 (57%) were most often concerned about their own health, and 15- to 19-year-olds were least concerned (43%) (CZ1).

Fears may also stem from concerns related to losing freedoms and access to health services, being separated from family members or infecting loved ones, or from more general concerns about an insecure future (SI2). In Croatia, at the time of lockdown, older people (aged 65+) were most concerned about their own health and the health of their loved ones, and 67% said that they felt worse than usual (HR1). In the Netherlands, at the beginning of the crisis, fears were mostly related to being infected with COVID-19, passing away and loved ones being unable to be present during their last moments or attend their funeral. In May 2020, when asked to rank their worries about the crisis on a scale of 1–10, 64% of older people scored their level of concern as 6 or higher, and 8% scored it as 10 (extremely concerned) (Stolte et al, 2020; NL2). Information on the specific impacts of the pandemic on older migrants, even for countries with sizeable groups of migrants, is rare. However, a study of older Moroccan migrants in the Netherlands found that many were concerned for the people around them and their relatives in their home country, as they were unable to support them (Harroui et al, 2020).

There are indications that health was not always the main source of worry. A Swedish survey found that 45% of people aged 65–71 worried about health, and 69.5% about societal consequences (SE9). Among care home residents, 51% reported suffering from moderate worry and anxiety in spring 2020, a rise from already high levels (48%) in the previous year. The share with severe worries or anxiety remained at 12% (SE5). In Croatia, 82% of retirees worried about the pandemic having a bad effect on their quality of life (HR2). Psychogeriatric patients tend to be affected by emotional consequences resulting from changed living conditions due to the pandemic rather than from COVID-19-related concerns (Miklitz et al, 2021).

Concerns have fluctuated during the pandemic. In Czechia, fears about the pandemic were more common among people aged 55+ than among other age groups, and lowest among people aged 18–34. This pattern held when infections peaked in spring and autumn 2020 and during the dip in summer 2020. During the peaks, over half of people aged 55+ were very worried, whereas in summer 2020 this share dropped to around one-quarter (CZ4). Concerns can also differ by gender, education and living situation, for instance. In Ireland, high levels of concern about the pandemic were most common for people aged 70+ living alone (54%), women (52%), those educated to primary level (56%) and those living in rural areas (51%). Concerns were less common among those educated to tertiary level (40%) (IE1).

Stress

Stress levels often increased compared to prior to the pandemic and were highest among younger people. A Hungarian survey examined stress using a stress level index. Stress levels increased from a pre-pandemic level of 26.4 to 32.4 (on a scale of 0–56) during the pandemic. Among older people, women aged 60–69 had particularly high scores (31.0), although younger men (aged 30–39) had the highest scores (32.9) (HU2). In Slovenia, older people experienced greater mental distress during the second wave of the pandemic (in autumn 2020) than during the first wave, which lasted from March to May 2020 (SI2). However, it seems to be more common for stress to have decreased or to have not increased further over the course of the pandemic. In Denmark, stress declined from October 2020, with people aged 56+ being 15–25 percentage points less likely to be stressed than younger age groups (DK5). In a Lithuanian survey, the proportion of people aged 50–74 experiencing stress declined from 29% in April 2020 to 26% in June 2020, well below the proportions for people aged 18–29 and 30–49 (53% and 46%, respectively, in June 2020) (LT2). In Estonia, in October 2020, 47% of people aged 75+ felt stressed compared with 71% of people aged 50–74, with even higher rates among younger age groups. High levels of stress were particularly rare among older people (1–2% of 65- to 75-year-olds and 4% of 50- to 64-year-olds, compared with 11–17% of younger age groups). The overall age pattern was the same in December 2020 and February 2021 (EE1).

Healthy living

Smoking, alcohol consumption and unhealthy eating

The pandemic has resulted in an increase in smoking, alcohol consumption and unhealthy eating by some people, with associated health risks. However, for others, the pandemic has had the opposite effect, often motivated by the desire to have a healthier lifestyle to become less vulnerable to the adverse impacts of COVID-19 (LV1). These impacts of the pandemic have generally been more positive for the oldest age groups.

With regard to smoking, Irish survey data found that the proportion of people reporting increased tobacco consumption was highest among those aged 45–54 (37%) and by far the lowest among those aged 70+ (less than 10%) (IE4).

In terms of alcohol consumption, Austrian survey data found that the proportion of those consuming more alcohol since the onset of the pandemic was similar to the proportion of those consuming less alcohol; decreased alcohol consumption was more common among older age groups (AT1). In Ireland, younger age groups were more likely to report changes (decreases and increases) in alcohol consumption than older people. Younger people more often increased than decreased their alcohol intake. For people aged 55–69 and 70+ the reverse was true: 15% and 15.5%, respectively, reported a decrease, and 13% and 7%, respectively, reported an increase (IE4). Latvian survey data suggested that the pandemic situation did not have a net effect on alcohol consumption among people aged 50+ (LV1).

With regard to healthy eating, there are some signs that people have switched to healthier eating habits during the pandemic. In Italy, 19% of the population reported consuming at least four portions of fruit and vegetables a day in 2020, a slight increase from the previous year after declines in the four years before that, with higher rates among people aged 60+ (24%) (Istat, 2021a). Similarly, respondents to a Finnish survey, including those aged 50–69, reported increased consumption of berries and other fruit (FI5). In Ireland, while an overall increase in the consumption of sweets and junk food was reported, this was less common among older people, in particular those aged 70+ (29.5%, compared with 69% among all age groups); 8% reported a decrease in the consumption of sweets and junk food (the decrease was equal among all age groups) (IE4).

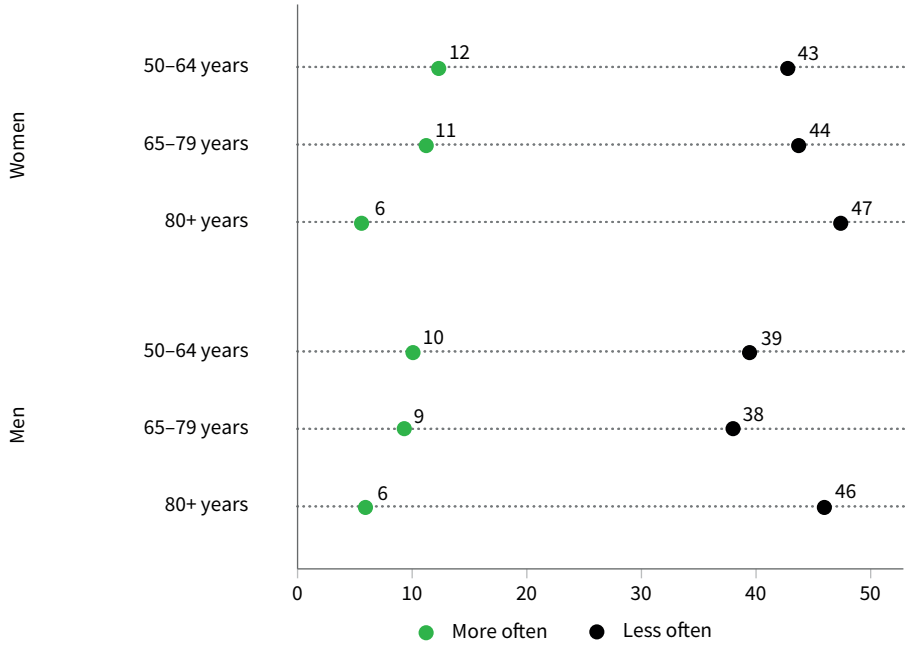
Physical activity

The pandemic had a more clear-cut negative impact on physical activity, and more so for older than for younger people.

In summer 2020, over two-fifths (41%) of people aged 50+ in the EU reported going out for walks less often than before the pandemic (Figure 4). The decrease in physical exercise was concentrated among the oldest age groups: 46% of people aged 80+ reported a decrease, compared with 40% of those aged 65–79 and 41% of those aged 50–64. The oldest age group was also least likely to report going out for walks more often. Especially for people aged 50–79, reductions were more common among women. One in three (35%) care home residents reported going out for walks less often than before the pandemic, compared with 44% of other people, which may reflect that fewer care home residents already went out for walks before the pandemic.

In six Member States, more people reported increases in walking than decreases (Belgium, Denmark, Finland, Luxembourg, the Netherlands and Sweden). The proportion reporting reductions ranged from 9% in Denmark and Sweden (22% and 16%, respectively, reported increases) to 82% in Spain and 76% in Italy and Romania (1%, 2% and 1%, respectively, reported increases). By summer 2020, the last three countries had particularly stringent lockdown measures (with population-wide home quarantine in Italy and Spain), whereas Denmark and Sweden had imposed some of the least stringent lockdown measures (University of Oxford, 2021).

Figure 4: Going out for walks more or less often than before the pandemic, by age group (50+), summer 2020, EU (%)



Note: *Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

Physical activity takes many forms, and not going out for walks may be compensated for by other activities. National evidence, however, suggests that people reduced their overall physical activity, including in countries where reductions in walking were rarer. A Danish survey found that, by April 2020, 25% of people aged 60+ had decreased their physical activity compared with the pre-pandemic period (the decrease was higher only among teenagers, at 36%) (DK3). In Portugal, decreases in physical activity were highest among those aged 50–59 (71%) and 60+ (70%) and lowest among people aged 18–29 (57%) (PT4). A Finnish survey showed that reduced physical activity was concentrated in groups with lower levels of education and of a younger age (FI5). In Ireland, people aged 70+ most often reported a decrease in exercise frequency (28%) and least often an increase in exercise frequency (19%) (IE4). Among people aged 60+, 17% exercised at home more often than they had previously (IE1). An Austrian survey found that around half of those aged 60+ had reduced their level of exercise since the onset of the pandemic, while one-third were exercising more often, and in some cases there had been a shift from outdoor to indoor exercise (AT5).

In some cases, people have turned to physical activity as a coping strategy. In a French survey, 11% of people aged 65+ reported engaging in healthy behaviours (e.g. indoor physical exercise) as a coping strategy. Other strategies included engaging in leisure activities (reading, watching television, playing games, gardening, doing crafts) (67%), simply maintaining daily activities or routines (24%), and seeking social support (6%) (FR2). In Austria, 74% of people aged 60+ saw outdoor exercise and 85% saw physical activities inside the home or garden as an important coping strategy (AT5).

Regular physical activity can be particularly effective if it is part of frequent routines such as going to work, taking people to school or day care, or shopping for groceries (Eurofound, 2019). It is thus of concern that for many people these routines were interrupted during the pandemic. Among people aged 50+ in Latvia, 60% were less likely to go shopping than before the pandemic (LV1). In a German survey, among people aged 75+, many indicated that they avoided public places (62%) or left their homes only when needed, for example to buy food (51%) (DE1). In Ireland, 69% of those aged 50+ reported leaving the house less often because of the pandemic, and 53% reported doing grocery shopping less often (Irish Longitudinal Study on Ageing, 2021; IE2).

Measures and initiatives

This section discusses support phone lines for older people with mental health problems during the pandemic and measures to stimulate healthy lifestyles. Access to (mental) healthcare services is discussed in Chapter 6. Suicide prevention lines, which often existed before the crisis and do not specifically focus on older people, are not included. Many prompt response measures involved phone lines that people could contact to combat loneliness (see Chapter 2) or access immediate practical support, such as home delivery of medicines and groceries (see Chapter 5). In addition to

their primary goals, these support services have provided a listening ear, possibly benefiting the mental health of the beneficiaries. However, here the focus is on phone lines providing psychological support.

Mental well-being phone lines

Existing initiatives that integrated mental health support into their services in response to the pandemic: One example is the 'telephone accompaniment platform' in Spain, which went online and added a psychological advice service.

Initiatives established in response to the pandemic: In Bulgaria, in April 2020, specialised psychological support was made available to older people through the Ministry of Labour and Social Policy's call centre. Dobre słowa ('Good words') in Poland already used external psychologists when it took off in March 2020, but later employed its own psychologists. In July 2020, Lithuania approved the development of an emotional support line included in the long-term action plan for managing the negative consequences of the COVID-19 pandemic on mental health.

Initiatives that increased their capacity in response to the crisis: One example of such an initiative is the private non-profit support line in Sweden, MIND, which addresses mental health issues and loneliness and which received additional private donations during the pandemic.

In some initiatives, people who answer calls may not be mental health professionals, but their training includes aspects of mental health, or they explicitly seek to assess mental health needs. An example of the first is Warm Hands in Lithuania, with psychologists among those providing training for volunteers. Training in 2020 included topics such as bereavement and suicide prevention. Municipalities in Finland called people aged 70+ to assess their social and mental health situation, among other things (see 'Long-term care' on p. 50).

Furthermore, psychological services were sometimes added to long-term care packages. For example, in Bulgaria's health and social services care programme, 'patronage care' was expanded during the pandemic into 'patronage care +', which entitled people aged 65+ with care needs, people with disabilities and people who were quarantining to up to two hours' care a day. In Austria, psychosocial telecounselling was added to home care and day care packages.

Healthy living

Advice through helplines

In Czechia, the Linka senior helpline received calls from people who thought that they should stay at home. Those answering the calls clarified that it was important to leave the house for walks for health reasons.

Guidelines with tips

An online guide in Croatia advised people how to protect their physical and mental health. To reach older people, 20,000 hard copies were disseminated in care homes, pensioners' clubs, health centres, general practices, pharmacies and retail stores. Furthermore, information about the guide was provided on national television and local radio. In Slovenia, in April 2020, the National Institute of Public Health issued guidelines for older people on how to deal with anxiety. It provided phone numbers that people in need could call, and tips to reduce anxiety, such as the following.

- 'Do not stop your daily routine, maintain a positive attitude and look for opportunities; dedicate part of your day at home to your favourite routine or ritual.'
- 'Let's not indulge in cigarettes, alcohol and other drugs to relax. Engage in activities that make you feel good and happy.'
- 'Stay in touch with loved ones, by phone or otherwise, and nurture a sense of interconnectedness that can increase the feeling of security.'

Online/video exercises

In Poland, in March 2020, the Polish Chamber of Physiotherapists and the Ministry of Health launched a series of videos demonstrating short exercises for older people that could be performed at home without professional equipment. The videos were available online or through public television. There was also a paper version with instructions on how to perform the exercises. In Slovenia, social enterprise Simbioza and a private company developed the Magda mobile application (app) to provide exercise videos tailored to older people.

Outdoor exercises and sport

In Finland, social housing associations (for example, in Kauniainen municipality) arranged for physical instructors to provide short outdoor exercises designed for older people, who could participate from their balconies or on their patios. Instructors put notices up in the housing areas or in residents' mailboxes. While many people had participated in such training in centres before the pandemic, the outreach activities probably induced others to join. In Latvia, during the state of emergency in early 2021, the local government of Sigulda region provided pensioners with below-average incomes (around €1,118 gross monthly) with up to €80 worth of downhill and cross-country skiing at their local sports centres (for example, in one of the three participating ski centres, this covered 10 hours of skiing).

Creating an environment that facilitates healthy living

Some measures focused on the home. In Tartu, Estonia, at the start of the pandemic, well-being helpers were available to help older people with tasks that needed to be done and/or to help them improve their living spaces to avoid falls or reduce discomfort (for example, by installing handrails). They are considered to have been particularly useful when family members were unable to visit.

Other measures focused on the local area. The crisis increased people's reliance on cars and taxis instead of public transport, further decreasing physical activity. However, several cities widened footpaths and improved their cycling infrastructure in response to the pandemic. This helped reduce the risk of transmission of the virus (for example, by facilitating cycling for those who would otherwise use public transport) and stimulated physical activity.

2 Social interaction

Social contacts

Older people experienced a reduction in their social contacts during the pandemic, with negative impacts on mental health and well-being (Helliwell et al, 2021; Litwin and Levinsky, 2021; SHARE-ERIC, 2021). Over four in five people aged 50+ (85%) visited family members less often (Figure 5). Nine in ten people aged 50+ (90%) met groups of more than five people less often, with rates increasing with age.

People aged 80+ in particular said that they had not left the house since the pandemic began, but also many people aged 50–79 had not left the house. For people aged 50+, the proportions were highest in Malta (44%), Croatia and Cyprus (both 34%) and Italy (33%), and lowest in Denmark (2%) and Sweden (3%). In these early months of the pandemic, Denmark and Sweden were among the Member States with the least stringent lockdown measures (University of Oxford, 2021).

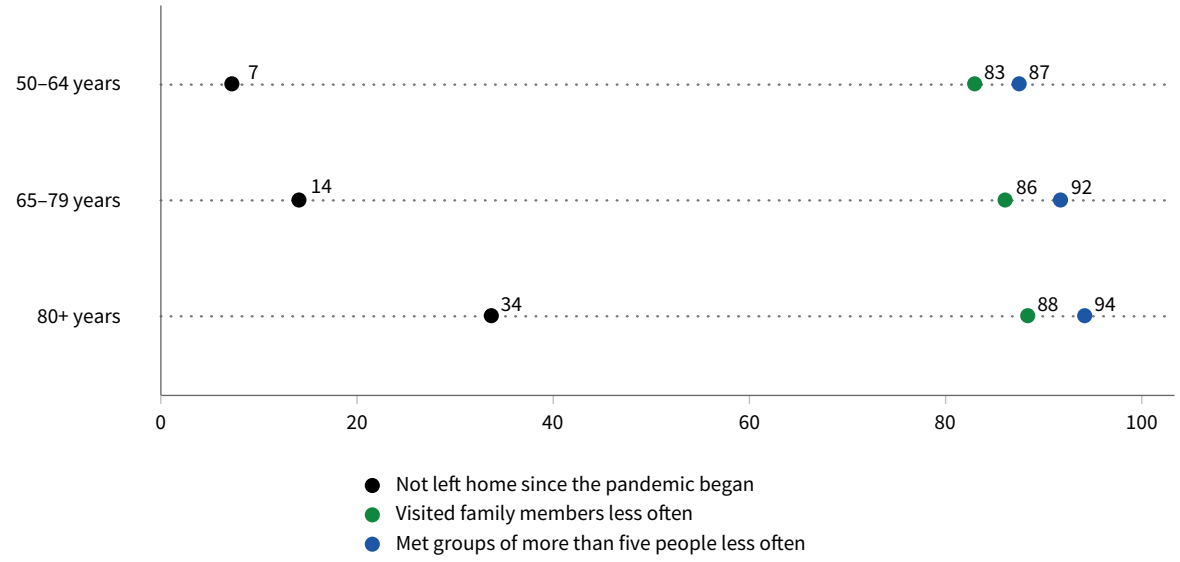
The proportion of people aged 50+ reporting frequent contacts with non-relatives decreased with age (Figure 6).

For people aged 80+, frequent in-person contact with their own children was particularly common.

For all age groups, and all types of frequent contacts, remote contact was more common than in-person contact. However, the difference was largest for contacts with relatives who were not parents or children. Face-to-face contact may have been particularly likely to be substituted with remote contacts for them.

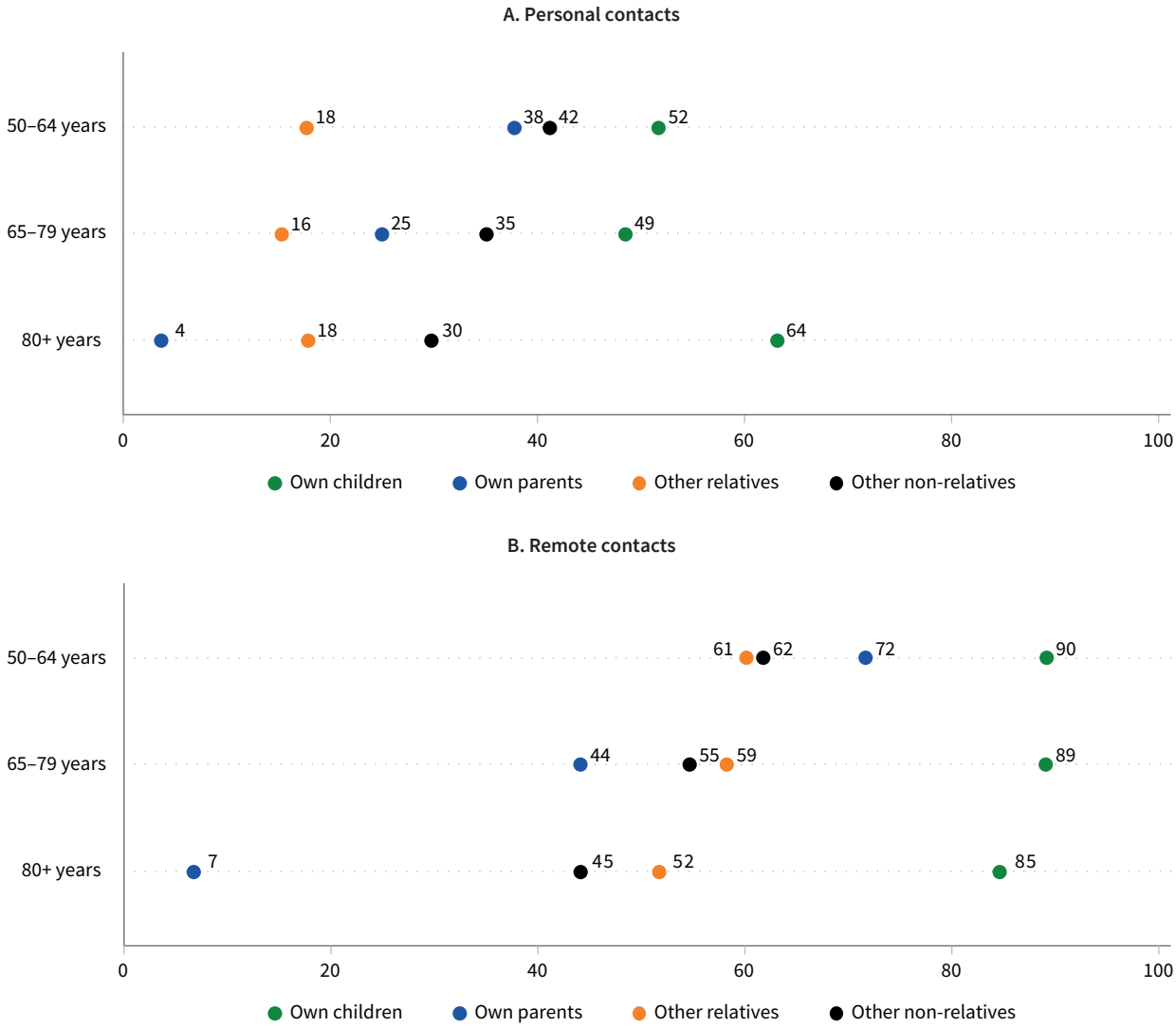
National surveys shed more light on the pandemic's impact on social life overall. For instance, in Belgium, the impact was considerable for all age groups but decreased with age. In total, 74% of people aged 55–64 and 70% of those aged 65+ experienced a negative impact on their social life (compared with 82% of 18- to 24-year-olds) (BE1).

Figure 5: Social contacts, by age group, summer 2020, EU (%)



Note: *Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

Figure 6: In-person and remote contacts at least weekly, by age group, summer 2020, EU (%)



Notes: *'Other non-relatives' include, for example, neighbours, friends or colleagues. Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

These developments did not leave people indifferent. In Denmark, for example, 60% of people aged 65+ worried about being unable to see their families and friends (50% for all ages) (DK2). In Lithuania, people aged 50+, in particular, missed being able to communicate directly with friends and relatives (scoring 7.6 on a scale from 1 to 10, where 1 means 'I don't miss it at all' and 10 means 'I miss it very much'). Attending mass and sports, cultural and other leisure events (6.2) and communicating with other people in public places (6.1) were also missed (LT1). In Luxembourg, 25% of both those aged 55–64 and those aged 65+ had become more aware of the importance of social contact and would give it more importance in the future (below the average of 32%) (LU3). In Lithuania, those aged 50+ tried to relax by watching television, listening to the radio or reading books, but preferred having face-to-face communication (LT1). In Romania, 53% of people aged 65+ watched more television, 53% prayed more, 27% read more books (the highest proportion of all age groups) and 17% spent more time on the internet (the lowest of all age groups). However, 49% of people aged 65+ felt the need to talk to someone dear to them more than usual (RO1).

Much of the national survey evidence points to the importance of the quality and type of social engagement, rather than just the quantity of it. In a Spanish survey conducted among people aged 65+ in Madrid, among the 74% not living alone (mainly living with their spouse), 95% reported that the experience of living with someone else had been equally good or better than before the lockdown (ES3). In evidence from the Netherlands, more people saw their relationship with their family improve (11%) than get worse (5%). The youngest (below 35 years) and oldest (aged 75+) groups most often indicated that their bond with their family had been strengthened (NL4).

In some instances, older people had more visits at home from people outside their household than younger people. For example, in a Spanish survey, 22% of older adults (70+) reported regularly having a person visiting their home, compared with 14% of younger adults. Some of these visitors may have been cleaners, nurses and carers, but they may also have been relatives (ES6). National evidence further highlights specific problems that arose, such as older people being unable to visit in person their (grand)children living abroad (for example, in Slovakia – Kuruc et al, 2020).

Visitor restrictions meant that many living in care homes were isolated, but living in residential care also provided vital social interaction (DK4). In a Slovenian survey, 57% of care home residents felt worse during the pandemic than before, mainly because of reductions in socialising and contacts with relatives (SI3). In Germany, care home staff reported that social isolation was the most significant issue of concern for residents; they used terms such as 'sadness', 'suffering' and 'desperation' and reported cases of clinical depression resulting from social isolation. Family visits were partly substituted with phone conversations, 'window visits' and gifts. Sometimes there was increased contact among residents but also more conflict among them. Some respondents reported mixed effects of visitor bans on residents suffering from dementia: some benefited from there being less activity around them, while others suffered from confusion and decreased emotional resilience (Sporket, 2020). Many older people living in care homes faced difficulties in e-communication because of low levels of technological skills, limited access to equipment and lack of staff to provide support for e-communication (SK1).

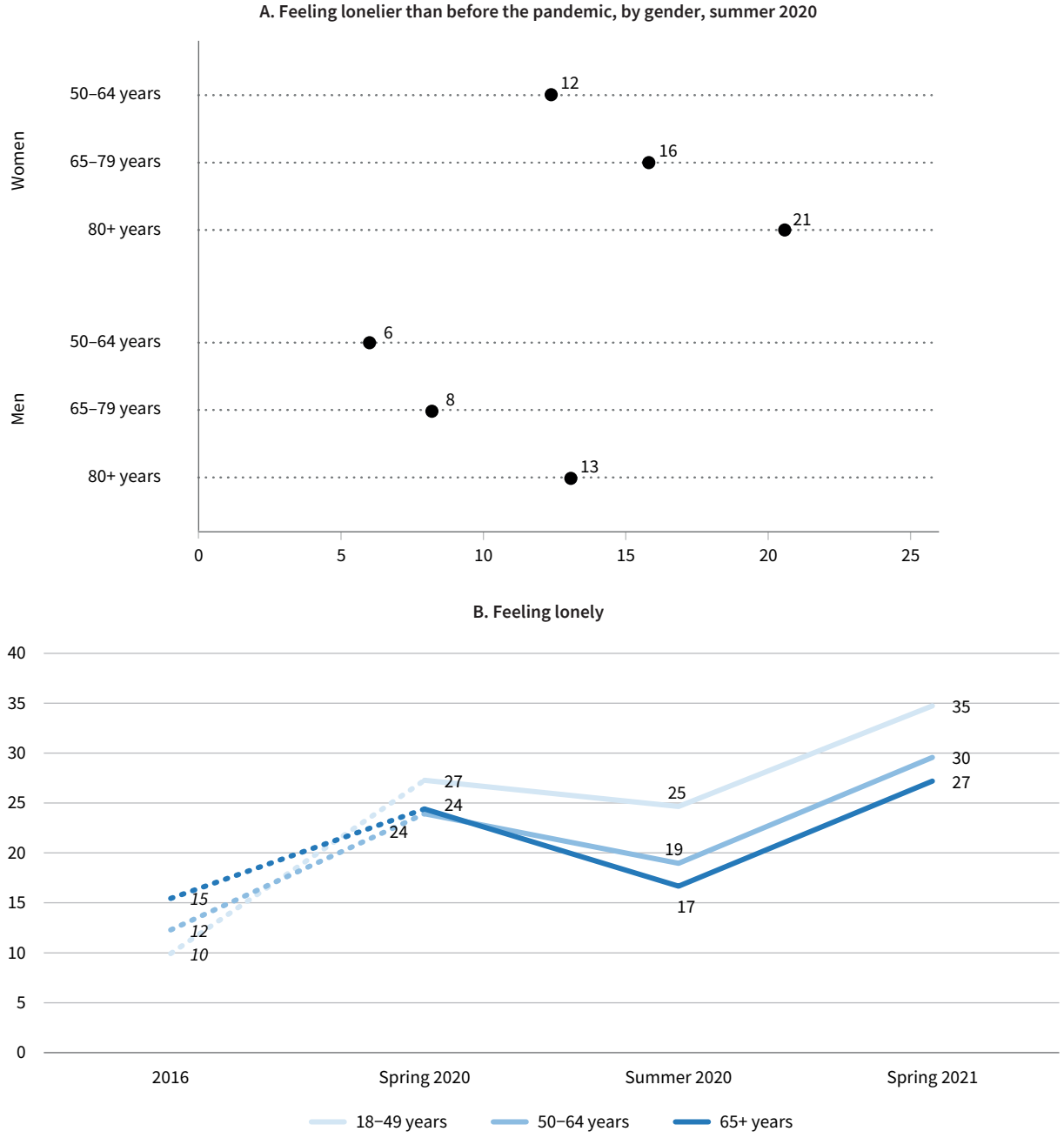
Loneliness

Among people aged 50+, an increase in loneliness was reported by 9% of people living with others, compared with 20% of those living alone. Increases were more common among women and among older age groups, in particular people aged 80+, 18% of whom reported an increase in loneliness (Figure 7A). Fewer than 1% in each age group felt less lonely. For some groups of older people, increases in loneliness may not have been large, but loneliness was already very common before the pandemic. For instance, in Sweden, in spring 2020 (when there were few restrictions), 50% of care home residents reported suffering from loneliness (at least occasionally), up from 47% in 2019.

