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Making Prevention Work

Preventive structures and policies for children, youth and families

Comprehensive report

Stephan Grohs, Niclas Beinborn, Nicolas Ullrich

German Research Institute for Public Administration

BertelsmannStiftung

In 2011, the state government of North Rhine-Westphalia and the Bertelsmann Stiftung launched the model project, "Kein Kind zurücklassen! Kommunen in NRW beugen vor" ("Leave no child behind! Municipalities in North Rhine-Westphalia providing equal opportunities for all children") (KeKiz). The goal of this initiative remains unchanged: To partner with model municipalities in creating opportunities that enable every child and young person – regardless of background – to benefit from a successful upbringing and participate in society. The initiative has been guided by academic research since its inception. Together with its partners from academia, the Bertelsmann Stiftung oversees the research that accompanies the initiative. In partnership with a range of academic collaborators, we will periodically publish the insights and findings from the accompanying academic research on municipal prevention efforts. The "Materials about prevention" series also aims to communicate findings on related issues and the insights gained from taking a broader academic view of the model project.

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Making Prevention Work

This report maps preventive structures and policies for children, young people and families in 12 European countries. By examining what works in each of the countries surveyed, it aims to provide a foundation for the development of prevention policies across Europe.

The report draws on **a concept of prevention** that is framed in universalist and integrative terms. The concept is universalist in that it addresses all children and young people, even those not seen as being "at-risk." It is integrative because prevention should be organized from a child's point of view, not in terms of administrative responsibilities. As such, this concept targets the establishment of prevention chains that link different institutions over the life-course.

The report includes summary **factsheets of the preventive concepts, structures and practices** mapped in 12 EU member states (Austria, Czechia, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden). In addition, three **in-depth case studies** (Austria, France and the Netherlands) featuring data from interviews with experts and implementing actors are also presented.

Key findings

Varieties of prevention: Despite widespread awareness of the underlying problems and a common frame of reference provided by the European Commission's recommendation "Investing in Children. Breaking the Cycle of Disadvantage," existing preventive concepts, interpretations and measures vary greatly across Europe.

Universalist vs. targeted approaches: Most countries take a universalist approach that addresses all children and families. The Nordic countries are most consistent in this regard, followed by continental European countries such as the Netherlands, France and Germany. Other countries, such as Ireland and England as liberal welfare states, feature prevention strategies that target those in need more specifically.

Integration vs. fragmentation: Whereas some countries aim to integrate different services both across sectors (i.e., health, education, youth welfare) and throughout the life-course, others maintain rather fragmented structures. We see here the Nordic countries pursuing an integrated approach, which contrasts with the rather fragmented departmental structures observed in Ireland and England. Countries in continental, east-central and southern Europe are rather inconsistent in this regard, but generally pursue integrated approaches by establishing cross-institutional networks.

Voluntary offerings vs. incentives vs. obligation: How prevention programs are brought to the public differs from country to country. While in some countries programs are provided as voluntary offerings (e.g., early health examinations), other states try to "nudge" people toward participation through incentives (e.g., early child education), whereas others "urge" them to engage through obligation mechanisms (e.g., compulsory education).

Centralization vs. decentralization: The extent to which services are integrated into an administrative architecture depends on a country's broader administrative setting. The three Nordic countries of Denmark, Finland and Sweden each have a long-standing tradition of extensive welfare provision and municipalities that are competent in educational, social – and to varying degrees – health matters. Introducing reforms in 2015, the Netherlands has moved toward bundling all relevant competences (excepting schools) for preventive measures at the municipal level. England and Ireland take a more centralized and single-purpose oriented approach in which local governments play a lesser role. The continental, East-Central and Southern European countries vary in their approaches, but generally aim to establish networks that include actors in centrally governed policy areas (mostly health and employment) and those areas for which local administration bears responsibility.

Financing: Most programs have distributed liabilities with regard to financing. In many countries, budgets are focused on the main responsibilities of the institutions involved.

Prevention and other cross-cutting issues often fall outside of these silos. In some cases – once again the Nordic countries stand out in this regard – there are additional lines of funding for preventive offers or strategies, but these are based on individual applications and limited in time.

Making use of additional funding: Drawing on the European Social Fund (ESF) and other European funds to finance prevention remains an exception. Most projects financed with ESF resources target specific groups (e.g., Roma) or transitions (e.g., from school to employment). The "Leave no child behind!" project in Germany's North Rhine-Westphalia is a good example of a universalist and integrated approach that draws on ESF funding.

Leveraging other governance instruments (information, networking and performance management): In addition to funding, governments have other resources to offer. The countries with the greatest degree of centralization provide more materials (e.g., manuals) and are consistent in applying some forms of performance management. Many continental European states by contrast do not issue national guidelines, with the exception of Germany and Austria, where there are fora for a national exchange on their early intervention programs. While information and guidelines are often discussed in voluntary horizontal networks, no binding structures are implemented and, for the most part, performance management is lacking (with some regional or program-based exceptions). In Austria, Germany, France and, to a certain extent, the East-Central and Southern European countries, **preventive services are arguably under-governed by central actors.**

Country clusters: On a rather abstract level, three different approaches can be identified that reflect geographical lines and welfare state traditions: The **Nordic cluster** (i.e., Denmark, Finland and Sweden), takes a universalist and integrated approach to prevention. Responsibilities are concentrated at the level of functionally and fiscally strong local governments. At the same time, the central government supports local governments by communicating good practices and providing (some) financial support. The **Western European cluster** (i.e., Ireland and England) pursues a targeted and segmented approach. The targeting of measures is strongly related to the tradition of the liberal welfare state, where public action requires a special testable need to get things started. The segmentation of governance is reflective of public administration in England and Ireland where, since the 1980s, single-purpose agency administration has become the

norm and local government has lost several competences to specific agencies, Quangos and the private market. In many ways, the **continental European cluster** (i.e., Austria, France and Germany) falls somewhere in between these two clusters. This stems from the inertia that is a function of their welfare state architecture, which relies on centrally provided and/or financed services as well as decentralized services financed by local governments. Limited in their constitutionally stipulated powers, local governments in these countries have little fiscal leeway to finance tasks that go beyond the tasks delegated by central (and state) governments. In these states, diverse networks that reach across administrative levels, the public sector and civil societies develop innovative preventive solutions. However, these solutions are rarely scaled up across the country. Spain and Lithuania do not fit a specific model, while the Netherlands falls somewhere between the continental and Nordic models. The relative dependence of local Dutch governments on the national government, particularly in fiscal terms, is the main obstacle to achieving a successful reform of prevention.

Four consequences for Germany and Europe

First, Germany must reform the **design and character of preventive services** in order to reach more addressees of preventive offerings and convince parents to participate in programs at an early stage. This can be achieved by lowering barriers to such services and increasing obligations or nudges to make use of preventive services.

Second, Germany must **enhance cooperation** through networks to compensate for the status quo of fragmented responsibilities. Although local governments are generally tasked with childcare, youth welfare and social services, the federal states are responsible for schools and job training, and the health sector is governed by a complex network of health insurances (financing), free medical practitioners, medical associations *(Ärztekammern)*, and hospitals operated by diverse providers.

Third, given their diverse personnel and financial capacities, local governments – particularly less-wealthy ones – need greater support.

Fourth, given the lack of planning capacities and robust databases for evidence on preventive measures, **more research and data collection are needed to monitor performance and allow for sustainable policy-planning.**

The study identifies common **challenges for Europe** as a whole that require stronger EU involvement. Topping the list is the absence of a common understanding of prevention and social investment. Second, there is a lack of a clear will to cooperate calls for greater structural and practical coordination efforts. Third, we need more community-driven, integrated preventive care that brings services closer to people where and when they need it. Fourth, the visibility of such services and general knowledge of them must be strengthened in order to ensure that both professionals and clients are aware of existing services. Fifth, an effort to balance centralized approaches with those emphasizing local adaptation could bring together the best of both worlds. Sixth, budgets for preventive measures follow sectoral lines or are otherwise restricted, which leaves no room for cross-sectoral innovation.

The **European Union** could help strengthen preventive action across Europe. Though a powerful instrument, the ESF is rarely drawn upon for prevention funding in part because the **administrative burden** involved with apply for and managing these funds is too high for many potential users, such as local governments. Lowering these thresholds would mark a step in the right direction.

Within the context of EU discussions already underway regarding "social investment" – also for children (cf. the European Commission's "Investing in Children" recommendation) and the Child Guarantee to tackle child poverty, the **EU should promote prevention and preventive measures** as part of this paradigm. This could precipitate the creation of a shared understanding of prevention in Europe while enabling member states to learn more from each other's best practices.

The EU's recently developed **European Pillar of Social Rights,** which includes support for children, is accompanied by a Social Scoreboard that aims to measure member states' performance in different social areas. These instruments should be (and to some extent have already been) included in the process of the **European Semester,** which delivers country-specific recommendations to member states that include possible actions to be taken concerning prevention for children and young people.

Contents

Preface

Since 2012, the Bertelsmann Stiftung has partnered with the German federal state of North Rhine-Westphalia on the **"Leave no child behind!"** (in German: *"Kein Kind zurücklassen!"* or *KeKiz, Kommunale Präventionsketten,* now *"kinderstark"*) initiative. Together with 40 participating municipalities, we have been united in aiming to **improve children's prospects for development while providing them equal opportunities.** Each municipality involved is creating local prevention chains, that is, systematic and ongoing collaboration between stakeholders in administration, agencies and civil society to improve the effectiveness and efficiency of local support and intervention practices.

Building on this initiative and its research, the Bertelsmann Stiftung, together with the German Research Institute for Public Administration, decided in 2017 to carry out a cross-national study of prevention activities across the EU. The results of this study, titled **"Making Prevention Work – Preventive Structures and Policies for Children, Youth and Families" are presented here in this comprehensive report.**

What is prevention in a policy context?

Most broadly, prevention refers to efforts designed to ensure the well-being of children and youth so that they can make the successful transition to adulthood. As applied here, our definition of prevention involves mitigating risk factors among children and their families – particularly those most vulnerable – as well as strengthening protective factors and resilience.

Driven by the needs of children and youth rather than institutions per se, this concept of prevention, as a policy objective, seeks to have a direct influence on the behavior of a target group (behavioral prevention) and bring about positive change in the group's environment (setting-based prevention). Prevention encompasses universal offerings (e.g., home visitation programs for families with a newborn) that take effect before risks become problems as well as targeted approaches aimed at those families specifically disadvantaged or in need.

As a policy objective, prevention is highly complex because it involves engaging health, education and child/youth welfare systems – at once. This demands effective coordination and cooperation across different sectors and institutions, which is lacking in many countries, including Germany.

Why are we interested in a cross-national comparison of prevention?

The research accompanying the "Leave no child behind!" project initiated in 2012 in Germany highlights both the consequences of segregation on disadvantaged children and their families and the positive impact local support and institutions can have on these children.

Our German research shows that the educational opportunities of disadvantaged children can be improved considerably with just a few good preventive measures, such as improving day nursery attendance in the first three years of life and sports club attendance. Because the preventive services utilization rate is much lower among disadvantaged families, increasing their participation in such services is crucial. Many municipalities demonstrating success have developed and implemented services with a low access threshold, some of which are tailored to the needs of disadvantaged families.

However, our research in Germany shows that municipal "child-centered" policies depend strongly on the political will of municipal decision-makers, stakeholders' abilities to cooperate, and the breadth of local resources, all of which vary among municipalities. Consequently, not all children and youth – particularly those from families in need – are provided the support and care needed to ensure a successful transition into adulthood.

What is the goal of the "Making Prevention Work" study?

In an effort to learn from other contexts, we decided in 2016 to look beyond our national borders in order to identify successful facilities and institutional arrangements with potential applicability for the German welfare system. Although Germany's federalist system and other distinctive features of its institutional architecture may prohibit a direct transfer, factors of success in effective arrangements found elsewhere could nonetheless be adapted in one way or another to the German context.

As a product of this desire to learn from other examples, the study presented here examines prevention activities in 12 EU member states[1] and maps the goals, contents and legal basis of each, as well as their information, financing, organizational and cooperation structures. Case studies in France, Austria and the Netherlands provide deeper insight into how cooperation structures work and the daily challenges of preventive work.

What are our key findings?

In addition to providing prevention advocates across Europe with examples of good practices, the study clearly shows the importance of EU funding instruments to fostering inclusive prevention in education, health and social welfare, particularly with regard to youth and children in need. Furthermore, the study shows that an effective local implementation of prevention depends on the following:

- an integrated, cross-sectoral approach involving actors and institutions in health, child welfare and education;
- the promotion of such an approach at the EU level;
- the extent to which the EU fosters prevention locally and its influence on prevention policies in federal states and municipalities.

We are strongly aligned with the European Commission's recommendation on child-friendly investment (Recommendation 2013/112/EU; Investing in Children: Breaking

1 Germany, Austria, France, the Netherlands, Sweden, Denmark, Finland, Spain, Ireland, United Kingdom, Lithuania and Czechia.

the Cycle of Disadvantage). We therefore find the ongoing initiative to introduce a child guarantee scheme throughout Europe a promising approach. Although this scheme focuses on the basic needs of children, we see a strong link to the objectives outlined in our study and recommend that it be adopted quickly so that implementation can commence.

In addition, we recommend that the EU draw upon its Pillar of Social Rights and the European Semester process to communicate the urgency of joined-up prevention efforts that link local, regional and national measures. In order to ease local municipalities' access to funding for prevention, we recommend that barriers to ESF funding be reduced. We support European efforts to implement the European Pillar of Social Rights through the Structural Funds and hope that the findings presented here help foster a European-wide discussion on ways to create a better future for expanding generations to come.

A study of this nature requires the efforts and cooperation of many people and institutions. We would like to express our sincere gratitude to **Prof. Dr. Stephan Grohs, Niclas Beinborn** and **Nicolas Ullrich** at the German Research Institute for Public Administration for their outstanding work in conducting the cross-national study. The 12 fact sheets provided here and which offer an overview of preventive systems and policies in the countries surveyed have been reviewed and audited by experts from each country. We are deeply appreciative of their constructive criticism and invaluable input. We thank **Niclas Beinborn** in particular for his work on the Dutch case study and **Caroline Vink,** Senior Advisor at the Netherlands Youth Institute, for her ongoing support.

Special thanks go to **Dr. Renate Reiter** at the FernUniversität Hagen for her extensive work on the France case study. For their work on the France case, we also thank **Prof. Claude Martin,** School of Public Health (EHESP) Rennes, Marie-Renée Guevel (PhD), School of Public Health (EHESP) Rennes, and **Dr. Marie-Paule Martin-Blachais,** Director General of the Consensus Approach to Children's Basic Needs in Child Welfare 2017. We are also indebted to **Dr. Falk Ebinger** at the Vienna University of Economics and Business for his authorship of the Austrian case study and, for their contribution to the report, we thank **Dr. Sabine Haas,** Gesundheit Österreich GmbH and Director of the National Centre for Early Prevention (NZFH), **Birgit Kraus** at the Styrian State Governor's Office (A6 Department of Social Affairs, Unit for Family Affairs, Adult Education and Women), **Bernhard Mager,** Director of the Eastern Region at Vienna Child and

Youth Support (Municipal Department 11), and **Ursula Berner,** Spokesperson for Social, Family and Children's Affairs for the Green Party in the Vienna parliament and city council. For her tireless support, we owe a special debt of gratitude to **Ingrid Krammer,** Head of the Youth and Family Office Graz.

Finally, we are particularly indebted to **Jana Hainsworth** and **Reka Tunyogi** of Eurochild and **Alfonso Montero** of the European Social Network for their immensely helpful recommendations and contacts.

Christina Wieda and Dr. Anja Langness
Bertelsmann Stiftung
"Leave no child behind!" project
May 2020

1 Introduction

Most EU member states feature concepts that aim to prevent a diverse set of social and health problems from developing in childhood and youth. Yet the type of concepts, ways in which prevention is understood and the reach of programs differ widely. Indeed, while the concepts of "prevention" and "social investment" in children and youth policies have gained prominence in the debate on sustainable social policy, which is promoted by several "soft" (i.e., not binding) EU initiatives such as the European Commission's "Investing in Children – Breaking the cycle of disadvantage" recommendation (European Commission 2013), a uniform interpretation and implementation of prevention and its specific contents across Europe is lacking (European Commission 2017).

In Germany, the "Leave no child behind!" project (formerly "*Kein Kind zurücklassen!" KeKiz,* now *kinderstark*) stands as a prominent example of recent efforts to strengthen the role of prevention in promoting the well-being of children and youth in their development. These approaches differ from "classic" policies that take action after a problem has emerged by focusing on preventive measures that are applied early on, that is, before problems develop. Preventive approaches involve the concept of investment; the promotion of education or health at an early stage in life can provide children and young people improved opportunities for participating in society and better prospects. In other words, prevention helps children and youth achieve a more "successful" transition into adulthood. This, in turn, helps society avoid the higher costs associated with a variety of social problems.

The design and success of such preventive concepts in children and youth policy, however, differs across the EU. These differences are manifest not only in the allocation

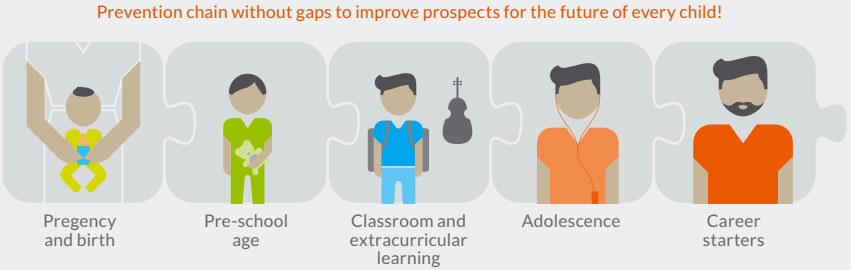
of responsibilities across different state and administrative structures, the fragmentation of delivery structures or financing and governance arrangements, but also in the respective content alignment and ways in which the term "prevention" is understood. These differences make a European comparison challenging – but also promising. In this publication, we look beyond national borders in order to identify successful concepts and structures that are transferable to the German context and to determine how European ideational and material support is applied in different national contexts. Although the federalist state structure and other distinctive features of the German administrative system may prohibit a direct transfer, it still seems fruitful to look for working structures that could be adapted in one way or another. In addition, this European comparison identifies problems in preventive services that are common to the member states and offers recommendations for enhancing prevention through European and national actions. As part of the research accompanying the "Leave no child behind!" *("Kein Kind zurücklassen!" KeKiz)* project in the German state of North Rhine-Westphalia, this report is funded by the European Social Funds, the state of North Rhine-Westphalia and the Bertelsmann Stiftung.

1.1 Aims

The aims of this publication are twofold: First, it aims to investigate how European states tackle connecting elements of the so-called prevention chain. A prevention chain is an important element of successful preventive work in local communities within the *KeKiz* concept. It refers to those links between different governmental and non-governmental actors that play a role throughout the course of a child's life – from pregnancy to the school-to-work transition (see Fig. 1).

The notion of prevention or preventive structures is herein understood in terms of primary prevention, meaning measures that are implemented before a problem has a chance to emerge. The terminology derives primarily from the health sciences (Caplan 1964; Gordon 1983), where primary prevention is intended to prevent people from becoming ill (Hartmann 2016). However, as Hartmann states, illnesses are rarely monocausal and have roots in different areas (Hartmann 2016). The same applies to many other, non-medical, problems, such as those associated with children who find it difficult to keep up with their classmates. The problem could be caused by a variety of factors, including poor nutrition, parenting deficits, social problems or special

FIGURE 1: **Interlocking prevention chain**



teaching needs, to name just a few. Usually, two or more factors that interlink and reinforce each other are to blame. Measures designed to tackle the symptom should bear this dynamic in mind – and focus not exclusively on the educational context, as is often the case with more traditional, interventionist approaches. Educators must work together and with social workers, health professionals as well as parents – each of whom are part of a child's local environment – in finding a holistic solution to acute problems. Future problems can therefore be averted as the conditions for a child's upbringing are improved (see e. g., Bogumil and Seuberlich 2015). Ideally, this implies coordination among actors over time. The core institutions a person typically deals with over the course of their life include hospitals, childcare facilities, schools and vocational training institutes. In transition periods, the exchange between these institutions becomes crucial for adaptive measures in so-called chains of prevention. In order to be effective, preventive measures should therefore take a universal and cross-sectoral integrative approach.

Second, the report strives to identify those concepts that strengthen such universalist and integrative approaches and discuss the extent to which they are transferable to the German and EU context. While we cannot simply import blueprints, we can highlight the challenges currently faced in Germany and identify solutions in other member states with potential applicability. In addition, we point to problems concerning pre-

vention that are common across Europe and offer advice as to how to tackle them – and how the European Union might address these issues. This European comparative report therefore involved three steps:

The first step required mapping the preventive structures in 12 EU member states (chapter 2). Findings have been distilled into **fact sheets** providing a core inventory of each surveyed country's governmental and administrative structures, their systems of social security, health and education, relevant prevention programs and relevant actors. The following four criteria were used to select the member states for this core inventory:

- They represent different welfare state traditions.
- They face varying degrees of "problem pressure" (e.g., the number of vulnerable families, public finances etc.).
- They cover different regions of the EU.
- They offer (to varying degrees) potential in terms of transferability to the German context.

The selected countries include Austria, Czechia, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden. To understand how different elements of the prevention chain interlock, six different scenarios were explored for the countries. The comparison of structures and services was guided by the following seven dimensions that are explained in detail in chapter 3:

- Preventive approach: universalism vs. targeting
- Coordination: integration vs. fragmentation over the prevention chain
- Bindingness: voluntary vs. incentivized vs. obligatory offerings
- Administrative responsibilities: centralization vs. decentralization, fragmentation vs. integration
- Finance: decentralized vs. centralized
- Additional funding: use of special programs and European Funds
- Other governance instruments: information, networking and performance management

The second step entailed conducting **in-depth case studies** in three countries selected from the core inventory (chapter 4). These case studies deepen the report with qualitative data derived from interviews that offered insight into the extent to which

measures have succeeded. Due to scheduling and budgeting restrictions, we were unable to provide the same depth of analysis for all 12 countries surveyed and decided to focus on three countries with promising prevention concepts that are potentially transferable to the German context:

- Austria (case study authored by Dr. Falk Ebinger, Vienna University of Economics and Business)
- France (case study authored by Dr. Renate Reiter, FernUniversität Hagen)
- The Netherlands (case study authored by Niclas Beinborn, Nicolas Ullrich and Prof. Dr. Stephan Grohs, German Research Institute for Public Administration)

The case studies are available in this series (see page 163 for further information).

The third and final step involved exploring the **potential transferability of** successful prevention concepts to the German context, identifying **problems in prevention that are common to various contexts across Europe** and offering **recommendations for EU actions to be taken** that would strengthen child and youth-oriented prevention efforts throughout the EU (chapter 5).

1.2 Methods

As pointed out above, problem constellations for prevention policies are usually rather complex and involve not one but several different actors and institutions. Cross-national comparisons that focus on specific institutions (e.g., childcare facilities) would therefore yield misleading results, as the specific organization of institutions, as well as their functions or obligations, will vary from country to country. We have chosen instead to pursue a combined approach involving both structural and qualitative analyses: We analyze the institutional, financial and social policy setting in each of the 12 member states surveyed, but we also provide specific scenarios that depict typical situations to be addressed by preventive measures. These scenarios make it much easier to compare the processes and actions set into motion to prevent future problems from emerging from a specific situation. In our research, we examined the relevant laws, web pages, brochures, data sets, government and other documents (e.g., from statistical offices, the OECD, the European Commission) on these topics. In addition, we consulted experts on each country and subjected each fact sheet to review by

at least one domestic expert. Interim results were discussed with experts from several European states, EU institutions as well and NGOs at three workshops held in cooperation with Eurochild in Brussels (June and November 2018; November 2019). The recommendations presented here are heavily informed by the outcomes of these discussions.

The fact sheets begin by providing a general overview of the government architecture in each country and how preventive structures and measures in each work. Information specific to each country's social, health and education systems – through the lens of prevention for children and youth – is then provided. And while information regarding individual programs and policies would be helpful, providing this level of detail would go beyond the scope of this project.

Each fact sheet includes five scenarios developed together with experts consulted in a workshop in October of 2017. These scenarios, which depict the various stations in the life of a child from birth to the transition from school to work (see "Key institutions/actors" in the fact sheets), help frame the comparison of different prevention measures in the EU member states and thus improve our understanding of them.

Scenario one refers to the prenatal period and envisions a situation in which a pregnant woman needs counseling and/or guidance with pregnancy. As a very basic and familiar scenario, it is particularly important that measures be in place to assist an expectant mother in ensuring a healthy and uncomplicated childbirth. Scenario one identifies the existing obligatory services and programs for pregnant women and any other additional services.

Scenario two refers to the period immediately following birth and up to the first 12 months of a child's life. This scenario is concerned with infants showing non-severe developmental delays or problems. It identifies the obligatory local services and programs in place to support the age-appropriate development of infants. It seeks to identify additional services that might be offered and determines if there are established ways of bringing parents in contact with counseling centers, specialists and so on. This scenario also examines whether or not actors cooperate across sectors and looks at how parents might become involved with a specific measure.

Scenario three is concerned with the later stages of a child's life, from the age of one to six, that is, the period in life when a child usually attends preschool (or some other form of early childhood education and care facility) (note: in the following, we use the term "preschool" broadly as we focus primarily on educative measures). This scenario envisions a situation in which a child misbehaves at preschool and examines how it is handled. Guiding questions include: Are there established practices able to deal with these problems? Do preschools cooperate with actors in the health, child welfare and education sectors? How might parents be involved? Are there other services tailored to the child? Are there institutional services or practices in place that support facilities that are severely impacted by children with behavioral issues?

Scenario four is concerned with children and youth of primary to middle school age (about 6 to 12 years old). It envisions a child with behavior issues such as frequent in-class disruption, concentration problems, or a lack of speech development and examines how schools deal with such cases. Guiding questions include: Do schools cooperate with health and child or youth welfare specialists.? Do parents get involved (and if so, how)? Are there institutional services or practices in place that support facilities that are severely impacted by misbehaving children?

Scenario five is concerned with 12 to 18-year-olds who exhibit violent behavior, both in and outside of school. Guiding questions for this scenario include: How do schools deal with such problems? Which services are already firmly established? What additional services are available? When dealing with violent youth, do schools cooperate with health and child and youth welfare specialists? Do parents get involved (and if so, how)? Are there institutional services or practices that support facilities that are severely impacted by violent youths?

Scenario six is concerned with the welfare of children, regardless of age and looks at what happens when a family files for social assistance. Guiding questions for this scenario include: Are monetary transfers and other support services granted in ways appropriate to the current life situation or other criteria? To what extent do family-focused payments (e.g., social transfers, child-rearing allowances, health benefits and education support) granted from one provider account for potential interdependencies? What are the government institutions involved in these processes? How do they communicate with each other and coordinate their actions? Are there additional services for children that families applying for support can take advantage of?

2 Core inventory findings

The following **fact sheets** summarize the institutional systems and prevention measures found in 12 European member states: Austria, Czechia, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden. The fact sheets present basic information regarding state administrative structures and the various aspects of a prevention system (i.e., health, social security and education) in each surveyed state. Specific features of prevention approaches in each state are also provided. For illustrative purposes, each fact sheet also features a short description of typical situations involving preventive measures in the country.

2.1 Fact sheet Austria

2.1.1 General structure

8.8 million residents
105 residents per km²
GDP per capita of € 38,189

The Republic of Austria is a federal republic with a population of 8.8 million (2018). The government is comprised of four administrative levels: The federal government *(Bundesebene)*, nine federal states (*Bundesländer* or *Länder*), 94 districts (*79 Bezirke* (cities acting as districts)) and 2,096 municipalities *(Gemeinden)*. Legislative powers are shared among the federal and state-level governments. Administrative power lies mainly with the states, districts and municipalities. Decision-making authority and responsibility for each level depends on the policy issue. A distinctive feature of Austrian politics is its culture of consensus in which the various levels of government work together with key social and economic associations in order to reach a consensus on central issues. This is often referred to as the *Sozialpartnerschaft* (social partnership).

2.1.2 Preventive structure

General context

Regional competences for children: States bear legislative and administrative responsibility for daycare, schools, as well as pregnancy and youth care services, most of which are implemented by the districts. Regional networks carry out the Early Prevention *("Frühe Hilfen")* program.

Local competences for children: Municipalities and local governments are responsible for the construction and maintenance of all compulsory education buildings, and for the operation of 60 % of daycare facilities.

Health system: In Austria, public health insurance is mandatory for all employees and self-employed persons, persons claiming unemployment benefits and pensioners.

The federal government is in charge of legislation and administration of the scheme. Responsibility for financing medical services is divided among the federal government, states, health insurance providers and social insurance providers, and is a complex issue.

Social security: Austria features mandatory insurances for common life risks (e. g., health insurance, unemployment insurance, pension insurance). In addition, the country offers tax-financed, means-tested public assistance *(Bedarfsorientierte Mindestsicherung, BMS)* to ensure basic needs are met for those who are not eligible for insurance benefits and not able to provide subsistence-level welfare for themselves. The Early Prevention program was designed to overcome the problem of overlapping responsibilities across a diverse set of actors in regional networks focusing on young families (for more details see section "distinctive features, special projects and cooperation."

Education: Children have no general legal right to childcare and the provision of services varies greatly between states and regions. Parents are required to make copayments for childcare. Use of childcare is below the EU average for children under three years, but this varies heavily between the states and rural areas versus cities. The states require by law that children aged 6 to 15 receive schooling. Schools are run primarily by a joint agency of the federal government and the federal states, the educational directorates *(Bildungsdirektionen)*, while municipalities are responsible for school buildings alone.

