



## **FINAL CASE STUDY REPORT:**

Report on income and social protection  
for the EU Drivers Project: Synthesis of  
case study evidence compiled by  
European Anti-Poverty Network

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## Summary

- The research evidence indicated that income inadequacy was a core issue impacting individuals across the countries within the research and this often had negative impacts on their lives as subsistence did not allow them to fully meet their needs including health needs.
- Low incomes were a result of life circumstances and the adequacy of basic levels of support provided by the state.
- Experiences around the support individuals received were shaped by both the thresholds and entitlements in the system and knowledge of their rights and entitlements.
- Access to employment and support received through the social protection system were key areas of concerns. In particular for those with underlying health conditions or disabilities or more difficult life circumstances i.e. experiences of homelessness and addiction there was a need for more personalized tailored support.
- The integration of social protection system meant that individuals in several countries experienced points of financial hardship at points of transition, i.e. changing life circumstances such as a family breakdown.
- The attitudes of staff delivering and administering the social protection and healthcare system were critical and individuals spoke of the importance of a non-judgmental approach. Several examples were given of stigma individuals had experienced.
- Healthcare provision was seen as a useful resource for individuals to draw upon as cushion against ill health and disability. Reduced access and coverage to health care, particularly for key groups was a key factor in generating health inequality.
- Poor income levels had impacts on individuals' health such as food poverty and increased stress which had health consequences.
- Some limited relationship was seen between the degree of support received through social protection systems and the experience of health/self-perceived greater integration with the social protection system was needed and to ensure individuals were able to exercise their rights and access the support they required.

## Introduction

The aim of the focus groups is to provide case studies of countries, under Work Package 6 (WP6) of the Drivers of Health Inequalities Project. The case studies results relate to the research under WP4 (Income and Social Protection). 'Drivers' is a three year research program funded by the EU 7th Framework Programme. It brings together leading researchers, civil society organizations, business, and a European network of public health bodies with the aim of understanding and promoting health equity through policy and practice. The case studies will aim to explore in a comparative country context, the impact of social protection system, both operations and provisions, on health inequality.

The core research questions for this Work Programme are:

- To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package) act as a collective resource for people to draw upon when their own resources are failing?
- How does this system of support help prevent health inequalities?

This research undertook a case study approach to explore the questions across five countries. The following countries were involved – Hungary, Poland, United Kingdom, Sweden, and Portugal, carried out by EAPN organizations in each country.

- Poland: Dr Justyna Godlewska-Szyrkowa & Łukasz Łotocki
- Hungary: Krisztina Jász & Szilvia Németh
- Portugal: Fátima Veiga, Paula Cruz
- Sweden: Märta Brandts, Sophia Lövgren
- UK: Fiona McHardy, Peter Kelly

EAPN Brussels provided overall co-ordination between the five partners: Sian Jones, EAPN Policy Coordinator, Tanya Basarab, Senior Development Officer and Fintan Farrell, Project and Fundraising Manager.

Countries followed a pre designed toolkit to conduct the research which was developed together with researchers at CHESS (see Annex 2). This included collecting evidence on a pre-determined population (youth) and an 'at risk' group of interest designed by the individual country (see below). The national reports as well as this synthesised report were discussed at a workshop held in Brussels in May 2014, where also some key links with the research undertaken in DRIVERS WP4 were identified by Olle Lundberg. These links are presented and discussed in a concluding section of this report.

## Case Study Methodology

As the research was carried out in a number of countries, with different models of social protection system and contexts, it was important to adopt an approach where the data could be comparable and robust. Time was taken before the beginning of the focus groups to develop a common research toolkit, developed by countries taking part in the research.

The research case study approach consisted of the individual countries participating collecting focus group data using a structured design. The toolkit outlined procedures for recruitment, data collection and analysis and well as reporting. The toolkit was carefully designed to minimise bias within the research but also to capture the depth of information required for the research.

The research set out to explore a common core population (youth) and a population deemed as 'at-risk' which was selected by the individual country partners.

Within the toolkit the original research design has been to conduct focus groups across the following stratification.

Network	Focus Group A	Focus Group B
	Common group, selected in conjunction with academic partners.	At risk group country specific
United Kingdom	1 <sup>st</sup> Group would be common – youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home.	2 <sup>nd</sup> group: aged (18 -65)  People with experience of addiction and in recovery: substance misuse drugs or alcohol or dual addiction.
Portugal	1 <sup>st</sup> Group would be common – youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home.	2 <sup>nd</sup> group:  <ul style="list-style-type: none"> <li>• Age 35 – 65</li> <li>• Long term unemployment;</li> <li>• Precarious work (formal vs informal economy);</li> <li>• Living in poverty and social exclusion</li> </ul>
Sweden	1 <sup>st</sup> Group would be common – youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home/	2 <sup>nd</sup> group:  Single parent families/NEETS /people with drugs and alcohol problems
Poland	1 <sup>st</sup> Group would be common	2 <sup>nd</sup> group:

Network	Focus Group A	Focus Group B
	Common group, selected in conjunction with academic partners. – youth (18-30). Mix of lone parents, employed/unemployed/living independently/at home.	At risk group country specific Former drug and alcohol users and/or homeless people.
Hungary	1 <sup>st</sup> Group would be common – youth (18-30). Mix of lone parents, employed/unemployed/living independently/at home.	2 <sup>nd</sup> group: Adults – age between 35 and 65 <ul style="list-style-type: none"> <li>- long term unemployed</li> <li>- with experience of public work (workfare) system</li> <li>- mixture of single adults and adults with children</li> <li>- mixture of homeless and non-homeless people</li> <li>- people from different ethnic background</li> <li>- different educational level</li> <li>- mixture of people living in large cities and small villages</li> </ul>

## Sampling

The sampling framework in the toolkit was modified in practice as some countries had difficulty accessing the population sample. Participants were recruited through a multi method approach; countries reported using posters, through social media, project work, local networks, word of mouth and so on. A breakdown can be found below.

Sweden	Through network, other NGO's members register, young adults were problematic – posters in universities
United Kingdom	Through Poverty Alliance network and partner organisations
Portugal	Through cooperation of EAPN regional networks of Operato and Averio and local organisations.
Hungary	Through social media, webpage and contacting other organisations they work with.
Poland	Personal network of researchers as well as snowball technique, social welfare centre asked to assist, NGO support centre.

Some countries reported challenges in recruitment. Poland reported difficulties in accessing populations and experienced high rates of refusals to take part. They indicated that it had been difficult to recruit people with lower levels of education and or receiving financial support within the younger adult population group.

Sweden reported challenges in accessing young adults in particular and had tried additional recruitment measures to recruit people but these had been unsuccessful. Sweden sought to undertake a survey to collect additional data and undertook an anonymous web based questionnaire as well as undertaking a focus group with single parents in place of the group of young people. In addition, Poland undertook an interview with a participant that was unable to attend the focus group. On the whole the research was well received and countries reported participants engaging well with the discussion.

## Analysis

Data collected was transcribed then thematically coded. This was important as it allowed for multiple examinations of what people have said and provided a fixed and clear starting point for analysis. Analysis was conducted using a process of grounded theory. Grounded theory is particularly useful for the discovery of theory from data – systematically obtained and analysed in social research' (Glaser & Strauss, 1967: 1)<sup>1</sup>. Data was analysed and coded thematically until no new themes emerged, which allowed the analysis framework to emerge from the data itself. Grounded theory is an approach that seeks 'the development of theory, without any particular commitment to specific kinds of data, lines of research, or theoretical interests . . . Rather it is a style of doing qualitative analysis that includes a number of distinct features . . . and the use of a coding paradigm to ensure conceptual development and density' (Strauss, 1987)<sup>2</sup>.

On applying coding categories, partners were asked to implement the following

- Homogeneity (in each set of categories we can use just one analysis dimension)
- Relevance (to the research and to the questions guide)
- Objectivity (clear definition of categories.)
- Productivity (the categories must allow reflection, new ideas for the analysis).

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<sup>1</sup> Glaser, B., Strauss, A (1967) '*The Discovery of Grounded Theory Strategies for Qualitative Research*', London, Aldine Transaction

<sup>2</sup> Strauss, A (1987) '*Qualitative Analysis for Social Scientists*', Cambridge, University of Cambridge



## Ethical issues

The toolkit had outlined the importance of conducting ethical research and following procedures to ensure confidentiality of the data, etc. Some sensitive data was collected through the research, for example information relating such as addiction, mental ill health including suicide, bullying, discrimination, bereavement and homelessness. All networks were experienced in dealing with and working with people in a sensitive and informed manner and were able to manage such issues. It was anticipated that the research given that it was exploring the area of social protection and health, would uncover difficult life circumstances. Some participants within groups did disclose distressing and sensitive life experiences. All participants were made aware of additional sources of support if required.