Loneliness is a key driver of mental well-being problems (Santini and Koyanagi, 2021). Like depression, feelings of loneliness increased dramatically for all age groups compared with pre-pandemic times. However, while in 2016 older cohorts were more likely to feel lonely, during the pandemic the picture reversed (Figure 7B). The increase in loneliness among those aged 65+ may be somewhat underestimated, as people aged 70+ are underrepresented in the *Living, working and COVID-19* e-survey, while increases have been particularly common among these oldest old (Figure 7A). From spring 2020 to spring 2021, loneliness increased in all age groups, after a slight decrease from spring to summer 2020. The increase was largest among women aged 18–49 (+10 percentage points, compared with +5 percentage points among men aged 18–49 and women aged 50+, and +3 percentage points among men aged 50+). Across the three waves of the *Living, working and COVID-19* e-survey, 16% of people aged 50+ who lived with a spouse or partner felt lonely more than half of the time, whereas 39% of people without a spouse or partner in the household did.

There are different types of loneliness. Emotional loneliness is a result of the lack of a close emotional attachment, while social loneliness is a result of the lack of an engaging social network or not belonging to a group. In the Netherlands, social loneliness increased and remained more common than emotional loneliness among people aged 65+ (30% in October 2019, 37% in April 2020). However, emotional loneliness increased more markedly, from 15% in October 2019 to 30% in May 2020. Slight declines in emotional and social loneliness by June 2020 (to 28% and 35%, respectively) coincided with increased engagement with a broader social network, including friends, acquaintances, neighbours, home carers and domestic helpers. Activities in and around the home increased (more so than with family members), facilitated in part by technology and an increase in volunteer projects (Steinmetz et al, 2020; NL2).

Figure 7: Loneliness, by age group, EU (%)



Notes: *(A) Austria and Ireland are not included. (B) Those reporting feeling lonely all, most or more than half of the time. The dotted lines indicate that 2016 and 2020/2021 data are not perfectly comparable, as they are from different surveys.*
Sources: *(A) SHARE COVID-19 (June–August 2020); (B) EQLS 2016 (EU27) and* Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

Social tension

Older people sometimes experienced age-related tensions. For instance, a Croatian survey showed that 10% of pensioners had experienced complaints or disapproval from strangers in shops, pharmacies or parks because they had gone out during the recommended lockdown periods for seniors (HR2). In Hungary, 44% of older people experienced conflict with a young person (HU3). In Lithuania, in spring 2020, 34% of people aged 50+ living alone had experienced discrimination based on age (ageism). One-fifth (22%) had personally experienced discriminatory practices during the pandemic and lockdowns: not receiving help, feeling like a second-class citizen compared with younger people or being conversed with in a raised voice (LT1).

Sometimes age-related tensions involved interactions with family members. In Slovakia, about 15% of people complained of 'being lectured' when, for example, the new pandemic measures or changes in measures were explained (SK1). Although people had the best of

intentions to protect senior family members, this led to paternalism and sometimes ageism (Voľanská et al, 2020). In Croatia, 30% of pensioners experienced complaints and disapproval from their own family members (HR2).

Measures and initiatives

Addressing loneliness

Some initiatives addressing loneliness among older people already existed before the pandemic. However, there was increased demand for their services, or they were adapted to the pandemic situation, for instance by changing face-to-face meetings to remote contacts. For example, in Sweden, the non-governmental organisation (NGO) Äldrekontakt had previously organised in-person meet-ups in 34 municipalities to enable lonely people aged 75+ to socialise; these were converted into telephone meet-ups. In Lithuania, the Silver Line was set up in 2016 and focused principally on addressing loneliness among older people by connecting them with volunteers for chats. During the pandemic, it received more requests for practical support from its callers (see Chapter 5). Before the crisis, the Netherlands allocated €26 million to municipal initiatives addressing loneliness (Een tegen eenzaamheid – 'United against loneliness'). Some initiatives were halted and received an extension of the subsidy period, while other initiatives adapted to the situation. Some countries have strong existing networks of senior clubs (for example, Austria (Vienna), Luxembourg, Spain and Sweden), which sought to maintain contact with members.

Other initiatives – mostly helplines – were quickly set up in response to the pandemic situation. For instance, in March 2020, Malta set up a 24/7 support line – called 'You are not alone' – which was financed by the Ministry for Social Justice and Solidarity and run by the Foundation for Social Welfare Services. Between March and September 2020, 7,861 people called the helpline number. While it was open to people of all ages, most callers were older people struggling with loneliness. In June 2020, the line was amalgamated with an existing support line. Koetjes en Kalfjes ('Cows and Calves') in the Netherlands connected students with older people for chats during the pandemic and envisages continuing activities in the future. Around 900 students registered.

During the pandemic, governments increased their funding for existing and new initiatives. For instance, in 2020, the Swedish government allocated SEK 67 million (€6.7 million)[3] to NGOs working on social isolation among older people and SEK 30 million (€3 million) to municipalities to address social isolation among older people; in 2021, SEK 15 million (€1.5 million) was allocated to senior citizen organisations to address social isolation among their members. In 2020, the Danish government allocated DKK 4 million (€538,000) to an NGO that supports older people (Ældre Sagen) to operate a phone line for older people (Ældretelefonen) to combat loneliness and provide counselling. The government allocated a further DKK 6 million (€806,000) to Ældre Sagen and an NGO working with people with Alzheimer's disease (Alzheimerforeningen) to provide counselling and information to fragile older people on how to deal with the pandemic situation.

Most of these initiatives relied on older people finding their way to the support lines. However, there are some examples of particularly active outreach approaches. For instance, in the Netherlands, Een tegen eenzaamheid also includes a national coalition against loneliness that promotes and maintains national-level awareness of loneliness. This is accomplished through partnerships with charities and businesses, such as a postal and parcel services provider pilot programme in which delivery people reported on cases of loneliness and a welfare organisation provided help. In Ireland, during the pandemic, a post delivery service offered people the opportunity to have a delivery person pick up post from their homes by registering on their website or posting a note on their door saying 'I have mail'. Delivery people were instructed to recommend that individuals call ALONE (a charity that supports older people), or to call ALONE on their behalf, in instances when they suspected well-being/loneliness issues.

Facilitating social contact among residential care users

Most of the measures discussed above were also accessible to care home residents. However, some measures facilitating social contact were specifically aimed at care home residents, usually in response to visiting restrictions. In 2020, the Danish government allocated DKK 100 million (€13.4 million) to municipalities to fund new ways of enabling social contact between visitors and residents in public and private care homes during the visiting restrictions, providing guidelines such as allowing residents to receive visitors in outside areas. A total of DKK 30 million (€4 million) was made available for activities to accommodate cohabiting relatives of people with dementia, as well as relatives of care home residents with dementia. The Estonian government requested that care providers ensure the availability of

3 All currency conversions were made on 1 November 2021.

video-calling equipment. In Ireland, An Post, the state-owned provider of postal services, waived stamp fees for letters sent to care home residents.

However, in practice it has often been difficult to reach people in care homes. For instance, the 'adopt a grandparent' initiative in Malta set up during the pandemic pairs older people with volunteers, enabling weekly contact by phone or video call. The initiative enrolled around 100 users and it is envisaged that it will continue after the pandemic. While initially also targeting care home residents, this proved difficult, mainly because of the support from carers needed for these calls, which was challenging amid the increased work demands and understaffing.

3 Paid and unpaid work

Employment

The long-standing trend of increased employment among older people in the EU continued during the pandemic while employment among young people decreased. While still well below that for younger people, the employment rate among 50- to 64-year-olds increased from 51.5% in 2005 to 66.7% in 2020. However, from 2019 to 2020, the rate increased by just 0.2 percentage points (from 66.5% to 66.7%); since 2004, a smaller year-on-year increase was observed only from 2008 to 2009 (+0.1 percentage points). The employment rate for people aged 25–49 decreased from 80.7% in 2019 to 79.8% in 2020, and for people aged 20–25 from 51.5% to 48.7% (EU Labour Force Survey (EU-LFS), lfsa_ergan).

This long-standing trend of increasing employment has been driven mainly by women – with age cohorts with more women in employment becoming older, rather than older women taking up employment (Eurofound, 2014a). However, employment rates among women are still well below those of men, and women more often work part-time. From 2019 to 2020, the overall employment rate increased for women aged 50–64 (by +0.4 percentage points, from 60.3% to 60.7%) while that for men aged 50–64 remained unchanged (at 73.0%).

Employment rates among older people also differ between Member States, with the lowest rates in Croatia (53.6% in 2020) and Greece (54.1%) (largely because of a lack of employment opportunities) and Luxembourg (58.4%, largely because of opportunities to retire at a younger age), and the highest rates in Sweden (81.3%), Germany (76.6%), Czechia (76.4%) and Estonia (76.3%).

While the employment rate of people aged 50–64 kept increasing, there was a slight decline in employment for people aged 65–74, from 9.6% in 2019 to 9.5% in 2020. In recent years, there has been a particularly large increase among people aged 65–69 in employment, most working beyond the pensionable age in their countries (Eurofound, 2012, 2016a). The proportion of people aged 65–69 in employment increased from 8.1% in 2005 to 13.1% in 2019. However, it showed a rare decrease in 2020, to 13.0% (EU-LFS, lfsa_ergan).

Job loss

2020 marked a change in the trend of decreasing unemployment rates among people aged 50–64 in the EU, which started from a peak of 8.3% in 2013. While younger age groups saw considerable increases in unemployment between 2019 and 2020 (from 6.5% to 6.9% among 25- to 49-year-olds), the unemployment rate remained stable at 5.1% among people aged 50–64 (EU-LFS, lfsa_urgan). This EU average masks increases in unemployment among older people during the COVID-19 crisis in 19 Member States. Increases were largest in Lithuania (2.5 percentage points), Estonia, Latvia and Malta (all 1.8 percentage points), Croatia (1.0 percentage points), Sweden (0.9 percentage points), Austria, Romania (both 0.8 percentage points) and Bulgaria (0.7 percentage points). The change in unemployment rates from 2019 to 2020 was more unfavourable for people aged 50–64 than for people aged 25–49 in only five Member States: Croatia, Greece, Italy, Lithuania and Malta. Regardless, in four of these countries (all except Malta), unemployment rates in 2020 among 25- to 49-year-olds remained higher than among 50- to 64-year-olds. Overall, unemployment rates among older people remained the highest in Greece and Spain (both 12.4%).

At the EU level, from 2019 to 2020, among people aged 50–64, unemployment decreased slightly for men (from 5.1% to 5.0%) and remained stable for women (at 5.2%). These slightly less favourable data for women may be because women are overrepresented in the sectors affected by job loss during the pandemic: travel and transport, tourism, arts and entertainment, and hospitality (European Commission, 2021b). Unemployment rates developed less favourably for older women than for older men in particular in Finland, where the female unemployment rate increased by 1.2 percentage points while that for men remained stable. Particularly unfavourable developments in the unemployment rate for women were also seen in Romania and Sweden, where it increased by 0.6 percentage points and 0.4 percentage points, respectively, more than for men, and Italy where unemployment decreased for both men and women, but by 0.4 percentage points more for men. In some countries, unemployment data suggest a more favourable situation for older women than for older men. This is particularly true for Latvia and Estonia, where unemployment increased by 0.9 percentage points and 0.6 percentage points, respectively, more for men than for women, and Greece where it decreased by 0.9 percentage points less for men than for women.

Such aggregate data hide the dynamics, with many people exiting and entering unemployment. Overall, 10% of EU adults who were working before the pandemic reported being unemployed in spring 2021 (Eurofound, 2021a). Job losses were most common (14%) among people aged 18–34, whereas fewer than one in ten workers became unemployed in the other age groups (8% of 35- to 49-year-olds, 9% of 50- to 64-year-olds, and 8% of those aged 65+ years). There were no notable gender differences: the figure was 9% for both men and women aged 50+ (and 9% for men and 10% for women aged below 50).

In contrast, the likelihood of having transitioned from unemployment prior to the pandemic to employment by spring 2021 showed a clear negative trend with age: 32% for 18- to 34-year-olds, 25% for 35- to 49-year-olds, 12% for 50- to 64-year-olds, and 2% for those aged 65+. This suggests that unemployment is a more permanent state among older people and that transitions may take place from unemployment into economic inactivity rather than into work. National data also suggest that there are pockets of workers aged 65+ who are particularly affected by unemployment. A Polish survey suggested that 4% of workers aged 55–64 lost their jobs because of the pandemic, compared with 16% of workers aged 65+, the highest rate of all age groups (PL1).

In the EU, 5.2% of people of all ages in employment (breakdown by age is unavailable) transferred into inactivity rather than unemployment from 2019 to 2020, up from 4.2–4.4% in the previous five years (EU-LFS, lfsi_long_a). Women transferred more often into inactivity (6.4% of women of all ages transferred from employment to inactivity, up from 5.1–5.5% in the previous five years). Both the rate and its increase lie above those for men (4.2%, up from 3.4–3.6% in the previous five years). Older people may have retired earlier than planned because of the deteriorating working conditions during the crisis, changing life priorities and fear of catching the virus while working. This may be part of the explanation for the higher retirement rate in 2020 in the Netherlands: 6.8% of workers aged 55+ retired in 2020, compared with 5.5% in 2019 (CBS, 2021). In Cyprus, pandemic support restrictions pushed workers aged 63–65 into retirement (see 'Guaranteeing basic living standards for unemployed people' on p. 28). However, the opposite trend has also been observed: in Finland, many people seem to have postponed retirement during the pandemic, possibly because the prospect of having more leisure time was less attractive during this period (Finnish Centre for Pensions, 2021).

Hours, income and job security

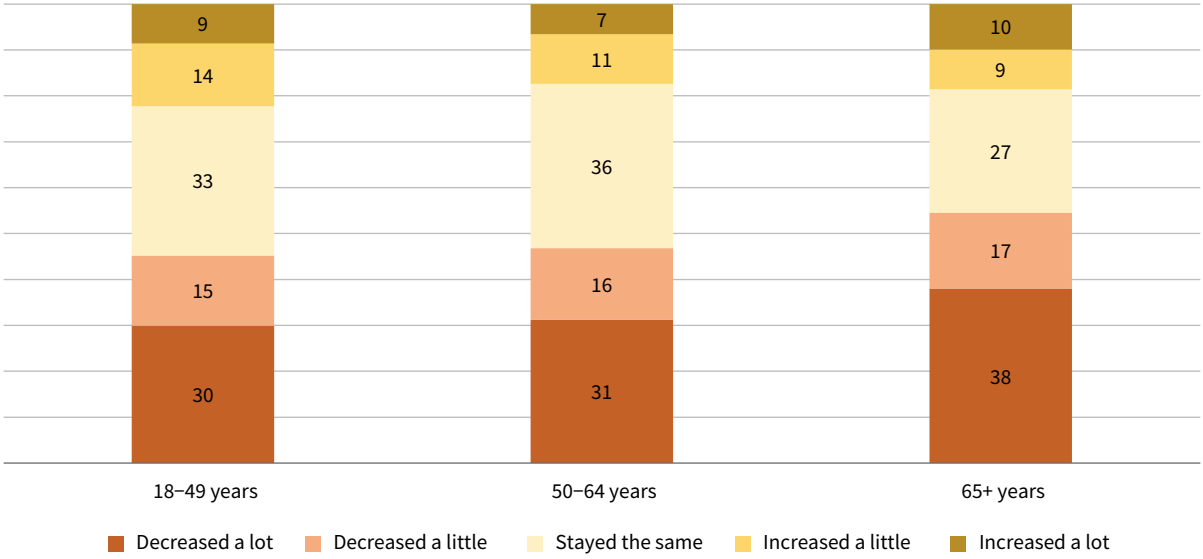
While younger people more often became unemployed than older people, older workers' working hours decreased more often – and increased less often – than those of younger workers (Figure 8). Hours decreased for 45% of workers aged below 50, 47% of workers aged 50–64 and 55% of workers aged 65+, without notable gender differences. In addition, in particular workers aged 65+ were more likely than younger workers to report that their working hours had decreased by a lot rather than by a little. A reduction in working hours among workers aged 50+ was most common in Cyprus and Greece (both 62%) and France (61%), and least common in Finland and Sweden (both 21%) and Denmark (27%). Part of these working time reductions may relate to people on job retention schemes (for example, furlough schemes and short-time work schemes).

At the same time, working hours increased for 18% of workers aged 50–64 and 19% of workers aged 65+ (compared with 23% of workers aged below 50) (see Figure 8). The increase in hours was more pronounced among women than men, regardless of age. This may relate to increases in working hours in healthcare and residential long-term care, with little change in the past decade in the overrepresentation of women in their workforces (Eurofound, 2020b).

The age pattern in the reduction in working hours seems to relate to the higher rate of self-employment among older workers (with stable rates from 2019 to 2020): 13% of workers aged 20–49, 17% of those aged 50–64 and 43% of those aged 65+ were self-employed both in 2019 and 2020 (EU-LFS, lfsa_egaps). Self-employment is particularly common among working pensioners (Eurofound, 2012, 2016a). Overall, 42% of employees and 68% of self-employed workers reported a decrease in working hours during the pandemic (authors' calculations using data from the *Living, working and COVID-19* e-survey). These rates were similar across age brackets, but younger self-employed people more often reported that their hours had decreased a lot, and older people more often reported that they had decreased a little.

Income from work decreased for many older people, including those on job retention schemes (for example, furlough and short-time work schemes) whose income was not fully compensated. For instance, in a Polish survey, 21% of respondents aged 55+ (same rate for those aged 55–64 and 65+) declared that they or someone in their household had lost earning

Figure 8: Changes in working hours, by age group, spring and summer 2020, EU (%)



Note: *Pooled data from spring and summer 2020.*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 1 and 2*

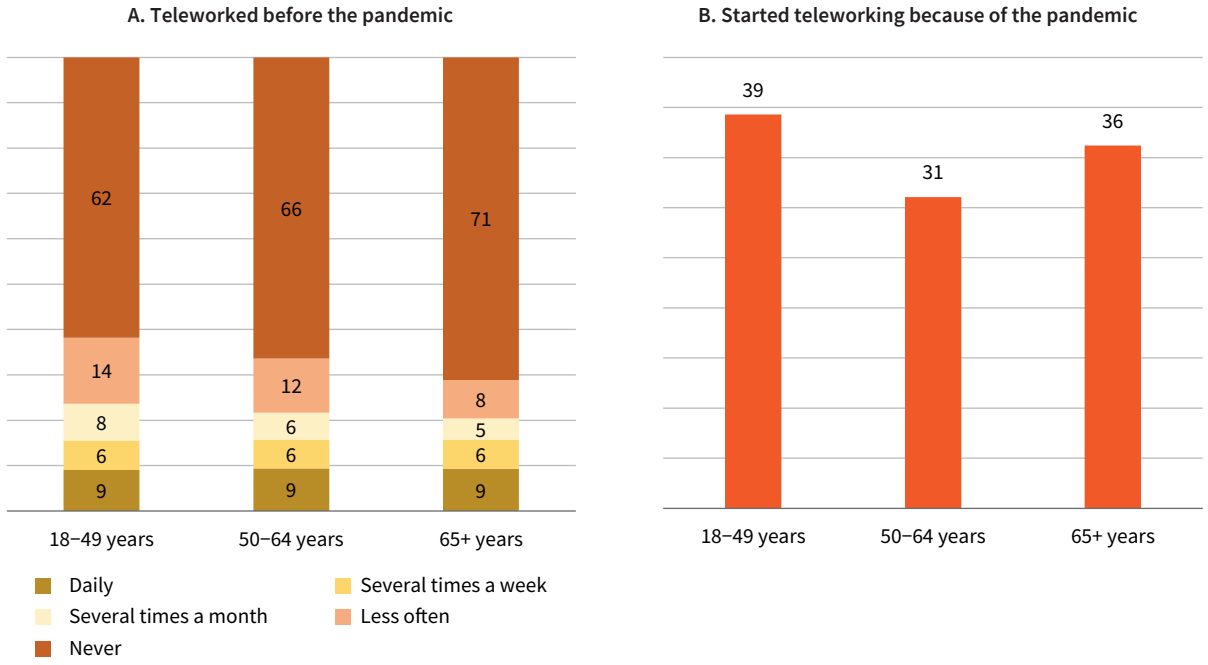
opportunities (18–24: 24%; 25–34: 26%; 35–44: 28%; 45–54: 32%). Among those reporting a decrease in their income, 20% of those aged 55–64 reported a decrease in their hours, compared with 30% of those aged 65+. Other reasons for decreased income included interruptions to company operations (10% and 12%, respectively), company closure (6% and 9%, respectively) and job loss, which was reported by 3% of people aged 55–64 and fewer than 1% of those aged 65+ (PL5). In Lithuania, loss of a permanent source of income was reported by 5% of people aged 50+ (compared with 14% and 7% of those aged 18–29 and 30–49, respectively) (LT6).

Aside from job loss, reduced hours and pay cuts, the pandemic has also triggered feelings that one's job was at risk. Such insecurity can negatively affect people's well-being (Eurofound, 2018a). A Bulgarian survey found that, in November 2020, 46% of workers aged 50–59 and 38% of those aged 60–69 were afraid of losing their job because of 'the worsening economic situation in the country and worldwide' (compared with 49% of those aged 40–49, 40% of those aged 30–39 and 45% of those aged 18–29) (BG3). While the survey question differed slightly, these rates are well above the 9% of workers aged 50–69 in Bulgaria who in 2016 found it likely that they might lose their job in the next six months (EQLS 2016). Another important aspect of feeling secure is whether people whose employment situation was affected expected to return to employment after the lifting of restrictions. Among those who lost employment, were temporarily laid off or were on paid or unpaid leave, 97% of people aged 35–44, 45–54 and 55–64 expected to return to the same job after the lifting of restrictions, compared with 90–91% of those in younger age groups (IE1).

Telework and work–life balance

The pandemic has had an impact on the way people work. Older people were less likely than younger people to telework (work from home) before the pandemic, (in particular to telework occasionally (Figure 9A)) and were also less likely to start teleworking because of the pandemic (Figure 9B). The proportion of people aged 50+ who started teleworking because of the pandemic was highest in Finland (69%), Luxembourg (51%) and Italy (46%). It was lowest in Romania (15%) and Estonia and Slovenia (both 21%), but in Estonia telework among those aged 50+ was already more common than in any other country before the pandemic (36%), while in Slovenia it was least common (9%).

Figure 9: Teleworking, by age group, spring and summer 2020, EU (%)

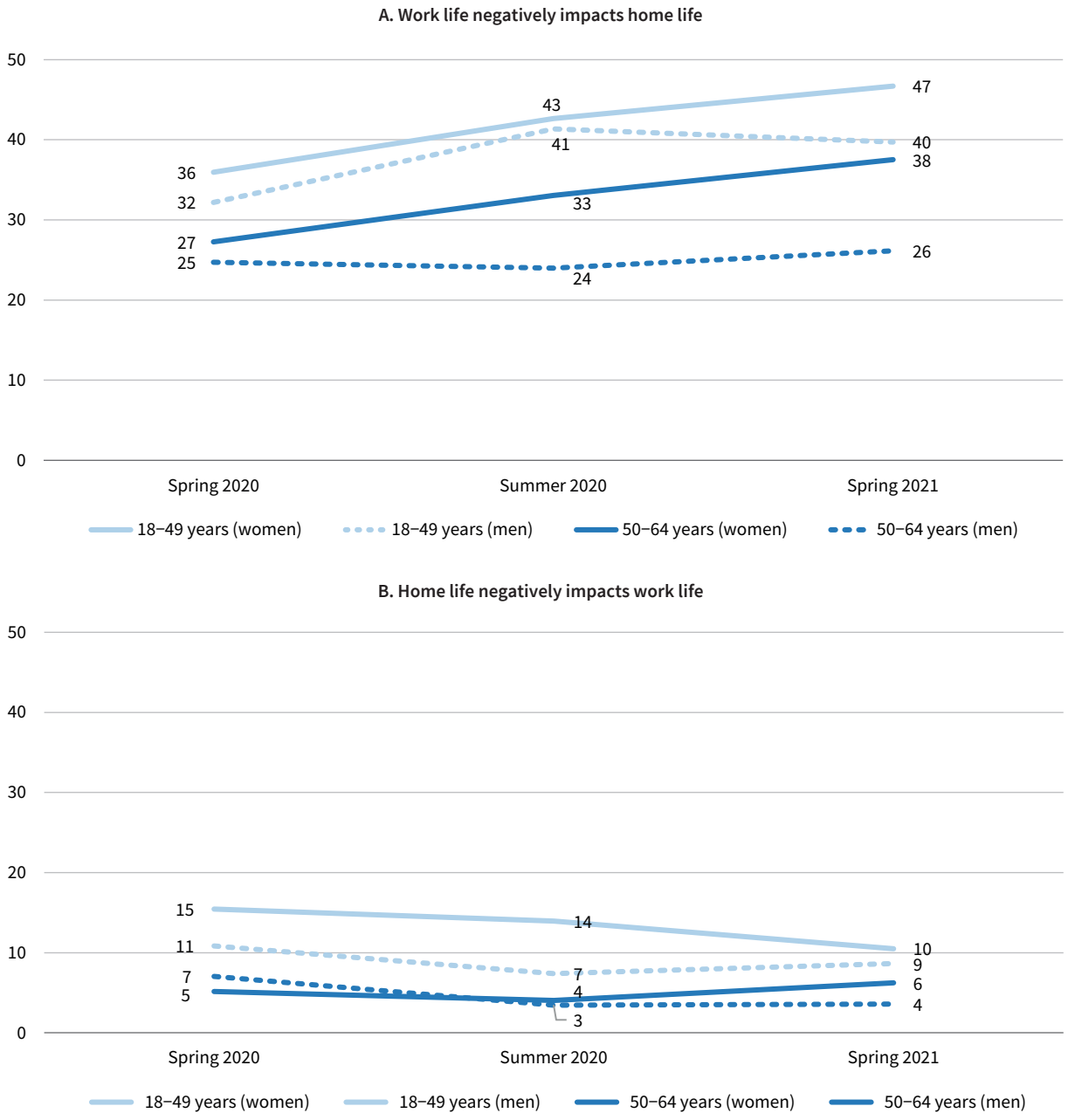


Note: *Pooled data from spring and summer 2020.*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 1 and 2*

Work–life conflicts during the pandemic were most common among younger (especially female) workers. However, an increase in work–life balance problems was also observed among older women. For both groups this was mainly in terms of work negatively impacting home life (Figure 10A). While it is important to acknowledge the sensitivity of results to the timing of data collection (if it was during the summer holidays, for example), home life was less often reported to negatively impact work life, and this issue has generally decreased over the course of the pandemic (Figure 10B). Among people aged 50+, it was particularly common for work life to negatively impact home life in Greece (43%), Italy and Cyprus (both 35%) and Croatia (34%), with the largest gender difference in Malta (20% for men and 40% for women; the other four countries had differences of between 2 and 11 percentage points). It was least common for work life to negatively impact home life in Slovenia (15%), Denmark (17%) and the Netherlands and Finland (both 18%).

National evidence adds to the general picture by asking about people's experiences of the new working situation. A Latvian survey asked respondents to assess how their work–life balance had changed while working remotely: work–life balance had least often (21%) changed for workers aged 63+ (the age from which people can claim their pension early). This group also most often indicated not feeling anxious about the new work and living environment (71%), followed by workers aged 55–63 (64%) (LV2). In Spain, workers aged 60+ had a satisfaction index of 3.89 for taking up telework (on a scale of 1–5, with 5 being the highest), compared with 3.56 among 18- to 29-year-olds (ES4). This could be related to them being less likely to have children at home to care for, experiencing less pressure because of their seniority in their organisation, having more flexibility in terms of time and feeling protected from catching the virus while working from home (Martín et al, 2020).

