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Joint Report on Social Protection and Social Inclusion 2007

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Joint Report on
Social Protection and Social Inclusion
[2007]

Social inclusion, Pensions, Healthcare and Long Term care

European Commission

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Joint Report on Social Protection and Social Inclusion 2007

European Commission

Directorate-General for Employment, Social Affairs and Equal Opportunities
Unit E2

Manuscript completed in March 2007

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KEY MESSAGES

- For the first time Member States have submitted integrated National Reports on strategies for social inclusion, pensions, healthcare and long-term care.[1] They have done so against the background of demographic ageing and intensified globalisation. They all face continuing challenges of social exclusion, poverty and inequality and of a need to modernise social protection systems. Starting points differ between Member States, but the following key messages emerge clearly from the analysis of their reports:

- Member States have responded to the Spring 2006 European Council challenge to reduce child poverty, with clear commitments to breaking the cycle of deprivation. This will contribute to stronger and more sustainable social cohesion. Ensuring access to quality education and training for all, focussing especially on pre-schooling and on tackling early school leaving is vital. The situation of immigrants and ethnic minorities needs particular attention.

- Active inclusion emerges as a powerful means of promoting the social and labour market integration of the most disadvantaged. Increased conditionality in accessing benefits is a major component, but this must not push those unable to work further into social exclusion. While most Member States champion a balanced approach combining personalised labour market support, including skills training, for those who have the potential to work, and accessible, high-quality social services, more attention needs to be given to ensuring adequate levels of minimum resources for all, balanced with making work pay.

- In their first European plans on healthcare and long-term care, Member States identify as a priority the need to: ensure equal access for all; reduce health inequalities in outcomes; guarantee safe and high-quality care; and manage the introduction of new technology for health and independent living. More rational use of resources is an essential factor in rendering healthcare systems sustainable and in maintaining high quality, and needs to be exploited by all countries. But some countries may need to expand their financial and human resources to ensure adequate coverage of the whole population. Improved coordination, promotion of healthy life styles and prevention could be win-win strategies, contributing both to improved health status and to reduced expenditure growth.

- Confronted with rising long-term care needs arising from demographic change, care systems will have to be reformed, properly resourced and put on a sound financial footing. Stronger coordination between healthcare and social services, support for informal carers and exploiting new technology can help people to stay as long as possible in their own home.

- Many countries are adapting pension systems to increases in life expectancy and creating a transparent relationship between contributions and benefits. Older people often face a higher poverty risk than the general population. Reforms aim at achieving adequate and sustainable pension systems. Ageing means that pension adequacy increasingly depends on more people working – and working longer. It is therefore vital that older workers in particular have the opportunity to do so. The effects of reforms on adequacy need close monitoring.

[1] http://ec.europa.eu/employment_social/social_inclusion/naps_en.htm

- Despite current reforms, ageing will increase expenditure on pensions, health and long-term care by four percentage points of GDP by 2050. The long-term sustainability of public finances is still at risk. A recent Commission report2 showed that six Member States face a high risk, ten a medium risk and nine a low risk. Coping with this is a key policy challenge and requires a three-pronged strategy to reduce public debt, raise employment and reform social protection systems, as well as increased productivity growth. The sustainability report also considers the risk of inadequate pensions which may result in unforeseen pressure for ad hoc increases of pensions or higher demand for other benefits. Thus the issues of pension adequacy, sustainability and modernisation need to be considered jointly.

- Member States are taking more account of linkages both within the streamlined social protection and social inclusion process and between this process and economic and employment policies at national level, in particular through pension reforms reducing access to early retirement schemes and increasing incentives and opportunities to work longer, so that results can start to show in increased employment rates of older workers. Improving further this interaction in implementing the National Reform Programmes for growth and jobs3 and the strategies for social protection and social inclusion will help deliver results.

- The governance of EU and national social policies is being strengthened. Stakeholders, including the people directly affected, are increasingly involved in preparing social reforms. But the quality of the involvement could be improved. Stakeholders' role should be extended to implementation and follow-up. Interaction should be reinforced between national and EU policy levels and regional and local levels – where implementation largely takes place. Across all strands of European cooperation there is much scope for mutual learning.

1. INTRODUCTION

The integrated Open Method of Coordination (OMC) introduced in 2006[4] is strengthening EU capacity to support Member States in their drive for greater social cohesion in Europe. This is starting to create more impact on the ground, making the EU attachment to social values more visible to European citizens. The OMC is helping to deepen mutual learning and to widen involvement of stakeholders at national and European levels. It has increased awareness of the multi-dimensional nature of exclusion and poverty and forged a shared approach to social protection reforms based on the principles of accessibility, adequacy, quality, modernisation and sustainability. For the first time, healthcare and long-term care are addressed showing that these areas are well suited for policy exchange. The national reports illustrate how joint consideration of all the objectives improves policy effectiveness and the quality of public spending. The new working methods of the OMC are starting to bear fruit, though further efforts at EU and national levels are required to make full use of its potential.

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2 COM (2006) 574 final.

3 Latest Annual Progress Report: COM(2006) 816

4 Common objectives: http://ec.europa.eu/employment_social/social_inclusion/objectives_en.htm

2. OVERARCHING ISSUES FOR SOCIAL PROTECTION AND SOCIAL INCLUSION POLICIES

Greater social cohesion

Recent developments are encouraging: reforms have been carried out or are under way in practically all Member States to make systems more fiscally and socially sustainable and more responsive to people's evolving needs. There is strong convergence towards active inclusion, recognising that people's right to play an active role in society has to be supported. On pension reform, there is a will to progress both on adequacy and sustainability. Improving accessibility, quality and sustainability emerges as the central aim of healthcare and long-term care strategies.

As reflected in the OMC objectives, promoting the equality between men and women is an essential element in addressing these issues. Overall, Member States are incorporating **gender** concerns more effectively and data are more often broken down by sex. Some are pioneers in applying gender mainstreaming systematically. But there is still considerable room for ensuring that policy measures are better informed by gender considerations across all three strands of cooperation.

Interaction with Jobs and Growth

Member States acknowledge more clearly that economic and labour market reforms must contribute to strengthening social cohesion and social policies must support economic and employment growth. Active inclusion policies can increase labour supply and strengthen society's cohesiveness. Increasing child well-being will help more people to develop their full potential and contribute fully to society and to the economy. Ongoing pension and healthcare reforms have a clear effect both on sustainability of public finances and on labour market behaviour. Action on healthcare improves quality of life and productivity and helps to maintain financial sustainability.

Member States nevertheless recognise that healthy economic growth and job creation do not automatically lead to reduced income inequalities, in-work poverty or regional disparities. Some National Reform Programmes also show a stronger commitment to the most disadvantaged in society by, for example, addressing labour market segmentation and precariousness, and helping poor households benefit more from employment growth. Measures to ensure the sustainability of public finances are accompanied by provisions to protect the most vulnerable groups. Strengthened and more visible interaction is required at European and national levels.

Governance

Civil society and social partners are increasingly involved in the preparation of national strategies and modernisation of social protection. Pension reforms enhance transparency and individuals' understanding of their own position. Still, there is scope for further improving the quality of the involvement, not least in implementation and follow-up phases. Coordination between European, national, regional and local levels needs to be stepped up. The importance of effective monitoring and evaluation is now generally acknowledged, but few details are given about the precise arrangements envisaged. There is some increase in the use of indicators and targets and national strategies increasingly allocate resources and responsibility to measures tailored to the targets and objectives, but this is still not done systematically. There is better co-ordination between the implementation of social inclusion and healthcare policies and the use of the Structural Funds, notably the European Social Fund, but its visibility in this area could be improved.

3. KEY CHALLENGES IN THE DIFFERENT STRANDS OF OMC WORK

3.1 Fighting poverty and exclusion

Member States' Reports are more strategic than in previous years, focusing on a more limited set of priorities. But they continue to recognise the multidimensional nature of exclusion, tackling their priority issues from many angles.

Breaking the transmission of poverty from one generation to the next

Children have a higher-than-average risk of poverty in most Member States. In some, almost every third child is at risk. Living in a lone-parent or jobless household further compounds the risk. This threatens social cohesion and sustainable development. Deprived children are less likely than their peers to do well in school, stay out of the criminal justice system, enjoy good health, and integrate into the labour market and society.

The March 2006 European Council asked Member States "to take necessary steps to rapidly and significantly reduce **child poverty**, giving all children equal opportunities, regardless of their social background". The vast majority of Member States prioritised the need to develop an integrated and long-term approach to preventing and addressing poverty and exclusion among children.

Member States approach the issue with a mix of policies addressing different angles of the problem: increasing family income; improving access to services, including decent housing; or protecting children’s rights. Member States tend to target the most disadvantaged children and families within a broader universal approach.

Two aspects stand out: equal opportunities with respect to education, including pre-school and adult education, and promoting parents' labour market participation. Measures to make work pay are being taken and reconciliation of work and family life is being facilitated through improved access to quality child care and flexible working arrangements. This raises also the question of promoting a more equal sharing of domestic work and care responsibilities.

On average, 15% of students leave school early, but in some countries more than a third of young people are affected. Tackling early school leaving and strengthening young people's skills and qualifications reduces the risk of social exclusion and improves labour market prospects. Some Member States have set specific targets and are introducing preventative measures (pre-primary education, guidance and counselling, tutoring, grants) and compensatory actions (e.g. second-chance schools). Developing these into comprehensive strategies will help to achieve significant results.

In all Member States, youth unemployment, especially among people of immigrant origin, is twice as high as the overall rate (18.7% for EU-25 in 2004). Young people often find themselves in a vicious circle of "low pay - no pay". Many Member States are expanding apprenticeships, providing individualised support or active alternatives after short spells of unemployment, focusing on socially deprived areas or improving access to mainstream measures.

Promoting active inclusion

Quality jobs are a sustainable way out of poverty and social exclusion, strengthening future employment prospects, human and social capital. Healthy and sound working conditions allow more people to work and to stay in work longer.

Member States are increasingly focusing on "active inclusion"[5] to strengthen social integration. There is a clear trend towards making benefits more strictly conditional on active availability for work and improving incentives through tax and benefit reforms. Some Member States show how conditionality can be successfully combined with gradual tapering off of benefits on re-entry to the labour market and with tax credits for low-paid jobs to enable the labour market participation of disadvantaged people. Reinforced active labour market policies, opportunities to upgrade skills, including IT, efforts to address educational disadvantage and appropriate counselling are also vital elements in a balanced policy mix for active inclusion. Importantly, to ensure that strengthened conditionality does not weaken support for those who are unable to work some Member States have set out to improve the coverage of benefits. But the need to guarantee adequate levels of minimum resources receives insufficient attention in many strategies.

Economic and employment growth will not of itself bring on board people who are furthest from the labour market. Some Member States have put in place policies such as in-work support for job retention and advancement, on-the-job training and a rise in minimum wages to ensure that work pays. The social economy is a vital source of jobs, including for people with poor qualifications or reduced work capacity, and provides social services not met by the market economy. Anti-discrimination measures, action to combat financial exclusion and over-indebtedness, promotion of entrepreneurship and adaptability, labour law in conjunction with social dialogue and raising awareness of the benefits of labour market inclusiveness are also crucial elements.

Labour market integration often needs to be joined up with a range of other services. Some Member States are developing a more structural approach to **housing exclusion and homelessness**, looking at prevention and housing quality rather than mainly rough sleeping. Reconciling the need to ensure universal access to quality services with cost constraints will be a key challenge.

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[5] For in-depth exploration of the concept: COM(2006) 44 final

The European Council has identified disabled people as one priority category for increased labour market participation. Some Member States are facilitating access of physically **disabled people** to the labour market, while others are addressing the inclusion issue more broadly: mainstreaming of policies, independent living, and better access to quality social services. But less attention is devoted to mental illness and disability.

Several Member States are adopting a more holistic approach to the integration of migrants and the social inclusion of **ethnic minorities,** also singled out as priority categories. This involves addressing educational disadvantages and developing language skills, but also fighting discrimination and promoting participation in civic life more broadly.

Reinforcing the social inclusion of disadvantaged people with a view to their sustainable integration in employment is now a specific ESF priority. Actions can be supported under all ESF priorities for 2007-2013 and plans do give stronger visibility to the Structural Funds. The ERDF will contribute to the improvement of infrastructure related to social inclusion and fighting urban deprivation.

3.2 Healthcare and long-term care

In this first year of coordination, the reports document striking differences in health outcomes among and within Member States. Life expectancy varies between countries from 65.4 to 77.9 years for men and from 75.4 to 83.8 for women. Significant divergences by socio-economic status can also be found within many countries. These outcomes are affected by many factors, including living and working conditions. Member States are trying to reduce these differences by improving prevention and health education as well as access to health care.

(Unequal) access to healthcare and long-term care

All countries are strongly committed to ensuring access to adequate healthcare and long-term care. However, this does not necessarily translate into universal access and **significant inequities** remain. Out-of-pocket payments have consistently increased due to the exclusion of certain types of care from the benefits package and to rises in co-payments to increase revenue and reduce excess consumption. To avoid barriers to access for the most vulnerable groups Member States introduce exemptions, pre-payments and expenditure ceilings.

The distribution of care is sometimes uneven. Regional disparities in provision result not only from geography but also from institutional features. While allowing services to adapt to local circumstances, decentralisation has also led to varying treatment coverage and practices. Funding capacity may also differ between regions. EU structural funds support improvements in health infrastructure to reduce such differences.

There is **a need to develop long term care systems** to meet rising demand. Current provision is often insufficient, resulting in high personal costs and long waiting times. The changing structure of families, increased geographical mobility and increased female labour market participation require more formalised care for the elderly and disabled. There is a consensus on giving priority to home care services and introducing new technology (e.g. independent living systems) which can help to enable people to live in their own home for as long as possible. Member States also stress the importance of rehabilitation, helping dependents return to an active life. There is growing recognition of the need to create a solid basis for financing long-term care and some Member States are moving in this direction.

Improving quality through standards, evidence-based medicine and integrated care

Member States use a mix of tools to achieve and maintain high quality care across the system. These include: quality standards, e.g. minimum structural and procedural requirements for providers, accreditation or certification of providers, and quality monitoring systems based on reporting exercises, and inspections. Health care professionals are encouraged to use centrally evaluated and accessible clinical guidelines based upon the best available evidence. National health technology assessment agencies have been established and are cooperating at EU level (EUnet-HTA). They help to ensure that new interventions are effective, safe and cost-effective.

To enhance system responsiveness and patient satisfaction, a more patient-centred pattern of care is developing. This includes tailor-made services (notably within long-term care) and ensuring patients' rights, choice, involvement in decision-making and feedback through patient surveys.