The research operated an inclusive approach. Across the research the care was taken to remove all barriers that may prohibit or restrict participants from taking part. For example focus groups were arranged at a time that would be suitable for those with caring responsibilities. Across the focus group, care was taken within the facilitation to allow people the opportunity to engage with the research. Reaching a range of participants was important to the research. Portugal for example discussed using sign language to assist some focus group members to participate.

## Results

The research sought to answer the following questions:

1. To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package) act as a collective resource for people to draw upon when their own resources are failing?
2. How does this system of support help prevent health inequalities?

Grounded analysis was conducted across the groups. This was drawn from an overarching framework that looked at three main areas: Baseline of Social Protection, Coverage of Social Protection and Health and Future Policy Areas and Recommendations.

Across the countries included the model of social protection differs, both in terms of principles and levels of ambition. Although it has proven difficult to demonstrate clear and stable relations between more generalised descriptions of welfare state efforts (welfare regimes), it has also been shown that differences in terms of coverage and replacement rates across countries are related to levels of health and health inequalities<sup>3</sup>.

In terms of the coverage and protection provided by each welfare state model there are key similarities and differences across each model. Coverage rates across the countries “have remained quite steady however between 2005 and 2010 more dramatic changes can be seen in terms of the net replacement rates”<sup>4</sup>.

In terms of changes and decreases in social protection within the countries this has impacted most on Sweden which has seen the decrease across all of its social protection programs<sup>5</sup>.

Poland, Hungary, Portugal and United Kingdom have seen a decrease in support across sickness cash benefits and to a degree social assistance benefits<sup>6</sup>. This impacts must be considered in light of the tax systems applied which may in boosting replacement rates within certain countries<sup>7</sup>. Interactions with the tax system can have important implications in

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<sup>3</sup> Bergqvist K, Åberg Yngwe M, Lundberg O. (2013). Understanding the role of welfare state characteristics for health and inequalities – an analytical review. *BMC Public Health* 2013, 13:1234. <http://www.biomedcentral.com/1471-2458/13/1234>

<sup>4</sup> Doctrinal, L & Fredriksson, D (2013) ‘Social insurance in five EU member states Report to EU Drivers’

<sup>5</sup> Doctrinal, L & Fredriksson, D (2013) ‘Social insurance in five EU member states Report to EU Drivers’

<sup>6</sup> Doctrinal, L & Fredriksson, D (2013) ‘Social insurance in five EU member states Report to EU Drivers’

<sup>7</sup> Doctrinal, L & Fredriksson, D (2013) ‘Social insurance in five EU member states Report to EU Drivers’

terms of the system for example within Portugal all social insurance benefits are exempt from tax<sup>8</sup>.

Overall these changes mean that there are shifts in the social protection system and this will have implications for those who are recipients.

## Question One

*To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package) act as a collective resource for people to draw upon when their own resources are failing?*

Overall, across the countries involved there was variance in the levels of coverage and the perceived adequacy of the social protection system and how this impacted on individuals and households. The countries involved in the case studies represented different types of social protection policies as outlined below.

Sweden has a model of social protection which has universal coverage. A range of policies covered a variety of basic needs including: health insurance; benefits in respect of accidents at work and occupational diseases; invalidity benefits; old-age and survivors' pensions; unemployment insurance; family benefits and parental insurance. The Swedish social security system is founded on the principle of national insurance. The group of people protected is thus not defined according to a certain social status, and no major distinction is made between employees and the self-employed<sup>9</sup>. Sweden as discussed earlier has seen some of the biggest decreases across its social protection system.

Portugal's system is also based around principles of universality. Policies included the citizenship social protection system, the insurance system and the supplementary system<sup>10</sup>.

The citizenship social protection system includes elements such as family protection. The Insurance system is based on mandatory contributions, paid by employers and employees. It provides certain cash benefits which replace lost or reduced income in cases of sickness, maternity, unemployment and so on<sup>11</sup>. The supplementary system includes policies such as a public funded scheme which is a voluntary and individual affiliation scheme that aims at

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<sup>8</sup> Doctrinal, L & Fredriksson, D (2013) 'Social insurance in five EU member states Report to EU Drivers'

<sup>9</sup> European Commission (2013) 'Your Social Security Rights in Sweden' page 5

<sup>10</sup> European Commission (2013) 'Your Social Security rights in Portugal' page 5

<sup>11</sup> European Commission (2013) 'Your Social Security rights in Portugal' page 5

providing benefits complementary to those granted by the general social security scheme and other policies<sup>12</sup>.

In Hungary people receive support through a social insurance scheme based around employment. The system is structured and organised around different forms of support. Pensions and health services (including the statutory work accident system) are classified as social insurance<sup>13</sup>. The other three branches are the unemployment insurance, the family support system and the social assistance system<sup>14</sup>. The management, organisation and administration of the Hungarian social insurance system are centralised; the social benefits service is decentralised<sup>15</sup>.

Within Poland the social security is made up of the following: old-age pension; invalidity pension; sickness and maternity insurance; insurance against accidents at work and occupational diseases; health insurance. It also incorporates support through a system of family benefits, social assistance benefits and unemployment benefits. The social security system covers practically all people in active employment, i.e. employees, self-employed people and their family members and operates a system of social insurance either mandatory or voluntary<sup>16</sup>.

The UK system of social protection includes is structured through the National Insurance Scheme (NIS), which provides cash benefits for sickness, unemployment, death of a partner, retirement, etc<sup>17</sup>. People earn entitlement to these benefits by paying National Insurance contributions. Support is also provided through child benefit and Child Tax Credit schemes, which provide cash benefits for people bringing up children<sup>18</sup>. Non-contributory benefits are available for certain categories of disabled persons or carer<sup>19</sup>. The system also includes statutory payments made by employers to employees when a child is born or placed for adoption<sup>20</sup>. Healthcare is provided through The National Health Service (NHS), which provides medical, dental and optical treatment and which is normally available free of charge only to people who live in Great Britain and Northern Ireland<sup>21</sup>.

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<sup>12</sup> European Commission (2013) *'Your Social Security rights in Portugal'* page 5

<sup>13</sup> European Commission (2013) *'Your Social Security rights in Hungary'* Page 5.

<sup>14</sup> European Commission (2013) *'Your Social Security rights in Hungary'* Page 5.

<sup>15</sup> European Commission (2013) *'Your Social Security rights in Hungary'* Page 5.

<sup>16</sup> European Commission (2013) *'Your Social Security rights in Poland'* Page 5

<sup>17</sup> European Commission (2013) *'Your social security rights in United Kingdom'* page 4

<sup>18</sup> European Commission (2013) *'Your social security rights in United Kingdom'* page 4

<sup>19</sup> European Commission (2013) *'Your social security rights in United Kingdom'* page 4

<sup>20</sup> European Commission (2013) *'Your social security rights in United Kingdom'* page 4

<sup>21</sup> European Commission (2013) *'Your social security rights in United Kingdom'* page 4

Despite the variations across the systems some core themes emerged on the coverage, generosity of benefits and integration of the system and the extent to which the system provided a level of support for individuals to draw upon when their own resources were failing.

Across all countries with the exception of Sweden the issue of income adequacy and the extent of coverage provided by the social protection system emerged. There was consensus amongst the participants on the importance of support but often the social protection system did not go far enough in providing this support.

### **Levels of financial support**

Levels or thresholds of financial support were set at minimal levels across the UK, Hungary, Poland and Portugal. In relation to the social protection this often left people experiencing poverty. The subsistence level left people unable to meet many needs such as heating, food and transport. Sweden differed from the other countries studied in that the levels of subsistence provided through the social protection system were seen as adequate but often had the effect of 'trapping' people within the system. The concept of adequacy was discussed across several countries in terms of the support the country provided and how adequate this was for an effective quality of life. Within Sweden there were different views on the adequacy of the benefit system, there was a perception that the benefit system was open to fraudulent exploitation of the system and this affected the 'adequacy' of support that individuals in need actually received. Adequacy against wider structural factors was also highlighted for example entitlements against rising living costs. Adequacy at points of transitions i.e. moving into work as result of activation policies was also highlighted.

Points about minimum levels of quality life people should experience were also raised. Feeling humiliated and having low feelings of self-worth as a result of surviving was also a key theme to emerge from both Hungary and the UK.

In the focus groups in Portugal, Hungary, UK and Poland, points emerged on the coping strategies people would apply to alleviate or manage with the minimal levels of support they were receiving. Coping strategies varied but included limiting food, heating, missing out on social activities and so on.

Across the research evidence different populations outlined different needs but a consensus emerged that overall basic needs were only being met and sometimes not being met at all.

In the example of Poland, participants spoke of the support being predominately supplemented by that of non-governmental organisations. Indeed for the most vulnerable or poorest they were most dependent on this additional support. For example the NGOs

provided support in the form of subsidised accommodation within the Homeless centre. Without access to NGO support they would have been unable to meet their living costs even if they had obtained employment. The importance of NGO supplementing state support was emphasised within other countries. Portugal emphasised food access for households through NGO provision.