Key institutions / actors

- Pregnancy: Midwifes and gynecologists provide mandatory examinations. Early Prevention also provides services.
- Issues of special concern und the age of one: Gynecologists provide mandatory examinations. Early Prevention also provides services.
- Infants (1-6) with behavioral problems: Daycare facility (e. g., municipal, church or private). Early Prevention also provides services.
- Children (6-12) with behavioral problems: Primary-school psychologists and school social workers.
- Youths (12-18) who express violent behavior: Schools; in severe cases, schools cooperate with a municipality's youth department.
- Family applications for social assistance: There is no standardized approach; some municipalities have social affairs offices that incorporate different social services. Early Prevention also provides services.

2.1.3 Overall impression

In recent years, Austria's traditional health-oriented focus of prevention has broadened in scope. This has been in part due to the Early Prevention program. However, the fragmentary nature of services within the complex federal system of responsibilities is a key barrier to providing effective prevention for all children in Austria, especially in the many small municipalities. Standards and offerings of preventive services vary significantly between the states. The potential for effective prevention is considerable when programs like Early Prevention have been implemented across the entire country and lead to new institutionalized structures of cooperation. The low take-up rate for childcare is improving, particularly with regards to care for children under three years of age. There is an urgent need to raise awareness of prevention in the implementation of the 2018 constitutional reform.

2.1.4 Insights regarding the country's specific preventive features

Structure and financing of the local government

Austria has three levels of government administration below the federal level: states, districts and municipalities. The country's 94 districts, which are basically a lower administrative body of Austria's nine states, also carry out certain tasks for the federal government. Districts are responsible for implementing the largest share of child and youth-related services, including universal youth care, social assistance, public health, mandatory schools, services for the disabled, and sports and leisure. District administrations are led by a non-elected district commissioner who answers directly to the federal and state governments, depending on the task. Given the ratio of residents to number of municipalities (i.e., approximately 4,200:1 or 3,330:1 without Vienna), municipal administrative structures in Austria are rather small-scaled. The smallest municipality has only 15 residents. Geographical differences are also worth noting, as the challenges and opportunities faced by small municipalities in mountainous regions are very different than those facing the capital city of Vienna or other urban regions. Regardless of their size, Austrian municipalities have the constitutional right to municipal self-government in all areas that are not regulated by the federal or state governments. In practice, however, municipalities in Austria have rather limited powers with regard to the research issues addressed here and act more as a local arm of the federal and state governments. Municipalities also have limited local tax

revenues. Local taxes account for some 20 % of their revenue. Fees and other charges (e. g., water supply and waste collection) account for another 20 %, federal taxes for another 30 %, grants from the federal and state governments for 15 % and other sources for another 15 %.

Health system

In Austria, public health insurance is mandatory for all employees, self-employed persons, persons claiming unemployment benefits and pensioners. Depending on the employer and an individual's residence, certain insurance providers are statutory bodies under public law; one does not have the right to choose their insurance. Insurance benefits and contributions are, however, very similar. Family members of the insured person (non-working spouse and children) are co-insured without having to pay a contribution. Employers and employees pay equal parts in terms of contributions. Unemployment insurance pays contributions for those who are unemployed, while the states cover these costs for those people receiving public assistance *(Bedarfsorientierte Mindestsicherung, BMS).*

Financing for medical services is divided among the federal government, the states, health insurance providers and social insurance institutions through a complex calculus. In sum, the costs of in-patient treatments (hospitals) are paid by the states' health funds *(Landesgesundheitsfonds),* which are financed by the Federal Health Agency *(Bundesgesundheitsagentur),* states and social insurance institutions. Outpatient treatments are covered by health insurance providers.

Social security

Austria's social security system is based on several forms of mandatory insurance for common life risks. The most important types of social insurance are health insurance, unemployment insurance and pension insurance. Each one is organized by regional health insurance providers *(Gebietskrankenkassen)* and professional health insurance providers *(Berufskrankenkassen),* the Pension Insurance Authority *(Pensionsversicherungsanstalt),* and specific types of insurance targeting certain groups such as farmers. Insurance premiums are usually shared 50:50 by employers and employees, though there are some exceptions. In addition, there is needs-based minimum benefit *(Bedarfsorientierte Mindestsicherung, BMS)* form of public assistance designed to provide a basic

income for those who are not eligible for insurance benefits and cannot provide for their own welfare. The BMS is financed jointly by the federal government, the states and municipalities, with each level bearing a different share of the costs.

In addition to social insurance benefits, there are other benefits relevant to children, youth and families that are paid by the Family Burdens Equalization Fund *(Familienlastenausgleichsfond, FLAF)*. The FLAF is a federal fund administered by the Federal Ministry of Labor, Family and Youth at the Federal Chancellery. Financing is derived from a mixed system in which all employers are required to pay a 4.5 % tax on the gross wage sum of their employees. This accounts for nearly 2/3 of the funds' resources. The fund is also financed by a percentage of other general taxes and contributions paid by farmers and the forestry industry.

In late 2018, both chambers of parliament approved legislation that amends the constitution and transfers the responsibility for child and youth welfare from the federal to the state level of government. The subject of intense debate, this devolution of responsibility has raised fears that it will result in a further fragmentation of services and standards in child welfare. To alleviate concerns, the legislation was amended so as to require in advance an agreement on common standards among the states before any such transferal of responsibility can take place.

Education

Usage rates for formal childcare in Austria are increasing, but for children under three, Austria remains below the EU-28 average. In 2016, 20.6 % of all children up to three years of age were in daycare, which is far more than 2006 (4 %), but still lower than the EU-28 average of 32.9 %. The share of children between three and six (compulsory school age) in daycare increased from 71 % in 2006 to 88.7 % in 2016 (EU-28 average for 2016: 86.3 %). The last year of daycare before starting school is provided free of charge, though parents in most cases have to make a copayment for the previous years. The copayment amount varies significantly depending on the state and the specific daycare facility, though it is usually based on the weekly care time and parents' income and generally ranges from € 40 to € 200 a month for half-day care. Some states (e. g., Vienna and Tirol) provide free daycare before noon. About 60 % of daycare facilities are operated by the municipalities, 13 % by churches. The rest are operated by different private providers (e. g., foundations, companies, specialized daycare providers).

The responsibility for providing and financing daycare is shared among municipalities, states and the federal government. Legislation regarding daycare, however, is left to the federal and state governments. The states are *de jure* responsible for implementation but in practice rely on municipalities to provide daycare facilities. The municipalities therefore receive grants from both the federal government and the states for facilities run by local governments themselves or for private facilities. Because not all costs are covered by the grants, municipalities must also allocate some funds from their budget.

Federal laws regulate the Austrian educational system in all relevant aspects. The states, however, can issue laws that regulate implementation in some areas. Children are obligated to receive nine years of schooling, usually from the age of six to 15. For the first four years of their education (age 6–10), all children attend a primary school *(Volksschule)*.[2] For the remaining years, parents can determine whether their child attends a secondary school *(Hauptschule/Neue Mittelschule)* for four to five years or an academic secondary school *(Allgemeinbildende höhere Schule)* for eight years. This can be followed by either an additional four years of education in schools for intermediate vocational education *(Berufsbildende mittlere Schule)* or three to four years at a vocational school for apprentices *(Berufsschule)* that is combined with a practical apprenticeship. The municipalities do not play a major role in the Austrian education system as they have no crucial powers in this area. They are nonetheless important in financial terms because they are required to finance the construction and maintenance of all compulsory schools (primary and secondary schools) and are responsible for specific aspects of the education system such as bus transportation for schoolchildren.

Distinctive features, special projects and cooperation

Austria's **Early Prevention** *(Frühe Hilfen)* program, which targets parents and children from pregnancy to three years of age, has been in place since 2011. The program's main objective is to facilitate the provision of prevention services for families in need by improving linkages between different actors in prevention, avoiding gaps in service provision and reduce non-pickup rates. Early Prevention involves the development of regional networks among social, medical and educational stakeholders in early childhood intervention services. Any professional with contact to a child who identifies the need for support and acquires parental consent is encouraged to pass this infor-

2 Exemptions for homeschooling exist, but this option is altogether insignificant in numbers.

mation on to the network. Then, a family support specialist *(Familienbegleiter),* through regular visits and engaged encounters, helps the family ensure a child is provided a safe and healthy environment *(gelingendes Aufwachsen).* Thanks to this regional network, parents have a single contact for all questions and problems regarding pregnancy and early childhood. Child development is thus addressed holistically as all actors involved are in contact with each other and are familiar with the different approaches, measures and goals involved. The Austrian National Centre for Early Prevention *(Nationales Zentrum Frühe Hilfen, NZFH)* coordinates the strategic development of the networks, provides guidelines for consistent practice, collects data, and takes care of public and political communication. Since 2016, Early Prevention measures have been established in all states, but not in all municipalities and therefore reach about half of Austria's young families. Early Prevention measures are financed primarily by the health sector through prevention funds under the aegis of the Federal Health Agency *(Vorsorgemittel der Bundesgesunheitsagentur)* and the states' health funds *(Landesgesundheitsfonds).*

Austrian **states** have several prevention **programs for their respective administrative area.** Most of these programs are focused on health issues, such as those provided by **the state of Styria** *(Steiermark)* in cooperation with its districts (shared financing). Many of these programs restricted to a specific time-frame and involve preventive measures targeting children and youth. These include:

- Alcohol and tobacco prevention measures that provide information and counseling for parents, employees in education-related jobs, as well as special programs targeting risk groups.
- Nutrition counseling services for pregnant women and young families.
- Programs that promote healthy lifestyles in childcare and schools (e.g., exercise, nutrition, addiction prevention).

Instruments of explicit **performance management** are mainly known within special projects such as the Early Prevention program or state initiatives and programs. For preventive measures that are rooted in non-specific policies such as general health or social instruments, performance management is rather limited to statistical returns.

2.2 Fact sheet Czechia

2.2.1 General structure

10.6 million residents
134 residents per km²
GDP per capita of € 20,400

The Czech Republic (official short form: Czechia) is a Central European unitary state with 14 regions (one being the capital city of Prague) and 6,258 municipalities. Legislative power is located exclusively on the national level, but regions may submit motions to the parliament. The local self-government principle is guaranteed in the constitution for both regions and municipalities.

2.2.2 Preventive structure

General context

Regional competences for children: Secondary schools, leisure time and art education, aspects of social services, adoption, foster care, aspects of healthcare (especially hospitals).

Municipal competences for children: Primary schools, preschool education, aspects of social services, childcare, public health promotion.

Health system: Mandatory health insurance is provided by one of seven national health-insurance funds, which are quasi-public, limited-profit self-governing bodies. Primary healthcare is provided by doctors in private practice, with payments provided by the national health-insurance funds; municipalities and regions have distinct competencies, with the former being responsible for promoting public health and the operation of some small hospitals and the latter bearing responsibility for most hospitals. The highest-grade specialized hospitals are run by the Ministry of Health.

Social security: Largely insurance-based social security system, basic social assistance is tax-financed and open to every resident. Variety of special benefits for families, which are also tax-financed and mainly income-tested or income-based.

Education: Very low usage of childcare for children under three, and a massive shortage of childcare facilities. There is a right to childcare beginning at the age of four. Children undergo nine years of compulsory basic education (usually between the ages of six and 15), with basic schools a municipal responsibility, and secondary schools a regional responsibility.

Key institutions / actors

- Pregnancy: Gynecologist performs regular examinations (not mandatory).
- Issues of special concern under the age of one: General practitioner or pediatrician performs regular examinations.
- Infants (1-6) with behavioral problems: Childcare facility (if the child attends one).
- Children (6-12) with behavioral problems: Municipal school.
- Youths (12-18) who express violent behavior: Municipal / regional school.
- Family applications for social assistance: No special processes in place.

2.2.3 Overall impression

Prevention services in Czechia have a strong focus on health. With mandatory examinations and vaccinations for children, as well a number of programs combating various addictions and issues such as obesity, health aspects dominate this picture. However, the fact that health-oriented competences are split between private-practice doctors, health-insurance funds, municipalities and regions undermines the unity of the system. One focus of social policy is an effort to reduce poverty, especially among the poorest. Policies or programs with a universal, primary preventive approach are relatively rare. The relatively low share of children under three in childcare carries the danger of discovering problems too late. Additionally, the division of competences between three ministries, regions and municipalities (a split that also varies in different areas of the country) impedes information flows and hampers efforts to treat prevention work as an integrated service.

2.2.4 Insights regarding the country's specific preventive features

Structure and financing of the local government

With 6,258 municipalities and 10.6 million residents, Czechia features rather small-scaled municipalities (approximately 1,700 residents per municipality on average, with many municipalities being much smaller). This results in frequent recourse to inter-municipal cooperation, for example in childcare, with the specific form of cooperation varying from issue to issue and case to case. In addition, there are three different types of municipalities with regard to the extent of delegated competences, depending on size and number of residents. The regions also possess significant competences in the area of child and youth services, for example holding responsibility for foster care, adoptions, secondary schools and institutions for children with special needs. Like the municipalities, regions are partly self-governing, and to some extent perform tasks delegated by the national government.

Municipal and regional financing is based on a mix of their own taxes, shared tax revenues and national government grants. Municipalities receive approximately half of their revenue via taxes; however, most of this represents shared taxes, so they cannot influence the amount. The rest is mainly made up of national government grants, and to a lesser extent some local fees. More than 80 % of the regions' finances are derived from national government grants, with the remainder mainly coming from shared taxes. The largest share of local government spending (regions and municipalities together) goes to education (approximately 32 % of the whole); social protection (approximately 6 %) and healthcare (approximately 2.5 %) account for much less, because these services are mostly financed by the national government and insurance bodies.

Health system

The Czech health system is based on an insurance principle. Every resident is obliged to register with one of the country's seven health-insurance funds, which are quasi-public, limited-profit self-governing bodies. Premiums are income-based for working people; the state finances insurance coverage for retired and unemployed persons, persons receiving social assistance, and children. The main actors in this area include the Ministry of Health as the main administrative and regulatory body, and the self-governing health-insurance funds, which administer the collection of contribu-

tions and provide benefits to the insured. The Ministry of Health owns and runs all university hospitals and some psychiatric institutions. Regional authorities own many of the country's hospitals and some outpatient care providers. Some smaller hospitals are owned by municipalities. General practitioners in private practice account for the vast majority of primary care (>90 %), but do not serve a gatekeeper function in Czechia. Many patients choose to go directly to specialists or hospitals, which creates the danger of a lack of comprehensive knowledge, especially with regard to the healthy development of children. Links between the health sector, other social services and the education sector are rather weak.

Social security

The Czech social system is based on two principles: On the one hand, mandatory insurance programs provide pension, sickness and unemployment coverage. On the other, a noncontributory, tax-financed social-benefit system provides special benefits for certain groups (e. g., people with chronic diseases, families, single parents, etc.), while a general social-assistance program offers help to people in material need (e. g., minimum resources needed for living for people who cannot provide for their own subsistence). Social benefits are financed almost exclusively by the national government. Relevant benefits for families include:

- A pregnancy and maternity benefit (income-based)
- A parental allowance (income-based; differences for unemployed parents)
- A maternity benefit (income-based)
- A child allowance (income-tested)
- A birth grant (lump sum)
- A housing allowance (income-tested)
- Various tax benefits

The state's social support programs for families are administered by the Labor Office of the Czech Republic, along with its regional and local contact offices. The same goes for the basic social-assistance program. There is no institutionalized connection to municipal or regional education or healthcare services.

Education

Only 6.5 % of children under the age of three attend professionally provided childcare in Czechia, a share far below the EU average of 34 %. Since the 1989 revolution, Czech family policy has been biased toward children under three staying at home with the family; as a consequence, the country's once-substantial nursery capacity has been reduced almost to nothing. In recent years, there has been some effort to increase the number of children in childcare, but the share remains quite low. This is largely due to a lack of capacity, along with the continuing provision of incentives for mothers to stay at home with long maternity leaves. This is also reflected in the very low employment rate among women. Most childcare facilities for children under three are private and expensive.

Usage of kindergartens for three- to six-year-old children is much higher, with about 80 % of this group attending, a figure closer to the European average. However, marginalized groups such as Roma children have a low attendance rate. Kindergartens are in most cases operated by municipalities, but some church- or privately-run kindergartens also exist. Currently, children have a formal right to childcare beginning at the age of three. A plan to extend this right down to the age of two from 2020 onward was canceled in 2019 before it became effective. Younger children do not have a right to childcare, and municipalities are not legally obliged to ensure capacities. Municipalities or regions finance the majority of childcare costs, but parents have to pay a (rather small) fee, which still prevents many socially excluded children from attending. The last year of kindergarten (usually at the age of five or six) is a fee-free, non-mandatory preschool year.

Compulsory education takes nine years, usually from the ages of six to 15. There are different forms of school, but children usually attend a nine-year basic school, which is divided into two stages: a primary (grades 1-5) and a lower secondary stage (grades 6-9). With the exception of a few private schools, basic schools are municipally operated and free of charge. Compulsory basic education is followed by voluntary secondary schools, with three main types offered: a general secondary school *(gymnázium)*, a secondary-level technical school *(střední odborná škola – SOŠ)* and a secondary-level vocational school *(střední odborné učiliště – SOU)*. These are mostly operated by the regions, free of charge; however, about one-sixth of the country's children attend private secondary schools that carry high tuition fees. Parents tend to withdraw their

children from schools that have comparatively high shares of Roma pupils – resulting in "racially" segregated schools in some municipalities.

Distinctive features, special projects and cooperation

Municipalities and regions are key players in the prevention field, but do not exploit the full potential for integration between social, educational and healthcare services. Together, the two forms of subnational governments are responsible for elementary and secondary schools, public health services (municipalities) and hospitals (regions), and aspects of the social services. The intensity of cooperation and the division of competences between municipalities and regions varies, and sometimes creates breaks in the prevention chain, as does the national administration's responsibility for providing cash-based family-oriented social benefits.

The Ministry of Health, in cooperation with the ministries for Education and Agriculture, offer some health-oriented initiative. For example, the "Health Consciousness Program" and the "Nutrition as a Way to Health" program are intended to raise awareness of health issues for children in school and childcare.

Unlike most other European countries, Czechia conducts mandatory vaccinations against tuberculosis, diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella hepatitis B and Haemophilus influenzae type B. Regular childhood examinations (until the age of 12) are also mandatory. In case of non-compliance, penalties of up to CZK 10,000 can be imposed. Children who are not properly vaccinated are not allowed to attend kindergartens or school outdoor education projects. The anti-vaccination movement is weak, but court trials on the issue are underway.

2.3 Fact sheet Denmark

2.3.1 General structure

5.8 million residents
135 residents per km²
GDP per capita of € 51,000

Denmark is a unitary state with nine state administration offices (national government service offices for special issues and oversight), five regions serving as subnational administrative bodies, and 98 municipalities. Key features of the welfare-state system include the tax-financed and universal social, education and healthcare services, with a strong reliance on the local level. With an average of approximately 57,000 residents per municipality, Denmark features the EU's second-largest municipality size in terms of residents.

2.3.2 Preventive structure

General context

Regional competences for children: Hospital care, health services provided by general practitioners and specialists in private practice.

Municipal competences for children: All social services (financing, supply and authority), childcare, primary and lower secondary school, disease prevention and health promotion, school health services, child dental treatment, nurse-provided medical services for children. High share of non-mandatory services, but with a long tradition of strong use of public offerings for children and social services in general.

Health system: Universal, tax-financed social security and health system, providing free access for all residents (exceptions are prescription drugs and dental care, which are partly cofinanced by patients).

Social security: Generally universal, tax-financed and free of charge. Multiple benefits for parents, including a general, non-means-tested child benefit, a child allowance for single parents, and special allowances for individual problematic situations. Expenditure on children and families is very high (11.2 % of total social benefits, compared to an EU-28 average of 8.6 %; Eurostat 2017).

Education: All children are entitled to (subsidized) daycare from the age of 26 weeks until the start of school. Country has Europe's highest percentage of children in daycare. Mandatory schooling for all children between six and 16, with 35 school-hours per week, either in free public schools, subsidized private schools or a home-school setting.

Key institutions / actors

- Pregnancy: General practitioner / midwife, regular examinations.
- Issues of special concern under the age of one: General practitioners, municipal nurses / doctors via home visiting, information exchange with municipal social services.
- Infants (1-6) with behavioral problems: Municipal daycare facility, information exchange with municipal social services.
- Children (6-12) with behavioral problems: Public school *(Folkeskole)*, municipal school nurses / public doctors, information exchange with municipal social services.
- Youths (12-18) who express violent behavior: Public school, the School, Social Service and Police (SSP) program for information exchange and cooperation between the different actors.
- Family applications for social assistance: No special cooperation / services.

2.3.3 Overall impression

Overall, Denmark has one of the most extensive prevention systems among the EU member states examined in this study. The integration of social services, childcare and lower-level schools, and public health services at the municipal level makes efficient cooperation possible. Challenges in this regard include the regions' responsibility for healthcare services and the state's responsibility for higher education. However, some cooperation measures meant to bridge these fractures are in place.

2.3.4 Insights regarding the country's specific preventive features

Structure and financing of the local government

The structure, tasks and finances of the regional and local administrations underwent a series of reforms over the last 15 years. In 2007, the 14 counties were transformed into five regions, and the 271 municipalities were subject to a process of combination, so that today we find 98 territorially consolidated municipalities. As a result, with an average of approximately 57,000 residents, and the vast majority of municipalities being larger than 20,000 residents, Danish municipalities now have the second-largest average size in the EU (after the UK). This size gives the municipalities the administrative capacity to carry out a wider range of responsibilities than can small municipal entities. Within relevant fields such as social services, education and healthcare, the municipalities and regions together hold most key service-provision responsibilities. Municipalities account for about half of all state expenses. About 75 % of their revenues come from their own taxes (mainly income taxes, land taxes and service charges, with municipalities setting these rates by themselves, within certain limits); the remaining revenues derive from national government grants.

Health system

All citizens in Denmark are entitled to publicly financed healthcare without having to pay insurance premiums. While the regions are responsible for hospitals, general practitioners and specialists in private practice, the municipalities are responsible for other public healthcare services (e.g., home-visitation services for newborns by nurses). The regions' expenses are financed by national government block grants and equalization schemes, as well as use-dependent municipal co-financing. Municipal healthcare expenses are covered partially by national government grants and partially by local taxes.

Families are entitled to receive five free visits during the first year of a child's life by a municipal health specialist. This service is not mandatory but is used by nearly all parents. In addition to this home-visitation program, there are several (also non-mandatory) scheduled examinations provided by general practitioners (a total of seven before the start of school, which are combined with vaccinations against several diseases) and municipal doctors or school nurses (at school entrance, regularly during

the whole of school attendance, and again when leaving school). Dental care is also free for all children until the age of 18 (and subsidized above the age of 18); this is offered by public dental clinics and practicing dentists who have a contract with the municipality.

Health promotion is in general a municipal task. The national law does not define specific measures in this area; thus, municipalities can choose what to offer. Because municipalities co-finance their residents' hospital and general practitioner treatments using local tax revenues, they have an economic inventive to improve their residents' health status.

Social security

In general, Denmark has one of the most extensive and expensive social security systems in the EU. Services are generally universal, tax-financed and free of charge. For example, there are a number of benefits for parents, including a general, non-means-tested child benefit depending on the child's age, a child allowance for single parents, allowances for parents in (vocational/university) education, allowances for multiple births and special allowances for individual problematic situations. Paid maternity or paternity leave is very flexible, with a total amount of up to one year allowed (depending on the distribution between the partners and the employment situation), which is quite generous in cross-European comparison.

Another important aspect of the Danish social system is the considerable effort made in the area of active labor market integration. Measured by expenditure, Denmark has the most extensive active labor market policies in the world (3.3% of GDP; European Commission, 2017). Through these efforts, the government wants to bring as many people as possible into employment, which is seen as an important factor in social integration and parental well-being, which also helps children to grow up successfully.

Education

Denmark has Europe's highest percentage of children in daycare. All children are entitled to a place in daycare beginning at the age of 26 weeks and lasting to the point they start school (usually at the age of six). In practice, 77% of all children under three and 97% of all children between three and the minimum school age attend professional daycare (EU Commission 2017). Parents have to pay only a small share of the cost them-

selves (a maximum of 25 %). For families with low incomes, additional subsidies render daycare nearly completely free. The vast majority of daycare facilities are run and financed by the municipalities. That facilitates information exchange for the transition to school.

The Danish education system contains public and private schools, while also allowing home schooling. According to the Ministry of Education, 78.8 % of children attended public schools in 2018 – 2019, with the remainder mainly in private schools (17.8 % in 2018 – 2019) or in home-schooling settings. Children attend public school *(Folkeskole)* for nine years (from the ages of six to 16). During these nine years, all children are taught together, with no separation occurring. Public school is free of charge and run by the municipality. Considering both daycare and public schools, nearly all children attend municipal education or care facilities from the age of half a year until they are 16. This fact, combined with the municipal responsibilities for public health and social services, enables municipalities to monitor children's development over a long period of time.

Private schools are to a large degree financed by the state, receiving state subsidies that are approximately 76 % of what the local municipalities receive for public schools. The remaining costs are paid by parents. The use of private schools has increased over the last 10 years, mostly due to the creation of new private schools by parents after the closure of many small local schools following the 2007 municipal reform *(Strukturreformen)*.

Upper secondary education is optional, although most children opt to attend one of the several upper secondary education programs (both general and vocational programs are available). Public institutions provide these courses for free, while private schools are only partly publicly financed, and therefore charge fees.

Distinctive features, special projects and cooperation

A portion of the national government's grants are made under special equalization and subsidy schemes, depending on sociodemographic factors and the municipalities' specific activities relating to children and youths. Examples of the first category include subsidies based on:

- The number of residents in specific age groups
  (with children and elderly people weighted more strongly)
- Municipalities that have economic problems or significant structural deficits
- Municipalities with a large share of socially disadvantaged citizens
- Families with low incomes
- Children in families with parents who have low levels of educational achievement
- Children with single parents or families in social housing

Examples of activity-based subsidies include grants for municipalities seeking to improved childcare quality, or which reorganize primary and secondary schools to implement innovative and quality-improving measures (e.g., enhanced integration of children with special needs or from migrant families).

The Danish healthcare system stands out for its use of digitalization, electronic communication and shared data. General practitioners and hospitals systematically collect data on all their diagnoses, treatments and medications, which is then shared between all healthcare providers. The standards are set by MedCom, an organization established in 1994 as a non-profit entity financed and owned by the Ministry of Health, the regions and the municipalities. Looking ahead, a number of concepts for targeted data-driven prevention have been developed, intended to predict risks and enable effective early interventions.

One peculiarity of the Danish system is the public school, which children attend for nine years (from the ages of six to 16). During these 10 years, all children are taught together, with no separation occurring. Following a reform process initiated in 2014, the average time in school per week has been raised to 35 hours (depending on the grade – the higher the grade, the more hours per week). This gives teachers plenty of time to work with the children. This model also facilitates a high level of social integration. Especially after the 2011 reform, public school is regarded not only as a means of conveying knowledge to children, but also as a place of social development and integration.

The SSP program (school, social services and police) is a special program for information exchange and cooperation between these different participating actors. It is active in managing, coordinating and implementing measures. It has three aims, with general preventive action meant for all children, a specific effort targeting specific risk groups, and individual-oriented work targeting individual children or families that have shown problems.

Denmark's health visit program is one of the oldest prevention-oriented services in all of the countries examined for this study. It was introduced in 1937 and has undergone many changes since. However, the basic concept is still the same: All young families are offered in-home counseling and support by a specialist provided by the municipality. The families have a right to at least five visits during the first year of their child's life. The health visits are not mandatory, but the program is very widely used.

In all research-related policy sectors, Denmark shows a trend toward engaging in more evidence-based policymaking. Ministries and their national boards finance, collect and disseminate information about good practices through meta-reviews, pilot projects and evaluations.

2.4 Fact sheet England

2.4.1 General structure

55.6 million residents
424 residents per km²
GDP per capita of € 32,589 (UK)

England is a part of the United Kingdom, which is a constitutional monarchy with a parliamentary democracy. The king/queen is the head of state but has mainly representative functions; the government is led by a prime minister and his or her cabinet. Civil service is traditionally politically neutral. The legislative is vested in the bicameral parliament with an upper and a lower house; the latter enjoys greater legislative powers.

Below the central level there are two different types of local government, with two-tier (counties and districts) and single-tier (unitary) structures. Competences of these structures vary; education and social care are competences of the counties and unitary authorities. The primary source of finances for lower levels of government services are derived from taxes, retained business rates and, to a lesser degree, state subsidies.

2.4.2 Preventive structure

General context

Health system: A universal, extensive and strongly centralized National Health Service (NHS) provides coverage for all legal residents. The NHS is financed through a general tax and payroll tax; there is no insurance system. Private practices contract their services to the NHS and provide most of healthcare services. NHS works together with networks of general practitioners to commission the medical services. Public health services are nowadays commissioned by local authorities due to a recent reform. Coverage of free services is extensive; certain special service and prescribed drugs are subject to copayments. Children under 16 and pupils under 18, as well as pregnant women and women who have recently given birth are exempt from any copayments.

Social security: Statutory insurance-based system; financed by contributions of employers and employees. Most benefits are contribution-based and means-tested. Child benefit and child tax credit are, however, not contribution-based.

Education: Obligatory (free public) education between ages five and 18; children below the age of five are entitled to a certain amount of free preschool visits. Some school types are directly financed by the central government and managed by, for example, non-profit organizations, whereas others are financed by local education authorities and are under the control of local authorities, churches or even foundations. The curriculum for local-authority-maintained schools is nationally prescribed.