Member States are aiming at better coordination between primary, outpatient and inpatient secondary and tertiary care and between medical, nursing, social and palliative care. eHealth can help. This is expected to lead to better, more efficient patient flows through the system, reduce inappropriate interventions, favour independent living and increase patient satisfaction and safety.

Promotion and prevention programmes are being implemented to tackle non-communicable diseases and health inequalities (e.g. cancer, cardiovascular diseases, vaccination programmes).

Achieving financial and long term sustainability

Sustainability of health and long term care has financial and human resource aspects. Resources are significant though there are striking differences in expenditure (between 5% and 11% of GDP in 2003) and personnel employed (between 3% and 10% of working age population).

The need to **control costs** growing substantially faster than GDP clearly emerges from the reports. The main pressures arise from new technologies, price trends, rising patient expectations and in future, from an ageing population. A key challenge is to allow everyone to benefit from medical progress quickly and equitably. Most Member States are promoting a more rational use of resources through: e.g. overall caps on expenditure, co-payments and the use of generic medicines, staff guidelines and health technology assessments. To promote efficiency, some Member States are separating the provision and funding roles and fostering competition between health service providers. Private expenditure now stands at 24% on average of total healthcare expenditure, due to the implementation of cost-containment policies and to increased demand, driven by higher per capita income. Member States accelerate **healthcare restructuring**, often challenging entrenched interests, through referral systems, strengthening primary care and its link with the territory, reducing the number of hospital beds and increasing day case surgery, and rationalising specialised care by concentrating it in a few centres of excellence.

The expected increase in care consumption represents a major area of employment growth. There is however a general surplus of specialists and lack of generalists and nurses. High demand for staff in some countries is also draining medical resources from others, underlining the need for a common approach. There is a need for measures to increase the retention and **supply of medical staff** in the long run. Also for long-term care, there are shortages in the workforce. Informal carers require training, peer supervision, counselling and respite care and the possibility to reconcile family care and paid employment

With these varying situations, specific challenges for Member States differ greatly. Some need to devote more resources to healthcare and long-term care to ensure adequate coverage while improving efficiency, whereas in others efficiency itself will be the key to maintaining sustainable systems.

The search for a win-win strategy

Member States recognise the inter-linkage between access, quality and financial sustainability: policies to broaden access have to be reconciled with improved financial sustainability and long term sustainability has to meet the need of high quality care for all. There are trade-offs as well as synergies between different policies. Making trade-offs transparent and developing synergies helps to secure adequate social protection against healthcare and long-term care risks. Promoting healthy and active life styles, health and safety at work and more preventive care and taking account of health concerns in all policies is seen as a win-win strategy. Improving coordination, both between types of care and between the different levels of competence (national, regional, local), and greater use of evidence-based medicine and technology assessment can also improve the quality of care and patient safety and help control expenditure.

3.3 Adequate and sustainable pensions

Reporting on pensions already took place in 2006. The comprehensive synthesis report on adequate and sustainable pensions[6] makes it clear that reform strategies need to consider the synergies and trade-offs between the broad objectives of adequacy, sustainability and modernisation. General structural reforms have taken place in most countries in the past decade and continued in some Member States in 2006. They build on a life-cycle approach by strengthening the link between contributions and benefits and managing increasing longevity and on active ageing strategies by reducing access to early retirement schemes and strengthening incentives to work longer. They must be matched by progress in opening labour markets for older workers. To guarantee both adequacy and sustainability of pension systems, more people need to work and to work longer. Continued rises in employment rates of older workers are encouraging but no reason for complacency.

There is a clear recognition that sustainability and adequacy questions go hand in hand. Unsustainable pension systems put pensions at risk and conversely inadequate pensions generate unforeseen demands to avoid pensioner poverty. Theoretical replacement rates, showing how a typical worker's pension would vary up to 2050, indicate drops in most countries at a given retirement age, notably in those which have enacted comprehensive reforms (and improved sustainability). Member States are projecting to compensate for this decline by extending working lives or increasing supplementary pension savings. For those countries that count on supplementary pension provision, securing private pensions and extending coverage remain essential.

Work in 2006 focused on specific issues, such as the higher poverty risk of older women, minimum pensions or minimum income within social assistance provisions. Widely differing provisions exist, with some countries having improved coverage considerably in recent years, while in others reliance on minimum pensions is declining as a result of the maturing of earnings related pensions and higher employment rates. Member States need to consider the future adjustments, in particular to ensure that recipients do not fall too far behind the overall wage level, while maintaining strong incentives for working longer and saving.

Another focus has been flexible arrangements towards the end of working life. Appropriate financial incentives for working longer are crucial. The effects of such incentives may vary at different times regarding the standard retirement age and for different levels of earnings. Such systems tend to be complicated and it is important to promote transparency and a better understanding for the individuals.

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6 SEC(2006)304 of 27/02/2006

Supporting document

SEC(2007) 329

1. SCOPE AND OUTLINE OF THE REPORT

This supporting document provides the analytical background for the 2007 Joint Report on Social Protection and Social Inclusion [COM(2007) 13 final]. It draws on the material provided by the Member States in their National Reports on Social Protection and Social Inclusion, as well as analysis provided by independent experts, and uses the common indicators agreed for this purpose by the Social Protection Committee and its Indicators Subgroup. Where appropriate, it also draws on studies and research carried out in the framework of the Open Method of Coordination (OMC) on Social Protection and Social Inclusion.

The document is divided into two parts. The first part relates to the common objectives for promoting social cohesion and ensuring effective interplay between the social OMC and the Lisbon and Sustainable Development strategies; it provides an analysis of the social situation across the fields of social inclusion, pensions and health and long-term care. The second part examines the policy strategies presented by the Member States and looks in turn at social inclusion, health and long-term care, and pensions.

Part One of the supporting document begins with an analysis of the economic and demographic context in which measures to combat poverty and exclusion and to ensure the adequacy, quality and sustainability of pensions, health care and long-term care are being implemented. The first chapter describes the more limited economic growth which has characterised in particular the first years of this millennium, while the second highlights the disparities that continue to be a feature of EU societies and in particular the extent of poverty and social exclusion affecting considerable groups of the population. It also looks at the labour market situation of older people and the interplay with the pension system, before looking at the role of pensions more widely in maintaining adequate living standards in retirement. Finally, it examines the health dimension, looking at the indicators of levels of health across the Union and at health care spending, health status and inequalities. The third chapter examines the complex issue of the interrelationship between, on the one hand, efforts to promote inclusion and the reform of social protection systems and, on the other, the Lisbon goals of growth and jobs.

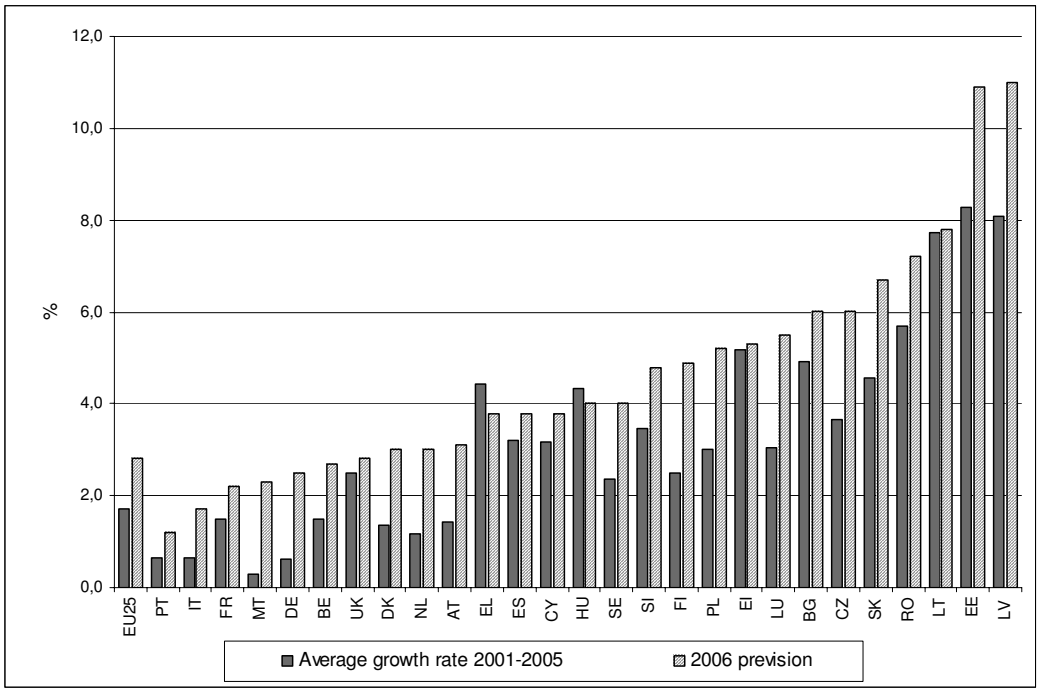
Part Two has three sections. Section 1 assesses Member States' Strategies for Social Inclusion. It explores how Member States set out to address inequalities in access to the resources, rights and services needed for full participation in society, to achieve active social inclusion while fighting poverty and exclusion and to further improve governance of social inclusion policies. Reflecting the priorities set in Member States' Reports, it devotes particular attention to the strong commitment across the EU to tackling child poverty and to promoting active inclusion. Section 2 summarises the national strategies for health care and long-term care to ensure access for all to high quality care in a sustainable manner. This is the first report of its kind, given that the open method of coordination was extended to cover health care and long-term care only from 2006. Section 3 summarises the work carried out in 2006 on pensions. National strategies for pension reforms were reported in 2005 and work on pensions in 2006 within the OMC focused on: replacement rates, minimum income guarantees for older people and flexibility in retirement age.

2. PART ONE: QUANTITATIVE ANALYSIS

2.1 The Economic and Demographic Context and Developments

Between 2001 and 2005, average economic growth in the EU25 was 1.7% per year, but this hides the good performance of countries like Ireland, Greece and Spain (over 3% per year on average) and the new Member States (around 4.6%). The gap between the richest and the poorest countries in Europe continued to narrow during the period. While the average GDP per capita of the five richest countries in Europe remained at 125% of the EU25 average[7], the average GDP per capita of the five poorest moved up from 42% of the EU25 average in 2000 to 51.4% in 2005. For 2006, a projected 2.3% EU25 average growth rate reflects signs of recovery observed in most Member States.

Figure 1: GDP growth over 2001-2005 and 2006 forecast.

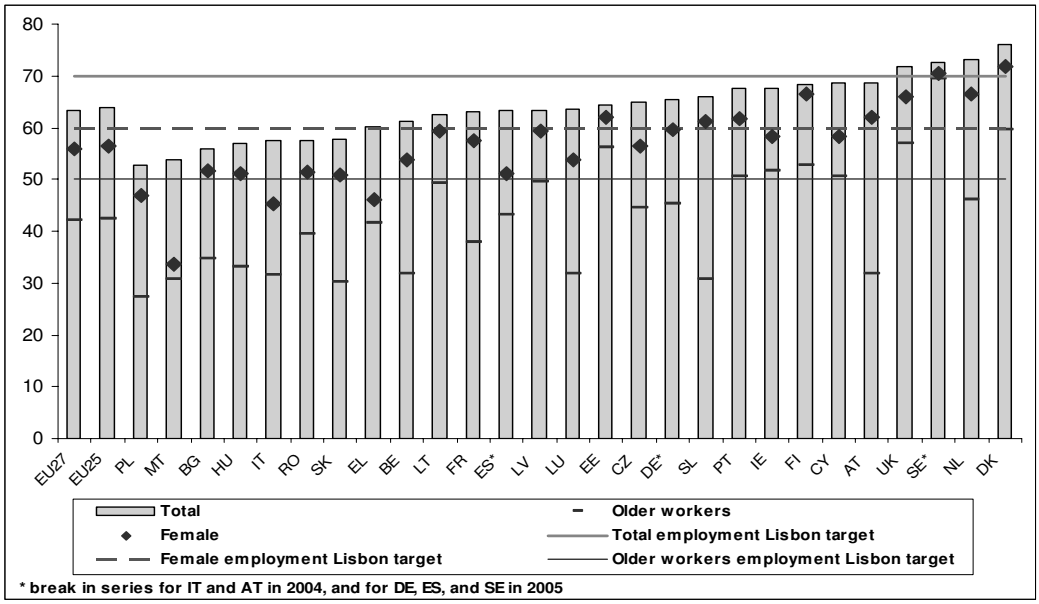


Source: Eurostat – National Accounts

In 2005, employment growth in the EU25 continued to recover gradually from the low in 2003. Employment growth averaged 0.8% for the year as a whole, slightly up on the previous year's level of 0.6%. The employment rate in the EU25 increased to 63.8%, mainly driven by the growth in the employment rate for women (from 54.3% in 2001 to 56.3% in 2005) and for older workers (from 37.5% to 42.5%). The share of part-time employment (including involuntary part-time) have risen from 16.3% in 2001 to 18.4% in 2005, as well as the share of fixed-term employment (from 12.9% in 2001 to 14.5% in 2005).

[7] In PPS and excluding Luxembourg

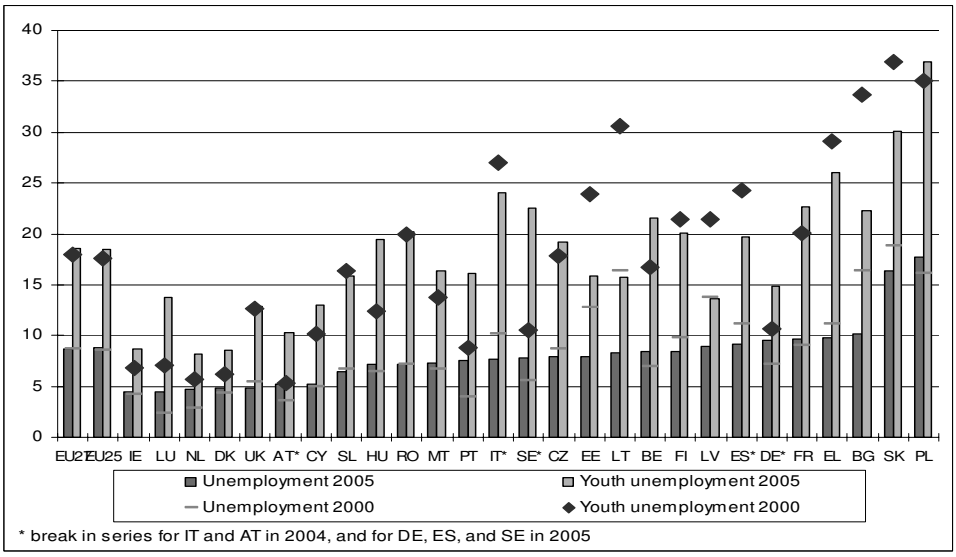
Figure 2: employment rates in the EU; total, women and older workers; 2005.



