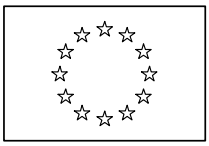

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Joint Report on Social Protection and Social Inclusion 2006
Country profiles

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INTRODUCTION

These 25 country profiles aim at providing a synoptic view of key trends, major efforts and challenges ahead in each of the Member States with respect to their policies in the fields of social inclusion, pensions and health and long-term care.

The first section of the fiches, "situation and key trends", identifies those aspects of performance deserving to be highlighted in the OMC context or presenting greater risks and therefore calling for particular policy efforts from the viewpoint of social protection and social inclusion. The social inclusion section describes and analyses major policy initiatives taken in the context of the implementation of the National Action Plans for inclusion. The section on pensions draws upon the national strategy reports on pensions of 2005 and on the Commission Services Document that analyses them. The section on health and long term care is based on the Preliminary National Policy Statements that the Member States presented in 2005 and on the Memorandum of the Social Protection Committee that reviews them. The final section of the country profiles lists for each country the key challenges that the Commission services have identified on the basis of the analysis carried out in the context of the OMC. All sections have benefited from bilateral exchanges with the Member States.

A specific sub-section of the fiche also presents a short analysis of the national reform programmes that all Member States presented in 2005 in the framework of the revised Lisbon strategy. When reading these analyses one should also consider the wider context that is set in the country chapters of the first Annual Progress Report on the implementation of the Lisbon strategy.

BELGIUM

Situation and key trends: GDP went from a near-stagnation growth rate in 2002 (0.9%) to 2.9% in 2004 but growth slowed to 1.4% in 2005. The overall employment rate remains significantly below the EU average (60.3% compared to 63.3% in 2004). With just over a quarter of people aged 55-64 in employment, Belgium has one of the lowest employment rates for older workers in the EU. Important regional disparities persist in both employment (63% in Flanders, 55% in Wallonia, 53% in Brussels) and unemployment (6% in Flanders, 11% in Wallonia, 16% in Brussels). Long-term unemployment, at almost half of the overall unemployment rate, remains proportionally high and also shows stark regional variation. Employment of low-skilled, non-EU nationals and disabled workers remains a challenge. In 2003, transfers (excl. pensions) reduced the overall at-risk-of-poverty rate from 28% to 15%. Categories with a high poverty risk are: women, older persons, persons relying on social transfers including the unemployed, single elderly persons, and persons living in single parent households. Social protection expenditure rose by 0.5 percentage points over the 2002-2003 period (to 29.7% of GDP – ESSPROS data), but this has gone together with greater efforts as regards activation of those claiming benefits. Total health expenditure as a percentage of GDP at 9.1% in 2002 (WHO-HFA database) is relatively high and the expenditure dynamics have been strong in recent years.

Social Inclusion: The Belgian NAP shows a good understanding of the multi-dimensional nature of exclusion. The *"active welfare state approach"* to social inclusion dominates very strongly. While benefits are increasingly linked to activation, steps have been taken to link the lowest benefits to wages and to reduce the tax wedge. But improvements in minimum benefits are often absorbed by rising housing costs. The monitoring of the challenges stressed in 2003 is being well followed-up; policy measures are numbered and listed in a publicly accessible data-base. Almost half the measures in the NAP are related to increasing labour market participation and some of these have produced encouraging results. The social economy and, in particular, "service vouchers" have been used to reach some vulnerable groups and to tackle undeclared work with a good deal of success. While the greater part of financial resources goes into employment creation, there are efforts to tackle early school leaving, the lack of formal qualifications and lifelong learning, which will be necessary to create a true knowledge economy. There are some measures to make life easier for working parents and carers. The legislative and institutional framework to prevent and tackle over-indebtedness is being worked on. In spite of budgetary pressures, free medical care has been introduced for very young children, attention has been paid to health needs of refugees and the Maximum Health Bill reduces patients' own contribution. However, few measures have been designed to address the difficulties faced by immigrants. Overall, the Belgian approach is one of consolidation while its well identified challenges demand continuing integration efforts from different levels of government.

Pensions: The Belgian government has taken steps to enhance the adequacy of pensions. In particular, the design of minimum retirement income has been strengthened in recent years. Recently reforms with regard to early retirement to encourage a higher labour-force participation of people in their 50s and 60s have been agreed in the so called "*Pacte entre les generations*" that was adopted at the end of 2005. This reform should make an important contribution to adequacy and financial sustainability. Moreover, the promotion of occupational pension schemes could raise replacement rates in the long run and hence the relative living standards of pensioners. While a guaranteed minimum return is provided on the contributions paid by the employee and the employer in all complementary pensions, further efforts to ensure a high coverage of the working population (especially women) by

occupational pension schemes might be needed. Besides the measures already taken and approved to raise the labour force participation of people in their 50s and 60s, the strategy for securing financial sustainability continues to rely strongly on the global management of the social security and reallocation of contribution therein and on the reduction of public debt (and hence reduced future interest payments). Savings resulting from the reduction of public debt are transferred to a reserve fund and thus earmarked for future expenditure on ageing related needs. For salaried workers, the legal retirement age for women (and the required number of years for a full pension) will be equalised with that of men (65) by 2009.

Health and long-term care: Although the Belgian system ensures high population coverage (99%) there is concern that co-payments for several services, introduced as a response to expenditure pressure, could create a high financial burden for vulnerable groups. Authorities are addressing this through an array of measures including annual limits, favourable reimbursement and free preventive care for all. The Government intends to address the challenge of growing health care expenditure by improving care coordination and promoting rational use of resources through, for instance, plans to prioritize the use of primary care via financial incentives and the promotion of the use of the patient's file and patient long-term care plan. Other related measures include technology assessment, a more favourable reimbursement of generics and better prescription practices, hospital peer reviews and hospital prospective financing. The challenge of improving long-term care is being addressed through home and day care services; its quality is to be ensured through training, assessment and accreditation of practitioners.

National Reform Programme: There is clear and coherent policy integration (both as regards process and policies) between the growth and jobs strategy in the Belgian National Reform Programme and the social inclusion and social protection policies covered under the open method of co-ordination. The NRP presents a comprehensive strategy through the "contract for solidarity between generations" based on fiscal consolidation aimed at financial sustainability, socially adequate pensions and increasing labour market participation. The programme also covers recent measures taken to limit the growth of healthcare expenditure but does not fully explain how the authorities plan to achieve the budgetary surpluses announced. The social inclusion progress report forms an annex to the National Reform Programme.

Challenges ahead:

- To balance budgetary restrictions with good social protection;
- To accelerate the rise in labour-force participation, in particular for older workers, for unqualified workers in long-term unemployment areas, for women and the long-term unemployed;
- To better address the social and labour market integration of immigrants;
- To guarantee the sustainability of pension schemes by further reducing the public debt, and to make second-pillar pension schemes more accessible especially to women;
- To address the financial burden of care on disadvantaged groups, enhance long-term care provision and promote use of primary care and care coordination.

CZECH REPUBLIC

Situation and key trends: Economic growth has been robust in recent years. It accelerated to 4.4% in 2004, driven mainly by investment and strong exports. In 2004, both the total employment rate (64.2%) and the employment rate for older workers aged 55-64 (42.7%) stayed above EU average but below the Lisbon targets. There were slight increases in the unemployment rate (8.3%) and the long-term unemployment rate (4.2%) in 2004. The population is ageing and the fertility rate is one of the lowest in the world. Life expectancy (males 72.1, females 78.7 in 2002) is below EU average but it has consistently increased over the last decade. The at-risk-of-poverty rate is the lowest in EU (8% in 2002). Most at risk are the unemployed (36%) and single-parent families with at least one dependent child (30%). The disadvantaged Roma experience higher risk as well. The poverty-reducing effect of social transfers is particularly evident, as they reduce the poverty risk from 39%. Social protection expenditure is steadily increasing, having reached 20.1% of GDP in 2003 (ESSPROS data). Total health expenditure reached 7.1% of GDP. Both are below EU average.

Social inclusion: The Czech Republic continues to follow a multi-dimensional approach to social inclusion as set out in the NAP Inclusion 2004-2006. The objectives identified remain valid and are long-term; however, social inclusion could be further mainstreamed and better addressed at the regional and local levels. Nevertheless, there has been progress in several areas. A significant shift in emphasis towards proactive measures can be observed. The basic principle of the Czech strategy is that employment is the most important means to prevent or tackle poverty and thus, the main focus is on facilitating access to the labour market. Recently, new measures have been implemented or proposed to provide financial incentives for the transition from social benefits to work and for making work pay, but a comprehensive reform of the social benefits system, though drafted, has not been adopted yet. Facilitating access to social services and increasing their quality is addressed by the Bill on Social Services, which intends to introduce personal benefits – allowing persons with disabilities to choose between services – and set of compulsory quality standards.

Regarding the most vulnerable, some progress is evident especially at overall planning level. In relation to education, the so-called "special schools" attended especially by Roma children were dissolved and instead the conditions should be created within the primary schools to provide all pupils with education according to their needs. Moreover, the Czech Republic joined the Decade of Roma Inclusion 2005-2015 and drafted an NAP. The role of the ESF in promoting social inclusion has been growing and it should make an important contribution to specific groups (including the Roma and the homeless) and to improving the quality of social services through targeted grant schemes. To improve the situation of the most disadvantaged regions with over 14% unemployment an additional investment incentives programme, which also finances training, was introduced in June 2004. Although the Committee on Social Inclusion was set up in 2003, there has not been systematic follow-up of the NAP on Inclusion so far. However, recent initiatives such as the information project "Stop Social Exclusion" and regional conferences of the "Forum on Social Inclusion" could help raise general awareness.

Pensions: The Czech Republic managed to ensure adequate pensions over the last decade, achieving a low rate of poverty among older people, but replacement rates are projected to decline and future adequacy needs to be carefully addressed. While the employment rate of people aged 55-64 increased significantly in recent years, the creation and the take-up of jobs for older workers should be further encouraged so as to help balance financial sustainability

and pension adequacy, while incentives to work longer need to be strengthened. While budgetary pressures are growing due to the ageing population, the extent to which further reform efforts will help strengthen the sustainability of pensions, while securing adequacy, remains to be seen. A new pension reform is expected to follow from further negotiations based on the final report of the Expert Team. Measures suggested include further increasing retirement age, changing the calculation and indexation of benefits, reviewing non-contributory periods and possibly creating a reserve fund and increasing the state support for private pensions.

Health and long-term care: According to the preliminary health policy statement, Czech authorities consider the development of and access to long-term care as their main priority in terms of ageing and socio-economic policy. Current supply appears insufficient and there are large regional differences. Moreover, a large part of the costs of long-term care is paid by patients or their relatives, constituting a financial barrier to access. New legislation, allowances to carers, the combination of allowances with other income, grants to NGOs, and stronger regional and local authority involvement in care provision are some of the measures proposed to improve access to and quality of long-tem care services. The authorities also wish to improve the general quality of health care through an array of policies including: setting standards, inspecting facilities, accrediting institutions, training social workers, developing and using indicators, evaluating technology and increasing patient choice. Some of these measures are expected to improve system efficiency, too. Finally, performance-related remuneration, prospective global budgets, needs-based provision, stronger promotion and prevention are strategies intended to control costs and ensure financial sustainability.

National Reform Programme: The NRP recognises that long-term sustainability is a central problem of public finance and must be addressed by a coordinated approach to medium-term budgetary consolidation, systemic pension reform, healthcare financing reform and labour market reform, aiming at increasing the employment rate. Other issues addressed by the NRP are modernizing the social benefits system, making work pay, increasing employability and modernizing education. Several groups are identified as clear priorities: the young, older workers, women, and foreign workers. The NRP does not cover measures targeted at promoting the inclusion of disabled people or of resident ethnic minorities such as the Roma population, though the Czech authorities have indicated some separate information on this.

Challenges ahead:

- To support the implementation of social inclusion policies at regional and local level;
- To improve the situation of vulnerable groups (for example the Roma) and support disadvantaged regions;
- To encourage the creation and take-up of jobs for older workers so as to help balance financial sustainability and pension adequacy;
- To improve access to long-tem care services and ensure general quality of health and long-term care services while promoting system efficiency.

DENMARK

Situation and key trends: The Danish economy is showing clear signs of recovery with GDP growth reaching 2.4% in 2004. Denmark continues to record employment rates well above the EU targets (75.7% in 2004), particularly for women (71.6%) and older workers (60.3%). Unemployment is decreasing (5.4%). Long-term unemployment (1.2%) and unemployment among young people are among the lowest in EU. At the same time, Denmark has a good record as regards the risk of financial poverty (11% in 2003), though the income of people aged 65+ (for whom the at-risk-of-poverty rate is 17%) as a group relative to that of people under 65 is low. Immigrants and the long-term unemployed are overrepresented in the lower income brackets. The social protection system is based on the principle of universality with all citizens guaranteed fundamental protection against social risks, such as unemployment, sickness or dependency. The Danish model is based on close involvement of social partners, local authorities and other stakeholders. Danish gross expenditure on social protection ranks as one of the highest in EU (30.9% of GDP in 2003 – ESSPROS data). Data on life expectancy situates Denmark at the bottom in the EU, and the increase between 1960 and 2000 has been the lowest in the EU25.

Social inclusion: The overall strategic approach to tackling poverty and social exclusion in Denmark is to develop an inclusive labour market by increasing the labour market participation of vulnerable groups. The short-term focus of the NAP 2003-2005 is on vulnerable, disadvantaged and already socially excluded groups, notably immigrants. The strategy for integrating immigrants has so far not been particularly successful and is being reoriented. New initiatives imply further requirements to learn Danish, the involvement of local authorities and anti-ghetto measures. The long-term focus of the NAP 2003-2005 is on combating "negative intergenerational transmission", by requiring early and targeted intervention, improved early learning among children and an increased focus on formal qualifications. The strength of the NAP is its focus on very specific groups. The weakness of the NAP is its lack of more strategic aspects, targets and indicators to help monitor the activities. The latter implies a risk of limited evaluability, fragmented management and blurred accountability. Measures to combat negative intergenerational transmission have been continued as the major tool for preventing the risk of social exclusion in the long term. Basic education is seen as important in this regard, coupled with a more individualised focus on the pupil. Special attention has been paid to trafficking in women and on informing ethnic minority women about their rights.

Pensions: The Danish public pension scheme pays out a universal, flat-rate pension, complemented by occupational pension schemes which have developed rapidly in the recent decades and now cover almost the entire population in employment. Replacement rates are therefore expected to rise significantly and reduce the current relative income gap between people aged more than 65 and people below the age of 65. The first pillar will nevertheless continue to play a dominant role in pension provision. The strategy for ensuring adequacy and financial sustainability of public pension provision seems appropriate. A budget policy leading to quick debt reduction has already been sustained for some years and all major parties support the continuation of this policy until 2010, by which time the public debt is expected to be substantially lower. New rules introduced in 2004 allow people (including people over 65, who are already in receipt of their pension) to opt for a deferred old-age pension and to remain longer in (or return to) the labour market in exchange for a higher pension at a later stage.

Health and long-term care: Regarding access, the main issues revolve around waiting times and provision of long-term care. Strategies like State pooling of non-emergency cases and free choice of hospital aim at decreasing waiting times with apparent positive results. Concerning long-term care, to continue ensuring timely and financially easy access for all in view of ageing and growing demand, the authorities foresee: a) an increase in the provision of home care including personal care and practical assistance (following an assessment of each individual's functional capacities and needs and irrespective of whether the person lives at home, in a residential home or sheltered housing), day care and homes with associated care facilities and staff and b) the establishment of a two-month home guarantee and legislation to limit the use of patient charges in this area. This is to be coupled with availability of financial allowances and offers of relief care to support informal carers. Personal budgets attributed to dependent elderly people, allowing them to acquire services from whoever they wish, are being piloted to increase provision and choice of care. The authorities are also focusing on improving care quality via the use of standards, the use and publication of indicators and other survey data, hospital self-evaluations with external validation, increased patient choice and surveys of patients' experience. To address the recent expenditure dynamics, the authorities wish to develop an effective referral system, based on a GP/family doctor as the first point of access to care, which guides patients towards specialist and hospital care (and thus acts as gatekeeper). Whenever feasible, care should be pursued within the primary and outpatient sectors to lead to a more rational use of resources. Activity-based hospital financing, sale and reimbursement based on the cheapest same-active-substance product and stronger prevention policies aim at ensuring financial sustainability. The current local government reform will also allow centralisation and specialisation of care with potential efficiency gains, while ensuring better care coordination.

National Reform Programme: The NRP is very convincing in demonstrating how the social inclusion and protection processes are seen as integrated parts of the programme. The policies on social inclusion and social protection are presented as an integrated part of the Danish Lisbon strategy, and measures are seen as key elements in pursuing the targets of this strategy. The NRP identifies higher labour force participation as a key challenge against the background of the ageing population.