Key institutions / actors

- Pregnancy: General practitioner / midwife / nurse, health visitor, Sure Start child centers, family nurse; general practitioners / midwifes / nurses inform mothers of additional care solutions. An initial visit by a health visitor, who cooperates closely with other actors and midwives in particular during pregnancy paves the way for later check-ups. Child centers, which were initially run by the central government but are now under municipal jurisdiction, are staffed with professionals from different sectors. The provision of a family nurse who visits young parents aged 24 and below is a NHS service.
- Issues of special concern under the age of one: Health visitors (a NHS service providing regular home visits to assess infants' health), Sure Start child center. Health visitors work together with other professionals to refer parents / children to further help if needed; they also cooperate with Sure Start child centers.
- Infants (1-6) with behavioral problems: Preschool facility; there are very general national guidelines for preschools on how to address behavioral issues as well as a code of conduct. There are no guidelines for cooperation with other actors.
- Children (6-12) with behavioral problems: Schools, school nurses, education welfare officers; there are very general national guidelines for schools on how to address behavioral issues as well as a code of conduct. There are no general guidelines for cooperation. School nurses, who are employed by the NHS, conduct medical check-ups and provide counseling services for students; they might also refer children to other medical professionals. Councils employ education welfare officers who are to ensure regular school attendance and offer support for related problems.

- Youths (12–18) who express violent behavior: Schools, school nurses, education welfare officers; there are very general national guidelines for schools on how to address behavioral issues as well as a code of conduct. There are no general guidelines for cooperation. School nurses can refer young people to other medical professionals. Councils employ education welfare officers who are to ensure regular school attendance and offer support for related problems.
- Family applications for social assistance: Department of Work and Pensions / Her Majesty's Revenue and Customs is responsible; there are no formal / further cooperation effort or related services provided by other entities.

2.4.3 Overall impression

Preventive structures in the UK are generally rather weak, as health issues are the near-exclusive focus of the health system. Actors in different sectors rarely cooperate with each other, which is a factor of the highly centralized structures in healthcare and social security that have few links to the education sector. School nurses are the only linkage between healthcare and education. While recent reforms have shifted responsibility for public health to local governments, there are no signs of improved cooperation. Indeed, according to a 2018 statement by the Secretary of Health and Social Care (Department of Health and Social Care 2018), much more must be done in order to ensure NHS and local authorities work together and thereby enhance prevention policy in England. Despite current struggles with a reduced budget, local Sure Start child centers represent a promising step forward in advancing prevention.

2.4.4 Insights on countries' specific features regarding prevention

Health system

The NHS, which is under the remit of the Department of Health, is the primary provider of healthcare services in the UK. England is split up into five NHS regions with regional NHS teams coordinating the commissioning of primary and specialized (tertiary) medical services in their respective areas that are supported by several regional offices.[3]

3 As the point of entry into the health system, primary services include, for example, general practitioners. Secondary services involve specialists, who are usually accessed through a general practitioner referral, and tertiary services involve highly specialized medical services such as cancer treatments.

Clinical Commissioning Groups (CCGs), which are also set up by the NHS, are responsible for realizing secondary medical services. Currently numbering 211, each CCG consists of general practitioners within a geographical area and are a product of a recent (2012) reform. More recently, the NHS and CCGs have begun co-commissioning primary care services. These services are provided mainly by private practitioners who contract their services to the NHS. Most hospitals, however, are run directly by the NHS, and in regions where sufficient general practitioner coverage cannot be guaranteed, the NHS may provide services instead. Public health services (e.g., disease prevention, health promotion) have been commissioned by local authorities since 2013.

The NHS is not financed by any dedicated public insurance scheme, as is the case in other countries. It is financed indirectly through taxes that go to the government (i.e., Department of Health) budget. As a result, most services are free at the point of use for all legal residents. The coverage of provided services is extensive. However, prescribed drugs and certain special services are subject to copayments. Nevertheless, children under 16 and students under 18, as well as pregnant women and women who have recently given birth are exempt from making copayments. There are private insurance schemes, the primary purpose of which is to have access to the faster delivery of care, particularly in hospitals.

Social security

The UK's social security system builds on the National Insurance Scheme into which both employers and employees pay (the latter through fees deducted from wages). The self-employed pay contributions in the form of direct payments. Most benefits are therefore also contribution-dependent and can only be claimed if a sufficient amount has already been paid. Means-testing is used to calculate amounts for certain benefits. Child benefits and child tax credits are not based on contributions. Most social security benefits are paid out by the Department of Work and Pensions and involve either an online process or application by phone. Family-related benefits are centrally managed by Her Majesty's Revenue and Customs. Other involved actors include the Department for Business, Innovation and Skills (legislation on parental leave and pay), local authorities (housing benefit) and employers (maternity/paternity pay). A universal credit is currently being introduced in an effort to unite various benefits (e.g., child tax credit and income support) into one lump sum.

Education

Education in England is both voluntary and compulsory, depending on the age and institution. Children below the age of five can attend a kindergarten or preschool (public or private), as the government entitles all children to a certain amount of free preschool education (see "Special programs and other features"). Full-time education is compulsory for children aged five to 18, though the last two years can be spent in a traineeship or in volunteering and part-time education/training. Primary and secondary levels of education feature several types of schools, most of which are publicly financed. Publicly financed schools are subject to different models of financing and management, depending on their type. Some school types are funded directly by the central government, but are managed by non-profit organizations (so-called academies and free schools). Others are financed and run by local education authorities or are financed by local authorities and run by foundations or churches. In most of these cases, local government has the most influence as it finances these schools' operating costs. However, there are also so-called voluntary-aided schools, where the governing body of the school (i.e., foundations or trusts) pays a (small) share of the capital costs in turn for more autonomy and influence in running the school. The curriculum for most school types is nationally prescribed, only academies and free schools are exempt and can therefore develop their own curriculum, though they are required meet certain broad requirements (e.g., English and mathematics as core subjects). Private schools often charge high fees and do not have to follow nationally determined curricula, though they are subject to regular monitoring by a government body.

Special programs and other features

Free early education

All children aged three and four in England are entitled to 15 hours of free childcare per week. If both parents (or one, in the case of single-parent families) are working at least 16 hours per week and earn at least the corresponding national minimum wage, this can be expanded to 30 free hours per week. However, there is an income cap, above which one is not eligible for the additional 15 hours of free childcare. If parents receive certain social benefits, they might even receive free childcare for children aged two years and older.

Health visitors

Health visitors are usually nurses or midwives with special training. They offer regular, usually at-home check-ups for children up to the age of five. Health visitors are also

there to provide parents with support and answer any questions concerning their infant's health or parenting. If health visitors identify an issue with the infant/child/family, they contact outside professionals or authorities. Health visitors are financed by the NHS and are provided as a free service, which is part of the government's "Healthy Child" approach targeting prevention in children's health up to the age of 19. As a public health service, it falls under the responsibility of local governments. Recent budget cuts in public health have resulted in understaffing and a lack of capacity to reach all parents equally.

School nurses

School nurses are the first medical contact point for children aged five to 19 and form the second part of the "Healthy Child" approach. Throughout their attendance at school, children and adolescents come to the school nurse for medical check-ups and are provided guidance and counseling for social problems. School nurses are employed by the NHS.

Education welfare officers

Local councils are legally obliged to ensure regular school attendance and therefore provide so-called education welfare services through education welfare officers. Providing support to schools, parents and students, these officers are required to intervene in cases of severe problems with regular school attendance. Schools can also refer students and families to education welfare officers for counseling and guidance. In rather severe cases, the education welfare service can also take legal action to compel families to ensure a student's regular school attendance. Every school has an assigned officer.

Family Nurse Partnership

The Family Nurse Partnership is a voluntary program for parents aged 24 and younger. The program offers young parents the opportunity to receive regular visits from a specially trained family nurse who provides guidance and support during pregnancy and throughout the first two years of a child's life. Midwives, who are usually the first contact person for a pregnant woman, can decide whether they think a referral is needed or prove effective. Young parents can also self-refer themselves. This is a free service provided by the NHS.

Sure Start children's centers

Dating back to a central government initiative in 1998, Sure Start children's centers have been managed by local authorities and funded through a general early years

grant by the central government since 2005. Initially targeting support for particularly disadvantaged families, Sure Start centers have since shifted toward a more universal approach. However, 2013 national guidelines state the centers' core purpose should return to "families in greatest need" (Department for Education 2013). Staffed by multidisciplinary personnel, the centers provide services such as counseling or medical care for children up to the age of five and their parents. They cooperate closely with other institutions such as preschool facilities or childminders. According to a recent report (Smith, Sylva, Smith, Sammons, & Omonigho 2018), the number of centers and services are decreasing because many local authorities are struggling with budget cuts and, despite the 2013 guidelines' emphasis on families in greatest need, many centers continue to offer universal services.

Maternity transformation program

This currently underway reform, which is designed to enhance the overall quality of maternity services and deliveries in particular, is implementing the findings of a 2016 government review report. Improving prevention is one of its main goals. The reform also has a fund intended to support and explore innovative projects that incorporate feedback from mothers and their partners into efforts to improve maternity services. The program is being piloted in seven regions and is expected to be expanded.

Paid time off for antenatal care

This is a measure for pregnant and working women. All pregnant employees are entitled to paid time off for antenatal care dates. Antenatal care comprises all sorts of antenatal measures that go beyond medical exams. The father/partner of the pregnant employee is also entitled to paid time off in order to attend two antenatal appointments with their partner.

Publicly financed schools

The two different models of publicly funded schools are a unique to England. There are community schools that are financed and controlled by local authorities and which are required to follow a nationally set curriculum. In addition, there are so-called free schools and academies which are financed by the central government and are not required to follow the national curriculum, though they are subject to regular control of a state agency. These later schools are not managed by local authorities but are often self-governing institutions. Most academies and free schools are secondary schools, but there are also some primary schools among them.

2.5 Fact sheet Finland

2.5.1 General structure

5.5 million residents
16 residents per km²
GDP per capita of € 46,000

Finland is a unitary Nordic state with 19 regions *(maakunta)*, 70 sub-regions *(seutukunta)* and 311 municipalities (*kunta* or *kaupunki*). Legislative power is located exclusively on the national level. The local self-government principle, however, is guaranteed in the constitution, and municipalities are relatively free to choose their local administrative structure. Municipalities are financed mainly through their own taxes, but also through government grants and other sources such as fees.

2.5.2 Preventive structure

General context

Regional competences for children: None. (The regions' main tasks are regional development and planning, and administration of EU funding).

Municipal competences for children: Social services (including all child and youth welfare services, with cash benefits paid partly by the Social Insurance Institution of Finland, Kela), healthcare, childcare, primary and secondary school, public health, culture and sports programming. Municipalities have considerable freedom in determining the kind and extent of services they will offer, and how to organize those services, including those for children.

Health: Every resident of the country has universal access to comprehensive health services. Healthcare is primarily publicly provided, financed through general taxes. This takes the form of municipal health centers with general practitioners, dentists, maternity and child welfare services, school healthcare services, and hospitals owned

and operated by hospital districts. Some specialists also work in private practice, with services financed through the mandatory national health insurance system.

Social security: System is close to the Nordic welfare-state model, with generally universal social services financed by a mix of taxes and/or compulsory insurance payments, which are free of charge at the point of service for the user. Financial benefits are usually paid by Kela, the Social Insurance Institution. There is a variety of benefits available for parents and children. Apart from benefits paid by Kela, municipalities generally bear the responsibility for proving social services.

Education: Children have a right to fee-based early childhood education and care (daycare) from birth until primary school, followed by a free compulsory pre-primary school year (beginning at age six) and free state-funded compulsory education from age seven for every child residing in Finland. Facilities are operated mainly by municipalities, with some private providers also active. Children are required to attend nine years of education in a comprehensive school, with basic education starting at the age of six, the first year serving as compulsory preschool education. These schools are municipally run, provide every child with a free meal and are usually all-day schools.

Key institutions / actors

- Pregnancy: Maternity clinic (part of the municipal health center).
- Issues of special concern under the age of one: Municipal health center, compulsory information exchange with municipal social services.
- Infants (1-6) with behavioral problems: Municipal daycare facility, information exchange with municipal social services.
- Children (6-12) with behavioral problems: Psychologists and school social workers based at municipal school.
- Youths (12-18) who express violent behavior: Psychologists and school social workers based at municipal school.
- Family applications for social assistance: In some municipalities, family centers serve as a coordination center for all family-related social, health and educational issues. Since 2014, the Social Welfare Act has obliged all municipalities to offer free family services to all families who apply for such services, after an individual assessment of their needs.

2.5.3 Overall impression

With its municipally operated childcare services, schools and healthcare centers, Finland has a strongly decentralized system for providing prevention-related tasks. There is a long-standing tradition of prevention (mainly health-oriented) and social inclusion that is quite advanced in comparison to counterparts in other European countries. However, the high degree of municipal independence, combined with the substantial variation in the size of municipalities, hampers the development of comprehensive nationwide measures. The family-center model makes good use of the combined municipal competences, as these centers' main goal is to intervene at an early date, while taking a child-oriented perspective. Experiences with the model thus far are very promising, and the number of family centers in Finland is growing (2019: 138), with varying organizational forms.

2.5.4 Insights regarding the country's specific preventive features

Structure and financing of the local government

In 2018, there were 311 municipalities in Finland; this number has decreased in recent years due to mergers (2005: 444 municipalities). Finnish municipalities vary considerably with regard to geographical size and the number of residents. The municipalities' tasks, however, are the same no matter what their size. As a consequence, municipalities show significant variation with regard to their internal administrative structures. Many engage in cooperative ventures with other municipalities, or contract with private providers to provide services. Municipalities are governed by elected councils, which have direct decision-making power over the municipal administration. Historically, "municipal managers" (*kaupunginjohtaja, stadsdirektör* for cities, *kunnanjohtaja, kommundirektör* for other municipalities) rather than mayors *(pormestari/borgmästare)* have held the most senior positions in the municipality governments. Today, however, both models exist. Nevertheless, both models give the elected council a strong role as compared to other European models.

Municipalities have the right to levy their own taxes. About 40 % of their revenues come from an income tax, 20 % from other taxes such as a property tax, 20 % from means-tested grants from the national government (based on the municipality's relative wealth), and 20 % from other sources such as fees or profits derived from municipal operations.

Regional State Administration Agencies serve as supervisory bodies overseeing the municipalities. These entities review formal compliance with the law; in other respects, however, municipalities are independent in their decisions.

Health system

The Finnish healthcare system is similar to those in the other Nordic countries. It provides universal access to comprehensive health services for every resident of the country, is publicly owned and operated, and is financed mainly through general taxes. In comparison to systems in the other Nordic countries, the Finnish model is more decentralized, and has a more complex mix of funding sources. While they must adhere to the terms of national regulations, municipalities are rather free in determining the form and specific contents of their health services. Municipal health centers providers all primary care services (general practitioners, dentists, maternity and child welfare services, school healthcare). Because of this combination of competences, the municipal health centers are the primary locus for prevention for all age groups, from unborn children up to the elderly. The health centers support parents and cooperate directly with other municipality social services. As a first aspect of prevention, pregnant women (at least 11 examinations during the course of a pregnancy) and small children (16 examinations until school start) receive frequent check-ups in the municipal health center, as well as two visits by a nurse to the family's home. These services are not compulsory, but non-compliance does in some cases carry penalties (e.g., the examinations during pregnancy are a prerequisite for receiving maternity benefits), and they are in fact widely used. Hospitals are owned and operated by a total of 20 hospital districts (21 if the Åland Islands are taken into consideration) that are essentially intermunicipal associations. Municipalities fund their health services through taxes and subsidies provided by the national government. Apart from the municipal services, there are also private healthcare services (doctors in private practice), which mainly handle specialized issues. Patients can receive reimbursement for use of these services from the (obligatory) national health insurance system.

Public health and health promotion in general are also municipal tasks. As is true of the primary health services, the national law does not define specific measures in this area; rather, they are up to the municipalities' choice. Because municipalities co-finance their residents' hospital care and general practitioner treatment using local tax revenues, they have an economic inventive to improve their residents' health statuses. On the whole, health prevention is an important focus in the Finnish health system.

Social security

Falling as it does into the tradition of the Nordic welfare-state model, Finland has an extensive array of general social services. These are generally universal, financed by a mix of taxes and/or compulsory insurance payments, and free of charge for the user. Financial benefits such as pension or unemployment benefits are usually paid by Kela, the Finnish Social Insurance Institution. There are a number of benefits for parents, all paid by Kela, including maternity grants; special maternity, paternity and parental allowances; child benefits; childcare allowances (one of these, the so-called home care allowance, is topped up by some – but not all – municipalities); assistance for ill or disabled children; and child maintenance allowances. The general social assistance benefit, which serves as a last resort for people who are otherwise unable to cover their living costs, is paid by the municipalities.

Apart from the benefits paid by Kela, the municipalities have a general responsibility to provide social services. Institutionally, municipalities and Kela are separate; Kela also runs its own offices across the country, and is increasingly providing online services. In practice, municipalities are the first contact point in all social-services matters. As part of their general counseling work, they refer people who are unaware of the benefits available to Kela. The Child Welfare Act (section 7) also obliges municipalities to exchange information and cooperate in providing municipal services for children (especially social, health, education).

Education

Fees for daycare facilities are relatively low or even nonexistent (depending on the family size and the parents' income, with fees varying between free and approximately € 300 per month). The staff-to-child ratio is very low in cross-European comparison (1:4 for zero- to three-year-olds; 1:7 for older children in regular daycare; and 1:4 in family daycare). In addition, qualification requirements are high, as daycare teaching staff must hold a diploma equal at least to ISCED level five. Municipalities can decide if they want to provide daycare services themselves or contract this out to private providers or cooperative entities run by several municipalities. Parents also have the right to receive an allowance for private daycare for children over three, or to care for the children themselves at home. In this latter case, parents will receive the state home-care allowance benefit beginning when the child is roughly ten months to three years

old. During the child's first nine or ten months of life, the parents care for the newborn at home, while receiving maternal, paternal and parental leave benefits based on income.

Compulsory education begins when the child turns six years old. The first year is a compulsory pre-primary school. After this year, all children attend a comprehensive school for nine years of basic education. These schools are municipally run, provide every child with a free meal and are usually all-day schools. This basic education can be followed by voluntary attendance at an upper-secondary school or vocational school.

Distinctive features, special projects and cooperation

Taking inspiration from Norway and Sweden, some municipalities have implemented a multidisciplinary family-center model. There are national guidelines that apply to these family centers. Their basic approach is to connect all services important for the successful upbringing of a child from a family-oriented perspective (which also involves the parents). The family centers create a network and coordinate public social, healthcare and education services, services provided by non-governmental organizations and parishes, and volunteer-based services. Different municipalities have created different types of family centers, with some being more network-like and others being more municipality-centered. All centers put a strong emphasis on low-threshold services, with the goal of getting in touch with as many families as possible in order to detect problems at a very early stage. As needed, the family centers can provide further help or counseling, or refer families to specialized services. The establishment of family centers is a key element of the National Development Plan for Social Welfare and Healthcare (Kaste Program 2012 – 2015). Extensive research has been performed on the impact of the family centers. They have not yet been implemented in all municipalities, but the overall number is growing (2017: 62, 2019: 138).

Regional State Administrative Agencies oversee the provision of municipal and private social welfare and healthcare services. They evaluate the scope and quality of the basic services provided by local authorities, and grant operating licenses to private service providers. For citizens who want to check whether their local municipality complies with national regulations, the Regional State Administration Agencies are the first point of contact.

The National Institute for Health and Welfare *(Terveyden ja hyvinvoinnin laitos, THL)* conducts research, gathers data, reviews performance, provides information to other administrative bodies, facilitates cooperation, and helps propagate national health and welfare policies. For example, it is the main actor promoting the family centers, providing guidelines, an organizational model, information and experiences from other municipalities, and organizational assistance for the transition phase. The institute also engages in data collection and conducts performance reviews for governmental and non-governmental actors in the health and welfare sector. This of course includes the municipalities. The institute has limited ability to intervene, however, due to the municipalities' broad leeway in the implementation of national regulations and in their actual service provision.

2.6 Fact sheet France

2.6.1 General structure

64.8 million residents
117 residents per km2
GDP per capita of € 31,979

France is a unitary semi-presidential representative republic. The directly elected president has significant influence over the policy landscape and the power to appoint the prime minister and other ministers. The legislature consists of a bicameral parliament, with one body that consists of elected representatives from the territorial communities (the Senate), and one popularly elected body (the National Assembly). The latter plays a more significant role in legislation.

France has a traditionally strong central government. Below the central level there are 13 regions, 96 departments *(départements)* and more than 35,000 municipalities. Lower levels of government are funded through the provision of a share of national taxes, state subventions and taxes levied at that territorial level.

2.6.2 Preventive structure

General context

Local-level competences: Most competences lie with the central government. However, some competences for children and young people are decentralized. For example, the regions are responsible for the infrastructure of senior high schools while *départements* are responsible for certain social and welfare benefit programs, junior high schools, and health services for mothers and children. The municipalities are responsible for preschools, primary schools and voluntary social services.

Health system: There is a mandatory and universal state-run health insurance program that is financed by payroll taxes, income taxes, taxes on certain goods and state subsidies. This covers a large proportion of medical procedures, prescriptions and medical

devices; however, a small copayment is usually necessary. Additional voluntary health insurance (usually by non-profit organizations) may cover these copayments. Children under the age of 18 are generally exempt from any copayments. Many pregnancy-related expenses are fully covered, as are certain medical examinations during a child's first six years. Five preventive dental examinations for children (ages 3, 6, 9, 12 and 15) and three for adolescents (ages 18, 21 and 24) are also covered.

Social security: There is a mandatory and universal system that is financed by income deductions, taxes, social contributions and state subsidies. Noncontributory "active solidarity income" is paid on the basis of a person's status and number of children. A wide range of family benefits is offered.

Education: Compulsory and free public education is currently offered between the ages three and 18 (before September 2019, this was between the ages six and 16). Public preschools are also free of charge. The central state is responsible for school curricula and teaching staff; lower levels manage school infrastructure and technical personnel.

Key institutions / actors

- Pregnancy: Pregnancies are handled by family physicians / hospitals, midwives or social centers; a pregnancy has to be declared officially (usually by a midwife or family physician). Networks of medical actors work together to make sure pregnant women get the best support possible. Social centers in *départements* and municipalities might offer additional services.
- Issues of special concern under the age of one: Family physicians / hospitals; social centers. Networks of medical actors work closely together, and there are additional support networks for parents in place for referrals to other sectors. Social centers in *départements* and municipalities might offer additional services.
- Infants (1-6) with behavioral problems: Issues of this nature are handled by preschool facilities. "Education teams" at every school that include a head teacher, specialized teachers and school physicians determine problem-solving measures which can involve external professionals. Networks preschools and primary schools provide mutual support.
- Children (6-12) with behavioral problems: Primary schools are responsible for addressing these issues. "Education teams" at every school that include a head teacher, specialized teachers, school physicians determine problem-solving

measures which can involve external professionals. Routine nationwide "skill checks" are conducted every year, personalized measures can be designed afterwards.
- Youths (12–18) who express violent behavior: Secondary schools are responsible for addressing these issues. Educational committees that consist of teachers, health personnel and representatives of other institutions (e.g., local authority, police) draft violence prevention programs. Police representatives are assigned to every school, and there is a catalogue of disciplinary measures.
- Family applications for social assistance: Local family-benefit funds office; social centers. Children-parent centers offer services for families, financed by the family-benefit funds and the municipality. Social centers in *départements* and municipalities might offer additional services.

2.6.3 Overall impression

France's benefit systems are dominated by networks, especially in the education and health sectors. These are designed to guarantee the best support possible for women, families, children and adolescents by connecting them with a variety of actors in these sectors. However, the country's social sector seems to be excluded from this network-based approach. Interestingly, we find here a centralized approach, with somewhat overlapping institutions at the different levels. Moreover, the *départements,* which are designated as lead policymaking actors in this sector, are required to coordinate the different services. The team/committee-approach in education is well-suited to tackling any school-related problem; this is further supported by close cooperation with external actors. The *départements* offer many additional voluntary services, especially for adolescents, such as youth health centers, youth houses and youth centers.

2.6.4 Insights regarding the countries' specific preventive features

Health system

Thanks to its expansive approach and coverage, France's health system is often deemed to be one of the world's best. The State Health Insurance (SHI) system, which is essentially mandatory and universal, is the system's foundation. Nearly every French citizen is covered by SHI; opting out is rarely possible. It is financed by payroll taxes, income taxes, taxes on certain goods (e.g., tobacco) and state subsidies. The central govern-

ment plays a role in overseeing the public insurance funds and their structures, and in negotiating insurance reimbursement rates. The Ministry of Solidarity and Health wields general oversight authority; in the regions, it is represented by regional health agencies that are responsible for implementing national health policy.

SHI covers a large proportion of procedures, medications and medical devices; however, patients generally have to provide a small non-reimbursable copayment for services, and are reimbursed only a percentage of their overall expenditures (e.g., only 78 % of the costs of physician visits are covered by the SHI). The copayments may be covered by voluntary health insurance plans that offer complementary insurance. Most voluntary health insurance is provided by non-profit organizations such as employment-based mutual associations; private, profit-oriented insurance offers further supplementary insurance for a limited number of services. Children up to the age of 18 do not in general have to pay the non-reimbursable copayments. Persons with incomes below a certain threshold are entitled to use the health system for free (in addition to the regular SHI coverage, they are entitled to a state-financed complement, so that 100 % of their expenditures are covered).

Services related to compulsory prenatal examinations are covered to a level of 100 %, as are all medical expenses (including doctoral visits, medicine, care etc.) incurred between the first day of the sixth month of pregnancy and the 12th day following birth, even if they are not pregnancy-related. A total of 17 medical examinations during a child's first six years are also fully covered by the insurance.

Children and youths are also entitled to five preventive dental examinations at different ages; two of them are obligatory, but all five are covered by SHI.

Every person insured by the SHI is eligible for a prevention health exam; this is to identify diseases one might be unaware of, and to prevent the further development of problems.

Social security

All French persons are subject to the social security system. This is financed by contributions deducted from incomes (the percentage varies for earnings beyond a certain threshold), taxes, social contributions and state subsidies. This is meant to

finance social benefits and allowances in five areas (important in the prevention context are the health/maternity/paternity branch and the family branch). Besides payments for taxpayers, there is also a benefit system called "active solidarity income" paid to persons without resources. Its level varies according to the beneficiary's income status and number of children. Recipients must apply with different institutions depending on the type of social transfer; in the case of maternity/paternity and family benefits, for example, the local family-benefit funds are responsible.

Education

The education system in France consists of several components, some of which are compulsory, while others are not. A child starts their school career by attending a preschool *(maternelle)* or kindergarten or daycare facility. Preschool attendance is not obligatory until the age of three but is free of charge and therefore rather popular. Preschool attendance between the ages of three and six became obligatory in September 2019. Compulsory primary school *(primaire)* starts at the age of six and lasts until the age of 10 (fifth grade). Afterwards, children are required to attend a junior high school *(collège)* through the age of 16 (ninth grade). After passing a final exam *(brevet)*, children can either conclude their school career or attend a senior high school *(lycée)* in order to gain permission to study at a university *(baccalauréat)* or obtain a vocational training certificate *(Certificate d'aptitude professionnelle)*. Since September 2019, young people aged between 16 and 18 have been required to pursue either individual education or some other personal-development activity (e.g., traditional schooling or vocational training, another form of training, or participation in a voluntary service or employment).

The central government, specifically the Ministry of Education, is responsible for the content and structure of school curricula and for hiring educators. The lower levels of government are in turn responsible for funding other education needs (e.g., infrastructure and technical personnel). For example, *regions* manage senior high schools, *départements* the junior high schools and *communes* the primary schools and preschools. Kindergartens and other preschool level institutions can be managed by local authorities, parents, associations or private companies.

The majority of schools are public (in 2016, a total of 52,014 or 85.6 % of all schools were public, compared to 8,709 or 14.4 % that were private; this figure includes all pre-

schools, primary schools, junior and senior high schools). Public education is free of charge. Most private schools also receive state funding (specifically for teacher salaries) and are required to follow the official curriculum. Additional expenses are paid through school fees, which are usually not significant.

Special programs and other features

Family-benefit funds

The family-benefit funds *(Caisses d'allocation familiale, CAF)* are responsible for the family branch of social security. There is one national fund subject to public oversight and one in each *département,* each of which is privately organized. The national fund manages a network of all the local funds, and signs agreements for disbursements, such as copayments when joining local funds in sponsoring certain measures or activities for families and children. Though organized privately, the local funds perform a public service, and are responsible for paying benefits for families, births and early childcare. Furthermore, they carry out and finance other social services related to children and families, such as counseling and training for private childcare workers.

Social centers

Départements and municipalities operate social centers (typically *Centers départementaux d'action sociaux* at the departmental level, and *centers communaux d'action social* at the municipal level, although names may vary throughout France). Because they provide a range of different services depending on the structure and inter-level relationship, the character of such services may vary across the country. Usually, these centers offer counseling and guidance, health services, or assistance with navigating the social system. To avoid conflict between the services provided by municipalities, *départements* and the family-benefit funds, *départements* coordinate the various actors' services.

Children-parent centers *(Lieux d'accueil enfants-parents)*

These are social facilities designed for parents and their children (up to the age of six) to spend time together (e.g., playing games). Trained personnel in these facilities also offer support such as counseling for parents. The centers are financed by the local family-benefit funds and local authorities or associations, and thus charge no fees (though symbolic fees are charged in some cases). The centers can be found in many places across France.