Source: Eurostat - Labour Force Survey

Unemployment remains a concern for most EU Member States, with 8.8% of the EU25 labour force unemployed in 2005 (against 8.6% in 2001), and long-term unemployment rising from 3.6% to 3.9%. Seven countries (IE, LU, NL, DK, UK, AT and CY) have unemployment rates around or below 5%, while two (SK and PL) have rates above 15%. The unemployment rate for women is higher than for men in most EU countries and on average in the EU it is 2.1 percentage points higher. Youth unemployment remains very high (18.5% in 2005). In most countries, youth unemployment is at least twice as high as the overall rate, and up to 3 times as high in IT and LU. While some Member States have managed to reduce youth unemployment significantly between 2000 and 2005 (the Baltic States, Slovakia and Bulgaria from higher levels), it has increased sharply in LU, HU, PT and BE.

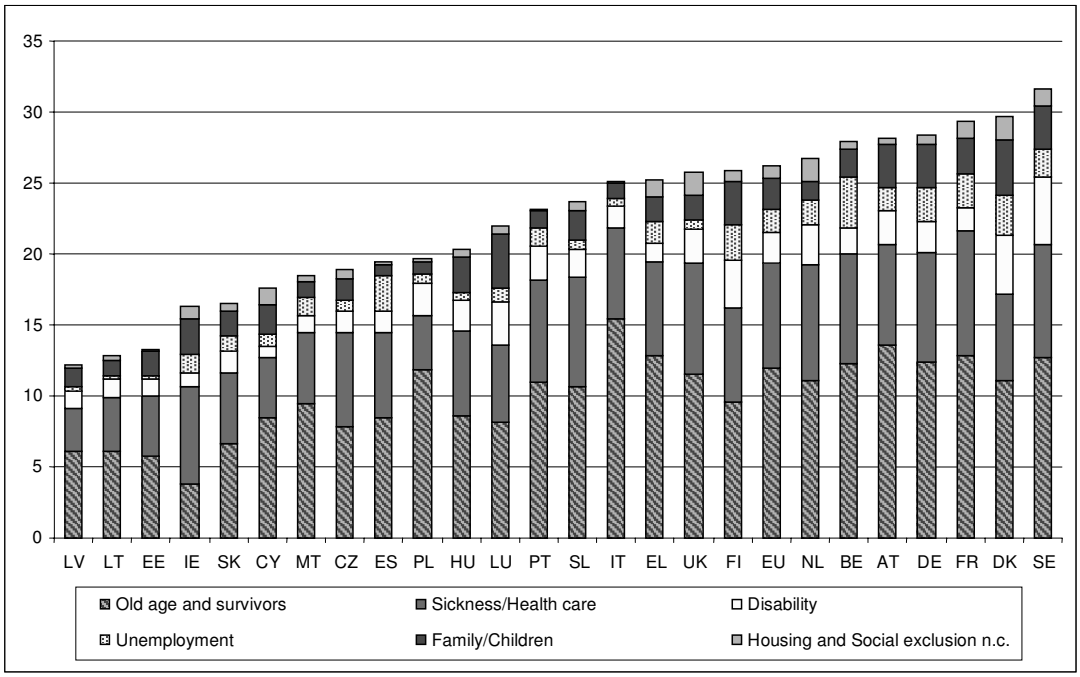
Figure 3: Unemployment and youth unemployment; 2000 and 2005.



Source: Eurostat - Labour Force Survey

Average spending on social protection (excluding administrative costs) in the Union in 2004 represented 26.2% of GDP. In general, the relative levels of social protection expenditures are highest in the richest countries as measured by GDP per capita. Social protection expenditures range from 12% to 20% in the Baltic States, IE, MT, SK, CZ, PL and HU to around or even above 30% in DK, SE, DE and FR. In all EU countries, pensions and health care represent the bulk (three quarters) of social protection expenditure, reaching on average 46% and 28% respectively of social protection expenditure. The rest is spent, to varying degrees, on disability, family-related benefits, unemployment, housing and other social exclusion benefits.

Figure 4: social protection benefits, by function, in % of GDP – 2004.



Source: Eurostat - ESSPROS

In the coming decades, the size and age-structure of Europe's population will undergo dramatic changes due to low fertility rates, increases in life expectancy and the retirement of the baby-boom generation. Member States have started to address the demographic challenge in a context of tight fiscal constraints. The situation in public finances in the EU has deteriorated in a number of countries since 2000. Debt ratios in 2006 remained above the 60% of GDP threshold in Belgium, Germany, Greece, France, Italy, Austria, Portugal, Cyprus and Malta. Reforms have had a significant impact in BE and EL (where however the debt ratio remains close to 90% or more), and in AT and CY where the debt ratio is expected to fall below the 60% thresholds in the coming two years.[1]

Pensions and health care functions that mostly benefit elderly people are most likely to be affected by the expected ageing of the population. According to Eurostat projections, the age structure of the EU population will change dramatically. By 2050, the EU will have lost 48 million 15 to 64-year-olds and will have gained 58 million people 65 and over. The old-age dependency ratio, that is the number of people aged 65 years and above relative to those between 15 and 64, is projected to double, reaching 51% in 2050. This means that from four working-age people supporting each pensioner in 2004, this ratio will drop to two to one by 2050.

[1] See statistical annex for full data.

Nevertheless, ageing is a consequence of the positive fact that life expectancy has continued to increase. For the EU-25, from 1995 to 2005 life expectancy at birth has increased from 72.8 to 75.8 years of age for males and from 79.7 to 81.9 for females. Between 1993 and 2003, significant increases in life expectancy at the age of 45 (from 30.5 to 32.5 for males and from 36.3 to 37.8 for females) and at 65 (14.7 to 16.3 for males and from 18.9 to 19.9 for females) indicate that gains in life expectancy are more and more happening in older age. The challenge is now for social protection systems to ensure that people are living and working longer in good health, not only to improve the well-being of citizens but also to help maintain a healthy work-force and to limit increases in expenditure on health and long-term care in old age.

2.2. The Social Situation in the EU and the Role and Effectiveness of Social Policy

The first objective of the streamlined Open Method of Co-ordination in the field of social protection and social inclusion is the promotion of social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies.
There are a number of aspects to social outcomes, including income and living standards, access to good quality health services, educational and work opportunities. This chapter aims to give a snapshot of the social situation in the European Union from this multidimensional perspective, based on the set of indicators agreed at EU level to monitor progress in this area. It will also highlight the role of social protection and employment policies in fighting against poverty and social exclusion.

2.2.1. Poverty and social exclusion: the income dimension

Poverty and social exclusion take complex and multi-dimensional forms and, among these, living on very low incomes probably resonates best with what is commonly referred to as "poverty". Being at risk of poverty is a relative concept: it refers to the capacity of the individual to participate fully in the society in which she or he lives. That is why the income measures of poverty are related to some extent to the overall income distribution nationally and are expressed as a percentage of the median income in any given country.

Income poverty still affects 16% of the EU population…

In 2004, the average **at-risk-of-poverty rate** in the EU was 16%[9] while national figures ranged from 9% in Sweden and 10% in the Czech Republic to 21% in Lithuania and Poland and 20% in Ireland, Greece, Spain and Portugal. In most countries, the at-risk-of-poverty rate (for the population aged 16 or more) was higher for **women,** the difference reaching 4 percentage points in Bulgaria and Italy, while at EU level the gender gap was 2 percentage points. Only in Hungary and Poland was the at-risk-of-poverty rate marginally greater for men. However, when looking at the gender dimension, it is important to interpret figures with caution since they assume equal distribution of resources within the household, which might not necessarily be the case.

[9] The newly implemented reference source of statistics on income and social exclusion is the European Survey on Income and Living Conditions (EU-SILC) framework regulation (No.1177/2003). For the first time this year, EU-SILC data is available for 25 EU Countries. During the transition to EU-SILC, income based indicators were calculated on the basis of available national sources (household budget survey, micro-censuses, etc.) that were not fully compatible with the SILC methodology based on detailed income. Following the implementation of EU-SILC in a given country, the values of all income based indicators cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. This is why no trends in income based indicators are presented in this year's report.

…and is even higher for children, young people and the elderly.

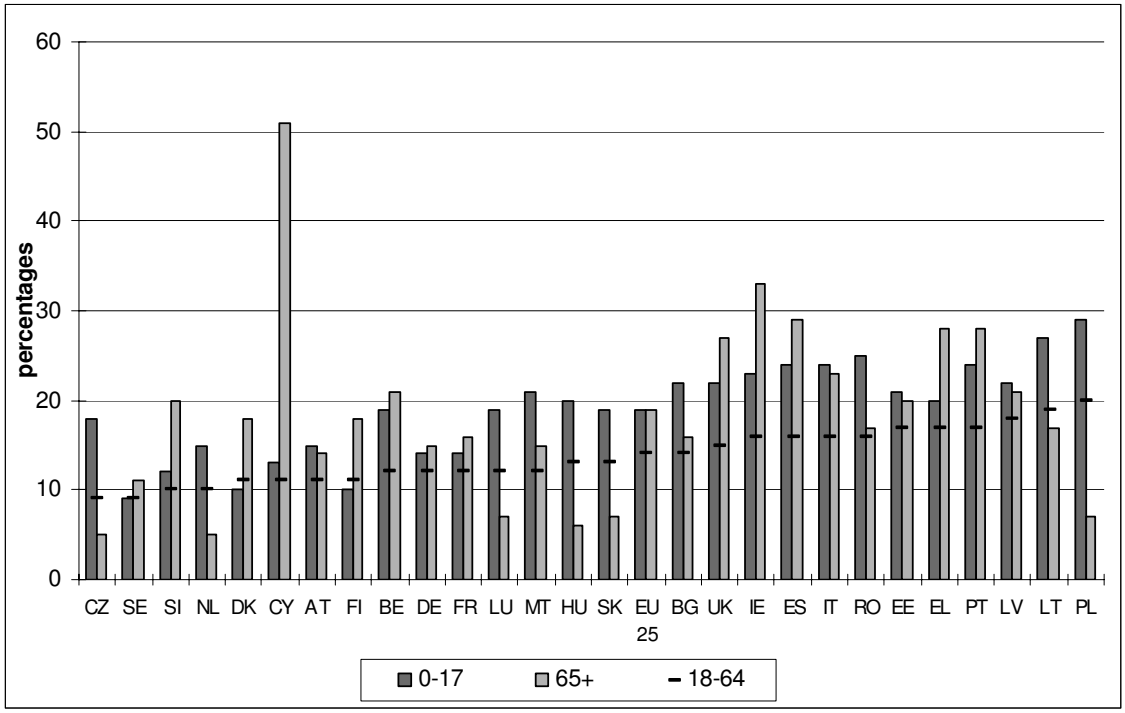
The young have the highest at-risk-of-poverty rate, at 19% for children aged 0-17, and 18% for the 18-24 age groups. The at-risk-of-poverty rate then decreases with age as individuals progress in the labour market, before it rises again after people retire and cannot rely anymore on income from work. The risk of poverty for **children** is particularly high in Poland (29%), Lithuania (27%) and Romania (25%). One person households and those with dependent children tend to have the highest poverty risk, with the highest poverty rate affecting single parents with one dependent child (33% in the EU as a whole).

The risk of poverty for **people** aged 65 and more is particularly high in Ireland (33%) and Cyprus (51%), while it is also significantly high in comparison to the population as a whole in a number of Member States[10]. However, recent measures introduced in some Member States, including minimum income guarantee schemes and increases in the minimum income guarantee, are likely to have decreased the poverty risk in recent years. Older women, without exception, are at greater risk of poverty than older men, who are on the whole no more exposed to the risk of poverty than their younger counterparts. The oldest cohorts (aged 75 and over) tend to be more at risk of poverty than those over 65 and women represent a majority of these older people. Higher poverty risk amongst the oldest people is linked to several factors. Low incomes or interrupted careers, which particularly affect women, coupled with the indexation rules in some countries, generally result in a progressive worsening of retirement incomes as older cohorts grow older.

Comparing the poverty risk in the EU for the youngest and the oldest segments of the population, which are both higher at EU level than the poverty risk of the working age population, approximately half of Member States have a higher child poverty risk and the other half have higher elderly poverty risk. It should, however, be noted that in almost all Member States the poverty risk for children is higher than that for the working age population, while the poverty risk for elderly people varies to a greater extent (but in most Member States it is still significantly above average). Income poverty among children is generally recognised as affecting their development and future opportunities and so the life chances of future generations.

[10] To evaluate the relative position of older people, only monetary income (notably deriving from pensions) is taken into account. The wealth of pensioners, in particular house ownership (and associated imputed rents) and private savings, which have a strong effect on the income distribution of pensioners, are not taken into account, nor are other non-monetary benefits (free healthcare, transport, etc.). For this reason, the poverty risk of older people may be somewhat overestimated.

Figure 5: At-risk-of-poverty rate for children, elderly people and the overall population - 2004 – percentages

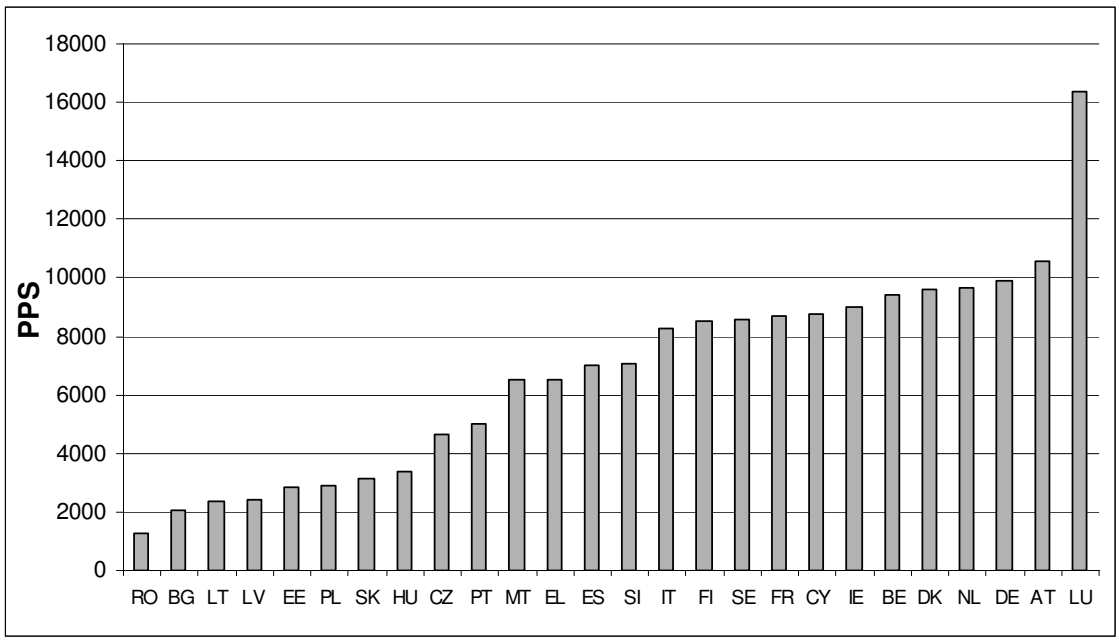


Notes: provisional data for HU and the UK; age brackets 0-15, 16-64 and 65+ for BG, RO and SI.
Source: EU-SILC, Eurostat; national sources for BG and RO. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004), and the UK (survey and income year 2005)

Being poor means having very different living standards in different Member States

At-risk-of-poverty thresholds are country-specific and the economic well-being of individuals at risk of poverty in Member States can therefore be quite different in absolute terms, so that, for example, individuals with similar real incomes may be classified as being at risk of poverty in one Member States but would not be in another. The following graph presents the illustrative values of the **at-risk-of-poverty thresholds** for a single adult household, expressed in purchasing power standards. Member States with the lowest at-risk-of-poverty threshold include all new Eastern European Member States and Portugal. At the other end of the distribution, the highest at-risk-of-poverty thresholds are those of Luxembourg and Austria, where they are respectively more than seven and four times higher than in Latvia, Lithuania and Bulgaria and more than twelve and eight times higher than in Romania. In euros, this means that the at-risk-of-poverty threshold for a single person household and for a household with two adults and two dependent children ranges from 558 euros and 1172 euros respectively a year in Romania to 17087 euros and 35883 euros respectively in Luxembourg. This means that in Romania single people at risk of poverty live on less than two euros a day, while in Bulgaria Latvia and Lithuania they live on less than four euros a day.