Figure 10: Work–life conflicts among workers, by gender and age group, EU (%)



Notes: *Questions relate to the previous two weeks. (A) 'Felt too tired after work to do some of the household jobs which need to be done' or 'Found that your job prevented you from giving the time you wanted to your family'; (B) 'Found it difficult to concentrate on your job because of your family responsibilities' or 'Found that your family responsibilities prevented you from giving the time you should to your job'. Percentages relate to those answering 'always' or 'most of the time'.*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

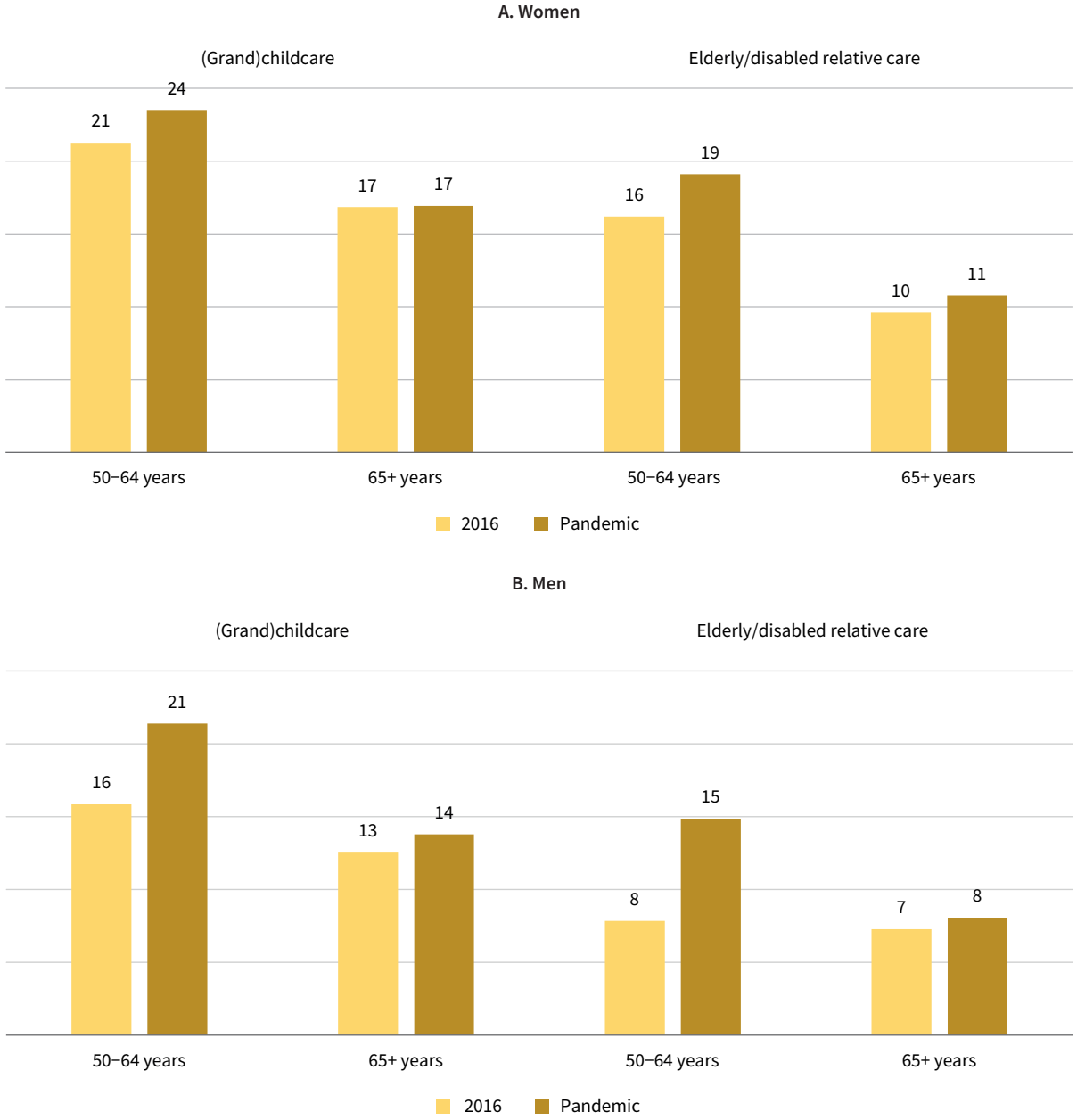
Unpaid work

Informal childcare and elderly care

Many older people provide informal care. A comparison of 2016 data with those collected during the pandemic suggests that it has become more common for older people to care for or educate their (grand)children, and to care for family members who are elderly or have a disability (Figure 11). Higher rates of (grand)childcare during the pandemic, however, may partially be due to some of the data collection coinciding with the 2020 summer holidays, in contrast to the EQLS, which was fielded in late 2016.

The increase in informal childcare and elderly care is concentrated among carers aged 50–64. Caring by people aged 65+ has remained near pre-pandemic levels. One might expect that this group of older people especially would not have increased their care provision because of the risk of infection. The stability over time may also reflect that social distancing was less relevant

Figure 11: Informal care for more than five hours a week, by gender and age group, EU (%)



Notes: *Caring for and/or educating children/grandchildren and caring for elderly family members or family members with disabilities (2016 EQLS data also include caring for neighbours or friends).*
Sources: *EQLS 2016 (EU27) and* Living, working and COVID-19 *e-survey (EU27) rounds 2 and 3 ('Pandemic')*

in countries where many older people live with their adult children (and provide care for their grandchildren), and that many older people provide care for their spouses.

Men are less likely than women to provide informal care. However, there was a particularly pronounced increase in both (grand)childcare (from 16% to 21%) and care for other relatives (from 8% to 15%) among men aged 50–64.

The frequency of providing personal care to parents by people aged 50+ increased in almost all European countries (Bergmann and Wagner, 2021). Parental caregivers who increased the frequency of providing personal care reported significantly greater mental health strain.

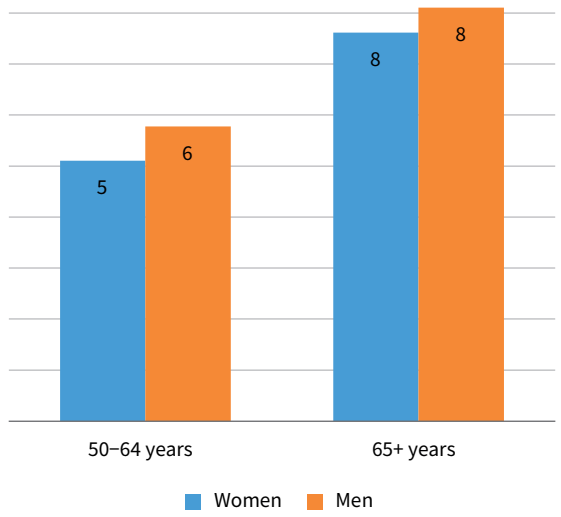
Older people played key roles in mitigating the impacts of the pandemic in multigenerational households. Research from Slovakia shows that it seemed to be easier to cope with the pandemic in multigenerational households where household duties were divided between family members, for example a grandparent cooking and a parent caring for or teaching a child, or grandparents providing grandchild care (Voľanská et al, 2020).

Caring activities by older people do not only involve care for someone who lives in the same house or care for a relative. In Latvia, 5% of those aged 50+ provided personal care to someone who did not live with them in the same home (LV1). In Lithuania, among those aged 50+ living alone, 32% provided unpaid assistance to someone other than a relative at least once in May 2020 (LT1).

Volunteering

Older people have often volunteered during the pandemic. In contrast to informal care, the proportion of men involved in volunteering is slightly higher than that of women, and volunteering is more common among people aged 65+ than among those aged 50–64 (Figure 12).

Figure 12: Volunteering for over five hours a week during the pandemic, by gender and age group, EU (%)



Source: *Authors' calculations using data from the* Living, working and COVID-19 *e-survey (EU27), rounds 2 and 3 (merged)*

Measures and initiatives

Preventing, addressing and alleviating unemployment

Support schemes to prevent, address and alleviate unemployment during the pandemic have been discussed elsewhere (Béland et al, 2021; ESPN, 2021; Seemann et al, 2021). Here the focus is on examples with specific relevance to old age, and on implementation challenges and take-up.

Schemes can support labour market integration of older people by targeting employers or employees (Eurofound, 2018b). They can aim to prevent unemployment or to integrate unemployed people back into the workforce; they may also focus on integrating economically inactive people, including retirees and those involved in caring activities (Eurofound, 2016a, 2017a). Schemes can also focus on guaranteeing decent living conditions for unemployed people or those with low income from work. Such support can provide people with resources to enhance their chances in the labour market (Eurofound, 2020c).

Integration into work

Targeting employers

In May 2020, Romania introduced financial support for employers who hire people aged 50+ who were dismissed between 16 March and 15 May or 18 May and 18 June 2020. The measure also covers people aged 16–29 registered as unemployed. Support consists of half the employee's salary (capped at RON 2,500 (€505) per month) paid for one year; the employer is obliged to maintain an employment contract for at least another year. By 28 November 2020, 1,621 people had been supported, 409 (25%) of whom were aged 50+.

Targeting unemployed/inactive people

In July 2020, Austria implemented a 'restart subsidy' for unemployed people who took up work for at least 20 hours a week between 15 June 2020 and 30 June 2021 (later extended to 31 December 2021) and who were earning a net monthly income below that of their previous job. The subsidy (€950 per month maximum) brings their total salary up to 45% (for a restart job of 20–25 hours per week), 55% (25–30 hours) or 60% (30+ hours) above the unemployment benefit. Without the bonus payment, income would be below the unemployment benefit, a disincentive to taking up work. The bonus is paid for up to 28 weeks, or for up to one year for people aged 50+ if they have been unemployed for at least 90 days or have a low chance of employment, for example because of a health impairment. For people aged 59+ the subsidy is paid for up to three years, under additional conditions (participation in occupational rehabilitation measures, revocation of the rehabilitation allowance). Initially, a new job under this initiative had to be registered as a vacancy with the public employment service, but this requirement was abolished in December 2020. The regulation was valid until December 2021. By July 2021, 3,785 subsidies had been approved, of which 515 (14%) were for people aged 50+ (including 35 for people aged 60+). In another national-level example, Czechia introduced regional counselling programmes for jobseekers over 50+ before the pandemic, supported by the European Social Fund (ESF). They focus on building self-confidence and developing communication and presentation skills. While other activities were suspended, the provision of advice over the phone continued during the pandemic.

Preventing unemployment

Multiple schemes aimed to prevent unemployment during the pandemic. While many older people benefited from them, these usually did not include specific measures for older people. One exception can be found in Lithuania. Employers were required to pay at least the gross national minimum wage (NMW) (€607 per month in 2020) to employees on downtime. From 12 June 2020 to 1 January 2021, to protect older workers, employers could choose to get a subsidy equal to the NMW for employees aged 60+, without the need to contribute to the employees' wages. For employees under 60 years, employers could get a subsidy equal to 90% of the NMW and had to contribute 10%. To encourage employers to make a greater contribution to job retention and retain employees with higher wages, the maximum amount of the subsidy was set at 1.5 times the NMW (€910.5) if they contributed 30% or more of the calculated wages; this was the same for all employees regardless of age. Employers had to retain at least 50% of the jobs for which subsidies were paid for at least three months after the furlough period ended. In cases of partial downtime, employers paid employees their normal salaries for the time worked, while the wage support rules described above applied to the downtime. In total, 93% of employers paid only the NMW to their employees on downtime during lockdown (28 July 2020 data, Ministry of Social Security and Labour). From 1 January 2021, the requirement to pay at least 10% of the furlough wage for employees aged under 60 was dropped, eliminating the age difference (and the NMW was raised to €642). From March to June 2000, Estonia paid 137,500 employees whose employer's activities were disrupted 70% of their previous wage, up to €1,000 per month, and amounting to 50% of the employee's previous wage or up to €800 in June. The measure was estimated to have prevented a rise in relative poverty and inequalities among all age groups, but particularly among people aged 50–63 (below Estonia's pension age). Relative poverty in this group increased from 18.3% to 18.5%, whereas it would have increased to 22.9% without the subsidy (Koppel and Laurimäe, 2021).

Guaranteeing basic living standards for unemployed people

Unemployment and minimum income benefits have played an important role in guaranteeing basic living standards for unemployed people during the pandemic (Béland et al, 2021; ESPN, 2021; Seemann et al, 2021). Such benefits were often provided by national schemes. For instance, in Ireland in May 2020, 80,600 people aged 55+ received the Pandemic Unemployment Payment (13.5% of all recipients). This number declined to 56,218 in April 2021 (13.3% of all recipients). There have also been local initiatives. For instance, Budapest's District XI initiative provides emergency financial support (means-tested cash benefits) for those who have lost their jobs.

While older people benefited from such schemes, they were often not specifically targeted. However, an example of the opposite (older people being excluded) can be found in Cyprus. There, workers aged 63–65 are entitled to an early pension, with a 0.5 percentage point pension cut for each month their pension is advanced. These workers were not entitled to pandemic unemployment support.

Targeting low-income workers

Measures for low-income earners of all ages also benefited older people. In Italy, 'emergency income' of a maximum of €800 per month for five months was introduced in May 2020 for households with low-income workers (excluding households consisting only of pensioners). In total, 28.7% of beneficiaries were aged 45+ (Istat, 2021b). Age-specific measures are again rare. One example can be found in Slovenia: in January 2021, low-income farmers aged 65+, without a retirement allowance, were entitled to a one-off pandemic allowance of €150.

Facilitating work after retirement

In some countries, the pandemic situation seems to have accelerated the longer-term policy trend of stimulating the earning of declared income from work while receiving a pension (Eurofound, 2012, 2016a). In other countries, such reforms happened to coincide with the pandemic but were not caused by it. In Germany, prior to the pandemic, pensioners could earn up to €6,300 a year without being subject to pension deductions. This was raised to €44,590 in 2020 and €46,600 in 2021, mainly to stimulate continued employment and re-entry into work by retired essential (e.g. healthcare) workers. In Greece, since February 2020, pensioners who continue working lose 30% of their pension, while previously this was 60%. In Spain, in 2021, a reform was agreed whereby workers' pensions will increase by up to 4% each year that they postpone taking their pension beyond 44.5 years of work. Sweden has reduced taxes on income from work after the pension age.

Such reforms have further stimulated the increase in declared paid work among pensioners and in income for working pensioners. However, the pandemic may curb these trends somewhat, as, among older people, people aged 65+ have been most affected by job loss and reduced hours (as discussed earlier in this chapter). Furthermore, there have also been policy discussions in other directions. In Slovenia, in December 2020, the parliament adopted a pandemic-related law (No. PKP7). This includes an amendment that gives employers the right to terminate – without justification and with 60 days' notice – employment contracts of workers meeting the conditions for an old-age pension. Trade

unions and the Advocate of the Principle of Equality took this decision to court, which suspended the measure's implementation, which was to have taken place in February 2021, until a final judgment is made.

Care allowance

Policy measures to facilitate informal care are discussed in Chapter 6. Here the focus is on monetary care benefits, with older carers as recipients.

Slovakia already had an allowance for informal long-term care givers prior to the pandemic, but take-up increased. In December 2020, 63,385 carers received an allowance. Over two-thirds (67.3%, 42,683) of them were aged 50+ (57.5% of those aged 50+ were aged 50–64 years, 38.3% were aged 65–79 years and 4.2% were 80+). Compared with December 2019, the number of carers aged 50+ increased (by 6%), but the number of those below 50 years increased by more. The number of carers may have increased to meet the care needs emerging from the closure of daily social services facilities, but also (by replacing formal with informal care) because of greater availability of carers due to unemployment, furlough and reduced working hours, and the need to mitigate decreases in household income.

In Italy, from March to August 2020, public compensation was paid for childcare provided by individuals employed by families for children aged under 13 or children with a disability (€1,200 per month, and up to €2,000 per month if the parents were healthcare or social care workers). Parents had to be self-employed or private sector, health and social care sector (public or private) or police services workers. They could not work remotely from home nor be on parental leave. Carers could be workers, unemployed people, pensioners or students, but could not live with the children and their parents. By September 2020, 1,303,309 applications had been submitted; 72% had been accepted, 13% had been refused and 15% were still under examination. About 60% of these carers were aged 60+. The measure was reintroduced in March 2021 but excluded carers who were relatives of the children being cared for.

4 Finances and deprivation

Income

People aged 75+ are more likely to have incomes below 60% of the median income in their country (that is, the poverty threshold) than age groups between 25 and 74, and this gap increased from 2019 to 2020. In 2020, in the EU, 19.0% of people aged 75+ were living in poverty (up from 17.2% in 2019). The rate was 15.9% among 65- to 74-year-olds (up from 15.2% in 2019) and 15.6% among 50- to 64-year-olds (down from 15.7%). Such relative poverty was by far most common for people aged 16–24 (23.0%, up from 22.2% in 2019), and least common for 25- to 49-year-olds (15.1%, up from 14.8% in 2019) (European Union Statistics on Income and Living Conditions and European Community Household Panel, ilc_li02).

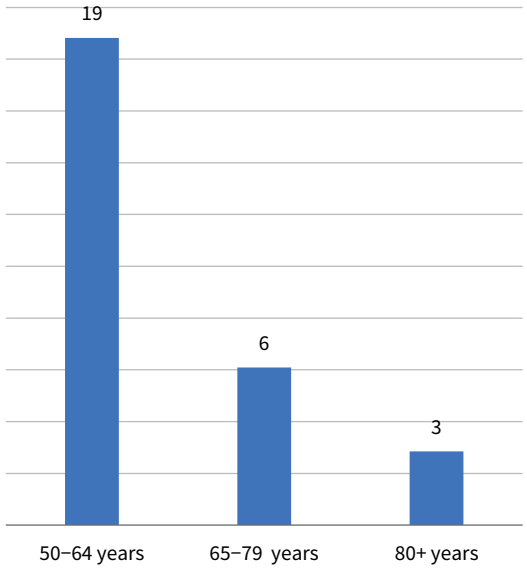
Pensions have generally not been cut during the pandemic and scheduled increases have taken place. For instance, since 2019, the Polish government has paid an annual additional (13th) monthly pension. This was made permanent in 2020 and the amount was doubled in 2021.

However, some groups of pensioners have experienced decreases in income. For instance, in some Member States, many working pensioners saw decreases in their income from work (see Chapter 3). Furthermore, some older people relying on financial support from their children had that support reduced when their children's income decreased (Senior Italia, 2020).

Overall, almost one in five (19%) people aged 50–64 experienced a decrease in household income of more than 10% during the first months of the crisis (Figure 13). Decreases were rarer among people aged 65+, reflecting the stability of pension income. Among people aged 50+, such income drops were most common in Italy and Portugal (both 20%), Bulgaria (19%) and Spain (18%), and least common in the Netherlands (5%) and Czechia and Denmark (both 6%).

Younger age groups were hit more than older age groups by income decreases. In a survey across 21 EU Member States, Norway, Switzerland and the UK, 50% of people aged 18–21 said that their incomes had decreased during the pandemic, compared with 15% of people aged 65+; decreases were most common among low-income groups (Intrum, 2021). In a Lithuanian survey in July/August 2020, 21% of people aged 50+ reported that their income had decreased during the six months prior to the survey (compared with 44% and 35% of those aged 18–29 and 30–49, respectively) (LT6).

Figure 13: Reduction in household income of over 10%, by age group, summer 2020, EU (%)



Notes: *Proportion of respondents with a larger than 10% decrease in household income. Calculated using answers to questions about typical overall monthly net household income before the pandemic and the lowest overall monthly net household income during the pandemic. Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

For 14% of people aged 50+ the decrease was over 10%; again, this rate was lower than the rates for those aged 30–49 (22%) and 18–29 (19%). In Bulgaria, by May 2020, drastic drops in income were most common among people aged 31–40 (44%) and least common among those aged 61+ (14%) and 51–60 (18.5%). However, many people aged 51–60 (38%) reported that their income had dropped somewhat but that they were still able to make ends meet (compared with 24.5% for those aged 31–40 and 20% for those aged 61+) (BG2). In Austria, 69% of people aged 65+ reported stable incomes from February to September 2020, well above the rate for other groups (51% for 30- to 64-year-olds, 45% for those under 30) (AT1). In Italy, absolute poverty (meaning that income is below the level needed to maintain basic living standards) across all age groups increased from 7.7% in 2019 to 9.6% in 2020. However, absolute poverty among those aged 65+ has been relatively stable: in 2020, 5.6% of households with at least one member aged 65+ were in absolute poverty, compared with 5.2% in 2019 (Istat, 2021a).

Interestingly, national survey evidence suggests that increases in income have also been rarer among older people than among younger people. In Austria, 16.7% of people aged 65+ reported a loss of income between February and September 2020 (compared with 25.5% of 30- to 64-year-olds and 33.5% of 18- to 29-year-olds) and 14.4% reported a gain (compared with 24% of 30- to 64-year-olds and 22% of 18- to 29-year-olds) (AT1). In Lithuania, people aged 50+ were least likely to report a loss in income (see above) but also least likely to report an increase in income of more than 10% (3.7% compared with 9.3% and 7.9% of people aged 18–29 and 30–49, respectively) (LT6). Furthermore, in 2020, 19% of people aged 50+ reported income growth, down from 46% in 2019 (LT6).

Expenditure

Older people's financial situations do not depend only on income, but also on living costs and other expenditure. In particular, those with incomes below the poverty threshold often face a delicate financial balance that is disrupted by even small expenditure increases and have fewer opportunities to cut expenditure.

During the pandemic, many people reduced their expenditure, mainly because of the restrictions, but also to enhance their financial security and because of a reduced interest in buying new things (Intrum, 2021). However, national survey results suggest that some groups of older people faced increased expenses. In Lithuania, in summer 2020, an increase in expenses as a result of the pandemic was reported by 14% of people aged 50+, a higher rate than those in younger age groups (8% and 10% of 18- to 29-year-olds and 30- to 49-year-olds, respectively). In contrast, 8% reported decreases in expenses, less than half the rate in other age groups (19% among 18- to 49-year-olds) (LT6). In Romania, among people aged 65+, 21% saved more than usual, while 32% spent more than usual. Among 51- to 65-year-olds, 18% saved more (the lowest percentage) and 26% spent more (RO1).

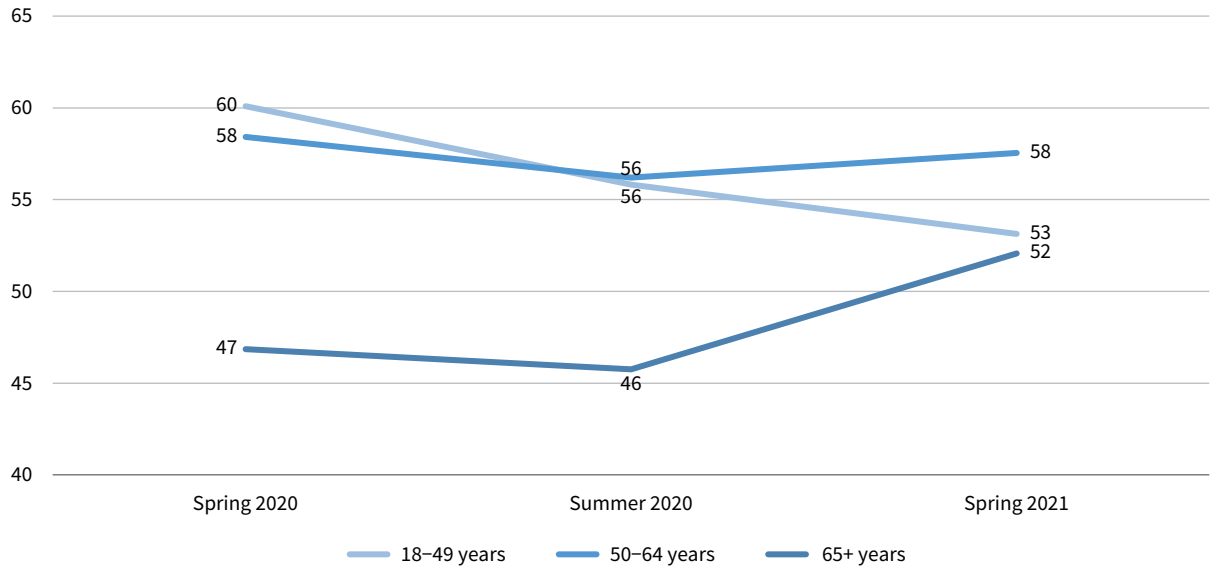
Overall, increased expenditure was reported in relation to:

- delivery services (Finland – Eronen et al, 2020)
- taxis and fuel for private transport instead of public transport (Finland – Eronen et al, 2020; Ireland – The Irish Times, 2020)
- support for family members – for example, in Germany, 11% of those aged 75+ increased financial support for their children and 13% increased support for their grandchildren (Horn and Schweppe, 2020); in Italy, 55% of people aged 65+ attending Senior Italia social centres supported their children during the pandemic, to a value of €354 per month on average in 2020 (IT5); and, across Member States, many older people borrowed money to buy an item for their children as a result of the pandemic situation (Intrum, 2021)
- private care and support services, as a result of the discontinuation of publicly funded services (some municipalities in Finland – Eronen et al, 2020)
- hygiene/protective goods – for example, the purchasing of masks was a financial problem for one-third of people aged 65–90 in Madrid (ES3)
- healthcare services (Latvia – nra.lv, 2021)
- rehabilitation services for residential care users after recovering from COVID-19 (Slovenia)

Financial resilience: Savings

Savings provide resilience against shocks to household finances. At the start of the pandemic, more younger people than older reported having no savings, or that their savings would sustain their standard of living for less than three months. However, while this proportion decreased steadily for younger people over the course of the pandemic, it did not do so for older people, but rather increased from summer 2020 to spring 2021, especially for people aged 65+ (Figure 14). The increase was particularly large among people aged 65+. This group was least likely to have low levels of savings at the beginning of the pandemic, but the proportions with low levels of savings among all three age groups were very similar by spring 2021. These developments reflect the impact of the pandemic on income, expenditure and inequalities described in this chapter.

Figure 14: Low levels of savings, by age group, EU (%)



Note: *Survey question: 'If your household would not receive any income, how long would your household be able to maintain the same standard of living?' Percentages relate to those answering 'less than three months' or 'no savings'.*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

Overall financial situation

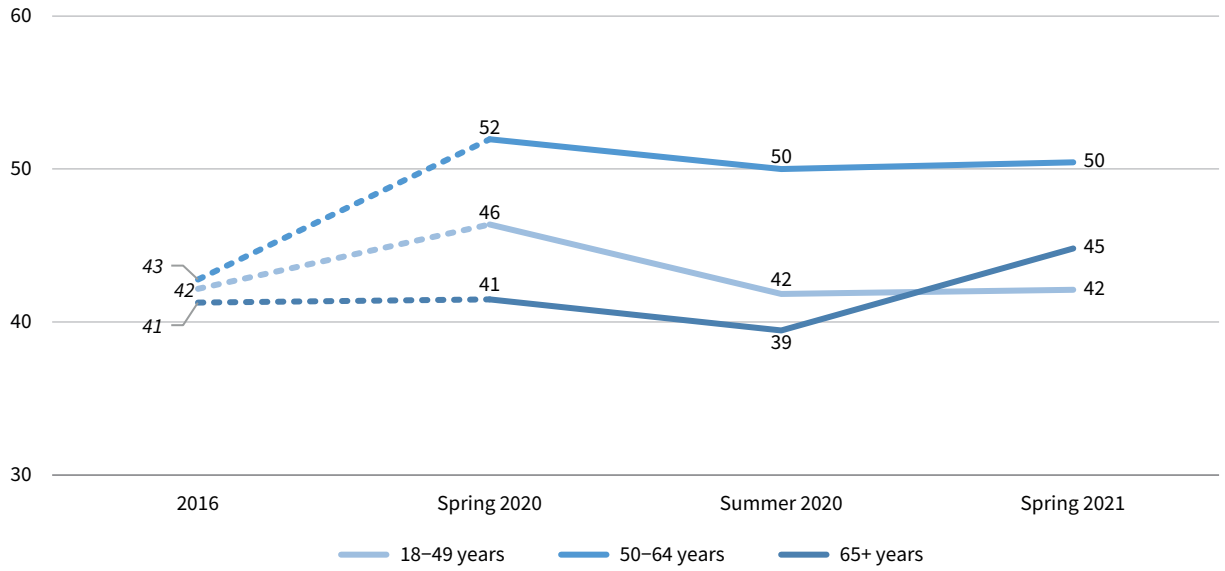
The impacts of increased expenditure may explain some of the economic hardship reported by older people on low incomes. In Italy, 31% of 50- to 69-year-olds declared that their economic situation had worsened as a result of the pandemic, a lower rate than that among younger groups (36% for 35- to 49-year-olds), but considerably higher than that among those aged 65+ (12%). While rates are lowest for people aged 65+, pockets of them facing worsening economic situations seem to be concentrated among those who were already in the most vulnerable situations. Among people aged 65+ the picture is U-shaped, with 14% of people aged 65–74, 9% of people aged 75–84 and 12% of people aged 85+ stating that their economic situation had worsened. Especially in the last group, increased costs (for example, in relation to care services and transport) may have played a role. Among those aged 65+, men (14%) and people with a primary level of education or lower (13%) more often reported a worsening financial situation than women and people with a higher level of education (both 10%). People aged 65+ with economic difficulties before the pandemic were particularly likely to have seen a worsening of their financial situation (22%) (IT1). In a Cypriot survey carried out between late March and May 2020, 29% of respondents aged 50+ indicated that their financial situation had worsened and 8% reported that it had improved since the pandemic began (CY1).

In Malta, people aged 65+ were most likely to report that their overall financial situation in 2020 was better than in 2019 – the proportion was 27%, almost double the proportion among people aged 51–64 (14%).

Compared with 2016, the proportion of people having difficulties making ends meet increased most for people aged 50–64 during the pandemic (from 43% in 2016 to 50% in spring 2021) (Figure 15). In the pandemic period, difficulties making ends meet among people aged 50+ were most common in Croatia (77%), Slovakia (75%) and Hungary (69%). They were least common in Denmark (15%), Luxembourg (26%) and Austria (28%). People aged 65+ were less often affected during the first months of the crisis, but the proportion reporting difficulties making ends meet increased from summer 2020 to spring 2021, possibly because of increased expenditure and reduced working hours.