Centers of mother and child protection *(Centers de protection maternelle et infantile)*

Located in and organized by the *départements*, these centers offer guidance and protection/prevention services for mothers and children (up to the age of six). Services include birth preparation or other medical consultations conducted by trained personnel; the centers are led by a medical doctor. Every mother is issued a pregnancy record book to keep track of examinations and birth preparations; this booklet also provides further additional practical information.

Health networks *(Les réseaux de santé)*

There are a number of health networks across France that coordinate medical experts and other professionals in the health sector. These networks are financed and organized by the regional health agencies. There are also specialized health networks for pregnancy and motherhood, which aim to provide women seeking guidance and counsel with the best possible support.

Networks to listen to, support and accompany parents *(Les Réseaux d'Écoute, d'Appui et d'Accompagnement des Parents)*

Départements organize these networks, which consist of voluntary actors from different sectors (e.g., parents, social workers). They are intended to support parents, for instance by providing counseling or connecting parents to other parents. They also convey requests and opinions to political actors. There is a single network at the *département* level which, in turn, organizes local networks in the bigger cities. The networks are financed by the national government, family-benefit funds and other public bodies.

Support network for single-parenting families *(Le réseau "Parents solos et compagnie")*

This is an initiative started by the national government in conjunction with several parental associations. These networks unite a variety of actors in the area of single-parenting, with the goal of gathering ideas and creating projects to support single parents. The networks started in five *départements* and have slowly expanded throughout France since 2016. The networks are funded by a foundation which, in turn, receives private donations and public subsidies.

Youth houses *(Maisons des Adolescentes)*

Youth houses are public "open spaces," that are located in nearly every *département* for young people aged 11 to 25. Trained staffers here listen to problems and offer advice and/or support. The houses collaborate closely with partner institutions (e.g.,

youth centers). The houses can also be used by entire families. Generally financed by the state (regional health agencies, departmental councils, sometimes also regional council and other public entities); additional financing sometimes comes from other public and private partners.

Youth centers *(Points Accueil et Ecoute Jeunes)*

Youth centers generally complement youth houses, usually with more than one per *département.* These are places for young people to receive advice on a variety of youth-related problems. They can be visited by individuals, groups and families. Usage is free; they are financed by the national state and departmental institutions, usually with participation by additional local partners.

Child daycare for unemployed / job-seeking people *(Les crèches à vocation d'insertion professionnelle)*

This is an initiative organized by three ministries, the family-benefit funds and the employment agency, which created a special designation for certain daycare institutions. This designation indicates that the daycare institution offers special places to the children of unemployed people (for a certain amount of time per week) to support these parents in caring for their children while they are looking for a job. The parents have to sign a contract that obliges them to take part actively in job-seeking activities; in exchange, they get a free place in the daycare center for their child.

Personalized education success program *(les Programmes Personnalisés de Réussite Educative)*

This is a measure that can be enacted at any time during the course of compulsory education. Its aim is to make sure every pupil acquires the needed skills at each stage of their compulsory school career. If a teacher notices a pupil has problems with the curriculum (or has failed at the annual national evaluations at the primary-school level) the school can enact personalized measures to help the pupil improve. The school's education team is involved, and further external experts may be consulted. The measures conclude once the teacher finds a pupil's problems have been solved.

Local school contracts *(contrats locaux d'accompagnement à la scolarité)*

Local school contracts are financed by local family-benefit funds and organized by the *département.* These contracts establish sessions for children in which trained personnel provide support for school-related problems. Parents are also meant to participate in

these sessions, in part to spend time with their children, and in part to obtain parenting support. The contracts are conducted in close cooperation with schools.

Education prioritaire

This is a government program for underprivileged pupils in problematic areas. The overarching idea of this program is to support these pupils and prevent them from being socially excluded due to educational deficits. Participating teachers and other school personnel are given special training, and the curriculum is different than that in regular schools. Usually, the schools participating in this project are organized in networks.

2.7 Fact sheet Germany

2.7.1 General structure

83 million residents
232 residents per km²
GDP per capita of € 37,602

The Federal Republic of Germany is a parliamentary democracy with two chambers of parliament, the *Bundestag* (elected by the citizens) and the *Bundesrat* (with representatives of the states). Germany is a federal state with a three-tiered system of government: the national level (the *Bund* or federation), the states *(Länder),* and a two-tiered system of local government with counties *(Kreise)* and municipalities (*Städte* and *Gemeinden*). Overall, Germany consists of 16 states, 294 counties *(Landkreise)* and 11.014 municipalities *(Gemeinden)*. A total of 107 independent cities *(Kreisfreie Städte)* combine the functions of counties and municipalities. Combined with the important role played by the social insurance programs, this results in a rather fragmented administrative landscape. Legislative power is shared between the federal level and the federal states. Administrative power lies mainly with the federal states, counties and municipalities, with the specific level depending on the issue. The German local-government structure is very diverse, and ranges from large units in North Rhine-Westphalia to very small-scale units resembling those of France (e.g., in Bavaria and Rhineland-Palatine).

2.7.2 Preventive structure

General context

Legislative powers are generally shared between the federal level and the states. Most issues having to do with prevention are governed by federal laws which are then adapted into state law. The core functions of the German welfare state are administered on the one hand by autonomous administrative bodies *(funktionale Selbstverwaltung)* operating as social insurance entities with a single-purpose logic from the federal level down to local agencies, responsible for areas such as old-age pensions, long-term care insur-

ance, employment insurance, health insurance and occupational-risk insurance. On the other hand, the basic functions of the welfare state, such as provision of minimum subsistence benefits, childcare and youth welfare services, are decentralized to the – also self-administered – local governments. This fragmentation of social-services provision is further increased by the delegation of direct social-services provision to third-sector associations and (to a lesser but increasing extent) private for-profit providers.

Local-level competences: Local governments are tasked with administering most child- and youth-related responsibilities *(Selbstverwaltungspflichtaufgaben).* Usually, social tasks are delegated to the upper level of the two-tiered system of local government, the counties and independent cities. In addition, municipalities are free to implement additional voluntary policies with no restrictions. These non-mandatory policies include childcare, youth work, social work and various counseling services provided in youth welfare offices. The municipalities are also responsible for interventions into families and the provision of special care and foster care. Besides youth-related tasks, local governments are responsible for social assistance and the material aspects of school administration (buildings and building maintenance).

Health system: The public health insurance system is mandatory for every employee, for persons claiming unemployment benefits, and for pensioners. Exceptions exist for civil servants and self-employed people. The federal government holds legislative and administrative competences in the area. Financing of the medical services is divided between the federal states (hospitals), the health insurance entities and the social insurance entities in a complicated manner.

Social security: Mandatory insurance programs for common life risks (e.g., health insurance, unemployment insurance, pension insurance). In addition, there is a tax-financed public assistance program *(Grundsicherung für Arbeitslose, ALG II)* for unemployed work-seekers who are not covered by the primary unemployment insurance benefit (ALG I); this is aimed at covering the basic needs of individuals who are ineligible for insurance benefits and who are unable to cover living costs on their own. There are two distinct provision models for ALG II: the common local government job centers or employment agencies and the so-called Opting Model *(Optionskommunen),* which involves a decentralization of all tasks to local governments.

Education: Since 2013, children older than one year have had a right to childcare, with the level of copayments dependent on the state and municipality. The rate of childcare use is lower than the EU average for children under three but is increasing. School attendance is mandatory between the ages of six and 15, under federal-state law. Schools are administered by the states, while municipalities are responsible for maintaining the school buildings.

Key institutions / actors

- Pregnancy: Midwives and gynecologists provide mandatory examinations. Early prevention services also offered.
- Issues of special concern under the age of one: Gynecologist and family midwives provide mandatory examinations. Early prevention services also offered.
- Infants (1-6) with behavioral problems: Daycare facilities (municipal, church and private).
- Children (6-12) with behavioral problems: Primary school: school psychologists and school social workers.
- Youths (12-18) who express violent behavior: School: school psychologists and school social workers; in severe cases, these entities work with the municipal youth department.
- Family applications for social assistance: No standardized approach. Social offices in some municipalities incorporate multiple social services. Early prevention services also offered.

2.7.3 Overall impression

The administration of social policy and services in Germany is marked by a high degree of fragmentation, significant autonomy from direct state control *(Staatsferne)* and functional differentiation. The core functions of the German welfare state are administered on the one hand by autonomous self-administrative bodies operating as social insurance entities with a single-purpose logic from the federal level down to local agencies, covering areas such as old-age pensions, social care, unemployment insurance, health insurance and occupational-risk insurance. On the other hand, basic welfare-state functions such as the provision of minimum subsistence benefits, childcare and youth welfare services are delegated to the local governments, which are also self-administered. This dual architecture is a challenge with regard to the universality of preven-

tive systems. Nevertheless, several programs on the state level address these problems, mostly by the establishment of networks and additional resources for cooperation

2.7.4 Insights regarding the country's specific preventive features

Structure and financing of the local government

State power is divided between the federal level and the states. As a basic rule, the Basic Law stipulates that the execution of power is a matter of the states (Art. 30 GG, Art. 83 GG). The states thus bear primary responsibility for implementing policy. The usual model is that administrative tasks are defined by federal laws, but executed by the states and local governments. Local governments have autonomy in handling any local problems unless there are conflicting federal or state regulations (Art. 28.2 GG). This also applies to counties. Important areas of local self-government include land use plans, construction plans, municipal road management, planning of green areas, waste disposal, wastewater disposal, energy supply, child and youth services, museums, libraries, kindergartens, public baths, and local economic development.

Social tasks are usually delegated to the upper level of the two-tiered system of local government, the counties and independent cities. These entities hold the largest share in the implementation of child- and youth-related tasks, with their responsibilities encompassing general youth care, social assistance offices, public health offices and services for the disabled. Youth welfare offices *(Jugendämter)*, whose tasks are regulated by the Child and Youth Act (SGB VIII), are key actor with regard to child-related tasks. Their responsibilities encompass childcare, youth work, social work and a variety of counseling services. They are also responsible for family interventions and the provision of special care and foster care. As a downside, they are often not popular among families, as they still have the stigma of intervening in family matters against the family's will (an area of activity which in fact constitutes only a small segment of these offices' portfolios). Counties and independent cities also administer social assistance programs, and to a certain extent also the basic assistance program for long-term unemployed people (SGB II). However, two alternative administrative models are used to serve this latter population; most often, local governments work with the federal employment agencies, but in a minority of cases *(Optionskommunen)*, local governments address this task on their own.

Local governments have the right to municipal self-government in all areas of the local community that are not regulated at the federal or federal-state level. Municipalities have a limited ability to raise their own tax revenues. About 24 % of their revenue comes from their own taxes (usually property taxes and business taxes), while 9 % comes from fees and other charges (e.g., for water supply and waste collection), 13 % from sharing in national taxes (15 % of the income tax and 3.2 % of value-added tax go to local governments), 38 % from grants from the state government, and 16 % from other sources. As business taxes and national taxes are highly correlated with economic performance, vicious cycles can develop, with poorer communities left with less resources.

Health system

Regular employees and public benefit recipients in Germany are required to belong to a public health insurance scheme. These are funded through equal contributions paid by employers and employees. Employees can choose between 117 different health insurance entities, which are constituted as public law bodies *(Körperschaften des öffentlichen Rechts).* However, their offerings and the associated contribution levels are very similar. Exceptions exist for self-employed people, who can choose between public and private health insurance plans. Civil servants are provided with public subsidies *(Beihilfe),* and thus pay reduced private health insurance contributions. Within the public system, family members of the insured person (non-working partner and children) are insured without having to pay a contribution. The unemployment insurance system pays contribution for unemployed persons, while welfare offices pay the contributions for people receiving public assistance.

The states are responsible for planning hospitals, and for part of their financing. While hospitals are often run by third-sector organizations or churches, private for-profit providers are accounting for an increasing share. Outpatient health services are run mostly by independent doctors acting as general practitioners or specialists, whose services are reimbursed under the health insurance schemes. Provisioning and licensing is organized by the doctor's professional associations *(Ärztekammern).* As a consequence, the healthcare sector has a great deal of autonomy from local governments, which presents a challenge with regard to developing integrated prevention policies. Some local networks seek to coordinate the actors (e.g., health conferences, health networks), but these structures are rather diverse.

Social security

Germany's social security system is based on several mandatory insurance programs covering common life risks. The most important social insurance schemes include health insurance, unemployment insurance, pension insurance and long-term-care insurance. The Federal Employment Agency *(Bundesagentur für Arbeit)*, which counsels young people on their entrance into the labor market, is also responsible for important social security tasks. In addition to handling placement services and the payment of insurance benefits, the employment agency is involved in the administration of basic security benefits (*Grundsicherung* according to SGB II), which it delivers in partnership with local governments. This means-tested benefit is intended to cover the basic needs of persons (and their families) who are not eligible for insurance benefits and are not otherwise able to meet the requirements of subsistence. The basic security benefits are jointly funded by the federal government (for general living costs) and the municipalities (for rental and heating costs). Federal subsidies can also be provided for rental and heating costs. Families with children can receive extra payments for costs arising in schools or in cultural or sport activities.

Apart from social insurance benefits, there is general child allowance which can be increased for needy families *(Kinderzuschlag)*, and several programs for parents, including a per-child benefit and paid parental leave (*Elterngeld* und *Elternzeit*).

Education

Use of formal childcare in Germany is increasing, but for children under three, the rate is still below the EU-28 average. In 2019, 34.3% of all children between zero and three were in daycare. By contrast, 93% of all children between three and the compulsory school age attended daycare. In this latter age group, Germany is above the EU-28 average of 86.3%. Copayments for daycare vary substantially between states and local governments. Whereas some states (e.g., Rhineland-Palatinate) offers free childcare, other states have varying schemes, often with specific rules for families with low incomes. The amount of the copayment varies significantly between the federal states, and even the specific daycare facility, and usually reflect both the amount of time spent in care per week and the parents' income. About one-third of the country's daycare facilities are operated by the municipalities, and about two-thirds by third-sector organizations or churches. Municipalities are responsible for providing daycare

or for financing delegated daycare services. Legislative power in this area rests with the federal government and the federal states. The federal states are responsible for infrastructure investments, but not for daily maintenance or staff-related costs.

Schools are the responsibility of the federal states. Children are obliged to attend nine or 10 years of school, usually from the ages of six to 15. For their first four to six years of education (depending on the state), all children attend a primary school *(Grundschule)*. In the following years, parents can decide whether their children will attend a secondary school (terminology depends on states) for four or five years, or an academic secondary school *(Gymnasium)* for eight or nine years. Most state have reformed their school systems to encompass more inclusive schools with an internal differentiation according to achievements (*Gesamt-* or *Gemeinschaftsschulen*). The main school can be followed by vocational schooling *(Berufsschule)* in combination with a practical apprenticeship. Networks of school psychologists responsible for schools with a certain area offer counseling to teachers and pupils who experience specific problematic situations. The psychologists are employed by the states and have no direct links to local governments or other service providers.

The municipalities do not play a major role in the German education system. However, they do finance the construction and maintenance of all compulsory schools (primary and secondary schools), and are responsible for some additional aspects such as pupils' transport by bus.

2.7.5 Distinctive features, special projects and cooperation

Preliminary note: Due to the federal nature of the German political system, all German states have specific programs of relevance to this study. The diversity of these programs makes it impossible to include all of them in these fact sheets. These include special offers for families, childcare facilities, programs for children's health, language lessons, and programs preparing youths for school and the job market. In this fact sheet we concentrate on widespread (mostly national) projects with a universal approach.

Early prevention

The Early Prevention *(Frühe Hilfen)* program was created in 2007, and codified in 2012 *(Gesetz zur Kooperation und Information im Kinderschutz)*. Its goal is to provide assistance to families at the earliest possible stage, by offering coordinated and multidisciplinary child-development. It focuses on families with young children, with personal counseling services for mothers and fathers as well as pregnant women and their partners (early intervention). One goal is the development of stable cooperation structures between relevant child protection services and institutions. The network of providers is organized by local youth welfare offices. The program is responsible for the provisions of midwives to the expectant parents, but also involves numerous other stakeholders (doctors, teachers, police) in the establishment of an early warning system with special authorization to provide information to the youth welfare office. A National Center for Early Prevention *(Nationales Zentrum Frühe Hilfen)* coordinates the activities, gathers data and provides information and professional development, seeking to ensure a consistent practice.

Family centers

Nearly all German states have initiated funding programs for family centers. In most cases, these are centered on daycare facilities or primary schools, and are not robustly funded. The inclusion of other services tends to be handled on a case by case. Their main purpose is to be in the neighborhood beyond the usual opening hours.

Social work at schools *(Schulsozialarbeit)*

Nearly all states have programs that fund social workers in the schools. In contrast to school psychologists (see above), these social workers are employed by local governments or third-sector organizations, and are tasked with connecting the schools with other services.

All-day schools *(Ganztagsschulen)*

In the last decade, all-day schools have become more common in all states, and are supported by state funding (especially for the necessary facilities adjustments, such as the establishment of canteens; but also for additional service offerings and social work).

The most important funding program in this area was the Future Education and Supervision Investment Program *(Investitionsprogramm Zukunft Bildung und Betreuung, IZBB)*

Prevention law *(Präventionsgesetz)*

The 2015 Prevention Act establishes a prevention conference, and allows health and care insurance programs to fund preventive measures. In addition, some funding under the act is provided to support groups. Specific programs for children and young people are not ongoing and involve intermittently provided services (e. g., vaccinations). The Social Security Code (SGB V, §20) supports prevention programs in specific life situations (daycare centers, schools, independent institutions, municipalities).

Prevention chains

A number of states have sought to establishment local prevention chains. Several states (Berlin, Hamburg, Baden-Wuerttemberg, Lower Saxony) have funded local-government pilot projects similar to North Rhine-Westphalia's "Leave no child behind!" program. Whereas in the city states of Berlin and Hamburg, these projects are led by actors and institutions in the health sector, in Baden-Wuerttemberg and Lower Saxony, youth welfare offices are responsible for the coordination of preventive offers.

2.8 Fact sheet Ireland

2.8.1 General structure

4.85 million residents
69 residents per km²
GDP per capita of € 58,846

Ireland is a parliamentary republic. The government consists of a strong prime minister and a cabinet of ministers. Legislative power is vested in a bicameral parliament with an upper and a lower house, with the latter enjoying most of the legislative powers. The head of state is the directly elected president, who has mainly ceremonial functions. Ireland's administrative architecture is strongly centralized. Below the rather strong central government, which has most political responsibilities, there are 31 local authorities. These are divided into three types: city councils, county councils, and city and county councils. On a lower level, these localities are again divided up into 95 municipal districts. Local authorities depend on government subsidies and, to a lesser degree, on local taxation.

2.8.2 Preventive structure

General context

Local-level competences: Nearly no competences in children- and youth-related areas are vested in the lower administrative levels; one exception are the local authority representatives in 16 statutory regional education and training boards, which usually manage specific schools. The government has created local children and young people's service committees to coordinate local services in 27 overarching regions.

Health system: The central national public Health Service Executive (HSE), organized in four administrative areas, provides nearly all medical services, which can be used by all permanent residents in Ireland. The national health system is tax-subsidized, but (in contrast to the United Kingdom) there are some fees for general medical services (non-cost-coverage share; however, means-tested "medical cards" and "general

practitioner visit cards" provide free access to certain services. Optional private insurance may cover certain additional medical services. Children aged six or below can claim a "general practitioner visit card for children under 6" that allows for free doctor visits up to the age of six. Certain services for children and expectant mothers are provided for free.

Social security: Employees pay social insurance contributions that are in turn used to finance several contribution-based benefits. In addition, there are also certain non-contributory but means-tested benefits, as well as universal benefits. The system is centrally organized, with 125 local offices.

Education: Education is compulsory from the ages of six to sixteen, though most children start at the age of four in so-called infant classes at primary schools. Children are entitled to two free preschool years. The central state has overall (funding) responsibility, but management of schools is usually private (e.g., by churches or foundations), sometimes by statutory regional boards.

Key institutions / actors

- Pregnancy: HSE (public health center / hospital with general practitioners), family resource center (Tusla); free antenatal care and postnatal examinations (Maternity and Infant Care Scheme) are provided by general practitioners in public health centers and maternity units in hospitals. Family resource centers, a Tusla service, provide information and support to families; these are additionally connected to other community actors.
- Issues of special concern under the age of one: HSE (public health center with general practitioners and public health nurses); every child is entitled to certain developmental exams after the birth, provided for free by a general practitioner in the local health center. A public health nurse visits the family at home during the first six weeks after the birth at no cost. There is no formal cooperation with other sectors.
- Infants (1-6) with behavioral problems: Preschool facility; every child is entitled to two free preschool years. There are no formal cooperation guidelines with other sectors or professionals; however, there are general guidelines for development of a code of behavior. Preschool facilities are subject to oversight by Tusla. Furthermore, there are special programs for especially disadvantaged

areas (the so-called Area Based Childhood Program and the Early Start Program) with different projects (e. g., information for parents, special courses for practitioners etc.).

- Children (6-12) with behavioral problems: Schools, educational welfare officers. There are no formal guidelines for cooperation with other sectors or professionals. Special programs for especially disadvantaged areas exist, as described above. Schools must have a code of conduct and are the main actors in this area. Tusla can be involved, with educational welfare officers at every school; these help to support school attendance by helping schools, parents and pupils that have problems that impede regular school attendance; these officers may also take legal action against parents if they fail to ensure a child's regular school attendance.
- Youths (12-18) who express violent behavior: Schools, educational welfare officer. There are no formal guidelines for cooperation with other sectors or professionals; special programs for especially disadvantaged areas exist, as described above. Schools must have a code of conduct and are the main actors in this area; educational welfare officers may also be involved.
- Family applications for social assistance: Social welfare local and branch offices; no formal guidelines for cooperation with other sectors or professionals. However, receiving a social welfare payment (and passing a means test) might entitle parents to additional benefits, such as further financial support to buy school uniforms ("back to school clothing and footwear allowance").

2.8.3 Overall impression

There is a strong centralized health sector, but cooperation with other sectors is (currently) weak. The administrative services within the various sectors vary in size, and are incongruent. There are many special but uncoordinated programs with a focus on especially disadvantaged target groups. In general, there is a focus on targeted rather than universal support measures. Currently, a number of reform programs are ongoing, with the aim of improving prevention and cooperation between sectors. One such example is an extensive national policy framework for children and young people ("Better Outcomes, Brighter Futures"). Children and young people's service committees on the local level are tasked with improving cooperation between different service providers to realize the goals set out in this framework. The 2014 creation of Tusla, the national child and family agency, brought a number of services from within different sectors under one roof, and might enhance cooperation structures and processes.

2.8.4 Insights regarding the country's specific preventive features

Health system

The central national HSE is a public entity overseen by the minister for health. It provides nearly all medical services in the country and can be used by all permanent residents in Ireland. HSE is responsible for all health centers (local centers providing several health services in nearly all cities) and their staff, including doctors and public health nurses, as well as many hospitals and other medical services. The country is divided into four administrative HSE areas, with HSE branch offices managing all health services in these areas; the branch offices also consult regularly with the local authorities in their regions. There is no obligatory state insurance of the kind seen in other countries, so in general – with a few exceptions, as for laboratory services or specialist assessments – a fee has to be paid for medical services. However, a means-tested medical card for the poor gives free access to many services. In 2018, 32.4 % of the population held a medical card. People with slightly higher incomes that are still under a certain income threshold may receive a so-called "general practitioner visit card," which allows for free visits to general practitioners. In 2018, 10.4 % of the population held a general practitioner visit card. Private insurance may be purchased to cover costs for certain medical services; according to the national Health Insurance Authority, around 46 % of the population had a private insurance plan in 2019. Children aged six or below can obtain a "general practitioner visit card for children under 6" that allows for free doctor visits up to the age of six. This card also entitles children to two free developmental exams at the ages of two and five. Certain services for children are free in general, such as school entrance health exams and additional early-life developmental exams.

Social security

In Ireland's social insurance system, employees pay social insurance contributions that are in turn used to finance different contribution-based benefits (e. g., unemployment or illness benefits). The amount of contributions paid usually determines the amount of benefit payments a person receives. There are also certain noncontributory but means-tested benefits targeted especially to people or families in need, such as payments for working parents or long-term unemployed parents. Certain benefits such as child

benefits are paid universally upon fulfillment of the requisite conditions. Applications for social benefits have to be filed with the social ministry, which has around 125 local branches in the Irish counties.

Education

Education in Ireland is compulsory between the ages of six and sixteen. However, most children start so-called infant classes at primary schools at the age four. Schools are usually organized privately (e.g., by religious communities), but are funded publicly by the central government and are therefore free to attend. However, many secondary schools are organized by local education and training boards, which are statutory education authorities organized in 16 regional areas (which usually include multiple counties and/or cities), financed by the central government. There are also (rather costly) private schools. The Irish constitution gives parents the right to teach their children at home, so there is no duty to attend a school; however, the state has to provide at least primary education for free, and is required to ensure that children receive a certain minimum degree of education. Before going to school, many children attend a preschool facility, as all children are entitled to two free preschool years. Preschool activities are usually privately organized but have to fulfill public regulations. Furthermore, there are several schemes that help parents pay childcare costs, for example if they take part in certain public-employment measures, or which pay for after-school care if a family cannot otherwise afford this. In 2019, these various schemes were replaced by a new universal scheme that offers universal subsidies for all families with children under three, as well as targeted, means-tested subsidies for families under a certain income threshold with children aged 24 weeks to 15 years.

Special programs and other specific features

Early Start Program

The Early Start Program is a targeted national development program managed by the Irish Education ministry that addresses children aged three to four in disadvantaged regions. A total of 41 primary schools in preselected areas participate in this program. The program consists of one free preschool year for children in these areas, and provides special lessons in speaking, cognition, and social and personal development. The core idea of this program is to prevent children in disadvantaged regions from suf-

fering further disadvantages in their school career and personal life; it also addresses parents, who play a vital role in their children's education. The program has been running since 1994.

Early Childhood Care and Education Scheme (ECCE)

ECCE entitles all children to two free preschool years between the ages of three and five-and-a-half. The program pays for a specified number of hours per day and week, depending on the type of preschool facility. Parents can claim this entitlement directly at their preferred facility. The facilities need to comply with nationally set standards on early education and care, and are subject to regular inspection by Tusla.

Better Outcomes, Brighter Futures

In 2014, the Irish government released its first national policy framework for children and young people. This sets a variety of overarching goals aimed at transforming and enhancing the lives of young people up to the age of 24. It is slated to run until 2020. It explicitly addresses prevention and early intervention, and strives for an equal approach among the various ministries and agencies concerned with young people. In 2017, a new indicator set was released for the purposes of tracking and measuring the outcomes of the framework.

First 5 Strategy

The First 5 Strategy was released in 2018 as a decade-long "whole-of-government strategy for babies, young children and their families" covering the 2019 – 2028 period (Department for Children and Youth Affairs, 2018). It includes several goals associated with families and children, as well improving access to a range of options in the "first five" areas of work-childcare balance, parenting support, child health, early education and care, and efforts to combat child poverty. The first implementation plan (2019 – 2021) sets several concrete milestones (e.g., increasing paid leave for parents, establishment of a digital immunization information system), and makes preparations for later implementation plans. The Department of Children and Youth Affairs (DCYA) takes the lead role in implementing the strategy; however, other government departments and agencies are involved, as well as civil society organizations.

Tusla

Tusla (rather than an acronym, this is a new word, symbolizing a new start) is the name of a new child and family agency, founded in 2014 by the DCYA. It combines

several different services targeting children, young people and families that had previously been separated into different institutions; for example, the Children and Family Services of the National Health Service, the functions of the Family Support Agency, and the National Educational Welfare Board. Tusla's main tasks include child protection, the provision of information and counseling for parents (online and in 109 local family resource centers, especially located in disadvantaged areas; these centers have existed since the end of the 1990s, but are now managed by Tusla), the use of educational welfare officers to improve school attendance (mainly preventive and supportive actions, with legal action as a last resort), and inspections of facilities catering to young children (e.g., preschools, kindergartens). One of the entity's overall goals is to strengthen interagency cooperation and take an interdisciplinary approach in improving children's and families' lives. Tusla regularly reports on the performance and quality of its child and youth welfare services using its National Performance Activity Dashboard.

Children and young people's service committees

Also created by the DCYA, these committees are county-level structures that connect all service providers relevant to children and young people. They enhance cooperation between such actors, and work to improve the provision of such services. There are 27 committees across Ireland, with five in Dublin and some covering two counties. The committees also play a major role in the implementation of the national Better Outcomes, Brighter Futures policy framework.

Area-based childhood program

This program is explicitly directed at prevention and early intervention in 13 preselected disadvantaged areas in Ireland. It provides money for many different services targeted at children, parents, teachers, doctors. The goal is to support disadvantaged families and children. It was previously financed by the DCYA and a private welfare organization, and had a budget of € 34 million for the 2013 – 2017 period. Since 2018, it has been solely funded by the DCYA.

Prevention, Partnership and Family Support Program

This Tusla-led program is explicitly directed at early intervention and prevention, and is intended to support children and parents by enhancing organizational structures and coordination processes. It has a variety of different focuses, such as participation, parenting and finances, and engages in a variety of tactics such as workshops for parents and the establishment of child and family support networks. One of its core

features is the implementation of the so-called Meitheal Model, which refers to the effort to tailor all services and cooperation structures to specific contextual needs. For the 2015 – 2018 period, it had a budget of € 8.3 million and was financed by a private welfare organization; since 2018, it has been solely funded by the DCYA.