Figure 6: Illustrative value of the at-risk-of-poverty threshold for a single adult household, in PPS, 2004

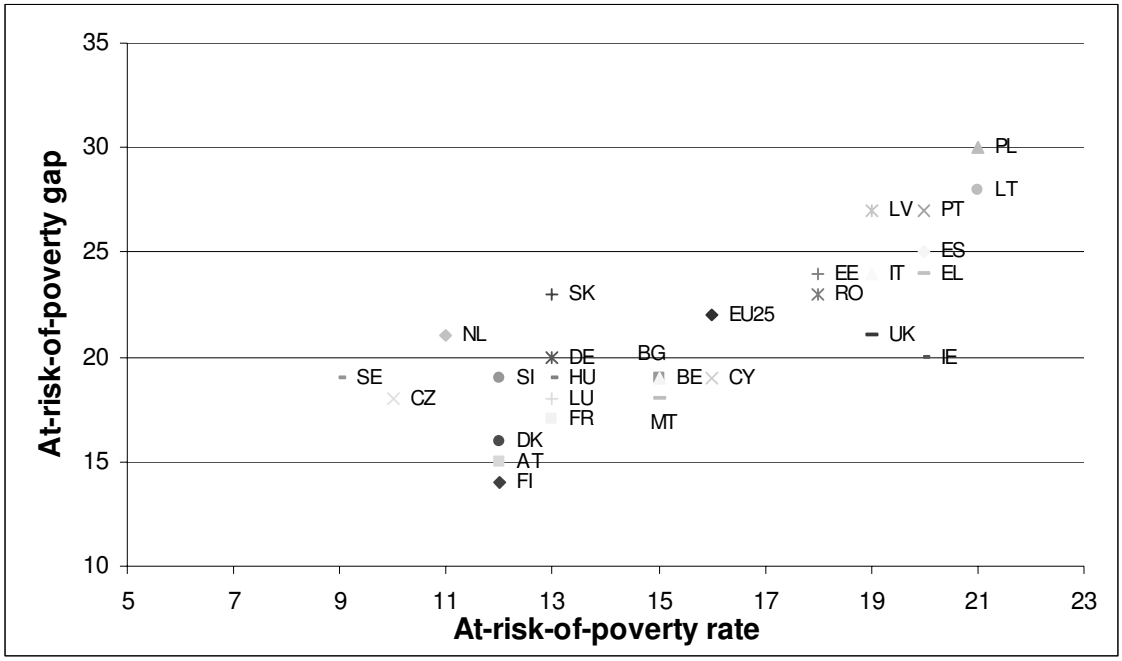


Notes: provisional data for HU.
Source: EU-SILC, Eurostat; national sources for BG and RO. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004). Data for the UK not available.

In Member States where poverty affects a larger share of the population, it also tends to be more severe, but this is not always the case.

Headcount figures on poverty risk do not answer the question "how poor are the poor?". Information on the **intensity of poverty** can be obtained from the *relative median at-risk-of-poverty gap* indicator, which measures how far below the threshold the income of people at risk of poverty is. In 2004 the median at-risk-of-poverty gap for the EU was 23%. Member States with low headcount measures of poverty tend to have the lowest intensity of poverty as well. On the other hand, countries with a high at-risk-of-poverty headcount tend to have a relatively higher median at-risk-of-poverty gap as well. This is particularly high in Poland, where it reaches 30% of the at-risk-of-poverty threshold.

Figure 7: At-risk-of-poverty rate and median at-risk-of-poverty gap for the total population - 2004 – percentages

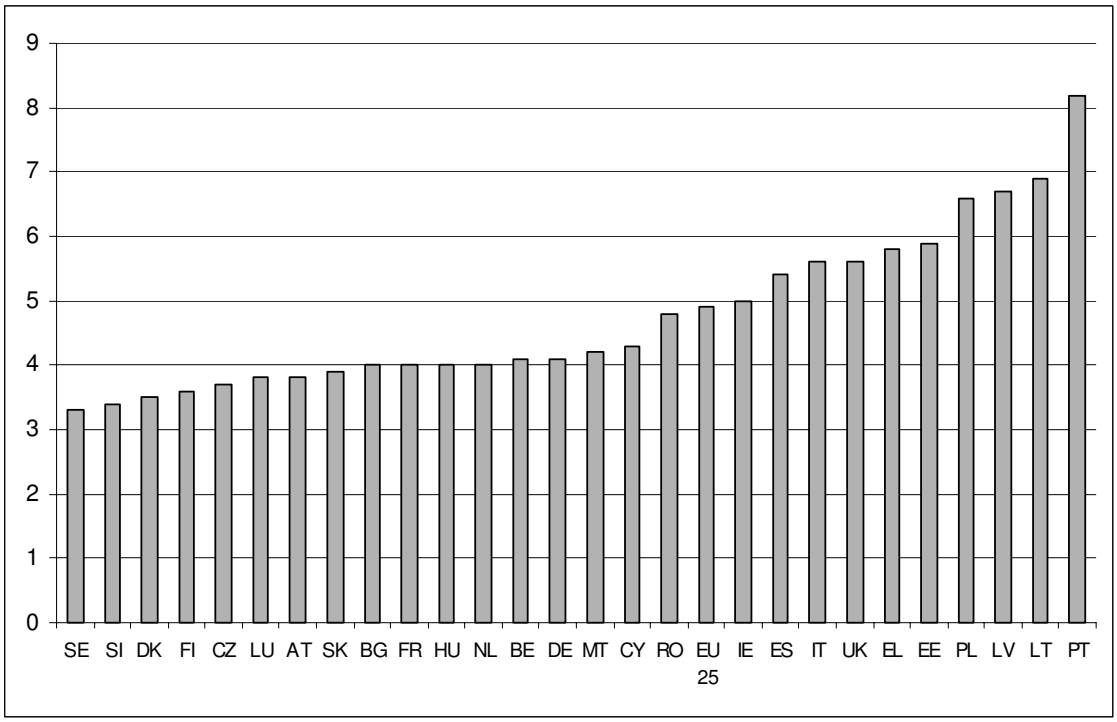


Notes: provisional data for HU and the UK.
Source: EU-SILC, Eurostat; national sources for BG and RO. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004), and the UK (survey and income year 2005)

Member States that succeed in achieving low rates of poverty risk are the ones with the most equal income distributions

The figures presented so far, focus on analysis of the lower end of the income distribution. To assess the degree of social cohesion within Member States, one must explicitly consider how the income situation of those at the bottom of the income distribution compares with that of individuals at the top, as measured, for example, by the **income quintile ratio**. The value for this indicator was 4.9 for the EU in 2004, which means that the ratio of total income received by the 20% of the EU population with the highest income (top quintile) was nearly 5 times that received by the 20% of the EU population with the lowest income (lowest quintile). Member States with the lowest income inequality are also among the countries with the lowest at-risk-of-poverty rate. Member States with the highest disparities between those at the top and those at the bottom of the income distribution are Portugal (with a ratio of more than 8 to 1), followed by Lithuania, Latvia and Poland.

Figure 8: Inequality of income: S80/S20 income quintile share ratio – 2004.



Notes: provisional data for HU and the UK.
Source: EU-SILC, Eurostat; national sources for BG and RO. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004), and the UK (survey and income year 2005)

2.2.2. The impact of social protection expenditure in reducing the risk of poverty

Social protection expenditure plays a decisive role in reducing the risk of poverty

A comparison between the standard at-risk-of-poverty rate and the hypothetical situation where social transfers are absent, other things being equal, shows that such transfers have an important redistributive effect that helps to reduce the number of people who are at risk of poverty. In the absence of all social transfers[11], the average poverty risk for EU Member States would be considerably higher than it is in reality, by the order of 10 percentage points (average pre-transfer risk rate of 26% compared with the post-transfer rate of 16%). Figure 9 shows the percentage drop (in absolute terms) of the at-risk-of-poverty rate allowed by social transfers[12].

The poverty-reducing effect of social transfers is particularly evident in France, the Netherlands, Austria, the Czech Republic, Hungary, Finland, Denmark and Sweden, where all social transfers reduce poverty by 50% or more. Conversely, in Lithuania, Spain, Bulgaria and Greece social transfers only reduce the risk of poverty by 20% or less.

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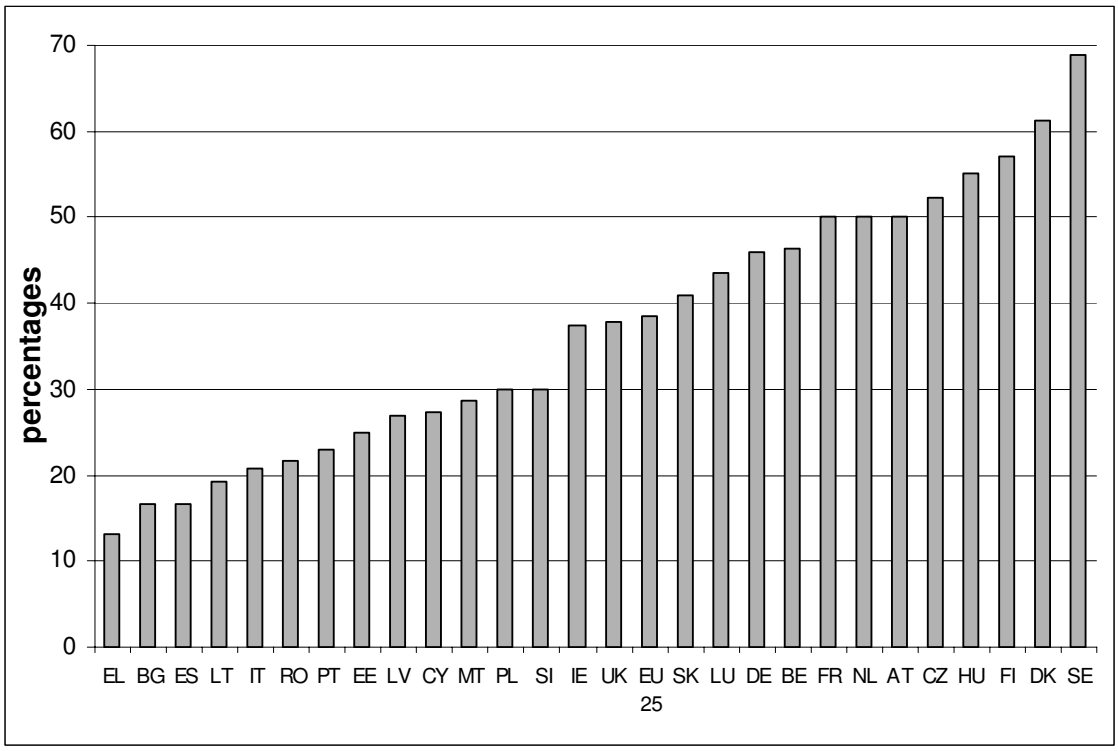
11 For the purpose of this analysis, pensions are considered primary income since their role is not only to redistribute resources across income groups but also, and primarily, over the life-cycle of individuals and/or across generations.

12 The indicator of poverty risk before social transfers must be interpreted with caution for a number of reasons. First, no account is taken of measures that, like social cash transfers, can have the effect of raising the disposable incomes of households and individuals, namely transfers in kind, tax credits and tax allowances. Second, the pre-transfer poverty risk is compared to the post-transfer risk keeping all other things equal – namely, assuming unchanged household and labour market structures, thus disregarding any possible behavioural changes that the situation of absence of social transfers would involve.

Figure 9: The impact of social transfers (excluding pensions) on the at-risk-of-poverty rate, 2004

% reduction in the total poverty-risk rate allowed by social transfers

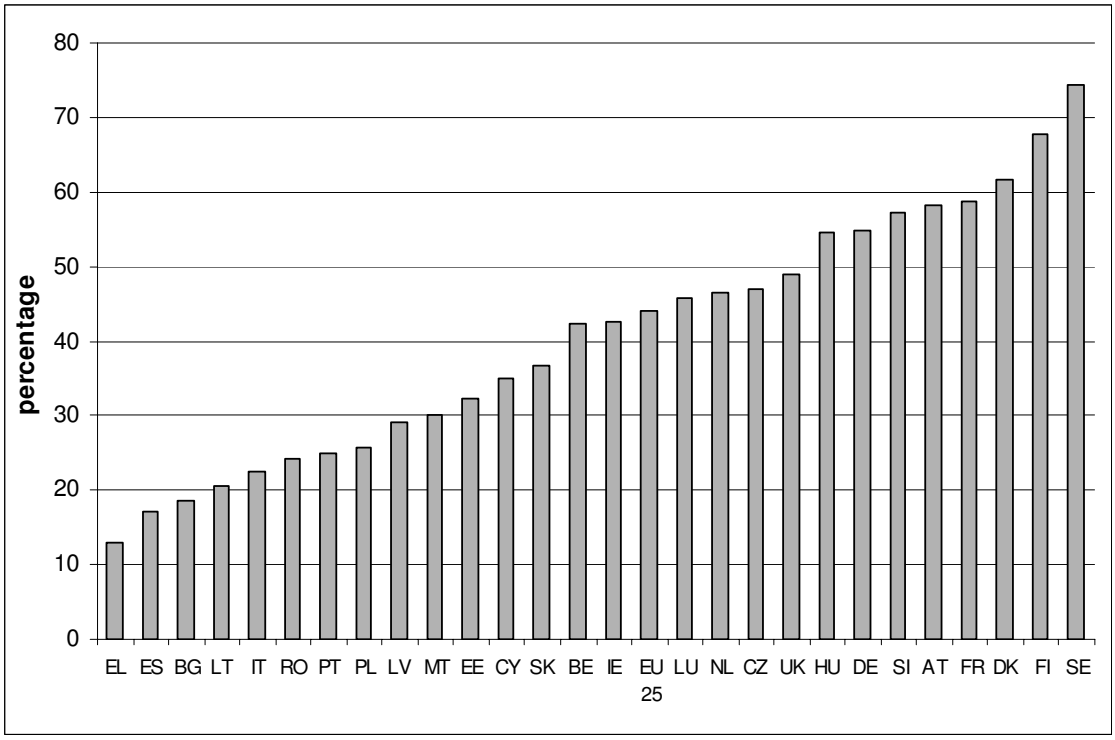


Notes: provisional data for HU.
Source: EU-SILC, Eurostat; national sources for BG, RO and the UK. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004) and the UK (survey and income year: 2003).