Challenges ahead:

- To safeguard the current high level of protection while satisfying increasing demands for health and welfare services in view of the ageing population;

- To develop labour market tools designed to improve integration of ethnic minorities into the labour market;

- To encourage more people with disabilities and older workers to stay on in the labour market;

- To continue the on-going restructuring of the health care system in order to improve effectiveness and efficiency.

GERMANY

Situation and key trends: In 2004, GDP grew at nearly 1.6%, bringing a period of stagnation to an end (EU: 2.5%). Social protection expenditure as percentage of GDP stood at 30.2% in 2003 compared with 28% in the EU in 2003 (ESSPROS data). The unemployment rate rose to 9.5% in 2004 (EU: 9%) with a persisting high disparity between East and West. The employment rate of the total population was 65% in 2004. For older people, it has been on a steady growth path since 2000, and from 2003 to 2004 it increased from 39.5% to 41.8%, the gap to the Lisbon target remaining still substantial. The overall risk-of-poverty-rate in Germany stood at 16% in 2003 and at 20% for the age group up to 15 years of age[1]. Older people (65+) had a risk of poverty of 15% (Eurostat) in 2003. Life expectancy (75.7 and 81.4 years for males and females in 2003) and healthy life expectancy (65 and 64.7 for males and females in 2003) are high and above EU average. Total health expenditure (10.9% of GDP and 2817 PPP$ in 2002 – WHO-HFA) is among the highest in the EU, though it is noticeable that the growth of health expenditure has decelerated in recent years compared to GDP growth.

Social inclusion: The strategic approach of the NAP 2003-2005 follows three strands: encouraging participation, opening up opportunities, especially in education and training, and securing basic needs. A number of initiatives focus on integrating young people into the labour market, including special provisions of the Hartz reforms and the "National Pact for Training and the Next Generation of Skilled Craftsmen" (in June 2004) addressing the lack of apprenticeship places which presented a serious challenge in recent years. A number of initiatives have been launched at all government levels for people with disabilities in order to improve their integration into the labour market, as well as into social life. Furthermore, the Health System Modernisation Act now gives access to health services for all recipients of social assistance on an equal footing, independent of the contribution paid. The Government adopted a law which aims at drastically expanding the number of child care facilities in particular in the West, while stabilising the supply in the new Länder. By 2010, the local authorities are encouraged to create 230.000 care places for children in the age group 0-3, a third of which should be all-day care facilities. The Federal Immigration Act, which came into force on 1 January 2005, concerns various dimensions of integration of immigrants, who face a significantly higher rate of poverty than the rest of the population. Nationwide courses should facilitate the integration process of this group typically at a high risk of social exclusion. First interim evaluation reports will be submitted in early 2006.

Pensions: The last pension reform made substantial progress in terms of financial sustainability of the statutory pension scheme, and at the same time foresees a significant reduction of future replacement rates (at a given age). From 2005 on, the introduction of the sustainability factor in the pension adjustment formula will automatically slow down annual pension adjustments, including new pensioners, due to changes in the ratio of pensioners and contribution payers. In addition, Germany introduced a gradual change in taxation from the accrual to the pay-out phase. In order to contribute to future adequacy, voluntary private

[1] The data are derived from the GSOEP survey following, as far as possible, the EU-SILC methodology. During the transition to data production under the EU-SILC regulations, it has been agreed to use indicators derived from national sources harmonised ex-post according to a commonly agreed methodology. While such indicators cannot be considered to be fully comparable with those produced for other countries or with EU-level aggregates combining data for different countries, every effort has been made to ensure the maximum comparability. See the methodological note in the statistical annex on data sources for at-risk-of-poverty rates.

provision, either through occupational or personal pension schemes, are heavily subsidised through tax allowances and direct public grants, especially for low income groups and for people who bring up children. Future adequacy of overall pension provisions will depend on the take-up rates of these new opportunities and on the improvement in the employment of older workers. Finally, the new Government has announced its intention to raise the retirement age from 65 to 67 (beginning in 2012 until 2035).

Healthcare and long-term care: The most recent policy measures focused on stabilising the financial situation of the statutory health insurance systems, and reducing the effects of insurance contributions on general non-wage-salary-costs and employment. It also included several measures to improve quality further, provide more even choice for patients, provide more integrated health care services and support more preventive care and actions. Given the high expenditure level, there is consensus on the need to improve the long-term sustainability of health care system financing, maintaining high quality, universality and equity of health care, but opinions differ on the way forward. Since 1995 Germany also has an insurance system for the long-term care of disabled elderly people, and other disabled people (*Pflegeversicherung*). A major objective was to make long-term care a general social insurance function and make such services less dependent on local social assistance. The long-term care insurance seems to have helped start a market for services in this field, with considerable job growth potential. The key issues remain to safeguard the quality and scope of long-term care provision by finding a sustainable financing model that takes account of the significant demographic changes and of the upcoming new needs of elderly and dependent people, and to address the need for better care coordination between health care, long-term care and social care. Finally, preparations continue under the new government on a law regarding prevention measures to improve the health of the population, in order to save on the costs of acute treatment in the medium- and longer-term perspective.

National Reform Programme: The NRP proposes that major reforms in the field of inclusion, pension and health are carried out. Reconciliation of work and family life, ensuring full participation of people with disabilities in working life, and improving chances in the education system for disadvantaged groups are major elements of the NRP. The NRP commits Germany to continue reforming the social protection systems to improve sustainability while maintaining adequacy in pensions, health and long-term care. In healthcare the focus is on improving resource use and the intention is stated to establish prevention as a full pillar.

Challenges ahead:

- To ensure that the ongoing and planned labour market reforms, especially the Hartz IV reforms, do not have negative effects on the social and economic integration of groups at risk;

- To ensure the sustainable integration of migrants – in particular second and third generation migrants – into the labour market, notably through adequate access to education;

- To prevent an adequacy gap in pension provision, by promoting longer working life and increased participation in supplementary pension provision;

- To reach a broad consensus in 2006 on sustainable long-term financing for both the health care system and the long-term care system, and maintain high quality standards for both.

ESTONIA

Situation and key trends: A strong growth performance in Estonia is translating into sustained employment gains and lower unemployment. Also, regional disparities in the labour market are starting to decline. While the Lisbon employment targets for older workers and women have already been achieved, the overall employment rate, at 63%, is 7 percentage points below the overall EU target level. The unemployment rate decreased to 9.2% in 2004 but is still higher than the EU average; the long-term unemployment rate is also high, at 4.8%. The unemployment rate of non-Estonians remains higher than that of Estonians. There is great potential for increasing employment among the inactive population. The overall education level is high but the skills of the labour force often do not correspond to the needs of the labour market. Overall living standards in the country remain well below the EU average: GDP per capita in PPS in 2004 was 50.6% of the EU average. The at-risk-of-poverty rate has remained high at 18% in 2003. The Estonian NAP and other available evidence point to serious problems of material deprivation in the country, especially as regards quality of housing. Negative demographic developments have resulted in a decrease in population in recent years. Life expectancy (66 and 76.9 years for males and females in 2002) is among the lowest in the EU. In 2003, 13.4% of GDP was spent on social protection, the lowest share in the EU (ESSPROS data). Total health expenditure as a percentage of GDP and as per capita PPP$ (respectively 5.1% and 625.26 in 2002 – WHO-HFA database) is the second lowest in the EU, having decreased over time.

Social inclusion: Estonia's first NAP on inclusion for 2004-2006 is a well focused plan which builds on the long term objectives identified in its 2003 Joint Memorandum on Social Inclusion. It outlines clear objectives, includes quantified targets and, in the main, proposes specific actions to achieve them. The main emphasis is on expanding active labour market measures for the reintegration of the long-term unemployed and other groups at risk into the labour market. Significant attention is also given to measures to prevent and tackle educational disadvantage and to promote lifelong learning. The implementation of the NAP on inclusion is supported by the ESF through various activities. Improvements in social protection so as to decrease and prevent child and family poverty and to secure appropriate income for the elderly are proposed. Attention is also given to the protection of children's rights, to improving access to social services and to affordable housing as well as to increasing e-inclusion. However, the plan is somewhat cautious in relation to the scale of the poverty and social exclusion problems in Estonia. Sometimes the objectives are not translated into specific measures but simply point to areas for action.

Pensions: The reform of Estonian public pension scheme introduced a strong link between pensions and individual contributions as well as mandatory and voluntary funded tiers. Transition costs are estimated to be moderate, requiring additional public subsidies only during the period from 2007 to 2012. The implementation of the mandatory funded scheme also had a positive impact on the coverage of voluntary funded schemes. While poverty rates among the elderly are moderate at present, the main challenge concerns the future adequacy of pensions, as already current replacement rates are rather low and projected to decline even further. Although the employment rate of older workers is in line with the Lisbon target, attention should be paid to special retirement schemes where retirement ages remain considerably lower than in the public PAYG old-age pension scheme. Moreover, the mandatory funded component of the system still requires further legislation to define the modalities for paying out benefits from 2009 onwards.

Healthcare: Regarding access, the high and growing share of private expenditure (partly due to the high level of direct payments for care) results in a substantial financial burden for the most vulnerable groups. Another challenge is geographical accessibility in remote areas. The authorities recognise the need to address these issues. Strong emphasis is placed on providing adequate long-term care. Additional funding is being allocated and the existing overcapacity in hospitals is to be released and allocated to nursing care. Other strategies include increasing the provision of home and day care services particularly via joint provision by local authorities, financial and non-financial help to carers, and individual assessment of long-term care needs via multidisciplinary geriatric teams. The authorities also wish to promote more efficient use of resources through the development of an effective referral system based on family doctors as the first point of access. The provision of home and close to home long-term care services vis-à-vis institutional care may also lead to better use of resources and care quality via increased personal freedom and flexibility.

National Reform Programme: In the National Reform Programme (NRP) there are several policy measures that are likely to have a positive impact on social inclusion. One of the key challenges targeted by the NRP is low employment, structural unemployment, skills and lifelong learning. It is planned to further develop public employment services and to improve the coordination of labour market and social services. These measures are supplemented by special instruments aimed at risk groups. However, some categories of inactive and unemployed people, such as ethnic minorities, are not covered by the NRP. In order to increase the female employment rate, the availability of childcare services will be improved. Further measures to increase the female participation rate, including gender mainstreaming measures, are not considered in the NRP. Several policy measures, particularly related to vocational training and support for lifelong learning, are presented in order to improve quality and access to education and training. The NRP highlights the importance of achieving both adequate and sustainable pensions, notably through an increase in retirement age, but also mentions the need for further pension reform, and stresses the importance of improving access to health care.

Challenges ahead:

- To increase the labour market participation of ethnic minorities and at risk groups and strengthen the institutional arrangements for mainstreaming social inclusion in national policy making and ensuring better coordination between the organisations involved;

- To reduce the high proportion of people at risk of income poverty and ensure an adequate income for those in need, especially families with children, the elderly and persons with disabilities;

- To ensure that sufficient resources are available to guarantee adequate pensions and to organise the conversion of pension savings into safe annuities;

- To improve system efficiency via a stronger primary care sector and enhanced long-term care provision.

GREECE

Situation and key trends: Over the last decade, real GDP has been growing at an accelerated pace, outstripping the EU25 average. In 2003 the growth rate was 4.7% and in 2004 it was 4.2%. Projections for 2005-2006 indicate that, although slightly lower, it will remain at high levels. However, with the notable exception of 2004, employment creation was generally low and the employment rate continues to lag behind the EU25 average (59.4% against 63.3% in 2004). The employment rate of older workers was 39.4% in 2004, down 2 p.p. from 2003 and far below the Lisbon target. Unemployment has been declining gradually since 2000 but remains higher than the EU-25 average and continues to affect mainly the young people and women. Social protection expenditure as a percentage of GDP has reached almost the level of the EU average and in 2003 stood at 26.3 (ESSPROS data). Still in 2004, Greece exhibited a poverty rate of 20%. Expenditure on pensions was 12.3% in 2004 but is projected to increase sharply until 2050. Life expectancy (76.5 years for males and 81.3 for females in 2003) is one of the highest in EU, while healthy life expectancy (66.7 years for males and 68.4 for females in 2003) is as well above average. Total health expenditure as percentage of GDP (9.5% in 2002 WHO-HFA database) is above EU average, while expenditure has stabilised in recent years. However, per capita spending on health in purchasing power parity (1814 in 2002 WHO-HFA database) is below EU average and high private health care expenditure – almost half of the total – may signal inequities in access for vulnerable groups.

Social inclusion: Over recent years, there has been an increasing level of policy reform to improve the ability to meet existing and emerging needs of all citizens at risk of social exclusion and poverty. The strategy followed has been based on a combination of general and specific policies to address the key social problems of the country. The employment policy mix pursued since the establishment of the NAP-inclusion reflects a shift of emphasis towards improving the employability of socially vulnerable groups instead of relying on income support and other passive measures. For certain vulnerable groups, a number of integrated action plans are also under way, complementing the employability measures. Income support measures have been extended to cover more social groups in need, but no commitment to a form of "guaranteed minimum income" has been recorded so far. A substantial increase in the number of structures and programmes providing community social support and care services throughout the country has also been observed. These are largely co-financed by the ESF. A limited number of actions taken towards improving governance and mobilizing all relevant bodies have not had satisfying results up to now, which has hindered the effective implementation of strategy interventions.

Upgrading and extending, in qualitative and quantitative terms, the provision of services to the most vulnerable social groups constitutes the main overriding concern. In this respect, increasing the efficiency of the social protection expenditure is crucial. Particularly important steps are efforts to combat early school leaving and to promote lifelong learning. However, rapid and effective implementation will be essential if they are to succeed. Other challenges remain to be adequately addressed such as extending a "safety net" for all groups experiencing poverty, integrating immigrants and reducing regional inequalities.

Pensions: Implementation of the 2002 reform is considered to be crucial for modernising the pension system and rebuilding confidence in it, as well as for laying the groundwork for further reform efforts, certain aspects of which are under way. In order to meet the significant financial challenge of ageing, the process of pension reform needs to continue and to be strengthened. Pending further reform, which is subject to the results of the social dialogue recently launched, the system's sustainability relies heavily on increasing employment rates

and curbing contribution evasion. The unification of the fragmented pension system is also a challenge. Recent measures such as the unification of different funds point in the right direction.

While most recent reforms have translated into strengthened incentives to work longer, further measures are needed to help raise employment rates especially for women and older workers. Gradually equalising the legal retirement age for men and women and also for people already contributing to the system before 1993, might be taken into consideration.

Health and long-term care: The authorities are concerned to improve general access to services, including geographical disparities. Thus extra funding has been allocated to the sector to increase its capacity and distribution (including primary care centres and hospital care).

The authorities' main goal is to improve the quality of health and long-term care through various measures. According to the preliminary policy statement, one priority covers generalised use of ICT, more data gathering and use, exchange of information and improved access to it, and system efficiency. Other measures proposed include: quality requirements, accreditation, inspection and quality control of facilities, and stronger enforcement of patient rights (e.g. an Ombudsman). Focusing on home and close to home day care centres (developed locally) and support for informal carers aims to bring both quality gains and more efficient use of resources in view of an ageing population.

Ageing, socio-economic changes, excessive and unjustified use of medicines and technology, and supply-induced demand are challenges to the financial sustainability of the system. Responses to these challenges include computerisation and better data utilisation, more rational prescription and use of medicines and technology, transparent procurement, effective primary care referral system, prevention-based policies and promotion of active ageing.

National Reform programme: In the NRP particular emphasis has been placed on the expected inclusion effects of the outlined policy reforms. The upcoming setting-up of the National Council of Social Protection which, amongst other tasks will study the need to set a poverty line was presented. Actions for supporting the family, for financially assisting vulnerable social groups and tackling the social exclusion of various groups at such risk, including people with disabilities or immigrants are mentioned. Other issues that could have a positive impact on growth and jobs such as strengthening lifelong learning especially for vulnerable groups, the reform of the social security system acting as a "safety net" for certain groups among those experiencing poverty, the fight against youth unemployment and promoting policies for older workers would benefit from greater clarity. Moreover, integrating immigrants needs to be given further attention.

The NRP does not present a comprehensive strategy for reforming the pension system, with the exception of the banking sector, and actions on meeting important challenges are postponed to a future social agreement, reflecting the fact that there is substantial scope for improving the adequacy and sustainability of the pension system.

Regarding health care reform, the measures announced in the NRP go in the right direction, although their presentation could benefit from more clarity and detail which might support their projected effectiveness.

Challenges ahead:

– To upgrade and extend in qualitative and quantitative terms, the provision of services to the most vulnerable social groups;

– To mobilise the full range of relevant actors, also in order to increase the efficiency of the social protection expenditure;

– To implement multidimensional policy approaches in order to make progress towards the integration of immigrants into all aspects of life;

– To ensure current and future pensions are adequate, while pursuing efforts aimed at improving the financial sustainability of the pension system in the medium-to long term, notably by increasing employment so as to broaden the contribution base;

– To improve the quality of care and control costs e.g. by using more effective referral systems, more rational use of care and effective prevention.