Delivering Equality of Opportunities in Schools (DEIS)

This project aims at schools in disadvantaged areas, supporting them by providing funds for day-to-day expenses such as food or books. There are different programs for different categories of disadvantage, enabling a targeted disbursement of funds. Schools can apply for this project, which is overseen by the Department of Education. The School Completion Program, with measures targeted at pupils at risk of quitting school, is a part of DEIS; this program is organized by Tusla.

School Meals Scheme

This scheme supports disadvantaged families by defraying the cost of school meals. There are two different support schemes; one serves schools in urban areas, while the second supports local initiatives for low-cost school meals. The scheme is funded by the Department of Employment Affairs and Social Protection, which works closely with local authorities (e.g., to select the funded schools).

Youthreach

This Department of Education program addresses young people aged 15 – 21 who have left school without a formal degree. It offers free courses on general education, personal development, vocational training and work experience. The courses last one to two years, depending on the individual situation, and are held in special centers all around Ireland. Once they have completed the program successfully, participants are awarded a special certificate, and have the opportunity to take further courses to qualify for different jobs.

Back to Education Initiative

This project is comparable to Youthreach, and also addresses early school leavers. It is targeted at people aged 16 or older who have few or no formal qualifications, and offers part-time courses. There is also the possibility of earning a degree that qualifies its holder to begin vocational training. This initiative is managed by the education and training boards.

2.9 Fact sheet Lithuania

2.9.1 General structure

2.79 million residents
43 residents per km²
GDP per capita of € 25,010

Lithuania is a semi-presidential representative democratic republic. The directly elected president is the head of state, and has several political responsibilities; for example, he/she can veto parliamentary decisions, takes the lead on foreign and security policy, and makes appointments to several important positions (with the consent of the parliament) including that of prime minister. The government consists of a prime minister and a cabinet of ministers, with the former being elected by the parliament. The legislature consists of a unicameral parliament.

Below the central level of government, there are three additional levels: 10 regions (that serve only statistical purposes) at the first level; 60 municipalities at the second level; and around 500 "elderships," or municipal subdivisions, at the third level. The municipalities have their own elected political assemblies and directly elected mayors; they also elect the "elders," who hold administrative responsibility within the elderships. The elderships themselves are municipal districts and are merely local administrations without political powers. Municipalities are financed by central government grants, shares in tax revenues and their own taxes.

2.9.2 Preventive structure

General context

Local-level competences: The municipalities implement and administrate national policies. However, they also have many of their own competences in the areas of education, primary and public healthcare, and social services. They are also explicitly responsible for providing preventive assistance to children and families, and for the coordination of social, educational, healthcare and other services.

Health system: An obligatory public health insurance system covers all residents of Lithuania. This is financed by contributions provided by regular employees and self-employed persons. The state pays the contributions for certain groups such as children and unemployed pregnant women. Responsibility for the health system is shared between the central government (regulation) and the municipalities (implementation). Public health insurance covers many medical services provided by public health centers / clinics, including preventive health services; costs for medicines are partly reimbursable. Private healthcare is rather expensive. Voluntary health insurance plays nearly no role, due to the high level of coverage provided by the compulsory insurance system.

Social security: Participation in the public social security insurance system is compulsory for all regularly employed people in Lithuania, and some aspects of it are also compulsory for self-employed persons. Insured persons (and their employers) pay contributions (in the form of deductions from total income). Certain benefits such as family benefits are provided without the need for contributions. Family benefits include flat-rate payments such as the child benefits or child grant. Unemployed pregnant women may also receive a lump-sum benefit if they are not eligible for the (contribution-based) maternity benefit. Responsibility is shared, with the central state holding responsibility for the contribution-based benefits, and the municipalities bearing responsibility for noncontributory benefits.

Education: Education in Lithuania is compulsory between the ages six or seven and 16. Education is mostly provided for free in public schools. Preschool is voluntary for children under the age of six, with four state-funded hours per day. Since 2016, there has been a compulsory pre-primary school year offered before a child starts primary school, consisting of four state-funded hours per day. The central level is responsible for general education policy and school funding, while municipalities are responsible for the organization of schools.

Key institutions / actors

- Pregnancy: (Family) doctor, nurse; every woman has free health insurance covering services at least 70 days before and 56 days after the birth.
- Issues of special concern under the age of one: Family doctor; children have access to free healthcare and get regular health check-ups, can be referred to specialists if needed.

- Infants (1-6) with behavioral problems: Family doctor, preschools; in order to attend a preschool facility, children must have a medical check-up certificate, which has to be renewed annually. Schools have educational-support staff that provide guidance and counseling to pupils, teachers and parents; this in turn takes place in cooperation with other actors. Action for children exhibiting difficulties might be coordinated by the school's child-welfare commission, which in turn typically works closely with the municipal child-welfare commission.
- Children (6-12) with behavioral problems: Family doctor, primary schools; in order to visit a primary-school facility, children need to have a medical check-up certificate, which has to be renewed annually. Schools have social pedagogical support staff who provide guidance and counseling for pupils, teachers and parents; these teams cooperate in turn with other actors. Action for children exhibiting difficulties might be coordinated by the school's child-welfare commission, which in turn typically works closely with the municipal child-welfare commission.
- Youths (12-18) who express violent behavior: Schools, school child-welfare commissions. Schools are obliged to take preventive measures against violence; the school child-welfare commission organizes and coordinates prevention measures and handles violent behavior in schools; the municipal child-welfare commission might also be involved.
- Family applications for social assistance: These are handled by municipal social assistance units; social workers offer support and cooperate with other actors in the municipality.

2.9.3 Overall impression

Most preventive measures are provided by the lower, decentralized levels of government, while the central level primarily sets the general framework. Municipalities have a fair degree of independence in terms of organizing education, family benefits, social services and healthcare, and have all the tools needed for effective prevention. The education sector cooperates closely with other sectors such as healthcare and social services so as to ensure the success of every pupil. The municipality is the main actor in all sectors relevant to preventive policy. In fact, in every municipality, an inter-institutional cooperation coordinator is tasked with facilitating cooperation between all relevant services, especially for children. This figure usually chairs the municipality's child-welfare commission. Furthermore, the law on self-government states that the municipalities are responsible for taking a universal and preventive approach toward

services for children and their families. However, there are differences between the various municipalities, with larger cities being able to act more effectively than their smaller counterparts due to their greater financial resources.

2.9.4 Insights regarding the country's specific preventive features

Health system

An obligatory public health insurance program covers all working residents of Lithuania. The system is financed via contributions, which are paid by regular employees and self-employed persons. The state covers the cost of contributions for certain groups such as children and unemployed pregnant women. Responsibility for the health system is shared between the central government, which develops the relevant regulations, and the municipalities, which implement the regulations and organize the associated services. The obligatory public health insurance plan covers many medical services that are provided in public health centers or clinics. Public health services, including preventive health services such as medical check-ups, are also among the municipalities' responsibilities and are covered by the health insurance plan. Most services are free at the point of use, with small fees paid only in certain cases. Prescribed medicine is subject to reimbursement. Emergency medical care is provided freely to all residents irrespective of insurance status.

Social security

A compulsory public social security insurance plan covers all employed people in Lithuania. Only some aspects of the insurance program are compulsory for self-employed persons (e.g., healthcare, maternity/paternity). The system is financed through contributions made by insured persons and employers, in the form of deductions from total income. The system is further supported by general tax revenues. As in the case of the health system, the state subsidizes contributions for certain groups of people, such as children. Certain benefits such as family benefits are granted even if no contributions have been made in advance; thus, these are open to all residents of Lithuania. Among the family benefits are flat-rate payments such as the child benefit or child grant. Unemployed pregnant women may also receive a lump-sum benefit if they are not eligible for the (contribution-based) maternity benefit. Responsibility for the social security system is shared, with the central state being responsible for the contribution-based benefits, and municipalities for the noncontributory benefits.

Education

Education in Lithuania is compulsory between the ages six or seven and 16. Education is mostly provided for free in public schools. Preschool is voluntary for children under the age of six, with the state providing funding for four hours of care per day. Since 2016, children have been required to attend a year of pre-primary school before starting primary school, involving four state-funded hours per day. Parents pay only for learning materials or school meals. Private schools are usually expensive and are not very common. The central government is responsible for general education policy, the curriculum and the funding of schools, while municipalities are tasked with organizing specific local schools and education services. Municipalities often develop medium-term education strategies for their area and construct a network of education providers.

Special programs and other features

Educational assistance

In every municipality, special centers staffed with personnel from multiple disciplines provide (special) educational assistance and psychological services for target groups such as children and young people. They provide counseling and guidance services, and are tasked with preventing the emergence of problems; moreover, they can intervene if difficulties do arise. They work closely with the municipality government, local education facilities and other actors. The municipalities establish and finance these institutions. There is also a central government center that drafts regulations for the general service-provision system, and which provides support to the municipal centers.

School child-welfare commission

Every educational establishment is required to have a child-welfare commission tasked with ensuring the well-being and educational success of every child in the school. These commissions consist of various educational and educational-support personnel, such as teachers, psychologists, social pedagogues, health professionals, parents, representatives of local groups, and municipality administrative staff. These commissions are tasked with coordinating and organizing preventive and educational-assistance work; ensuring a child-friendly and safe learning environment; gathering information about children with learning problems; and making a primary assessment of special educational needs. The national level is responsible for the general regulation of these commissions; details such as the specific composition of the commissions are left to the responsibility of the schools.

Municipal child-welfare commission

Every municipality has a child-welfare commission tasked with ensuring the well-being of all children in the municipality, in part by working with school-based child-welfare commissions and other child-welfare entities. The municipal commission coordinates the activities of all institutions working in the child-welfare sector, including the local school-based child-welfare commissions. The municipal commission consists of representatives of municipal-level entities such as healthcare and educational organizations, the police, the municipality's administration, and non-governmental organizations; appointments are made by decree of the director of the municipal administration, and the body is usually chaired by the municipality's inter-institutional cooperation coordinator. This latter position was established by the Lithuanian government in every municipality, with the goal of ensuring coordination between the various services in the child-welfare sector. The national level is responsible for the regulation of these commissions; details such as their specific composition are the responsibility of the municipalities.

Law on education

The general law governing the structure and provision of education in Lithuania has undergone major recent reforms. Since 2017, it has obliged schools to implement prevention programs, especially relating to pupils' social and emotional competences – for instance, with the goal of preventing bullying or alcohol abuse, and of creating conditions in which pupils will take part in these prevention programs. School staff have been trained to implement these prevention programs since 2017, with the training programs mainly financed by the EU social funds.

Preschool / pre-primary education

The municipalities are responsible for organizing preschool and pre-primary education. However, there are differences in the specific regulations for these two systems. Preschool is viewed primarily as a task in which the parents themselves teach their children according to national recommendations; however, municipalities are also obliged to organize preschool facilities. The state funds four hours of instruction per day in these facilities. Pre-primary education, however, was made obligatory for all children in 2016, with the goal of preparing them for primary school. This is one of the main educational tasks performed by municipalities.

Law on self-government

Since 2018, the Lithuanian law on self-government has obliged municipalities to ensure the organization "of preventive assistance for the child and the family, coordination of services provided by social, educational, healthcare establishments as well as by other establishments" (Art. 6 no. 44). Municipalities also have the delegated responsibility to implement youth policy; this involves a state-funded coordinator for youth affairs who is tasked with overseeing these implementation activities, coordinating the actors involved on the local level and managing cooperation with the national level.

Law on strengthening the family

This law, passed in 2017, has the goal of strengthening families, which are seen as the most important factor in ensuring child welfare. The law stresses the importance of cooperation between different levels and actors, and applies to the national government, which is responsible for general family policy, as well as the municipalities, which implement these policies. Potential measures implemented under this law could aim at supporting the overall health of families, providing further assistance to families with difficulties or increasing parent's capabilities to prepare their children for their later lives. The government adopted a basic family-services package in 2019, consisting of 14 different measures for families to be implemented in all municipalities, such as the provision of counseling services and parenting support. The municipalities must ensure that these services are provided, but can contract with external providers such as NGOs if necessary. The Ministry for Social Security and Labor monitors the accessibility of the services. The services are jointly financed by the government, municipalities and the European Social Funds.

2.10 Fact sheet Netherlands

2.10.1 General structure

17.2 million residents
414 residents per km²
GDP per capita of € 39,895

The Netherlands is a decentralized unitary state with a central administration, 12 provinces *(provincies)* that serve as regional administrations, and 355 municipalities *(gemeenten)* (January 2020) that function as local-level administrations. Legislative power is held exclusively at the national level. However, the lower two levels of government are important as implementing bodies. Municipalities are relatively free to determine their local adminis≠≠trative structure.

2.10.2 Preventive structure

General context

Regional competences for children: No significant competences.

Municipal competences for children: Aspects of health and social care, childcare, youth care, public health, culture, sports and leisure.

Health system: Obligatory, insurance-based health system for every permanent resident. General practitioner acts as the anchor contact for general health services. Municipal health services (typically in the form of intermunicipal cooperation between multiple municipalities within a region) are responsible for public health and most prevention-related issues.

Social security: The social security system is based on mandatory insurance programs organized by the national government. Social insurance programs are partly financed by general taxes and partly through contributions based on individual income lev-

els. Several special benefit programs for children and parents are in place, including a significant child benefit for low-income families.

Education: The daycare/preschool system is well established and widely used. Children have a legal right to daycare; municipalities are responsible for guaranteeing this right. School attendance is mandatory between the ages of five and 16, but most children start school at four. School system is largely privately organized but is governmentally regulated and subsidized.

Key institutions/actors

- Pregnancy: Midwife, regular examinations
- Issues of special concern under the age of one: Municipal health service *(Consultatiebureau of the GGD)*
- Infants (1-6) with behavioral problems: Daycare facility, municipal health service *(Consultatiebureau of the GGD)*
- Children (6-12) with behavioral problems: Schools; psychologists and school social workers, often in "school care and advice teams" from the municipal multidisciplinary social neighborhood team *(wijkteam)*
- Youths (12-18) who express violent behavior: Schools; psychologists and school social workers, often in "school care and advice teams" from the municipal multidisciplinary social neighborhood team *(wijkteam)*
- Family applications for social assistance: Depends on the municipality; multidisciplinary social neighborhood team that brings municipal actors from different services together might offer additional services

2.10.3 Overall impression

In recent years, prevention has gained considerable attention as an aspect of Dutch child and youth policy. Initiatives bundling all administrative competences at the municipal level and creating the multidisciplinary social neighborhood teams show great potential for successful preventive work. Budgetary restrictions (i.e., a 15 % budget cut following 2015 decentralization efforts) are a problem in many municipalities; the link between municipal services and privately operated schools can also be problematic. The effect of the municipalities' independence is double-edged: While it undermines homoge-

neity with regard to the nationwide implementation of policies, it allows innovative solutions adapted to each individual municipality's context to be developed.

2.10.4 Insights regarding the country's specific preventive features

Structure and financing of local government

The Netherlands has three administrative layers: The central administration, 12 provinces (*provincies)* that serve as regional administrations and 355 municipalities (*gemeenten;* as of January 2020) that function as local-level administrations. As a decentralized unitary state, the central government is responsible for all legislation having to do with the topic of this report. The lower two levels of government do not have lawmaking competences, but they are important as implementing bodies. The heads of provincial assemblies (king's commissioners) and municipal mayors are neither directly nor indirectly elected but are appointed by central authorities. Since 2001, however, provincial and municipal councils have had an important say in their selection, which has always been respected by the central government. Dutch municipalities are widely viewed as the vital foundation of government structures. This is reflected in their right to execute tasks without close supervision by the national government. Typically, no more than the core of assigned tasks is defined and supervised by the national government, with the majority of implementation details falling to the discretion of the municipalities.

Dutch municipalities have very little of their own tax revenue (constituting approximately 10 % of their spending). The majority comes from grants provided by the national government and the provinces (approximately 70 % of their spending) and other revenues such as fees (approximately 20 %). Intergovernmental financial relations are regulated by the 1996 Financial Relations Act. Transfers to municipalities can be divided between a general grant (Municipalities Fund or *Gemeentefonds*), a decentralization grant (including a new fund for social affairs), an integration grant and specific grants covering expenses for obligatory delegated tasks. The Municipal Fund provides lump-sum payments. It has a strong equalizing function, with a multitude of criteria used for its allocation.

From a legal perspective, provinces supervise the municipalities. However, their role is in practice rather limited.

Health system

Four national healthcare-related acts constitute the present Dutch health system: The Health Insurance Act *(Zorgverzekeringswet)*, the Long-Term Care Act *(Wet langdurige zorg)*, the Social Support Act *(Wet maatschappelijke ondersteuning)* and the Youth Act *(Jeugdwet)*. Before 2015 a different regime existed. The main difference relative to the old system is that municipalities have now been given responsibility for social support and youth issues in the health sector (formerly a task of the provinces)

Most health-related issues fall under the Health Insurance Act. It obliges everyone who permanently lives in the Netherlands to purchase a basic insurance package from a private insurance company; insurance bodies have to accept everybody regardless of age, gender, health status or other personal aspects. This basic insurance package covers the vast majority of medical services. The national government defines the contents of the insurance package, as well as the price, which is currently about € 1,200 per year. An additional income-related portion is paid by the insured individual's employer. The national government pays the fees for all residents under 18, so that they are insured without further costs. In addition to the mandatory basic insurance package, most people (about 90 %) in the Netherlands have a privately financed insurance for medical services going beyond the regular list of covered services (e. g., some dental care services or homeopathic treatments).

Medical services for disabled people and children are regulated under the Social Support Act and the Youth Act. In both cases, a municipal service-delivery model is employed: The national government grants all necessary payments via a tax-financed municipal fund to the municipalities, which then organize the services. The provision of medical services for children and youths represents one aspect of the multidisciplinary neighborhood teams' work.

The primary anchor point in the provision of medical services is the general practitioner, usually working on a self-employed basis in solo practice or small joint practices of around two to five doctors. This figure acts as a gatekeeper, as referrals are needed to visit a specialist or a hospital. The general practitioner is also an important provider of individual, health-related prevention for children as well as adults.

The vast majority of hospitals in the Netherlands are privately run (usually organized as foundations) but non-profit. They are financed through payments of the health insurances.

Under the terms of the Public Health Act *(WCPV)*, public health services are to be provided by the municipalities. Municipal-level public health services *(Gemeentelijke gezondheidsdienst, GGD)* are responsible for executing these services. The 380 municipalities have formed 25 GGDs, which serve as critical actors with regard to health-related prevention for children and adults. The GGDs; main tasks with regard to children and young people are: Child healthcare, socio-medical advice, health education and community mental health.

Social security

Most aspects of the Dutch social security system are based on mandatory insurance programs organized by the national government. Some portions are mandatory for all residents, while others are only applicable to (and also mandatory for) employed persons. Social insurance programs applicable to all residents are partially financed by general taxes and partially (if the individual is employed) by contributions relative to the employees income; the contributions are deducted by the employer and transferred to the Tax and Customs Administration. Such programs include the pension system, child benefits, survivor benefits and long-term care. Social insurance programs specifically for employed individuals are also financed by contributions; these programs include unemployment benefits, sick leave, and disability benefits.

A number of social policy measures for children and their parents exist on the national level. Examples are:

- 16 weeks of fully paid (based on net income within the 12 months before giving birth) maternity leave, paid by the General Unemployment Fund *(Awf)*.
- 26 weeks of parental leave for both mother and father to take care of their children; to take advantage of this benefit, the individual must have had the same employer for at least a year before the birth. Parents can take this leave anytime during the child's first eight years of life. This time is generally unpaid, but many employers voluntarily pay around 50 % of the individual's regular wage based on agreements with the parent.

- Child benefit and benefit for families with low income: Every child of a resident in the Netherlands receives a monthly child benefit (between about € 200 and € 300, depending on the child's age). In addition to the general, non-means-tested child benefit, there is an additional benefit for families with low incomes *(Kindgebonden budget)*. This is also tax-financed by the national government. Only families with a low income and a limited amount of savings are eligible for this benefit; its amount depends on the family's actual income. The maximum payment for parents with a combined income of less than about € 27,000 per year is about € 1,000 per month for the first child, € 500 for the second child, € 200 for the third and €100 for any additional children.

Education

The Dutch daycare/preschool system is well established and widely used. Every child has the right to attend a daycare facility. Municipalities are responsible for implementing this right and receive grants from the national government for this purpose. The municipal-level public health services oversee the quality of these childcare facilities. Parents (and employers, if relevant) also pay a share of the costs, the amount of which is dependent on income. An average of 65 % of the costs are financed publicly, though for families with low income these costs can be nearly completely publicly financed. There are two main types of daycare:

- Private daycare centers *(kinderdagverblijven):* Care for children between birth and the age of four years old.
- Public pre-kindergarten facilities *(peuterspeelzalen)*, or playgroups: A more formal type of care for children two to three years old.

School entrance is possible at the age of four. Approximately 95 % of all children start school when they turn four years old. Children in the Netherlands are obliged to participate in full-time (five days a week) education from the age of five until the end of the school year in which they turn 16. If they have not already gained a basic qualification certificate, young people between the ages of 16 and 18 are required to obtain a basic qualification *(startkwalificatie)*. The aim is to provide all young people with at least a certain amount of secondary-level education. An important characteristic of the education system in the Netherlands is the freedom of education – that is, the freedom to found schools, to organize the teaching in schools and to determine the principles

on which they are based. This means that people have the right to found schools and to provide curriculum that is based on religious, ideological or educational beliefs, and that they are entitled to determine how they wish to organize and design their education. Most of these special schools *(bijzondere)* are associated with Protestant or Catholic Christian denominations and are financed by the national government in the same way as the public schools *(openbaar)*. About two-thirds of children in the Netherlands attend special schools. Since these schools are usually governed by a foundation and a board, the influence of the national government or the municipalities is limited. This is an obstacle with regard to the provision of comprehensive nationwide prevention (see case study Netherlands for more details and approaches to address these problems).

Distinctive features, special projects and cooperation

In recent years, the Dutch child and youth policy and its implementation went through substantial reforms. The Dutch youth care and welfare system basically consists of different services: universal services, preventive services and specialized services. Examples of universal services include youth work, childcare and schools. Preventive services include child healthcare, general social work and parenting support. Examples of specialized services include youth care services, youth mental-healthcare services and child protection services. Until 2015, the municipalities were responsible for universal services and preventive services, the provinces were responsible for specialized services. Since that time, the provinces' responsibilities with regard to children and youths have been transferred to the municipalities. The goal here was to collect all related tasks under the auspices of a single administrative body so that multidisciplinary teams could more efficiently address all children-related needs. A special focus of the new Youth Act is to decrease the number of children in specialized care and increase preventive and early intervention support, and to promote the use of social networks within children's close environments.

On the municipal level there are a multitude of different specific prevention measures. One feature established in virtually all municipalities is the generalist approach. This approach refers to a method (or variety of methods) by which child and family support is provided to the clients. The generalist teams, which include youth child healthcare workers, social workers, psychologists, general practitioners and others, aim to provide early and direct support. They additionally try to help families find their own

solutions to parental and care issues while improving coordination efforts among the different participating specialists. Generalist teams can work within the preventive field, but generalist approach models are also used in providing care to multi-problem families.

Cooperation between municipalities is quite strong and happens on different levels. For example, there is a large number of regional cooperation bodies, such as the municipal health services, jointly organized hospital care services and special youth services. However, this kind of cooperation happens on a voluntary basis, and cannot be prescribed by the government.

Performance-management measures were imposed in the context of the 2015 reforms to monitor the municipalities' implementation of the reforms. This included a formal evaluation of the act. Monitoring and evaluation, especially of municipalities' implementation of the central government policies, also happens in the form of regular ministerial supervision and reports. The Netherlands Youth Institute is one of the important actors in the area of performance management, as it gathers data on all aspects of youth-related policy, makes evaluations and provides support to all levels of government.

2.11 Fact sheet Spain

2.11.1 General structure

46.7 million residents
92 residents per km²
GDP per capita of € 28,127

Spain is a constitutional monarchy. While the king or queen is the formal head of state, he or she has mainly representative and ceremonial functions. The government consists of a prime minister and several ministers. The legislature takes the form of a bicameral parliament that includes a Senate (territorial representation, partly elected and partly appointed by the regions) and a Congress of Deputies (elected popular representation).

At lower governmental levels, there are 17 autonomous regions and two autonomous cities in Spain. The competences accorded to these units vary for (mostly) historical reasons. They also have their own parliaments and governments. The regions are in turn split into 50 provinces. The most important function of the regions today is largely forming the electoral regions for the national parliament; however, some also fulfill certain supra-municipal administrative tasks. The lowest level of government includes the country's more than 8,000 municipalities.

Two of the regions possess a considerable degree of financial autonomy, while the others depend largely on shares of the taxes they levy for the central government, money derived from a financial-equalization process, and to a lesser extent, their own tax revenues. Municipalities are financed via transfers, a share in national and regional tax revenues, and to a lesser extent, their own taxes and further sources of revenue (e.g., fees).

2.11.2 Preventive structure

General context

Local-level competences: In general, the regions possess all competences that the constitution does not grant directly to the central government. However, they also share some responsibilities with the central government, for instance in the areas of education and social services, in which the government has basic legislative competences. Nevertheless, the competences held by the regions vary according to their individual autonomy statutes. Larger municipalities (over 20,000 residents) are required to provide social services in social service centers. Provinces provide these services for municipalities with fewer than 20,000 residents.

Health system: Responsibility is shared between the central government and the autonomous regions. The public health insurance system covers all Spanish citizens. It covers many health-related expenses, with medication subject to co-financing. Regions may cover further services if they can afford it. The first point of contact for patients are general practitioners' offices or health centers (which are in turn staffed with general practitioners and other primary care services such as family doctors). Visiting a specialist requires a referral from a general practitioner.

Social security: Contribution-based and noncontributory services cover all Spanish citizens. Contributions are paid by employees and employers according to the job type and salary. Most benefits, including family benefits, are managed centrally, but certain noncontributory services are managed by the regions. Social services are provided by the larger municipalities and provinces.

Education: Compulsory, free public education is provided between the ages of six and 16. Attendance at a public preschool is also free of charge between the ages of three and six. Overall responsibility in this area is held by the central government, but regions may add additional services.

Key institutions / actors

- Pregnancy: Health center, staffed with a variety of professionals; regions can offer additional services; no further institutionalized cooperation.
- Issues of special concern under the age of one: Health center with a variety of professionals; regions might offer additional services.
- Infants (1-6) with behavioral problems: Preschool facilities; teachers are the primary actors, but can also seek the support of external guidance, counseling and psycho-educational teams that work closely with other institutions. Early-intervention care centers can offer additional support, depending on the severity of the problems.
- Children (6-12) with behavioral problems: Primary school; teachers are the primary actors, but can also seek the support of external guidance, counseling and psycho-educational teams that work closely with other institutions.
- Youths (12-18) who express violent behavior: Secondary-school facility; teachers are the primary actors, but can also seek the support of external guidance, counseling and psycho-educational teams that work closely with other institutions; internal counseling departments in secondary schools may also offer support.
- Family applications for social assistance: Filed at social-service centers, with special benefits provided to large and single-parent families. Additional (preventive and assistive) services designed for families are offered.

2.11.3 Overall impression

The health / social security and education systems feature separate, parallel preventive structures. External guidance, counseling and psycho-educational teams facilitate cross-sectoral cooperation for prevention activities offered in schools, using a networking approach. The health and social security sectors remain largely separated, potentially undermining efficiency. Common public and contribution-based services are extensive, with a rather good reputation. Certain aspects of services may differ from region to autonomous region, depending on their financial resources (and local political strategies).

2.11.4 Insights regarding the country's specific preventive features

Health system

Responsibility for general health policy is shared between the central government in Madrid and the autonomous regions, with the central state being responsible for the overall health policy and its coordination, and the regions holding responsibility for the implementation of national policy and the development of region-level regulations and policies. However, the financial crisis prompted the central government to recentralize some decision-making powers back to Madrid, especially in the financial area of health spending. There are currently three different state-organized subsystems: the general Spanish National Health System (SNS), and two smaller systems covering public employees and the general area of accidents and occupational diseases.

The SNS covers all Spanish citizens, and is financed by general tax revenues. The benefits included in the SNS were redefined in a major 2012 reform. On the one hand, there is a so-called common package that provides a common set of benefits within all 17 autonomous communities. This common package consists of a core package, a supplementary package and accessory services. The core package contains (extensive) mother and child health services, among other features; these services are not cofinanced by patients, and are jointly regulated by the central government and the regions in a so-called Interterritorial Council. The supplementary package supports services such as prescribed medications; these services and goods require some co-financing on the part of patients (depending on the annual household income and a monthly threshold). The list of services included in the third package is rather vague, as it encompasses non-essential services and goods. In addition to the common package, there is also a complementary package regulated by the regions. This comprises any measures not included in the core package that the regions nevertheless deem to be essential; however, these services must be financed by the regions on their own.

Private health insurance plays a minor and rather supplementary role; it usually provides faster access to healthcare for those willing to pay, compared to the universal SNS.

Most healthcare services are delivered by public providers; only a small share of the healthcare budget goes to private providers. The first contact point for patients is usually a public healthcare center. These each cover a certain area within every region,

and are staffed by doctors and nurses, and sometimes by additional specialists (e.g., social workers), who provide a whole array of primary healthcare services. General practitioners usually provide referrals to specialists.