The impact of social cash transfers on the poverty risk rate differs across age groups. Figure 10 illustrates the percentage drop in the poverty risk rate for children aged 0-17 years allowed by social transfers (excluding pensions). In the Nordic countries, the drop in the poverty risk rate for children allowed by social transfers other than pensions was as high as 60% or more; on the other hand, in Bulgaria, Spain and Greece children benefit least from poverty relief allowed by social benefits (the percentage drop was less than 20%).

Figure 10: The impact of social transfers on the at-risk-of-poverty rate for children, 2004

% reduction in the total poverty-risk rate for children (aged 0-17) allowed by social transfers other than pensions



Notes: provisional data for HU and the UK; age bracket 0-15 BG, RO, SI and the UK.
Source: EU-SILC, Eurostat; national sources for BG, RO and the UK. Survey year: 2005; Income year: 2004; except BG and RO (survey and income year 2004) and the UK (survey and income year: 2003)

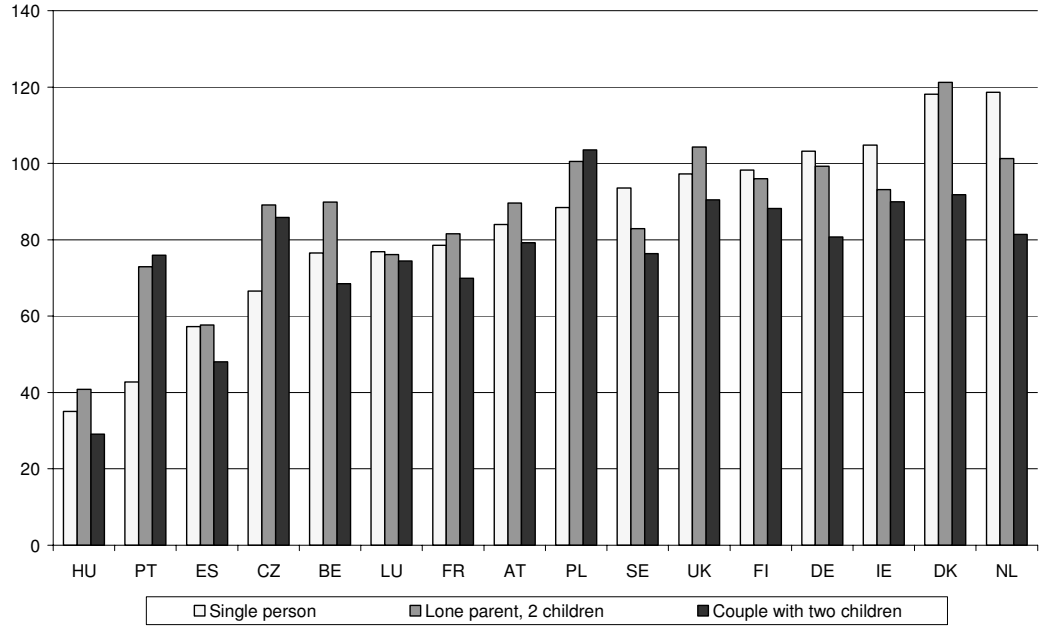
BOX 1: Social assistance and risk of poverty

Countries differ substantially in terms of the minimum safety nets they provide to workless households[13], even when comparing them relative to the at-risk-of-poverty threshold that depends on living standards in each country. Only a few countries provide workless households with a minimum income and related (i.e. housing) benefits that are sufficient to lift them close to or above the 60% of median income threshold, and this only with respect to some family types. So, for example, lone parents can receive benefit income at or above the poverty threshold level only in Poland, the United Kingdom, Germany, Denmark and the Netherlands; whereas in all countries but Poland, couples with two children relying on social assistance benefits would have disposable income levels below 60% of the median. In Hungary and Spain, all three family types are likely to receive less than 40% of median income with out-of-work benefits. Some Member States argue that the main purpose of social assistance is to meet basic needs rather than compensate for income differences between low income households and the rest of the population. Furthermore, these basic needs can be met by cash transfers, benefits in kind or a mixture of both.

[13] This indicator reflects assumptions that households rely on social assistance benefits for the entire year, and that no other income stream (from other social protection benefits such as unemployment insurance or disability or from work) is available. For the calculation of housing benefits, it is assumed that housing costs consist entirely of rent, and the level of rent for all family types regardless of income level and income source is estimated as 20% of the gross earnings of an average production worker. This assumption may affect the level of transfers regarding different household types.

Figure 11: Net income of social assistance recipients – 2003

As a % of the at-risk-of-poverty threshold for three jobless family types, including housing benefits.



Only countries where non-categorical social assistance benefits are in place are considered.
Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat

2.2.3. Joblessness: a cause of income poverty and an aspect of social exclusion

Social protection can provide relief from poverty but does not in itself help individuals and families durably elude poverty. If they are to be effective in combating poverty and social exclusion, social transfers must be accompanied by adequate health care, education, housing, social services and measures facilitating integration into the labour market for those capable of working. This is why many Member States are increasingly focusing their policies on promoting individual self-sufficiency through an employment-friendly social protection system that fosters participation in the labour market.

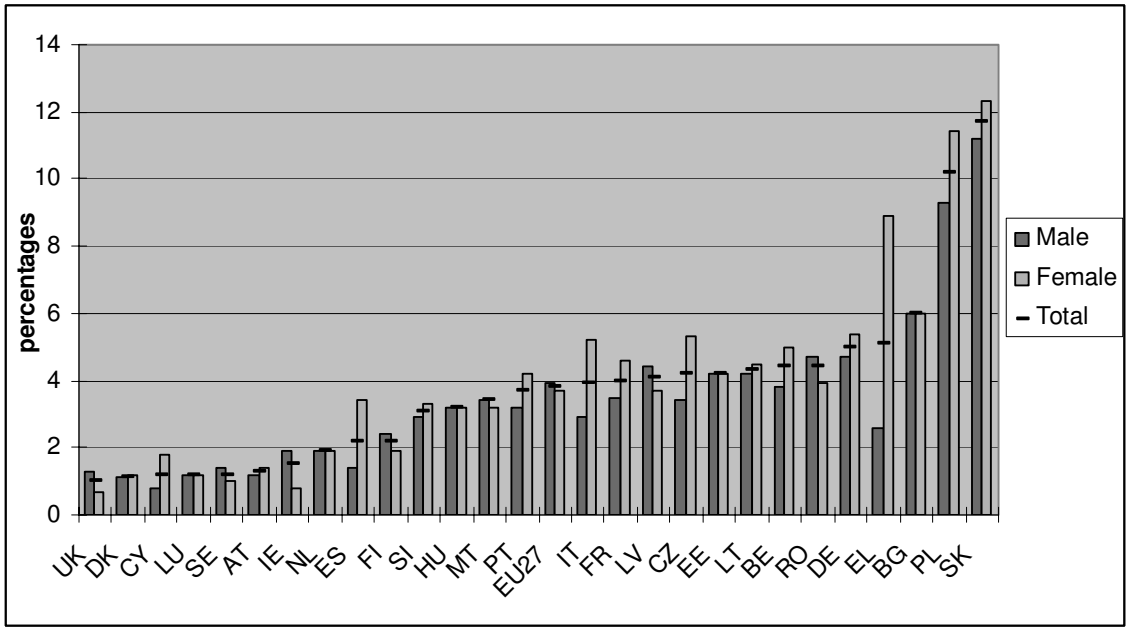
Joblessness is not only one of the main causes of poor living standards but is also in itself a central dimension of social exclusion, since a job is a key determinant of people's ability to fully participate in society, build a social network and realise their potential. Among all the different types of joblessness, long-term unemployment is clearly associated with social distress. The term covers people who have been searching for a job, but who have been unable to find one for more than 12 months[14]. Long-term unemployment represents an important loss of income for the individuals concerned, who also tend to lose their skills and the self-esteem necessary to regain a foothold in the labour market.

In 2005, **long-term unemployment** affected 3.8% of the active population in the EU-27 (3.9% in the EU-25), on average more men (3.9%) than women (3.7%). The differences between Member States are considerable. Long-term unemployment rates are equal or below 1.5% in Ireland, Austria, Sweden, Luxembourg, Cyprus, Denmark and the United Kingdom, where only 1% of the active population is affected, but is equal or more than 5% in Germany, Greece and Bulgaria and 10% in Poland and Slovakia. The gender gap is particularly large in

[14] Long-term unemployment is defined as the total long-term (over 12 months) unemployed population (ILO definition) as a proportion of the total active population aged 15 years or more.

Poland, Italy and Greece where the long-term unemployment rates for women are respectively 2.1, 2.3 and 6.3 percentage points higher than for men. In only seven Member States - the United Kingdom, Sweden, Ireland, Finland, Malta, Latvia and Romania - are long-term unemployment rates higher for men than for women. Long-term unemployment has remained broadly unchanged in the five-year period between 2000 and 2005 for the EU-25 and decreased by 0.3 percentage points in the EU-27. The long-term unemployment rate decreased by more than 2 percentage points in Bulgaria, Spain, Italy, Latvia and Lithuania, while it increased by 1.4 percentage points in Slovakia and 2.8 in Poland.

Figure 12: Long-term unemployment rate by country and gender – 2005.



Notes: provisional data for SE.
Source: Eurostat, Labour Force Survey, annual averages, based on 1990 census.

The term "at risk of poverty" refers to those individuals whose *household* income is below a certain threshold, since economic well-being depends on the sum of all the resources contributed by all members of the household. Therefore, joblessness is even more problematic when it concerns not only one individual, but all the members of the household. Furthermore, the potentially adverse impact of living in a **jobless household** goes beyond the lack of work income, as it extends to the lack of contact with the labour market.

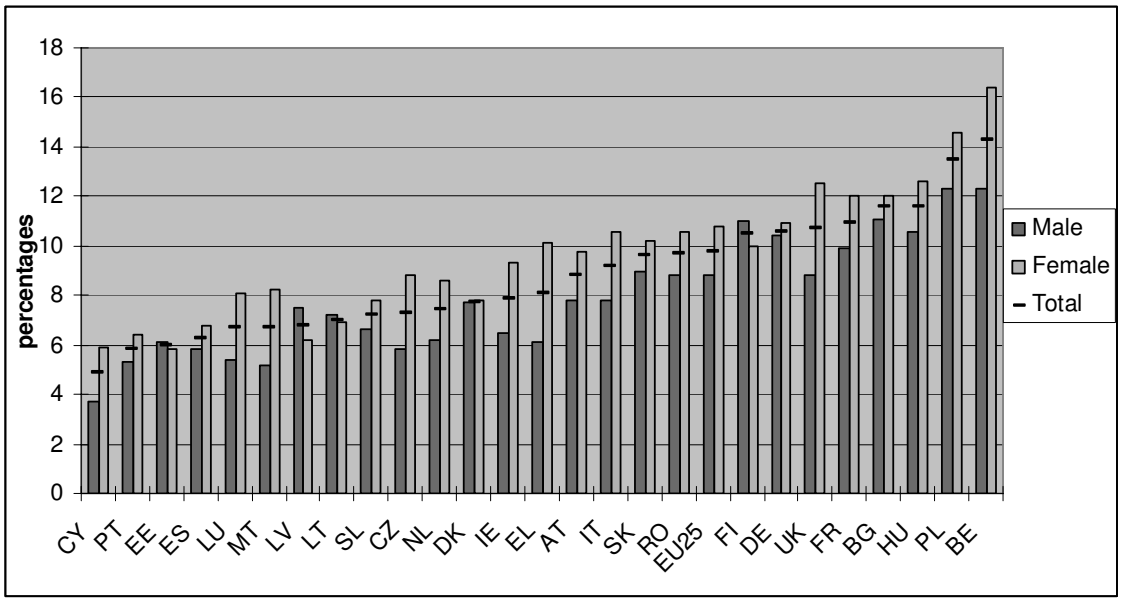
In the EU25, the percentage of people aged 18-59 and living in households where no one works was 9.8% in 2006. This proportion ranged from below 6% in Cyprus and Portugal, to 13.5% in Poland and 14.3% in Belgium. It is interesting to note that even Member States with relatively high employment rates, such as Finland, Germany and the United Kingdom, also have above-average rates of people living in jobless households, pointing to a greater polarisation between "job-poor" and "job-rich" households in these countries[15].

In the EU, the proportion of women living in jobless households at 10.8% is two percentage points higher than for men, and this gap is equal to 3 percentage points or more in the Czech

[15] When comparing the national percentages of joblessness, it is important to keep in mind the differences in the national distributions of people living in jobless households by household types (as shown in the statistical annex).

Republic, Malta, the United Kingdom, Greece and Belgium, where it reaches 4.1 percentage points.

Figure 13: People aged 18-59 living in jobless households by country and gender, 2006.