SPAIN

Situation and key trends: During 2003 and 2004, Spain experienced high economic and employment growth. Economic growth stood at 3.0% in 2003 and 3.1% in 2004 (1.2% and 2.4% in the EU25). Despite economic growth, 20% of the population was below the at-risk-of-poverty threshold in 2003 (16% in the EU) and older people are particularly at risk. Spain continues to have one of the lowest levels of social expenditure as a percentage of GDP of the EU (19.7% compared with 28% in the EU – ESSPROS data). Life expectancy (76.9 years for males and 83.6 years for females, 2003) and healthy life expectancy (66.8 years for males and 70.2 years for females, 2003) are among the highest in the EU. Total health expenditure as a percentage of GDP and as per capita PPP$ (7.6% and 1646 in 2002 – WHO-HFA database) are below the EU average. Spain has witnessed a significant population increase, of more than 3 million people between 1998 and 2005, as a result of migration flows. These migration flows are also likely to have a favourable effect on the old-age dependency ratio. The number of foreign workers entering the labour market and the increase in women's employment are the main factors responsible for the increase in the general employment rate (more than 10 percentage points since 1996), to 61.1% in 2004. Nevertheless, the employment rate continues to be below the EU average, and fixed-term employment (33.3% in the second quarter of 2005) is the highest in the EU, affecting women and young people in particular.

Social inclusion: The main aim of the Spanish NAP on inclusion is to combine economic growth with social welfare, correcting territorial imbalances, reducing disparities and preventing social exclusion. A key element is the increase both in the minimum wage and in the lowest pensions. In addition, some measures relating to people with disabilities, a new national housing plan, a revision of the grant system to NGOs and actions to combat early school leaving were also included in the NAP. One important development has been the regularisation of undocumented immigrants**,** which has helped to reduce undeclared work and increase the social protection of immigrant workers. Regarding long-term care, the drafting of a White Paper and the preparation of a new Law, along with the establishment of a specific public fund, should be mentioned. In relation to gender violence, the new Law on Domestic Violence provides physical protection and legal defence for victims. Vulnerable groups face specific problems: young people have a high rate of fixed-term contracts and difficult access to housing; women face higher unemployment, a high rate of fixed-term and (unwanted) part-time contracts and lower salaries than men; people with disabilities have a much higher rate of unemployment and added difficulties due to physical barriers; immigrants have difficulties regarding the adequate integration in the school system, and poor housing conditions, the Roma, despite a general improvement of their living conditions, still face a situation of clear inequality with respect to the rest of the population, especially in the fields of health, employment, housing and household income. An improvement of the national statistical data and official reports and surveys is also needed, with the objective of quantifying the impact of social inclusion policies on Roma population. Between 2000 and 2003, more than 1,500,000 people participated in activities co-financed by the ESF and the EQUAL Community Initiative in the field of social inclusion.

Pensions: Recent reforms, in particular through strengthening the link between contributions and benefits and the gradual implementation of the reform of minimum pensions, should translate into an improvement in the adequacy of pensions and into a reduction of gender differences in living standards and poverty risks. Thanks to sustained economic growth and the discipline required by the budgetary stability Law, Spain has made major efforts to achieve balance in public finances. Moreover, the national social security system acknowledges surpluses since 1999. Spain faces a major challenge with regard to financial

sustainability due to demographic trends. Nearly all the pension expenditure increase is projected to occur after 2015. Although a reserve fund exists that would enable deficits to be delayed until 2020, additional reforms ensuring the financial sustainability of the pension system in the long-term will be needed soon to ensure a smooth transition. In this regard, actual work in the Social Dialogue Table on social Protection has been recently intensified. Given the low female employment rate, and the low participation rate of older people, further efforts are also necessary to enable a greater participation in the labour market, which would help sustainability and adequacy. This could be achieved through further measures proposed by the government, notably linking the level of contributions more closely to the level of benefits for earnings related pensions, further facilitating of flexible and gradual retirement, and further restricting early retirement schemes.

Health and long-term care: The Government considers that the main challenges concern the consolidation of system financing, cost control, service coordination and integration of the various health services into the National Health Service. According to a preliminary policy statement, adequate provision and equitable financing of long-term care services are among the authorities' main goals, as these services are deemed insufficient and unevenly developed across the regions to cope with growing demand for care due to socio-economic changes and ageing. Long-term care supply – at home or in day centres, hospitals, or nursing institutions – will require better coordination between health and social services in each autonomous region, and the involvement of and coordination between regional and local authorities. Allowances, fiscal benefits and family leave support informal care, primary health care, and the provision of home help. The development of long-term care provision is linked to a country-wide discussion process which has informed the drafting of the White Paper on dependency, which contains various innovative actions. A draft Law on dependency will now be presented to Parliament, after having been agreed with the Social Partners. On the financing side, income-base cost sharing aims to increase the funding of the long-term care system while maintaining access for those more vulnerable. Finally, this process is to be linked to health promotion and disease risk prevention programmes dedicated to the elderly population, aimed at increasing healthy life expectancy.

National Reform Programme: The NRP acknowledges several specific issues highlighted in the NAP on inclusion, such as the high number of early school leavers (in this regard the NRP sets the objective of halving the proportion of early school leavers (from 30% in 2004 to 15% in 2010); the need to better integrate immigrant pupils in the school system; and the need to facilitate access to housing for young people, even if there is not an explicit mention of the NAP on inclusion in the NRP. Concerning the pension system, the NRP reflects the importance of further steps in pension reform, notably reform of minimum pensions and of the design of earnings-related pensions, and in particular a strengthened link between contributions and benefits (renewed Toledo pact).

Challenges ahead:

- To address the needs and demands arising from the progressive ageing of the population, including ensuring the provision and equitable financing of long-term care services;

- To enable a greater participation, notably of women, in the labour market; this would help secure the sustainability and adequacy of the pension system;

- To develop and implement appropriate measures to support the integration of immigrants;

– To address the alarming early school leaving rate (and the consequent increased risk of social exclusion).

FRANCE

Situation and key trends: After a strong resumption of growth in 2004 (2.3%), economic activity slowed down again in 2005. Employment growth has been very weak since 2001. The overall employment rate, at 63.1%, is close to the European average, but the situation is less favourable for older workers (37.3%) in spite of a constant rise since 2001. The unemployment rate, which continued growing in 2004 and reached 9.6% (and 23.3% for young people), has been giving signs of improvement beginning in mid-2005. The persistently high structural unemployment is an important factor in determining the risk of poverty, which is higher for non-EU nationals, whose unemployment rate reached 29.8% in 2003 (national data). If the risk of poverty, estimated at 14% in 2003, has little changed since 2001, "administrative poverty" (the number of social minimum recipients) has increased, in particular because of the increase in the number of RMI (minimum insertion income) recipients following the reform of the unemployment benefits. The share of expenditure related to social protection as a percentage of GDP remained stable at 30.9 on the whole and 13 for pensions (ESSPROS data). Life expectancy (75.9 years for men and 82.9 for women in 2003) is higher than the European average. Health-related expenditure in relation to GDP per capita and in PPPS (9.7% and 2736 in 2002 – WHO – HFA databases) ranks at the second place in Europe and has increased regularly in recent years.

Social inclusion: In continuity with the policies followed since 1998, the strategy implemented in 2003-2005 was based on a broad range of measures pursuing the four Nice objectives with a strong emphasis on employment. 90% of the envisaged provisions have been implemented. As from 2004, the fight against exclusion benefited from a revival of the political dynamics thanks to the social cohesion plan (PCS) 2005-2009, aimed at employment, housing and equal opportunities, and expanded in 2005 by an emergency plan for employment services. The PCS puts the emphasis on the reorganisation of the public employment services, the re-design of subsidised employment contracts, the strengthening of accompanying measures and a priority action for young people. The measures for employment aim to strengthen the pathways in order to make of unemployment spells real moments of activation. The accentuated role of the commercial sector in vocational integration is accompanied by a more recent strengthening of subsidised jobs in the public and associative sector, thereby consolidating the social treatment of unemployment. The phenomenon of the working poor (2 millions in 2001 at the threshold of 60% of the median standard of living) is treated via several mechanisms including extra benefits. The PCS steps up the efforts to increase the offer of housing and promote equal opportunities for people and territories at risk of exclusion (the creation of a high authority for the fight against discrimination - HALDE - should be noted, together with the strengthening of the actions aimed at vulnerable students and territories). Since 2004 the State has renewed its control function (inter-ministerial co-ordination with a mainstreaming document presenting indicators and performance targets within the framework of the budgetary reform, national conferences in 2004 and 2006 preceded by local forums). If the approach by objectives remains cautious, limited primarily to setting implementation goals for the measures, the budgetary reform should make it possible to achieve them.

Pensions: The financing of the pension system for the decades ahead has been significantly improved by the 2003 reform, which preserved the basic architecture of the current system and contributed to more equitable treatment of members of different schemes. However, further measures will be needed in order to put the pension system on a financially sustainable footing in the long run. While current adequacy does not constitute a key issue, projected

replacement rates are expected to decline in the future and the level of pensions will have thus to be monitored attentively, in particular for the most vulnerable groups of the population.

The employment rate of older workers remains relatively low, in spite of recent increases. While incentives to work longer have been strengthened by the last reform, further steps may be necessary as regards early exit from the labour market. Current reforms will only be fully effective if they are accompanied by an effective and sustainable strategy to increase participation by older workers in the labour market and to raise employment in general.

Health and long-term care: The French system provides extensive care coverage to all residents. However, there are variations in care use across social groups. To avoid co-payments and complementary insurance premiums resulting in a financial burden for disadvantaged groups, the Couverture Maladie Universelle Complémentaire covers the fees and insurance premiums of low income groups. Moreover, there are numerous fee exemptions : reductions including 100% state care coverage of those with long-term illnesses. Geographical disparities of supply (across regions, urban versus rural areas) constitute another challenge. The authorities are considering increasing the supply of primary care doctors in deficit areas and needs-based provision is implemented in hospital care supply.

High and rising care expenditure has led to the implementation of several measures to control costs and rationalise the use of resources, including assessment-based reimbursement, encouraging the prescription of generics, activity-based hospital financing and a new contribution of 0.3% of wages as a result of an extra working day and 0.3% on certain incomes to support long-term care. The 2004 reform aims at making the referral system more effective through financial incentives and the use of a patient's file to ensure more rational resource use. Technology assessment and the development and use of a wide array of indicators should lead to increasing quality and efficiency of the system.

National Reform Programme: The NRP, prepared through an inter-ministerial process is overall coherent in relation to the challenges identified in the Joint Report 2005 on social protection and social exclusion as regards employment, the reform of the pension system and the implementation of a new budgetary culture based on performance. The social inclusion perspective is visible in the measures of access or return to employment, with an emphasis on young people and social minimum recipients, which was already evident in the social cohesion plan. The creation of HALDE is also mentioned as well as the territorial dimension of social inclusion.

Challenges ahead:

- Within the framework of employment policy, promote access and return to the labour market of the people most distant from it with particular attention to the effective professional and socio-economic integration of the visible minorities, in particular youth of foreign origin of second and third generation;

- Address the housing shortage, in particular in the most exposed urban areas;

- Consolidate the mainstreaming of social inclusion within the framework of the budgetary reform and ensure consistency between the interventions of the state and of the local authorities;

- To ensure pension adequacy and financial sustainability by putting in place the conditions for older workers to remain longer in employment and positively respond to improved employment incentives in the pension system;

- To keep addressing the financial burden of care for disadvantaged groups and those with a long-term illness, tackle geographical disparities of supply and improve care quality whilst controlling care costs notably by making referral systems more effective, better incentive structures and use of generics.

IRELAND

Situation and key trends: Ireland's performance is characterised by sustained economic growth (GDP +5.4% in 2004), an improving employment rate and continued low levels of unemployment (4.5%) and long-term unemployment (1.6%). In this context, inactivity levels are relatively high (30.5%, close to the EU average), and Ireland is increasingly dependent on migrant workers to meet the demand for labour. Significant increases in incomes from employment, and particularly the growth of two-income households, contributes to the proportion at risk of poverty (21%) remaining amongst the highest in the EU, with elderly people, larger families and lone parents particularly at risk. The moderate level of coverage of income-related pension provision is reflected in the average incomes of older people (about 60% of that of the population aged 0-64). Expenditure on social protection has increased substantially in real terms in recent years, and has also increased as a proportion of GDP – from 15% (2001) to 16.5% (2003) (EU 28% in 2003 – ESSPROS data). Life expectancy (75.8 and 80.7 years for males and females in 2003) is about average as is healthy life expectancy (63.4 and 65.4 years for males and females in 2003). Total health expenditure as a percentage of GDP (7.3% in 2002 – WHO-HFA database) is below average, while per capita PPP$ (2367 in 2002 – WHO-HFA database) is above average.

Social inclusion: Ireland has continued to follow the strategic approach set out in 2003, which takes into account the multi-dimensional and complex nature of poverty and social exclusion, and is centred on increased employment and employability and improvements in benefit levels and in access to services. A shift in emphasis towards addressing the issue of jobless households (and inactivity) is signalled in the 2005-06 update report. Progress across the range of 35 targets set out in the 2003-05 NAP has been variable. Increases in social security payments should ensure that the key income support target will be met while progress is also being made on reaching employment rate targets. A more mixed picture emerges in relation to other areas such as health and education but the recent establishment of the Health Services Executive and the recent publication of an action plan on educational inclusion (Delivering Equality of Opportunity in Schools) are both potentially positive steps. As regards vulnerable groups, progress is particularly evident in relation to people with disabilities and the elderly, compared with other groups, notably Travellers. The absence of base-line data limits reporting capacity but efforts are underway to address these deficiencies. While progress is being made in raising awareness among policy makers of gender issues, continuing efforts are required to ensure that the gender dimension is fully taken into account in the development and implementation of policies.

Pensions: Ireland has made progress in making provisions for increasing the adequacy of pensions and further steps have been announced by the government. Nevertheless, extended coverage of supplementary pension provisions is important to ensure the effectiveness of the income replacement function of pension systems. The national strategy report pointed out that early retirement is still common, in particular for reasons of illness or disability. Although employment rates of older workers have already reached the European target of 50%, further strengthening of incentives to work longer would contribute to ensuring future adequacy and sustainability.

The government is committed to accumulating a considerable reserve fund in order to partially pay for future liabilities, and thus make a significant contribution to financial sustainability, despite projected major increases in future pensions expenditure. The commitment to monitoring the adequacy of contribution rates through regular actuarial

reviews should help to react to indications of a need for adjustments, and thus help to keep the system on a sustainable footing.

Health and long-term care: One challenge identified is service fragmentation and lack of service coordination, which has impacted negatively on access and on the quality and financial sustainability of the system. The authorities consider the creation of the Health Service Executive as a first step towards improved coordination bringing together various health-related agencies in charge of care delivery. The lack of capacity in the acute system and the organisation of emergency services are addressed by the government through increased funding and capacity, through better coordination and through a clearer definition of tasks to improve patient flows. Measures to reduce waiting times include a fund to facilitate treatment for all those waiting more than three months. Addressing the potential financial burden on patients in the health and long-term care sectors remains a challenge, as does the provision of long-term care services.

Standards and guidelines, inspection of facilities and accreditation involving self-assessment and peer review are means to bring about quality gains. Finally, a focus on technology assessment and evidence-supported best practice is thought to improve both quality and efficiency of care. Indicative drugs targets for GPs, emphasis on the use of generics and centralised procurement of drugs are some measures to curb increases in expenditure on medicines. A process of consulting older users and carers is intended to increase system responsiveness. Several prevention and promotion initiatives are intended to tackle health inequalities and improve the general health status of the population.

National Reform Programme: The NRP notes explicitly that Ireland's approach to social inclusion is set out in the 2003-05 NAP, as well as in the National Anti-Poverty Strategy 2002-07. The need to extend coverage of supplementary pension provision is a key part of a Pensions review cited in the NRP, and the NRP also addresses the need to have a more inclusive labour market and measures to tackle educational disadvantage.

Challenges ahead:

- To sustain investment in service provision, notably in relation to childcare and elder care;
- To address the high proportion at risk of poverty, affected particularly in recent years by increased employment and economic growth, and reflected in income disparities which are amongst the highest in the EU;
- To ensure the ongoing adequacy of income support for pensioners, in order to avoid their exclusion in a context of rapidly rising general living standards and to achieve wider coverage by supplementary private schemes;
- To increase healthcare capacity in various areas and improve service integration and coordination to improve patient flows.