The precarious nature of support and the social protection system was highlighted, evidence from Poland highlighted issues with the tapering or thresholds within rates of support, and for example benefits were withdrawn if a person obtained additional income or in some cases had been falsely accused of having a source of additional income. Conditionality around benefit seemed particularly a cause of concern within Poland, this appeared to have an impact in discouraging people applying.

Participants discussed this in relation to transition to employment in relation to accessing the labour market, grey zone employment was not accessible whilst on benefits, this would result in it being withdrawn.

### **Attitudes to Claimants**

On a wider level, themes emerged on the experiences of accessing support. Attitudes of staff employed in areas such as the labour office or the job centre were felt to be often judgemental and stigmatising and detrimental to accessing rights and entitlements. This was discussed amongst UK, Hungary, and Portugal.

In Hungary the young people spoke clearly of distrust of the social protection system and of accessing support. There was a perception that they would not be able to obtain the support required. This was also reflected in their experiences of being unable to access support. This did not apply with the other population sampled -long term unemployed people including those with experience of homelessness who were aware they would be able to access support but that this support would be inadequate for their needs. Despite this, evidence emerged on barriers to accessing support entitlement such as administrative barriers.

### **Accessing Entitlements**

Within the evidence collected on young people within Portugal, points were raised about the precarious nature of income when trying to obtain employment and access support, the inflexibility of the system was a key factor. Again this was similar to the experiences of those in Hungary in that several of the young people within the focus group did not get financial support when trying to find work. Young people within the UK seemed to fare better in gaining financial support when seeking employment but highlighted challenges in trying to access work.

Across the adult population focus group, experiences of accessing entitlements in Portugal provision appeared to be more integrated and support provided more effectively. For example participants discussed support being provided with emergency accommodation such as hostels as well as financial assistance.

Evidence from Sweden on the adequacy and coverage differed from some of the other groups. Coverage was limited in regards to housing allowances where levels were insufficient to cover their rent. Participants discussed being placed under pressure to obtain cheaper accommodation however barriers to this were credit history or a requirement by landlords for a higher income. Participants emphasised the structural barriers that the social protection system constructed and their feelings of powerlessness in relation to the system.

The experience of powerlessness was largely related to the degree of 'control' or people had within their collective experience of the social protection system. Participants described that they were unable to make choices and that their lives were shaped by the social protection system. Power was seen to be in the hands of those administering the benefits system, this again was a theme that emerged across all the countries involved in the research.

### **Conditionality**

An overarching theme emerged of being subject to meeting the conditions of the system, and of needs and requirements not always fitting the system in terms of service and support provided through the social protection system. Gaps and thresholds led to a complicated picture where individuals fell between layers of support resulting in periods of hardship and needs being unmet such as support at transition points such as obtaining employment. Clear evidence was presented across all countries on the challenges faced in the administrative process around social protection. Participants discussed the complexity of the system and the problems they face understanding and navigating this. For those with disabilities or within more complex situations, particular challenges were highlighted in terms of obtaining clear and comprehensive advice. Processing errors were reported in several countries including Portugal and the UK. This was an issue for both at risk groups and the youth although more issues were reported across Hungary in regards to youth accessing their entitlements. Understanding rights and entitlements was felt to be the responsibility of the claimant and not of those administering the social protection system. This was seen as a barrier across several countries to effective support.

One key barrier was the issue of documentation required for access of support. For more marginalised groups this was often a problem. Other barriers reported were the literacy of participants and the need to complete official forms. Evidence also emerged on transition points within the system such as changing circumstances i.e. family breakdown and the

inflexibility of the system to deal with this. It was clear that social protection systems were not always equipped to deal with difficult, changing life circumstances. This was in particular a theme that emerged strongly within the UK. Multiple examples were given such as the transition of one individual on obtaining refugee status, leaving rehabilitative health facilities as being difficult points in terms of accessing effective Income support. This also emerged through the research evidence compiled in Portugal which discussed an example of a long term unemployed female who lives with a family member and her child but is not classed as a lone parent and this in turn meant they were ineligible for specific support.

Several points were raised on the training and expertise of individual advisors within services. Attitudes of staff were also seen as important: non-judgemental and inclusive support was seen as important but despite this participants often described being made to feel judged rather than supported. Such attitudes were seen as a barrier to effective support. Stigma and the level of assistance people were given made them feel unimportant and participants spoke of feeling humiliated obtaining support across the UK, Portugal and Hungary.

### **Activation Policies**

Across European social policy there has been a strong focus on activation policies, in supporting people into employment. Across the research accessing the labour market and the support and conditionality on obtaining employment was discussed.

Adequacy of support to obtain employment was widely discussed. Participants discussed the appropriateness of training and the understanding of their skills and experiences. It was highlighted that participants were moved into training programmes that were woefully inadequate in terms of tailoring of support. The need for personalisation of support was cited as a key area and for people's situation to be considered on an individual basis rather than dealt with in standardised way. Participants across all countries discussed the need for effective tailored support to assist people to access effective sustainable employment. Several examples were cited of participants employing other techniques to obtain employment such as using contacts of support networks such as family members. In Hungary these were discussed as more useful than the support provided by the state. Informal work and volunteering was also discussed. Volunteering was seen a key opportunity to improve skills and experience. Informal work was discussed as being often a route that people accessed as it was seen as preferable means for support than relying on state support although this was not a finding across all countries.

Other support methods used to access employment were that of social network connections i.e. family and friends. Related to problems with administration documentation highlighted



earlier, registration of residence emerged as a barrier to employment from those in Poland who had experienced homelessness. This resulted in many taking on 'Grey Zone' employment – i.e. employment without any social protection. This results in a further complexity as people were unable to access their entitlements.

In terms of integration of the social protection system as a collective resource for people to draw upon when their own resources were failing the research evidence illustrated a mixed picture. On the whole the experiences reported across both the youth groups and the at-risk groups of participants spoke of a system that was disjointed and where gaps in provision or coverage left participants vulnerable and with limited choices. Within Hungary, Portugal, UK and Poland participants discussed situations of people facing greater vulnerability than Sweden.

Experiences around labour market support illustrated clearly that there was a need for this to be more effective working in particular in terms of the quality of training programmes provided.

Integration of entitlements was also problematic. Participants discussed being falling through or being trapped by the current system. This was a key issue in all countries. For both the adult and at risk groups problems were reported. The linkage of policy areas and peoples personal situations were not always supported and as a result participants described powerlessness and drawing upon other support such as that of non-governmental organisations. In particular points of transition were seen as problematic i.e. gaining employment and so on.

Some examples of good practice for example participants in the UK discussed some positive experiences in the transition to accessing support upon release from prison and the new Scottish welfare fund. In Portugal, examples were raised of participants who received better support in social services due to allocated workers who followed their case closely and provided support.

## Question 2

*How does this system of support help prevent health inequalities?*

The degree to which the system of social protection support can help prevent health inequalities is difficult to determine. Despite the limitations in support the social protection system was generally considered to provide some degree of protection against health inequalities, by safeguarding living standards and providing a secure base thereby reducing a key social determinant of health inequality and served to provide a preventative function in regards to allowing people access to health care services which they may not otherwise be able to afford or obtain through other support or mechanisms. In this sense, it helped to reduce health inequalities by preventing individuals from having no access to health care during periods of financial hardship in their life. The degree of impact the social protection system provided across these two areas varied across the countries studied and this report will now go onto highlight some of this.

Examples could be found across the research evidence of people having obtained treatment for a range of conditions including support with mental health, addiction, physical ailments and disabilities. Despite this provision was not universal and specifically some health care areas, participants described more gaps in provision and entitlements such as around mental health care.

Within Hungary points were raised about the impact of austerity within the country with participants within the at risk focus group perceiving that it had contributed to higher rates of mental illness. Points were raised about provision of mental health support such as counselling being difficult to access.

Evidence indicated that although health care access and provision was available the scope and availability of this provision influenced individual's health and in turn led to health inequity.

This was also an issue raised within the UK, whereby those in the at risk group discussed a lack of specialist support in regards to mental health and support to move into employment, thereby increasing risk of poorer mental health for individuals subject to such policies.

For example within Poland concerns were highlighted on being able to access specialist doctors and waiting lists. As individuals were only available to access state funded support this led to inequality in comparison to those who were able to access support within the private healthcare system.

Research evidence illustrated that the impact of the protection and its effectiveness against health inequalities was dependent on the demographic and circumstances of the individuals involved as well as other factors such as the degree of coverage offered through the social protection system.