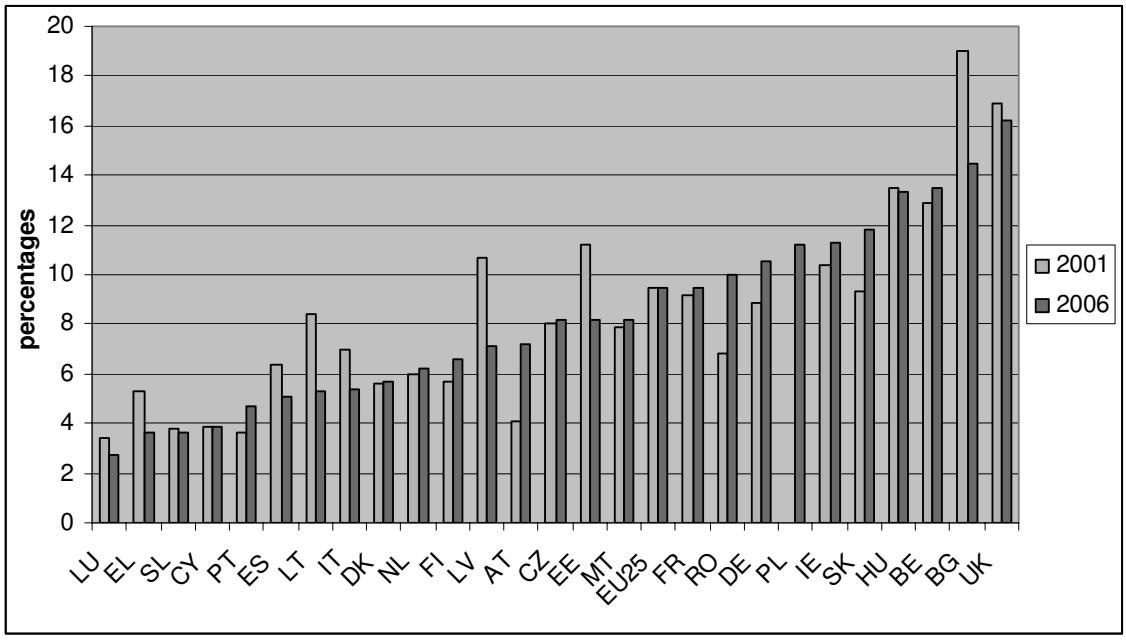
Notes: In CY, the reference population (denominator) excludes students abroad.. Data for SE not available. Provisional data for DK, LU and FI.
Source: Eurostat, Labour Force Survey - Quarter 2 results

Between 2001 and 2005, the proportion of prime-age adults living in jobless households remained essentially unchanged in the EU. Only in the Baltic States and Bulgaria has there been a marked decrease equal to more than 3 percentage points.

Particular concerns are raised when children grow up in a jobless household, as the absence of a working adult could be a factor affecting the educational and future labour market achievement of children. In 2006, the proportion of **children living in jobless households** was slightly lower than that of prime-age adults (9.5%), but variations across Member States are more marked, ranging from 2.7% in Luxembourg to 16.2% in the UK.

In the past five years, the proportion of children living in jobless households has not changed in the EU, but has decreased by over 3 percentage points in the Baltic States and Bulgaria and increased by the same amount in Austria and Romania.

Figure 14: Children living in jobless households, 2001 and 2006.



Notes: data for the EU estimated. In DK, LU, EE, LV, LT, CY, MT and SI, the degree of variation of results over time is partly influenced by a low sample size. In CY, the reference population (denominator) excludes students abroad.
Source: Eurostat, Labour Force Survey - Quarter 2 results; in the first column, 2002 data for DK and LT, 2003 data for FI; data for SE and for PL prior to 2006 not available.

BOX 2: Social protection and employment: making work pay

In line with Integrated Guideline No 19, strengthening incentives and support for labour market participation continues to be the main driver of many welfare and tax reforms in the Member States. The concern is to reduce reliance on social protection and increase self-sufficiency by supporting labour market participation and "making work pay", that is, making work an economically attractive option relative to welfare. However, it should also be noted that non-monetary incentives are just as important as monetary ones, and a generous benefit level and incentives to work do not necessarily contradict each other. Balancing the two goals of increasing labour supply incentives and at the same time alleviating poverty is a challenge for policy-makers, who also have to take account of the budgetary costs that any tax and benefit reform may involve.

The unemployment trap

- Unemployment benefit systems are intended to provide income security during unemployment and to allow a better and more efficient match between workers and jobs as they allow individuals to spend more time on job searching. At the same time, unemployment benefits can reduce the financial incentives to return to work and thus lower job search intensity. The term **unemployment trap** refers to the situation where net in-work earnings are low relative to out-of-work income of the unemployed and their families.

Table 1 Unemployment traps for unemployed persons returning to full-time work at 67% of the APW[1], 2004 and changes 2001-2004

	Single person no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
	METR %	% point change 2001-04	METR%	% point change 2001-04	METR %	% point change 2001-04	METR %	% point change 2001-04
Belgium	88	-1	79	0	76	0	77	-2
Czech Republic	65	-2	69	-1	78	-11	65	-9
Denmark	89	-2	89	-2	89	-1	92	-3
Germany	87	-1	93	0	84	0	98	0
Greece	76	7	83	7	83	7	56	-3
Spain	80	1	79	1	78	-1	81	1
France	82	-5	90	-1	90	-1	82	-5
Ireland	73	0	12	-8	87	-1	52	-5
Italy	59	0	54	1	52	-2	74	4
Luxembourg	85	-3	88	2	104	0	82	-4
Hungary	66	-9	68	-3	68	-3	63	-10
Netherlands	87	1	85	-2	88	-1	76	-1
Austria	73	-2	81	-1	96	-1	75	1
Poland	83	5	73	3	95	4	78	0
Portugal	87	-1	97	11	82	0	85	-1
Finland	80	-1	86	-2	94	-5	76	-2
Slovak Republic	43	-38	34	-72	31	-80	47	-22
Sweden	87	0	91	0	100	0	87	0
United Kingdom	71	0	64	6	73	3	61	8

1.Results refer to the situation of a person who has just become unemployed and receives unemployment benefits (following any waiting period) based on previous earnings equal to 67% of APW (full-time work). Social assistance top-ups and housing benefits are assumed to be available in either the in-work or out-of-work situation where applicable. 2. METR: marginal effective tax rate, due to the combination of tax to be paid on the wages and withdrawal of previously received benefits. *Source*: Joint EC-OECD project using OECD tax-benefit models.

Table 1 shows that for an unemployed person previously employed at a wage of 67% of average national earnings (here measured as the average earnings of a full-time manual worker in the manufacturing industry – APW), taking up a new job at the same wage as before the unemployment spell would imply facing a marginal effective tax rate of over 70% in almost all countries and for all four household types shown in the Table. This means that taking up a new job would increase net income by just 30% or less of the increase in gross earnings: this is due to the fact that when people take up a job, they have to pay taxes on their salaries, but also lose the benefits to which they were previously entitled and so the increase in their final disposable income when taking up employment can be rather limited. There are notable exceptions to this pattern, and low METRs are found in countries where in-work benefits are in place (e.g. Ireland, the United Kingdom) or in countries with low net incomes during unemployment (e.g. Italy).

Comparing across family types, the Table shows that unemployed people with a non-working spouse and dependent children are faced with the highest METRs in several countries. This is due not only to the withdrawal of unemployment benefits but also to the phasing out of the additional social assistance payments to which this household type may be entitled.

Table 1 also shows percentage point changes in METRs faced by unemployed persons between 2001 and 2004: for most countries the figures are negative, which shows that policy efforts to review tax and benefit systems to enhance financial incentives to work are bearing fruit. In most cases, reductions in METRs have been achieved through mechanisms that allow in-work earnings to be topped up, rather than by reducing out-of-work incomes, notably by allowing beneficiaries to retain part of their benefits upon taking up work. In general, reforms of benefit systems aimed at getting beneficiaries

into work tend to attach conditions with regard to active job search or participation in active labour market programmes, affecting benefit coverage rather than levels. However, in some countries, benefits have been increased by less than nominal wages, resulting in lower replacement rates and lower METRs. In the Slovak Republic, the "stronger incentives to work stem in large part from the relatively low level of social assistance that is now offered, together with the fact that social assistance is reduced less abruptly if the recipient begins to earn labour income" following the welfare reform that came into force on 1 January 2004.[16]

The inactivity trap

METRs faced by inactive individuals considering taking up a job and who are not or no longer entitled to unemployment benefits are generally lower than those affecting unemployment-to-work transitions. This is to be expected given that out-of-work income support benefits on which these people can rely are lower than unemployment benefits. Still, in many cases, the entry into a low-paid job would result in an increase in net income of no more than 30-40% of the increase in gross terms. Greece, Italy and, to a lesser extent, Spain, Hungary and Portugal, are notable exceptions: in these countries, the absence or low level of minimum income schemes[17] explains the very low level of METRs. In Ireland, METRs are also low, due to in-work benefits to raise incentives to work for lone parents, whereas the combination of low out-of-work benefits and income supplements for workers explains the low inactivity METRs in the Slovak Republic.

Across family types, METRs are generally higher for members of workless households with a dependent spouse and children (i.e. the one-earner couple with two children). METRs are close to or higher than 90% in 10 out of the 19 countries for which data are available: in these cases there is no or little pay-off from taking up employment. This is mainly due to the withdrawal of social assistance benefits, in some cases in combination with the withdrawal of housing benefits. On the other hand, employment, even if low-paid (or, more realistically, a part-time job that pays the hourly APW), appears to bring significant income gains to spouses whose partner is already working, by at least 40% of the additional gross income.

The case of the two-earner couple with children can be seen to illustrate the case of potential second earners, normally women, who have to choose between staying at home and looking after their children or working and using child care services. While the availability of quality child care services is essential to ensuring the participation of parents, especially mothers, in the labour market, child care costs can be a major expenditure item for working parents. Low-wage second earners in about half the countries for which estimates are available see more than 70% of their additional earnings consumed by child care fees, taxes and reduced benefits. For lone parents, the payoff from employment can be even lower. The best example is Ireland, where a METR of 54% for lone parents (with two children, but with no childcare costs) shoots up to 131% when childcare costs are included.

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16 Brook, A. and Leibfritz, W., (2005) *Slovakia's introduction of a flat tax as part of wider economic reforms*, Economics Department Working Papers No 448, OECD, Paris, p. 17.

17 In Greece, there is no universal guaranteed minimum income benefit, but a number of categorical social assistance benefits. In Italy, the experimental income support scheme adopted by some 300 municipalities out of 8000 for the whole country was terminated in 2004. In 2004, the Government had expected to introduce a new scheme – the Last Resort Income - fully administered at regional level and co-funded by the State and the regions. This scheme, however, has not been applied (for more details, see http://europa.eu.int/comm/employment_social/social_inclusion/docs/2005/it_it.htm).

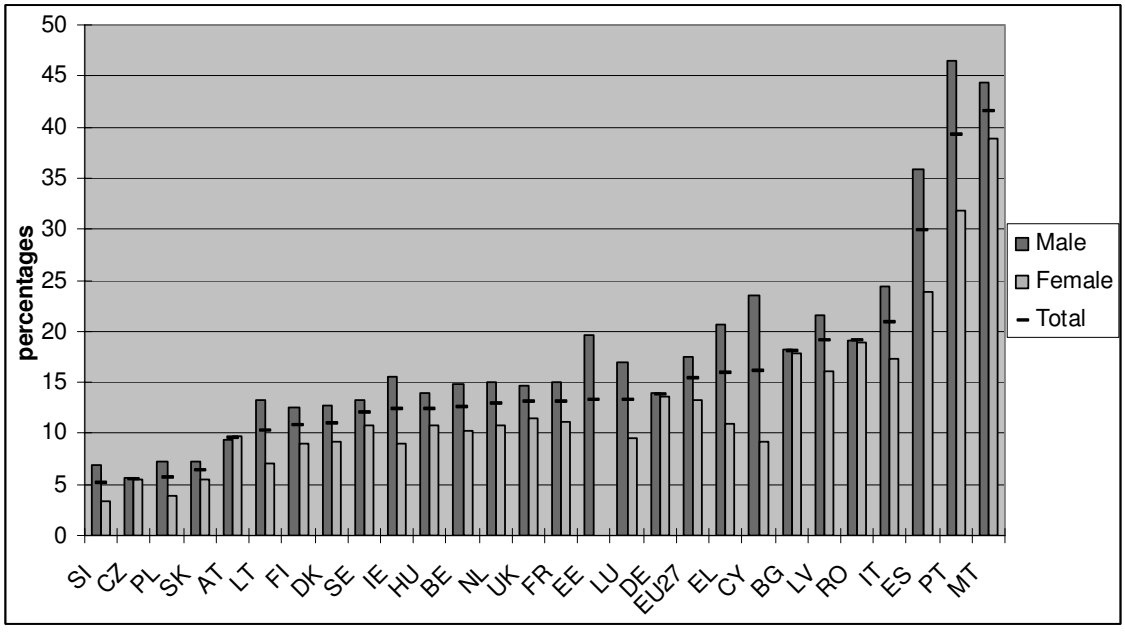
2.2.4. Educational barriers to social inclusion: early school leaving

The lack of basic competencies and qualifications is a major barrier to inclusion in society. This is even more the case in an increasingly knowledge-based society and economy and a skilled workforce is a key factor in supporting the Lisbon agenda for jobs and growth. This is why improving the adaptability of workers and increasing investment in education and skills are also key priorities of the European Employment Strategy. Those without adequate skills will find it more difficult to enter the labour market and find a quality job, are more likely to spend long periods out of work and if they do work they are more likely to be in low-paid jobs. Better educated people are also more likely to benefit from training opportunities over the course of their life and this is why a solid skill base is necessary for young cohorts.

However, in the EU almost 15% of young people aged 18-24 have at most lower secondary education and are not in further education or training (this group will be referred to as 'early school leavers'). This means that significant additional efforts are needed in order to reach the European benchmark set by Education Ministers of no more than 10% early school leavers by 2010.

This percentage reaches almost 30% in Spain, 39% in Portugal and almost 42% in Malta. On the other hand, countries with the lowest proportion of early school leavers include Poland, the Czech Republic and Slovenia, where the figures are below 6%. In all Member States, the percentage of early school leavers is higher for young men, except in Romania, Bulgaria, Germany, and the Czech Republic where they are broadly similar[18].

Figure 15: Early school leavers (% of the total population aged 18-24 who have at most lower secondary education and are not in further education or training) – 2006.



Source: Eurostat, Labour Force Survey – quarter 2 results.