ITALY

Situation and key trends: Despite weak economic growth, job creation has continued and the employment rate has risen to 57.6% in 2004 while unemployment has declined (to 8%). Gains have particularly benefited women and, to a lesser degree, older workers (although the employment rate of 55 to 64-year-old workers remains low, at 30.5% in 2004), but structural weaknesses have not been overcome yet: regional differentials are still wide and employment rates remain overall quite low. In 2003 Italy's at-risk-of-poverty rate was 19%, and national data based on income show the situation to be stable since 2000. However, official figures for the year 2003 based on consumption expenditure show a slight decrease in the number of individuals below the poverty line. The profile of poverty and exclusion has not changed, since it affects mainly the larger households and those whose head is unemployed and it remains overwhelmingly concentrated in the South. In 2003, Italy spent 26.4% of its GDP on social protection. Considering only pensions, such expenditure corresponded to 15% of the GDP (ESSPROS data). Life expectancy (76.8 and 82.5 years for males and females) and healthy life expectancy (70.9 and 74.4 years for males and females) are high and above EU average (the latter is the highest in the EU) (2003). Total health expenditure (including public and private) as a percentage of GDP (8.5%) and as per capita PPP$ (2166)[2] are about average.

Social inclusion: The legislative agenda regarding social inclusion progressed during the period 2003-05 (especially as regards the labour market and re-conciliation of work and family life, but with the relevant exception of "essential levels of assistance", which have yet to be determined); however, the ongoing process of building a new institutional framework, coupled with the need to contain expenditure, has resulted in some of the envisaged initiatives not being re-financed through the national budget. Measures such as childcare services and minimum income schemes are therefore being carried out at regional or local level and their overall impact is uneven, depending on the regional and local authorities' administrative and financial capacity, which is not always adequate to the task. In this sense the ongoing attempt at mapping out social protection expenditure at national and sub-national level may also help determine the areas in which more equity in outcomes could be needed.

Pensions: Italy undertook reforms in the 1990s leading to a gradual shift from the defined-benefit scheme to a notional defined-contribution scheme. These reforms created a stronger link between contributions and benefits, thus providing appropriate incentives for new entrants to the labour market to work longer, but entailed a long transition period. After the increase of minimum pensions in 2002, new measures introduced in 2004 strengthen these reforms and also affect those who still have the right to retire early under the old rules. Raising employment rates, particularly those of women and older workers, remains crucial for meeting future challenges, and continuing the process aimed at equalising the effective retirement age for men and women would help to reduce the gender gap in pension entitlements and would also contribute to increasing the employment rates of older workers. Future pensions adequacy will also depend developing supplementary social security entitlements, by transforming the TFR (a firm-based compulsory saving scheme for private employees). The mechanism of automatic transfer of TFR contributions (starting from 2008) to private pension schemes (except where the employee refuses) could contribute strongly to the development of supplementary pensions. Pension rights for atypical workers also remain to be improved.

[2] Data for 2002, WHO-HFA database.

Health and long-term care: Some concern has been expressed about the impact of cost-sharing on vulnerable groups. There are exemptions from co-payments based on age, income, disability/dependency and chronic or rare disease. Local authorities take charge of the institutional care costs of people on low incomes. Regarding long-term care, although some specific initiatives have been adopted at regional and local level, in accordance with the institutional reform, they are deemed insufficient for an ageing population and there are significant geographical disparities in supply and quality. The strategies proposed include enhanced provision of home, day and residential (in small units) care, financial aid and vouchers to dependents to buy services – although only in some regions – and better care coordination via the family doctor and the "Custode Sociale", who look at the healthcare and social needs of elderly dependent people and draft a patient care plan. Besides, some regions have instituted a dedicated Fund for ageing people in dependency aiming at financing services and allowances, within the framework of the essential levels of health services. Furthermore, the (national) definition of essential levels of social service provision and quality should help to address regional differences in standards. In this light, provinces, regions and local authorities are to plan and work together on the definition and provision of services and establish their respective responsibilities. Finally, a set of measures has been adopted to promote quality and financial sustainability. These measures include the increased use of indicators to produce better monitoring of activity, quality standards, a public relations office to help users, patient surveys, technology assessment and benchmarking/rating. To control the rising cost of pharmaceuticals, staff will be given incentives to improve their prescription practice and centralise the purchasing of drugs.

National Reform Programme: Italy's National Reform Programme does not refer to the social protection and social inclusion OMCs, nor does the contribution of the relevant government entities appear to be taken into account in the programme. The 2004 pension reform is mentioned only in the context of budgetary consolidation; the importance of monitoring it for adequacy and sustainability outcomes could have been highlighted. Some measures to promote inclusive training and education activities are part of the NRP, such as projects on e-inclusion and interventions to address early-school leave, but the contribution of social policies to job creation and the need of specific policies to raise the inclusiveness of employment and to decrease regional disparities have been neglected.

Challenges ahead:

- To raise employment rates, particularly those of women and older workers and bring forward the entry into the labour market in order to further raise the overall participation level as well as to meet future challenges of the pension system, in particular increasing the volume of social contributions;

- To develop the South and strengthen co-ordination between national and sub-national interventions in order to reduce regional disparities;

- To continue the reform of "shock absorber" systems in order to accompany the reforms of labour markets already adopted and to reduce the risk of creating a two-tier labour market;

- To take steps to improve health care services for ageing people and improve coordination to achieve better use of resources.

CYPRUS

Situation and key trends: Cyprus maintains a record of sound macro-economic performance with real GDP growth standing at 3.8% in 2004 and projected to remain at least as high in 2005. Despite this, the long-term sustainability of public finances is not guaranteed, due to poor government finances, for example the high debt ratio (72%) and decreasing but still relatively high deficit (4.1% of GDP in 2004), plus the implications of an ageing population. Unemployment remains low by EU standards (5.2% in 2004). It is higher for young people (10.6%) and people with low educational attainment. The total employment rate (68.9% in 2004) and that of women (58.7%) are well on track to meet the Lisbon 2010 target, whilst that of older people has surpassed it (49.9%). Foreign workers make up 14% of the gainfully employed. The gender pay gap, although steadily decreasing, remains as high as 23.8% (2004). Cyprus boasts high levels of educational attainment. Data from the 2003 Family Budget Survey (FBS) point to an improvement in poverty indicators. People at risk of poverty represented 15% of the population, on a par with the EU average. However, and despite a decreasing trend attributed to the progressive maturity of the current social insurance scheme (introduced in 1980), the figure rises substantially (52%) for persons over 65 years of age. The risk of poverty amongst elderly single people remains very high, at 73%. Child poverty has decreased to 11%. Social protection expenditure as a share of the GDP was estimated at 16.4% in 2002 (ESSPROS data). Life expectancy (77 for males and 81.4 years for females in 2003) is high and above the EU average and healthy life expectancy (68.4 for males and 69.6 years for females in 2003) is also high (second highest in the EU). On the other hand, total health expenditure as a percentage of GDP and as per capita PPP$ (respectively 6.4% and 1161.6 in 2002 – WHO-HFA database) is one of the lowest in Europe despite some increases in recent years.

Social inclusion: Cyprus' comprehensive approach to social inclusion is confirmed both in the NAP 2004-6 and the 2005 update. While conditions of social cohesion prevail, pockets of exclusion exist amongst the elderly, people with disabilities, single-parent families, and people falling outside social networks, for example immigrants, to whom efforts are directed. Policies seek to make effective use of domestic labour reserves, focusing on facilitating access to and the return to employment of vulnerable groups, through properly defined activation measures which include tailor-made training programmes, the promotion of flexible forms of employment and the improvement of care services. Access to good accommodation and education for all and the importance of life-long learning are also treated as fundamental. Special attention is paid to improving the situation of the people with disabilities and the elderly. Quantified targets, set on the basis of the 2003 FBS figures, cover crucial areas and poverty indicators, and vulnerable groups. A long tradition of partnership with social partners and NGOs exists and the government appears committed to furthering the involvement of all relevant partners and strengthening their capacity. This would add to the ability to serve special groups of the population through swift and frequent contact. Developing the role of local authorities poses a particular challenge. The geographical dimension of poverty and social exclusion is acknowledged but the implementation of relevant policies or initiatives is expected to be spread over time. Efforts are also directed towards improving the social and economic status of women.

Pensions: The statutory General Social Insurance Scheme, compulsory for every employed or self-employed person, consists of two parts: a pay-as-you-go basic part replacing 60% of the lower part of earnings and a partially funded supplementary part replacing earnings in excess. The pension accrual rate is 1.5%. Access to second pillar schemes seems to pose difficulties and in particular a shift from lump sum payments to annuities would contribute to further

accumulation of pension rights. The amounts of minimum pensions (85% of the full basic old age pension) and social pensions (81%) for people aged over 65 do not protect against the risk of poverty. Reforms under consideration refer mainly to the General Social Insurance Scheme and include a gradual increase in social insurance contributions, an increase in the minimum qualifying period for pensions and a change in the indexation formula.

Health and long-term care: The health system provides extensive but not full population coverage (85-90%) and it suffers from fragmented financing and supply with a large share of private funding and provision. This leads to supply weaknesses, little care continuity, geographical disparities in supply and financial barriers for vulnerable groups (reinforced by a large proportion of out-of-pocket payments). Currently, means-tested free/reduced cost (public sector) care is offered to those groups and various allowances contribute to the income of the disabled and the elderly. Although a National Health Insurance Scheme is to be introduced to guarantee universal comprehensive care, to improve public-private coordination and to increase system funding, delays have been experienced. The new scheme will establish compulsory income-based contributions coupled with government funding and a health insurance organisation will acquire services from both public and private providers. A medical school, a new hospital and new primary care facilities in areas of need are to increase overall supply and address geographical disparities. Legislation, increased provision of home, day and residential care, financial aid for carers and NGOs all aim at enhancing access to long-term care. A referral system based on the family GP and emphasis on primary care are to improve access and care coordination. Whilst the authorities acknowledge the need to raise expenditure to a level closer to the EU level they wish to do so in an efficient manner through referral-based reimbursement, well-organised staff and hospital payment systems. The authorities also stress promotion and prevention (using routine screening, free maternal and child care) so as to control the overall costs of care and maintain the high health status of the population.

National Reform Programme: The enhancement of social cohesion is central to Cyprus' development policy. The NRP is strong on activation measures that target vulnerable groups. Furthermore, the improvement of public finances is attached to reforms in the social insurance and healthcare systems. The social inclusion and protection perspective forms an integral part of the programme, although the OMC is not mentioned explicitly. The policies set out are consistent with the corresponding challenges facing Cypriot society.

Challenges ahead:

- To continue to better the position of vulnerable groups in society, mainly through pathways to employment and through ensuring equal access to services;

- To develop methods for effectively monitoring and evaluating the implementation of interventions and orienting future policy formulation, including the use of indicators; and to help strengthen the institutional capacity of local authorities, NGOs and social partners in the field;

- To address the high risk of poverty among people aged 65 and over;

- To guarantee universal comprehensive care coverage and equitable financing through new organisation and financing of health services and increased funding and provision in an efficient manner.

LATVIA

Situation and key trends: Since 2000, annual average real GDP growth in Latvia (largely supported by domestic demand) has exceeded 7% (8.5% in 2004). Regional disparities are considerable and there is a rural-urban divide. Overall living standards are low (GDP per capita in purchasing power standards stands at 43% of the EU-25 average). Growing inflation (6.2% in 2004) erodes the income of low and average income groups and hinders efforts to make work pay. Income inequalities are increasing (the Gini coefficient increased from 34 in 2000 to 36 in 2004). The at-risk-of-poverty rate after social transfers in 2003 was 16% (14% of people aged 65 and more). Social protection expenditure is low (13.4% of GDP in 2003, pension expenditure representing 7.5% in 2001 – ESSPROS data). The employment rate for older workers (47.9%) is above the EU average, but still below the Lisbon target. Long term and youth unemployment remain issues for Latvia. The unemployment rate for ethnic minorities is higher, though poverty rates are similar to those for Latvians (except for Roma who are exposed to a higher poverty risk). Access to affordable housing remains a problem. The mismatch of skills and education with labour market requirements and school drop-out rates need to be addressed. The health situation of the population, as measured by life expectancy (65.7 years for males and 75.9 for females in 2002) is not satisfactory. Total health expenditure as a percentage of GDP and in per capita purchasing power standards (4.9% and 451.29 in 2002 - WHO-HFA database) are the EU's lowest.

Social inclusion: Following the Poverty Reduction Strategy (2000), the first National Action Plan for tackling poverty and social exclusion (2004-2006) encompassing a multi-dimensional approach has outlined a great number of general objectives and priorities, however, overall coherence and co-ordination of policies must be improved and future tasks better addressed. The objectives set relate primarily to national policies and measures already in place. Measures are implemented within the framework of the annual budget and with significant support from structural funds. The gender perspective is not consistently mainstreamed. The national implementation report on 2004 activities lists actions taken, but these do not sufficiently target specific social exclusion risk groups or concentrate on preventive measures. Measures aiming to ensure adequate income have been implemented or planned for 2006, including an increase in social security benefit amounts for families with children; pension increases, supplements and special adjustments for those receiving low pensions; gradual increases in the tax-free personal income threshold; higher guaranteed minimum income benefit and higher minimum wage. The issue of un- declared work remains high on the political agenda.

Pensions: The national pension system was transformed into 3-tier pension system consisting of a notional defined contribution scheme (NDC pay-as-you-go pension scheme), a state funded pension scheme and private pension schemes. Contributions to the pay-as-you-go public scheme will decrease, while those to the mandatory private pensions will increase. Regarding the impact of ageing on pensions, policy aims at a balanced budget position in the long term. The government expects to compensate the decline in contribution rate in the NDC scheme by increased employment and an increase in the declaration of work.

The early retirement option is to be eliminated by 2008 under present plans. The risk of poverty of the 65+ age group is currently lower than for the working-age population. Still the new pension formula, which establishes a strong link between personal contributions to the system and benefits, could lead to adequacy issues as the overall replacement rate is expected to fall until 2030, before increasing again when the mandatory private pensions come to

fruition. This could affect lower income earners and people who have taken career breaks, notably women.

Health and long-term care: Present health care policy aims to promote primary and preventive health care to reduce the high dependency on hospital care. One important task is to develop adequate provision of long-term care services. This implies efficient cooperation between social and health sectors. Current discussion is about financing and delivery of long-term care services according to patient need, given long queues for institutional care and a lack of alternative services. To improve access and quality, the focus is to be put on a variety of home and close-to-home care, following individual patient assessments. The authorities are concerned about potential staff shortages (e.g. due to emigration and ageing) and need to further develop and implement strategy in this area. The family doctor has a gate-keeping role in order to provide the patient with necessary care and effectively use allocated resources. Cost-sharing brings funding to the sector whilst exemptions and ceilings reduce the financial burden for disadvantaged groups.

National Reform Programme: Governance structure, ensuring inter-ministerial coordination, and the participation of social partners and other stakeholders have been enhanced in Latvia by their involvement in the drafting of the NRP. Civil society and local and regional government bodies have also participated in the discussion. An ambitious policy intention is expressed to reduce the at- risk-of-poverty rate to 11% by 2008, although no details have been given as to how this will be achieved. Minimum wages are being increased gradually, however, in future they will benefit by being balanced against the risk to job creation for the low-skilled. Measures aimed at ensuring inclusive labour markets will improve active labour market measures, provision of child care and social services. Detailed measures targeting the young and the disabled are envisaged.

Pension reform is described, although the implications for adequacy and sustainability would gain from being described in more detail. Although further efforts are planned to promote a life cycle approach in employment and longer working lives, there may be slight inconsistencies between the employment targets set out in the NRP and forecasts of funding for future pensions.

Challenges ahead:

- To develop a coherent strategic approach to promoting social inclusion, including quantified targets, which take into account regional and gender dimensions of poverty and social exclusion and further enhances employment opportunities;

- To tackle poverty and social exclusion by introducing more targeted measures for vulnerable groups and by addressing the adverse effects of inflation on low and medium income groups;

- To ensure that sufficient resources for adequate pensions are available until the funded schemes have matured and to monitor future adequacy;

- To improve the health status of the population through effective health promotion and disease prevention and ensure better access to care for all.

LITHUANIA

Situation and key trends: The pace of economic growth remains favourable (6.7% GDP growth in 2004). However, GDP per capita in purchasing power standards was only 48.2% of the EU-25 average in 2004. Although the unemployment rate decreased from 12.7% in 2003 to 10.8% in 2004, the employment rate remained stable (61.2%), partly due to economic emigration. Employment rates for older workers (47.1% in 2004) and women (57.8%) are above the EU average. Youth unemployment (20.8%) and long-term unemployment (5.6%) are still high. Social protection expenditure is among the lowest in the EU (13.6% of GDP in 2003, including 6.8% for pensions – ESSPROS data). Social transfers are increasing, but remain modest. The at-risk-of-poverty rate remains close to the EU average (15% after and 23% before social transfers, excluding pensions in 2003). Life expectancy (66.5 and 77.7 years for males and females in 2002) is one of the lowest in the EU. Total healthcare expenditure as a percentage of GDP and as per capita PPP$ (respectively 5.7% and 588.24 in 2002 – WHO-HFA database) are among the lowest in the EU, the former having even decreased over time.