The subjective nature of health within this study meant that it was difficult to understand in a degree of detail the impact of social protection system on individual's health or perception of health but several points could still be interpreted from the data. Participants were asked as part of profiling sheets to provide information on their subjective health status graded along a scale. A range of viewpoints were reported in terms of poor health to excellent health. Participants discussed a range of health conditions and disabilities affecting their physical and mental health<sup>22</sup>.

Within Hungary there was perception that ill health, in particular mental health had been adversely affected across the country as a result of the changing economic context and the additional pressures it had placed on people in their day to day lives.

Within Poland some participants reported that they did not have social insurance but due to their experience of having good health, had not utilised health services in such an acute manner as other participants within the study.

Key areas emerged in terms of access and support with health that the social protection system provided as well as the impact of interacting policy areas influencing health such as activation policies.

In countries with universal health coverage such as Poland and Sweden highlighted that due to the construction of the social protection system and the support offered that health inequalities were to a degree reduced as healthcare support allowed individuals some degree of support with health issues. This was also the case within the UK. Within Poland, however, concerns were raised about sometimes being denied rights despite having social insurance due to administrative processes for example within hospitals. Despite this, points were raised about the health inequalities occurring as a result of the system in terms of the adequacy of coverage provided in terms of income related benefit and related issues such as health and gaps in primary health care such as optical or dental care.

For example within Sweden participants reported that people were only entitled to emergency dental care and not ongoing dental treatment.

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<sup>22</sup> This included cognitive impairments or learning disabilities.

The coverage of the income support participants received was often related to their health status for example if they received additional coverage as a result of a disability or illness. The thresholds or eligibility criteria applied to support and assessment process for support was discussed in several of the countries within the research.

Within the UK this was highlighted in particular as people discussed medical assessments and the increased conditionality within the assessment process. Points were also highlighted on the effectiveness of the assessment process for example in terms of the specialism of those undertaking assessment processes in dealing with issues such as mental health or recovery from addiction. This was also a theme within Hungary. Changes within the disability pension payments have resulted in a drive to move people into work.

Poland discussed that coverage in health care was administered through a social insurance scheme. This social insurance scheme was supplemented by support that the unemployed or homeless could obtain through the labour or social welfare office. Despite this, coverage was not inclusive for those dependent on state support. Specific treatments were highlighted as difficult to access as staff administering healthcare were unsure if it would be covered by the fund. Understanding of rights and entitlements was also a key issue relating to this. This applied to people who had experienced homeless and they perceived that there was a stigma and more scrutiny applied to them when accessing healthcare.

Evidence was highlighted where individuals had borne the high cost of treatment as they were unaware they could access assistance such as – the right to a social nurse. A clear theme emerged that more was needed to inform people of their entitlements when accessing the healthcare.

Other key points emerging on coverage and adequacy were linked into the administration of support. For example periods where support was stopped or the support was slow to be administered resulting in difficult financial periods. Hardship payments in the UK had results of people accessing food banks to obtain subsistence influencing their physical and emotional health.

Access to primary care was also positive although there were variations across countries it was reported that people did tend to get access to basic services such as seeing a doctor when ill.

Dental care in particular emerged as a key theme with participants in both Portugal and Sweden. Being unable to access dental care was viewed within Portugal as a key barrier to employment as having bad teeth was felt to exclude people from employment. Sweden

discussed problems with optical care as well as dental care and the issue people faced accessing this.

Access to medicine emerged as theme within Hungary in that those who were most in need of support were finding it difficult to obtain medication.

Activation policies to move people into work were discussed. Within Hungary, participants had reported ill health but this was not perceived to be barrier to employment despite the fact they often had significantly lower levels of health due to long term experience of poverty.

UK participants discussed the challenges of accessing employment when experiencing ill health. Ill health as result of addiction was key barrier to employment. Long term substance misuse had left many with additional health conditions and problems. Underlying causes of addiction such as trauma and recovery were also highlighted. A theme emerged in the integration of support for those with underlying health conditions. Evidence was highlighted across several countries the UK and Portugal that support for those with disability or health conditions was disjointed and has negative impacts on health and well-being.

A theme emerged around the provision of mental health support, which appeared not to be as well supported as other health care needs. Administration of health care was an issue highlighted by several countries. Waiting lists for treatment was cited as a key issue for those within Hungary. On a wider level austerity cuts had impacted on the technical assistance provided through the social protection system and had impacts on the level of service provision.

Overall the social protection system across all countries studied provided some a degree of protection against health inequalities although support varied it still provided a relative buffer. Those with universal coverage appeared to have better health care support.

## Conclusions from the case studies

The importance and role of the social protection system was emphasised throughout the research across all countries. Focus group participants described the need for support to deal with changing life circumstances such as unemployment, ill health and so on.

The experience of social protection varied across countries, the levels, adequacy and coverage all varied and the research indicated that issues around administration, knowledge of rights and entitlements as well as thresholds and levels of support all shaped the experiences of claimants and their quality of life. Different demographic groups sampled across the research evidence had different needs from the social protection system however across the evidence there was a key theme of the importance of the social protection system and its relationship with health.

A number of barriers and issues affected individual's experiences of accessing support, including ill health, disability including mental ill health, issues such as literacy and numeracy, language barriers and so on. More targeted support was required to overcome these issues in order to improve the social protection system, in many countries participants spoke of distrust in the administration and service delivery of the system to support their collective needs

A core theme emerged of the overly basic level of support across almost all countries within the research with the exception of Sweden. Across the other countries, there was discussion on the effects that this had on people, in particular the poverty they experienced on a day to day level. There was limited mention of the impacts of austerity however it was highlighted with Hungary it was perceived that this had a negative impact on mental health.

Understanding and navigating the system particularly in light of increasing conditionality and austerity experienced within the countries was a core issue. The importance of advocacy to obtain support was highlighted in several countries and there were cases of people simply not obtaining support due to perceptions of the barriers to accessing the system.

The extent to which the social protection system could be argued to provide a collective source of support was a difficult question, on the one hand the system provided a source of support but its limitations and challenges meant that the experience and quality of provision was often unsuitable for the needs and requirements of households.

In regards to the degree which the social protection system helped to reduce health inequalities, the research demonstrated consensus that the systems did provide a buffer against ill health and supporting people with their healthcare needs. The depth and breadth

of the health care support people on a low income could access varied across the countries within the research. A theme emerged that even within countries with universal health care provision, there were problems in terms of areas that were excluded from health care provision and this in turn created inequalities in health. In addition, as people were dependent on state funded support this meant that they had little control over the healthcare they were able to obtain and issues with service delivery such as long waiting lists were key. Crucial to obtaining effective healthcare coverage through the social protection system was knowledge of rights and entitlements. Overall inadequate income levels contributed to reducing living standards with issues such as fuel poverty, food poverty leading to higher areas of stress and anxiety and having an influence on individual's health and well-being.

## **Recommendations from the case studies**

A range of recommendations emerged from the report from the data collected. Individuals reported a number of areas whereby the current social protection system and the healthcare system could work more effectively to support and protect individuals and support them through periods of need. The recommendations are based on are the key themes emerging from the youth group and the at risk groups sampled within the research.

### **Income Adequacy**

Rates of social protection need to be at a level that sustains their lives out of poverty levels and enables people to meet their basic needs. The support needs to be at a level whereby people are not left drawing upon other support such as family and friends, support from Non-Governmental Organisations. Income levels need to be at an adequate level in order to cushion people from shocks such as unemployment and other life events. In addition, levels need to be aligned with people's health care needs.

### **Rights and Entitlements**

Across all countries there was a need for greater sharing of information to enable people to access and obtain their rights in both the social protection systems and within the healthcare system.

### **Simplification of the system**

Across all the countries, the administrative process of the system was widely criticised as being inflexible and difficult to navigate. More transparency and accessibility is required within the system. Additionally there is a need for more sensitivity within the system from staff administering the services particularly front line staff.

### **Integration of support.**

Complexity of situations that households face and in particular changing life circumstances require a social protection system that allows for a holistic model of delivery supporting individuals in obtaining adequate support to meet their needs. Integrated support is needed at the points of transition in particular for those from more chaotic and difficult life circumstances for example entering the homeless system, leaving a rehabilitation unit, so that they are supported adequately.



## **Activation Policies**

Across the research, the area of employment and moving into work was raised as a key area for improvement. In particular, for those who had been out of the labour market for a prolonged period or had specialist needs for example a long-term health condition, or disability. Young people in the research were often key targets of the activation policies and often required more specialist support than they were able to access.

## **Health inequalities**

Coordinated action is needed to tackle both the social determinants of health inequality, ensuring predictable and adequate living standards through a universal social protection system as well as guaranteed access to health care.

## **Access to healthcare**

Ensuring healthcare provision was available to people living on a low income for all areas of their lives was viewed as essential to reducing health inequalities. Provision must be holistic and integrated effectively within the social protection system to ensure individuals were able to obtain support in times of need.