The 'making ends meet' indicator does not consider all aspects of people's financial situations. For example, people may have owned capital goods but were unable to make ends meet because of liquidity problems, or were only able to make ends meet because of landlords' and creditors' leniency in accepting delayed payments. In a Lithuanian survey, an increased debt burden was reported by 2% of respondents aged 50+, compared with 6% and 4% in the 18–29 years and 30–49 years age groups (LT6). Some groups needed to cut expenditure to make ends meet. An Irish survey found that 14% of people aged 55+ cut back on heating or electricity and

Figure 15: Difficulty making ends meet, by age group, EU (%)



Notes: *Survey question: 'A household may have different sources of income and more than one household member may contribute to it. Thinking of your household's total monthly income, is your household able to make ends meet?' Percentages relate to those answering 'with great difficulty', 'with difficulty' and 'with some difficulty'. The dotted lines indicate that 2016 and 2020/2021 data are not perfectly comparable, as they are from different surveys.*
Sources: *EQLS 2016 (EU27) and* Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

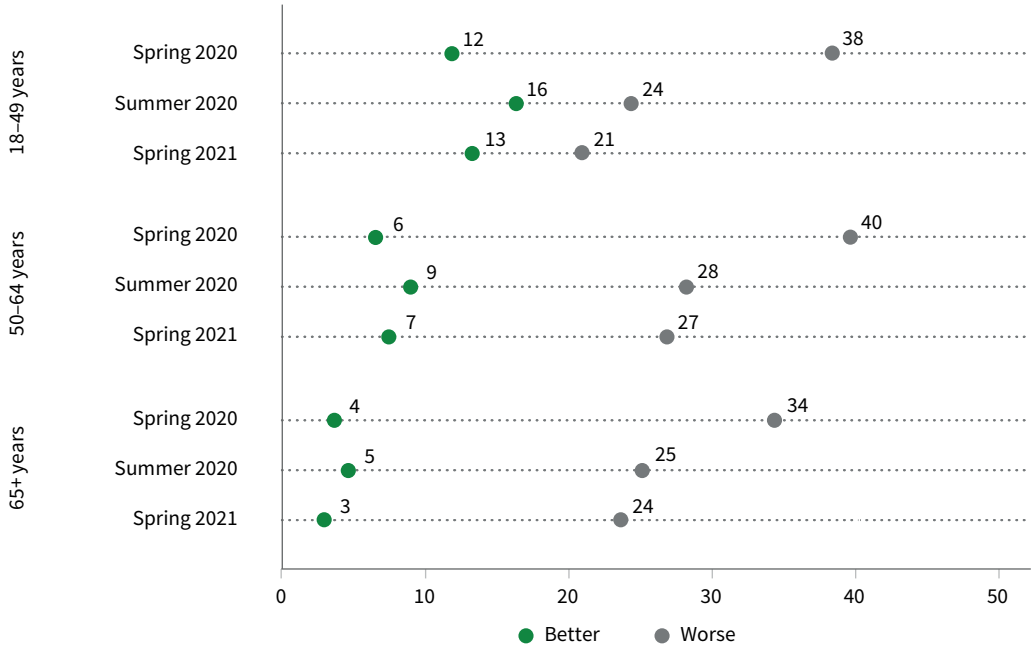
9% on food during the pandemic because of cost (17% and 18%, and 20% and 22% of those aged 18–34 and 35–55, respectively) (IE6). Ireland is among the countries where, on average, older people are better off financially than younger people. In many of the EU's lowest income countries the reverse is true, with large groups of older people on very low incomes (Eurofound, 2017b). Therefore, while groups of older people in Ireland needed to cut back on electricity or food during the pandemic, in these lower-income Member States older people have probably been even more affected (but no such survey data were identified in these countries).

Income security

Feelings of income security among older people may have been more severely affected by the pandemic than income itself. This includes fear of income loss and loss of confidence in the sustainability of pensions. In Portugal, 42% of people aged 65+ worried about income loss because of the COVID-19 crisis (the highest rate of 48% was found among 16- to 25-year-olds). In Croatia, 69% of pensioners were concerned that the payment of their pension might be jeopardised (HR2). In Sweden, 25% of older adults worried about the financial consequences of the pandemic (SE9).

Overall, older people were least likely to expect improvements in their financial situation in the pandemic (Figure 16). The proportion of people aged 50+ expecting their financial situation to worsen ranged from 52% in Poland and 49% in Hungary, to 6% in Denmark and 14% in Luxembourg.

Figure 16: Expectations: financial situation in three months' time, by age group, EU (%)



Source: Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

Measures and initiatives

Monetary support

Pensions

In some countries, additional pension payments were made during the pandemic.

Targeting all pensioners: From August 2020, the Bulgarian government paid a monthly supplement of BGN 50 (€26) to its 2 million pensioners (extended multiple times, until May 2021). In Lithuania, in May 2020, a one-off payment of €200 was made to the around 910,000 recipients of social insurance pensions and social assistance benefits (elderly people, widow(er)s, orphans and people with disabilities). In Latvia, in April 2021, a one-off payment of €200 was made to pensioners and people with disabilities; 431,311 (84% of all) beneficiaries were old-age pension recipients (including early retirees). Prior to this measure, financial support had been mainly targeted at workers, with 4% of people aged 50+ (or their household members) reporting having received additional financial support and 39% of them stating that it came from the government (LV1). In Czechia, in November 2020, a one-off payment of CZK 5,000 (€195) was made to all pensioners (around 3 million people).

Targeting people with low pensions: In April 2020, the Slovenian government paid €130–300 to pensioners receiving a pension of up to €700 a month. In January 2021, a second payment was made to those receiving a pension of up to €714 a month. Individuals on lower pensions received more (for example, in January 2021, those on a pension of up to €510 a month received €300).

While some countries have seen increases of pensions which were already scheduled (see 'Income' on p. 31), increases have also been implemented which may have been made higher due to the pandemic situation. For instance, in March 2021 the Slovenian parliament voted for an increase in the guaranteed full-time and minimum pensions from €581 and €260 to €620 and €279, respectively. In Malta, on top of the usual correction for cost of living, pensioners from 2021 received an increase, together amounting to €260 a year, and the tax-free base was widened.

Social assistance and allowances

While not targeting older people, minimum income increases have benefited many older people. For instance, in Lithuania, the minimum income was increased in May 2020. Among its 805,424 recipients, 26% (205,697) were aged 50+. Greece's decision in March 2021 to temporarily waive tax on minimum income benefits (and to move its application process online) also benefited groups of older people.

In Malta, in 2020, the yearly benefit for people aged 75+ living at home (€300 for those aged 75+ and €350 for those aged 80+) was also made available to people living in care homes. In 2021, annual benefits for people above the pension age with too short a work history to be entitled to a pension increased by €50 to €250 a year (€350 for people with at least five years of social security contributions). In addition, a card allowing free transport became available for people aged 70+

(previously the age limit was 75+). France extended by six months an allowance for people with reduced autonomy (Allocation personnalisée d'autonomie), to avoid loss of income because of an inability to renew their application.

Food support

Groups of older people also received food support. Some initiatives targeted all age groups but were often used by older people on low incomes. One example is the Victory Kitchen in Malta, which was established in March 2020 and had delivered 41,713 meals by 15 March 2021. Several initiatives existed before the pandemic but stepped up and adjusted their activities during the pandemic. Warm Lunch in Bulgaria modified its soup kitchen model to include home delivery of lunches to people aged 65+ whose income was below the poverty threshold (along with people in quarantine or with disabilities). It received additional government funds to enable it to reach more people in need. The measure has been extended several times, most recently until 31 December 2021. Around 50,000 people per day have been supported, 50% more than before the pandemic. In Bulgaria, the 'patronage care' programme funds municipalities to provide meals, food products, necessities and medicines, and to pay utility bills.

A nationwide initiative targeting older people in Romania, launched in July 2020, provides personalised electronic cards that can be used to buy hot meals. These cards, for people aged 75+ (and homeless people and single parents), are charged with RON 180 (€36) per month. Food delivery can be requested by phone, at no additional cost (this delivery option was added after the launch). Transactions cannot exceed RON 40 (€8) per day. By March 2021, over 285,000 cards had been issued (99% of which were issued to people aged 75+). Apart from 28% of the cards remaining inactivated, another challenge included reaching small rural communities without a registered food provider. For example, in Galati county, one-third of the registered food providers are in the main city (Galati). Municipalities sought catering companies to bring food to a central local location, where users could pick it up.

Some of the measures and initiatives discussed elsewhere in this report also provide food support to those in need. This is true of several of the support lines discussed elsewhere in the report, such as Dobre słowa in Poland (Chapter 5). Another example is Budapest's District XI initiative, which provides regular food support as well as financial support to fund care for people sent home from hospital.

5 Support for ad hoc needs resulting from lockdowns

Assessing the needs of older people

National surveys give some insight into ad hoc support needs among older people during the pandemic, mainly resulting from restrictions on their movements (healthcare and long-term care needs will mostly be discussed in Chapter 6). In a Croatian survey, people aged 65+ were asked which services they would find useful during the pandemic (HR1). In addition to the services already offered (delivery of food, medicines and necessities, and a psychological helpline), they underlined the importance of communication and mutual assistance, of being able to talk to someone (for example, on the phone), and expressed further specific needs:

- the continuation of medical treatment for chronic diseases
- financial assistance in paying bills
- help with household chores
- help during visits to medical services and with scheduling examinations
- help with taking pets for walks
- help with borrowing books from libraries
- help with online physical exercise

In Lithuania, at the start of lockdown, 38% of people aged 50+ who lived alone and were regularly visited by Red Cross volunteers stressed the importance of a safe supply of food and medicines, 25% highlighted the importance of receiving advice and information, and 13% stressed the importance of support for carrying out daily activities (collecting firewood or going to see a doctor). Fewer than 1 in 10 anticipated no need for help, and 14% were unsure about what help they might need (LT1). In Lower Austria, among people aged 60+, 7% needed to be accompanied to see a doctor (AT5). In Hungary, callers to a support line for older people requested information, assistance in dealing with administrative tasks, collecting prescription medicines and securing hot meals, and psychological assistance. Most callers (average age 79 years) were single (87%) and women (73%).

National surveys have uncovered gaps in addressing older people's needs. A Greek survey conducted among people aged 65+ revealed that 88% found social support insufficient to varying degrees (EL3). In Lithuania, many people aged 50+ who lived alone reported that during October 2020 they had been unable (because of a lack of support) to obtain food and medicines (76%), visit a doctor (56.5%), manage their accounts and documents (48%) or carry out daily household chores (26%). Among people living alone, 52% reported having reduced access to food supplies (LT3). In Slovakia, 59% of people aged 60+ experienced problems with obtaining the necessary aids to ensure their hygiene needs (51% among all ages) (SK3). About 11% were unable to access social services for senior family members during the first wave of the pandemic (SK2).

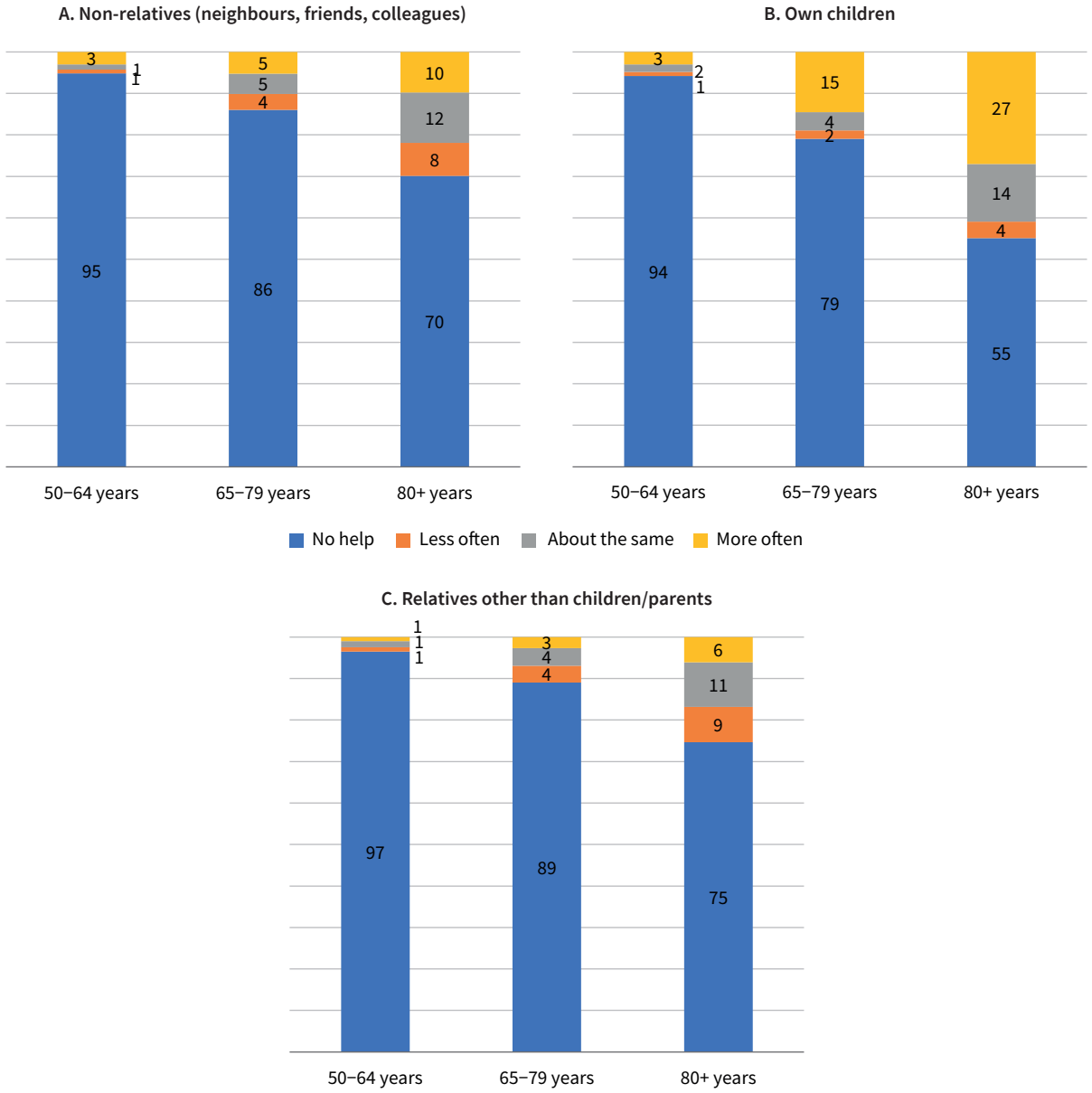
Lack of support often goes together with loneliness and mental health issues (Kuruc et al, 2020; SK2). In the Netherlands, in a survey conducted among people aged 65+, of those who did not receive the necessary help, the support that was missed most often was that for household chores and daily activities, physical or mental health issues, and social contact and interaction (Steinmetz et al, 2020; NL2). About half (54%) indicated they were emotionally lonely, compared with 20% of all respondents aged 65+. Those who did not receive support also ranked their mental health lower (at 4.4 on a scale from 1 to 6) than others (5.0). A survey of NGOs in Portugal found that they considered social support vital for fighting loneliness (74% of respondents) and supporting those with mental health problems (46%) (ATES, 2021).

Role of friends, family and NGOs

During the pandemic, many older people received support (of some kind) from family and friends (see Figure 17). This type of support was requested by 16% of people aged 50–64 and 13% of people aged 65+. While it was less frequent, many also received support from charities and NGOs; this was requested by fewer than 5% in both age groups (authors' calculations using data from the *Living, working and COVID-19* e-survey). While the type of support requested may be different, it is interesting to note that younger people more often requested support from family or friends: 26% of people under the age of 50 requested such support.

The benefits of such support go beyond the support itself; it also provides opportunities for social interaction. However, support is not always provided by people whom the older person being supported feels close to and able to talk to when needed. For instance, in Croatia, among respondents to a survey conducted among people aged 65+ mainly living alone or in care homes, 61% could (always or often) talk to someone, while more (69%) could (always or often) rely on someone when they needed help, for example with buying groceries, paying bills, seeing a doctor, cleaning,

Figure 17: Help from people outside the home with obtaining necessities, by age group, summer 2020, EU (%)



Notes: *Survey question: 'How often did the following people from outside your home help you to obtain necessities, compared to before the outbreak of Corona? Less often, about the same, or more often?' Austria and Ireland are not included.*
Source: *SHARE COVID-19 (June–August 2020)*

carrying out repairs or organising and cleaning the pantry (HR1).

People aged 50+ who were asked whether they had been helped by others from outside the home to obtain necessities (food, medicines, emergency household repairs) reported that support from children was most common (Figure 17). Support from parents was very rare (1% – excluded from Figure 17). Furthermore, support from children has been important in responding to people's needs arising from the crisis, showing a particularly significant increase compared with before the pandemic.

National survey data give more information on the types of support received and on providers, for instance who these family and friends were who provided support. Support for grocery shopping for people aged 60+ in Lower Austria was most frequently provided by children (40%), partners (17%), neighbours or acquaintances (15%) and grandchildren (12%), and less so by delivery services or friends. With regard to support for obtaining medicines, the proportions were similar, but less support was provided by partners and more by other relatives, possibly because those in need of such support are older on average and more likely to be single (AT5). A Croatian survey found that about 5% of people aged 65+ used delivery services for food, medicines or other necessities organised through the Red Cross or various associations and volunteers (HR1).

While certain public or private NGO services played a key role for specific groups of older people, they often also relied on assistance from relatives. A Lithuanian survey of people aged 50+ who were regularly assisted by Red Cross volunteers and were unable to perform certain activities independently most often indicated that they were assisted by these volunteers particularly often (77%), but many were also often assisted by family members/relatives (53%), neighbours/friends (38%) or social support centre/municipality staff (22%) (LT1).

The pandemic situation has contributed to shifts in support providers. A French survey shows that the proportion of people receiving support from neighbours during lockdown compared with the previous month remained unchanged, but it decreased for families with children (26% were supported by their neighbours during lockdown compared with 35% before lockdown) and increased for people aged 75+ (46% compared with 31% before lockdown) (FR1). In Latvia, 12% of people aged 50+ said that someone who did not live with them had helped with obtaining necessities, such as food, medicines or emergency repairs at home (LV1). Almost half were more likely than before to receive support from their children. Support from other relatives had sometimes become more frequent (15%) and sometimes less frequent (14%). Support from other people had also changed in frequency in both directions, but showed more fluctuation overall: 19% received support less often and 20% received support more often.

Requests for support from NGOs or friends or relatives were not always answered, or were even rejected (Eurofound, 2021a). Furthermore, many older people had nobody to turn to to request support in the first place. For instance, in Sweden, among people aged 70+, 14% either did not know where to turn to for help or did not have any help available if they had to quarantine at home for a longer period because of COVID-19 symptoms, almost double the proportion among younger age groups (SE2).

Measures and initiatives

Types of support

Support for ad hoc needs (mainly the delivery of groceries and medicines) during the pandemic included initiatives that existed before the pandemic and that expanded their operations. For instance, in Czechia, since spring 2020, the private non-profit phone line Linka senior (operating since 2002) has helped with the purchase and delivery of food, hygiene items and medicines, and from January 2021 with registration for vaccination. In Sweden, the NGO Äldrekontakt's initiative to tackle loneliness (see Chapter 2) also began helping with the delivery of groceries and medicines.

Other initiatives emerged during the pandemic. For instance, in Poland, Dobre słowa, a helpline for senior citizens established in March 2020, included material aid among its support services, which initially focused on support for everyday matters.

While delivery services may be available through supermarkets and online platforms, the support initiatives described here have reached people who may not have access to the internet, are unaware of such services or cannot pay delivery fees. Such barriers seem greater for older people with low levels of education. In a Latvian survey, 24% of people aged 50+ with higher education reported having made purchases online, but only 6% with a lower level of education had done so (LV1). Online shopping also involved long waiting times (for example, in Malta) amid exploding demand (while local grocery shops often did not provide delivery options). Furthermore, the support services described here often included the delivery of medicines, which may not have been available through regular online delivery services. There is also usually a social element in the interaction with the delivery person and call centre, which before the crisis may have come from visiting a local shop.

More rarely, support with transport was provided to older people. In Slovenia (where several municipalities and communities organised campaigns to help older people, such as with the delivery of food or medicines), the Sopotniki initiative provides free transport for older people in smaller Slovenian municipalities. The service is provided by volunteers.

Most initiatives included a phone line. However, web portals and apps were also created, sometimes alongside phone lines. Among other things, the Magda app in Slovenia provides contact information for emergency care, summarises news that is relevant to older people and provides information about service providers (for example, information about free transport, pharmacies, post offices, administrative units and libraries), which users can contact by clicking a 'Call' button.

The support lines discussed here focus on support for older people. Some also target people of any age with a disability (for example, Helpline 2590 3030 in Malta for people aged 60+ and people with mobility difficulties) or people vulnerable to COVID-19. However, even when the focus is on older people, usually no formal age threshold is applied. While the focus here is on support targeting older people, when the target group is not limited by age, older people sometimes use these support lines more often (for example, Invisible Hands in Malta).

Capacity

Initiatives varied in their geographical coverage. For instance, in Italy, many local public and private initiatives emerged (Ministry of Labour and Social Policies, 2020). Sometimes the national government drove municipal initiatives. In Sweden, a service delivering groceries and medicines (free of charge for all COVID-19 risk groups, including older people) covered all municipalities. It was funded nationally by the Swedish Civil Contingencies Agency (municipalities took over funding in October 2020).

Helplines were often launched very quickly (for example, the support line 1772 – 'You are not alone' – in Malta on 27 March 2020, and Dobre słowa in Poland on 30 March 2020). Many were initiated by NGOs that represent older people, often supported by government funding or sometimes by private donations.

Capacity and user numbers differed, with large initiatives implemented and/or funded nationwide by governments and smaller local initiatives often undertaken by NGOs (often receiving public funding). In Malta, under the Invisible Hands initiative, 337 volunteers had assisted 805 individuals by 16 March 2021, while Helpline 2590 3030 received 10,360 calls for assistance from 16 March to 23 June 2020. In Poland, Dobre słowa (which is privately funded) answered 1,066 calls from 30 March 2020 to 18 March 2021, while over 13,000 volunteers with the Solidarity Assistance Corps for Seniors (a national government initiative with a budget of €21.93 million through which people aged 70+ who are not supported by their families can request local social welfare centre support) had supported over 20,000 senior citizens by March 2021.

The delivery of goods was sometimes taken on by newly recruited volunteers, often drawing on existing networks. Linka senior in Czechia involved regional scouting organisations. In Sweden, volunteers providing shopping and delivery services came from the Volunteer Resource Group (Frivilliga Resursgruppen), which has branches in almost half of all municipalities. Other municipalities ran schemes with assistance from other NGOs or local volunteers. Sometimes public service employees were involved in the delivery of groceries (for example, the army in Malta). Where volunteers played a role in delivery, organisations' central staff often came from public services (for example, in the case of the Solidarity Assistance Corps for Seniors in Poland) or from established NGOs. In Finland, municipalities used staff from services that were reduced or closed (the social and healthcare sector, sports facilities and cultural institutions, schools and preschools, and technical services) to make phone calls to their older inhabitants.

Some initiatives existed before the pandemic but were more in demand because of the crisis, and usually adjusted their activities. Linka senior in Czechia had 31,505 contacts with users in 2020, up from 25,076 in 2019. Helplines often improved their reachability and capacity. The Silver Line in Lithuania extended its opening times in March 2021 to include weekends. The number of volunteers nearly doubled, from 323 to 610, between the fourth quarter of 2019 and the fourth quarter of 2020. Total call duration also nearly doubled, from 363,849 minutes in 2019 to 704,564 minutes in 2020. The line also began working in close cooperation with state and municipal emergency operation centres. In May 2020, Warm Hands in Lithuania doubled its number of volunteers to 350 (later to 550). In 2020, volunteers visited 1,700 seniors, including 754 (560 in 2019) receiving assistance on a regular basis. They provided 28,000 hours of service (16,000 in 2019), mostly by phone. Volunteers with another Lithuanian initiative, Warm Visits, initially visited over 400 older people. This figure more than doubled as the project continued, as more older people got in touch with municipal social services centres or the Lithuanian Red Cross to request support.

Access problems and mitigation

Despite increased capacity and the emergence of multiple support lines, there have also been access problems. One indicator of such problems is the number of unanswered calls. In Estonia, from 17 June (when it started) to 31 December 2020, 3,277 calls to a national phone line financed by the Ministry of Social Affairs (contracted out to the Pastorate of Tartu) were answered, while 3,697 calls (53% of all calls) went unanswered. In Malta, from March to June 2020, the support line 1772 – 'You are not alone' – answered 5,330 calls, while 1,390 (21%) went unanswered.

It is hard to reach older people in the most vulnerable situations. Groups in less vulnerable situations may find their way more easily to support services. In Lithuania, most callers to the Silver Line were well-educated widowed women aged 70–80 with several children but living alone in urban areas (usually in an apartment), often not the group in the most vulnerable situation (MCLPF, 2020). It has been hard to carry out physical outreach activities during the pandemic. However, local radio and leaflets, for example as used by the NGO Wiosna in Poland, have been used to reach isolated older people. Social media campaigns to alert relatives have also been undertaken (for example, #TellYourNanna in Malta). NGOs have played a role in reaching people who may not be in touch with social services.

Another barrier for beneficiaries can be the administrative hurdles attached to the usual support. In many cases, the pandemic support measures have reduced this barrier. For example, in Poland, the Solidarity Assistance Corps for Seniors provides support immediately, without the need to go through the usual administrative procedure.

Older people in rural settings have been more difficult to serve. In Poland, the local initiative Dobre słowa (through Wiosna, the NGO behind it) tries to find volunteers who live close to the people needing support. However, it can be a challenge to find local volunteers in remote settings. Facilitating transport for volunteers can help. For instance, in France, members of the civic solidarity corps receive a minimum monthly benefit of €107.58 net (in kind or in cash) to cover food and transport costs. In Romania, the May 2020–January 2021 ESF-funded project 'Support for vulnerable people in the context of the COVID-19 epidemic' covered transport and accommodation costs for social workers.

6 Healthcare and long-term care

Healthcare

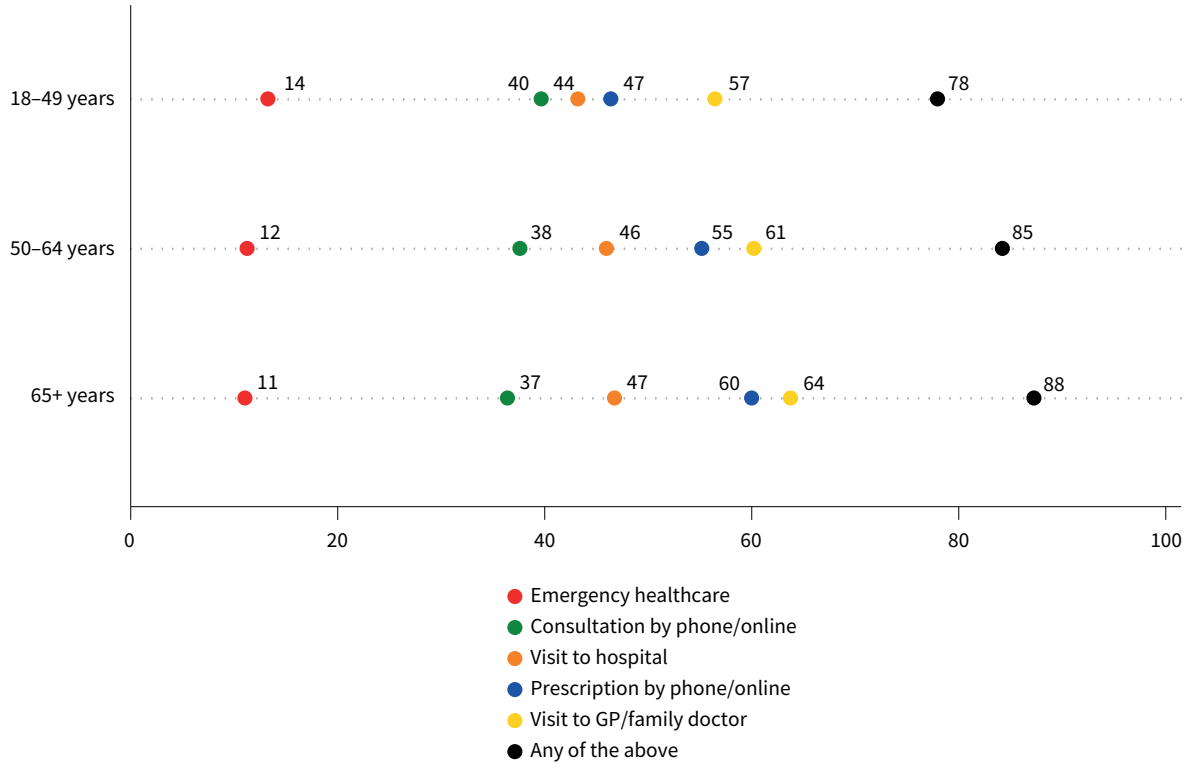
Use of services

During the pandemic, 82% of people of all ages received at least one of the types of medical care included in Figure 18, with higher rates for older age groups. Face-to-face consultations with primary care providers were the most common form of healthcare received by all age groups. However, the difference between the proportion receiving e-consultations and the proportion receiving face-to-face consultations was smallest for the youngest age group.

While there was a surge in COVID-19-related consultations, national administrative data also reveal decreases in care use. In Lithuania, in ambulatory healthcare, there were 39% fewer visits and 22% fewer users in March–June 2020 than in March–June 2019, largely because of reductions in scheduled cardiac care, patients' fear of contracting COVID-19 in healthcare establishments (given media reports of infections in healthcare institutions), and lack of clarity on whether hospitals were continuing to provide care (Vilnius University, 2020). In Italy, there were 28% and 30% fewer hospital admissions and outpatient ambulatory procedures, respectively, in January–September 2020 than in January–September 2019. With regard to hospital admissions, the reductions concerned planned ordinary (-50%), day hospital (-63.5%) and emergency (-26%) admissions. Reductions (especially in hospital admissions) were smaller in southern Italian regions, which were less affected by COVID-19 in that period (Agenas, 2021).