Social security

All Spanish citizens are subject to the Spanish social security system; however, there are differences between the contribution-based system and the noncontributory system. The contribution-based system is split between a general scheme and three special programs for specific occupations (e.g., sailors). Employees and employers each make contributions; the amount / rate varies according to the occupation and the salary, with employers paying larger sums. The contribution base largely mirrors real salaries; however, there are upper and lower limits, set at the national minimum wage plus one-sixth on the low end, and an annually renewed maximum base as a ceiling. The noncontributory system provides benefits to people who have now paid enough in contributions to claim contributory-system benefits. Certain family benefits (e.g., child benefits) are also noncontributory. Most benefits are administered on the central government level; however, certain noncontributory pensions (e.g., for elderly and disabled people) are managed by the autonomous regions. Social services such as counseling, support and guidance for families in social-service centers are offered by the provinces for municipalities with fewer than 20,000 residents. Municipalities with more than 20,000 residents offer these services themselves.

Education

Education is compulsory in Spain from the age of six to the age of 16. However, children can also attend a preschool facility beforehand, with two possible cycles, between the ages of zero and three and a second between three and six. The second cycle is free in public schools and publicly supported private schools; thus, many children attend this second cycle before starting primary school at the age of six. Education between the ages of six and 16 is also provided for free in public and publicly supported primary and secondary schools. Primary school lasts through the age of 12, followed by four years of secondary education. Children may then continue their secondary-school career for two additional years. In this case, after the final exams, they receive a diploma (Bachillerato) that provides access to higher education. There is also the option of shifting to a vocational training program after finishing the first four years of compulsory secondary education. Both options are non-compulsory, but free of charge.

Overall responsibility for education policy is executed by the central government. However, the autonomous regions have the responsibility of implementing these policies, and can complement or add to them, for instance by requiring specific subjects according to the regional language or culture.

Distinctive features, special projects and cooperation

Guidance, counseling and psycho-educational teams

An interesting approach in the education sector involves the use of external guidance, counseling and psycho-educational teams *(Equipos de Orientación Educativa y Psicopedagógica, EOEP)*. These have been established by most autonomous communities; however, the specific organizational model varies by community (e.g., central organization by the community government or by the province-level administration), as do the character of the teams themselves. These usually cover a certain geographic area and a certain school type; for example, there are different teams for early education, primary schools and secondary schools. Secondary schools have additional internal services called counseling departments *(Departamento de Orientación)*; these are similar to the external teams, but are located within the schools, and consist only of school staff. The external teams are staffed by professionals drawn from several different sectors, for example special teachers and nurses, and are usually coordinated by a psychologist or trained teacher. If a teacher, school or family needs support with a child, a group of children or even a whole class, the team can be called upon for a variety of different services, for instance by providing training for a teacher or designing special didactic programs. Furthermore, the team might assess a specific pupil's behavior in order to identify his/her special needs and problems, and carefully design a measure intended to counter these or prevent more severe problems. These teams focus primarily on pupils with special educational needs, but can also help other pupils having problems in school. The teams are therefore closely connected to other actors, including other educational teams, professionals from other sectors and public authorities.

Youth guarantee

The Youth Guarantee has its origins in a European initiative, and was comprehensively implemented in Spain in association with the National Youth Strategy 2020. The main focus of both the Strategy and the Guarantee are youth employment and entrepreneurship support, especially in the context of the high levels of youth unemployment caused by the financial crisis. Spain designed an online system in which young people under

the age of 30 are encouraged to register and receive job offers, training services and other measures aimed at enhancing their inclusion in the labor market. This is supported by the European Social Funds. The central government cooperates closely with the autonomous regions for this program. Youth information centers and information points all over Spain (currently more than 3,000) offer information on the guarantee; these centers also feature trained personnel who provide the young people with guidance and support, working jointly with other institutions to do so. These centers are financed by the regions, the municipalities and private sector organizations, and collaborate on the regional level. Furthermore, all autonomous regions and the two autonomous cities have coordination centers that work together at the national level.

Social-service centers

Local social security services are offered in these centers, which are established by municipalities with more than 20,000 residents, and by provinces that offer such services for municipalities with fewer than 20,000 residents. Some of these services are especially designed for families, and are of a preventive nature. Trained personnel offer services such as guidance and counseling for parents and support in difficult family situations; they additionally offer prevention programs for children and young people. While the full catalogue of services varies between the autonomous communities, some general services have to be provided nationwide; this includes family mediation, social pedagogical care, and after-school or family orientation services. Social-service centers cooperate with other actors in areas such as the health, child-welfare and education sectors.

Early-intervention care *(Atención temprana)*

The regions finance early-intervention centers with the goal of preventing developmental disorders in children. This early care is provided to children from zero to six years old. Usually, there are several of these centers per region, many of them organized privately by entities such as NGOs. They are staffed by a variety of specialists (e. g., psychologists, social workers); usually they are also part of a larger network, and thus cooperate with other institutions. General practitioners and social centers can provide referrals to these centers, but families can also visit them without a referral. Relevant support measures are offered after an assessment of the individual's needs.

Benefits for large families

Spain offers special financial benefits for large families with at least three children. Families have to apply for the "title" of a large family, but afterwards can claim a special single payment to defray expenses associated with their large family, or yearly tax deductions.

Strategic Plan for School Harmony *(Plan Estratégico de Convivencia Escolar)*

This is a national action plan developed in 2015 – 2016 by the national Ministry of Education, working together with the regions and several other institutions, to enhance the quality and inclusiveness of Spain's education sector. It is intended to develop measures addressing several problems, such as violence and bullying in schools, and involves cooperation and coordination between different institutions.

Positive parenting

In the early 2010s, the Ministry of Health, Consumer Affairs and Social Welfare; the Spanish Federation of Municipalities and Provinces; and several Spanish universities developed an alliance to support the development and application of positive parenting measures. They created a set of guidelines and best practices addressed to practitioners and policymakers, as well as an online platform that offers tools and resources for practitioners (e.g., evaluation tools, evidence-based measures) and families (e.g., training courses). Positive parenting and family education has in general been one of the government's recent priorities; the government has even included organizations offering such services on its list of income-tax beneficiaries (all Spanish citizens can elect to give 0.7 % of their income tax to charitable causes; such organizations can apply for subsidies out of this pot).

2.12 Fact sheet Sweden

2.12.1 General structure

10.2 million residents
23 residents per km²
GDP per capita of € 37,716

Sweden is a constitutional monarchy, but the king/queen has primarily symbolic tasks. The government consists of a prime minister and a cabinet of ministers. The government is accountable to the parliament. The legislature consists of a unicameral parliament. Numerous state administrative authorities are responsible for policy implementation (so-called *ämbetsverk*).

Below the central level of government, there is a regional and a local level. On the regional level, there is a dual structure with 21 county administrative boards (so-called *län* – these are incarnations of the state government) and 21 provinces (historically called *landstings* – "county councils;" since 2020, however, they have been called regions). These are incarnations of local self-government. On the local level, there are 290 municipalities. The provinces and municipalities both have elected political assemblies and administrations. Lower levels levy taxes and receive state subsidies and compensation through a financial-equalization process.

2.12.2 Preventive structure

General context

Local-level competences: Provinces (and in some cases municipalities) are responsible for the organization of healthcare. Municipalities are responsible for social services and education.

Health system: The healthcare system is universal and extensive, covering every resident of Sweden. It is financed through regional income taxes and state subsidies. Major actors include the county councils, who are responsible for guarantee-

ing the availability of most medical services; the fact that there is no predefined list of services / coverage leads to variance throughout Sweden. The central government passes general regulations in the area. In general, there is no differentiation among different classes of people, but certain special rules / subsidies apply for children / adolescents (e. g., no fees up to the age of 18 or 20) and pregnant women (e. g., free maternity care). Medication is subject to an annual maximum copayment.

Social security: This program is universal and extensive, covering every resident of Sweden. Social insurance is paid for by employers as a percentage of an employee's wage. The system provides universal, income-related and means-tested benefits, paid by a central agency. Social assistance is organized and financed by municipalities.

Education: This is compulsory, with free education provided between the ages of six and 16. Most children attend public preschool facilities (with the government financing a certain number of daily hours) between the ages of three and six. Compulsory school starts with a preschool class at the age of six, which has been obligatory since 2018. Compulsory schools may be publicly run by municipalities or privately operated; in either case, they are free of charge.

Key institutions / actors

- Pregnancy: Health center / family center; maternity care is free, and many provinces have family centers that offer a wide range of services and employ multidisciplinary staff.
- Issues of special concern under the age of one: Child healthcare centers / family centers; staffed with multidisciplinary personnel, offer many services free of charge.
- Infants (1-6) with behavioral problems: Preschool facilities; preschools need trained teachers and can employ staff from other sectors; cooperation with recreation centers.
- Children (6-12) with behavioral problems: Comprehensive school; teachers / principals are expected to look into such cases and try to change behavior; cooperation with recreation centers.
- Youths (12-18) who express violent behavior: Comprehensive school; teachers / principals are expected to look into such cases and try to change behavior; cooperation with recreation centers. Family applications for social assistance:

Social services are provided by municipalities; family centers offer guidance and counseling services.

2.12.3 Overall impression

Sweden offers extensive local prevention services; most services are free and easy to access. However, cooperation between different actors, especially in the educational context, lags somewhat. Schools/teachers are encouraged to solve problems on their own, and are expected to involve medical personnel. However, integration with other municipal services could be fruitful. The family-center approach brings together different actors, and offers multidisciplinary services. The degree of individual discretion accorded to provinces means there is no unitary Swedish approach.

2.12.4 Insights regarding the country's specific preventive features

Health system

The Swedish health system is well-known for its universal and extensive approach. Every legal resident of Sweden is automatically covered, and can use many different medical services for free or with a small copayment/fee. The public health system is financed by regional income taxes and state subsidies. Private insurance is used for additional coverage and to secure faster access to certain services. County councils are tasked with guaranteeing the availability of most medical services, for instance by contracting with private practices for such services. There is no predefined list of services that must be offered, so the county council must decide which services to provide. The central government creates general regulations concerning service quality and the obligation to offer the services. This leads to some variance across Sweden in terms of the range of services and their associated prices (e.g., the copayments required for doctor visits). In general, there is no differentiation among different classes of person, so every person is offered the same range of (free) services. However, there are certain special rules and subsidies given to certain groups of people; for example, children and young people do not have to pay any copayments or fees up to the age of 18 (in some counties, even up to the age of 20); moreover, dental care is free for people under the age of 20. Pregnant women are entitled to free maternity care. These special rules are valid in all counties. Medication is subject to an annual copayment maximum; all expenses above this maximum are fully covered by the state.

Social security

Much like the country's health system, Sweden's social security system is universal and extensive. It covers every resident of Sweden. Social insurance is financed by employers with contributions representing a percentage of the employee's salary (currently 31.42%). In addition to income-related benefits, there are also universal and means-tested benefits. Insurance-based benefits include family-related benefits such as parental benefits (paid leave to stay home with a child) and pregnancy benefits (paid leave for expectant mothers unable to continue a physically demanding job due to a pregnancy). Child allowances (and adoption allowances) are universal; that is, all parents receive a fixed monthly sum for each child, until that child turns 16. Finally, a set of means-tested benefits, including a housing allowance, supports families in need. All such benefits are paid by a central government agency. Social assistance (income support for the poor) is organized and financed by the social services of the municipalities.

Education

Education in Sweden is compulsory and free from ages six to 16. However, most children also attend a (public or private/independent) preschool facility between ages of three and six. The government subsidizes a certain amount of time in a preschool facility; further attendance has to be paid for by the parents. Fees are set by the provider (whether public or private), and must be "reasonable." There is a maximum-fee system in all municipalities, designed to ensure that families are not required to pay fees beyond a certain threshold. Compulsory school (so-called comprehensive school) starts with a preschool class at the age of six. This has been obligatory since 2018. Compulsory schools may be run publicly by municipalities or privately operated; in either case, they are free of charge. Compulsory school attendance lasts until the age of 16. Afterward, a child might attend an upper secondary school for three additional years; these are also free of charge and can be run privately or publicly. These upper secondary schools offer six different higher-education preparatory programs, along with 12 different vocational programs. Although it is not obligatory, nearly all children choose to attend an upper secondary school. There are also five different introductory programs for pupils who do not finish compulsory school with the grades needed to attend upper secondary school.

Special programs and other features

Family centers

Many municipalities feature so-called family centers, which are jointly administered and funded by municipalities and the county councils. They combine a variety of services under one roof, and usually consist of maternity health services, child health centers, preschool facilities and additional social services. Use of the services is usually free. One of the core features of family centers is the collaboration with other sectors due to their interdisciplinary character; they are typically staffed by nurses, doctors, social workers, teachers and other professionals drawn from a variety of sectors.

Child healthcare centers

Specialized health centers for children up to the age of six can be found in many municipalities, and are part of the public health system, financed by the county councils. These provide a variety of medical services for children, such as routine check-ups, vaccinations and further examinations. They also offer guidance and support for parents.

"Children at the Center" *(Barns behov i centrum)*

This is an initiative led by the National Board of Health and Welfare, designed to enhance the work of social services in all municipalities. It encourages multidisciplinary networking, equal opportunity and evidence-based child-welfare programs. Municipalities can receive a license to be certified under this program; most municipalities have been working with the initiative since 2006.

Recreation centers

These serve as a complement to the compulsory schools and are targeted at children whose parents are working or studying. In these centers, children and adolescents can spend time after school under the supervision of trained personnel. Municipalities are obliged to offer recreation centers for their residents. The centers may set a reasonable, though usually rather low fee for their services.

3 Comparing preventive structures in 12 countries

In the 12 countries of our study, we find considerable differences in the main dimensions of our comparison. These dimensions include the general preventive approaches, the modes of coordination between life stages and institutions, degree to which participation is obligatory or voluntary, administrative responsibilities, financing, and the use of governance instruments such as performance-management tools. Due to space limitations, we offer a condensed version of the available information that allows for an analysis of specific patterns in the 12 countries surveyed.

3.1 Target groups: Universal vs. targeted services

The first dimension examines the **target groups** for preventive measures. There are two distinctions to be made in this context. The first is between a universal approach and efforts to focus on specific at-risk target groups. The second is between approaches focusing on certain stages of life, and integrated approaches that address stages of life in an encompassing manner. The distinction between universal and targeted programs is closely related to the underlying understanding of prevention. In the common distinction made between primary prevention, secondary prevention and tertiary prevention (Caplan 1964; Gordon 1983), universal programs correlate to primary preventive measures, while targeted approaches are strongly linked to secondary preventive measures. In most of the states examined here, we find universal programs primarily in the very early stages of life, mostly within the areas of healthcare and child protection. The Nordic states have the most all-encompassing programs, with services accessible to all children in all geographic areas, although the specific service portfolios differ between local governments. A more mixed picture can be found in the continental European

states, where some offers have a general approach (e.g., programs for early-life medical examinations and early education), while others are targeted toward specific vulnerable groups). The "liberal" welfare states of Ireland and England follow a more targeted approach, addressing either special groups or (especially in Ireland) specific areas.

INFOBOX 1: **Area-Based Childhood Program (ABC) in Ireland**

This program was created in 2013 by the Department of Children and Youth Affairs (DCYA) and Atlantic Philanthropies, a private foundation. Since 2018, financing has been provided by the DCYA alone. In 2019, the program's budget was € 9.5 million. Organizationally, ABC has since 2018 been embedded in a broader prevention program managed by Tusla, the country's child and family agency. The program is specifically targeted at disadvantaged areas across Ireland, and supports several different integrated and evidence-based services for children, young people and families, for purposes such as improving health, learning capabilities or parenting skills. The areas were selected by application, and the measures are tailored to local area needs.

TABLE 1: **Universalism versus targeting in European preventive structures**

Strong universalism	Mixed	Strong targeting
Denmark	Austria	England / UK
Finland	Czechia	Ireland
Netherlands	Germany	
Sweden	France	
	Lithuania	
	Spain	

3.2 Integration vs. fragmentation over the prevention chain

The second dimension captures the degree of coordination between different stages of the prevention chain. We find the most integrated programs in the Nordic cases, a characteristic supported by their local governments' multipurpose profiles regarding

preventive services. After recent reforms, the Netherlands and Lithuania are on the way to developing similarly integrated structures.

INFOBOX 2: **Child welfare commissions in Lithuania**

Chaired by so-called inter-institutional cooperation coordinators – a position created to ensure the coordination of various services in the child-welfare sector – every municipality in Lithuania has a child-welfare commission tasked with ensuring the wellbeing of all children in the municipality. The commission includes representatives from a variety of municipal level entities, including healthcare institutions, educational institutions, the police, the municipal administration and non-governmental organizations; members are appointed by the director of the municipal administration. In addition to the municipal-level commissions, schools too must have their own child-welfare commissions. These consist of members such as teachers and social pedagogues, as well as municipal staffers, and are similarly intended to enhance all pupils' wellbeing and success. They work closely with the municipal child-welfare commission. These commissions are subject to regulation at the national level; however, details such as the concrete composition are the responsibility of the municipalities or the schools.

But there are still fractures in the chain. In Denmark and Sweden health services are less integrated than in Finland, while in the Netherlands the education sector is cut off from other preventive structures. The integration of schools into preventive structures is also a problem in other countries that lack the encompassing local structures of the Nordic countries or the Netherlands. In Austria, Germany and France, the dual structure of centrally governed social security institutions on the one hand, and social assistance and youth welfare measures carried out by schools and local or regional governments on the other, makes it difficult to develop integrated approaches. To a certain degree, governments have addressed these problems by trying integrate the sectors using special programs, but these do not cover all areas relevant to prevention policy. Ireland and England lack strong local-government institutions, and show a fragmented picture both with regard to institutional settings and to specific programs targeted toward specific groups and areas. One exception is Ireland's national "Better Outcomes, Brighter Futures" policy framework, which seeks to integrate several areas; another was Ireland's creation of Tusla, a centralized child and family agency.

INFOBOX 3**: Tusla in Ireland**

Tusla is a new child and family agency, founded in 2014 by Ireland's Department of Children and Youth Affairs. It combines several different services directed toward children, young people and families that were previously distributed across a variety of institutions, including the Children and Family Services of the National Health Service, the functions of the Family Support Agency, and the National Educational Welfare Board. Tusla's main tasks include child protection, the provision of information and counseling for parents (online and in 109 local family resource centers, located largely in disadvantaged areas), the use of educational welfare officers to improve school attendance, and the inspections of facilities catering to young children (e. g., preschools, kindergartens). One of the entity's overall goals is to strengthen interagency cooperation, while taking an interdisciplinary approach in improving children's and families' lives.

TABLE 2: **Integration versus fragmentation in European preventive structures**

Mostly integrated	Mixed	Mostly fragmented
Denmark	Austria	Ireland
Finland	Czechia	England / UK
Netherlands	France	
Lithuania	Germany	
Sweden	Spain	

3.3 Voluntary, incentivized or obligatory offerings

The preventive approaches also differ in the character of their approach to their target groups; for instance, programs may be offered on a voluntary basis, may be associated with incentives for their use, or may be associated with a legal obligation to take part (e. g., early-life health check-ups). This question is particularly important for a universal and integrated approach, as standard service offerings are the most important points of contact between the preventive systems and the individual children and parents. Preventive

work can succeed only if members of the target group are reached on a broad basis. Examples of incentives include tax exemptions and additional services. Most states promote the use of *early-life health examinations,* which are usually covered by the prevailing health system. In some countries there is a strong tendency to treat these early-life health examinations as obligatory, even if there is no legal obligation in place. However, proof of participation is often associated with certain other benefits, or is required in order to enter childcare facilities or schools (see Austria, for example, where child benefits are contingent upon early childhood examinations, or Finland, where maternity benefits are contingent upon undergoing medical examinations during the pregnancy. In Lithuania, access to childcare and primary school requires that the child undergoes yearly health check-ups). Similarly, *home-visitation programs* are offered on a voluntary basis in some countries.

INFOBOX 4: **Health visitors in England**

Health visitors are usually nurses or midwives with special training. They offer regular checkups for children from birth until the age of five. Health visitors typically come to the parents' home to carry out the check-ups; they are additionally able to answer any parental questions concerning the child's health or parenting more generally. If they see that something is wrong with a baby / child / family, they typically contact the appropriate professionals or authorities. Health visitors are financed by the public National Health Service, and are a free service.

In some cases, there are difficulties in meeting parental demand due to personnel shortages; thus, the universal approach runs into fiscal constraints that are poorly addressed in some countries. Childcare is provided as a voluntary service in all states (although Austria introduced one obligatory year in 2017, France introduced three obligatory preschool years in 2019, and Lithuania introduced one obligatory preschool year in 2016); thus, there generally exists no obligation, despite some experts' call for such a requirement (Hüsken, Walter and Wolf 2010). Some states offer incentives for childcare attendance (e.g., by waiving fees for all children or for children from socially disadvantaged families; for instance, in England, children whose parents receive social benefits can receive free childcare beginning at age two, a year earlier than usual). Although some states such as Germany have introduced an entitlement to childcare, some regions have had difficulty in meeting demand. While these basic offers are voluntary in all EU

TABLE 3: **Preventive measures: voluntary, incentivized and obligatory**

Voluntary	Incentives	Degree to which obligatory
Early-life health examinations		
Denmark England Finland Netherlands Lithuania Spain Ireland Sweden		Germany (quasi-obligatory) Austria (quasi-obligatory) France (quasi-obligatory) Czechia
Home visitation		
Austria Czechia Denmark England Germany (some local exceptions) Finland (Ireland)		
Childcare		
	Czechia (entitlement for children above 3; low fees) Denmark (entitlement and low / no fees) Finland (entitlement and low / no fees) Germany (entitlement and low / no fees) Ireland (entitlement to two free preschool years; universal and targeted support for childcare costs) Netherlands (entitlement and low / no fees) Spain (entitlement to three free preschool years) Sweden (entitlement and low / no fees) England (entitlement to two free preschool years, targeted support for more free hours per week and a further free year)	Austria (1 year mandatory; since 2017) France (preschool between ages 3 to 6; mandatory since 2019) Lithuania (compulsory preschool year; since 2016)

Voluntary	Incentives	Degree to which obligatory
Schools		
	Austria Denmark Finland England / UK France Ireland (in these states education is compulsory, but not bound to school attendance: home schooling is allowed)	Germany Lithuania Netherlands (home schooling in rare cases permitted) Spain Sweden Czechia (home schooling permitted on case-by-case basis)

member states, school attendance is compulsory in most states examined here (with the exception of Denmark, Austria, Finland, France, Ireland and the UK / England, where home schooling is allowed, but education of some kind remains compulsory).

3.4 Centralization vs. decentralization in services provision

As mentioned, the way in which services are integrated into the administrative architecture is closely related to the general administrative setting. The three Nordic countries of Denmark, Finland and Sweden have a long tradition of extensive welfare regimes and municipalities holding educational, social-services and, to varying degrees, even healthcare competences. Therefore, it is little surprise that prevention is institutionalized on the municipal level in these countries. In both Denmark and Sweden there is a critical gap between the healthcare sector – which in both countries falls partially under the remit of counties or regions – and the education and social-services sectors, which fall under the remit of municipalities. All three countries, however, have developed structures to overcome this gap between healthcare and social affairs / education, in the form of the multidisciplinary family centers in Sweden and Finland, and the health visitor programs in Denmark. Each of these programs provides a single point of contact for (expecting) parents, and offers the possibility of professional dialogue and cooperative action between all involved actors. Nevertheless, when structured as a voluntary program, this form of cooperation has not found universal application within its host country (as seen with Finland's family centers).

INFOBOX 5: **Family centers in Finland**

The basic goal of Finland's family centers is to connect all services contributing to a child's successful upbringing (while also involving the parents). The family centers create a network, coordinating public-sector social, health and education services as well as the activities carried out by non-governmental organizations, parish groups and volunteers. Guidelines have been established for the family centers at the national level. Municipalities have created different types of family centers, with some taking the form of networks, and others being more municipality-centered. All place a strong emphasis on low-threshold services, with the aim of reaching as many families as possible and detecting problems at a very early stage. In cases of need, the family centers can provide counselling or refer visitors to more specialized services. However, they are have not been implemented in all municipalities.

With its 2015 reform, the Netherlands pursued a similar path, shifting all prevention-related competences (with the exceptions of schools) to the municipal level. The Dutch youth-care and welfare system consists of a variety of different services, including universal services, preventive services and specialized services. Examples of universal services include youth work and childcare. Preventive services include child healthcare, general social work and parenting support. Finally, examples of specialized services include youth-care services, youth mental-healthcare services and child-protection services. Until 2015, the municipalities were responsible for the universal and preventive services, while the provinces were responsible for the specialized services. Since that time, all the provinces' competences relating to children and youths have been transferred to the municipalities. A key goal here was to concentrate all competences in one administrative body, so that multidisciplinary teams could take care of all of children's needs in an integrated way. Additional objectives of the Child and Youth Act are to decrease the number of children in specialized care, increase support for preventive services and early intervention, and promote the use of social networks within children's' direct environments (drawing on civil society's aid in a "parenting together" model). Although the reform has not yet been fully implemented across the country, it shows considerable potential with regard to establishing a functional set of integrated preventive measures.

Though starting from different positions (decentralized unitary state vs. federal state), France, Germany and Austria have all developed network structures designed to overcome the sectoral fragmentation of competences. As regional networks including all actors from relevant sectors, Austria's Early Prevention *(Frühe Hilfen)* measures for children up to the age of three are specifically designed to enhance prevention. Their aim is to intervene before problems arise, and to provide early and comprehensive support in cases of already-manifest problems, thus keeping children on successful paths. In so doing, they are exemplifying the concept of primary but not universal prevention. For its part, France has networks that connect various practitioners in the area of pregnancy healthcare, helping expectant mothers find the care they need while also focusing on primary prevention. However, the focus here is still largely on the health sector. In the preschool setting, school-based education teams bring together several different actors to decide what is best for the child in cases of problems; these teams can also draw on inter-school networks to access further expertise. Furthermore, specialized mother- and child-protection centers unite actors from different sectors in a way similar to the Nordic approaches, further bridging the gap between the health and education sectors.

England and Ireland follow a different pattern; here, policies are more single-purpose-oriented, with local governments playing a less prominent role. In both countries, healthcare issues are primarily the responsibility of a strongly centralized, single-purpose national body, the National Health Service in England, and the Health Service Executive in Ireland. However, in recent years, both countries have also created specialized centers for (expectant) mothers/parents and their children; in each case, these offer access to professionals from a variety of sectors, enabling better services for mothers and children.

INFOBOX 6: **Sure Start Children's Centers in England**

Created through a central government initiative in 1998, Sure Start Children's Centers have been managed by local authorities since 2005, while funded by a general early-years grant by the central government. These centers originally pursued a universal approach, but shifted their focus to addressing disadvantaged families in 2013. They are staffed by multidisciplinary personnel, and provide services for children up to the age of five, as well their parents (e. g., counselling or medical services). They cooperate closely with other institutions such as preschool facilities or childminders.

However, these countries show little in the way of cross-sectoral cooperation structures in the preschool area, leaving prevention services at the preschool level rather fragmented. There is often considerable frictions between schools and the other services, exacerbated by different administrative responsibilities.

TABLE 4: **Administrative responsibilities: Centralization versus decentralization, fragmentation versus integration**

Mostly decentralized and integrated	Mixed	Mostly centralized and fragmented
Denmark	Germany	Ireland
Finland	France	England
Sweden	Austria	
Netherlands	Czechia	
Lithuania	Spain	

Overall, the results tend to reflect the individual states' welfare traditions and basic administrative structures, with the sample countries' "prevention patterns" clearly grouping themselves into Nordic, conservative and liberal welfare regimes. Interestingly, though, we find a tendency toward "one-stop-shops" in the area of healthcare, with Ireland and England recently embarking on initiatives of this kind, following models that already exist elsewhere. At least in England, there is also an interesting trend toward the sharing of responsibilities; for example in 2013, local governments gained commissioning responsibility for children's public-health services. This is part of a bigger reform process described in a 2010 government white paper ("Healthy Lives, Healthy People" (Department for Health 2010)). For its part, Ireland created a new legal entity called "Tusla" in 2014, combining several previously fragmented services for children and young people under one roof, a move that also points in a rather cross-sectoral direction with regard to service delivery. It will be interesting to see whether these countries will show similar developments in the near future in the area of early-life education.

3.5 Financing: Decentralized vs centralized

The character of a prevention-program's financing – that is, whether it is financed generally by a central government institution or at the level responsible for delivering the service – also plays a key role with regard to uniformity and accessibility. A related question is whether each sectoral budget is separately affected, or whether there is a horizontally integrated prevention budget. Centralized financing (theoretically) allows for better allocation of budgetary resources to areas experiencing greater need, which might otherwise lack fiscal resources. Decentralization carries the danger of an uneven distribution of service offerings based on local governments' individual fiscal powers. As local government fiscal strength tends to be highly correlated with the socioeconomic pressures they face, there is a severe danger of vicious cycle; that is, local governments facing significant pressures (e.g., with regard to child poverty) find themselves unable to establish functional preventive structures, while good structures develop in areas where there are fewer problems (Grohs & Reiter 2017). For this reason, Ireland's area-targeted approach (Area Based Childhood Program, ABC) is interesting, and could be considered elsewhere, even though it could face substantial constitutional hurdles in Germany, for example. By contrast, the decline in overall resources effected during the decentralizing reforms in Netherlands threatens to exacerbate the vicious-cycle problem in the future.

TABLE 5: **General financing of preventive structures: Centralization versus decentralization**

Decentralized	Centralized
Denmark	Austria
Finland	England (UK)
Germany (local governments)	Germany (health insurance and other social insurance programs)
Sweden	Ireland
France (départements)	Netherlands
	Spain
	Lithuania

The empirical evidence shows a picture that contradicts our expectations at the first glance. For example, the "stronger" preventive countries of the Nordic countries use decentralized financing structures for most of their preventive measures, while a centralized financing system prevails in most other states. However, the Nordic cases also show a high degree of local variation (e.g., in the adoption of family centers in Finland, where there is no central steering structure, or the variance between health services in Sweden, where the government simply passes general regulations and leaves implementation to the county councils). On the other hand, the centrally financed systems show little in the way of coordinated programs, with funding usually taking place along departmental lines, and turf wars developing between central departments (for example, the strongly centralized National Health Service in England has few connections to other sectors or to the local level).