## Linking research and case studies on income and social protection

The focus of WP4 in the DRIVERS project is on general welfare policies and social protection schemes. Particular focus in the research package is on the design and quality of welfare policies across the life cycle, in particular unemployment protection programmes and early retirement schemes. Some of our key results regard the importance of coverage rates that are a primary prerequisite for replacement rates to be of importance. In short – with high coverage rates health becomes better with increasing replacement rates, in particular among the low education group. The key question for the case studies, therefore, was to what extent different social policy programmes actually works as collective resources for people in need of those programmes.

Hence, the case studies were designed to capture partly different aspects, not least the experiences of people being dependent or in need of social protection schemes of different kinds. Still, a crucial part of the tool-kit developed to guide the planning, conducting and analysis of the focus group interviews across the five countries involved was to create links with themes from the quantitative analyses. But since the quantitative comparative work and the focus group based case studies are intended to complement each other, it is important to notice that the differences in design and approach also create a number of ‘incomparabilities’. Differences in findings can therefore not be interpreted as flaws in one or the other of these approaches, but must be seen as mainly a result of their different design.

One key difference in approaches that may generate ‘incomparabilities’ is that the case studies primarily focus on specific, targeted groups. These include the homeless, those on social assistance or long-term unemployed. This means that the case studies in general deals with inequalities as marginalised groups rather than inequalities as a gradient running through society as a whole. In contrast, the comparative quantitative studies are more focused on general systems of social protection, such as unemployment insurance policies, and how these differ across countries. This difference also has importance for our findings. Where the quantitative studies in several cases show positive effects of high coverage and replacement rates also for the high educated and the employed, the case studies cannot detect such effects although they may well be present.

There are of course limitations and shortcomings in all our studies, regardless of design. Taking the case studies we would have preferred to have more focus groups in each country in order to cover a broader range of groups but also to get a richer material from the groups presently included. We would also have liked more time for analyses, in particular for the synthesizing phase and for the merging phase, but we have done what has been achievable within the time and resources available.

Having said that, it must be stressed that the focus group interviews from Hungary, Poland, Portugal, Scotland/UK and Sweden have produced a wealth of voices that give a complex and partly disparate picture, as well as some clear themes that are more or less common across the countries. In turn, some of these themes are strengthening and reinforcing the main findings from the quantitative analyses undertaken, while other themes and findings are rather complementary.

The most striking is perhaps the strong focus on *adequacy* that emerges from the case studies, where participants give testimony to the importance of sufficient levels of support, which often is not the case for them. This theme echoes the repeated findings concerning the importance of high coverage and high replacement rates<sup>23, 24</sup>. With low coverage or replacement rates there will be considerably less adequacy of the support given, and social protection policies will not be able to offer much of collective resources.

Another finding that comes out from the case studies is the importance of *access to employment*, and the potential importance of activation policies. This is reflected in the strong equalizing effects of active labour market policies seen for younger persons in one of our quantitative studies<sup>25</sup>.

But there are also important themes from the case studies that complement our comparative analyses. One is the recurring reports of *being degraded*, devalued and even discriminated in contacts with different workers of the welfare state. Unemployment officers, social workers and others, that many times may be pressured by cuts, big workloads and job stress, are not always treating their clients appropriately. Sometimes this may be personal shortcomings, but often it is rather systematic features, not least when e.g. unemployment 'services' are provided by private contractors.

Another important complementing issue relates to the increased use of *conditionality*, in particular in programs directed to the poorest. Conditionality, meaning that there are requirements that must be met in order to receive benefits, are not necessarily a bad thing, but like the issue of adequacy the conditionality encountered by people in need of support are often experienced as an extra burden and obstacle.

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<sup>23</sup> Ferrarini T, Nelson K, and Sjöberg O. (2014). Unemployment insurance and deteriorating self-rated health in 23 European countries. *JECH*. 2014; Online First, published on March 10, 2014 as 10.1136/jech-2013-203721.

<sup>24</sup> Ferrarini T, Nelson K, Sjöberg O. (2014). Decomposing the effect of social policies on population health and inequalities: an empirical example of unemployment benefits. *Scand J Public Health*. 2014;42(7):635-42.

<sup>25</sup> Sjöberg O. (2013). Labour market policies for young unemployed and their effect on health and health inequalities in Europe. Paper produced for DRIVERS. Stockholm: Swedish Institute for Social Research.

In our comparative quantitative analyses we have focused on the social rights as they are reflected in the type-case family coverage and replacement rates. However, these are in a way the end-products of the systems, the entitlements a typical person could count on to receive. The focus group interviews complement this with other aspects of the institutions that are set up to deliver social security. The organisation of these institutions and how to navigate through them in order to get the benefits are often brought up as problems and obstacles. A common theme coming out of the focus groups is the wish for more *integrated and personalized* services. While the organisation of services and support follow a certain logic, with different types of risks handled separately, the individual user is more often than not in need of support from several of these institutions.

This links to the common finding of the key role played, or that could potentially be played, by the *health services*. The health services come out as a central provider of support and care in several of the focus group case studies. The importance of various NGOs is also highlighted, and while neither NGOs nor health services has been studied in our comparative studies they are of course very important for many people, and not only to cover purely medical needs.

Taken together, the focus group case studies summarised in this report and the quantitative and comparative work undertaken in WP4 provides important insights regarding the role of incomes and social protection systems for health and living conditions in different segments of society. Health is better and inequalities smaller in societies where social security in terms of coverage *and* replacement rates is better. This applies to broad groups in society, but of course the more marginalised groups' struggles more when social security systems do not offer adequate protection for periods of unemployment, to take one key example. And while the replacement rates are important, a high degree of coverage must first be achieved for replacement rates to be important. Only that way can adequacy be achieved – by including large shares of the population. But in addition to that the focus group reports stress that the institutions that administer the social protection schemes must be fair and treat their clients as people with social rights and entitlements. This remind us of a central feature of the idea of social citizenship<sup>26</sup> – that modern welfare states offer its citizens a combination of duties and rights, and that the availability of social protection is such a right that can be used when in need rather than a form of charity organised by the state. While cost control measures can be necessary parts of efforts to handle economic crisis, and various controls of the people claiming their benefits can be important to retain a high degree of legitimacy for the system,

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<sup>26</sup> Marshall TH (1950). *Citizenship and social class and other essays*. Cambridge: Cambridge University Press.

there must also be a good deal of respect for the people that seek the assistance of the welfare state. The focus groups have revealed that this is still often not the case.

Our case studies have been performed in the aftermath of the economic crisis starting in the financial sector in 2008. The consequences of austerity policies, as well as the consequences of a stronger emphasis on a 'leaner' welfare state in several of the case study countries, are clearly felt and articulated by the people in need of support that participated in the case studies. While we have not made austerity policies to a main issue, also our quantitative studies provide evidence. Health is better where coverage and replacement rates are better, in particular so for the lower educated, and deteriorations in health from before to after 2008 are more common where coverage rates are lower.

This resonates the strong common theme emerging from both the quantitative comparative work as well as our case studies, namely that social protection is one important collective resource that contributes to better health and smaller health inequalities, in particular when individual and family based resources are not sufficient.

## Annex 1: List of Individual Case Study Reports

<b>Authors</b>	<b>Organisation</b>	<b>Report title</b>
Fátima Veiga & Paula Cruz	Rede Europeia Anti-Pobreza/EAPN Portugal	Portugal Case Study
Justyna Godlewska-Szyrkowa & Łukasz Łotocki	Polski Komitet Europejskiej Sieci Przeciwdziałania Ubóstwu EAPN Polska/Polish Committee of the European Anti-Poverty Network	Country report from the focus research in the Work Package 6 of the Drivers of Health Inequalities Project - Polska
Märta Brandts, Sophia Lövgren	European Anti-Poverty Network, Sweden & MAKALÖSA, Sweden	REPORT: DRIVERS for Health Inequity - Income and Social Protection
Krisztina Jász & Szilvia Németh	Hungarian Anti-Poverty Network	EAPN - Drivers Project Case study - Hungary
Fiona McHardy	The Poverty Alliance, Scotland	EU Drivers Focus Groups UK Report Drivers

Annex 2: The Focus Group Toolkit

**EAPN Focus Group Toolkit for Drivers Project**  
**October 2013**

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## 1. Introduction

The aim of the focus group is to provide case studies of countries, under Work Package 6 (WP6) of the Drivers of Health Inequalities Project. The case studies results relate to the research under WP4 (Income and Social Protection). 'Drivers' is a three year research program funded by the EU 7<sup>th</sup> Framework Programme. It brings together leading researchers, civil society organizations, business, and a European network of public health bodies with the aim of understanding and promoting health equity through policy and practice. The case studies will aim to explore in a comparative country context, the impact of social protection system, both operations and provisions, on health inequality.