In Portugal, there were 28% fewer external consultations in public hospitals in March–May 2020 than in March–May 2019 (882,333 fewer consultations). The decrease was larger among first-time consultations (40%) – usually referred by a general practitioner (GP) – than among follow-up consultations (23%) (Tribunal de Contas, 2020). In the Netherlands, in early 2021, the number of referrals to specialist care was 97% of that expected under non-pandemic circumstances (NZa, 2021).

Figure 18: Medical care use since the start of the pandemic, by age group, spring 2021, EU (%)



Notes: *Survey question: 'During the last 12 months, have you received any of the following services from a doctor? (1) Prescriptions online or by telephone, (2) medical consultation online or by telephone, (3) emergency healthcare (such as ambulance or emergency department), (4) consultation at the GP, family doctor or health centre premises, (5) consultation at the hospital or a medical specialist premises'. GP: general practitioner.*
Source: Living, working and COVID-19 *e-survey (EU27) round 3*

Access problems

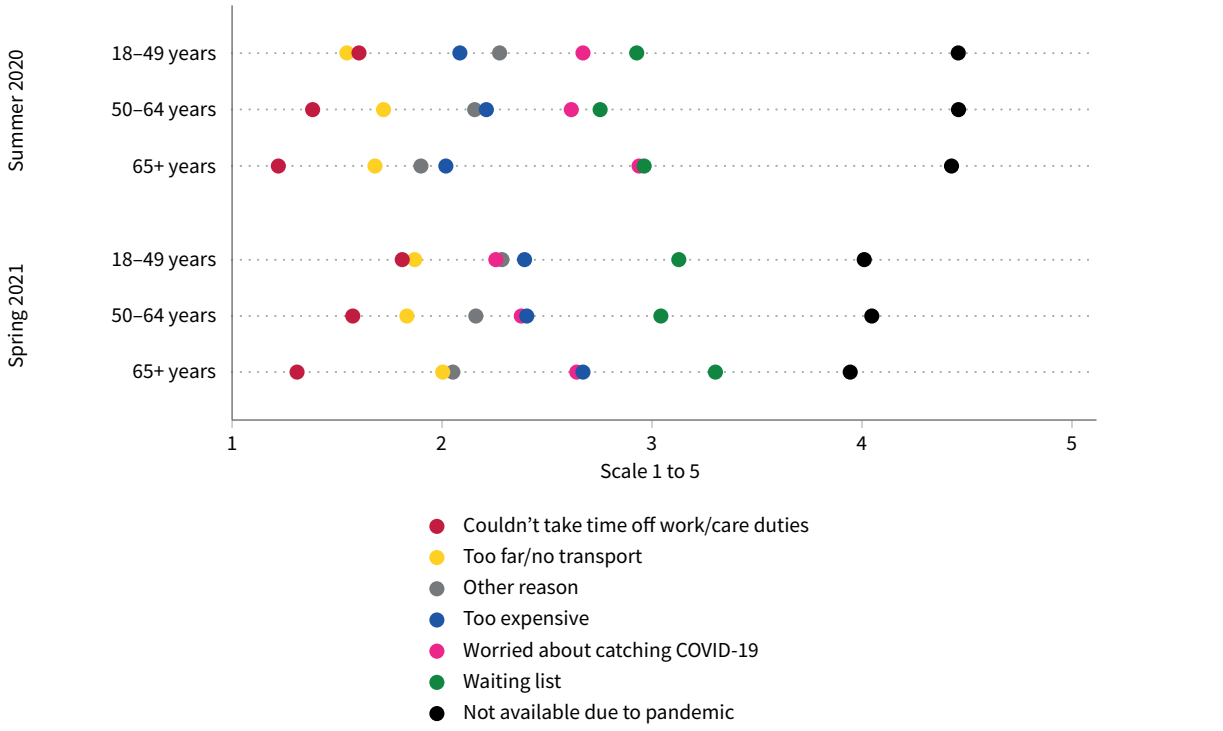
Unmet needs: Reasons

Before the pandemic, many people were already experiencing problems in meeting their healthcare needs, along the multiple dimensions of access (Eurofound, 2020d). The pandemic situation added to these problems. GPs limited face-to-face consultations and specialist care was postponed. Postponement rates differed between types of medical procedures, countries, regions and healthcare providers. For instance, in Italy, healthcare was often postponed in the first wave of the pandemic and restarted in late 2020 and early 2021, but strategies differed between regions. In addition, many people themselves postponed healthcare.

Overall, 21% of people in the EU needed, but did not receive, a medical examination or treatment at some point during the first year of the pandemic (Eurofound, 2021a). This compares with 3.1% reporting an unmet need in 2019 (3.4% for 55- to 64-year-olds and 3.7% for those aged 65+; Eurostat, hlth_silc_08). Among people with unmet needs for pandemic-related reasons (the unavailability of healthcare or fear of catching the virus), 32% did not rate any other reason as important (4 or 5 on a scale from 1 to 5, with 5 being very important). Their unmet needs were clearly mainly caused by the pandemic situation, as other reasons were not assigned much importance. Furthermore, unmet needs because of waiting lists (for instance, because of postponed treatments), having to travel too far or having no transport (reduced access to public transport or support for travelling to see a doctor), unaffordability (as a result of income loss or increased expenditure in other areas), lack of time (owing to childcare/elderly care commitments) and 'other reasons' (such as not wanting to overburden healthcare services) may also be partly pandemic related.

In summer 2020, unavailability of healthcare as a result of the pandemic was the most common reason for unmet needs, followed by waiting lists and worry about catching the virus (Figure 19). The ranking of the reasons is largely the same for each age group, but later on in the pandemic (in summer 2021), in particular, the barriers caused by reachability, unaffordability, fear of infection and waiting lists play a larger role for people aged 65+. Unavailability as a result of the pandemic was the most common reason for unmet needs in all Member States. Fear of catching the virus was most often reported in Bulgaria, Cyprus, Greece, Malta, Romania and Sweden. These countries have below-average levels of unmet needs as a result of unavailability caused by the pandemic.

Figure 19: Importance of reasons for unmet healthcare needs since the start of the pandemic, by age group, summer 2020 and spring 2021, EU



Notes: *Survey question: 'How important were the following reasons for not receiving the medical examination or treatment?'. Average scale from 1 ('not at all important') to 5 ('very important').*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 2 and 3*

While overall unavailability was a dominant reason for unmet needs, for some groups the fear of catching the virus was more prevalent. For instance, in Germany, 26% of people aged 75+ reported cancelling or not arranging medical appointments to reduce their infection risk; fewer people (15%) had medical treatments cancelled because of pandemic control measures (DE1). Among people aged 50+, unmet needs because of cancellation of appointments or fear of catching the virus were less common among the oldest old and more common among women, people with difficulties making ends meet, those with higher levels of educational attainment and those living in urban areas (Smolić et al, 2021).

Of people reporting waiting lists, being unable to take time off work or care duties, or reachability problems as the most important reason for unmet needs (scoring it higher or equal to all other reasons), 54%, 57% and 65%, respectively, also reported unaffordability as a reason to some extent (scoring it 2 or above). Such problems are hard to disentangle (Eurofound, 2020d). For instance, using alternative (privately funded) services, to circumvent waiting lists or access more easily reachable healthcare (or e-healthcare), or transport to reach healthcare (given the lower incomes and more limited access to public transport in rural areas), may be unaffordable.

The importance of waiting lists as a reason for unmet healthcare needs in the EU increased between summer 2020 and spring 2021 (see Figure 19). This was probably caused largely by the 'care debt' resulting from pandemic-related postponements. For instance, in Finland, waiting lists for primary, specialised and dental care increased during the pandemic (Kestilä et al, 2020). In Ireland, in March 2021, at least 622,000 people were waiting for an outpatient appointment and 81,000 for an inpatient or day case appointment – 22% more than in March 2020 (Houses of the Oireachtas, 2021).

Other 'traditional' reasons for unmet needs were also reported more often in spring 2021: reachability problems (too far to travel or no means of transport), unaffordability (could not afford it – too expensive) and being unable to take time off work or care duties. Of these reasons, unaffordability was the most common reason and increased the most. In contrast, the importance of unavailability as a result of the pandemic and fear of infection decreased (see Figure 19).

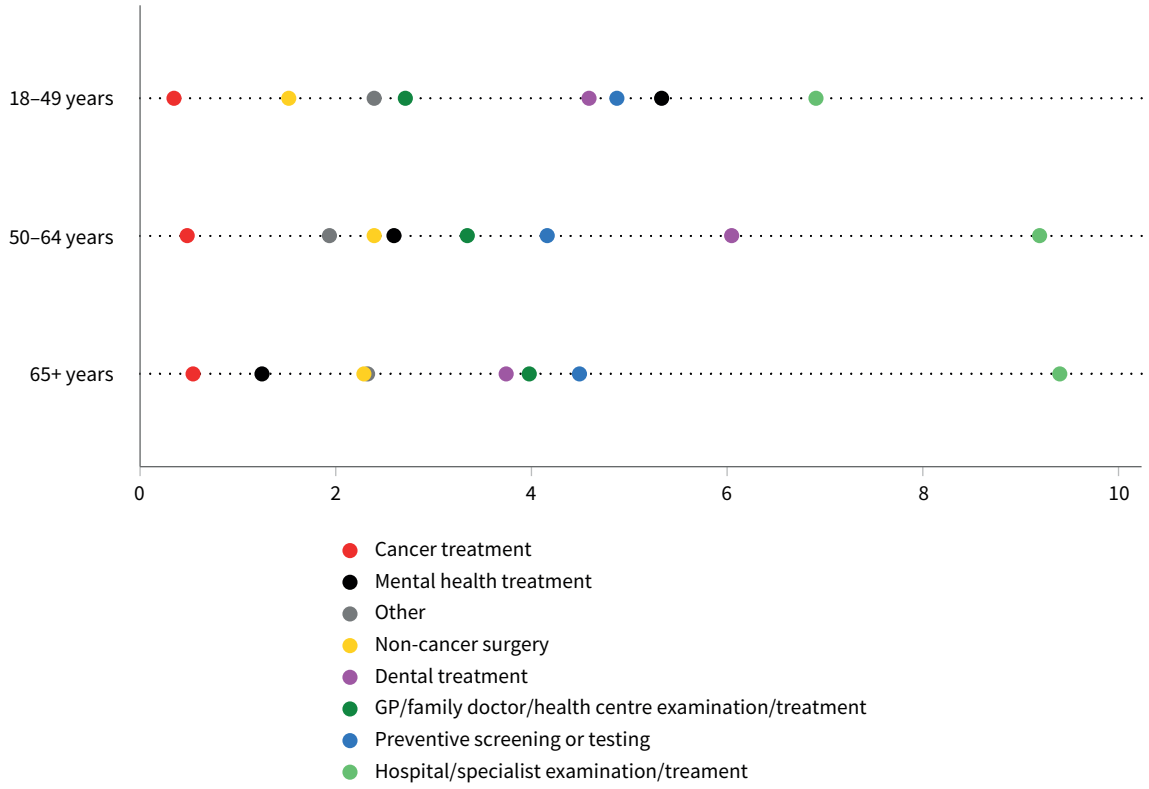
Some unmet needs emerged during the pandemic but were addressed by spring 2021, when 18% said they still had a medical issue for which they could not get treatment (17% for people aged 18–49, 18% for those aged 50–64, and 18% for those aged 65+) (Eurofound, 2021a). Other unmet needs reported during the pandemic already existed. In Latvia, for 15% of people aged 50+, a planned visit to a medical institution was postponed because of the pandemic, and 7% of those whose healthcare need arose during the pandemic wanted to register for a medical service but it was not possible (LV1).

Unmet needs: Type of care

For all age groups, the most common type of unmet need was a hospital or specialist examination or treatment, but this type of unmet need was particularly common among older age groups (Figure 20). Older age groups were also more likely to report an unmet need for cancer treatment or non-cancer surgery, whereas younger age groups were more likely to have unmet mental healthcare needs. Lithuania (13%), Poland (12%) and Estonia (8%) had particularly high unmet needs for primary care among people aged 50+. Hungary (23%), Latvia (21%) and Croatia and Romania (both 18%) had the highest unmet needs for specialist care. Denmark was the only Member State that had unmet needs of 2% or less for any of the types of care included.

National survey data provide insights into the differences in the specific reasons for unmet needs by type of care and how unmet needs for various types of care evolved during the pandemic, as well as information on types of care other than those listed in Figure 20. A Portuguese survey found that people aged 65+ most often reported an unmet need for hospital emergency care (46%, compared with 30% of 25- to 44-year-olds and 29% of 45- to 64-year-olds) (PT7). In Belgium, the proportion of people reporting that an appointment had been postponed or cancelled in the four weeks preceding the survey in early April 2020 varied from 25% for primary care to 90% for rehabilitation care (BE1). During the less strict lockdown in December 2020, proportions ranged from 4% for primary care to 30% for dental care. In Poland, in September 2020 (when the country had still largely been spared from the pandemic), 22% of people aged 55–64 and 28% of people aged 65+ had had a GP appointment cancelled or postponed because of the pandemic. The proportions were higher for specialist appointments: 28% and 33%, respectively. Cancellations by older people themselves were similar for GP (7% and 12%, respectively) and specialist (7% and 11%, respectively) appointments. Among people aged 55+, 4% had hospital treatment cancelled or postponed and 1% cancelled it themselves. A further 14% had a diagnostic test cancelled or postponed and 4% cancelled it themselves (PL6).

Figure 20: Types of unmet healthcare need, by age group, spring 2021, EU (%)



Source: Living, working and COVID-19 *e-survey (EU27) round 3*

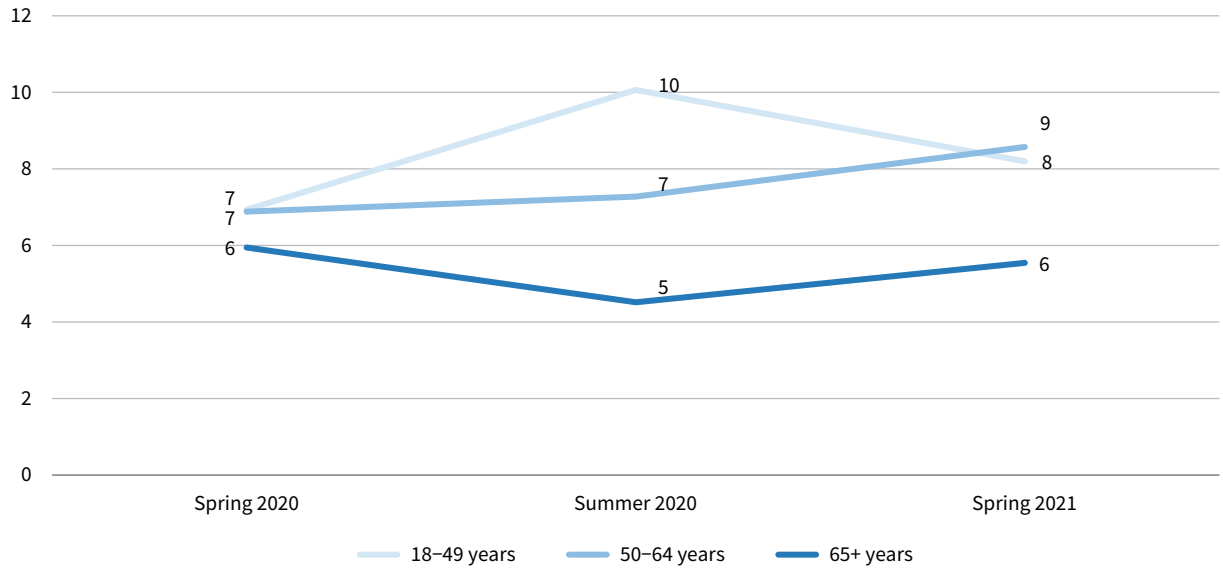
Other access problems

When reporting on access problems, the focus is often on unmet needs. However, sometimes needs are met but are met late or with difficulties (Eurofound, 2020d). A Polish survey found that, while receiving care, 12% of people aged 55–64 and 13% of those aged 65+ reported difficulties making a doctor's appointment (PL6). Some people also did not receive the type of care they wanted. In Malta, with the closure of many private general practices (or with many practices only offering remote care), people turned to public general practices or emergency care (European Observatory on Health Systems and Policies, 2020). Emergency care also fulfilled this back-up role during the 2007 crisis, with challenges in terms of efficiency and adequacy of care (Eurofound, 2014b).

Some people accessed care but were unable to pay the health insurance or healthcare fees (for example, co-payments, or fees for healthcare purchased privately). Such payment arrears can hamper future use of care. They can also build up and cause debt problems, which are themselves associated with health problems (Eurofound, 2020c). Overall, across the three rounds of data collection in Eurofound's *Living, working and COVID-19* e-survey, 7% of people in the EU reported having had healthcare or health insurance arrears in the three months preceding the surveys. The proportion of people with healthcare arrears increased from 7% in spring 2020 to 8% in summer 2020 (amounting to an increase of 18%), but then remained stable until spring 2021. However, the increase in arrears started later in the pandemic for older age groups, possibly because of greater financial resilience early on (Figure 21). For younger people it declined later in the pandemic (possibly being replaced by unmet needs).

Healthcare and health insurance arrears were most common in Bulgaria (20%) and Greece and Latvia (both 16%), followed by Croatia (11%), Belgium (10%), Cyprus, the Netherlands and Poland (all 8%), and Finland, Portugal and Romania (all 7%). They were least common (3% or below) in Austria, Czechia, Denmark, Lithuania, Malta and Spain. Lack of access to healthcare can be associated with arrears related to care bought privately (possibly contributing to the high rates of arrears in Bulgaria, Greece and Latvia). However, lack of access to healthcare may also prevent people from accumulating arrears. This may be the case in Lithuania, which ranks fifth (after Greece, Romania, Latvia and Bulgaria) among the countries where unmet needs are highest because of unaffordability.

Figure 21: Healthcare or health insurance arrears, by age group, EU (%)



Note: *Survey question: 'Has your household been in arrears at any time during the past 3 months, that is, unable to pay as scheduled … (6) payments for healthcare or health insurance?'*
Source: Living, working and COVID-19 *e-survey (EU27) rounds 1, 2 and 3*

Fear of being unable to access healthcare when needed matters for quality of life (Eurofound, 2018a). In Sweden, in May 2020 (when the pandemic had hit to a considerable extent), 59% of people aged 70+ worried about not receiving healthcare of sufficient quality if they became ill (SE2).

General survey questions on access are more likely to capture other access problems alongside unmet needs. In a Polish survey, 67% of people aged 60+ reported problems accessing healthcare during the pandemic. Interestingly, a group that did not seek the care needed because of fear of catching the virus did not report access problems: they did not see their reluctance to seek healthcare as an access problem (PL3). In a Lithuanian survey conducted among people living alone, 74% reported having reduced access to doctors during the pandemic (LT1). In Portugal, overall, 57% of people believed that the pandemic had hampered their access to healthcare, with higher rates among people aged 65+ (69%) and the chronically ill (70%) (PT7).

Health impact of unmet needs

Unmet needs can exacerbate health conditions. In Slovenia, by September 2020, because of reduced monitoring of gynaecological cancers in the first wave of the pandemic, 19% fewer high-grade pre-cancerous changes were detected in women aged 30–39 compared with the three-year average. This is of concern as the peak incidence of cervical cancer is in women aged 40–49 if not treated in time. In Malta, there was a decrease in the number of patients aged 70+ reaching hospital within three hours of experiencing symptoms of a stroke.

National surveys highlight that people think or fear that unmet healthcare needs impact their health negatively. In Hungary, 30% of people aged 60+ indicated that postponing health interventions because of the pandemic had worsened their health (25% of the overall population) (Medical Online, 2021). In Croatia, 60% of pensioners worried about their health conditions deteriorating because of the unavailability of healthcare during the pandemic (HR2).

Measures and initiatives: Facilitating access through e-healthcare

Measures were taken to facilitate access to healthcare during the pandemic. For instance, protocols were adopted to ensure safe face-to-face consultations and inpatient care, and hospitals were paid to increase their intensive care capacity. In this report, the focus is on the use of e-consultations and e-prescriptions; their increased availability is discussed in more detail elsewhere (Eurofound, 2020d). To illustrate, in April 2020, Malta set up two primary healthcare telephone consultation centres (run by GPs and GP trainees), one for monitoring COVID-19-positive patients who did not require hospitalisation, and a telemedicine 24/7 service for other consultations (free for users). Where e-healthcare systems had been in place prior to the pandemic, restrictions were lifted. Examples include the temporary removal of user fees (France) or the need for the first consultation to be face-to-face (Estonia and France). The use of e-prescriptions also became more flexible; for instance relatives were allowed to collect prescribed medicines from pharmacies (Hungary).

This section aims to map people's experiences of such measures, focusing on survey results and the extent to which these forms of e-healthcare were taken up (usage data). The challenges encountered are also highlighted.

Use

E-prescription and e-consultation use by people aged 50+ had almost tripled by spring 2021 (58% and 37%, respectively) compared with 2016 (19% and 11%, respectively – EQLS 2016). In spring 2021, e-consultations were less common among older age groups than younger age groups, but the use of e-prescriptions was more common (see Figure 18). This may be explained by repeat prescriptions being more common for older people than for younger people, who have fewer chronic conditions; these were more likely to be e-prescriptions than first-time prescriptions.

National data confirm that many older people used e-healthcare. In Estonia, of the 280,000 remote appointments made through the new e-consultation system between March and July 2020, 44% were made by people aged 50+. Of 781,546 specialist care appointments from January to March 2021, 82,199 (10.5%) were remote. In early 2021, just below half (49%) of all specialist appointments were made by people aged 50+, while remote specialist appointments were somewhat more often made by people aged 50+ (50%). Remote specialist appointments were particularly popular for people aged 50–64 (somewhat less so for people aged 65+): 26% were made by people in this age group (24% for people aged 65+) compared with 22% of all specialist appointments (Estonian Health Insurance Fund data). In Greece, the Region of Western Greece provided e-consultations with paediatricians, pathologists, GPs and pneumologists through an app, without user fees. Of the 1,000 consultations conducted between March and June 2020, 13% of users were aged 56–65 and 5% were aged 66+.

National data confirm increases in e-healthcare use. In Portugal, from March to May 2020 there were 57% fewer face-to-face consultations and 58% fewer home visits than in the corresponding period in 2019. Simultaneously, teleconsultations increased by 83%, accounting for 65% of consultations between March and May 2020 (compared with 27–30% in previous years) (Tribunal de Contas, 2020). In Austria, before the pandemic, 4% of people aged 50+ had used telemedicine; this doubled to 8% during the first lockdown in 2020 (Spectra, 2020). Familiarity with (the term) telemedicine increased. In May 2020, 37% of people aged 15+ had heard of telemedicine, with the highest rate (52%) among people aged 50+ (Spectra, 2020). In Belgium, e-consultations were virtually non-existent before the pandemic (Eurofound, 2020d). By November–December 2020, while still uncommon in rehabilitative and specialist care, about one-quarter of mental healthcare consultations and one-tenth of primary care consultations were provided electronically (Sciensano, 2020).

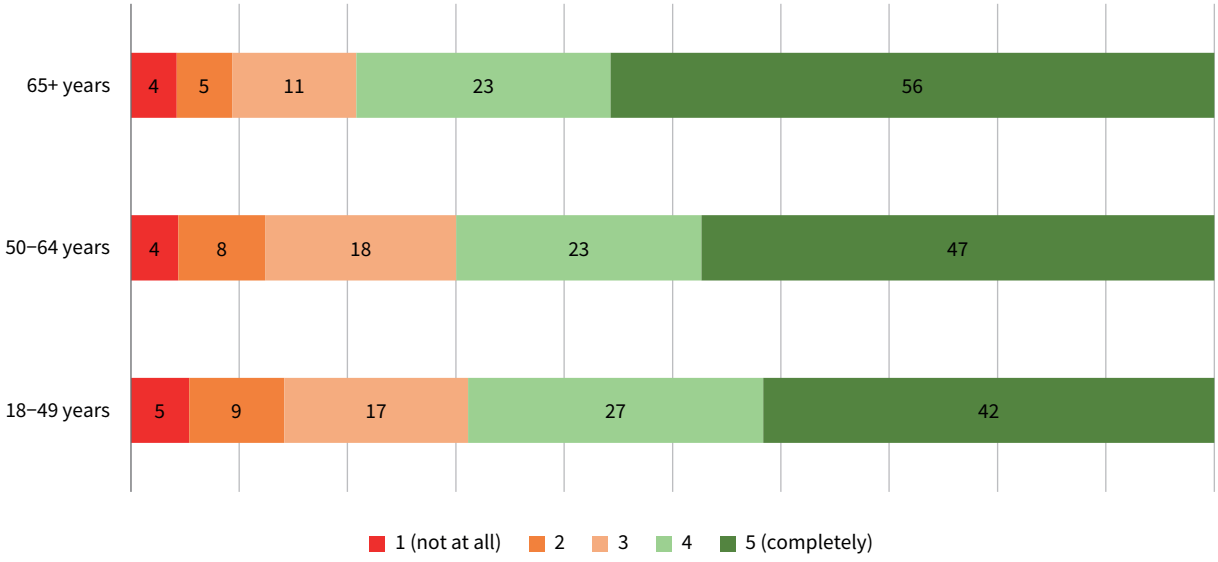
Challenges

E-healthcare has contributed to providing access to healthcare for many, while preventing the spread of the virus. The experience of using e-healthcare has been particularly positive for some specific groups. For instance, in Finland, occupational healthcare users aged 50–70 seemed particularly satisfied, especially regarding e-consultations with doctors and psychologists, online chat services and online booking services (Kestilä et al, 2020).

However, general limitations of e-healthcare apply and have been discussed elsewhere (for example, Eurofound, 2020d). The drastic move to e-healthcare during the pandemic has provided more evidence on experiences of e-healthcare. In spring 2021, among people who did not use an e-consultation, 48% of people aged 50+ did need a consultation, compared to 40% of younger people. Older people who did not use an e-consultation even though they needed to see a medical expert most often reported that they had not done so because they chose to have a face-to-face consultation, as it was their preference (56% versus 44% among younger people). The second and third most important reasons were that the issue could only be addressed through a face-to-face consultation (24% for people aged 50+) and the unavailability of e-consultation services (10%), both more common among younger people (34% and 17%). A reason that was less frequent, but more common among older people (6% versus 3%) was that the services were too difficult to use. Lack of access to the necessary devices and unaffordability were less frequent reasons for not using e-consultations when needed, but showed little difference between 50+ and 18- to 49-year-olds (2% for both age groups, and 5% and 6%, respectively) (authors' calculations using data from the *Living, working and COVID-19* e-survey). There have also been capacity problems. For instance, in Finland, some healthcare centres temporarily shut down call-back services, as they could not cope with the quantity of calls (Kestilä et al, 2020).

Some problems relate to the quality of the service. In Finland, concerns were raised about the quality of digitalised services in psychiatric care (Kestilä et al, 2020). Portuguese evidence suggests that the role of primary care in guiding users towards more differentiated hospital healthcare was hampered by the move to e-consultations (Tribunal de Contas, 2020). Being a trusted service, primary healthcare often plays an important role in guiding users through the broader social support system, such as making them aware of welfare and social services entitlements (Eurofound, 2019). This role is likely to have decreased.

Figure 22: Extent to which e-healthcare met users' needs, by age group, 2021, EU (%)



Notes: *Survey question: 'You indicated that you received a medical consultation online or by telephone. To what extent over the last 12 months did it meet your needs?' Response categories ranged from '1 – Did not meet my needs at all' to '5 – Met my needs completely'.*
Source: Living, working and COVID-19 *e-survey (EU27) round 3*

For people of all ages who used e-healthcare, 53% reported that it did not completely meet their needs. Older people (especially those aged 65+) were more likely than younger people to report that it fully met their needs (Figure 22). However, 49% of people aged 50+ reported that e-healthcare had not completely met their needs, scoring it 1–4 on a scale from 1 (not at all met) to 5 (completely met). On average, the extent to which e-healthcare met users' needs decreased with worsening health status, from 4.4 among people aged 50+ with very good health (4.2 for those aged 18–49 with very good health) to 3.6 among those with very bad health (2.4 for those aged 18–49 with very bad health). Bad health may be caused by unmet needs, or the healthcare needs of people with worse (or more complex) health problems are less likely to be met by e-consultations.

E-healthcare was often used in primary care and mental healthcare. Remote specialist care was rare. For instance, in Portugal, e-consultations in primary care surged early in the pandemic, but remained uncommon in hospital care, not exceeding 4,000 consultations per month (Tribunal de Contas, 2020). Estonia sought to stimulate specialist e-care (5% needed to be remote for service providers to be entitled to performance pay). In 2020, 363,932 remote specialist care appointments were made (11% of all specialist care appointments), mainly in internal medicine (38%) and psychiatry (22%) (Eesti Haigekassa, 2021). Nevertheless, barriers have been identified in Estonian specialist e-healthcare: blood tests need to be carried out in a hospital, usually where the consulting doctor works, rather than in a local healthcare centre.