3.6 Additional funding: Use of special programs and European funds

The last dimension in our study examined countries' general financial frameworks. These frameworks have the advantage of being reliable and sustainable with regard to establishing preventive structures. Nevertheless, they are not the only resources to rely on. Several states have national programs exist that allow local governments or other institutions (e.g., schools) to apply for funding for specific projects. This is generally conceived as start-up funding, with the expectation that the projects receiving funding will in the future be self-sustaining.

For the purpose of this study, the use of European funds, especially the European Social Fund (ESF), is of particular importance. In our research, however, financing through the ESF remained an exception. Most projects financed with ESF resources target specific groups (e.g., Roma) or specific transitions (especially between school and employment). The "Leave no child behind!" project in the German state of North Rhine-Westphalia is the only project with a universal and integrated approach that shows considerable use of ESF funding, at least as far as our investigations showed.

3.7 Other governance instruments: Information, networking, performance management

In addition to financial resources, information, guidance and benchmarking are all important government tools. The countries with the highest degree of centralization all provide more materials (e.g., manuals) and consequently use some form of performance management. These central governance instruments, such as Tusla's National Performance Activity Dashboard, are used for regular reports on key performance indicators. Similar instruments are used in some Nordic states. The main difference lies in the governance mode; whereas in England and Ireland, performance management is backed by a system of sanctions and rewards, the Nordic approaches rely on the provision of information and the will to learn. In both Finland and Denmark, activity-based support is conducive to the establishment of preventive frameworks – additional preventive results in extra funding.

Regarding informational tools, information manuals such as Finland's National Guidelines for the Family Centers are distributed widely. Incentives are used in Denmark and Finland, with state grants for local governments partly depending on these local entities' prevention activities. In Sweden, local governments can be certified, providing an incentive to establish preventive structures such as the Children at the Center program *(Barns behov i centrum)*.

INFOBOX 7: **Sweden's Children at the Center**

Sweden's Children at the Center program *(barns behov i centrum)* is an initiative by the National Board of Health and Welfare that seeks to enhance social services work in all municipalities. It encourages multidisciplinary networking, equal opportunity and evidence-based child-welfare activities. Municipalities can be certified under this program, and most municipalities have been working under the initiative since 2006.

In the continental European states, there is often a lack of national guidelines, with the exception of the Early Prevention programs in Austria and Germany, which draw on national exchange structures. Information and guidelines are often discussed in vol-

untary horizontal networks (e. g., the *Arbeitsgemeinschaft Jugendhilfe (AGJ)* in Germany), but no more binding structures have been implemented, as these would have far-reaching fiscal consequences. In Germany, according to the so-called connectivity principle *(Konnexitätsprinzip)*, the federal level would in such a case have to provide funding for the binding structures. In general, there are few performance-management structures here (with some regional or program-based exceptions). For these countries (Germany, Austria, France, and to a certain extent also the East-Central and Southern European countries), preventive services might be said to be under-governed by central actors.

In all policy sectors, Denmark, Ireland and England show a trend toward more evidence-based policymaking. Ministries and their national boards finance, collect and disseminate information about good practices through meta-reviews, pilot projects and evaluations. The Netherlands has joined this evidence-based movement since 2015, but faces some resistance from the local level. However, according to our interviews, local policymakers in the Netherlands are slowly starting to accept and support preventive measures based on empirical evidence; not least **because Nordic experiences are increasingly used by practitioners to convince their municipalities' policymakers.**

A final interesting but difficult issue is the use of digitalization. For example, "predictive prevention" projects driven by the use of interconnected ("big") medical data can be observed in Denmark. The use of such tools for prevention purposes raises ethical questions, with the dangers of data abuse and personal privacy violation being obvious.

3.8 Summary

Taken these findings together, there seem to be three quite clear-cut clusters, with some additional cases not yet clearly classifiable.

The two most distinct clusters might be labeled according to their geographic origins as the Nordic and Western European clusters, or in the terminology of comparative welfare-state research (Esping-Andersen 1990) as the "social democratic" and "liberal" systems. A third and less clear-cut cluster consists of the central continental European states (Austria, France and Germany) plus Czechia, which shares most of these others' characteristics. In the field of comparative public administration research, these states

TABLE 6: **Synthesis of preventive approaches in 12 EU countries**

Dimension	Denmark	Finland	Sweden	Austria	Germany	France	Netherlands	England	Ireland	Spain	Lithuania	Czechia
Definition and framing of policy problem: What is prevention and who is the target group?												
Universalism vs. Targeting	U	U	U	M	M	M	U	T	T	M	M	M
Integration vs. Fragmentation	I	I	I	M	M	M	I	F	F	M	I	M
Voluntarism vs. Obligation	M	V	V	O	O	O	V	V	V	V	M	V
Implementation of preventive measures: What institutions are implementing preventive measures, and how do they coordinate with each other?												
Centralization vs. Decentralization	D	D	D	M	M	M	D	C	C	M	D	M
(National) steering mechanisms: What mechanisms (e. g., rules, information, incentives, benchmarks) does the national level use to intervene?												
Central vs. Decentralized funding	D	D	D	C	M	M	C	C	C	C	C	C
Strong vs. Weak Central Guidance	M	M	M	W	W	M	W	S	S	W	M	W
Strong vs. Weak Performance Management	M	M	M	W	W	M	W	S	S	W	W	W

■ Nordic Cluster ■ Western European Cluster ■ Continental European Cluster

M = Mixed, U = Universalism, T = Targeting, I = Integration, F = Fragmentation, V = Voluntarism, O = Obligation, C= Centralization or central, D = Decentralization or decentral, S = Strong, W = Weak

have been labeled as featuring a rule of law *(Rechtsstaat)* culture (Kuhlmann & Wollmann 2019), and as being "conservative" welfare states (Esping-Andersen 1990).

Spain and Lithuania do not fit into any of these patterns, exposing one weakness of our study; that is, the comparison is lacking in other Southern and Eastern European states, which means that two other likely clusters may have been missed. The most intriguing case, the Netherlands, seems to be moving from a continental to a Nordic style. However, the relative dependence of local governments on the state, especially in fiscal terms, hinders a full shift at the moment, and seems to be a main obstacle to the success of the reform.

The three identified clusters may be characterized as follows (we prefer a classification in geographical terms, as some of the comparative public administration and Esping-Andersen terminology seems outdated and inappropriate in 2020).

Countries in the **Nordic cluster** pursue a universal and integrated approach to prevention. Responsibilities are concentrated in functionally and fiscally strong local governments. At the same time, the central government supports local government by communicating good practices and providing (some) financial support. This approach is backed by elements of the social-democratic welfare-state tradition (universalism) and the "Nordic model" (Kuhlmann & Wollmann 2019) of local government, with its functionally strong and relatively fiscally autonomous local governments.

The **Western European cluster** pursues a targeted and segmented approach. The targeting of measures is drawn from the liberal welfare tradition, in which the initiation of public action requires the demonstration of need. The segmentation of governance resembles the general public administration model in England and Ireland, where single-purpose agency administrations have been in place since the 1980s, and local governments have lost competences to agencies, quangos and the private market (Ebinger et al. 2011).

The **continental European cluster** occupies an intermediate position in many of the study's dimensions. This stems from the inertia of their dual welfare-state architectures, which rely both on centrally provided and/or financed services, and on decentralized services financed by local governments. The latter are in a constitutionally weak position and have little fiscal leeway to finance activities that go beyond the tasks delegated by the central and state governments. In these states, diverse networks connecting the various administrative levels, the public sector and civil society groups often develop innovative preventive solutions, but these are rarely rolled out across the whole country.

In 2015, the Netherlands decentralized a number of competences having to do with children and young people; as a consequence, municipalities are today responsible for implementing nearly all measures in the fields relevant to this research (Netherlands Youth Institute 2019). However, many local governments continue to struggle, as the central government provides little guidance, and the financial resources transferred are quite limited.

4 Case study findings

The three in-depth case studies developed as a part of this project allow us a deeper look into actual practices and results. . The case studies summarized in this section are available in full length in this series (see page 163 for further information). Whereas Austria shows no coherent set of preventive measures, but a number of interesting, mostly local initiatives, the Netherlands and France show a more coherent set of reforms, even if implementation in both countries is far from complete.

4.1 Austria

The Austrian implementation of the Early Prevention *(Frühe Hilfen)* program focuses on secondary and tertiary prevention, and features highly interesting conceptual and organizational characteristics that can be considered key to its success. For example, it is entirely voluntary, and is strictly separated from the public child-protection system. Set up using regionalized structures, it bridges fragmented local government structures and draws on a critical mass of potential clients and services; it is based on connections with existing organizations and services, and aims at linking families with special needs to relevant specialized services. This approach solves many problems conventionally encountered in heavily (organizationally or functionally) fragmented institutional setups, as well as those experienced in non-metropolitan areas. The Early Prevention model shows exceptionally high potential for transfer to other contexts. The organizational design is well-developed and tested. The approach is cost-efficient and easy to adopt, no matter what the character of the established organizational structures. The family support specialist could be integrated into any community-worker structure in any region.

The *Graz model* successfully combines several innovative approaches to child, youth and family services. With an office that hosts a number of professional services related to children's issues, a neighborhood-centered approach ***(Sozialraumorientierung)*** that has been in place for more than 15 years, and the use of numerous non-profit contractors integrated into the multidisciplinary service centers, the city is truly a highly interesting and instructive case. The neighborhood-centered approach challenges many of the assumptions and routines typical of case-oriented social work, as it switches the focus from individual problems to be "cured" to the resources available in a neighborhood, and ways that they can be made available to groups. Public sector and non-profit units work together successfully in the districts thanks to intensive dialogue and mutual support. The **Youth and Family Office** is the **key actor** for all of the above-listed programs, identifying needs, designing organizational regimes to address and contract with (generally non-profit) service providers. **Communication is key** in keeping the system functioning, and constant coordination on both the district and city level is required in order to adapt programs to changes in the various neighborhoods' problems and needs.

The primary focus of the pilot project in Styria is to connect established organizations and service offerings within local rural communities. The aim is to make existing potential for prevention more visible and better accessible for all children and youth in the community. Community coordinators serve as the key actors on the local level. Their primary tasks are to map all relevant organizational actors and their offers for children and youth; identify gaps in service coverage; mobilize the local community; raise awareness of issues related to children and youth; team up with existing networks; and if necessary initiate new networks, exchanges and services. The project was initiated in late 2017 and is funded for three years. It is a very ambitious and inclusive prevention project, as it encompasses all organizational actors with links to children and youth. The resulting inventory of actors and networking efforts appears likely to meet the established prevention targets. However, the project requires the expenditure of considerable resources and demands commitment from all actors involved.

As a fast-growing major metropolitan area, *Vienna* faces particular challenges in the provision of integrated preventive services to children and youngsters. The manifold public and non-profit organizations in the field exchange information with each other and coordinate with one another via a host of networking platforms specialized by issue, age group or urban region. The relevant departments within the city administra-

tion play a key role in many of these macro-networks. On the operational level, a second set of strategies comes into play. Here, the child-protection service relies strongly on in-house service provision while also cooperating with public sector or professional services, supplemented by vigorously maintained small-scale networks that incorporate all child-related actors within an urban quarter. The most instructive observation from the Viennese case is without doubt that a combination of seemingly contradictory approaches and strategies – that is, networking on various levels on the one hand, and the vertical integration and bundling of indispensable services in one public agency on the other – seems to be a highly successful approach in providing a rather tight-knit network of prevention services in a metropolitan context.

4.2 France

The overall assessment of local public sector preventive policymaking in France reveals a number of strengths, but also several weaknesses. However, these strengths and shortcomings are not always clearly separable. The classification of the features of preventive policymaking depends on the dimension of assessment; in particular, efforts to achieve the goals of effectiveness and legitimacy may induce mutual frictions.

With regard to effectiveness, French (local-level) preventive public policymaking oriented toward children and young people has the potential to be highly effective, as its institutional basis and the regulated division of labor between local actors make it possible to reach target groups.

Overall, policymaking with a preventive orientation in France is structured strongly along the life-courses of children and young people. In implementing prevention policies, the state uses the core local public institutions that structure children's or youngsters' daily lives outside of their homes and families (e.g., preschools, schools, associative life within the municipality). Thus, nearly all children and young people ultimately get in contact with the public institutions and actors charged with preventive functions, and which are skilled in the early detection of risks (in terms of health, personal development or social environments).

Generally, the effectiveness of preventive policymaking depends on the degree to which the general public or the target groups can actually be reached by policies. Simi-

larly, the way in which the passage from one life phase to another is managed through specific preventive services available at different life phases, and the transfer of information between actors relevant at these different stages, is also of crucial importance. For children and young people in particular, this transfer of information as they move from one life phase to another can be challenging, as relevant information is often distributed across different sectors of public action (e.g., healthcare, social protection, personal development and education).

In France, efforts to reach the target group are most effective for young children, as are the mechanisms for sharing information across sectors. However, there is a certain lack of clarity in the distribution of (prevention-relevant) functions and competences across the different levels of government. The transfer potential for French preventive practices targeting children and young people is mixed. On the one hand, an institutional distinctiveness to the preventive policymaking structures limits the potential for transfer. This is especially true in the area of healthcare. Even if there are considerable similarities between the French and the German healthcare system (both are Bismarckian systems based on a social insurance system), the underlying institutions are quite different. For example, France relies heavily on the department level centers for the protection of mothers and infants, as well as diverse medical staffs employed within the schools. Thus, there is a distinct system of health protection and preventive action focused on children and youth that is situated outside the normal health system, and which stands out due to its public/state-controlled character. Even if children or young people and their parents or legal guardians are free to consult actors within the "normal" French health system (private practitioners, hospitals), for instance to carry out obligatory preventive examinations, many children and young people (and their parents/legal guardians) use this public-health offering. Transferring structures of this kind to the German context would require local/municipal medical capacities to be enhanced, and would further require the medical sector's self-governing bodies (private practitioners; sickness funds) to relinquish some of their current functions and competences.

On the other hand, there is potential for policy transfer with regard to the planning of local preventive action oriented toward children and young people. Arranging for regular dialogue between local (public and private) prevention actors, extending as relevant to medium-term planning – particularly if actively promoted by higher levels of government such as the *Bundesländer* – could increase these actors' commitment

to preventive policymaking, while also encouraging public and private spending in this field as "social investment." Such planning could also follow the French model's tendency to structure services along the target group's life course. A life-course-oriented public policy oriented toward children and young people could help overcome any bias toward the early childhood and childhood phases.

Overall, this approach also resonates with the recent trend toward strengthening primary rather than secondary or even tertiary prevention measures, with observers calling for a stronger focus on early action across the various levels of government.

4.3 Netherlands

All in all, prevention policy in the Netherlands shows ambiguous results. Responsibility for carrying out preventive services today falls entirely to the municipalities, which can act rather independently from each other and from the national government. By law, they have to fulfill certain tasks and provide certain services, which are not regulated with equal specificity, and which sometimes leave considerable leeway for voluntary action. Healthcare services nationwide are subject to the mandatory content of the *Basispakket JGZ.* These preventive services have a low threshold for access, to the point that they are regarded as nearly mandatory, especially in the early years of childhood. However, other aspects of prevention lack this degree of encompassing commitment. This is due to the fact that although municipalities today possess all responsibilities in children- and youth-related areas, only healthcare services are regulated in detail by the national government. The social-services area in particular features only limited national-level regulations, with most details left up to the individual municipality. Thus, we find great policy variation across the country. By law, the municipalities are obliged to provide basic or general social preventive services but are free to select their own model and organizational structure. Since the reform in 2015, two basic models have emerged: the social neighborhood team, and the center for youth and family. The latter was the dominant model before 2015; however, many municipalities have since switched to the neighborhood team approach due to its greater flexibility. However, use of such services is voluntary, so people are free to choose whether they want to contact a neighborhood team if they are experiencing difficulties.

The character of cooperation between municipalities differs depending on the policy area. In the social domain, there was considerable cooperation when all municipalities were utilizing the youth and family center approach. Municipal coordinators would meet on a regular basis, and exchange information. Following the shift to neighborhood teams, there was confusion as to who to contact in other municipalities, and these cooperative structures nearly vanished. However, as the implementation of the reform measures reaches completion, people have found more time to seek out contacts in other municipalities, and are today again establishing networks of cooperation. Especially in the larger cities, key operational managers have found informal ways of exchanging information and experiences with their peers. In general, we have the impression that larger cities had an easier time navigating the reform process, while smaller municipalities were somewhat overstrained. In smaller municipalities, the role of individual staff members in the youth-services departments is far more important. For example, active youth-department heads, combined with a mayor and council open to new approaches and a preventive approach, were usually able to find promising ways forward. However, our research showed that the opposite scenario is also far from rare.

The 2015 shift in responsibilities was paired with budget cuts. Thus, municipalities had to balance the money needed for different tasks very carefully with mandatory tasks such as special care for youth (i.e, compensatory care provided by specialized institutions), which typically receive more funding than voluntary preventive tasks. This financial shift was accompanied by a shift in general awareness toward the compensatory aspects of care; as special care measures are expensive to provide, many municipalities sought to increase efficiencies and thus reduce costs. For example, some work together in informal geographical areas, coordinating on functions such as the commissioning of special care services. However, awareness of the benefits of preventive measures is slowly rising. This is largely driven by the cost factor; municipalities hope to lower the costs of special care by reducing the number of people who need such care. Thus, the underlying logic is that early preventive measures could prevent the development of problems requiring compensatory special care. As logical as this argument sounds, many representatives of youth-services departments report that their heads of local government demand statistical proof that investing in prevention can save money in the future.

Finally, municipalities are also cooperating on healthcare functions, for instance by jointly buying JGZ-related services within specified geographical areas. However, representatives of one of the municipalities examined indicated that this model was ineffective, and instead organized the way they commissioned JGZ services themselves, cooperating with surrounding municipalities. Similar concerns and approaches have also emerged elsewhere, with smaller municipalities often feeling not adequately served compared to larger cities within the areas.

A mixed picture also emerges with regard to cooperation within municipalities, and between prevention actors. The social neighborhood team approach is promising, combining different actors from different sectors, which work together to find the best solutions for problems. However, barriers between the social, healthcare and education domains often remain. Nevertheless, according to one official from a municipality that adopted this approach, coordination and cooperation are improving, with a first start being made inside the municipal administration. Obviously, it will take time to establish the team structure and logic within all preventive policy structures, especially following a massive reform kept municipal staffers busy for years.

Dutch municipalities have also established semi-formal or informal exchange platforms, designed to bring together different actors in the children and youth-services sector. However, in our visits, we got the impression that municipal officials also hoped that the actors would exchange information with each other on their own, without official organization by the municipality. Interviewees indicated that several prevention projects were often running at the same time, without their organizers' knowledge. Fora of this kind should help to better coordinate actors working in the prevention sector.

Cooperation with the educational sector represents another problem in the country. The Dutch system's freedom of education often makes it difficult for municipalities to work inside or with the schools outside the context of JGZ services. However, in one municipality studied, there is already a promising pilot project underway that brings together actors from a school and actors working in prevention in other sectors. Other schools are said to be interested in adopting the measures tested in the pilot project. A separate pilot project builds on the existing regional cooperation structures in the area of special education; in 11 of these regions, "political coalitions" of (regular) schools and municipalities are currently working to enhance cooperation between these actors in the areas

of youth welfare and education. Furthermore, there are plans to integrate special care actors into schools, with hopes that their expertise will help prevent children from falling into the special care system. However, some schools may be hesitant to take this step, fearing that it could stigmatize both the schools and the pupils.

The exchange of information between prevention actors, especially on a cross-sectoral basis or between different municipalities, is not generally regulated. Again, the health-care sector is an exception; here, there are digital JGZ files for each child and young person, which can be accessed by a variety of medical personnel. In other areas, we got the frequent impression that actors often had little idea what their counterparts in other sectors were doing. What communication does exist seems to take place on a general level, addressing general problems rather than talking about specific cases. Nevertheless, the neighborhood team approach seems suitable to overcoming this situation in the long run, if it is adapted consistently and results in truly cross-sectoral networks. At least in the municipality examined that made this change, we got the impression there is still much work to do. However, this municipality is also experimenting with a data-driven approach to prevention, where data on special care for youth is to be used to identify and address risk factors across different life phases, by different actors. All municipalities have had access to this data since 2015; thus, all could in theory use it to improve the situation of children and young people by employing an integrated, evidence-based prevention policy. Another municipality studied developed a risk-oriented approach with similar logic, trying to identify risks or potential risk factors, and then addressing these with general policies that would benefit all children.

5 Conclusions

5.1 The relative performance of the states and their implications

European welfare states have developed different approaches to address basic social needs and feature different governance architectures to implement and administer their welfare policies. Whereas the different policy approaches have been discussed at length in the welfare regime literature, less attention has been afforded the implementation side (Kazepov 2018; Sellers & Lidström 2007). Nevertheless, the public administration perspective on the welfare state is an important supplement to those provided in the welfare regime literature, as there are obvious complementarities between a regime type and the administrative architecture of a welfare state (e.g., the dominance of local governments in social-democratic welfare states, the significance of "indirect administration" by social insurance bodies in conservative welfare states and, finally, a centralized steering of welfare benefits by agencies in liberal welfare states). Focusing on public administration and governance arrangements becomes important when new policy initiatives are incorporated into existing welfare structures, as is the case in the new welfare "paradigms" of social investment and prevention policies.

In summary, we recognize in all countries a tendency to strengthen prevention efforts and enhance cooperation between different sectors. The modes of implementation take place primarily within the framework of procedures and institutional pathways that have been shaped by each country's individual welfare system and administrative tradition. The Nordic welfare states, for example, have incorporated prevention measures into their decentralized service architecture. By contrast, conservative and liberal welfare states continue to struggle with the transparent incorporation of prevention measures into their institutional architecture. As a result, they often develop parallel

structures that deliver ad hoc, fragmented services. In more effective cases, the responsible actors prove able and willing to connect with actors in other institutions or sectors, although the coordination of services and transparency regarding available services remains deficient. Services in these countries are therefore often distributed unevenly.

What can we learn from these practices in designing institutional approaches for Germany and other countries? And which approaches can the European Union take to help ensure that children and youth in each member state are provided safe and healthy environments?

5.2 Recommendations

5.2.1 Best practices and potential for transfer to Germany

The prevention landscape in Germany features several initiatives designed to strengthen local approaches, but there are problems with respect to fragmented responsibilities, a lack of conceptual cohesiveness, and major discrepancies in terms of local capacities and ambition. The research accompanying the "Leave no child behind!" project in North Rhine-Westphalia identified several preconditions for the successful implementation of (primary) preventive measures targeting children with a universal approach, the so-called community-based prevention chains (Bogumil & Seuberlich 2015; Strohmeier, Gehne, Bogumil, Micosatt, & Goertz 2016). The basic elements of this approach involve maintaining a clear focus on local-level needs, consistently taking a child-centered view, and ensuring that universal and targeted prevention approaches are interwoven.

The following accompanying success factors have been identified:

- **Strategic political support:** Prevention chains need the strong support of local politicians and administrative heads; mayors and city or municipal councils should introduce and implement a strategic agenda.
- **Administrative coordination:** Inter-administrative cooperation on operational and financial matters is essential for success.
- **Joined-up vision:** All relevant actors must have the welfare of children in mind and act accordingly.
- **Evidence-based:** Actions taken on the part of a municipality need to be evidence-based and impact-oriented. Evaluation and learning opportunities are essential.

- **Cooperation:** Local governments need to be closely connected with service providers and medical services in order to make prevention chains work.
- **Focus on early childhood as the most formative period for growing up:** It is essential to focus on early childhood and build prevention chains throughout the course of childhood and youth. Ensuring continuity in contexts of change, in particular with regard to institutions like childcare or schools, is important.
- **Empower parents and strengthen their skills.**

The primary aim of our comparative analysis was to identify good practices in national strategies and governance, as well as incentive structures that support local-level implementation efforts. What lessons can we derive from our comparison of European preventive structures that might foster success in the German context specifically? In the following, we outline the main challenges of the German system and explore potential transferable approaches. It is important here to distinguish the degrees of potential change. The first involves systemic reforms that would impact cornerstones of the German institutional architecture, that is, the federalist system, the system of social insurances, and the independence of local governments *(Kommunale Selbstverwaltung)*. A second type of change involves significant shifts in policies taking place (e. g., changes in oversight or the introduction of new funding instruments). The third type of potential change involves introducing more piecemeal-like reforms, which can be best labeled instrumental reforms. In the following, we focus on the latter two types of change, as the first, systemic reform, is unlikely to take place in the German context.

In the German context, the main deficiencies regarding governance and incentive structures for prevention can be categorized as follows:

Design and character of preventive services

There are still problems regarding the outreach of preventive offers and with convincing parents of early-on participation in programs. There is a strong focus on early childhood issues, but deficiencies in transitions between institutions. German parents often associate a stigma with youth welfare offices *(Jugendämter)*, which results in low levels of trust and parents tending to avoid establishing direct contact with such offices. The key question here is determining which offerings – as well as their specific contents and institutional locus – can lower thresholds for the voluntary use of preventive services. At the same time, it bears exploring how preventive offerings can be made

obligatory or how parents can be "nudged" to take advantage of such offerings. In any case, reaching children and their parents at an early stage in a child's life is essential for prevention to succeed. An approach that combines efforts to lower thresholds with introducing instruments that strengthen commitment is essential.

Lowering thresholds: Preventive offerings have to be easy to identify and accessible. They must be universal and non-discriminatory in nature. A common best practice found in several of the countries examined here is the one-stop service offering that is (ideally) based in the community, is familiar and convenient, provides a wide range of services, and which has no stigmatizing effects. Many local governments in Denmark, Finland or Sweden feature community-based family or health centers, where parents and their children find a broad range of guidance and counseling services. The United Kingdom's Sure Start centers follow a similar approach. In larger municipalities, family centers of this nature can be devolved to neighborhoods. Such community-based family centers lower thresholds for participation by holding events such as children's flea markets and theater performances, providing children's libraries and cafeterias, and offering opportunities for children to play together. By removing family centers from stigmatized settings (i.e., institutions that target "problem groups"), parents are more likely to visit them and take advantage of their offerings. In most cases, health services can serve as anchor points to include other services.

Germany features several family centers and many German states have established funding programs for them. In most cases, German family centers use daycare facilities or primary schools as an anchor and receive relatively low levels of financial support. They rarely feature additional services and if they do, they handle each case individually. This pragmatic approach has some downsides. Because family centers are often linked with daycare, not all children are reached systematically and across the life-course. In addition, parents can prove hesitant to discuss problematic issues in the familiar, everyday environment cultivated by such centers.

How might Germany introduce similar structures as identified in the aforementioned states? The challenges are threefold: the centers require solid financing, relevant services have to cooperate in such settings (see the section on fragmentation), and they need to be met with broad acceptance. Regarding financing, it is crucial that additional resources be provided, at least during launch phases. Given the dire financial situation faced by many local governments in Germany (particularly those in

economically weak areas), ensuring the spread of such approaches requires state and federal financial support. Meeting the challenge of cooperation involves starting within existing structures when introducing different services under one roof. It is unrealistic to expect that all actors will be included from the start within a centralized system. Thus, as others have recommended (Bogumil & Seuberlich 2015), building on existing institutions can prove useful in moving forward. Finally, decoupling such centers from even only somewhat stigmatized settings can help expand and deepen a center's reach and efficacy. In some cases, the health system may be better suited to lowering thresholds (e. g., Finland) for families to take advantage of prevention services, as social services and youth welfare institutions often bear negative connotations for potential clients in Germany. Another approach involves using the education system as an anchor (e. g., Denmark). Innovative approaches allow both the education and health systems to work together in advancing prevention (e. g., school nurses in France) or at least allow professionals to exchange more information.

Increase obligations and nudges: A complementary strategy to include more children and families in prevention measures involves increasing the use of obligations and / or nudges. Whereas some offerings such as early screening examinations are quasi-obligatory (at least in some states in Germany), the penalties for failing to participate are often unclear. The responsible institutions generally aim to support such families but, in cases where families prove unwilling, they have little authority to enforce participation. There are similar issues with regards to vaccinations. In some of the countries examined, we find interesting examples of participation in early health examinations being coupled with child allowances (e. g., Austria), childcare services, or starting school. In Finland, maternity benefits are linked to pregnancy examinations. In Lithuania, access to childcare and primary schools is dependent on yearly health checks. In the German context, requiring full vaccination records for access to childcare is an important discussion. The vaccination issue should be handled with care, as prevention efforts should not have the effect of disincentivizing school attendance or using childcare services.