Social inclusion: The 2005 NAP update aims to make the 2004 NAP's strategy more operational by identifying more specific measures, and the institutions responsible, and estimating the resources needed. All previous objectives and targets remain valid. The main focus of the update is on measures for social integration through employment, better access to the labour market (in particular for disabled, young and elderly people), and optimisation of labour market policies. Many measures are planned to assist the most vulnerable (especially children) and improve the social protection system, including the recently approved tax reform introducing a better balance between capital and labour taxes. A number of labour market and social inclusion measures are supported by the structural funds. Regional development measures focus on the diversification of rural activities. However, drafting a coherent and integrated regional development policy remains a recognised challenge. No specific measures have been envisaged for the declared objective of preventing homelessness and indebtedness, nor for the provision of housing. The establishment of the NAP's monitoring group should facilitate the mobilisation of all the relevant bodies and strengthen the NAP's coordinating role.

Pensions: Since the 2004 reform, the State-managed statutory pay-as-you-go pension scheme has been associated with a privately managed funded pension scheme. These schemes cover gainful employment, while a social assistance pension provides a minimum retirement income to those not entitled to a social insurance pension, including farmers and the self-employed. Legislation on voluntary supplementary pension provision is in place, and tax incentives were recently introduced. The financial sustainability of the public pension scheme will have to be closely monitored, although the transition costs are not expected to cause problems before 2020. However, thereafter, the ageing of the population could result in a deficit in the social insurance pension scheme. Further measures to increase employment rates, and the retirement age (including equalising statutory retirement ages for men and women) would contribute to both the future adequacy and sustainability of pensions. In that respect, while early retirement provisions were terminated in 1995, the introduction of an early retirement pension scheme for the long-term unemployed in 2004 seems to be in contradiction to the general trend.

Health and long-term care: The main issues for the healthcare system are to reinforce the primary care sector, to reduce the high dependency on hospital care and develop adequate provision of long-term care that is currently lacking. The authorities are apprehensive about possible staff shortages, particularly due to emigration of workers. Measures to improve

primary care (which is to also provide health promotion and prevention services) include raising the qualifications and motivation of staff (partly through increased wages) and allowing private provision. A stronger focus on primary, outpatient care and day case surgery vis-à-vis in-patient hospital care, reduced length of stay, increased bed use and needs-based provision is to render the services more efficient, as well as tackling regional differences in access. Improving population health status and tackling health inequalities through effective promotion and prevention (e.g. promote healthy life-styles, ensure healthy environment, strengthen prevention mechanisms – screening and immunisation – and timely diagnosis, ensure accessible care of quality) is a main goal of the authorities pursued through intersectoral collaboration.

National Reform Programme: The NRP refers to the National Action Plan on Social Inclusion, as an instrument for coordination of the social inclusion policies and actions. The implementation of the NAP is one of the NRP measures. The main synergies of the two strategic documents have been exploited in the area of making work pay and improving access to the labour market for vulnerable groups, where social integration measures have a strong emphasis on disabled and young people. The NRP also includes plans, though not always very concrete, to optimise labour market policies and institutions, and to improve healthcare and social partnership. The NRP also acknowledges the need for reforms of the pension and health care system, while further measures with the aim of increasing employment rates and increasing the retirement age would contribute to both the future adequacy and sustainability of pensions. The NRP sets a regional unemployment target for 2013 (unemployment per region should not exceed the national average by more than 35%). The 2004-2006 structural funds programme should provide essential funding for the social inclusion measures.

Challenges ahead:

- To develop and implement a comprehensive regional and local development policy, taking into account regional imbalances, the needs of the most deprived areas and the widespread rural poverty;

- To further strengthen the NAP's coordinating role and its strategic focus, develop monitoring and evaluation arrangements, further mobilise all the stakeholders and ensure visibility of the social inclusion policy;

- To ensure wider coverage of the population by the statutory pension system and the availability of adequate minimum pensions and sufficiently high replacement rates from the modernised pension system, as well as address transition costs beyond 2020;

- To improve access to care via a stronger primary care sector and an enhanced long-term care provision;

- To improve the health status of the population through effective health promotion and prevention.

LUXEMBOURG

Situation and key trends: The Luxembourg economy always shows considerably higher growth than the neighbouring countries (4.5% of GDP in 2004). The country also continues seeing a much more satisfactory expansion of internal employment: 1.8% in 2003 and 2.6% in 2004. But as in previous years, the growth of employment primarily benefited the non-residents. Consequently, job creation was not strong enough to prevent a new increase of internal unemployment, which passed from 3.7% of the working population in 2003 to 4.8% in 2004, as well as another slight reduction in the employment rate, which stood at 61.6% of the population in 2004, which is lower than the EU average. The employment rate is particularly low among older workers: 30.8% in 2004. Bu generally, the standard of living is rather high in Luxembourg; the at-risk-of-poverty rate is rather low (11% in 2004) and expenditure on social protection was equal to 23.8% of GDP in 2003 (source: ESSPROS). Life expectancy (75 and 81 years for males and females in 2003) is at about the EU average. Total health expenditure as percentage of GDP (6.2% in 2002 WHO-HFA database) is below EU average albeit a consistent increase and a strong dynamic in recent years while per capita spending on health in PPP$ (3065) is the EU highest.

Social inclusion: Luxembourg maintains a complex strategy based on 5 specific fields, resulting from the 2001 and 2003 NAPs. 27 of these measures are now considered as having been implemented, 74 are being implemented; the balance representing measures that were abandoned or merged with others. But the report on the implementation of this strategy presents few integrated analysis. Unfortunately, it does not always indicate whether the set objective was achieved, when the measure has been implemented; or, when the measure is being implemented, whether there has been progress or not since 2003 (or even 2001). It does not examine in the light of the most recent indicators and of the comments provided by the promoters whether the measures that are being implemented remain valid ones. The challenges identified in 2003 as regards housing and prevention were well addressed, thanks, inter alia, to considerable improvements in the tenants' legal position and a reinforcement of prevention mechanisms such as the houses for young people and the social accompanying measures. As regards promotion of access to employment, the most positive results ca be found in the activation of RMG recipients and the increase in the offer of crèches. Aiming to reduce the risks of persistent poverty, progress can be noted in the establishment of an emergency social service (SAMU), in the improvement of the legal position of people with disabilities and in the treatment of drug addicts. To reduce the situations of social exclusion affecting children, action targeted the improvement of the State socio-educational centres. The distribution of questionnaires to RMG applicants was the occasion to promote the participation and expression of this category. The laudable initiatives taken to mainstream inclusion policy in the other policies have not led yet to measurable progress. Lastly, the expansion in the composition of two co-operation authorities makes it possible to hope for a strengthening of the dialogue and of the partnership between all the concerned actors.

Pensions: The Luxembourg pension system is based on strong political consensus and guarantees appropriate pensions. Its financial sustainability depends nonetheless not only on relatively high rates of economic growth in the future, but also on a very important contribution to the Luxembourg economy and the pension schemes on the part of the non resident workers. Although a reserve fund was set up, it remains that in the event of a decline in the employment of non residents, an ageing population should then finance not only the resident pensioners' pensions, but also those of a large number of pensioners outside Luxembourg. Despite the recent increases and the strengthening of incentives to extend active life, the employment rate of those aged 55-64 remains appreciably below the Lisbon

objective. Financial sustainability would depend less on the availability of non-resident workers should the employment rates of the resident population be raised – and in particular those of women and of persons more than 55 years old.

Healthcare and long-term care: regarding access, inequalities appear not to be a major issue. Nevertheless, to take into account more vulnerable people, both favourable reimbursement and pre-financing of health interventions are foreseen. Also, ongoing extra investment in capacity aims at improving general service access. Long-term care has been defined as a social risk requiring specific social security. Thus a compulsory contribution based on various revenues has been established in return for access to a whole range of services independently of ability to pay. Moreover, for the elderly, greater emphasis has been place on geriatric care, gerontology education and the establishment of requirements for facilities and staff. The authorities put great emphasis on the development of strategies aimed at simultaneously improving quality and the financial sustainability of services. Measures include the definition of clinical practice recommendations based on assessment and evidence-based studies. They also relate to evaluating doctors' prescription behaviour, controlling antibiotic overuse and encouraging the use of generics, and to hospital collaboration and the designation of centres of excellence, the development of new management practices and centralised procurement of medicines. Finally, strong health promotion and prevention policies (e.g. screening, immunisation, AIDS, TB, nutrition and physical activity campaigns), pursued in a global and multidisciplinary way, are intended to improve the long-term financial sustainability of the system.

National Reform Programme: The plan for inclusion is mentioned under certain measures that are part of it and that are also included in the NRP, primarily as regards childcare, the revision of disincentives in the measures for employment, and the non-profit economy.

Challenges ahead:

- Ensure better control of the inclusion strategy; simplification of the mechanisms, better co-ordination and more precise formulation of the objectives and of the results achieved;
- Perform an analysis of the social implications of the constant rise of unemployment;
- To raise the employment rate of the resident population aged 55-64;
- To develop financially sustainable long-term care provision accessible for all and simultaneously improve the quality and financial sustainability of services.

HUNGARY

Situation and key trends: Following a temporary slowdown in 2003, GDP growth accelerated to reach around 4% in 2004 and 2005 – well above the EU average. The general government deficit has increased to over 6% of GDP in 2005. After a long-awaited acceleration in 2003, employment growth turned negative in 2004 and stagnated in 2005. As a result, both the overall employment rate (56.8%) and the employment rate for women (50.7%) declined by 0.2% percentage points from 2003 to 2004, thus drifting further away from the respective Lisbon targets. In addition, continuing the trend since 1999, employment among the 15-24 age group fell further to 23.6% (EU: 36.8%) from 26.8% in 2003. Despite further growth of 2 percentage points in their employment rate, older workers' employment was still only 31.1% in 2004. At the end of 2004, unemployment started to rise and the unemployment rate has now stabilised at around 7% according to the national definition; the long-term unemployment share continued to increase to 44%. Low employment, coupled with relatively low unemployment, results in the second lowest activity rate in the EU (60.5% in 2004). The problems of joblessness and poverty continue to have strong educational, ethnic, health and regional-related origins. The health status of the population continues to remain a real concern. Social protection expenditure rose to 21.4% of GDP in 2003 (EU: 28% - ESSPROS data).

Social inclusion: The 2004-2006 NAP had set five strategic objectives including employment, access to services and poverty reduction. The priority groups are the Roma, the disabled and children. A wide range of measures is aimed at the most disadvantaged, promoting their employment, training and life-long learning, but policy coherence and coordination could still be improved. Under the SZOLID initiative, important steps in the revision of cash allowances and personal care services have been taken, though other important elements of the reform plan of the social benefit system still have to be implemented. The elimination of certain disincentives to return to the labour market and the integration of the employment and social services system with ESF assistance are steps into the right direction. However, the social benefits system as a whole, including disability benefits, needs to be further reviewed to make work pay. The NAP and the update present a wide range of measures under the medium-term Roma Program and the "Decade of Roma Integration", but it remains to be seen how progress will be monitored. Measures aimed at children broaden their access to free school meals and books and increase the preschool attendance rate. In terms of access to financial provisions, the design of a new family support system has been a significant step in the framework of the government's "100 steps" programme. In a number of areas, the lack of targets, deadlines for action, assignment of responsibilities and details of funding will render implementation and monitoring difficult.

Pensions: A major reform package came into effect in 1998, overhauling the public pension scheme and introducing a mandatory funded scheme, while the voluntary funded pillar was established by 1993. The introduction of the funded tier, though, will cause transition costs which will constitute a major challenge for the sustainability of public finances. Further reforms may be required as regards limiting the scope for early retirement in order to motivate people working longer. Contribution evasion also remains a problem. Older people in general enjoy incomes almost comparable to those of the active population. Nevertheless, some measures of the recent reforms may pose adequacy risks in the future. In addition, some categories of workers (farmers) are not covered by the mandatory pension insurance system. Further policy efforts would be necessary to increase the employment rates of older people. The 2013 introduction of linear accrual rates in the pension formula will enhance incentives to longer working lives and fairness, but the acceleration of this process could be envisaged.

Health and long-term care: A significant part of the government's "100 steps" programme is devoted to improving the health status of the work force and the general population and to restructuring the health care system. In terms of access, the Hungarian authorities have committed themselves to enhancing provision and to improving emergency and long-term care currently deemed insufficient and of poor quality. All local authorities are required to provide information about social services, meals provision, home care and the access to any other social services, while means-tested cash and in-kind benefits and informal care allowances are to directly help dependents and their carers. New rehabilitation facilities (day care or home services) are being developed and emphasis is being placed on geriatric care and gerontology training in view of an ageing population. Increased cancer mortality and high disability rates have urged the government to increase the population's health status through stronger promotion and prevention policies in various sectors (cancer screening, tackling tobacco addiction, environment, and public health training for health professionals). The health problems of the population create a high financial burden which is amplified by low income base and high tax evasion and rising expenditures at the same time. Against this background, to improve system efficiency, measures are being taken to replace the current excessive use of in-patient and specialist care by increasing day care surgery, increasing the use of out-patient care, which has so far expanded more slowly than desirable and by ensuring an effective referral system based on guiding and gatekeeping general practitioners, which is also to improve care coordination.

National Reform Programme: Activation policies targeted on disadvantaged groups, policies promoting the reconciliation of work and family life and policies ensuring an employment-friendly economic environment have been fed into the NRP from the social inclusion agenda to contribute to attracting and retaining more people in employment. The NRP also stresses the importance of a comprehensive approach to promoting longer working lives. On the other hand, other synergies between activation and the modernisation of the social protection system have not been fully used but the steps taken to revise the family support system and the plans to integrate social and PES services and link healthcare entitlements to activity are encouraging.

Challenges ahead:

- To improve employment performance and, crucially, to address the issue of high inactivity, including the review of benefit systems;
- To ensure that sufficient resources for adequate pensions are available in the long run, in particular by implementing measures to reduce the evasion of contributions and handling effectively the transition costs;
- To increase resources dedicated to fighting poverty and exclusion, in particular among the Roma minority, to improve cooperation among the relevant governmental bodies and better mobilise civil society in the preparation and implementation of policies;
- To improve the health status of the population through healthy life styles and to improve health and safety in the work place;
- To increase system efficiency in the area of health care.

MALTA

Situation and key trends: Although Malta has recorded a slight economic improvement (GDP growth in 2004 of 1%) coupled with a lower unemployment rate (8.0% in 2003 and 7.3% in 2004, LFS data), activity and employment rates remain low. According to Eurostat data, female participation has worsened with the female employment rate decreasing from 33.6% in 2003 to 32.7% the following year. However, important positive trends have been reinforced in education (youth school attainment increasing from 43% in 2003 to 47.9% in 2004 and the rate of early school-leavers dropping from 48.2% to 45%) even if educational attainments remain below EU averages. Pension expenditure increased from 8.5% of GDP in 2000 to 9.4% in 2003, while total expenditure on social protection moved from 16.9% of GDP in 2000 to 18.5% in 2003 (ESSPROS data). Older people (aged 65 or older) record living standards close to the average for the population as a whole, although the risk of poverty is higher among older people. Life expectancy (75.9 and 81 years for males and females) is around the EU average, as is healthy life expectancy (65.1 and 65.7 years for males and females) (2002). Total health expenditure as a percentage of GDP (9.7%) is above average with a consistent increase witnessed in recent years, while per capita PPP$ (1709.32) is lower than EU average[3].

Social inclusion: Measures to improve access to employment constitute the bulk of the policy instruments, with emphasis on promoting reconciliation of work and family life, making work pay and preventing early school-leaving. One important sign of progress is the finalisation of Child Care Regulations providing standards for childcare centres. Given the decreasing trend in women's employment rate, such measures are to be welcomed and should be sustained.

The objectives of preventing the risk of exclusion and helping the most vulnerable have been reinforced with 10 new policy measures in the "light update" of the NAP 2005. The government took some initiatives to standardize the national approach to immigrants, refugees and integration in response to an unprecedented increase in the number of asylum seekers coming to Malta. This influx is forcing a substantial upgrading of accommodation facilities, which have already been the subject of a number of recommendations from the Council of Europe. New legislation regarding domestic violence is also in discussion, which may remedy the current legal void in this domain. Still to come is a white paper containing proposals for an urgently needed reform of rental housing.

Pensions: The government has issued the final report on pension reform in the 2006 budget. The precise way forward regarding various aspects of pension reform still remains to be determined. The government has to decide whether the system will develop in the direction of more flat-rate benefits or of strengthening the link between contributions and benefits. If it opts for flat-rate minimum pensions, a reasonable level should be set in order to cope with the risk of poverty among older people, especially women. The proposed new system may translate into lower pension entitlements from the current mandatory pensions, which should be offset by the introduction of a new pillar. In order to ensure adequate replacement income and sustained incentives to contribute in the scheme, easy access to the new mandatory scheme (SPPS) is essential.