Screen-to-screen (video) consultations were relatively common in only a handful of Member States prior to the pandemic (Eurofound, 2020d). Some countries (for example, Finland) reported large increases in screen-to-screen consultations during the pandemic. On the whole, e-consultations were usually carried out by phone. A Polish survey found that 33% and 32% of people aged 55–64 and 65+, respectively, had had a consultation by phone, and 2% and 1%, respectively, had had a consultation online (PL6). In Estonia, early in the pandemic, 67% of doctors carried out remote consultations only by phone, 15% carried out phone and email consultations, and 18% carried out phone and video consultations (Paat-Ahi et al, 2020). Lack of visual contact can compromise care quality. Estonia sought to address this by making a service provider's performance pay dependent on at least 10% of remote appointments per medical field being screen-to-screen consultations; patient satisfaction also needed to reach 70%. Prior to the pandemic, France already had a system in place that required e-consultations to be screen-to-screen. Access is facilitated through pharmacies, where users also have access to measurement instruments (Eurofound, 2020d).

Other problems related to barriers to using the services. In Latvia, by summer 2020, 23% of people aged 50+ had received e-healthcare services. However, 8% were not able to do so for financial reasons and 8% were not able to do so for disability or health reasons (for example, cognitive or visual impairment). In cities, 34% of older people used e-healthcare, double the rate elsewhere (17%); people with higher education were also twice as likely to receive e-healthcare as those with lower levels

of education (LV1). In Poland, 14.5% of people aged 60+ reported not having access to e-prescriptions (PL3).

Rapidly implemented changes have not always benefited from the types of integrated information and communications technology (ICT) systems needed to reap the broader benefits of e-prescriptions (Eurofound, 2020d). Furthermore, dropping the requirement for the person in need of medications to collect them from a pharmacy led to accountability problems (Hungary), while maintaining this requirement was a barrier to carers providing support (Estonia).

Long-term care

Home, community and residential care

In many Member States, especially early in the pandemic, access to **home and community care** was temporarily discontinued or reduced, and often restricted to the most urgent cases. This was to prevent the virus spreading among users and staff; staff shortages (for example, because of self-isolation) also reduced supply (SPC and EC, 2021b). For instance, in Finland, 19% of municipalities restricted home care visits (Kestilä et al, 2020). Day care services were often closed temporarily or access was restricted, or day care leisure activities reduced.

The pandemic situation mainly impacted supply. However, demand for home and community care services was also probably impacted. As with healthcare (see 'Healthcare' on p. 43), this is likely to have been the case in particular in countries where authorities reduced availability to a lesser extent.

Reduced access to home and community care is reflected in national data. In Sweden, while home care service users generally still received care between March and May 2020, the number of new service users decreased from 328 to 205 users per 100,000 people, reversing an upward trend, probably because of fear of contracting the virus when visiting social services workers (Socialstyrelsen, 2020). In June 2020, there was a slight increase in new service users, but the average was still lower than in previous years. The biggest decreases were for people aged 80+ (24% for women and 21% for men) and in regions with COVID-19 outbreaks. At the same time, limited supply also played a part: between January and June 2020, 18,200 people had to wait for more than three months for their first visit, up from 9,900 in the same period in 2019 (Socialstyrelsen, 2020). In Latvia, prior to the pandemic, 4% of people aged 50+ received regular home care. By late July–August 2020, 8% of them reported that receiving this care was difficult because of the pandemic situation (LV1). In Portugal, nursing activity in primary healthcare from March to May 2020 was 29% below that of the same period in 2019 (1,510,415 fewer nursing contacts) (Tribunal de Contas, 2020).

The supply of **residential care** was also reduced. Some residential care providers sent residents to live with family members. More often, however (for example, in Bulgaria, Croatia, Estonia, Luxembourg and Poland), access for new residents was temporarily restricted, sometimes to the most urgent cases (Bulgaria) (SPC and EC, 2021b). In Austria, residential care homes reduced capacity to create space and thus minimise the risk of infections spreading. In some countries with limited access to long-term care, hospitals play a role in long-term care provision (Eurofound, 2020b). The pandemic situation reduced the supply of such hospital-provided long-term care. In April 2020, in Hungary, almost 40,000 hospital beds were assigned to potential COVID-19 patients (this was reduced by one-third in May 2020). As a consequence, some people with healthcare and long-term care needs were sent home (European Observatory on Health Systems and Policies, 2021).

Demand for residential care has also probably been reduced, with high COVID-19 death rates in residential care and reduced attractiveness because of restrictions on visits. Few data on this were identified. None of the surveys identified asked about trust in or intended future use of residential care. In Hungary, moving into residential care was postponed by some, leaving some residential care homes operating below capacity (80–90% of beds filled). The pandemic may have accelerated the emphasis on home and community-based care. For instance, in January 2021, Italy established a national commission for the reform of social and healthcare assistance for the elderly. It emphasised the need for non-residential and home care services to play a bigger part in promoting and supporting older people's independent living.

With reduced demand for and supply of residential care, some people turned to home care, including private options where access to publicly funded home care was restricted. In Spain, demand for home care services on digital platforms increased by 160% between February and June 2020. Two-thirds (66%) of the platforms interviewed considered reduced trust in residential care (and increased trust in home care) because of the numbers of COVID-19 cases and deaths in residential care the main reason (Digital Future Society and Banco Interamericano de Desarrollo, 2021). In Finland, one-third of social and healthcare sector directors reported that the number of home care users had increased during the first months of the pandemic and one-quarter said that contacts regarding new users had increased, about half reported no change and 10% reported a decrease in the number of users and contacts regarding new users. In some municipalities, people turned to private care and support services because of the discontinuation of publicly funded services (Eronen et al, 2020).

Many were also left with **unmet needs**. In the EU, about one in five care recipients aged 50+ had difficulty in obtaining adequate care from outside the household during the pandemic (Bergmann and Wagner, 2021). Countries with longer stay-at-home orders had more unmet needs.

The quality of care was also impacted, leading to unmet needs among people who did receive long-term care services, alluding to the broader understanding of 'access to care services' (Eurofound, 2020d). For instance, the pandemic has impacted end-of-life care. In Sweden, fewer end-of-life discussions were held, and dying without relatives present became more common. In hospitals and nursing homes, examination by a physician in the last days before death, pain and oral health assessments and specialised palliative care consultations were less common among people dying from COVID-19 than among those dying from another cause. Compared with those dying in hospitals, people dying in nursing homes were older and more often women; they were more likely to die without relatives present, and medical investigations and end-of-life discussions were less common (Strang et al, 2020).

Live-in care

Some Member States rely particularly heavily on domestic care workers, employed by those in need of long-term care or their relatives. These care workers often live with the care receivers. Such live-in care is particularly common in Austria, Cyprus, Germany, Greece, Italy, Malta and Spain (Eurofound, 2020b). On the one hand, this form of care implies relatively few contacts with different carers, thus contributing to feelings of safety with regard to catching the virus. This, and reduced access to residential, community or home care during the pandemic, may have led to increases in live-in care. In Cyprus, an estimated 14,825 carers were employed by households in 2019. This increased to 15,947 in 2020 and 18,754 in the second quarter of 2021. Many of these carers were likely to be live-in carers and they were almost exclusively non-EU migrants. On the other hand, live-in care comes with risks for both the quality of care and carers' working conditions. Domestic carers feel financial pressure to work even when ill because of the absence of sick leave (Eurofound, 2020b). In Austria and Germany, these workers often come from other EU Member States (mainly Romania and Slovakia, and Poland, respectively) and alternate periods of care work with periods in their home countries. Travel restrictions during the pandemic left care gaps for users (and income gaps for carers) (Leiblfinger et al, 2021). It also left care providers with non-nationals in their workforce with staffing gaps. Long-term care services in Austria and Luxembourg rely particularly heavily on mobile workers (Eurofound, 2020d).

Informal care

During the pandemic, formal care was often replaced by informal care by relatives or friends. This was probably for both demand-side reasons (for example, the person in need of care being fearful of catching the virus and people on job retention schemes being more available to provide informal care) and supply-side reasons (see 'Home, community and residential care' on p. 50). In Slovakia, informal carers are entitled to a care allowance. In December 2020, 71% of the 65,197 people receiving care were aged 50+ (50% were aged 80+, 35% were aged 65–79, and 15% were aged 50–64). Compared with December 2019, the number of people aged 50+ receiving informal care from someone receiving an allowance had increased by almost 8% (from 42,973 in December 2019), whereas the number of younger people receiving informal care had increased by about 4% (from 18,148 in December 2019).

Informal care also ceased or was reduced during the pandemic, for example because of fear of infection, or reduced availability of informal carers because of their childcare commitments when access to childcare facilities and schools was reduced. In Belgium, 94% of those who used cleaning services reported that these services were discontinued, and 50% of those who used family or elder care no longer received this service. In December 2020, of those who usually received help from family, neighbours or friends, around 17% reported no longer receiving this help, 23% reported receiving less help and 15% reported receiving more help. The impact of the December 2020 lockdown on access to home help was smaller than that of the spring 2020 lockdown. Nevertheless, 4 out of 10 people aged 18+ indicated that family assistance or care for the elderly and help from relatives, neighbours and friends had stopped or decreased (BE1). Informal care for relatives or friends in residential settings was also more challenging because of visitor restrictions and fear of infection (Lorenz-Dant and Comas-Herrera, 2021).

Support services for informal carers were also affected. Even before the pandemic, these support services were rare across the EU (Eurofound, 2020d). During the pandemic in Finland, the reduction in access to substitute carers meant that some informal carers were unable to take the two days off a month to which they are entitled (Kestilä et al, 2020). Overall, 29% of directors in the social and healthcare sector and social workers said that support services for informal carers had decreased and 46% said that there had been no change. One-tenth (10%) estimated that there had been an increase in the services provided for informal carers (Eronen et al, 2020).

To reduce the risk of infection, informal care networks were tightened. In Ireland, 77% of those caring for someone with dementia said that their workload had increased since the outbreak of COVID-19 (IE5). In addition to changes in informal care patterns, providing

care in the pandemic context poses additional challenges for well-being. In Austria, the mental well-being gap between carers and non-carers increased during the pandemic, especially for men (Rodrigues et al, 2021). In Finland, with regard to the impacts of the pandemic on elderly people, the burden on informal carers was the second biggest concern, after loneliness, for directors of social and healthcare services (Eronen et al, 2020).

Measures and initiatives

Funding and reshaping services

Many countries implemented measures to guarantee some level of home care while services were disrupted. Spain allocated €300 million partly for funding home care services (instead of the usual community day services or even residential care), such as rehabilitation services, occupational therapy and hygiene services. In Finland, home carers were matched with smaller groups of clients, so that fewer employees visited a particular client. Contact with clients and relatives over the phone (or by video conference) was intensified. Sometimes care entitlements were increased. In Malta, from September 2020, people aged 65–74 were entitled to two hours of home help a week, and people aged 75+ no longer needed the Home Help Allocation Board's approval to receive home help. In 2021, the annual care at home subsidy was increased from €5,291 to €6,000. In Austria, the meals on wheels service was expanded.

Some initiatives showed particularly proactive approaches, reaching out to older people, including non-users of social services, to assess their needs. From May 2020 to January 2021, Romania established a scheme supporting people aged 65+ in specific vulnerable situations (for example, living alone or without family support nearby). Around 1,000 social workers identified eligible people, established individual intervention plans and set up community networks to provide long-term support. The project included a national call centre to coordinate requests by people in need of support and provide analysis of social needs at national level. The budget was RON 84.5 million (€17 million) and the scheme was co-funded by the ESF. In Barcelona, the ¿Cómo está? ('How are you') initiative involved municipalities calling older people who might potentially need support who were not already users of municipal social services; they were identified through institutional resources of other city council services (for instance, through home carers asking users if they had neighbours suffering from involuntary loneliness). In Finland, over half of the municipalities called inhabitants aged 70+ (usually focusing on those who did not use home or residential care) to determine their need for potential assistance and their care needs and to provide support for mental well-being. Implementation varied across the municipalities: in some, the focus was on ensuring that information reached those not used to finding information online; in others, the focus was more on mental health and social inclusion, with more time allocated per call (up to 30 minutes). In Hungary, municipalities were urged by the national government to contact older people to assess their needs and to address these needs through their local social services. This was a challenge for smaller municipalities lacking the necessary resources.

Facilitating informal care

Several countries adopted or reformed 'carer's leave' policies during the pandemic to facilitate informal care by relatives or friends (for example, France, Germany and Spain). This policy response was mainly triggered by the sudden closure of residential or community care, reductions in the scope of home care services or the unavailability of long-term care workers. Usually, these arrangements involve workers taking unpaid leave (unless pay is specified by company or collective agreement), with the agreement of their employers. Policies were implemented temporarily (Spain) or adjusted – Germany temporarily extended unpaid care leave entitlement from 10 to 20 days if related to COVID-19. In France, a public €44 daily allowance for up to 66 days for carers was voted on in 2019 before the pandemic but was implemented in September 2020.

Elsewhere, existing support measures for carers were impacted. In Czechia, courses for carers (supported by the ESF) that had been conducted since 2013 went online. Interestingly, they were better attended than previous face-to-face courses. Support lines sometimes also targeted carers of older people; for example, 80% of callers to Linka senior in Czechia were older people and 20% were carers. Other information resources established during the pandemic also targeted both older people and their carers, such as the web page *Rompre l'isolement des personnes âgées* ('Breaking the isolation of older people') in France, which provides information and support, and an associated phone line. Austria provided digital care courses for carers, and training videos on the correct use of protective measures were developed. In Lithuania, from 1 June 2020, when a flexible respite care service was implemented, until 1 February 2021, 221 people applied to municipalities for respite care services. In total, 131 people received them and 83 and 7 were put on waiting lists for day home care and short-term respite in a social care facility, respectively.

Top-ups of monetary benefits were also sometimes provided to carers. For instance, the April 2021 bonus for pensioners in Latvia (see Chapter 4) was also paid to 18,827 recipients of the carer's allowance.

Facilitating live-in care

In Austria and Germany, live-in carers often work in shifts, alternating periods in the care receiver's country with periods in their (bordering) home EU Member State. In 2020, Austria provided €100 million to safeguard continuity of care. For live-in care, the funding included organising charter flights or trains and quarantine hotels for care workers, bonus payments for carers who stayed with their clients beyond their regular two- to four-week shift, and the establishment of a hotline to coordinate live-in care across regions (Leichsenring et al, 2020). In Germany, measures introduced mostly consisted of extending shifts and facilitating cross-border mobility (Leiblfinger et al, 2021).

The European Commission (2020b) issued guidelines on the free movement of workers during the pandemic, stating that Member States should permit and facilitate the crossing of frontier workers, in particular those working in 'the health care and food sector, and other essential services (e.g. childcare, elderly care, critical staff for utilities) to ensure continued professional activity'. However, especially in Germany, live-in care workers often work irregularly and are unable to demonstrate their elderly care work with a (legal) contract. National implementation of the guidelines created further hurdles. In Austria, commuters had to work within a certain distance of the border to be entitled to cross the border more easily (for example, to be exempt from providing a recent COVID-19 test result), disqualifying many live-in care workers, who tend to work at longer distances from the border.

In May 2020, Italy, where many domestic carers are undeclared workers, promoted the regularisation of migrant domestic and rural workers by making COVID-19 support dependent on it. Applications could be made from 1 June to 15 August 2020. Despite a €500 fee for employers, 207,542 applications were made (85% of home and domestic care workers), including 176,848 requests for regularisation. By December 2020 only 1,480 residence permits (and 8,887 temporary permits through a separate procedure under the May 2020 regulation) had been issued, partly because of administrative and human resource limitations (Morlotti, 2021).

E-long-term care

The pandemic hit at a time when many e-long-term care services were still at an experimental stage. In some cases the pandemic delayed digitalisation; however, as in healthcare, the pandemic also stimulated ICT use – often low-tech solutions (voice or video calls) – in long-term care. In Finland, video calls were implemented by home care units instead of physical visits. Austria added teleconsultations and digital care courses for relatives to day and home care packages.

The crisis sometimes induced governments to increase funding for e-long-term care. In 2020, the Netherlands added €23 million to its Incentive Scheme for E-health at Home (Stimuleringsregeling E-health Thuis) to finance digital technologies for providing care from a distance, targeting local care teams, psychological support professionals and hospitals. Later, €77 million was added (€53.7 million for district nursing and €23.3 million for primary care, mental health organisations and Social Support Act care providers). Spain also allocated funds to increase the provision of home e-care devices.

In Denmark, DigiRehab, a pre-pandemic programme of rehabilitation and physical exercises for the elderly receiving home care, saw an increase in take-up. Such courses typically last 12 weeks and users are assisted by instruction videos and supervised by caregivers. It has been argued that the programme reduces the time needed for home care by around 45 minutes per week. It is used by 20% of all municipalities, and user numbers increased in 67% of those municipalities during the pandemic.

Although planned pre-pandemic, the city of Tallinn (Estonia) reduced the administrative burden on home care workers during the pandemic by providing tablets for ordering food deliveries from grocery stores (paid for by the users) and contacting other specialists (for example, family doctors, with the option of sending photographs showing users' health problems). The delivery of medicines was excluded, as a power of attorney is required when ordering prescription medicine for someone else. In March 2016, the Swedish government entered into an agreement with the Swedish Association of Local Authorities and Regions to strengthen digitalisation and e-care in elderly care. This agreement was extended in 2020 for another three years. In 2021, SEK 200 million (€20 million) will be spent on digitalisation initiatives. In Övertorneå (Sweden), home care staff carry out needs assessments and provide relevant digital technologies to users. Most new technologies are at the testing stage (and implementation has been delayed because of the COVID-19 crisis), but camera surveillance overnight (along with automatic medicine dispensers) has been a popular measure among users and night staff, preventing users from being woken up during the night for check-ups and staff from having to drive long distances.

Healthcare and long-term care workforce issues

Staff shortages played a role in reduced access to health and long-term care before the pandemic, with larger problems anticipated in the future. Current and expected shortages are particularly acute for skilled nurses (Eurofound, 2020b; European Commission, 2020c). When asked in June 2020 about their greatest concerns regarding elderly care in the following months, municipalities in Finland considered adequacy, workload and the resilience of staff the greatest challenges (FI6). In Ireland, waiting lists are partly caused by vacant medical consultant posts. Although Bulgaria included psychological care in its home and social care programme, some municipalities were unable to provide this because of staff shortages.

Overall, while it is likely that care staff shortages were higher on the agenda of policymakers before it started, the pandemic situation has exacerbated staff shortages, for the following reasons.

- Working conditions have become increasingly challenging, with an even larger turnover of staff than previously; for example, in Ireland, in May 2021, 61% of nurses had considered leaving the profession because of the impact of the pandemic on well-being (Cornmarket.ie, 2021), and in Germany, in December 2020, 31% of care workers had considered leaving the sector.
- The introduction of COVID-19 protocols required additional human resources, for example meals had to be delivered to residents' rooms rather than to a common area.
- There has been an increase in sick leave (absenteeism) because of strain and increased awareness of and responsiveness to the risk of infection; for example, in the Netherlands, absenteeism in health and care was 7% in 2020, up from 5% in 2018 and 2019.
- Specifically in long-term care, the following apply.
  - The concentration of deaths in larger-scale residential care settings may have accelerated the emphasis on home and community-based care, already set in motion by deinstitutionalisation processes and endeavours to improve quality of life and inclusion in the community; such care tends to be more human resource intensive and needs different skills.
  - Healthcare tends to be a more attractive employer than long-term care (Eurofound, 2020b); the pandemic may stimulate governments to locate resources especially in healthcare, leaving long-term care at a disadvantage when competing with healthcare for staff, especially for skilled nurses, where shortages are concentrated already.

Measures and initiatives: Sustaining adequate care staffing

The long-term care workforce expanded by 33.5% from 2009 to 2019 (Eurofound, 2020b). The healthcare workforce has expanded by 12.8% in the same period.[4] During the pandemic, this trend may have continued or even accelerated. In the Netherlands, the number of nursing and care sector workers grew by 34,000 (20,000 full-time equivalents) between 2017 and 2019; in the first nine months of 2020, a further 8,000 workers (5,000 full-time equivalents) joined the sector. Because of increased care needs, improved access to care and many care workers retiring, the need for staff was already expected to continue increasing in the EU before the pandemic. From 2019 to 2020, however, employment in the health and social work sectors remained relatively stable in the EU. The average figure disguises nuances, such as a decline in the employment of people under 65, and an increase among those aged 65+. Employment in these sectors declined particularly strongly (by more than 2%) in Luxembourg, Estonia, Germany, Slovakia, Lithuania, Finland and Croatia, while it increased most notably in Spain, Cyprus and Greece (EU-LFS, lfsa_egan2).

During the pandemic, some countries took measures to maintain or improve staff–user ratios. In Finland, the crisis hit amid the implementation of reforms seeking to increase the number of staff per care user. In Upper Austria, the regional government approved a 2% increase in the staff–user ratio for care workers, which was optional for long-term care providers. In Estonia, the government supported care institutions by compensating them for additional labour costs arising from having to replace infected workers (as of December 2020, compensation of €367,214 had been paid to 14 care providers). Poland temporarily increased the remuneration (and sickness payment in the case of infection/quarantine) of medical and care staff. Spain also allocated additional funds to strengthen social services centre and residential centre staffing.

4 Based on an EU-LFS extraction provided by Eurostat and analysed by Eurofound for this report.

Trainees and volunteers were also engaged. In the Netherlands, Extra handen voor de zorg ('Additional hands for care') recruited volunteers in healthcare and long-term care. The number of internships at care homes grew as part of a longer-term strategy, but the large increase (by 15% between 2019 and 2020) was probably explained by the pandemic. Long-term care workers were also recruited from professions hit by the crisis, such as flight attendants and waiters (Eurofound, 2020b). In Spain, public administration and private sector strategies to cope with staff shortages consisted of relocating public employees, recruiting retired staff and facilitating the hiring of newly qualified workers. Long-term care services further resorted to the Military Emergencies Unit and other emergency services (such as SUMMA 112 in Madrid) to carry out basic tasks in residential care (Hernández-Moreno and Pereira-Puga, 2021).

Summary of the report's findings

The COVID-19 health crisis has hit the EU's growing older population particularly badly, with higher rates of severe illness, hospitalisation and death. Older people also have greater needs for healthcare and long-term care services – access to which has been disrupted during the pandemic. On average, younger people have been hit harder in terms of their mental health, employment, finances, closure of childcare services and educational institutions, and challenges in coping with the social distancing measures.

Social isolation and anxiety

Many older people faced a reduction in social interaction, went out for fewer walks and hardly left their homes. Loneliness and mental health problems increased among both younger and older people, hitting hardest at the extreme ends of the adult age spectrum (the oldest old and youngest adults). Older people living alone were more affected overall. Older people were affected more than younger people in terms of fears and worries (relating to the health impact of the virus, separation from family and the broader situation), but less in terms of stress, which may relate to work, finance and family issues.

Employment and unemployment

The trend of decreasing unemployment came to a halt in 2020. Unemployment among older people remained stable from 2019 to 2020 while that among younger groups increased. Employment rates among people aged 50–64 kept increasing, albeit at a slower pace, in particular due to reduced economic inactivity among older women. However, many older people lost their jobs during the pandemic, particularly in some Member States. While men were hit hardest by unemployment in the 2007–2008 financial crisis (with the male-dominated construction and financial sectors most severely affected), the picture was more mixed during the pandemic. Older people were at a higher risk of remaining unemployed for longer than younger people who lost their jobs. Furthermore, the trend of increased employment among people aged 65+ came to a halt. Groups of older people were also pushed into economic inactivity rather than unemployment, often retiring earlier than planned; women were more likely than men to become economically inactive. Older people were more likely than younger people to have their working hours reduced; this was mostly the case among self-employed people, who are overrepresented among older workers, in particular those aged 65+. Consequently, older workers often saw their earnings reduced. It remains to be seen how these figures will develop over the next few years, with early signs of a strong economic recovery amid the risks associated with pandemic support schemes coming to an end and of groups being left behind.

Finances

Overall, older people's finances were less affected than those of younger people. This was especially the case for people aged 65+, mainly because pensions were generally not cut. At the same time, the proportion of people aged 75+ with incomes below the poverty threshold is particularly high and increased relatively significantly from 2019 to 2020. Older people were also less likely to see improvements in their economic situation, and faced income insecurity. Expenditure increases were more common among older people than among younger people, posing problems for those with low incomes. The proportion of younger people with low levels of savings was higher than that of older people, but during the pandemic the proportion increased for older people and decreased for younger people.

Telework

Before the pandemic, telework was less common for older people than for younger people, and it was also less common for older people to start teleworking during the pandemic. Work negatively impacted the home lives of older people less often, but work–life balance problems increased over the course of the pandemic, especially for women.

Childcare and elderly care by older people

Older people increasingly provided informal (grand)childcare and elderly care; while this was more common among women, the increase was larger for men.

Support initiatives

Many older people relied on support from their children (for example, for grocery shopping, delivery of medicines and transport). Many support initiatives emerged in response to the pandemic; these may have been particularly needed by older people living alone and those less able to rely on support from relatives or friends.

Healthcare

Unmet healthcare needs because of postponement by healthcare services and fear of catching the virus added to the 'traditional' reasons for unmet needs. Unmet needs due to waiting lists, reachability problems and unaffordability increased during the pandemic, and are particularly important factors in the unmet needs of people aged 65+. Most people who report unmet needs due to the first two reasons also indicate that unaffordability plays an important role. Increased provision of e-healthcare facilitated access for many, especially in primary care, but less so in specialist care. Many older people also faced problems accessing e-healthcare. Those who could access e-healthcare often opted for face-to-face care because they preferred it, and many reported that the e-healthcare received did not completely fulfil their needs.

Long-term care

Before the pandemic, access problems in long-term care were already widespread (Eurofound, 2020d). Care gaps were often filled by informal care by relatives, neighbours or friends. The pandemic led to additional long-term care needs and problems in meeting them, and to less sustainable forms of informal care. Shifts have occurred in types of care – from residential to home care or informal care, from home care to informal care, and from informal care to (temporary) residential care or home care. Shifts in care providers have also taken place, with informal care being carried out by fewer carers (increasing their care burden) and home care providers being replaced. The aggregate picture can mask such flows. Furthermore, the quality of care has been affected. The role of e-care has been limited, but phone calls served to maintain contact with people whose home care services were temporarily discontinued.

7 Discussion and policy pointers

Building on existing support structures

Essentially, all larger-scale support initiatives that emerged in response to the crisis built on existing support structures, increasing their capacity or adjusting their services to better match emerging needs. Existing NGOs supporting older people often obtained additional public or private funds to respond to increasing and changing needs. 'Senior clubs' or NGO initiatives addressing social isolation among older people continued some of their activities, but these were often moved temporarily online. Countries with more developed welfare systems arguably have needed to implement fewer ad hoc measures (Honkanen, 2021). In countries where long-term care and healthcare services were relatively well developed, these catered for many emerging needs.

Sometimes, there was already a broader framework in place to improve the situation of older people, which facilitated the implementation of pandemic support measures. For instance, in the Netherlands, Een tegen eenzaamheid ('United against loneliness') quickly provided a framework to support local initiatives financially, and the pre-existing Pact for Elderly Care (Thuis in het verpleeghuis – 'At home in the care home') provided a framework for residential care. There was also a framework for e-care, which received additional funding in response to the pandemic. In a municipality in Sweden, there was already a team working on preventive elderly care as part of a 'senior-friendly municipality' initiative, which facilitated prompt implementation of a support line. EU funding programmes (notably the ESF) also provided a framework for facilitating rapid responses to the needs of older people during the pandemic.

Policy pointer: Invest in social infrastructure to improve the resilience of society, by ensuring well-developed, flexible welfare systems, health and social services and civil society. Maintain support structures that facilitate flexible and rapid responses to concrete needs, including when needs are low. More efforts are needed to reach rural communities with no pre-existing strong support structures.

Building trust

Not seeking care or support because of fear of infection is sometimes seen as a person's own choice. However, this choice depends on people's trust in society to effectively protect them against the risk of infection, both on their way to the care service and while using it (Eurofound, 2021b). A broad perspective on access takes such problems into account (Eurofound, 2020d).

Overall, unmet needs because of lack of trust (for example, in the ability of health services to protect against infection, in the quality of care or in how confidential data are dealt with) are likely to be eased by building trust in institutions, beyond care providers alone. Trust can be built by demonstrating institutions' ability to meet needs and adjust swiftly to changing needs, while ensuring transparency, fairness and accountability. It is important to be aware of differences between age cohorts, and to build trust among generations whose care needs will increase as they become older. A Portuguese survey found that 75% of people aged 65+ trusted the ability and capacity of health services to respond to the crisis, compared with 59% and 54% of people aged 16–25 and 26–64, respectively. Looking at more qualitative input to this report by the Network of Eurofound Correspondents, it seems that both care providers and receivers appreciated that access to various types of support was often less regulated during the pandemic, reducing red tape and increasing the role of trust.

Policy pointer: Work continuously towards demonstrating institutions' ability to meet needs and adjust swiftly to changing needs, while ensuring transparency, fairness and accountability.

New and existing vulnerabilities

The 2007–2009 Great Recession put many people at risk of losing their jobs, homes or access to services (such as healthcare), which they had previously taken for granted (Eurofound, 2014b). The pandemic situation also revealed the vulnerability to shocks of people whose situations were not considered vulnerable before, including along different dimensions than those seen during the Great Recession. People suddenly felt more at risk of poor health caused by catching the virus, or experienced loneliness or mental health problems.

The pandemic has increased awareness that anyone can suddenly end up in a vulnerable situation. This may contribute to increasing support for comprehensive access to support and care services for people in need, regardless of their age or other characteristics. For instance, when the pandemic ends, older people may again be more likely than younger people to be at risk of mental health problems and loneliness. However, there may be increased awareness that anyone can end up in such a situation and that action is needed. For instance, in December 2020, a German survey found that 42% of all adults thought more about old-age loneliness because of the pandemic (DE2).