The core research questions for this Work Programme are:

- **To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package, including services and support into work) act as a collective resource for people to draw upon when their own resources are failing?**
- **How does this system of support help prevent health inequalities?**

Some of the issues that should be covered include:

- Basic principles: coverage, replacement, mixture of contributive and non-contributive
- Income replacement, absolute v relative poverty, (how far access to key products and services are covered, allowing participation in society)
- What happens with consumption when income is lost/reduced? How are income losses/reductions handled when the state is not covering them
- Recent trends versus present state
- What are the barriers to use/take up of programmes/benefits (hardened conditionality, stigma, knowledge of rights etc)
- Impact of package of social protection provisions ( i.e. access to income support, services and support into work)
- Perceptions of link to health (i.e. subjective).

This toolkit sets out what a focus group is and why we are using them in this research. It then goes on to consider some of the practical and ethical issues that should be considered when planning the focus group. It also sets out the schedule of questions and topics that each of the focus groups should cover, and provides a template for collecting the profile of the selected participants and gaining their consent, as well as capturing the profile of the group (in the annex). Finally it sets out how to report and transcribe the focus group, and provides a template of contents. In preparing this toolkit we are aware that many of those conducting focus groups in each of the five countries have experience of organising similar activities in the past. This toolkit is designed to ensure that whatever the users' previous research experience, we will have a consistent approach to our work for the Drivers project, and can produce comparable results.

This tool kit has been drafted by Fiona McHardy (EAPN UK/Scotland – Poverty Alliance) with the support of Paula Cruz (EAPN Portugal) and the EAPN secretariat (Sian Jones and Tanya Basarab) and in consultation with the other National Network partners (EAPN Sweden, EAPN Poland and EAPN Hungary).

## **2. Focus Group Approach for Drivers Project**

### **Definition of a Focus Group**

Focus group research involves organised focused discussion with a selected group of individuals to gain information about their views and experiences of a topic. The added value of a focus group is to deepen qualitative knowledge on the research question and hypothesis. It will primarily explore subjective opinions and detail of individuals' perception of how social protection systems operate and their impact on individuals. The facilitator guides the group through a structured discussion following the focus group schedule within a controlled environment.

### **Cross Comparative Focus Groups**

Within WP6 focus groups are being conducted across five different EAPN National Networks (UK/Scotland, Hungary, Poland, Portugal and Sweden). When focus groups are being conducted within several different countries, questions of comparability of data can arise. To limit the impacts of this, the research design and process outlined must be followed across all National Networks. This will allow for robust and rigorous data and comparisons to be made.

### **Sampling for the Focus Group**

Groups across the network will be stratified as follows.

<b>Network</b>	<b>Focus Group A</b>	<b>Focus Group B</b>
	Common group with youth (18-30). Selected in conjunction with academic partners.	Adult (18-30) at risk group, country-specific involving key target groups of national partners, facing exclusion.
United Kingdom/Scotland	1 <sup>st</sup> Group: Youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home/ NEETs/ young people who have had employment	2 <sup>nd</sup> group: Adults (30 -65)  People with experience of addiction and in recovery: substance misuse drugs or alcohol or dual addiction.
Portugal	1 <sup>st</sup> Group: Youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home. NEETs/ young people who have had employment	2 <sup>nd</sup> group: Adults (30-65)  People with experience of alcohol/substance addiction/ and homeless people.
Sweden	1 <sup>st</sup> Group: Youth (18-30)  Mix of lone parents, employed/unemployed/living independently/at home/ NEETs/ young people who have had employment	2 <sup>nd</sup> group: Adults (30-65)  Single parent families/ and people with drugs and alcohol addiction problems
Poland	1 <sup>st</sup> Group: Youth (18-30) Mix of lone parents, employed/unemployed/living independently/at home. NEETs/ young people who have had employment	2 <sup>nd</sup> group: Adults (30-65)  Former drug and alcohol users and/ homeless people.
Hungary	1 <sup>st</sup> Group would be common – youth (18-30).  Mix of lone parents, employed/unemployed/living independently/at home. NEETs/ young people who have had employment	2 <sup>nd</sup> group: Adults (30-65)  Long-term unemployed, experience of workfare and/ homeless people.

### 3. Understanding Focus Groups

#### Recruitment of Focus Group Participants

It is recommended to recruit around 10 individuals to allow for dropout rates. Groups should be sized between (6- 8) and apportioned according to sampling criteria. Participants should

be provided with accessible invitation materials ahead of the focus group explaining purpose of group, rationale of research etc.

#### Selection of participants

- Individuals with resilience to take part in discussion.

Group one: Common Group between all national partners, focused on Youth (18-30)

- Young people aged between 18 and 30.
- If possible, include at least one young person who is a lone parent.
- Should include young people with NEET experience, young people who have had employment , young people who are parents

Group two: Country-specific at risk groups selected by national partners, focused on Adults (30-65).

- The selection of groups is decided on by EAPN National Networks, according to the criteria of most at risk groups working as part of the network. Please see table above.
- Some commonality/overlap between selected groups has been encouraged, where relevant.

#### **How long should a focus group last?**

Approximately two and a half hours. In two and a half hours a great deal of 'data' will be produced, which will need to be transcribed and analyzed. Retaining participant's attention and engagement for more than two and half hours would also be a challenge.

#### **Environment of Focus Group**

The focus group should take place somewhere that is comfortable and convenient for the participants. It should be in a quiet accessible room away from street noise, etc. as this can interfere with the recording of the discussion.

Refreshments should be provided to ensure that participants are comfortable. The focus group can be conducted around a meeting room table or in a more informal setting, but take care to arrange the seating so that no one is in a dominant position. Place your recorder in the middle of the table or on the floor within the circle. Make sure the focus group assistant is seated near to the recorder so that they can check that it is recording the discussion. When you plan the focus group you should think about what time will be convenient for your participants (e.g. single parents in terms of child care).

### **Staffing of the Focus Group**

Ideally you will have one person to facilitate the focus group and an assistant who will observe the group, take notes, and check the tape is recording and sort out any organizational issues. The assistant should not take part in the discussion and can sit within the group or apart from them.

### **Recording the focus group**

The focus group assistant is responsible for taking notes during the focus group. They should take notes about what was said, write down any notable quotes and note down any observations about how the group acts and the interaction between them. The focus group should be recorded and a full transcription made in your native language. Digital recorders will give best quality recording. Ahead of the focus group remember to test the range and quality of recorder. It is always useful to have back up equipment, for example, tapes and batteries for the group.

### **Ethical Considerations**

All focus groups facilitators should ensure they have considered the ethical considerations of this work.

### **Recruitment**

Participants recruited to the study should be able to take part in this work. The facilitator is responsible for ensuring people at risk of emotional distress from such work are not recruited to this focus group activity.

### **Consent**

No person should be compelled to participate in a focus group, nor should they be made to remain if they want to leave. Written consent should be obtained from each participant prior to the focus group (see Appendix 1 for Sample Consent Form), and a clear statement of the purpose of the focus group should be provided, to allow prospective participants to make an informed decision. No use should be made of the information provided in a focus group other than for the purpose for which consent was given.

### **Confidentiality**

People who participate in focus groups must be assured that no information will be revealed that can identify them, and that comments they make are not reported (either verbally or in

writing) in such a way that specific people or incidents can be identified. Participants should be reassured (both at the time of invitation and in the introduction) that their comments will be recorded, but will not be attributed to them as individuals. The facilitator should assign random letters or numbers to participants for recording/note taking purposes.

### **Handling disclosures or sensitive material**

The facilitator must ensure that the focus group discussions remain at an appropriate level for those involved. If discussion provokes issues of sensitivity or concern, the facilitator must approach those participants affected and take appropriate action.

### **The role of the facilitator/moderator**

The main purpose of the moderator is to facilitate the group discussion to ensure that the discussion is balanced and allows all participants an opportunity to contribute. In addition to ensuring that all of the topics are discussed in the focus group schedule, the facilitator must also be able to identify interesting issues as they emerge during the discussion and further deepen discussion on those emerging issues.

Facilitators must ensure that they:

- Lead the focus group through the discussion using the schedule.
- Avoid revealing their own opinions or thoughts as this may influence the group.
- Ensure that everyone in the group is getting the opportunity to contribute to the discussion.
- They must draw out differences of opinions and experiences, probe for details and keep the discussion focused and applicable to the schedule.

They should avoid displaying bias through verbal or non-verbal communication to participant's responses.

### 3. Delivering Focus Group

Before starting the focus group you will require:

- Consent forms. (see Appendix 1)
- Participants profile sheet (see Appendix 2) capturing basic information of selected participants
- Focus Group Profile form (see Appendix 3)
- Focus Group Schedule (see below).
- Working Definitions (Appendix 4)
- Recording equipment.