Health and long-term care: Ageing, increasing expenditure on medicines and technology, and patients' growing expectations are reported as the main challenges to the system.

[3] Data for 2002, WHO-HFA database.

Furthermore, staff shortages emerge as a real threat to the system's sustainability. Regarding access, the issue of waiting times is being addressed. A new hospital which is expected to replace the main acute general hospital is currently the main focus of activity and planned reforms. An increase in rehabilitation facilities is being contemplated. A policy document on the future of long-term care is currently being drawn up to enhance long-term provision. On staff shortages, a staff strategy is under development, focusing on post-graduate training and continuous professional development, balancing work and private life, providing greater autonomy and accountability, establishing support mechanisms and managing performance. On quality, the emphasis is placed on developing a monitoring system using process and outcome indicators and on improving coordination between primary and hospital care and between health and social care. To control upward expenditure pressure, the authorities are introducing a system of pricing for pharmaceuticals and introducing corporate management and technology assessment into the system. Strengthening primary and community services vis-à-vis hospital care is another key response. Stronger health promotion and prevention policies are also intended to bring expenditure gains in the long run.

National Reform Programme: The Ministry of Social Solidarity and the social partners were consulted when drafting the Maltese National Reform Programme; still, the link with the Social Inclusion and Social Protection processes is not explicit. Nevertheless, the challenge of ensuring a sustainable social protection system and the need to promote female participation in the workforce, either through the review of tax and pension system or some family-friendly measures, are taken into full consideration. Overall, the contribution to growth of social inclusion policies is limited, since the strategic approach does not give priority to ensuring inclusive labour markets.

Challenges ahead:

- To increase the overall – particularly female – employment rate and develop policies to make work pay while promoting more and better jobs for both women and men who are currently inactive or who are recipients of social benefits, while encouraging labour market integration of the most vulnerable groups;

- To combat illiteracy and improve the educational attainment levels of both young students and adults;

- To reform the pension system by strengthening the incentives to work and to remain in the labour market and ensuring adequate replacement income, notably through easy access to pension provision;

- To control cost pressure, particularly on medicines and high technology procedures in the healthcare system, through various types of measures including health promotion and prevention policies; retain staff in the sector, avoiding brain drain; and address the increasing need for long-term care as a result of the larger numbers of elderly persons.

THE NETHERLANDS

Situation and key trends: With weak economic growth between 2001 and 2004, unemployment increased from 2.8% in 2002 to 4.6% in 2004 and long-term unemployment to 1.6% of the labour force in 2004 (0.7% in 2002). The number of people entitled to social assistance also rose in these years and over-indebtedness became more persistent. In 2003, 12% of the population was at risk of poverty; although growing, this remains one of the lowest shares within the EU-25 (15%). While employment rates are well above the Lisbon targets, inactivity (23.4%) remains relatively high. The upward trend in the employment rate for older workers continued, reaching 45.2% in 2004. According to national data, the employment rates for ethnic minorities were 48% overall in 2004 and 39% for women (50% and 36% in 2002). While the percentage of early school leavers slightly decreased, the nationally targeted 54% employment participation rate of ethnic minorities was not achieved. Life expectancy (76.2 years for males and 80.9 for females in 2003) and healthy life expectancy (61.7 for males and 58.8 for females in 2003) are high. Total health expenditure increased to 9.1% of GDP (EU-25: 8.7%) and to 2643 PPP$ per capita in 2002 (WHO-HFA database). Social protection expenditure was 28.1% of GDP in 2003 (EU: 28%, ESSPROS data).

Social inclusion: The primary focus in the Netherlands is on activating social systems. The emphasis has shifted from the role of government to fostering greater personal responsibility. Under a policy of decentralisation over recent years many key decisions on social inclusion policy are now taken at the local level. Policy measures are increasingly focused on improving individuals' chances and competences while, to a lesser extent, also addressing direct and indirect poverty risk factors including gender, age or ethnicity. A new decentralised social benefit system (Work and Social Assistance Act, 1.1.2004) gives municipalities a direct interest in achieving a strong benefit-to-work performance while facilitating a more tailor-made approach at individual level. While since its introduction slightly fewer people are dependent on social assistance, the act runs the risk that difficult-to-place individuals may be left behind. The future role of national policy in implementing measures in a decentralised model needs to be monitored in the context of strengthening the links between the national and locally-based approaches. From 2003 a mix of policy measures has been applied to prevent youth unemployment and to improve cooperation between institutions dealing with youth. Nevertheless youth unemployment increased in 2004. In relation to immigrants, integration policies have been firmer in tone, focusing on promoting active participation in society including acquaintance with the Dutch language and culture. The gender dimension of poverty and social exclusion is less developed in the implementation report, as was the case in the 2003 NAP. In 2005 and 2006 a number of new plans were proposed in the area of health, social support, income and work capacity; the impact of these acts should be closely monitored.

Pensions: The Dutch pension system performs well in terms of adequacy, as it is based on a universal flat-rate public pension and on earnings-related supplementary pensions which cover a very large share of the population. The Dutch strategy for the first pillar relies on an ambitious goal of achieving budgetary surpluses over a long period of time (though this strategy may be weakened by the risk of remaining public deficits), supported by intensified employment policies and reduced incentives to early exit from the labour market. Regarding second-pillar pensions, the strategy relies on conducting sound macroeconomic policies and reinforcing surveillance, in particular through safe funding margins. The employment rate for people aged 55-64 has increased significantly in the past decade but it remains to be seen whether increased labour-force participation and the inclusion of part-time workers in

occupational pension schemes will allow women to catch up with men in terms of incomes in old age. While further steps are planned to be taken in order to remove obstacles preventing people from working after they reach the current retirement age of 65, measures aiming at reducing the use of early exit from the labour market (early retirement and disability schemes) are being implemented and could be further strengthened.

Health and long-term care: The new Health Insurance Act and Health Care Allowance Act took effect on 1 January 2006, aiming to contain health care costs by encouraging competition between care insurers and to obtain more efficient health care through better negotiated contracts between care insurers and health care providers. The authorities expect this to help match the needs of different consumer groups, increase citizens' choice between different options and give them more responsibility for their health care insurance. The new legislation unifies the former social health insurance scheme that covered 63% of the population and private health insurance. A care insurer is legally obliged to offer the same premium to all applicants for a standard health care package, although care insurers can compete on price (the premium) and on additional care packages they offer. To further prevent risk selection by the insurers, they must accept any citizen as a customer regardless of age and health risk profile, and are compensated through a risk adjustment scheme. Further restructuring measures are likely, e.g. significant amendments are also expected to the Exceptional Medical Expenses Act (AWBZ) to make it more effective in the longer term. It is also intended to introduce a Social Support Act in 2006 that should transfer responsibility for some elements of care from the AWBZ to local authorities.

National Reform Programme: The NRP focuses mainly on labour supply and deals in depth with measures aimed at "activating" the social security system and the reforms in health care. It addresses the educational problems of ethnic minority youth through a general, integrated approach to disadvantaged youth and extra efforts to reduce early school leaving in general. The NRP cites continued efforts to raise the effective exit age from the labour market. Early labour market exits due to long-term sickness and invalidity benefits should be reduced by the new disability scheme that contains financial incentives for both employers and employees to keep the partially disabled at work or help them to acquire a job. The NRP also cites the creation of a new surveillance scheme for pension funds. However, the NRP does not assess the impact of activation policies on the most vulnerable groups.

Challenges ahead:

- To closely monitor the impact of reforms in the area of social support, income and work capacity;

- To facilitate the integration of ethnic minorities and to recognize and take into account their cultural diversity in the development of social inclusion policies;

- To further reduce the number of early labour market exits, in particular due to long-term sickness and invalidity benefits;

- To implement the major health reform successfully and to monitor its medical, social and financial effects, and safeguard the functioning of the newly formed health insurance market.

AUSTRIA

Situation and key trends: GDP growth accelerated from 1.4% in 2003 to 2.4% in 2004. The overall employment rate stood at 67.8% in 2004, well above the EU average, whereas for older people, at 28.8% in 2004, it is among the lowest in the EU. The unemployment rate has increased for the third consecutive year, to 4.8% of the labour force in 2004, affecting youth in particular. The youth unemployment ratio increased from 3.8% in 2003 to 5.6% in 2004. Social protection expenditure, as a percentage of GDP, has increased since 2000, reaching 29.5% in 2003 (ESSPROS data). Life expectancy (75.9 and 81.6 years for males and females in 2003) and healthy life expectancy (66.2 and 69.6 for males and females in 2003) are high and above the EU average. People aged 65 and above have a living standard, as measured by average income, close to that of the 0-64 population. The at-risk-of-poverty rate was 13% in 2003, with a higher risk for women, elderly people, children, people with disabilities and immigrants. Total health expenditure as a percentage of GDP (7.7% in 2002 – WHO-HFA database) is below the EU average and has increased only moderately in recent years, while per capita PPP$ (2220) is slightly above EU average.

Social inclusion: Under the Austrian inclusion strategy, the promotion of employment, reconciliation of family life and work, development and improvement of social services for people with high social risks and investment in education are identified as the key policy levers. The Implementation Report of the NAP on inclusion advocates a continuation of the present policies and mentions a number of upcoming initiatives to address the challenges. As a measure to improve the situation of the working poor, a monthly minimum wage of EUR 1000 is now part of almost all collective agreements. While the reform of the pension system aims at financial sustainability, measures have been introduced to maintain the incomes of people on low pensions. To address the needs of the long-term unemployed, expenditure on active labour market policy will be raised further in 2005 and 2006. With a view to increasing the very low employment rate of older workers, incentives in the pension system to remain active have been strengthened, and the 56/58 campaign has been launched. This campaign entails the reduction of statutory non-wage costs for 56 to 58-year-old workers. The employment campaign "A billion for people with disabilities" is also intended to continue in 2005 and 2006. The "equalisation package for people with disabilities" (*Behinderten-Gleichstellungspaket*) will come into effect on 1 January 2006. The aim is to abolish all forms of discrimination. Starting from the school year 2005/2006, children who do not yet know enough German are to be supported in pilot experiments in the year before school entrance. The 2005 package of legislation concerning foreigners (*Fremdenrechtspaket*) further expands the “integration agreement” (extension of the target group, better knowledge of the German language, access to the labour market). The harmonisation of the social assistance schemes of the Länder has not yet been implemented and remains a major challenge.

Pensions: Austria harmonised the pension systems of blue-collar workers, white-collar workers, the self-employed, farmers and especially federal civil servants by introducing a uniform pension law for all these professions for persons aged less than 50. The last pension reform contains a fairly thorough redesign of the calculation of the benefits leading to a much stronger link between contributions and benefits, including a “bonus malus” system for deferred and earlier retirement (a cap has been introduced with a maximum loss of pension rights from 5% to maximum 10% by 2024), and a switch in the indexation of pensions to consumer prices as of 2006). The retirement age for women will remain lower than for men for a long time and will be raised from 60 to 65 years between 2024 and 2033. While early retirement options will be restricted to people with long careers after a transition period until

2014, there is a possibility that such long phasing-in periods could weaken the message that change is necessary.

Health and long-term care: Eurobarometer indicates that the Austrian health care system receives a relatively high satisfaction rating. On the financing side, it is basically a compulsory social insurance system, but significant funding comes also from regional governments, private co-payments and additional private insurances. On the provision side, it is a mixture of mostly private self-employed doctors and mainly public hospitals. The Austrian Preliminary National Report on health care and long-term care of May 2005 describes various measures implemented for persons in need of long-term care. The Report stresses that it is a continuing challenge to improve the situation of informal care providers. To this end, various measures have to be adopted, e.g. offers of regular counselling and measures to reduce the strain on care providers, and improved social security. Social policies supporting people in need of long-term care will also lead to increased financial requirements. The higher expenditure is, however, counter-balanced by significant employment effects.

National Reform Programme: The Federal Ministry of Social Security, Generations and Consumer Protection, responsible for social inclusion, has been involved in the development of the National Reform Programme (NRP). The NRP emphasises the contribution of the latest pension reforms to ensuring financial and social sustainability, notably through the importance given to the issue of working longer. The programme underlines Austria's good performance with regard to the poverty rate and the long-term unemployment rate (respectively fifth and third lowest in EU25). The NRP also addresses a number of measures for target groups announced in the Implementation Report on the NAP on inclusion. In relation to lifelong learning (IG 22), the NRP refers explicitly to measures from the NAP on inclusion targeting early school leavers (18 to 24-year-olds). Reforms of the tax and the social benefit system are designed to reduce both the risk of poverty and the risk of unemployment.

Challenges ahead:

- To step up efforts to address the increasing risk of social exclusion, especially with respect to elderly workers, the long-term unemployed, immigrants and young people, in particular against the background of the rising unemployment; in this context to pay special attention to the low participation in lifelong learning of the less qualified;

- To ensure both adequacy and sustainability of future pensions by significantly increasing the employment of older workers. It will be important to monitor the poverty risk for pensioners as well as replacement rates, in particular for women, and review policy options if necessary;

- To maintain the relatively good health care expenditure trends through continuous work to counteract various cost-raising factors, such as pharmaceuticals. In order to raise the overall efficiency of the system, special efforts have to be made to address issues of quality, telematics and interface management;

- To continue to improve various support functions for informal carers, e.g. to address care quality, and at the same time recruit and train care workers that will be needed for future long-term care, especially with changing family conditions.

POLAND

Situation and key trends: In 2004, Poland experienced strong economic growth (5.3%), which has not translated into employment creation. Poland's employment rate is still the lowest in the EU (51.7%), particularly for women (46.2%) and older workers (26.2%). The unemployment rate declined by 0.4 percentage points from 2003 to 18.8%. The youth unemployment ratio of 14.2% remains a concern, as does the long-term unemployment rate of 10.2%. Total social protection expenditure as a percentage of GDP reached 21.6% in 2003 (14.3% are related to pensions – ESSPROS data). The at-risk-poverty rate stood at 17% in 2003. Life expectancy (70.4 and 78.7 years for males and females in 2002) is below EU average but has consistently increased over the last decade. Healthy life expectancy (62.5 and 68.9 years for males and females in 2002) is about average for men and quite high for women. Total health expenditure as a percentage of GDP (6.1%) and per capita (654 PPP$) in 2002 (WHO-HFA) is below EU average and indeed one of the lowest in the EU.

Social inclusion: Poland adopted a National Social Inclusion Strategy (NSIS) in June 2004 setting out objectives and targets until 2010. The NAP reflects the most urgent priorities set out in the NSIS, but fails to define in operational terms (including budgetary aspects) how the strategic objectives will be achieved. The NAP signals the shift from traditional income redistribution to a more multidimensional approach in promoting social inclusion. The key policy measures aim at both activating vulnerable groups and improving the institutional effectiveness of the welfare system and the labour market. Newly implemented principles for determining means tests for social assistance and family benefits should simplify the complicated benefit system. But the complex institutional structure at local level will continue to hamper efficient implementation of social programmes. The supportive role of the ESF is visible in measures related to education, employment and inclusion. It concentrates mainly on the vocational and social integration of at-risk groups. The short time since the launch of the NAP, and lack of a monitoring system, do not allow an overall assessment of NAP's performance so far.

Pensions: Poland has introduced significant reforms in its old-age pension system, the new system being in place since 1999. It has, however, created high transition costs, the financing of which will require a major effort over the coming decades. The reform also introduced options for voluntary pension insurance, but as the participation in the scheme remained very low, a new scheme offering tax incentives – voluntary individual retirement accounts – was set up in 2004. A major challenge is to increase the currently low level of employment (partly linked to undeclared work and a high level of unemployment). Whether incentives in the new pension system translate into higher employment and hence improved financial sustainability will, however, depend on the employability of older workers and overall demand for labour. Following the projected decline in the replacement rate, adequacy of pensions may translate into an issue in the future, notably in connection with shorter contribution periods and lower average earnings (due to high unemployment, especially for women). Moreover, equalising the legal retirement age for men and women would help reduce the gender gap in pension entitlements and would contribute to increased employment rates. Other major issues that remain to be addressed are a comprehensive reform of the farmers' pension scheme and of disability pensions, which have become a major pathway for early labour market exit.

Health and long-term care: The main problem is the low level of public funding compared to the high growth-rate of costs, which are external to the health care system (e.g. increasing prices of medicines and medical equipment), growing health care demands (as a result of e.g. raised educational levels, advertising), and the ageing of the Polish population. To increase

the financial resources flowing into the healthcare system, the contribution rate of insured persons in the National Health Fund is steadily increasing and is expected to reach 9% in 2007. This, and the tasks of public authorities aimed at ensuring equal access to health care service, is laid down in the Act of 27 August 2004 on health care benefits financed from public funds. In November 2004, the Ministry of Health presented a "Green Paper on the Financing of Health Care in Poland", with a view to obtaining a comprehensive picture of the current situation and holding a broad public debate. One of the challenges noted in the report concerns the remuneration of employees in public healthcare, which has become more acute with growing economic emigration of medical staff since Poland joined the EU. Quality improvement is one strategic, self-standing objective for the health care system, as well as a precondition for increasing patient satisfaction. Several activities are being undertaken to improve the quality of service provided, as reported in the Polish Preliminary National Report on health care and long-term care in 2005.