In public policy, nudges are a less invasive form of intervention designed to facilitate a desired behavior by improving the set of choices available to an individual (Thaler & Sunstein, 2009). A standard nudge entails changing the default choices available within an architecture of options. One easy-to-implement type of nudge involves issuing a proactive invitation to standard services like health examinations or vaccinations (e. g.,

the Netherlands.) Other types of nudges involve the ways in which referrals work: are parents required to apply for each service separately or can they expect to be referred from service provider to service provider without having to submit details regarding their particular situation to various agencies and institutions? Introducing small changes to such options can promote the use of services without interfering too much in one's private life. There are also cultural constraints to consider, as the countries examined have different cultural conceptions regarding the extent to which the state should interfere in private life. Whereas an interventionist state is a widely accepted tradition in Denmark, this is not the case in the UK or Germany. The obligatory exchange of information between institutions such as that seen between the Kela and municipalities in Finland would be very difficult to achieve in Germany. Whereas Nordic countries tend to perceive institutional access to or the transfer of personal data as normal, this is not the case in Germany, where stringent data privacy laws and practices apply. Even where data protection laws and protocols have been relaxed – as is the case with the Early Prevention model – practitioners remain reticent to exchange information *(Bundesregierung 2015)*. Such cultural norms are relevant in determining the acceptable reach of obligations. In the German context, it might prove useful to establish norms such as those seen in the Netherlands, where the usage of low-threshold services is widely accepted because "everyone does it" and doing so means one can avoid greater interference in the form of specialized care. Too strict or mandatory policies and programs can have adverse effects (e.g, parents are reticent to seek help early on), while low-threshold services are more effective for those in need of help (e. g., the municipal *consultatiebureau* in the Netherlands is widely used because of its non-invasive character). Another effective low-threshold service are so-called Welcome Baby Visits, which are also provided in Germany, though a lack of resources means they are not available in all states and municipalities.

Fragmented responsibilities

In Germany, responsibility for childcare, youth welfare, and social services lies primarily with local governments, but education and job-training are administered primarily by the states. The healthcare sector is governed by a complex network of health insurances (for financing), practitioners, professional organizations *(Ärztekammern)*, and hospitals of diverse providers. Local governments' health offices have a rather restricted portfolio, which means that the coordination of childcare, youth welfare, general social services, education, health, and employment in many communities is deficient. The

barriers to coordination are institutional and financial (i.e., who pays and who gains?), as well as cultural (e.g., educators, social workers, physicians, nurses and so on all have different professional identities). In what follows, we explore potential solutions that support stronger children and youth-oriented coordination between these sectors.

The **fragmentation of services** is one of the biggest challenges to implementing a holistic and cross-sectoral approach to prevention. Among the European countries examined, those states with strong decentralized local governments seem to feature the best preconditions for integrating different sectors and services (even if there is no guarantee that actors will cooperate once they are working under "one roof"). There are several drivers of service fragmentation: legislative fragmentation, a diversity of professional conceptions, and silos in administrative architectures. In Germany, this latter driver is a product of German federalism and the fact that tax-based welfare benefits are administered by municipal authorities, while health, pension, unemployment and accident insurance benefits are administered by contribution-based national social insurances. Since a systemic reform of both is unlikely, establishing stable working arrangements that cut across institutions and predefined responsibilities would be preferable.

Network approach: As observed in different EU member states, the institutionalized cooperation of different actors is crucial to establishing genuinely interdisciplinary prevention approaches. In addition to the aforementioned family center approach, we find compelling network-oriented approaches, such as the maternity "health networks" in France that connect professionals from different fields in helping individuals find the best solution to their individual situation. Further examples include the Early Prevention networks in Austria and the external guidance, counseling and psychoeducational teams for school interventions in Spain, which are institutionalized forms of cooperation among different professionals able to support students who need help with various issues. The presence of an (ideally) independent *inter-institutional steering body* is a marker of a best practice in ensuring the success of such approaches (e.g., Austria's Early Prevention networks and Lithuanian municipalities' inter-institutional cooperation coordinators). Financing such structures is a challenge, as most budgets are constrained by narrow remits defined by law and administrative responsibilities. Establishing centralized lines of funding for the moderation of horizontal networks across local and regional levels seems promising, as evinced by the good practices identified in Austria, France and Lithuania. In Germany, the federally supported Early Prevention program is an example of such an approach. Launched in 2012 by the Federal Minis-

try for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) under the auspices of the National Centre on Early Prevention, the Federal Initiative for Early Prevention has supported the federal states, cities, municipalities and districts in establishing local networks. After 2017, when the initiative came to an end, the BMFSFJ established permanent funding through the Federal Foundation for Early Childhood Intervention *(Bundesstiftung Frühe Hilfen)*. As a result, the expansion of Early Prevention networks and psychosocial support for families with children under three years of age has continued.

Staff continuity and network exchange are critical resources, as networks with impact build on personal relations, trust and common visions. Stable funding is therefore needed to avoid personnel turnovers due to job insecurity. At the time of this writing, ringfenced budgets for specific services leave gaps for generalized and cross-cutting services. To make matters worse: Some actors can act as burden-shifters as they try to shift responsibilities onto other actors in an effort to protect their own resources. This is an issue, for example, in institutional battles between education and social security systems or between healthcare and social assistance providers.

Heterogeneous capacities of local governments

The financial and personnel capacities of local German governments to implement prevention chains are rather diverse. This heterogeneity is manifest in a variety of impressive best as well as ineffective practices. While capacities are often understood in terms of financial and personnel resources, the political will to address an issue and awareness of it can also be understood as capacities. The questions derived from our cross-national comparison are therefore: How can the capacities of local governments be improved? How can political and administrative actors be informed of and incentivized to support the establishment of prevention chains?

In the context of our research, the **status of local governments** in the respective countries is one of the most important features for establishing effective prevention chains. In nearly every country surveyed, municipalities are seen as the appropriate and primary locus for prevention because of their proximity to citizens and the spectrum of responsibilities they already carry. The centralized systems with national agencies such as those found in England and Ireland are exceptions here. The legacy in Germany of local government's bearing considerable responsibility for various measures renders a shift to a centralized system with national agencies unlikely. We there-

fore recommend that Germany pursue a strategy that strengthens local governments' capacities to strengthen coordination with actors beyond the remit of local government (i.e., healthcare and education) and to develop broader approaches to prevention that do not heavily interfere with local autonomy.

Scope of jurisdiction: Determining the appropriate scope – in terms of geographical territory and clientele – of preventive structures is an important factor in their success. Larger structures allow for economies of scale, specialization and professionalism, while smaller structures are more accessible and associated with decreasing costs of coordination (e.g., Early Prevention networks in Austria). Once again, the Nordic countries stand out here, as the large scale and functional strength of their local governments are conducive to success in prevention. By contrast, in Germany, local government structures are very diverse and range from the small-scaled administrative units in Bavaria and the Rhineland Palatinate to the large units of North Rhine-Westphalia (Grohs 2013). Efforts to consolidate the size of administrative units have proved unsuccessful in the last decade (Ebinger, Kuhlmann, & Bogumil 2018), which means that a uniform approach for Germany as a whole is not possible. Whereas cities and counties might be the most appropriate administrative level for administering prevention in North Rhine-Westphalia (cf. Nordic countries), intermunicipal cooperation (cf. intermunicipal cooperation on health issues in the Netherlands' GGD regions) or regional approaches (cf. Austria and France) might prove more effective in other parts of the country.

Financial leeway: Finances and the financial context are essential – in all cases. Many local governments in Germany will not have the financial resources to support additional prevention programs on their own (Geißler, Hammerschidt, & Raffer 2019). As the federal level of government is constitutionally restricted to providing direct support to local governments, the states are the appropriate administrative level for conditional funding. The Nordic states and Denmark in particular are key models for such funding lines. In Denmark, local governments and regional programs of cooperation can apply for additional funding for prevention concepts. These activity-based subsidies for specific municipal activities targeting preventive measures can be seen as an important instrument in empowering local governments and convincing local decision-makers to engage in prevention. The establishment of such prevention funds (also in combination with European funds, as discussed in what follows) would help level discrepancies in local governments' financial powers. Such incentives would also

mobilize actors such as local politicians and administrative heads who might be disinclined to support prevention.

Prevention as a mandatory responsibility ***(Pflichtaufgabe):*** An interesting approach to ensuring prevention is treated as a mandatory responsibility can be found in Lithuania. Lithuanian legislation on strengthening the family obliges municipalities to offer a certain catalogue of (preventive) services for families, including counseling. In addition, the Lithuanian law on self-government obliges municipalities to ensure the organization "of preventive assistance for the child and the family, coordination of services provided by social, educational, healthcare establishments as well as by other establishments" (art. 6 no. 44 law on self-government). Municipalities are also responsible for implementing youth policy with the support of a state-funded coordinator for youth affairs. Municipalities also have a state-funded inter-institutional cooperation coordinator who supports the work of the municipal child welfare committee and coordinates all actors involved with child welfare services. A similar approach can be found in France, where the departments are obliged to submit child protection schemes every five years.

Transferring a similar approach to Germany would bring with it two consequences: Local governments would be better positioned to argue against cuts to prevention budgets, particularly **vis-á-vis fiscal supervisors,** who tend to classify prevention as an "optional" responsibility – and therefore among those first affected by cuts. Second, the state level governments would be compelled to reimburse (to a certain extent) municipalities for carrying out such tasks. Both outcomes would help boost prevention efforts considerably. Given the conceptual fuzziness associated with prevention, it is often difficult to specify individual claims. Like other mandatory responsibilities lacking individual entitlements (e.g., youth work) such measures run the risk of being neglected by authorities, particularly when austerity measures or budget cuts have been introduced.

Administrative guidance: Many local governments in Germany lack the capacity to develop local structures on their own. State and federal level government can support them by providing information and organizing events such as those already underway in the context of the Early Prevention program. Though often regarded as a soft instrument, centrally provided information can be expanded to include manuals, such as the Dutch manuals on health issues that target professionals in childcare facilities and schools.

Lacking evidence-based and planning capacities

In Germany, there is a weak tradition of evidence-based policymaking and planning. Diagnostics, evidence-based operations, controlling and impact assessments are underdeveloped in most German municipalities and are therefore difficult to compare with such efforts found in other countries. Germany also lacks robust data that goes beyond simple sociodemographic indicators. This prompts the question: How do other states implement monitoring systems and to what extent are such instruments transferable to the German context? Establishing additional **qualified planning** units are an important means of facilitating coordinated service provision. Strong orientation toward establishing evidence-based prevention policies can be found in Denmark, the UK and Ireland, and now in the Netherlands as well, where performance management has been intensified strongly. This approach is associated with two difficulties in the German context: First, because there are different departments responsible for prevention at the state and federal levels of government, effective monitoring requires joined-up efforts on the federal level. Second, as many tasks under scrutiny fall under the remit of local self-government *(Selbstverwaltungsaufgaben),* the federal and state governments lack the authority to interfere in local governments conduct or control their performance other than to exercise regulatory oversight *(Rechtsaufsicht).* A performance-based monitoring system would therefore have to rely on voluntary agreements with local governments.

A convincing evidence-based monitoring system would be an important instrument for decision-makers. As the inclusive and integrative approach of prevention implies, this research needs to be interdisciplinary in character. We need a more broad and robust evidence base that monitors effects over time and which is able to identify practices that work and those that fail. It seems imperative that the federal and state level governments engage in further research on what works.

5.2.2 Common problems in prevention across Europe: Lessons learned

Germany is not alone in the challenges it faces. We find common challenges across the European sample of our core inventory and case studies. Despite the institutional and policy differences among these states, all prevention policies must deal with the following issues:

Clarifying prevention: A shared understanding of prevention across the different sectors and administrative levels/units is absent virtually everywhere. In many cases, prevention is restricted to approaches in health policy or violence and drug abuse issue. In order to clarify things, we need to combine universally applicable national inputs and targets (guidance) with local government networks and other actors providing services. These networks could also include European level actors and their networks (see "EU-level actions necessary to strengthen overall prevention activities"). A continuous exchange on how prevention is understood and applied that is supported by centralized expertise on best practices and concepts could harmonize local approaches and establish a culture of learning.

Breathing life into coordination mechanisms: Both formal structures and administrative practice matter. Even if some states feature institutional frameworks more conducive to the coordination of different children- and youth-related services, there is no guarantee that this potential is effectively leveraged. Although the more integrated administrations of the Nordic countries, and to a lesser extent Lithuania and the Netherlands, provide better opportunity environments than their western and continental European counterparts with more fragmented administrative architectures, we nonetheless find gaps in coordination and a diversity of measures at the local level in Nordic countries that does not resemble a unified model of prevention. This suggests that local administrative practices are at least as important as their surrounding formal architecture. The demonstration of a clear political commitment to prevention policies on the part of local councils and administrative leaders is one key factor in this regard. A culture of cooperation among administrative actors and local service providers is another. In order to foster such facilitative conditions, individual states as well as the EU can apply instruments that oblige certain actors to cooperate (e.g., by tying additional funding to binding cooperation agreements). Coerced cooperation of this kind has only limited effects when it is not backed by other instruments. For politicians, being able to present themselves as successful actors is one key incentive. Introducing benchmarks, awards and additional grants can therefore be an effective instrument in motivating the "willing" to strengthen local cooperation, as the Nordic countries have shown. These instruments can prove valuable to administrative actors as well, especially when it comes to defending their approach vis-á-vis political and ministerial leadership that may be inclined to cut prevention programs. Intra-administrative tools that support coordination, such as non-ring-fenced budgets, communication rules, fora that support coordination on the operative level, and being afforded some discretionary power, are even more relevant.

Bringing services to the public: Community-based care and support services ("piloting") are difficult to establish. Most countries view community-based integrative services as a best practice to be pursued, and there is a broad spectrum of models in place that range from integrated (public) one-stop agencies to community-based working groups to more diffuse networks providing community-driven programs. A key factor to consider in targeting such practices is the scale of community. If the community targeted is too small, those responsible for service delivery will find it difficult to integrate specific services that are less-frequently used. If the community targeted is too large, potential clients may find it difficult to access services. The nature of a lead agency ("hub") where integrated services are docked is another issue to consider. Establishing entirely new structures is expensive, and it is often difficult to raise awareness of them among potential clients. The alternative – building on pre-existing structures – may result in less transaction costs, but involves battling any bias among those who have already been reached by the institution. There may be a particular stigma associated with an established agency – as is the case with German youth welfare authorities – which gets in the way of successful client outreach. Because families generally express greater trust in healthcare institutions and pediatricians, linking services to these actors may prove more effective.

States can foster improved integrated services by providing additional funding, as the lack of financial resources is the main difficulty in establishing intersectoral institutions. Integrated services also involve integrating staff from different institutions into teams. Though clearly a management issue, states can support this by establishing guiding principles, providing professional training and publishing manuals. Overall, states need to promote a cultural shift away from siloed thinking among professionals in the fields of health, education and well-being.

Strengthening clients' and professionals' administrative literacy: One of the most intriguing challenges for preventive offerings involves reaching target populations early on, that is, before problems manifest themselves. Many countries feature several preventive offerings, but they are often fragmented and lack visibility. Enhancing the visibility (and therefore awareness) of offerings while developing clients' competencies can promote early-on participation in prevention (Franzke, Schmitt, & Schultz 2017). Both approaches are facilitated by the presence of common structures across communities and municipalities. In such cases, centralized "piloting services" can be established that have the potential to attract (ideally) national publicity. This, in turn, improves

the likelihood that both clients and **professionals, who often also lack a comprehensive overview of services,** are better informed of the available opportunities and structures associated with such services. More centralized systems, such as those seen in England and Ireland, may grapple with other shortcomings, but they are nonetheless able to provide systematic information regarding their services. By contrast, decentralized systems generally do not have the capacity to engage in broadscale information campaigns.

Managing tradeoffs in enforcement versus adapting to local needs: As is the case with administrative literacy, there are pros and cons associated with centralized standardization and local adaptation. The same is true regarding the content of preventive measures, as well as their financing and oversight. Whereas centralized steering mechanisms strengthen the uniformity of services and effective targeting, they often frustrate efforts to adapt to local needs. As discussed, success in prevention policies depends on a strong decentralization of administrative responsibilities down to the level of municipalities (i.e., community-based approach). What is needed is a balanced approach integrating centralized aims and standards and local discretion and knowledge.

Insufficient resources for measures not easily included in established sectoral funding lines: In most countries, sector-specific budgets are the source of financing for preventive measures, which reinforces siloed thinking within administrative structures and how they frame problems. Funding lines that cut across policy issues are essential to prevention. This includes, for example, funding for shared facilities, promotion efforts and continuing education. Unlike most European countries and the EU itself, the Nordic countries examined here feature such funding lines. Financial limitations in most countries often result in underfunded prevention measures as resources are allocated for other measures deemed to be more urgent. Prevention policies that invoke evidence-based arguments like those currently being formulated in the Netherlands can be effective in overcoming short-term or ad hoc policymaking.

Insufficient use of evidence-based arguments and underdeveloped performance measurement: A strong evidence base is essential for the monitoring and redevelopment of prevention programs. To date, there is not enough broadscale evidence-based research to permit an exhaustive cross-national comparison of prevention programs' performance. While the Nordic states as well as England and Ireland do a better job of

leveraging evidence-based research in this regard, Europe as a whole lacks an overarching evidence base. As an evidence-collection mechanism, the European Social Scoreboard (see the next section) is incomplete. Establishing a solid foundation of evidence on prevention could prove effective in motivating subnational actors to take a more active stance with regard to prevention policy. While the use of evidence-based research in prevention policymaking is rare, the vast majority of policymakers and administrative actors want more information on how policies actually work and the extent to which they impact targeted groups. As the example of municipalities in the Netherlands shows, collecting and evaluating data on their preventive services has proved extremely helpful in monitoring their progress, improving their offerings, and convincing policymakers of their relevance.

5.2.3 EU-level actions necessary to strengthen overall prevention activities

With EU member states facing this common set of challenges, the question arises as to whether stronger EU-level coordination might provide national governments and subnational actors with useful support in their efforts to develop prevention policies. Most of the shared problems fall under the jurisdiction of the individual member states. Nevertheless, the European Union could work to support and coordinate national and subnational policies through different means. For example, local prevention policies could be promoted through the use of financial instruments such as the European Social Fund (or especially the proposed ESF+). At the moment, the ESF is used only infrequently for prevention policies in European countries (with *KeKiz* being one of the few exceptions), even though the European Commission promotes its use in this manner (European Commission 2013).

In addition to its funding role, the EU acts via recommendations and "soft-law" mechanisms such as the European Semester, benchmarking mechanisms and a discrete use of "naming and shaming." Following the release of the Social Investment Package and the "Investing in Children – Breaking the Cycle of Disadvantage" recommendation (European Commission 2013), the issue of child development has gained considerable attention at the EU level. Nevertheless, the concept of investment in this sense is neither uniformly interpreted nor utilized, in either a conceptual, structural or substantive sense (European Commission 2017). The EU should promote a more consistent conception of prevention as an aspect of social investment. This framing should focus not only on investment in individual children, but also on the institutional

and societal components – that is, how such activity will help shape the future of a continent whose most critical resources are its people. Our case studies showed that practitioners in the areas have a general interest in relevant structures in other countries; to feed this interest and further the exchange of best practices, for example, policymakers could hold European summits on prevention, at which actors could exchange information on effective prevention mechanisms.

In recent years, particularly under the Juncker Commission (2014 – 2019), children's issues have risen in prominence on the European agenda, and European social policy has gained momentum at least on a rhetorical level. The focus within the European Semester on issues of social inclusion, the declaration of a European Pillar of Social Rights and the recalibration of the European Social Fund all represent key aspects of this new social agenda. The latest development is the introduction of a **Child Guarantee,** slated for inclusion in the European Commission's 2021 working program. This idea is drawn from the 2013 Recommendation on Investing in Children (European Commission 2013), with a final report on its feasibility recently published (European Commission 2020). These developments show a growing awareness of the problems facing children, even if most such initiatives have had emphases other than the universal preventive approach that is the primary focus of this study.

The Child Guarantee is focusing on securing children's access to free healthcare, free education, free childcare, decent housing and adequate nutrition (European Commission 2020). This orientation toward children's basic needs represents an important focus on the material conditions experienced while growing up in the European Union's member states. Prevention policies and especially the concept of universal prevention chains can be important assets in these discussions, as they highlight the role institutions can play in addressing disadvantages experienced by young people. The provision of institutional support across different life phases can help give children a safe and healthy environment in which to grow up.

In our study, we explored the impact of these European discussions on national policies. We found little evidence that they were having a broad impact in matters of prevention. For example, the European Social Fund is currently used only infrequently for prevention policies focusing on children. The "Leave no child behind!" program in North Rhine-Westphalia represents the exception rather than the rule. In addition, we identified several training programs for teachers (e.g., in the Netherlands), and sev-

eral other smaller projects. Most common are ESF-funded projects providing support for transitions into the labor market, as well as for school leavers and other specific vulnerable groups (e.g., minorities like the Roma). These are mostly financed through the Fund for European Aid to the Most Deprived (FEAD). There is currently a lack of integrated programs taking a universal approach. The idea of early prevention as a means of reducing future problems has not yet become an integral part of the ESF's strategy.

The introduction of the **European Pillar of Social Rights** (EPSR) and its integration into the European Semester remain at an early stage. The EPSR is an inter-institutional proclamation made by the European Parliament, the European Commission and the European Council. However, it is also classified as a recommendation according to Art. 292 TFEU. It consists of a list of 20 principles organized into three chapters. While the first and second chapter can be classified as traditional EU social policy ("Equal opportunities and access to the labor market" and "Fair working conditions"), the third chapter at times goes well beyond the typical reach of EU competences. One such example is Principle 11, which contains the following statements:

"Children have the right to affordable early childhood education and care of good quality."

"Children have the right to protection from poverty. Children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities" (European Parliament, European Counci and European Commission, 2017).

The Child Guarantee clearly mirrors this principle. The European Pillar of Social Rights is accompanied by an evidence-collection mechanism, the European Social Scoreboard (ESSC), which also functions as a governance tool. This tool monitors performance across EU countries through a dozen indicators associated with the Pillar of Social Rights. However, only one, the share of "children aged less than 3 years in formal childcare" relates specifically to children's issues. Others, like indicator 4 – "People at risk of poverty or social exclusion" – are not broken down by age group, an approach that could be helpful in developing a set of core data on the situation of children in the European Union. While some of these data are available elsewhere, their inclusion in the ESSC would strengthen the political weight accorded to the issue of children's rights.

The most important move with regard to strengthening the impact of the EPSR and the Social Scoreboard has been their integration into the process of the European Semester. The European Semester was initiated as an instrument for coordinating and monitoring EU member states' economic and fiscal policies. It was introduced within the framework of the Europe 2020 Strategy, following the economic crisis of 2007 – 2009 and the post-2009 European debt crisis. The European Semester is now organized as an annual cycle, based on a fixed timeline of steps, designed to coordinate economic and fiscal policy within the EU. As part of the European Semester, the European Commission reviews the member states' draft budget plans, national reform programs, and stability or convergence programs. Over time, the originally narrow focus on stability and growth has expanded beyond fiscal and economic recommendations to include a growing focus on social policy issues. In 2017 – 2018, the EPSR was included in this process. Until now, it has been unclear how this integration would change the content and direction of country-specific recommendations (CSRs) (Grohs 2019; Hacker 2019). In 2018 and 2019 (European Parliament 2019), most children-related recommendations referred to affordable childcare; however, rather than using prevention-related arguments in their framing, they were largely justified through the goal of ensuring equal access to labor markets (Czechia 2019 (2); Ireland 2019 (2); Italy 2018 (2), 2019 (2); Cyprus 2019 (3); Poland 2018 (2), 2019 (2); Slovakia 2018 (2), 2019 (2)).[4] Some recommendations relate to educational achievements by disadvantaged groups (e.g., Germany 2018/2019 (2); Romania 2019 (2)). A recommendation to enhance the level of support provided to families (Spain 2019 (2)) was more direct. This entire set of child-specific recommendations makes clear that there could be more emphasis on these topics, especially with reference to Principle 11b of the EPSR, and the "right to specific measures to enhance equal opportunities."

As Eurochild (2019) mentions in its publication of alternative county-specific recommendations, there are some additional statements on child-related issues in the annexes, especially regarding funding priorities. One general recommendation resulting from our research is that the status of integrated and preventive measures in the ESF, the proposed ESF+ and the regional operational programs should be strengthened. The ESF was created to enhance worker mobility and support employment across the EU. Since the adoption of the Lisbon agenda, it has been additionally driven by aims including inclusion and cohesion. In its 2014 –2020 programming period, the ESF for the first

4 The number in brackets refers to enumeration of the CSRs.

time included the aim of reducing poverty. More specifically, it stated that 20 % of its funds were to be used for the purposes of social inclusion and poverty reduction. During the 2021 – 2027 multiannual framework (MFF) programming period, the ESF is to be fused with the Fund for European Aid to the Most Deprived (FEAD), the Youth Employment Initiative, the Employment and Innovation Initiative, and the Health Program, with the goal of addressing these issues in a more coordinated and flexible way. In the discussions over the creation of the ESF+ for the 2021 – 2027 funding period, the European Commission proposed 11 specific objectives, including improving access to childcare and promoting the social inclusion of people at risk of poverty or social exclusion, including the most disadvantaged persons and children (European Commission 2018).

The ESF+ will be closely linked to the EPSR and the CSRs in the European Semester and the associated funding priorities. The share of funds allocated to address the issues of social inclusion and poverty reduction will be increased to 25 %. As we have seen, child-related issues are at the moment underrepresented in the European Semester; increasing this emphasis would also mobilize resources and encourage member states and regions to include these objectives in their own operational programs. The European Parliament strengthened this approach in its amendment to the Commission proposal; for the first time, the social inclusion of children and a reduction in child poverty feature among the specific objectives contained in the ESF. For example, under this version of the proposal, member states are to allocate at least 5 % of their ESF+ resources to the implementation of the European Child Guarantee (European Parliament 2019). Negotiations on the issue were still ongoing as of the time of writing (June 2020), and the priorities set by the European Commission and the European Parliament had not yet been met in all operational program drafts. To foster preventive approaches effectively, it will be necessary to include overarching, coordination projects with a preventive character in European funding programs, especially the ESF+. These would ideally support the creation of cooperation structures between services – for example, by giving money for the creation of fora in which actors can exchange best practices, and to build up communication between prevention actors more generally.

Gaps in national and subnational operational programs should be avoided. The European Semester has largely neglected the issue of investment in children, as well as related administrative structures. It should include recommendations that address child poverty, particularly with an integrated approach (following Principle 11 of the EPSR). EU funding should be used to support these goals.

In addition, we should learn from recent experience, in which many opportunities to raise funding for preventive approaches were ultimately missed, in part due to implementing actors' lack of knowledge regarding such opportunities, and in part due to the excessive administrative burdens associated with application. One goal should be to reduce the administrative burden associated with applying for and managing European funds. Subnational (and other) actors should be provided with information regarding ESI/ESF+ funding opportunities, and an effort to increase the competencies and capacities of potential users and coordinators should be made. Today, the local governments and regions most dependent on external support are also the least likely to apply for such funding. We need also further ideas for how to ensure that successful projects become established structures; consolidation is important. Evaluation and monitoring are important tasks in identifying what works, but also provide the arguments needed to secure decisions in national policy processes. For this reason, the European Social Scoreboard indicators should be adjusted so as to provide the evidence base necessary to persuade member states to invest in prevention.

As we have seen in our study, European welfare states still have fundamentally distinct structures, and face multifarious challenges. The Covid-19 pandemic has exposed the huge differences between the capabilities of national European health and crisis-management systems. At the same time, it has increased pressure; social and health inequalities will increase as a result of the crisis, with disadvantaged families in particular suffering negative consequences. In this situation, a focus on the topic of prevention is more important than ever. A real push toward harmonization and convergence is likely to emerge only if the principles of the European Pillar of Social Rights are better integrated into other, less symbolic EU policies, especially the structural funds and regulatory policies. This would boost the visibility of the EPSR and the European Semester for actors on the ground, so that the principles of the EPSR emerge as a guiding focus not just for those in the Brussels NGO scene, but also for those working in social policy across the EU-27.

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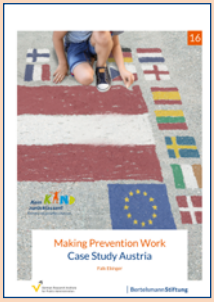

Making Prevention Work – Case Study Austria

As a supplement to the "Preventive structures and policies for children, youth and families" study, the analysis of Austria presented here examines how prevention is implemented in Vienna, Graz, rural Styria and through the country's Early Prevention initiative, offering insight into the potential transfer of measures. This case study is also available in German.

Making Prevention Work – Case Study France

As a supplement to the "Preventive structures and policies for children, youth and families" study, the analysis of France featured here offers a close look at prevention chains in France and the competences, institutions, services and networks promoting equal opportunities for children throughout their life course.

Making Prevention Work – Case Study Netherlands

As a supplement to the "Preventive structures and policies for children, youth and families" study, this publication examines the Dutch system fostering children's well-being and education as well as the opportunities and challenges posed by the 2015 reform shifting all competences regarding family affairs to municipalities.

This comprehensive report maps the preventive structures and policies for children, young people and families in 12 European countries. By examining what works in each of the countries surveyed, the study aims to provide a foundation for the development of preventive policies across Europe.

The report includes summary fact sheets of the preventive concepts, structures and practices in 12 EU member states (Austria, Czech Republic, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden) as well as a synthetical chapter which compares the national approaches in terms of their overall preventive approach, their administrative organization, financing and other aspects of the governance of prevention. In addition, it presents conclusions for the national and European level.

Despite widespread awareness of the need for prevention and a common European frame of reference, existing preventive concepts and measures vary greatly across Europe. There exist different approaches of targeting and universalism. The most urgent problem in most countries is to coordinate offers between sectors and the life-course to develop community-driven, integrated preventive care that brings services closer to people where and when they need it. The visibility of such services and general awareness of them must be strengthened.

Making Prevention Work draws on research findings associated with the German initiative "Leave no child behind!" *("Kein Kind zurücklassen!")* that show how local support mechanisms and institutions can have a positive impact on disadvantaged children and their families. The initiative demonstrates just how effective a few good preventive measures can be in improving the educational opportunities of disadvantaged.

In addition to the comprehensive report presented here, Making Prevention Work features three case studies on Austria, Netherlands and France which deepen the findings of this comparative study.

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