#### **Focus Group schedule**

##### **Introductions and Informed Consent**

- Explain purpose of group, how information will be handled and stored and ground rules of the group.
- Allow an opportunity for the group to ask any questions.
- Signing of consent forms. Once consent has been secured, the group can then move on.
- Begin recording once consent has been obtained.

The schedule below is intended to allow the exploration of the issues outlined in section one above. It has been designed to ensure that all the issues are covered and that they can be explored in depth through the interaction between members of the group.

In addition, facilitators should hand out/help participants to fill in the Participants Profile Form (Annex 2) to obtain a breakdown of the group. These should be collected and stored correctly. These forms should reflect the country specific needs and then be used to complete the Focus Group Profile Form at the end (Appendix 3).

Each of the questions here are essentially starters that you will need to translate into your own context, however it is important to stick to the specific focus and point in each question. Remember that you should encourage all the members of the group to respond to each of the questions!). It will be down to the facilitator to identify themes and issues that can be explored in more depth throughout the focus group.

The prompts listed under each question are designed to explore issues in more depth. These may not be needed depending on how the discussion progresses, but they will help ensure that all issues are covered.

Whilst attempting to cover all the issues and themes, it is important to remember timescales, and to keep to the two and a half hour limit.

### Icebreaker

Spend five to eight minutes on an appropriate icebreaker to warm up the group and to make people comfortable.

### Guidelines for structured questions

#### Phase One: Base line of social protection

Opening question:

- What financial assistance are you currently getting from welfare system? (type of benefits not amounts – this will be explored in more detail in the Participants Profile) *(Prompts: types of benefits: out of work benefits, unemployment or social assistance/sickness/disability benefits, support/services i.e. payment of housing or other costs, support to access work, payment of rent/mortgage, child benefits, in-work financial support)*
- Can I ask what your experiences of accessing the current income support system are? *(Prompts: ease of access, what barriers, knowledge of rights/entitlements, stigma, delivery/structure of system, relationship with the benefit offices/services)*
- Has your entitlement changed during the past 12 months, if so in what way? *(Prompts: Increase or decreases in levels of benefit, explore conditionality, loss of entitlement (sanctions), impact – however leave details of actual amounts to the written profile form)*
- Can I ask about the level of adequacy and coverage through the current system of welfare, how does this support your needs? *(Prompts: Adequacy of the level of support to cover needs (including access to key services e.g. housing/health/*
- Can I ask about the changes in your income, and how you have coped? *(Prompts: Loss of income – changes coping mechanisms /what has been reduced/ ways of meeting any shortfalls?) or increase of income or coverage if appropriate –changes*



*that have been made and where additional income or coverage has benefited the participant?)*

- How far does the welfare support enable you to participate as an equal in your local community/society? Are there particular difficulties? *(Prompts: trying to pick up the absolute/relative poverty issue – how far the support is important to access basic needs or whether other issues are at stake, including stigmatisation)*
- Do you think the social protection system helps or hinders you to get work *(Prompts: whether getting good social protection stops them looking for work, or is a help..., extra help that is available e.g. counselling, childcare cost/help etc and why).*
- What level of financial and other support does the social protection system provide in terms of the transition to and from employment? *(Prompts: follow on financial and other support on gaining employment, impacts of increase or loss of income, and other protection).*
- What support does the system provide for people to engage in work /in the labour market? *(explore conditionality / compulsion to work/ flexicurity and so on, type of employment achieved, sustainability of employment)*
- In the transition to employment, what types of employment have you been able to access and what have the impacts on your health been? *(prompts positive and negative health impacts, types of jobs and pay levels , impacts on income levels*
- How well does the welfare or social protection system provide you with a combined and comprehensive package of support? Is this important and why? *(Prompts: income support, access to services and support into work and/or participation, degree of integrated services)*
- In terms of your experience of the welfare system how integrated or joined up do you feel the system is? *(Prompts: where do individuals believe services/support are or are not joined u, are there problems with having very joined up services?)*

## **Phase Two: Coverage of Social Protection and Health**

- Can I ask about your current state of health? *(Prompts: Explore perceptions round health, physical and emotional, note registered disability, intermittent conditions, etc)*

- How does this current system of social protection/income support affect or meet your health needs? How do you think your current situation and the quality of the support you receive affects your health? And in what way? (*Prompts: role of financial support, additional supports – counselling etc.*)

### **Phase Three: Future challenges and recommendations**

- How could the current system of social protection support be more effective in meeting health needs? (*Prompt: refer back to previous questions and points raised in the discussion*)
- What do you see as the main obstacles? (personal or from the social protection system)
- Any final issues you wish to raise before session ends?

### **Finishing**

- Thanks for participating.
- We are around to take any questions you might have after recording is switched off.
- We will send you an executive summary of the results of the research, please leave contact details with us.

## 5. Reporting Template and Timeline

It is important that consortium members follow the common agreed methodology and schedule, which are outlined in this toolkit. Facilitators running the focus groups should aim to collect the background information (consent forms, participants profile and group profile). All this information will be retained, and some will need to be translated and sent as an annex to the Country Report.

**National Partners will be expected to send to EAPN secretariat and WP6 Coordinators:**

- a) The Country Report: Case Study of the two focus groups in English
- b) An Annex with Annex 2 and 3 completed, in English. They will also be expected to keep
- c) Other background information, in your native language

The details of these 3 areas are set out below

### Country Report

Aim:

To capture the main findings and conclusions from the analysis of the 2 focus groups as a basis of the national case study, based on the common analytical framework and the research questions.

Report Contents:

Each focus group should have its own analysis conducted and written up within the report. The report should be written in English and should include the following chapters:

1. Introduction: with presentation of the EAPN Network (Background)
2. Process and Methodology followed: Information about who was involved in the groups (people who took part in the discussion) and how they were selected, according to the agreed criteria; brief description of how well the group went and any problems encountered.
3. Main Findings (Summary of findings from each area covered by the questions) for each focus group, drawn from the common analysis).

4. Overall Analysis: using for this each question and analysed separately across each focus group, and then compared:

- To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package including access services and help to access jobs) act as collective resource for people to draw upon when their own resources are failing?
- How does this social protection system impact on health and help prevent health inequalities?

It may be useful to illustrate analysis with profiling information. An example could be such as ‘a woman in her 40s, unemployed for 5 years says’

5. Conclusions/Recommendations (Summary of main messages and recommendations)

**Annex: background Information (to send with report)**

- A full written transcript from the tape recording of the focus group in your native language.
- Copies of the *Sample Participant Profile* sheets and *Focus Group Summary* for all participants in English and your native language (see Appendix 2 and 3).

**Other information that you will need to keep, but not send**

- Consent forms together with contact details (Appendix 1) Each organization should aim to complete and store the consent forms with the participant’s contact details. These should be kept securely in line with network data protection procedures. All of this in your native language.

Analysis notes of transcript by question in your own language.

**Timeline of reporting deadlines**

Early June 2013	Preliminary Frame (above) agreed by EAPN partners
Mid June 2013	Contextual Information sent by CHES to EAPN
Early September 2013	Draft focus group methodological guide and template for topics/questions, common reporting frame, sent to CHES for comments. Agreed by end of September

October- December 2013	Focus groups carried out in 5 countries.
End of January 2014	Draft country reports prepared and sent to WP4 coordinators and comments prepared.
February 2014	Develop the synthesis thematic work (intermediate stage)
March-April 2014	Exchange with UCL before finalizing products

## 6. Approach to Transcription

### Stages of Analysis

#### What is transcription?

Transcription is a very important stage within the research process. Care and time should be spent to ensure an accurate transcribed record of the focus group is obtained. Listening to the recording and capturing it will be a time consuming process however this is essential to ensure that next steps of the research can be accurately completed.

Transcribing the discussion provides many benefits for the analysis stage.

- It allows for multiple examinations of what people have said.
- It provides a fixed and clear starting point for analysis as opposed to field notes which may miss key points.
- It allows for repeat checking and cross checking of the analysis drawn up.

Transcribing provides an opportunity to familiarise yourself with the research data collected. When transcribing focus group it is important to identify the individuals within the transcription such as person A, person B and so on.

#### Stage One

##### Transcription

Transcription would take place of all digital recordings from the focus group. This takes around a day and a half for a 2/ 3 hour recording. Transcription write up would be written in a three column template with details of focus group and facilitator at the top

At this point in the process only column A and B will be filled in. See example template below.

Focus Group 1: – youth (18-30). Mix of lone parents, employed/unemployed/living independently/at home.		
Facilitator : Jill      Notetaker : Jack		
<b>A</b>	<b>B</b>	<b>C</b>
Time in recording		

filled in at interim points		
0.00-1.30 Facilitator	F: Can I ask what assistance people are getting in the current welfare system?	
Participant	P: I am currently receiving job seekers allowance	

Transcription should provide a complete record of the points raised. For example the facilitators questions and sub prompts, participant responses and time noted at interim points in the recording.