National Reform Programme: Although the NRP does not refer directly to the NAP on inclusion, it includes plans, some lacking in detail, for optimising labour market policies and institutions, integrating disadvantaged persons into the labour market and activating disabled people. The NRP sets the ambitious target of reducing the unemployment rate to 14.6% by 2008. The NRP identifies poor housing as a factor in social exclusion, unemployment and lack of labour mobility and proposes initiatives to address this problem. The programme acknowledges the need for continuing reforms of the pension and health care system, while further measures with the aim of increasing the employment rate of older people would contribute to strengthening the future adequacy and stability of pensions. The issue of removing barriers to access to education, particularly those resulting from poverty and disability, is also addressed in the NRP.

Challenges ahead:

- To reverse the negative poverty trend by defining a policy framework encompassing social inclusion priorities and employment creation measures, while ensuring adequate support for those most at risk of poverty;
- To step up administrative capacity, strengthen social policy institutions and improve policy coordination at local level;
- To raise the overall employment rate (particularly of older workers and people with disabilities), ensuring that sufficient resources for adequate pensions are available until the funded schemes have matured, while monitoring future adequacy;
- To reform the farmers' pension scheme and organise the conversion of funded pension savings into safe annuities;
- To continue with further improvements in the provision of various interrelated health and social services for the care of elderly, as done within the Long-term Care Development Programme, e.g. to meet the changing family situations due to emigration for work.

PORTUGAL

Situation and key trends: Key social and economic indicators underline a worrying situation that has deteriorated since 2001. Portugal is close to achieving the Lisbon target on overall employment (67.8% in 2004) and slightly exceeds the employment targets for women (61.7% in 2004) and older workers (50.3% in 2004). However, the economic slowdown has strongly increased unemployment, in particular long-term unemployment which now accounts for around 50% of the total. The labour market continues to be highly segmented, with a large number of working poor**.** In spite of recent progress in educational attainment levels, almost 40% of young people leave the education system with at most lower secondary education. The at-persistent-risk-of-poverty rate (15% in 2001) and inequality of income distribution (ratio 7.4 in 2003) are the highest in the EU and show little improvement since 1995. At-risk-of-poverty levels, however, fell to 19% in 2003 (was 23% in 1995). In 2003, social protection expenditure represented 24% of GDP, far below the EU average of 28%, and pension expenditure was 11.9% of GDP (ESSPROS data).

Population health has improved considerably in the last 20 years. Nevertheless, life expectancy (74.2 and 80.5 years for males and females in 2003 ESTAT) and healthy life expectancy (59.8 and 61.8 years for males and females in 2003 ESTAT) remain below the EU average. Mortality rates from cardiovascular disease and from stomach and lung cancers are higher than the EU average. Total health expenditure as a percentage of GDP (9.3% in 2002 – WHO-HFA) is above the EU average, while per capita PPP$ (1702 in 2002 – WHO-HFA) is below.

Social inclusion: The 2003-2005 NAP presented a broad list of principles and described more than 207 policy instruments to support a set of key challenges. The Plan brought some coherence to widespread and piecemeal existing measures, but failed to provide a clear strategic focus or set of priorities. A significant number of measures made no reference to financial resources, and lacked both precise deadlines and clear measurable monitoring/impact indicators. The fact that three governments were in power between 2002 and 2004 partly explains the difficulties in pursuing a coherent strategy amidst sometimes conflicting political priorities and unstable administrative structures. The implementation process has also suffered from weaknesses in intra-governmental coordination and the participation of the major stakeholders. The NAP is not part of the political debate, but it has contributed to increasing debate among experts in the field, and improved general awareness of social exclusion issues.

The "Social Network" has been a major achievement, bringing together local authorities, social partners and civil society, all with extensive knowledge of local realities. Reinforcing these networks and providing them with resources to improve their social intervention should be strongly pursued. The vocational training and apprenticeship measures aimed at reducing the number of early school leavers and improving their employment prospects have made important progress. The Social Integration Income scheme (SII) focusing on those living in poverty and most vulnerable to exclusion has been reviewed. Public services need to adapt to the increased demand for SII support, and reinforce its social integration approach to prevent the system from becoming a simple monetary subsistence scheme.

Pensions: In response to the adequacy challenge, a major priority has been to improve the level of the minimum old-age pension, which should alleviate poverty risks. To further reduce

old age poverty, a new tax-financed social benefit (Solidarity Supplement for the Elderly) will start to be implemented as from 2006. Furthermore, complete insurance careers in better-paid employment will produce higher pensions for new generations. The most recent reforms will strengthen incentives to work longer and also contribute to more equitable treatment of members of different schemes. Further harmonisation of the pension system and measures to promote longer working lives would contribute to strengthening adequacy and sustainability. The Government intends to create incentives to expand supplementary pension schemes. It remains to be seen whether this modernisation of the legal framework for private pensions will allow occupational pension schemes to make an appropriate contribution to future adequacy.

Health and long-term care: Weaknesses in the primary care sector, including a lack of primary care physicians, undermine the primary-care-led national health system. In view of the ageing population, long-term care services need to be further improved. Proposals include an increase in home and close to home services, day care, hospital care for chronic patients, support to families (relief), use of ICT (call centres, patient file, email consultations, internet prescriptions) and partnerships between primary care and social services. An effective referral system based on the family GP is seen to promote access, care coordination and system efficiency, whilst choice and patient involvement are to increase quality and system responsiveness. Further reforms are necessary to firmly establish a primary-care-led system. This should include improved access for patients and autonomy for providers. To control the high medicines expenditure, strategies include use of generics, evidence-based reimbursement and liberalisation of non-prescription medicine sale. Day case surgery, bed turnover and common management of beds are to improve hospital efficiency. To reduce the current disease burden various health promotion and disease prevention programmes are being developed. A national coordinator for the Health of Elderly People and Citizens with Handicaps has been appointed. His responsibilities include implementing national health policies that promote the adequacy of health care for the elderly and citizens with handicaps; interventions for active and healthy ageing; a network of long-term care facilities, and continuous education and research.

National Reform Programme: Social cohesion is rightly presented as a fundamental challenge in the NRP, but this lacks a focused approach on fighting poverty and only partially addresses the challenge by including measures for the disadvantaged and socially excluded among other items such as education, active labour market policies and the modernisation of social protection. The NRP stresses the importance of modernising the pension system by reducing access to early retirement schemes and bringing effective retirement age closer to legal retirement age. This is welcome, but the links with the OMC on social protection and inclusion could be more developed.

Challenges ahead:

- Mainstream social inclusion in all relevant policy initiatives with the aim of addressing the high poverty levels, inequalities in income distribution, high numbers of early school leavers, large numbers of working poor, and the significant gender pay gap in the private sector;

- Streamline and define targets and implementation frameworks for the large number of existing social inclusion measures, while closely involving stakeholders from the stage of conception through implementation, monitoring and evaluation of the policy instruments;

– Continue to harmonise the civil service pension scheme with the general scheme, and introduce further steps towards ensuring that sufficient resources for adequate pensions are available, notably through the promotion of longer working lives;

– Ensure provision of long-term health care services and address primary care weaknesses, while providing an effective referral system and improving the efficiency of the services.

SLOVENIA

Situation and key trends: After three years of moderate slowdown in economic growth, the pace of economic activity picked up in 2004. GDP per capita measured in purchasing power standards stood at around 80% of the EU average in 2004. Total expenditure for social protection as a percentage of GDP (24.6% in 2003) was below the EU average (ESSPROS data). Total health expenditure was also below the EU average as a percentage of GDP and as per capita PPP$ (respectively 8.2% and 1404.66 in 2001, WHO-HFA database). The at-risk-of-poverty rate has been declining since 1997 and stood at 10% in 2003 (below the EU average). While the employment rate is at the EU average, and the unemployment rate is one of the lowest, the labour market is characterised by a low employment rate for older workers (29% in 2004) and high youth unemployment (15.9%). Regional disparities are considerable, with Eastern Slovenia significantly lagging behind. Life expectancy (72.6 and 80.4 years for males and females in 2003) is below the EU average, but has consistently increased over the last decade.

Social inclusion: The adoption of the Programme to Combat Poverty and Social Exclusion in 2000 defined and recognised social inclusion as a government policy priority. This is well reflected in the 2004-2006 NAP, whose comprehensive strategy focuses on the four EU common objectives in the fight against poverty and social exclusion. Although key priorities, such as the inclusive labour market, appropriate education, suitable living conditions and reducing regional differences, are well identified in the NAP**,** the measures envisaged do not always respond adequately to the challenges, and do not cover the broad range of priorities listed in the strategy. A number of objectives are not sufficiently translated into operational measures and quantified targets. Although the reference in the NAP to the use of structural funds is not precise or clear, some measures are in fact supported by the ESF. The majority of the measures announced in the NAP have given rise to some initiatives. However, in the absence of a formal implementation report or an update in 2005 and given the lack of monitoring data, an assessment of their adequacy and efficiency is not possible.

Pensions: Although the most recent reform constitutes an important step towards ensuring adequate and sustainable pensions, budgetary pressures due to age-related expenditure are significantly stronger in Slovenia than in most other Member States. This highlights the need for further measures. Improving incentives to work longer is urgently needed as the employment rate among older workers is very low. Reducing early exit from the labour market is a major challenge and would contribute to ensuring future adequacy (through further accrual of pension rights which are otherwise planed to decrease) and sustainability. Following the introduction of strong incentives to participate in voluntary provision, about half of all actively insured persons currently have voluntary supplementary pension schemes, highlighting the importance of adequate portability as well as risk sharing rules. While the 1999 reform provides for a long-term difference in retirement ages of women (61) and men (63), further reduction of the gap in retirement age would also contribute to ensuring future adequacy.

Health and long-term care: Regarding access, the issues revolve around primary care shortages, regional disparities, waiting lists and out of pocket payments. To decrease the financial barrier for the more vulnerable groups, amendments to the law provide for discounts and exemptions for people on low incomes. The authorities have established regional targets for staff supply. Regarding system efficiency, the authorities are aiming at improving the referral system, increasing the use of day care surgery, reducing the length of hospital stays and promoting prevention. While institutional and non-institutional capacity for long-term

care for the elderly is insufficient, the need for long-term care and social services will rise further as a result of ageing. A major part of long-term care is provided as institutional care, while long-term care at home is still developing gradually. To meet this need for long-term care, capacities were increased to serve 4.5% of the population over 65, giving priority to home care. Efforts have been geared towards increasing the share of health care services within institutional care and at the patient's home with the aim out of providing and improving the quality of rehabilitation services, especially physiotherapy and occupational therapy. To further reduce inequalities, the government envisages the introduction of a special compulsory social insurance, covering all long-term care services on an equal footing.

National Reform Programme: The majority of the challenges in social protection and inclusion are recognised in the NRP, and modernising social protection systems is one of the key development priorities of the NRP. The NRP highlights the fact that further reforms of pension and health systems are needed, notably in order to promote longer working lives, which would contribute to the sustainability and adequacy of social protection provisions. However, the priority measures in these fields are rather general, thus limiting the scope for assessing their actual contribution to the reform programme. The priority measures to combat discrimination are limited to gender. Among the most disadvantaged groups, the NRP targets people with disabilities and older workers with priority measures. Roma and other ethnic groups are mentioned, but concrete measures for their social inclusion are not provided. A reform of social transfers is planned. The new national programme of social protection up to 2010 announced in the NRP and the new Social Protection Act will target unemployed people on benefits to promote their return to the labour market.

Challenges ahead:

- To introduce new and further develop existing measures for bringing people who depend on benefits back to the labour market, while maintaining a proper level of social security and avoiding poverty and disability traps;

- To increase access to accommodation especially for the most vulnerable groups, to fight against discrimination as one of the major obstacles to social inclusion with the introduction of a concrete strategy and measures and to tackle the existing regional disparities;

- To implement the rise in the pension age, moving towards increasing the employment rates of older workers and full equality between men and women;

- To enhance and ensure long-term care provision and health care services for elderly people (patients) in accordance with their specific and changing needs within health care institutions and in their home environment; to improve policy coordination and service organisation in these fields in order to reduce incapacities and inequalities further and to reach efficiency gains.

SLOVAK REPUBLIC

Situation and key trends: In 2004, GDP growth kept its high level from the previous years and reached 5.5%. The overall employment rate (57.0%) is well below the EU25 average (63.3%). The employment rate of older workers (26.8%) is far from the Lisbon 2010 goal, with extremely low employment rate of older female workers (12.6%). The unemployment rate increased again reaching 18%, but is expected to decrease below 17% in 2005. The long-term unemployment rate (11.7%) and the youth unemployment rate (32.3%) remain very high. The at-risk-of-poverty rate (21%) is one of the highest in the EU with unfavourable dispersion around the threshold: 12% of the population in 2003 had incomes lower than 40% of the national threshold. Social protection expenditure is on a declining trend (from 20.2% of GDP in 1998/9, to 19.2% in 2002 and 18.4% in 2003 – ESSPROS data); the relative decline is, however, partly related to strong GDP growth. At 7.5% of GDP in 2003, pension expenditures are low in comparison with the EU average. Life expectancy (69.9 and 77.8 years for males and females in 2003) is below the EU average (5th and 4th lowest respectively). Total health expenditure as a percentage of GDP (5.7%) and per capita (698 PPP$) in 2002 (WHO-HFA database) is among the lowest in the EU.

Social inclusion: The Slovak Republic did not submit an update of the NAP on inclusion in 2005, but several strategic documents have been adopted in the meantime. In February 2004 the Government adopted the Competitiveness Strategy for the Slovak Republic to 2010 (National Lisbon Strategy) with two main objectives: completion of structural reforms in the social area, health care and pension insurance, and development of priority areas such as education and development.

In May 2005 the Ministry of Labour, Social Affairs and Family introduced the Action Plan for preventing and alleviating poverty and social exclusion in Slovakia for 2005/06. It concentrates on intergenerational poverty: main focus is on children and the promotion of social and community services.

In July 2005, a new measure supporting mothers with children under 3 years of age came into effect. In 2006, new social inclusion measures are planned to be adopted, in particular focusing on education of the unemployed and on the implementation of new types of social services, with higher availability and quality. Measures supporting active ageing policy need to be defined.

Employment and integration of the marginalized Roma community (estimated at 320,000, with 150,000 in desperate living conditions) represents a key challenge. In addition, the situation of Roma people is characterised by social segregation, unequal access to health care (plus increased risk of various diseases and accidents), unequal access to legal protection, and insufficient political participation.

Pensions: The Slovak pension system underwent major reform in 2005 which split the statutory old age pension scheme into pay-as-you-go financed and privately managed funded pension tiers. The introduction of the latter tier entails a significant loss of contribution revenues, creating a large deficit in the financing of the public PAYG scheme and thus also limiting the scope for improving current pensions. The voluntary supplementary pension saving scheme consists of pension insurance provided by employers or trade union organisations and since 2005 other financial tax deductible products from other financial institutions.

A key challenge for the Slovak Republic is to raise its employment rates in general and of older workers in particular and to lower unemployment, which would both strengthen the contribution base and allow people to accrue additional pension rights. The new system design also establishes a strong link between personal contributions to the system and benefits that could lead to adequacy issues in the future for the lower income earners and people who have taken career breaks, notably women.

Health and long-term care: The health care system in Slovakia has been experiencing consistent problems since the 1990s, characterized by payment difficulties, poor quality of service delivery and a lack of social cohesion. The new government in 2002 looked for new solutions to stabilise the financial situation for health care, focusing on deregulation, decentralisation, increased competition and the mobilisation of private resources.

In October 2004 the government enacted six interconnected laws on: health insurance; health care insurance companies and the health care surveillance authority; health care providers; emergency services; health care services; and a basic treatment/benefit package, which took effect in January 2005. The Health Insurance Act defines (public) social health insurance and private health insurance. The compulsory social health insurance entitles each citizen to basic healthcare and related services to the extent specified in the Treatment Act. The actual provision of health care is entrusted to community health centres, hospitals, polyclinics, sanatoria and spas. The voluntary private health insurance schemes provide coverage for services not included in the compulsory package.

Long-term care provision is currently based on legislation for disabled persons and for a number of other risks (invalidity, old age, health care), and financed partly through contributions of employers, the self-employed and employees and partly through the state budget. The benefits are provided as a combination of benefits in kind and cash benefits. From the 2005 Statement on health care and long-term care it seems that the government is considering a new set of legislation for long-term care.