At the same time, this report confirms that older people who were already in a vulnerable situation were often hit the hardest. A country-level effect is apparent: countries with more stringent pandemic policies and lower levels of development must deal with more economic risks and have fewer opportunities to cope with the risks faced by people aged 50+; however, socio-economic inequalities within countries, rather than between them, seem to have a larger impact on individual economic stress (Chłoń-Domińczak and Holzer-Żelażewska, 2021). Older people in residential care, the oldest old and those living alone, who were already in vulnerable situations, were often affected more by reduced social contact during the pandemic. While pensioners were rarely affected in terms of reduced income, some with the lowest incomes and savings suffered from increased expenditure related to the pandemic. Unemployment disproportionally affected those individuals who were already economically vulnerable (Ksinan Jiskrova et al, 2021). The upturn following the 2007–2013 economic crisis scarcely improved the situation of the lowest income groups. Therefore, measures that address their situation are needed if policymakers want to address deprivation and income inequality (Eurofound, 2020e).

Policy pointer: Improve the identification of vulnerabilities and resilience to shocks and shifts in service needs by ensuring access to social security and services, in line with the European Pillar of Social Rights.

Reducing the importance of income and employment in accessing care

Arrears in healthcare or health insurance payments have been considerable since the start of the pandemic; this is likely to have contributed to the increase in unmet needs because of unaffordability. This seems to support the argument that the reduction in unmet needs over the past few years has mostly stemmed from increases in income (increasing the ability to pay for healthcare and supplementary insurance) and employment (increasing access to employer-provided supplementary insurance). Access seems to have become more dependent on income and employment. When people's income decreases or they become unemployed, they are at immediate risk of reduced access to healthcare. To make access to healthcare more resilient to economic crises and sustain access to healthcare in agreement with the European Pillar of Social Rights, it is important to decrease its dependence on income and employment.

Other 'traditional' reasons for unmet needs in healthcare became more common during the pandemic. Some of them may similarly be explained by the unaffordability of alternative services, for example inability to circumvent waiting lists, lack of access to transport or being unable to take time off from work (Eurofound, 2020d). Usually, survey questions about unmet medical needs ask respondents to state the most common reason for unmet needs, hiding more complex explanations. Eurofound's e-survey allowed respondents to list multiple reasons, revealing, for instance, that many people reporting another main reason for unmet needs also found that unaffordability played a role.

For long-term care, fewer data are available on unmet needs, but similar developments may have occurred, with a shift towards informal care from residential or home care settings. For instance, uptake of an informal care allowance payment in Slovakia increased, probably partly to mitigate reductions in earnings from work among people who took up such care. Similarly, during the 2007–2009 Great Recession, some residential care users left care homes, with their pensions offsetting the reduction in relatives' household income (Eurofound, 2014b). In some countries, people have sought out private home care because of reductions in publicly funded care (for example, Finland and Spain), which is an option only for those who can afford it.

Policy pointer: Make access to care more resilient to crises and reduce the dependence of access to care on income or employment.

Understanding older people's needs

The COVID-19 crisis has clearly triggered a large research effort to explore people's experiences and needs, along various dimensions of quality of life. Many of these research efforts have focused specifically on older people and included groups that are not often heard (for example, residential care service users).

This report has also made clear that a range of policy responses emerged rapidly in response to the crisis.

Extension of pre-existing support measures, which experienced an increase in demand because of pandemic-related needs: Some of the people who found their way to these services for the first time in the pandemic may be more likely to turn to them in the future.

Large outreach efforts: Sometimes people above a certain age who were not already using residential or home care services were targeted (Finland and Barcelona). Sometimes the explicit purpose of such efforts was to gain a better understanding of how to support older people in the longer term (Romania).

Bringing to the surface vulnerabilities among groups requesting support: This includes, for example, people on low pensions, older unemployed people, and those lacking the support of informal networks. Entitlements to new support measures have also made clear that many older people qualify for such support, revealing their support needs.

Furthermore, in cases where governments were criticised for not having consulted enough with older people and carers of older people, or their representatives, reports have emerged outlining what could be done better (for example, The Alliance of Age Sector NGOs, 2021).

Overall, a better awareness of the needs of older people and their informal carers is likely to have emerged. The crisis has further highlighted the importance of social needs as well as care needs. Many of these care and social needs – and unmet needs – existed before the pandemic but they often became more prevalent or intense. Ideally, this will contribute to reshaping support measures and services, addressing vulnerabilities more structurally and allowing for a more individually tailored approach to meeting older people's needs. Support also needs to reach those who are entitled to it. Evidence of non-take-up of support services has emerged in this report, including, for instance, unanswered calls to helplines (Estonia and Malta) and non-use of food vouchers (Romania). This needs to be addressed along its multiple dimensions (Eurofound, 2015). Regarding long-term care, the provision of support for moderate needs early on prevents greater needs in the future. It also helps, for instance, to identify health issues such as dementia at an early stage (Eurofound, 2019). Better understanding of the needs of older people (and of their carers) facilitates tailoring of support for such early needs.

Policy pointer: Reap the lessons learned about older people's social and care needs and continue more systematic efforts to understand the evolving needs of older people and their carers.

Risk of overlooking groups in vulnerable situations

Among young people, a large group experienced a deterioration in their financial situation and another sizeable group experienced an improvement as a result of the pandemic. In contrast, older people's incomes have been relatively table. However, among older people the impact of the crisis has also been unequal along many dimensions. In reporting about the pandemic and in taking policy action, it is important not to overlook groups in vulnerable situations. The risks involved in this include the following.

Generalising based on averages and proportions: For instance, lower proportions of job loss among older people mask the fact that many older people lost their jobs during the pandemic and may find it particularly hard to find new employment. Also, while less common among older people, debt problems can affect them more severely than younger people, for instance because they often lack the opportunities to pay back their debts (Eurofound, 2020c).

Overlooking dimensions on which different groups are affected: An example of this is focusing only on incomes and ignoring expenditure. Furthermore, differentiation between different sources of income is important; for example, labour income was affected more than pension income during the pandemic. Intergenerational transfers are also frequently overlooked, but some groups of older people were able to make ends meet only because of transfers from their children (and vice versa).

Overlooking dimensions on which data are rare: This includes, for example, the abuse of older people and trust in long-term care.

Failing to acknowledge data biases: For instance, people in residential care and hospitals are often excluded from survey sampling frames (as are children), and isolated older people may be unlikely to fill out online surveys, leading to bias and an underestimation of care and support needs. Older people with disabilities or who are severely ill are usually not explicitly excluded, but surveys are rarely designed to include these groups. People with migrant backgrounds or experiencing housing deprivation (undocumented migrants and homeless people in particular) also tend to be underrepresented or excluded. Furthermore, surveys carried out during the pandemic often took place online, with gaps in coverage among people without access to the internet or with limited ICT skills. This results in the underrepresentation of older people in particularly vulnerable situations (partly because they are unlikely to find their way to online support measures).

Focusing on changes due to the pandemic: For instance, the proportion of men providing (grand)childcare and elderly care seems to have increased more than that of women, but women are still more likely to provide such care.

Policy pointer: Consult with stakeholders and service providers to understand the problems faced by older people who are less visible, and seek input from people in vulnerable situations themselves, primarily by stimulating research designs that facilitate the inclusion of hard-to-reach groups.

Wide range of support measures

While many older people were left with unmet needs, and few support measures at all were identified in some Member States (for example, Cyprus), support measures proliferated in many Member States. Often, scheduled end dates for initiatives were extended, and it is envisaged that some initiatives will become permanent. Sometimes, extensions came with adjustments, informed by experiences of implementing the measures in a short space of time. This overall landscape has provided a vast array of experiences. This report captures only some of these experiences, up until around mid-2021.

Early take-up data and challenges discussed in this report provide some insights. Some measures have reached only small groups of people (for example, the restart subsidy in Austria). Even without formal evidence it is clear that some support measures were welcomed by users (even where take-up was small). However, more evidence is needed on whether these initiatives had the intended effects, on their distributional impacts and on other lessons that can be drawn. For instance, evidence from Ireland suggests that financial support measures mitigated the impact of the pandemic situation on income inequalities between age groups and between groups of older people (Doorley et al, 2021).

Older people are often self-employed. Support for people with such non-standard forms of work has come later and in more limited forms, and has often been of a compensatory nature rather than a policy with longer-term potential (Seeman et al, 2021). Nevertheless, the experiences of these types of support and the vulnerabilities revealed can inform the debate on non-standard work.

Policy pointer: It is important to continue documenting and analysing experiences of the new support measures and to encourage Member States to learn from others' experiences.

Individual-level lessons

Longer-term lessons may also be learned by individuals as well as organisations. For instance, enhanced communication using the internet may to some extent be continued beyond the pandemic, alongside the reestablishment and reappreciation of face-to-face contact patterns. In France, 43% of people aged 40–69 years (48% overall) tested new forms of online communication during the pandemic (FR1). Facilitating continued and further engagement with online tools may also be of benefit to many. For instance, it is important to address the digital exclusion of many older people living in rural and remote areas, the consequences of which were exacerbated by the pandemic, by investing in broadband and e-skills (European Parliament, 2021). Similarly, while many people reduced their levels of physical activity, some groups of older people sought to engage in different forms of exercise or increased their awareness of the importance of exercise. Policymakers can contribute to facilitating such healthy behaviours by, for instance, improving walking and cycling infrastructure and encouraging home exercise programmes.

Policy pointer: Cultivate positive individual experiences and facilitate them, for example by ensuring good internet connections for those who want to continue parts of their social lives online and facilitating the healthy habits taken up by some groups during the pandemic.

Addressing mental health problems: Looking beyond health services

The crisis rapidly exacerbated mental health problems for many people, or triggered problems for those who may not have been previously at risk. Access to mental health services was key when mental health problems were caused by the bereavement of a close person during the pandemic, and to get people back on track.

However, it is also important to improve the circumstances leading to mental health problems during crises. During the 2007–2009 Great Recession, this entailed addressing unemployment (Eurofound, 2014b). Mental health issues that emerged during the pandemic called for the facilitation of social contacts and for loneliness to be addressed. Addressing such causes more generally also helps to reach people with mental health problems who do not contact mental healthcare services. Examples of measures in areas other than mental healthcare that were likely to have provided such support during the pandemic are the many practical support services (for example, delivery of groceries and medicines, and information provision). These measures provided not only practical support, but also opportunities for older people to interact with other people. These services may also have reached people at risk of depression, who may not have contacted services narrowly focused on mental health problems or on loneliness. Measures to combat social isolation and loneliness often focus on the local context, the construction of (new) social ties and on specific groups of society, rather than on national programmes of macroeconomic redistribution (Sandu et al, 2021). While such measures can be important, they may be more effective if complemented with better inclusion in meaningful activities, including by facilitating employment (for example, in the care sector, which needs significant numbers of staff) and the take-up of other activities (volunteering, sports and arts). Furthermore, good access to home and community-based care can help to prevent loneliness and facilitate inclusion among those with care needs (COFACE, 2021).

One group of older people at risk of poor mental health because of the pandemic is the group of older, mostly female healthcare and long-term care workers. This group was already at higher risk of mental health problems before the pandemic because of, for instance, exposure to adverse social behaviour at work from users of care services (verbal abuse, humiliating behaviour and threats) and work overload (often because of staff shortages). The pandemic has further increased the need to devote more attention to mental health risks in this rapidly expanding group of workers (Eurofound, 2020b).

Policy pointer: Invest in mental health services and awareness raising but, in particular, address the causes of mental health problems in the context of the pandemic (such as social isolation, job and income

insecurity and psychosocial aspects of working conditions) and seek to prevent them in the future. The crisis has highlighted the importance of social interaction for quality of life, and this should be given more consideration when designing policies, for instance to facilitate participation in meaningful activities and to improve home and community-based care services.

Information and communications technology: Important mitigation, with limitations

The crisis boosted the use of ICT for many purposes; for example, ICT usage facilitated contact with friends and relatives. In healthcare, where there was previously a low level of ICT usage in communications between patients and healthcare providers, the crisis led to a surge in e-consultations and e-prescriptions. For some informal carers, improved online resources (training, information and communities) facilitated access where previously resources were unavailable or a physical presence was required. E-care also helps to reduce under-the-table payments (Eurofound, 2014b). In general, online applications for support may be less susceptible to such payments than applications to local government officials, which may be treated as favours.

However, the crisis also put the spotlight on the limitations of ICT in terms of meeting needs. Electronic contact may not have the same potential as face-to-face contact to reduce the negative impacts of the pandemic situation on mental health (Litwin and Levinsky, 2021). In long-term care, where more advanced usage of ICT has often not moved much beyond the experimental phase, ICT was largely limited to maintaining some level of (phone) contact with people whose home care services were reduced. Furthermore, it can be questioned whether the use of ICT, which replaces human contact and may increase loneliness, is desirable in an area where the focus tends to be on care rather than cure, with a large role for human interaction. E-healthcare has facilitated mostly consultations with GPs and the issuing of prescriptions. Arguably, such low-tech solutions have particular potential for widespread usage, but they come with challenges for quality of care (Eurofound, 2020d). In e-healthcare, examples of how this can be addressed by facilitating the use of screen-to-screen options can be found, for instance, in Estonia and France. ICT has further limitations when it comes to addressing more demanding care needs.

It is important not to make generalisations about older people being less ICT literate (Eurofound, 2019). This report has confirmed that ICT enabled many older people to access services and undertake social interaction. Furthermore, more often than for younger people, e-healthcare fully fulfilled their care needs. However, it is also important to acknowledge that ICT formed a barrier for many older people. In Sweden, 54% of people aged 80+ worried about increasing levels of digitalisation, being unable to follow these developments and being left out (SE10). During the pandemic, only 4% of Greek people aged 65–74 used the internet (EL2). In Lithuania, of people aged 50+ living alone, 49% had never used the internet (LT1). The age divide in telework may also be partly explained by ICT forming a barrier for older people.

More can be done to improve access to ICT. Support or training may help. For instance, in Poland, 'digital volunteers' are recruited through the online platform Wspieraj seniora ('Support seniors') to help older people with managing their affairs online (Germany has a similar initiative). Communication in care homes using ICT often required support from staff, but they were not always able to provide the assistance needed, given the additional demands and staff shortages during the pandemic; additional resources for support staff may help in this regard.

It remains to be seen how permanent the crisis-induced e-care options will become. In healthcare, e-consultations and e-prescriptions were sometimes implemented quickly without a solid framework (Eurofound, 2020d). When designing future systems it will be important for policymakers to take into consideration the experience gained during the crisis in the Member States, and learn from the few countries that had relatively solid systems in place before the pandemic.

Policy pointers: Draw on others' experiences to continue facilitating ICT use where outcomes are positive, through improved structures. Acknowledge the limitations of ICT, especially for the provision of more demanding forms of care, and invest in ensuring the provision of such care.

Appreciate and facilitate volunteering

During the pandemic, volunteers have played a large role in responding to the emerging needs of older people, and older people have been particularly willing to volunteer themselves. Volunteering is of great value to the people benefiting from the services, but engaging in such a meaningful activity can also benefit the volunteers themselves, enhancing their well-being and providing social interaction.

Volunteers encountered barriers during the pandemic. In some countries, people receiving unemployment benefits needed authorities' permission to volunteer. Belgium suspended this requirement temporarily and the Netherlands dropped the need to wait for approval. In Wrocław (Poland), people who wished to volunteer faced the barrier of having to sign volunteering contracts during the local administration's working hours – a time when potential volunteers may have been unavailable due to engagement in other work – and were not able to do so at a later time.

At the same time, volunteering is not a long-term solution for addressing staff shortages and delivering reliable and high-quality services.

Policy pointers: Acknowledge the role played by volunteering and its demonstrated potential to respond quickly to emerging needs and crises. Facilitate volunteering by identifying and reducing administrative hurdles and providing training, but at the same time look for ways to develop sustainable staffing to enable the provision of reliable and high-quality services.

Harnessing human resources to meet care needs

During the pandemic, the use of volunteers and trainees, the relocation of staff and reduced staff–user ratios played a role in mitigating care staff shortages. However, these are not long-term solutions to staff shortages to guarantee access to high-quality care, and they come with the risk of a lack of necessary skills and accountability. The solution for addressing shortages lies largely in improving working conditions in the care sector (Eurofound, 2020b). While it is important to look beyond pay alone, pay is particularly low in some occupations (carers, social carers and assistant nurses) concentrated in social services, including long-term care (Eurofound, 2021c).

An initiative in Sweden referred to as 'elderly care take-off' addressed several issues around staff shortages (including raising the profile of care workers) and may provide lessons for other countries. New or existing staff can work part-time while studying to become care assistants or assistant nurses. They maintain their full salary (paid by the government) and have full-time job security on finishing the programme. While planned before the pandemic, the initiative received additional funding because of the pandemic and was implemented in early 2020. One of the challenges was that some municipalities (85% signed up) did not meet the 2020 deadline, mainly failing to establish collaborations with training providers (schools). The need to show quick results further stimulated municipalities to push for the quicker 'care assistant' route, resulting in shortages of assistant nurses.

Older workers (and women) are overrepresented in the health and long-term care sectors: in 2019, 36.7% and 37.9% of workers in the health and long-term care sectors, respectively, were aged 50+, compared with 33.2% of the EU's entire workforce.[5] The proportions of workers aged 50+ in health and long-term care have increased faster than the proportion of workers aged 50+ among all workers, increasing by 7.4 and 9.8 percentage points from 29.3% and 28.1% in 2009, respectively (by 7.3 percentage points for all workers from 25.9% in 2009). Increasing numbers of care workers are thus approaching retirement age. The pandemic drove Germany to facilitate working beyond the pensionable age. However, such measures have a limited impact if working conditions are not improved simultaneously, as many care workers report being unable to continue working even until the retirement age. Lifting people is a key challenge for long-term care workers; the use of new technologies, such as those assisting care workers in lifting people, may contribute to making care work more sustainable.

It is important that a further move away from residential care does not lead to care gaps, with appropriate investment needed in home and community-based care. Temporary discontinuation of home and community care during the pandemic has also highlighted the need to enhance the crisis preparedness of these services. Residential care also needs to be better equipped. While exploration of digitalisation and innovative solutions should be continued, it is key to invest in staff, acknowledging the specific challenges experienced by home care workers for whom the working environment is the care receiver's home (Eurofound, 2020b).

Policy pointer: Improve care workers' working conditions. While pay is important, especially for the lowest earners (carers, social carers and nurses), improvements should go beyond pay and deal with, for instance, adverse behaviour at work, having little say about work schedules, and the need for increased staffing to reduce the burden on staff and improve quality of care.

Regulating or preventing the employment of carers by households

Some Member States rely heavily on domestic care provision and there are signs of this increasing in other Member States. Domestic care often involves challenging working conditions, lack of control by inspectorates, and challenges for the quality of care (Eurofound, 2020b). Pandemic measures focused more on ensuring continuity of domestic care than on the situations of carers (Leiblfinger et al, 2021). However, a promising measure was identified in Italy, where pandemic support for domestic carers was dependent on formalising this type of care. Prior to the pandemic, Italy had already established a collective agreement for domestic carers. However, most care work remained undeclared. In Germany, a lack of legal contracts among domestic carers has posed a problem for the

5 Based on an EU-LFS extraction provided by Eurostat and analysed by Eurofound for this report.

implementation of the EU guidelines on free movement of workers during the pandemic, as cross-border care workers involved in undeclared care work often cannot present a legal contract. Policies working towards formalisation and legalisation of care services across national borders are required (Nowicka et al, 2020). Furthermore, ratification and implementation of the International Labour Organization's Domestic Workers Convention would be helpful. Most EU Member States have not yet ratified it, and those who have need to focus on its implementation. The longer-term solution may lie in providing access to flexible, high-quality long-term care services, rendering precarious forms of domestic care unnecessary (Eurofound, 2020b).

Policy pointer: Regulate domestic care more effectively and provide access to high-quality long-term care services, ensuring flexibility and user choice, and rendering precarious employment of carers by households unnecessary.

Redefining 'unemployment'

At the EU level, unemployment is measured by the EU-LFS. An unemployed person is defined as someone aged 15–74 (or 16–74 in Italy and Spain) who has been without work in the week prior to the survey, is available to start work within the next two weeks (or has already found a job to start within the next three months) and has actively sought employment at some time during the past four weeks.

This definition can be challenged, however, because someone who during the week prior to the survey has worked for just one hour is defined as being employed. Although older workers were hit less hard than younger workers by unemployment during the pandemic, they experienced higher reductions in working hours, leaving many with very few working hours. The definition also fails to consider the many economically inactive people (including many people with disabilities) who would like to work but who have given up active job searching as they regard their job prospects as hopeless (Eurofound, 2017a). This includes older people who, during the pandemic, retired earlier than they would have wished. In addition, entire sectors were closed during the pandemic, and finding work in these sectors was very difficult, rendering the job search futile. Indicators such as the number of people in involuntary part-time work and economically inactive people's preferred number of working hours capture these issues to some extent. More attention also needs to be paid to longer-term unemployment, which is associated with significant and increasing vulnerabilities, for instance in terms of social exclusion and mental well-being (Eurofound, 2017b).

With a policy focus on unemployment rates, these issues go unnoticed. Some countries adjusted the conditions for receiving unemployment benefit during the pandemic, for instance dropping the requirement to look for work. The statistical definitions of unemployment remained unchanged, however. Many unemployed people expect to return to their previous jobs as soon as restrictions are lifted. With job retention schemes coming to an end, however, the longer-term impacts of the crisis on the economy remain to be seen. In this regard, the current definition of unemployment provides a particularly short-term picture.

Policy pointer: Devote more attention to indicators reflecting, in particular, the desire to work more hours among people who work very few hours or who are inactive, and longer-term unemployment, or adjust the definition of unemployment so that it also reflects these labour market issues.

Caring and work–life balance: Looking beyond workers alone

For many people, the pandemic situation shifted the balance between work, care and other aspects of life. Entitlements for parents and guardians of young children tended to be more common than entitlements for elderly care or grandchild care. The 2019 EU Work–Life Balance Directive works towards improving the situation of (older) carers but focuses on workers. Many older carers are unemployed or economically inactive, sometimes because they cannot combine their work with care provision, and many are retirees. Improvements in the balance between care and non-care commitments are also important for them.

Measures addressing this balance include access to respite care (facilitating care breaks), information, consultations, mutual support groups and other measures that provide support to informal carers and care receivers (Eurofound, 2020d). This can make informal care more sustainable. In Italy, the COVID-19 crisis contributed to making older (grand)child carers more visible, as they were entitled to the child carer allowance that was introduced during the pandemic. Elsewhere, because of a sudden need for care for older people whose long-term care arrangements had ceased, governments amplified or implemented care leave policies. It remains to be seen whether these will have more lasting impacts.

Another limitation of work–life balance policies includes the risk of reinforcing the unequal sharing of care responsibilities within households (with women usually taking on the larger share). It is a challenge to address these inequalities while facilitating informal care. Solutions should probably be sought as part of stimulating gender equality more generally in society.

Policy pointer: Improve the balance between care and non-care commitments, including importantly for carers who are not in employment, for instance by increasing access to respite care and other support.

Improving living and working environments

Good working and living conditions throughout life are key to minimising care needs. Sustainable working conditions are also key to recruiting and retaining carers to address such needs.

The crisis has brought to the surface certain working condition issues, especially in the care sector, but also in front-line and essential services. One example is the meat processing industry, where poor working (and living) conditions contributed to the spread of the virus. The crisis has also highlighted needs that are specific to remote workers (for example, the right to disconnect). Social partners need to be involved in discussions on how to provide long-term solutions to address these issues.

With regard to living conditions, older people tend to spend more time at home and in their local area, highlighting the importance of the quality of these environments (Eurofound, 2016b, 2018c). The pandemic situation resulted in many people being confined to their homes and local areas, providing them with a snapshot of what their future living environment, and that of an increasing number of older people in the EU, may look like. There is a policy emphasis on facilitating independent living and it is likely that this increased because of the pandemic. It is important that such policy does not focus narrowly (but importantly) on care, but also acknowledges the role of high-quality housing and local areas in facilitating independent living.

Housing: In a survey among people aged 65+ in Bordeaux, 25% reported access to a balcony, 43% to a hallway, 75% to a garden; 5% had access to none of these (FR2). In Italy, 10% of people aged 75+ live in a dwelling without a private garden or terrace/balcony (Istat, 2020). Being confined to such a dwelling can be quite different from being confined to a dwelling that has a private garden or terrace/balcony. Better housing can enable people to live longer at home and prevent health problems. Some initiatives that aim to improve housing conditions for older people (for example, well-being officers in Tallinn who seek to prevent falls) emerged in this research, but more policy attention is needed in this area. However, survey data on the role played by housing quality in the impact of the pandemic on people seem scarce.

Local area: Similarly, spending time during the pandemic in insecure neighbourhoods without parks has been different from spending time in high-quality neighbourhoods along their physical, social and service dimensions (Eurofound, 2018c). High-quality neighbourhoods can mitigate the effects of poor housing conditions (for example, having access to parks can mitigate the lack of a private garden). Local area policies during the pandemic often narrowly focused on addressing pandemic-related issues, such as facilitating cycling to prevent people taking public transport (with its risk of infection), and widening pavements to allow people to pass each other at a safe distance. However, such policies can improve the quality of local areas, including facilitating healthy and safe modes of transport (and, for example, the ability to move around with a wheelchair or walker). They are in line with the EU's Green Deal in terms of reducing pollution and improving health. They have the potential to benefit lower socioeconomic groups in particular (facilitating low-cost transport options) and encourage physical activity. Obesity is highest among people aged 55 to 64 and 65 to 74 (both 22%), compared to between 6% (18- to 24-year-olds) and 18% (45- to 54-year-olds) for younger age groups. It is highest among bottom income quintile earners (28% and 26% among those aged 55 to 64 and 65 to 74, respectively) (Eurostat, hlth_ehis_bm1i, 2019 data).[6] These policies can also improve social interaction in a post-pandemic EU, the importance of which has been highlighted by the pandemic.

It is particularly important to invest in improving living and working conditions across the life course, not just during old age, by which point it may be too late to prevent health problems. The pandemic has highlighted the need for intergenerational solidarity, with younger people facing long-term risks of missed education and increased public borrowing, and taking a large hit in terms of their finances and mental health, against a backdrop in which many are already less likely to enjoy the same living standards as their parents. Investing in sustainable and healthy living environments and working conditions can contribute to longer-term progress for the benefit of younger and older people alike.

Policy pointer: Improve working and living environments to prevent and postpone health problems and to reduce care needs for people with health problems or disabilities. More data should be collected on housing and neighbourhood quality to inform policies. Opportunities in line with the digital and green transitions should be sought to reduce expenditure and deprivation and to contribute to the justness of transitions.

6 Based on Eurofound's analysis of the European Health Interview Survey; see also https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_ehis_bm1i&lang=en

Implementing age-specific measures

Focusing attention on the situations of older people helps to identify the problems facing today's older population, and those of the next generations. For example, many older people face long-term unemployment or age-based discrimination at work or are at higher risk in terms of the health impacts of the pandemic. However, many younger people also face long-term unemployment or age-based discrimination at work or are in a COVID-19 risk group. Similarly, younger people have more often faced mental health issues because of the pandemic situation, but many older people also have similar issues.

Age-specific support comes with risks of unfairness in terms of resource allocation, age discrimination and failing to address similar problems experienced by people of different ages. These concerns may be particularly important in the context of the pandemic and its aftermath, with its risks of intergenerational tensions and increased ageism (FRA, 2020; Monahan et al, 2020; United Nations, 2020).

Sometimes it can be beneficial to employ age-specific outreach initiatives (for example, NGOs that represent older people have played an important role in reaching isolated people), and discrimination may need to be addressed by measures focusing on the specific area of discrimination. However, it is important to target primarily the support needs related to, and the characteristics of, the problems experienced (for example, mental health problems or long-term unemployment).

Policy pointer: Focus services and other measures on addressing needs and problems, rather than on age groups.

Policy discourse

Discourse around old age during the pandemic has risked emphasising vulnerability. Older adults are a heterogeneous group and many are not in a vulnerable situation. Furthermore, many younger people have also needed support. Older people have contributed to providing such support by volunteering, providing informal care or helping financially. In addition, vulnerability along one dimension does not imply vulnerability along other dimensions, nor that these vulnerabilities are a given. It has thus become ever more important to speak of 'vulnerable situations', rather than portraying someone as vulnerable.

Policy discourse often emphasises employment and 'active ageing'. If interpreted broadly, active ageing policies can have benefits, for instance in preventing health problems (Sowa-Kofta et al, 2021). However, emphasising employment and active ageing also risks negatively stereotyping people who are (no longer) economically active or otherwise contributing productively (for example, by providing care or volunteering). Self-perceptions may thus become overly based on 'usefulness'; this may have been amplified by the crisis, with some groups of older people (especially the oldest old) performing fewer productive activities to prevent infection. Societies that emphasise the virtue of being productive thus risk lower resilience among groups of people to such changes in productivity. Overemphasising productivity contrasts with the EU's 'gross domestic product and beyond' thinking to facilitate a good quality of life along all its dimensions. While the urge for economic growth in the aftermath of the pandemic may challenge a shift in emphasis, the crisis has also changed some people's perspectives in other ways. For instance, in Luxembourg, 38% of people reported that the crisis had changed their relationship with material consumption and that other values had gained in importance (LU3).

Policy pointer: Be cautious about overemphasising employment and active ageing, and acknowledge that progress relates more broadly to overall quality of life.