[18] See the 2006 *Education and training progress report* for a detailed analysis of the phenomenon of early school leavers, at http://ec.europa.eu/education/policies/2010/doc/progressreport06.pdf

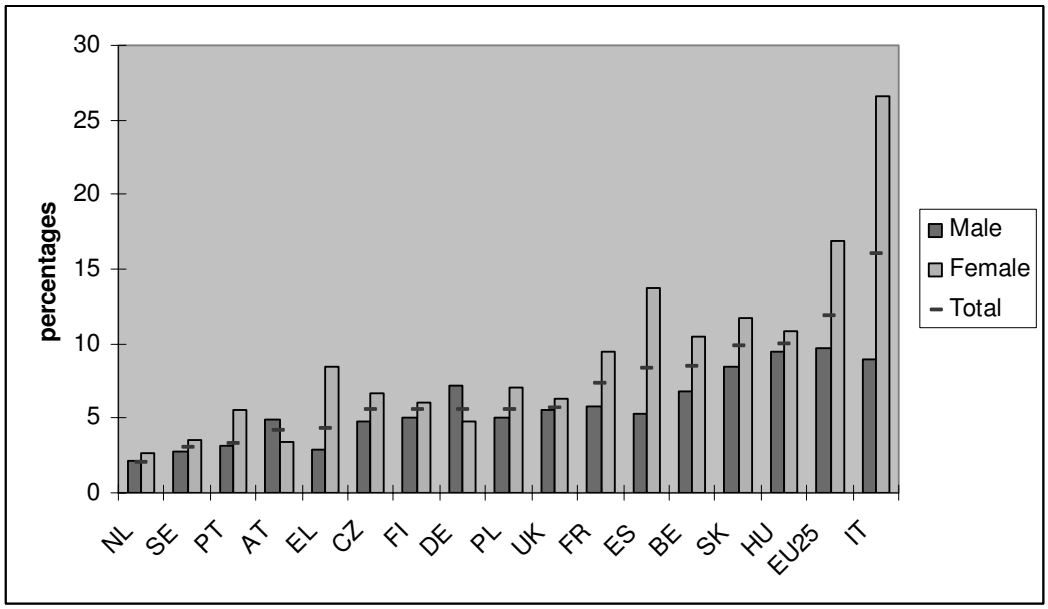
2.2.5. Regional cohesion

All the indicators that have been examined so far are calculated at national level. Yet territorial differences matter not only between but within countries. A clear understanding of the nature and situation of poverty and social exclusion at sub-national level is important for the design and implementation of effective policies to combat them. However, considerations of statistical reliability hinder the breakdown by region of most of the commonly agreed EU indicators.

A proxy measure of social cohesion across regions is represented by the dispersion (coefficient of variation) of employment rates at NUTS2 level. **Regional cohesion** is lowest in Italy, with a coefficient of variation which is seven times greater than the best performing country. Although regional cohesion tends to be greater in smaller countries, such as the Netherlands, Austria and Portugal, as might be expected, the correlation between regional cohesion and country size is not a perfect one; some of the bigger Member States, such as the UK and Germany, perform relatively better than some smaller countries. Within the regional spread, differences between men and women are particularly marked in southern countries, including Greece, Spain and Italy, where it is 17 percentage points.

Since 1999, regional cohesion has increased slightly in the EU as a whole, with consistent and more substantial progress in Spain, and to a lesser extent in the UK, Sweden, Italy and Finland. On the other hand, dispersion of regional employment rates increased in Austria and Slovakia.

Figure 16: Dispersion of regional employment rates – 2005.

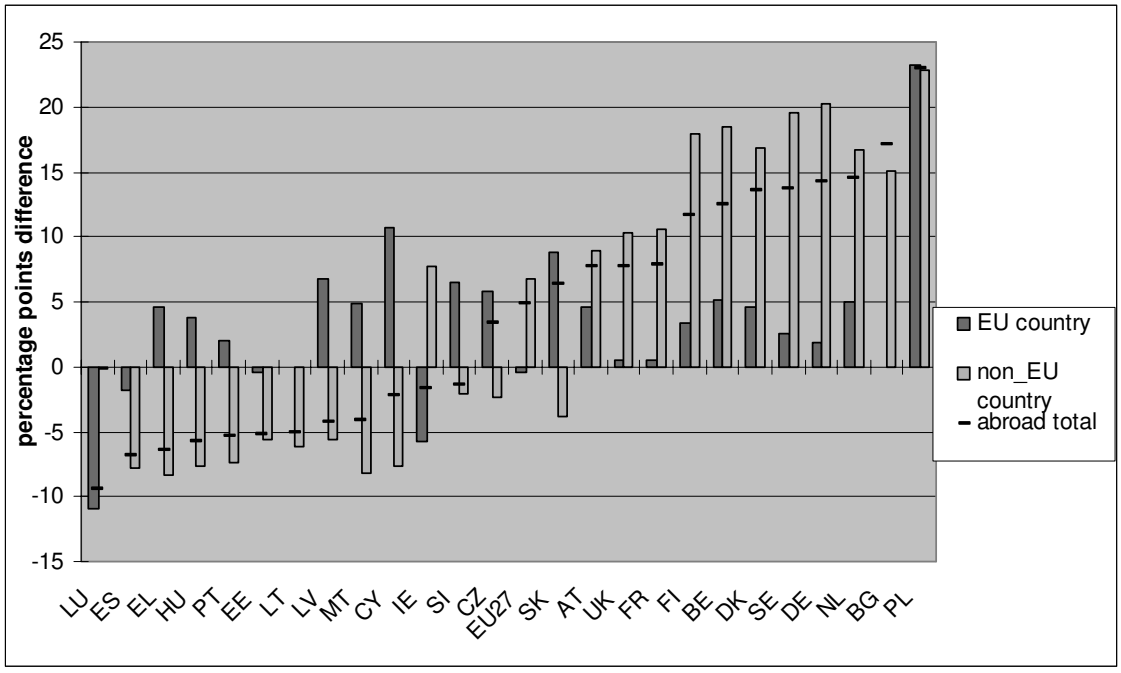


Notes: the dispersion of regional employment rates is measured by the Coefficient of variation of employment rates (of the age group 15-64) across regions (NUTS 2 level) within countries. Data for DK, IE, EE, CY, LV, LT, LU, MT and SL not applicable. EU average includes all countries.
Source: Eurostat - Labour Force Survey, Annual averages.

2.2.6. *The labour market situation of immigrants*

Concerning the employment situation of foreign born residents, the employment gap is positive in almost all old Member States, except Luxembourg, Greece, Spain, Portugal and Ireland, and in Slovakia, Bulgaria and Poland. If the foreign born population is divided as to whether they were born in another EU country or outside the EU, in the former case the employment gap with those born in the country is almost zero for the EU as a whole, but it reaches almost 7 percentage points in the latter. The employment gap depends on a number of factors, including the composition and size[19] of the migrant population in terms of age structure, skill level and household composition. Member States also differ in relation to developments in migration flows over time and in legal requirements for entry into the country – in particular whether a job is a pre-condition.

Figure 17: Employment gap of foreign born residents, in percentage points (Employment rate of born in country – employment rate of born abroad in the EU or outside the EU), 2005.



Notes: In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country". Country of birth is not available for BG, DE and RO. Nationality is used instead. Data for BG and MT should be interpreted with caution due to small sample size. Data for IT and RO not available or not reliable due to small sample size.
Source: Eurostat, LFS annual averages.

2.2.7. *The labour market situation of older people*

The Stockholm European Council has set a target of 50% by 2010 for employment rates of people aged 55-64 and, despite recent improvements, the EU has a significant way to go to reach this goal, as currently the employment rate is around 42.5% in 2005. A second target related to older workers was set by the Barcelona European Council in spring 2002. It focuses on the average labour market withdrawal age which is to rise by five years by 2010. The

[19] In particular, the percentage of working-age foreign born population is less than 1% in BG, CZ, PL and SK and 10 percentage points or more in the Baltic States, BE, DE, IE, ES, FR, CY, LU, NL, AT, SE and the UK.

average labour market exit age is currently (2005) estimated at 60.9 years[20]. In the long run, the adequacy and sustainability of pension systems will probably require an improvement in labour market participation of older workers even beyond these targets.

As highlighted in the 2006 synthesis report on adequate and sustainable pensions, Member States have generally increased the accrual of pension rights if people work longer and this should act as an incentive to work longer (see box 2), thus contributing to compensating for the projected decrease of replacement rates. Furthermore, some Member States have changed the eligibility rules for retirement.

BOX 3 – Strengthened incentives to work longer

In most Member States, recent reforms have increased incentives to work longer, notably by strengthening the link between contributions and benefits. Working longer is generally encouraged by providing pension supplements, while leaving earlier is discouraged by actuarial reductions, but also by the introduction of more restrictive eligibility rules to early retirement schemes and also possibly by a review of access to disability and incapacity schemes.

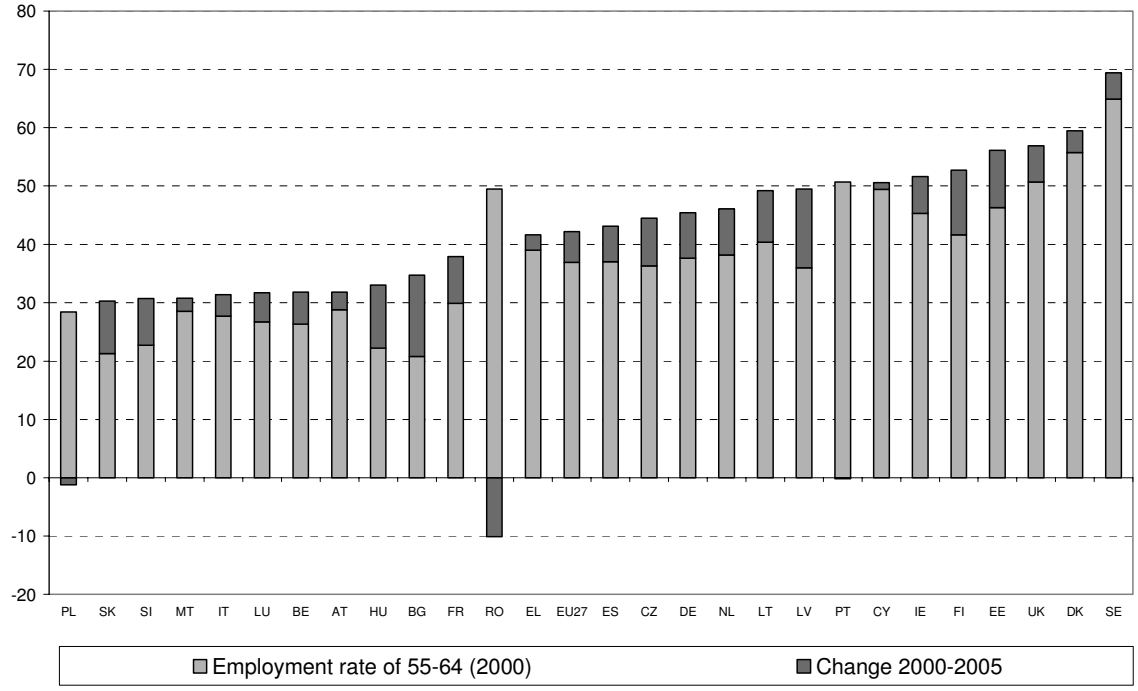
In defined-benefit schemes, the link can be strengthened by requiring a longer contribution period for a full pension, while applying actuarial reductions for early pensions and increases in pension rights for deferred retirement. This is the case for most Member States, such as recently BE, AT, FR, and FI, while the link was already strengthened under earlier reforms in a number of Member States. Nevertheless, in a number of Member States, the question remains whether the strength of incentives is now appropriate.

Some Member States have introduced major reform packages that have substantially amended their statutory schemes (DE, DK, FR, AT, FI, IT). Notional defined contribution schemes (such as in SE and PL) also build on a strong link between contributions and benefits, which by their nature ensure better rewards for longer working. Furthermore, since the end of the 1990s, the Swedish introduced the premium pension, and a number of Member States have also introduced statutory funded pension schemes (for example PL, HU, EE, and LV), while Lithuania did so in 2004 and Slovakia in 2005.

Employment rates of older workers have increased in recent years, reversing a long decline. The employment rate of older workers increased from 36% in 1995 to 44% in 2005 for the EU-15, while that for the EU-25 increased from 36.6% in 2000 to 43% in 2005. These figures mask significant disparities between Member States (see figure 18 below). It should also be noted that this increase is partly due to a demographic effect (the composition of the age bracket 55-64 currently changes towards more people aged 55-59, who have a higher employment rate), as well as the trend towards an increase in women's employment and of an increase in part-time work.

[20] The estimation is based on labour market exit probabilities between age 50 and 70. Note that the methodology can result in spurious variations from one year to the next which can make it more difficult to monitor progress over time.

Figure 18 – Employment rates of older workers in 2005 and evolution since 2000



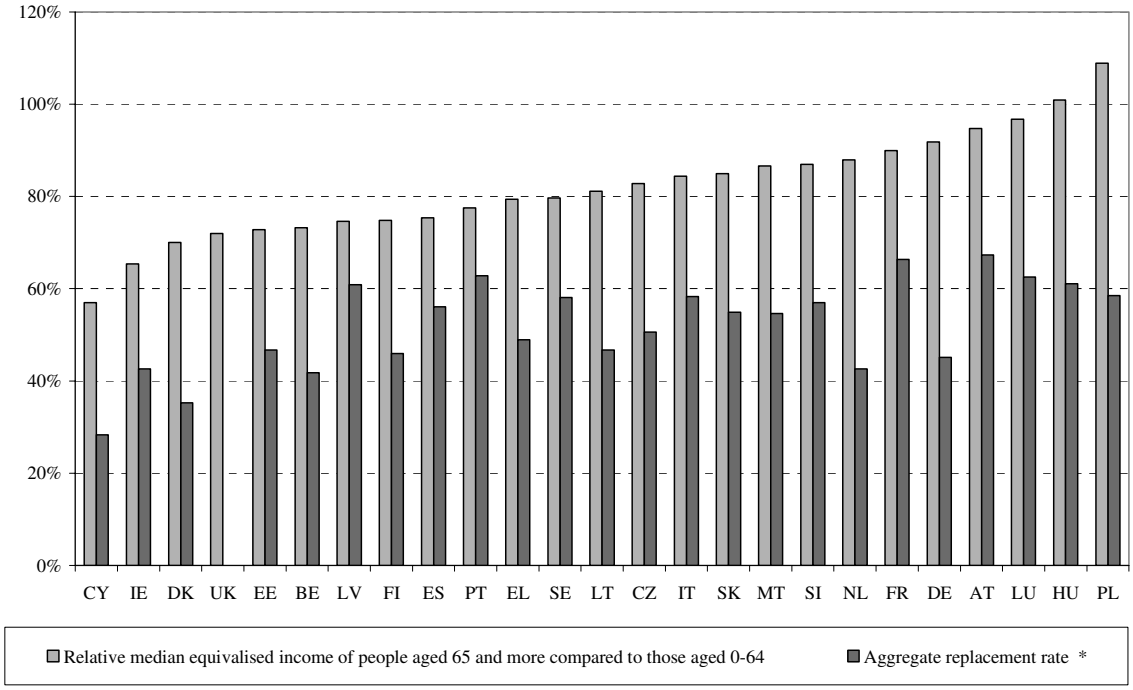
Source: Labour Force Survey, annual averages.