National Reform Programme: All relevant ministries under the leadership of the Office of the Government participated in the NRP process, together with social partners, academic representatives and members of the Parliament. Social inclusion has been recognised as one of the four target areas required for increasing employment, which is seen as the most efficient method to support economic growth under the development of an inclusive society. However, the programme does not address the integration of the Roma minority or the impact of reform of the social protection system on marginalized groups in a comprehensive manner. The future housing policy described in the NRP should support first-time occupation and social housing opportunities. However, there are concerns over its funding, since the resources of the State Housing Development Fund have seen recent cuts.

Challenges ahead:

- To increase the overall employment rate and of older workers in particular, to make work pay while promoting more and better jobs, to encourage inclusive labour market;

- To monitor the impact of the reforms on vulnerable groups, and to monitor and assess the implementation of programmes prepared for the Roma and to increase public awareness in relation to this minority;

- To continue to tackle the housing shortage and to combat homelessness;

- To ensure that sufficient resources for adequate pensions are available until the funded schemes have matured and to work out effective strategies to cope with transition costs;
- To successfully carry through the implementation of the new health care legislation, and follow up its medical, social and financial effects.

FINLAND

Situation and key trends: Finland expects to reach just 2% growth in total output in 2005 due to production stoppages in the forest industry. The forecast growth rate for 2006 amounts to 3% and thereafter less than 2.5% a year for a few years. Employment growth is set to slow down (employment rate 2004 67.6%), but the unemployment rate (8.8% in 2004) is projected to fall due to a decline in the labour supply. The employment rate among 55 to 64-year-olds was 50.9%, and has risen by 9 percentage points since 2000. Finland spent 26.9% of GDP on social protection in 2003, more than one third of which was pension expenditure (11.4% of GDP). The share of GDP spent on social expenditure has been slightly below the EU average since 1998 (ESSPROS data). Finland's relative poverty rate, at 11% in 2003, has nevertheless remained one of the lowest in the EU.

Life expectancy (in 2003, 75.1 and 81.8 years for males and females respectively) is high and above the EU average although healthy life expectancy (57.3 and 56.5 years for males and females respectively) lags behind. Total health expenditure as a percentage of GDP and per capita PPP$ (7.3% and 1943 in 2002 – WHO-HFA database) is below the EU average. The expenditure dynamic has been in line with GDP growth in recent years.

Social inclusion: The starting point of Finland's 2003-5 NAP on inclusion was to preserve the basic structure of the social policy system. The groups threatened by social exclusion were to be catered for mainly by coverage of services and benefits for the entire population, and by emphasizing the primacy of work; but the need to supplement the universal system with measures targeted at risk groups was underlined as well. The plan set out policy objectives for employment, development of the service system, income support, education, and housing, together with complementary objectives for measures targeted at risk groups. The overall strategic approach has been adhered to and all the objectives have been pursued.

The most important measures started by Finland with a view to reducing social exclusion are the measures and reforms to facilitate participation in employment, the National Health Project and the National Development Project for Social Services, the development of pupil welfare and counseling, and the programs to reduce homelessness. Practically all the measures identified in the NAP on inclusion for 2003-5 have been or are being implemented. The Structural Funds, namely the ESF, have played a useful role in supporting the implementation of the NAP on inclusion, especially in the fields of employment, education and measures targeted at risk groups.

The Government's budget proposal for 2006 comprises a multifaceted package of measures, consistent with the previous strategy, to improve the situation of the most vulnerable.

Pensions: In 2005, Finland introduced a reform of the earnings related scheme which aimed at dissuading people from early retirement and at encouraging them to remain in the labour market. With this reform Finland has made significant progress in meeting the challenge of financial sustainability of its pension system, while ensuring adequate pensions and adjusting the system to changing social circumstances, in particular through mechanism to adjust pensions to increases in life expectancy. In the long run, the last reforms will entail raising the age of retirement by about two or three years between now and 2050.

Finland has developed a strategy of accumulation of surpluses both in the private and public sector (in total, the assets of social security pension schemes accounted for59% of GDP in

2004). However, it is expected that a further increase in the contribution rate will be needed in the statutory scheme for the private sector.

Health and long-term care: Additional resources (including staff) will improve access and address regional variations in provision. Time guarantees for non-emergency treatment (access by phone, first visit to the GP, treatment, referral to hospital) aim at reducing waiting times and regional differences. Emphasis is placed on providing access to quality long-term care. Policy in the area aims at helping people continuing living at home, following a patient care plan, through the supply (namely via local authority collaboration) of home and close-to-home multidisciplinary care, allowances and vouchers for dependents, and financial aid and relief for carers.

Healthy ageing is central to the system's financial sustainability. It assumes a holistic approach with measures to be proposed in the different sectors affecting health and coordinated by the public health committee. For instance, regarding occupational health, employers are responsible for preventive care for their employees (including monitoring health hazards and organising medical check-ups). The use of indicators and data collection, technology assessment, an effective referral system and close integration of primary and hospital care also contribute to improve access, quality and financial sustainability.

National Reform Programme: Similarly to the NAP on inclusion, the NRP is based on the Government programme and the State budget and it was prepared in co-operation with all the relevant ministries, social partners and civil society. The NRP refers to the 2005 NAP implementation report as one of the measures to ensure inclusive labour markets. The social dimension is incorporated under all the three strands (macro, micro, and employment). The NRP prepares Finland for population ageing by underlining the necessity of sustainable fiscal policy in order to be able to safeguard welfare services also in the future and reflects as a main ongoing measure the phasing-in of the pension reform, which nevertheless will need careful monitoring. It also calls for improvement in competitiveness and productivity, more participation in employment, renovating the municipal and social service structures, and reforming the system of government transfers and grants to local authorities.

Challenges ahead:

- With an ageing population, to increase the employment rate at both ends at the age bracket, as well as among the disadvantaged, to avoid eroding the financial base of the welfare system;

- To reduce the relatively high unemployment, a major part of which is structural by nature;

- To ensure that the recent pension reforms will effectively translate into further increases in the employment rate of older workers, thus contributing to adequacy and sustainability, notably by maintaining surpluses in general government finances and accumulation of pension reserves;

- To ensure access to quality long-term care, enhance care coordination and improve population health status (i.e. reduce the burden of disease) through effective health promotion and disease prevention.

SWEDEN

Situation and key trends: GDP growth improved in 2004 to 3.6%. Employment rates overall (72.1%), for women (70.5%) and older workers (69.1%) are high in an EU perspective. Despite a strong economic performance, employment growth is still negative and the total employment rate has shown a decreasing trend since 2001. Recently, there has been a worrying trend of increasing unemployment and long-term unemployment, especially for young persons. Sweden continues to have the highest gross spending on social protection in the EU, at 33.5% in relation to GDP in 2003 (ESSPROS data – but net expenditure is significantly lower, at around 30% in 2001 according to OECD estimates), of which 12.7% corresponds to pension expenditure. The trend of increased spending on sickness, disability and administrative costs seems to have reversed last year. The poverty risk is one of the lowest in the EU at 11% (2003), although groups such as immigrants, young people, older people and lone parents are exposed to higher risk. Life expectancy (77.9 years for males and 82.5 for females) and healthy life expectancy (62.5 years for males and 62.2 for females) are high and above EU average (2003). Total health expenditure, as a percentage of GDP (9.2%) and as per capita (2517 PPP$), is also high and above the EU average.[4] Furthermore, expenditure has increased more rapidly in recent years.

Social inclusion: The 'primacy of work' principle and a universal social security system continue to be the cornerstone of the Government's strategy to fight poverty and social exclusion. The two national targets for 2004 on employment (80% for 20 to 64-year-olds) and on social assistance dependency (to be halved compared to 1999) have not been reached, although for the latter there has been progress. The targets have been retained and should be reached as soon as possible. The Government estimates that the target to halve the number of sick leave days between 2002 and 2008 can be reached. There is a strong focus on policies aiming at promoting an inclusive labour market, an efficient social security system and the importance of education and training in preventing poverty and social inclusion. Measures emphasise tackling youth long-term unemployment, integrating immigrants, including combating discrimination, reducing the number of sick leave days and improving the situation of elderly people.

The Government also encourages the production of new housing units for rent and will ensure that young people in particular should have easy access. National plans to tackle the abuse of alcohol and drugs have been implemented. Increased resources have been allocated to support people in vulnerable situations, such as drug abusers, mentally disabled persons, homeless people, people under threat of honour-related violence and newly released prisoners. There is continued emphasis on mainstreaming (gender, immigrants, children and young people), with the situation of disabled people as a new mainstreaming field.

Pensions: Sweden has managed to create a public pension system which is both adequate and financially stable, as long as people compensate for the significant projected decrease of replacement rates by leaving the labour market later. Sweden is also ensuring the financial sustainability of the pension system by expanding a reserve fund created at the beginning of the 1960s (amounting to almost 30% of GDP in 2005). Occupational pensions also make a notable contribution as they cover around 90% of employees and usually provide an extra income amounting to approximately 10-15% of a person's final wages/salary.

[4] 2002 data, WHO-HFA database.

The Swedish pension system provides very comprehensive information to individuals by, for instance, sending out annual statements of pension capital accumulated so far and a projection of future pension entitlements. Although actuarial neutrality in the system and possibilities for flexible retirement would keep people from retiring early, some channels of early exit from the labour market are tending to develop, in particular through sick leave and disability benefit.

Health and long-term care: The confidence of citizens in the public health care is to be reinforced by improving existing health care and care for the elderly, and by investing in new technology. Monitoring and evaluation of health care and care of the elderly is to play a key role, and continued financial support will be given to strengthen primary care. The health care sector is also to be adapted to an ageing population by measures to increase the status and quality of the caring professions.

This work has started and is in progress, but it must be pursued on a broad front and with a long-term perspective. It is possible that work on shortening queues and waiting times for health care is strategically the most important measure to be able to retain confidence in publicly run and funded health care. Achieving this requires not only internal work to improve efficiency in the health care organisation, but also much more developed cooperation between the different political and administrative levels responsible and between different care providers.

National Reform Programme: Many of the measures in the NRP have a strong social focus and are in line with social inclusion and social protection priorities. Many initiatives are related to social welfare and education policies, in particular a reinforced active labour market policy to tackle increased unemployment, and specific challenges as regards social inclusion (such as improving the situation of various groups at risk of exclusion, including immigrants) and social protection (such as reducing flows into sick leave and its duration) have received a lot of attention in the programme. The NRP was prepared in co-operation with all relevant ministries, and social partners and civil society were given the opportunity to contribute in the preparatory phase.

Challenges ahead:

- To maintain a high level of welfare services through a further increase in labour force participation, given the high dependency ratio, while keeping a balance between incentives and solidarity in welfare systems;

- To continue efforts to make the labour market inclusive, in particular to ensure better and quicker integration of immigrants into the labour market;

- To continue to address early exit from the labour market through sick leave and disability pensions and to monitor the outcome of current pension reforms;

- Demographic developments will require not only a much more streamlined organisation of care services and cooperation between different care providers, but also significant reorganisation of the political and administrative levels responsible.

UNITED KINGDOM

Situation and key trends: Recent UK GDP growth has been relatively strong and labour market outturns favourable. However, GDP growth has now slowed from 3.2% in 2004 to probably just around 1.6% in 2005. Strong economic performance over recent years has been combined with record levels of high employment (71.6% in 2004) and low unemployment (4.7% in 2004); the UK exceeds all quantitative Lisbon employment targets. Notwithstanding this positive overall climate, the proportion of the UK population at risk of poverty remains higher than the EU average (18% as against 15% in 2003). Relatively high inequalities persist such as those in income and wealth (Gini co-efficient of 34 in 2003), and in some cases such as health may be widening. Economic inactivity remains relatively high at 24.8% and concentrations of unemployment, inactivity and poverty persist among particular groups (lone parents, old people, those with few or no qualifications; ethnic minority groups; and residents of deprived neighbourhoods) but tailored measures have had some success in helping eg. lone parents and ethnic minorities. Life expectancy (76.2. and 80.7 years for males and females in 2003) is above the EU average with healthy life expectancy (61.5 and 60.9 for males and females in 2003) around average. There are significant variations between and within regions. Expenditure on social protection was 26.7% of GDP in 2003 (ESSPROS data), and whilst still below the EU average (28%), a trend of significant increased investment has continued in recent years. Total health expenditure as a percentage of GDP and as per capita PPP$ (respectively 7.7% and 2160 in 2002, WHO-HFA database) was below EU average but growing as a share of GDP.

Social inclusion: The UK adopts a multifaceted approach to combating poverty and social exclusion founded on a principle of 'work for those who can and support for those who cannot'. Work is seen as the primary route out of poverty and to strengthen social cohesion and many of the UK's initiatives find their foundation in activation measures, facilitating access to the labour market, and providing financial incentives to work. Substantial additional resources are being made available to key initiatives and to the reorientation of public services, particularly social protection, heath and education. Progress is reported against a majority of the wide range of established targets, including the key aim of eradicating child poverty and an aspiration declared to raise the employment rate to 80%[5]. Nonetheless, some concerns remain regarding the quality and sustainability of work and the risk of in-work poverty, and personal debt is at record high levels. Recent years have seen the introduction of additional measures to 'make work pay', in order to guarantee a minimum income for working households and encourage people to move into work (eg. National Minimum Wage and Working Tax Credit). Unemployment is at record low levels; the focus for significant further increases in employment is now those without work but not registered unemployed, such as the high number of people out of work for reasons of ill-health. The pilot scheme 'Pathways to Work' is showing encouraging early results and will be rolled-out. The scheme combines employment advice, heath support and financial incentives to take up work. A number of initiatives and benefits have been introduced to deliver the key commitment to eradicating child poverty. Progress has been made, but initial momentum seems to be slowing and more will need to be done by the UK to achieve its own ambitious target of eradicating child poverty by 2020. The European Social Fund in the UK contributes significantly to combating poverty and social exclusion; particularly via focused delivery models such as Global Grants.

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[5] This aspiration is based on the national measure, which is different from the one used by Eurostat

Pensions: Through recent reforms of the State Second Pension and 'Pension Credit', the UK has made progress in addressing the adequacy of pensions. Pensioner poverty rates have been declining in recent years and are expected to decline further once the full effect of Pension Credit appears. The UK Pensions system is also characterised for many workers by significant contributions from occupational and personal pension schemes, and it is possible to contract out of the State Second Pension (but not the out of the Basic State Pension) into such schemes. Subsequently, the adequacy, as well as the sustainability of pensions depends to a larger extent than in other countries on the coverage and performance of private pensions.

In this respect, at least three issues arise concerning future adequacy. The first is the impact of the shift to DC pension plans on the level of contributions to occupational pension schemes, the second is how to ensure that people enhance the rate of the Basic State Pension through increases in other sources of retirement income, and thirdly, how to continue to improve incentives to work later and save adequately.

The UK Government appointed a Pensions Commission in 2002 in order to keep under review the adequacy of private pension saving and in particular to assess whether there is a need to "move beyond a voluntary approach". In its recently published second report, the Pensions Commission made a number of proposals, such as an increase in the state pension age, a return to earnings indexation for the Basic State Pension, and the setting up of a low-cost and centrally-organised National Pension Savings Scheme into which workers would be auto-enrolled (with the right to opt-out). The UK government has now opened a new stage in the national pensions debate with the intention of presenting a White Paper containing its proposals for pension reform in Spring 2006.

Health and long term care: Healthcare is delivered through the mainly tax-funded National Health Service (NHS), which provides care services free of charge at the point of delivery, with universal coverage based on residency in the UK. The responsibility for healthcare is devolved to England, Scotland, Northern Ireland and Wales, their health departments together agreeing with the UK Treasury the budget allocations to the NHS for three to four years. Funding and decision-making are increasingly devolved to the local community level.

Waiting times have for a long time been a major issue in UK health service provision, and there have been substantial increases in public healthcare investment and expenditure in recent years to enable the NHS to modernise and expand its care capacity. Waiting times continue to give cause for concern for some types of treatments and in some geographic areas, although in some key specialties, such as cardiovascular treatment, waiting times have reduced considerably. The UK government is committed to investing further. However, some other countries have achieved high-quality and efficient health care with sustainable (lower than) average total health expenditure as a share of GDP. It would seem important to look both at necessary investment and at continuous efficiency improving measures, including the incentives for various health care actors.

National Reform Programme: Whilst the UK NRP does not specifically refer to the OMC on Social Inclusion, Pensions and Health, it is clear that the strategic approach put forward by the UK in the NRP is consistent. The UK stresses the importance of extending the opportunity of work to all and of providing specific assistance to people facing particular disadvantage in the labour market. The recent Pensions Commission report is likely to set the scene for more integrated provision and necessary reforms.

Challenges ahead:

– To continue efforts to reduce persistent inequalities such as those in income, health, skills and 'life chances';

– To tackle levels of economic inactivity by engaging those people traditionally hardest to reach via a holistic and tailored approach;

– To continue to address the pensions adequacy gap, in particular for those with more modest incomes;

– To continue improvements in health care service quality and capacity (addressing shortages of qualified medical staff and reducing waiting times) without increasing public health expenditure (investment) above the average as a share of GDP for EU/OECD countries.