It should also note any points where there may have been issues during the recording for example multiple people talking at once.

### Stage Two

The next stage of the research is the analysis stage. This involves identifying themes and patterns in the data and understanding what has been found out. This is again a very important stage within the research process. Decisions taken at this part in the research have implications for the analysis drawn from the research.

It is through the coding scheme that the researcher is working through the categorisation of the data and using this process to make sense of the data.

Coding can be built up within the process through a process of sub divisions allowing all information to be coded within the transcript.

An example of coding in practice is given below.

Identify categories and concepts that emerge from text (C)

Example:

Participant	P: I am currently receiving job seekers allowance	Social protection benefit : job seekers allowance
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Since categories allow us to simply represent all the data that we have collected, for us to identify and organise all the categories is quite important for the analysis.

In the end we can have several boxes like this one for example which outlines a coding scheme of the type of social protection the individual is receiving.

**(D)**

<b>Social protection received</b>
job seekers allowance
Income support
...

We can then build up the coding as we move through the data. When defining categories or codes the following must be applied.

A category must have the following characteristics:

- Mutual exclusion (each element can't be in more than one box)
- Homogeneity (in each set of categories we can use just one analysis dimension)
- Relevance (to the research and to the questions guide)
- Objectivity (you must have clear why you are defining those categories. Like this, you avoid judgements)
- Productivity (the categories must allow reflection, new ideas and good results for the analysis).

### **Stage three**

Then in the analysis we can use the boxes (D) for drawing findings and conclusions in reference to original research question.

- To what extent do social protection policies (i.e. coverage, generosity of benefits, integrated package including access services and help to access jobs) act as collective resource for people to draw upon when their own resources are failing?
- How does this social protection system impact on health and help prevent health inequalities?

Also using original transcription (quotes) to ensure accurate conclusions and other resources like documents (national researches) that can give you information to interpret/infer the data and so on.



Analysis should end when at the point of data saturation, when no new information can be drawn from the data. Profile information should be used within the analysis.

Please see reporting template for further details.

## Appendix 1: SAMPLE CONSENT FORM

*(to be translated into native language)*

### Drivers Project

Thank you for agreeing to take part in this research. This study is exploring the experiences of the welfare system and health inequalities. It is being undertaken as part of work between [NETWORK NAME] and the European Anti Poverty Network. This research is part of a project funded by the European Union. Drivers for Health Equity and is being coordinated by Eurohealthnet.

By taking part in this research

- I understand that my participation in the research is voluntary.
- I understand that my details will be kept anonymous.
- I agree that the information I give can be used as part of the research work.
- I agree that quotes can be used.
- I understand that I have the right to withdraw from the research at any time prior to publication deadlines.
- I understand that my information will be kept anonymous and will not identify me in any way without my consent.
- I understand that I have a right to ask further questions and to get in touch with the research project leader at the [NETWORK NAME] at any time to discuss any queries I might have.
- I understand that this information will be handled in accordance with the Data Protection procedures.
- I understand that if I disclose information such that put myself or others at risk of or display behavior at the discretion of the [NETWORK NAME] then my right to anonymity will be waived (disregarded) and that appropriate action will be utilized. This could involve information being passed to, police, social work or other relevant authority.

I have read and understood the above

Signed \_\_\_\_\_ Print Name \_\_\_\_\_

Participant

Signed \_\_\_\_\_ Print Name \_\_\_\_\_

Facilitator

Date of event \_\_\_\_\_

## Appendix 2: SAMPLE PARTICIPANT PROFILE

*(to be translated and completed by each participant – the completed forms should be translated back into English to send with the report)*

We would be grateful if you could complete and return this form. This information will be kept private and will be used only for monitoring purposes. Please choose one option from each of the sections listed below and then tick or place an X in the appropriate box.

**Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Gender:** Male  Female

**Region/District:** \_\_\_\_\_

**Contact (phone / email):** \_\_\_\_\_

### Household composition:

Single Person

Single person with children

Two Adults

Two Adults with children

Two or more adults

Two or more adults with children

**Which of these best describes your situation?**

1. At work as full time employee or employer/self-employed	
2. Employed, on child-care leave or other leave	
3. At work as relative assisting on family farm or business	
4. Part-time worker	
5. Temporary worker or in precarious work conditions	
6. Undeclared worker (Informal economy)	
7. Unemployed less than 12 months	
8. Unemployed 12 months or more	
9. Unable to work due to long-term illness or disability	
10. Retired	
11. Not in education, employment or training (NEET)	
12. Full time home care / caregiver	
13. In education (at school, university, etc.) / student	
14. Other (please specify...)	

**What is your main job? (in this moment or that you had recently)**

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How long have you had this employment?

What is the nature of this employment? (short term, permanent contact , seasonal).

**Which is the highest level of education you have completed?**

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**What income support benefits do you receive from the state and how has that changed over the past 12 months? (Please give us amounts if possible)**

**How is your health in general?**

Very Good

Good

Fair

Bad

Very Bad

Do you have any longstanding illness or health problem which has lasted, or is expected to last for six months or more?

Yes

No

Rather not say

**Can you explain:**

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**Thank you.**

### Appendix 3: SAMPLE FOCUS GROUP PROFILE SUMMARY

*(To be completed in English by researching team from the participants profiles, after both Focus Groups are completed and returned with the Country report)*

	Focus Group A	Focus Group B
Date of focus group(s)		
Location of focus group		
How many people participated in the group?		
Group make up in accordance with information obtained from participant profile forms.		
Recruitment Strategy : How were people selected for this discussion		

## Appendix 4: Working Definitions

The following definitions and understanding are used within this toolkit.

### **Coverage:**

The policy areas and levels of support or social assistance given from the welfare system or within that country.

### **Income support:**

This refers to the social assistance given to people on limited or no income.

### **Take up:**

This refers to the numbers of people who are classed as eligible for the social assistance or benefit available and are in receipt of that entitlement<sup>27</sup>.

**Employment** - Persons in civilian employment include all those employed above a specified age who during a specified brief period, either one week or one day, were in the following categories: *i)* paid employment; *ii)* employers and self-employed; *iii)* unpaid family workers; unpaid family workers at work should be considered as being self-employed irrespective of the number of hours worked during the reference period. For operational purposes, the notion of some work may be interpreted as work for at least one hour. Total employment is defined as the sum of civilian employment and members of the armed forces<sup>28</sup>

**Unemployment** - The unemployed comprise all persons above a specified age, who during the reference period were: *i)* without work, *i.e.* were not in paid employment or self-employment during the reference period; *ii)* currently available for work, *i.e.* were available for paid employment or self-employment during the reference period; *iii)* seeking work, *i.e.* had taken specific steps in a specified recent period to seek paid employment or self-employment.<sup>29</sup>

**Active Labour market:** Policies and schemes initiated by government that are designed to encourage labour market participation by those who are unemployed.

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<sup>27</sup> Matsaganis, M, Paulus, A., Surtheland, H. (nd) Research Note the Take up of Social Benefits

<sup>28</sup> OECD (nd) **Basic statistical concepts: employment, unemployment and activity in Labour Force Surveys**  
<http://www.oecd.org/employment/emp/onlineoecdemploymentdatabase.htm>

<sup>29</sup> IBID



**Activation Strategies:** help ensure that jobseekers have a better chance of finding employment. Key features of such strategies are to enforce work-availability and mutual obligation requirements, meaning that benefit recipients are expected to engage in active job search and improve their employability, in exchange for receiving efficient employment services and benefit payment.<sup>30</sup>

**Flexicurity:** refers to flexibility in the labour market associated with security in finding a new job and income security.<sup>31</sup>

**Conditionality:** Conditions placed on claimant required for them to be in receipt of the social assistance received.

**Social Protection:** Social protection is concerned with preventing, managing and overcoming situations that adversely affect people's wellbeing. It helps individuals maintain their living standard when confronted by contingencies such as illness, maternity, disability or old age; market risks, such as unemployment; as well as economic crises or natural disasters.<sup>32</sup>

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<sup>30</sup> OECD (nd) **Active labour market policies and activation strategies**

<http://www.oecd.org/employment/emp/activelabourmarketpoliciesandactivationstrategies.htm>

<sup>31</sup> Eurofound (nd) **Flexsecurity**

<http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/flexicurity.htm>

<sup>32</sup> United Nations Research Institute for Social Development (2010) '*Transformative Social Policy and Poverty Reduction*' section two page 135







DRIVERS (2012-2015) is a research project funded by the EU's 7th Framework Programme. It aims to deepen understanding of the relationships between some of the key influences on health over the course of a person's life - early childhood, employment, and income and social protection - and to find solutions to improve health and reduce health inequalities.

The research is undertaken by a consortium including leading research centres and organisations representing the public health sector, civil society and businesses.