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Annexes

Annex 1: National COVID-19 surveys consulted

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
AT1	Austrian Corona Panel Project	Approx. 1,500 per round	14+	Round 1: March 2020; latest: March 2021	Web	University of Vienna
AT2	COVID-19 prevalence studies (*Prävalenzstudien*)	1,500 (May), 2,700 (November)	16+	May and November	Web and phone	Statistics Austria
AT3	AKCOVID survey	2,000	20–64	June 2020, January 2021	Web and phone	Chamber of Labour
AT4	Effects of the COVID-19 pandemic on long-term care (*Covid-19 Care: Auswirkungen der Corona-Pandemie in der Langzeitpflege*)	259	Residents of 16 nursing homes	August–September	F2F	SeneCura and Karl Landsteiner University of Health Sciences
AT5	COVID-19 and social distancing in old age (*Covid-19 und Social Distancing im Alter*)	521	60+, Lower Austria	April–May	Phone	Karl Landsteiner University of Health Sciences
BE1	COVID-19 health-survey (*COVID-19 Gezondheidsenquête/ Enquête de santé COVID-19*)	20,000–40,000 per round	18+	Round 1: April 2020; round 7: June 2021	Web	Sciensano
BE2	Psychological distress in the general population during the COVID-19 health crisis (*Covid-Psychisch leed in de algemene bevolking tijdens de gezondheidscrisis COVID-19*)	6,337 (four rounds)	15+	March–November	Web	UCLouvain and University of Antwerp
BE3	The impact of the COVID-19 pandemic on wellbeing and cognitive functioning of older adults	640	65+	19 May–22 June	Web	KU Leuven and Ghent University
BE4	Elderly care during the COVID-19 pandemic (*Ouderenzorg in tijden van Corona*)	8,000	65–89	28 September–20 October	Web and paper	Socialistische Mutualiteiten
BG1	A year after the COVID-19 pandemic – How has our life changed? (*Година след началото на ковид пандемията – как се промени животът ни?*)	1,007	18+	8–15 February 2021	F2F	Alpha Research
BG2	Impact of the coronavirus crisis on Bulgarian citizens and businesses: Part I (*Отражение на кризата с коронавируса върху българските граждани и стопанските субекти. Част I*)	1,000	18+	13–23 April	Phone	Alpha Research, Head Office
BG3	Attitudes of Bulgarians with respect to the spread of COVID-19 (*Нагласи на българите спрямо разпространението на COVID-19*)	1,001	18+	2–19 November	F2F	Trend Agency
BG4	Public attitudes towards issues related to COVID-19 (*Обществени нагласи по въпроси, свързани с КОВИД–19*)	1,000	18+	November and December	F2F	Bulgarian National Assembly

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
CY1	COVID-19 IMPACT survey	Round 1: 957; round 2: 134	18+	Round 1: late March–May; round 2: late December 2020–late February 2021	Web	University of Cyprus
CZ1	Our society (*Naše společnost)*	950–1,100	15+	May–February 2021	F2F, phone and web	Institute of Sociology
CZ2	Research on COVID-19 (*Výzkum o COVID-19*)	774–3,725	18+	February 2020–February 2021	Web	SC&C market research
CZ3	SHARE COVID-19 survey	2,782	50+	June–August; October–December	Phone	Centre for Economic Research and Graduate Education
CZ4	Life during a pandemic (*Život během pandemie*)	2,200–2,600	18+	March onwards	Web	PAQ Research
DE1	The COVID-19 pandemic seen from the perspective of old and the oldest old people (*Die Corona-Pandemie aus der Sicht alter und hochaltriger Menschen*)	500	75–100	Late September–early October	Phone	University of Mainz
DE2	COVID-19 and ageing (*Corona und Alter*)	10,000	18–94	April–December	Web	University of Erlangen-Nuremberg
DK1	PAM COVID-19: Hidden voices during the COVID-19 pandemic – Health-related self-care in high-risk groups during the COVID-19 crisis (*PAM COVID-19: Skærmede stemmer I en coronatid – helbredsrelateret egenomsorg blandt særlige risikogrupper under coronakrisen*)	1,302	Citizens in Jutland receiving or who had recently stopped receiving health services	May–June/July	Web and paper	Defactum
DK2	Copenhagen COVID-19-related mental health survey (*Copenhagen Corona-related Mental Health (CCMH) spørgeskema*)	3,137	18–85	March onwards	Web	University of Copenhagen
DK3	Physical activity in crisis: The impact of COVID-19 on Danes' physical activity behaviour	1,802	15+	April	Web	University of Southern Denmark
DK4	Shared senior accommodation during the COVID-19 crisis (*Seniorbofællesskaber under coronakrisen*)	123	Residents in shared senior accommodation	May–June	Web and paper	Realdania
DK5	HOPE – How democracies cope with COVID-19: A data-driven approach	> 1,000	18+	March onwards	Web	Aarhus University
EE1	COVID-19 thematic survey (*COVID-19 temaatiline küsitlus*)	1,003	15+	(Bi)weekly during the pandemic	Web and phone	Ministry of Social Affairs
EE2	Mental health and well-being of the Estonian population during the emergency situation and the COVID-19 pandemic (*Eesti elanike vaimne tervis ja heaolu eriolukorra ja COVID-19 pandeemia ajal*)	1,252	18+	April–November	Web	Tallinn University
EE3	Coping with stress in an emergency situation (*Stressiga toimetulek eriolukorras*)	1,119	18+	April–November	Web	University of Tartu

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
EL1	First wave of the COVID-19 pandemic in Greece: The role of demographic, social and geographical factors in life satisfaction during lockdown (Πρώτο πανδημικό κύμα του COVID-19 στην Ελλάδα: Ο ρόλος των δημογραφικών, κοινωνικών και γεωγραφικών παραγόντων στην ικανοποίηση της ζωής κατά τη διάρκεια της απαγόρευσης κυκλοφορίας)	4,305	15–70	March–May	Web	University of Thessaly
EL2	Impact of COVID-19 on urban everyday life in Greece – Perceptions, experiences and practices of the active population (Ο αντίκτυπος του COVID-19 στην αστική καθημερινή ζωή στην Ελλάδα. Αντιλήψεις, εμπειρίες και πρακτικές του ενεργού πληθυσμού)	730	18+, active population, Greek cities (mainland)	6–27 May	F2F	Aristotle University of Thessaloniki and Hellenic Open University
EL3	Social exclusion in the third age (Ο Κοινωνικός Αποκλεισμός στην Τρίτη Ηλικία)	85	65–80	March–July	F2F	Hellenic Open University
EL4	Intolerance of uncertainty and loneliness in older adults during the COVID-19 pandemic (Μη ανοχή στην αβεβαιότητα και τη μοναξιά σε μεγαλύτερους ενήλικες κατά τη διάρκεια της πανδημίας COVID-19)	120	60+	13–15 April	Web	Frontiersin.org
ES1	Mental and social impact of the pandemic on older people (*Impacto psico-social de la pandemia en las personas mayores*)	315 (1 resident in a residential care home)	60+	From 1 April	Web	Autonomous University of Madrid and Comillas Pontifical University
ES2	COVID-19 and retirees: Impact on the healthy lifestyle habits of the Spanish population (*Covid-19 y Jubillennials: Impacto en los hábitos de vida saludable de la población española*)	3,400	35–75	8–13 May (also in 2019)	Web	University of Granada and Vivaz Seguros de Salud
ES3	Older people facing quarantine because of COVID-19 (*Personas mayores ante el confinamiento por COVID-19*)	1,815	65+, Madrid	9–22 September	Web	General Directorate of Older People of the City Council of Madrid
ES4	Working during the COVID-19 pandemic: Experiences of teleworking (*Treballar en temps de COVID-19: l'impacte del teletreball*)	810	Teleworkers	17–21 April	Web	UPF – Barcelona School of Management
ES5	Working conditions, insecurity and health in the context of COVID-19 (*Condiciones de trabajo, inseguridad y salud en el contexto del Covid-19*)	20,328	Worker population in Spain of any age	4–10 May	Web	Autonomous University of Barcelona, and Trade Union Institute for Work, Environment and Health
ES6	Impact of COVID-19 in the Valencia region and Spain (*Impacto del CoVID-19 en la Comunitat Valenciana y España*)	127,467	18+ living in Spain (but over-representation of those living in Valencia)	29–30 March (first of 18 rounds until December)	Web	Data Science for COVID-19 Taskforce, Valencian government
ES7	Subjective psychological impacts of the COVID-19 lockdown on older people, risk profiles and coping strategies (*Impactos psicológicos percibidos en las personas mayores, perfiles de riesgo y estrategias de afrontamiento*)	2,010	65+, Barcelona	21 April–10 June	Web	Autonomous University of Barcelona

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
FR1	Coronavirus and lockdown longitudinal survey (*Coronavirus et confinement enquête longitudinale*)	2,003	18+	30 April–4 May	Web	French Institute for Demographic Studies
FR2	Attitudes and behaviours of older people towards the COVID-19 crisis: A prospective general population survey (*Attitudes et comportements des personnes âgées face a`la crise du COVID-19: une enquête prospective en population générale*)	677	65+ in Bordeaux	April	Phone	Bordeaux University
FR3	10 years of observations of relational isolation: A growing phenomenon (*10 ans d'observation de l'isolement relationnel: un phénomène en forte progression*)	3,000	15+	20 April–4 May	Web	Fondation de France
FR4	COVID-PREV	2,000	18+	15–17 March onwards	Web	Santé publique France
FR5	Isolation of elderly people: Impacts of the health crisis (*Isolement des personnes âgées : les impacts de la crise sanitaire*)	100	60+	October–December	Phone	Les Petits Frères des Pauvres
FI1	Well-being during the COVID-19 pandemic – Survey of clients of elderly care services (*Hyvinvointi korona-aikana – kysely vanhuspalvelujen asiakkaille (VANKO)*)	7,440	Home care units and residential care homes	3 December 2020–13 January 2021	Web	Finnish Institute for Welfare and Health
FI2	Pension Barometer 2020 (*Eläkebarometri 2020*)	1,005	18–79	4–15 May	Phone	Finnish Centre for Pensions
FI3	The livelihoods and economic well-being of pensioners in 2020 (*Eläkkeensaajien toimeentulo ja taloudellinen hyvinvointi vuonna 2020*)	3,700	55–85	September	Web and paper	Finnish Centre for Pensions
FI4	Clients' autonomy and restrictive measures in residential care units for the elderly during COVID-19 (*Asiakkaiden itsemääräämisoikeus ja rajoitustoimenpiteet vanhustenhuollon yksiköissä Covid-19-pandemian aikana*)	1,082	Elderly care units	November–December	Web	Valvira
FI5	Serological population study of the coronavirus pandemic – Population survey (*Serologinen väestötutkimus – väestötutkimuksen kysely*)	3,489	18–69	April onwards	Web	Finnish Institute for Health and Welfare
FI6	The state of elderly care services (*Vanhuspalveluiden tila*)	165	Authorities for elderly care services, elderly care units	June onwards	Web	Finnish Institute for Health and Welfare
FI7	FinSote survey (*FinSote-tutkimus*)	16,600	20+	September 2020–February 2021	Paper and web	Finnish Institute for Health and Welfare

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
HR1	Quality of life of older people during lockdown (*Kvaliteti života osoba starije životne dobi u vrijeme lockdowna*)	215 (30 in residential care)	65+, Rijeka	5 March–4 May	Web and paper	University of Rijeka
HR2	Pensioners' experiences during the COVID-19 pandemic in Croatia (*Umirovljeničkog iskustva za vrijeme pandemije COVID-19 u Hrvatsko*j)	116	Pensioners	May	Web	University of Zagreb
HU1	The social impact of the coronavirus pandemic (*A koronavírus-járvány társadalmi hatásai*)	Four rounds: 878 (1), 1,000 (2), 998 (3), 6,400 (4)	18+	April–May	Phone (1, 2, 3), web (4)	TÁRKI (1), Medián (2), Publicus (3) and Závecz Research (4)
HU2	Changes in the living and working conditions of the Hungarian population (*Változások a magyar lakosság élet- és munkakörülményeiben*)	1,200	18–69	May	F2F	University of Pécs, Faculty of Health Sciences
HU3	Economic and social impacts of the coronavirus pandemic in Budapest's District VIII (Józsefváros)	Random sample of 600 people (a), web sample of 690 people (b)	Residents of the district	July	Phone (a), web (b)	Municipality of Józsefváros (Budapest district)
HU4	Research on the background to care activities among family caregivers of patients with dementia (*Véleményfelmérés a demens személyeket otthonukban gondozók körében gondozási tevékenységük hátteréről)*	500 carers and 500 care recipients	65+, care recipients	January 2020–January 2021	F2F	Psyma Hungary Kft (commissioned by the Ministry of Human Capacities)
HU5	COVID-19 – Functioning of family and child welfare providers during emergencies – Research report (*COVID-19 – A család- és gyermekjóléti szolgáltatók működése a veszélyhelyzet alatt – kutatási jelentés*)	711	Family and child welfare service providers	September	Web	Ministry of Human Resources
HU6	Survey of the opinions of social sector professionals, 2021 (*Szociális ágazatban dolgozók véleményének felmérése, 2021*)	1,300	Social sector professionals	January 2021	Web	Ecopolis Foundation
IE1	Q2 Labour Force Survey	2,288	15+	8–23 April	Phone	Central Statistics Office (CSO)
IE2	Altered lives in a time of crisis: The impact of the COVID-19 pandemic on the lives of older adults in Ireland – Findings from the Irish Longitudinal Study on Ageing	3,677	50+	July–November	Paper	Irish Longitudinal Study on Ageing (TILDA)
IE3	The older population of Ireland on the eve of the COVID-19 pandemic	5,016	58+	January–December 2018	F2F	Irish Longitudinal Study on Ageing (TILDA)
IE4	Social impact of COVID-19 survey	1,362	18+	April	Email	Central Statistics Office (CSO)
IE5	Caring and coping with dementia during COVID-19, July 2020	126 carers and 15 people with dementia	–	June	Web and phone	Alzheimer Society of Ireland
IE6	Financial strain due to COVID-19	1,026	18+	22–28 January 2021	Web	Society of St Vincent de Paul

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
IT1	STEPS and Silver STEPS – COVID module (*PASSI and PASSI d'Argento – Modulo Covid*)	4,901	18+	Late July–23 November	Phone	Italian National Institute of Health (ISS)
IT2	Daily diary and activities during the COVID-19 pandemic (*Diario della giornata e attività ai tempi del coronavirus*)	3,000	18+	5–21 April 2020 and 12 December 2020–15 January 2021	Phone	Istat
IT3	National survey on COVID-19 infection in residential and nursing homes (*Survey nazionale sul contagio Covid-19 nelle strutture residenziali e sociosanitarie*)	1,356 residential and nursing homes (97,251 residents)	18+	25 March–27 April	Email	ISS
IT4	Elderly people and relationship networks during the pandemic (*Anziani e reti di relazioni durante la pandemia*)	68	65+	1–2 May	Phone	University of Milan-Bicocca
IT5	Impact of COVID on families and especially seniors *(Impatto del Covid sulle famiglie italiane e in particolare sui senior)*	528	65+, attending Senior Italia social centres	November	Phone	Senior Italia FederAnziani
LT1	Older people living alone: Living/surviving during the coronavirus pandemic and quarantine (*Vieni gyvenantys vyresnio amžiaus žmonės: (iš)gyvenimas koronaviruso epidemijos ir karantino sąlygomis*)	108	50+, living alone	27 May–19 June	F2F	Lithuanian Social Research Centre and Lithuanian Red Cross
LT2	Emotional dynamics during the COVID-19 pandemic (*Lietuvos emocinio klimato tyrimai*)	–	18–74	5 waves: 25–30 March, 3–8 April, 25–30 April, 16–21 May, 3–8 June	Phone	Baltijos tyrimai
LT3	Impact of the COVID-19 pandemic (*COVID-19 pandemijos aplinkybių poveikis*)	1,139	Frontline workers	30 October–20 November	Web	KOG Institute for Marketing and Communication Sciences, Vilnius University
LT4	Opinion poll on the possibility of finding a job in the event of becoming unemployed (*Gyventojų apklausa apie galimybę rasti darbą, jei jo netektų*)	1,000	18+	–	Phone	Baltijos tyrimai
LT5	Lithuanian Red Cross survey of older people (*Lietuvos Raudonojo Kryžiaus vyresnio amžiaus asmenų apklausa*)	101	60+	May	F2F	Lithuanian Red Cross
LT6	Household survey overview (*Namų ūkių apklausos apžvalga*)	1,000	Households	July–August	Phone	Bank of Lithuania
LU1	Luxembourg in the face of the coronavirus (*Le Luxembourg face au coronavirus*)	986	16+	10–11 March	Web	TNS Ilres
LU2	Survey on the social and economic impact of COVID-19 (*Enquête sur l'impact social et économique lié au COVID-19*)	2,031	18+	29 April–8 May	Web	STATEC
LU3	Report for the Ecological Movement (*Rapport pour le Mouvement Ecologique*)	1,016	16+	15–18 June	Web	TNS Ilres

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
LV1	Impact of COVID-19 on the ageing population in Latvia: Recommendations for mitigating the health and social effects and preparing for potential crises in the future (*COVID-19 ietekme uz Latvijas iedzīvotāju grupām vecumā virs 50 gadiem: ieteikumi veselības un sociālo seku mazināšanai un sagatavotībai iespējamām krīzēm nākotnē*)	1,089	50+	1 July–31 August	Phone and F2F	Riga Stradins University
LV2	The reconciliation of work and private life for different sociodemographic groups during the restrictions introduced to reduce the spread of COVID-19 (*Dažādu sociāli demogrāfisko grupu darba un privātās dzīves saskaņošanas iespējām COVID-19 izplatības mazināšanai noteikto ierobežojumu periodā*)	1,006	Employed	28 September–27 October	Web	Riga Stradins University
LV3	COVID-19 impact: Employees working remotely (*COVID-19 ietekme: attālināti nodarbināto darbinieku skaits*)	Part of EU-LFS	–	–	–	Central Statistical Bureau of Latvia
LV4	COVID-19 impact: Household savings (*COVID –19 ietekme: mājsaimniecību uzkrājumi*)	Part of EU Statistics on Income and Living Conditions	–	–	–	Central Statistical Bureau of Latvia
LV5	Study of public attitudes towards COVID-19 (*Pētījums par sabiedrības attieksmi pret COVID –19*)	1,005 per round	–	Six rounds so far: April, May, November and December 2020; January and February 2021	–	–
MT1	Research on COVID-19 – How is it affecting our mental health?	Round 1: 1,064; rounds 2–7: 500	16+	2–9 April, 11–17 June, 19–31 August, 5–15 October and 27 November–10 December 2020; 22 January and 3–18 February 2021	Phone	Richmond Foundation
MT2	COVID-19 module of the EU-LFS	3,200 monthly	15+	From March onwards (monthly)	Phone	National Statistics Office
MT3	MaltaToday survey – Looking back at 2020	641	18+	30 November–4 December	Phone	MaltaToday
NL1	The impact of COVID-19 measures on vulnerable elderly people and home carers (*De impact van de coronamaatregelen op kwetsbare ouderen en mantelzorgers*)	57 (including 34 older people – 2 in care homes; 14 informal carers; 4 care professionals)	–	April–June	Phone	–
NL2	Longitudinal Internet studies for the Social Sciences (LISS)	May: 1,697; June: 1,716	65+, panel	May and June	–	LISS
NL3	Poll of the coronavirus crisis: Financial consequences for households (*Peiling coronacrisis: financiële gevolgen voor huishoudens*)	1,050	18+	25–29 March	–	National Institute for Family Finance Information
NL4	Well-being during the COVID-19 pandemic (*Welbevinden ten tijde van Corona*)	1,500	16+	–	–	Netherlands Institute for Social Research

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
PL1	Impact of the coronavirus pandemic on occupational activities and household budgets (*Skutki epidemii koronawirusa w życiu zawodowym i budżetach domowych*)	1,000	18+	23–27 April	Web	Centre for Public Opinion Research (CBOS)
PL2	Daily life during the pandemic (*Życie codzienne w czasach zarazy*)	1,000	18+	23–27 April	Web	CBOS
PL3	Health of Polish senior citizens during the pandemic (*Zdrowie polskich seniorów w czasie pandemii*)	1,118	60+	August	Web	National Institute of Silver Economy
PL4	The impact of the pandemic on the health behaviours of Poles (*Wpływ pandemii na zachowania zdrowotne Polaków*)	1,000	18–75	7–8 April	Web	IBRiS Market and Social Research Institute
PL5	The coronavirus pandemic and the occupational situation of Poles (*Epidemia koronawirusa a sytuacja zawodowa Polaków*)	1,304	18+	22 May–4 June	Paper, phone, web	CBOS
PL6	Healthcare during the pandemic (Opieka medyczna w czasie epidemii)	1,378	18+	7–17 September	Computer-assisted personal interviewing, CATI, computer-assisted web interviewing	CBOS
PT1	The social impact of the pandemic (*O impacto social da Pandemia*)	11,508	16+	Round 1: 25–29 March; round 2: 24 April–4 May	Web	University of Lisbon and Lisbon University Institute
PT2	Access to healthcare during the pandemic (*Acesso a cuidados de saúde em tempos de pandemia*)	1,009	18+	28 August–8 September	–	Order of Physicians and Portuguese Association of Hospital Managers
PT3	Mental health during the COVID-19 pandemic (*Saúde mental em tempos de pandemia COVID-19*)	2,097 health professionals and 3,982 other people	18+	22 May–14 August	Web	National Institute of Health Doctor Ricardo Jorge, University of Lisbon and Portuguese Society of Psychiatry and Mental Health
PT4	Pandemic diaries (*Diários de uma pandemia*)	59,902	16–89	8 waves from 23 March 2020 to 5 March 2021	Web	Institute of Public Health of the University of Porto and Institute for Systems and Computer Engineering, Technology and Science
PT5	Loneliness in the elderly and the COVID-19 pandemic (*Solidão no idoso e pandemia da COVID-19*)	–	–	–	Web	EIT Health
PT6	Impact of social isolation on adults and older people (*Impacto do isolamento social em adultos e idosos*)	250	50+	–	–	University of Coimbra
PT7	COVID-19 Barometer: Social opinion (*Barómetro COVID-19: Social opinião*)	183,242	16+	Phase 1: March–July; phase 2: ongoing	–	NOVA University Lisbon

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
RO1	The impact of COVID-19 on the quality of life of Romanians (*Impactul COVID-19 asupra calității vieții românilor*)	1,115	18+	12–15 February 2021	Phone	Romanian Institute for Evaluation and Strategy (IRES)
RO2	Vaccination against COVID-19 in Romania – A profile analysis depending on the intention to vaccinate against COVID-19 (*Vaccinarea anti COVID-19 în România. Analiză de profil în funcție de intenția de vaccinare împotriva COVID-19*)	1,512	18+	13–15 January 2021	Phone	IRES
SE1	Senior special! How do older people act around the coronavirus? (*Seniorspecial! Hur agerar de äldsta kring Coronaviruset?*)	1,347	70–89	27–30 March	–	Novus
SE2	Mental health during the COVID-19 pandemic (*Psykisk hälsa under coronapandemin*)	1,602	16–84	May	Web	Public Health Agency of Sweden
SE3	Survey on the consequences of the COVID-19 pandemic for relatives (*Enkät om covid-19-pandemins konsekvenser för anhöriga*)	–	Carers (relatives), 18+	Until 28 February 2021	Web	Eurocarers and Swedish Family Care Competence Centre
SE4	Health on equal terms – The national public health survey (*Hälsa på lika villkor – den nationella folkhälsoenkäten*)	Sent to 120,000 people	General population	February–May	Web or paper	Public Health Agency of Sweden
SE5	What do older people think about elderly care? (*Vad tycker de äldre om äldreomsorgen?*)	110,715	65+, living in a retirement home/ receiving home care	March–May	Web or paper	National Board of Health and Welfare
SE6	Habits during the COVID-19 pandemic among people aged 70 years and older (*Levnadsvanor under coronapandemin bland personer 70 år och äldre*)	Sent to 3,700 people	70+, Stockholm region	May–August	Web or paper	Stockholm Gerontology Research Center
SE7	Mapping of COVID-19 at special homes for older people in the Stockholm region (*Kartläggning av covid-19 på SÄBO I Stockholms län*)	227	Managers at special homes for older people, Stockholm region	April	Web	Stockholm Regional Council
SE8	Study about older people's experiences of risk and mental health in relation to COVID-19 (*Studie om äldre personers upplevelse av risk och psykisk hälsa i förhållande till covid-19*)	1,854	70+	April–May	Web	Karlstad University
SE9	Up and about: Older adults' well-being during the COVID-19 pandemic in a Swedish longitudinal study	1,071	65–71	March–April	Web	HEalth, Aging and Retirement Transitions in Sweden (HEARTS), Centre for Ageing and Health at Gothenburg University
SE10	The public aged over 80 years – Trust, thoughts and actions during the pandemic (*Allmänheten över 80 år – tillit, tankar och beteende i coronatid*)	700	80+	September	Phone	Kantar Sifo
SE11	In-depth analysis of the development of gambling addiction connected to the spread of COVID-19 (*Fördjupad analys av utvecklingen av spelproblem kopplat till spridningen av covid-19*)	4,178	18+	September–November	Web	Public Health Agency of Sweden

Code	Survey (title/topic)	Sample size	Population (ages, etc)	Period	Mode	Organisation
SI1	Needs assessment and psychosocial support during the second wave of the COVID-19 pandemic	3,552	18+	November 2020–January 2021	Web	National Institute of Public Health
SI2	Slovenian public opinion survey (SPO 2020/21) – Life and attitudes of Slovenians during the COVID-19 pandemic (*Slovensko javno mnenje 2020/21 – Življenje in stališča v času epidemije COVID-19*)	853	18+	1 April–31 May	Web	University of Ljubljana
SI3	Survey of the situation of residents of homes for the elderly during the epidemic *(Anketa o položaju stanovalcev domov za starejše med epidemijo*)	1,267	87 nursing home residents, 597 relatives, 72 directors, 427 employees and 84 NGO representatives	July–August	Web, phone and paper	Advocate of the Principle of Equality
SK1	When the world changed – The impact of the coronavirus pandemic on everyday life in Slovakia (*Keď sa zmenil svet. Vplyv epidémie koronavírusu na každodenný život na Slovensku*)	2,357	18+	18–26 March	Web	Slovak Academy of Sciences
SK2	Survey of the life situation during the COVID-19 pandemic (*Prieskum životnej situácie počas pandémie COVID-19*)	408	18+	Mid-May–late June	Web	Institute for Labour and Family Research
SK3	Dignified ageing in Slovakia (*Dôstojné starnutie na Slovensku*)	Phase 1: 62; phase 2: 1,000	Phase 1: political party representatives, experts, social care professionals and patient organisations; phase 2: 18+	Phase 1: October and November 2019; phase 2: August 2020	Web	SOCIA – Social Reform Foundation

Notes: *Year only mentioned if other than 2020. Surveys with fewer than 40 respondents were excluded. F2F = face-to-face. - = unknown to authors.*

Annex 2: Network of Eurofound Correspondents

List of correspondents who contributed to the research

Country	Contributor(s)	Organisation(s)
AT	Bernadette Allinger	Working Life Research Centre (FORBA)
BE	Dries Van Herreweghe	Research Institute for Work and Society (HIVA), KU Leuven
BG	Ivan Neykov and Nadejda Miteva	Balkan Institute for Labour and Social Policy
CY	Pavlos Kalosinatos	Pancyprian Federation of Labour (PEO)
CZ	Aleš Kroupa	Research Institute for Labour and Social Affairs
DE	Mona Aranea	Institute of Economic and Social Research (WSI), Düsseldorf
DK	Katrine Marie Larsen	Oxford Research Denmark
EE	Ingel Kadarik and Priit Purge	Praxis Centre for Policy Studies
EL	Elena Kousta	Industrial Relations Unit, Labour Institute of the Confederation of Labour (GSEE)
ES	Alejandro Godino	Autonomous University of Barcelona
FR	Frédéric Turlan and Pascale Turlan	IR Share
FI	Amanda Kinnunen and Vera Lindström	Oxford Research
HR	Predrag Bejaković Irena Klemenčić	Institute of Public Finance University of Zagreb
HU	Andrea Gyarmati	Independent researcher
IE	Martin Frawley and Andy Prendergast	Industrial Relations News
IT	Stefano Neri	University of Milan
LT	Rasa Mieziene and Inga Blaziene	Lithuanian Social Research Centre
LU	Franz Clément and Nicaise Misangumukini	Luxembourg Institute of Socio-Economic Research (LISER)
LV	Krišs Karnitis	EPC Ltd
MT	Christine Garzia	University of Malta
NL	Paul Vroonhof and Eelco Tammens	Panteia
PL	Marta Trawinska	Institute of Public Affairs
PT	Paula Carrilho and Heloísa Perista	Centre for Studies for Social Intervention (CESIS)
RO	Simona Ghiță, Cristina Boboc and Valentina Vasile Alexandra Deliu	European Institute of Romania SC Euractiv Network SRL
SE	Sofia Karlsson and Amanda Kinnunen	Oxford Research
SI	Monika Weiss	University of Ljubljana
SK	Daniela Kešelová	Institute for Labour and Family Research

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This report captures the impact of the COVID-19 crisis on the quality of life of older citizens, including the impact on their well-being, finances, employment and social inclusion. It explores the effects on the use of care services and older people's reliance on other support. The report presents policy measures that have been implemented in EU Member States to support older people along all of the above-mentioned dimensions. These include measures to support independent living and schemes to support the labour market integration of older people or to prevent unemployment, all of which play a role in the quality of life of older citizens.

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

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