In spite of these recent improvements, in a number of Member States, the employment rate of older workers lies below or around 30% (Belgium, Italy, Luxemburg, Malta, Austria, Poland, Slovenia and Slovakia), or between 30% and 45% (Bulgaria, Hungary, the Czech Republic, Greece, Spain, France and Romania), while it lies between 45% and 55% in some others (Germany, Latvia, Lithuania, the Netherlands, Ireland, Cyprus, Portugal and Finland), and exceeds 55% in only a few (Estonia, Denmark, Sweden and the United Kingdom). It is worth noting that progress is slower in Member States where the employment rates of older people are already lower, which indicates a need for enhanced efforts.

2.2.8. The role of pension systems in maintaining living standards

Pension systems not only aim to ensure that older people do not have to live in poverty (see section 2.1), but more generally facilitate the maintenance to a reasonable degree of the living standard achieved during their working lives. Public pensions are essential in this respect and they will generally continue to be the main source of pensions for retired people in the future. Older people report living standards that are relatively close to that of the general population, mostly ranging between 75% and 90% of that of the 0-64 population (see figure 19). In some Member States, the level is significantly below 75% (Ireland and Cyprus), reflecting relatively low pension entitlements as well as fast economic growth which mainly benefits people of active age, while in a number of Member States, the relative income of older people is close to 75% (Belgium, Denmark, Estonia, Spain, Portugal, Finland, Sweden and United Kingdom). By contrast, a number of Member States report levels higher than 90% (France, Germany, Luxembourg, Austria, Hungary and Poland).

Figure 19 – Indicators on current adequacy of pensions



Note: Relative income of 65+: relative median equivalised disposable income of people aged 65 and more compared to those aged 0-64. Aggregate replacement rate: median individual pension income of retirees aged 65-74 in relation to median earnings of employed persons aged 50-59 excluding social benefits other than pensions, based on gross income, except for some Member States (EL, ES, IT, LV, PT), for which it was calculated with net income as only net income were available for the first wave of EU-SILC. This indicator is thus not (yet) completely comparable across countries. It should also be noted that these calculations are by nature different from those of theoretical replacement rates (which are presented in part II of the Supporting document in section on pensions) and that for a great majority of Member States, the respective levels are different (see for instance ISG report on replacement rates 2006).
Source: Eurostat, data (income year 2004).

Pension entitlements generally provide around 70 % of this retirement income (in particular statutory pension schemes and widely developed private ones, such as those based on binding collective agreements). Pension schemes currently manage on the whole to ensure adequate income in most Member States (see figure 19). However, in certain cases, current average pension levels turn out to be low compared to current earnings, reflecting low coverage or low income replacement from statutory schemes as well as maturing pension systems, incomplete careers and / or under-declaration of earnings.

Future adequacy and sustainability of pensions

As highlighted by the recent AWG **expenditure projections**, not all Member States are in the same situation as regards forecast pension expenditure and thus sustainability of public pensions. These projections have also shown that some of the pension reforms already put in place are likely to contain/slowdown the projected increase in the level of expenditure.

Between 2004 and 2050, public spending on all age-related provision (pensions, health care and long-term care, education and unemployment benefits) is projected to rise in most Member States, on the basis of current policies, although the degree varies greatly between countries (some Member States have introduced reforms since 2004 that will also affect future spending). The budgetary impact of ageing in most Member States starts becoming apparent as of 2010. However, the largest increases in spending are projected to take place between

2020 and 2040. For the euro area and the EU-15 as a whole, public spending is projected to increase by about 4 percentage points between 2004 and 2050 (including the funded tier of statutory pensions and occupational pension, the increase is about 4.5 percentage points). For the EU-10, the increase in overall age-related spending is projected to rise by about 2.9 percentage points (when including the funded tier of statutory pensions and occupational pension).

For EU-15 Member States, **public pension spending** is projected to increase in all countries, except Austria, on account of its reforms since 2000. Very small increases in spending on pensions are projected in Italy and Sweden due to their notional contribution-defined schemes where pension benefits are based on effective working-life contributions. Relatively moderate increases (between 1.5 and 3.5 percentage points of GDP) are projected in most other EU countries, with the largest increases projected for Ireland (6.4 p.p.), Spain (7.1 p.p.), Luxembourg (7.4 p.p.) and Portugal (9.7 p.p.).

Reforms introduced in several EU-15 countries, since the last age-related expenditure projection exercise of 2001, appear to have curtailed the projected increase in public spending on pensions significantly in half of all EU15 Member States. Also the projections assume an increase in the general employment rate of about 8 p.p. and of nearly 20 p.p. in the employment rate of older workers. The inclusion of the EU-10 Member States increases the variation in the results. Between 2004 and 2050, public pension expenditure is projected to remain nearly stable (increasing by 0.3 p.p. of GDP), while including the funded tier of statutory pensions, there is a projected increase (of 1.7 p.p.). However, the overall trends (including the funded tier of statutory pensions) differ greatly between countries, ranging from a decrease of 4.6 p.p. of GDP in Poland and to an increase of 8.3 p.p. in Slovenia, 9.9 p.p. in Hungary and 12.9 p.p. in Cyprus. The challenges faced by Cyprus, Slovenia, Hungary and the Czech Republic are among the biggest in the EU.

As reflected above, pension schemes generally manage to ensure adequate retirement income in most Member States at present, in particular statutory schemes and those private schemes that are spread widely in terms of coverage. **Future adequacy** and, in particular, future levels of pensions in relation to earnings (income replacement levels) will depend notably on the pace of accrual of pension entitlements (which is linked to developments in the labour market), the maturation of pension schemes, the indexation of benefits and the effect of reforms introduced.

The effects of reforms are partly reflected in the evolution of the benefit ratio (average pension in relation to the average wage) projected by the AWG . However, it is not clear how or to what extent this will affect future adequacy. Another useful indicator for future adequacy is theoretical replacement rates, notably as they allow us to see how changes in pension rules can affect pension entitlements and to disentangle the various contributions to future changes. They are calculated for a hypothetical worker (in the base case, retiring at 65 after 40 years of a career average wage) and take into account enacted reforms of pension systems. As underlined in the 2006 Indicators Sub-Group report on replacement rates, it is essential to consider theoretical replacement rates with the associated information on representativeness and assumptions used and to consider the links between theoretical replacement rates and other indicators, and in particular the evolution of pension expenditure.

Reforms of statutory schemes will for most Member States lead to a decrease of replacement rates at given retirement ages (at 65 in the case considered). This also reflects the need to adapt pension systems to the trend towards an increase in life expectancy at 60 or 65, for all types of pension provision (be they financed on a pay-as-you-go mechanism or through

funded defined-contribution or defined-benefit schemes). Indeed, against a backdrop of rising longevity, unchanged levels of replacement rates at a given age inevitably mean greater pressure on pension expenditures for all types of pension provision.

Trends in theoretical replacement rates for the base case suggest that, for most Member States, overall replacement rates are set to decline over the coming decades.[21] Net theoretical replacement rates are projected to decline in 12 Member States.[22] Given that second pillar pensions generally do not provide full coverage of the population, it is significant that the decline in gross replacement rates of first pillar statutory schemes is even more marked: gross theoretical replacement rates for first pillar are projected to decline in 14 Member States (the situation does not change significantly in 8 other Member States).[23]

BOX 4: Promoting adequate and sustainable pensions

The 2006 Synthesis Report on Pensions and the 2003 Joint Report on Pensions underlined the interdependency between the financial sustainability and adequacy of pensions in ageing societies and the need for comprehensive reforms to secure adequate, accessible and financially sustainable pension systems. To monitor these developments the SPC and ISG agreed to use theoretical replacements rate trends as a context indicator for the overarching list of indicators, by also taking into account the projections for the sustainability of pension systems developed in the AWG, which are indeed mutually dependent.

Replacement rates show the level of pensions as a percentage of previous individual earnings at the moment of take-up of pensions. Public pension schemes and (where appropriate) private pension arrangements are included, as are the impact of taxes, social contributions, and non-pension benefits that are generally available to pensioners. Current replacement ratios describe the situation of people who retire today while prospective replacement ratios describe the projected pension income of people retiring in the future. They should allow the adequacy of pensions to be assessed, taking into account changes that have been decided in many countries as a result of recent reforms.

The base case describes the situation for a typical case including different types of schemes chosen depending on the national framework, while in practice situations are by nature diverse. The evolution of the overall (net) replacement rate indeed reflects different contributions, that of statutory schemes (pay-as-you-go and possibly including a funded tier) and, in some Member States, that of private pension schemes. In those Member States, the latter contribution will benefit only those who are actually covered by such schemes, so a significant share of pensioners will depend solely on the contribution provided by statutory schemes (for more information see the 2006 Report on replacement rates[24]).

The tendency towards a decline in prospective replacement rates at a given age is a result of various adjustments. In earnings-related pensions, the contribution period taken into account in calculating pensions, and the pace of revaluation of past wages (no revaluation, revaluation against prices, against wages, or a mix), the pace of indexation of current pensions, and the statutory retirement age are generally the target of adjustments during reforms. Pension levels can also be lowered by adjusting the formula used to calculate benefits, notably by introducing mechanisms to take into account future demographic trends.

Two major policies have been developed by Member States to cater for this projected decline in

21 See 2006 ISG Report on replacement rates.

22 As measured with the evolution in percentage points. The situation does not change significantly in 8 other Member States (a change of +/- 3 percentage points) and an increase in projected for 5 Member States (only one where this exceeds 5 percentage points).

23 The situation does not change significantly in 8 other Member States (a change of +/- 3 percentage points) and an increase in projected for only 3 Member States.

24 http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf

replacement rates at a given age: on the one hand strengthening incentives to work longer and, on the other, the development of private pensions. A number of Member States (such as Belgium and Denmark) have embarked on a strategy of reducing public debt, which can provide leeway for adequate and sustainable pensions in the light of the ageing society.

Longer working lives - and in some Member States higher retirement savings - are a key means to compensate for this projected development in theoretical replacement rates at a given age. Moreover, in a number of Member States, the development of privately managed pension provision is projected to account for a rising proportion of future replacement rates, whether through the funded tier of the statutory scheme (PL, EE, LV, LT, HU, SK, and SE), occupational pensions (such as BE and DK) or other private pensions (DE and, IT) that complement public pensions, while in some Member States (IE, NL and UK), this would remain roughly constant assuming that contribution rates are sustained. In these countries achieving good coverage rates and adequate contribution levels in order to reach expected benefit levels are particularly important goals for policy-makers.

2.2.9. The health dimension

It was previously mentioned that an ageing population could pose a financial burden on health and long-term care systems. In this context, it is important to know how long people can expect to live in good health or without disability, i.e. whether ageing is accompanied by extended ill-health/disability or, rather, by its compression i.e. people are living longer but are spending less time in ill-health/ disability. The two alternatives have different implications in terms of future care costs.[25] We therefore need to look at healthy life years (also called healthy life expectancy or disability-free life expectancy): [26] the number of remaining years that a person of a certain age is still likely to live without disability. The measure distinguishes between years of life free of any limitation of activity and years experienced with at least one limitation. The emphasis is not exclusively on the length of life, as is the case for life expectancy, but also on the quality of life. The indicator was developed to reflect the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty, and disability tend to become more prevalent at older ages, so that a population with a higher life expectancy may not be healthier. However, if healthy life years increase more rapidly than life expectancy then, not only are people living longer, they are also living a greater portion of their lives free of disability. Analysing this indicator together with life expectancy can help countries understand whether more effort is needed to promote health and prevent ill-health.

The figures[27] suggest that for the EU-15 the general increase in life expectancy has also meant a general increase in healthy life years. For the EU15 the number of healthy life years for males and females has increased respectively from 63.2 in 1999 to 64.5 years in 2003 and from 63.9 in 1999 to 66 years in 2003. Healthy life years at birth in the EU-15 are, on average, 12 years shorter than overall life expectancy for men and 17 years shorter for women. Healthy life expectancy is higher for women than for men in all countries with the exception of Denmark, the Netherlands, Finland the United Kingdom. While men have seen an increase in their healthy life years in all countries, some countries (Greece, Ireland, The

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25 See ECFIN and EPC-AWG projections.

26 Please refer to the following page for more detailed information on the computation of healthy life years: http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm. The "healthy life years" indicator is the health indicator in the set of the EU Structural Indicators and it is the first-level indicator for the "Public Health" theme in the EU Sustainable Development Indicators. The indicator is based on a sound methodology developed since the 1970s (Sullivan method, mixing both information on morbidity/disability - limitations in activity due to health problem in the case of HLY - and on mortality, being in practice a calculation of life expectancy weighted by morbidity/disability prevalence). The source for the morbidity/disability information is mainly health interviews surveys.

27 Note that ESTAT data goes back a decade to 1995 and refers to the EU-15 except Luxembourg. Ireland started reporting in 1999.

Netherlands, Finland and the United Kingdom) show a small reduction or only a very small improvement in female healthy life expectancy over the decade. In 2003, for all Member States with available data, men in the EU-15 can expect to live 84.9% of their life without disability. Women can expect to live 81.3% of their lives free of disability. Hence, though women live longer and more (absolute number of) years free of disability they also spend a higher proportion of their lives in disability (potentially at an older age). Looking at healthy life years at 65, a trend cannot be identified and the following remarks must be treated with caution. Overall, healthy life expectancy at 65 is greater for women than it is for men except in Germany and Portugal. The increase in healthy life expectancy at 65 is clearer for men than for women in all countries (from 9.4 in 2001 to 9.5 in 2003) except in Denmark, Greece and Sweden where a small reduction is noted. The healthy life expectancy of women at 65 shows no overall increase though Spain, France, Italy and Austria show an increase.

Population ageing has led to the belief that older people are an economic burden to society. This is not necessarily the case if an increase in life expectancy goes along with an increase in the number of years in good health. Older but healthy people can be an important resource to their families, communities and economies through formal employment and informal activities such as care for dependent relatives, friends and children and volunteer work. Moreover, as a 2005 European Commission report, *The contribution of health to the economy in the European Union*, highlights, together with the report by the Commission on Macroeconomics and Health (2001) and a vast academic literature in the area, a healthy population at all ages is positively associated with better cognitive functions and thus better education attainment in early years, better earnings and wages, higher labour market participation and a higher amount of hours worked in adult age, whilst ill-health is associated with early retirement. Health is also shown to be positively associated with economic growth (GDP) and social welfare.

Consequently, ensuring that people make positive/active contributions to society and enjoy a high quality of life throughout their life and well into their late years requires a high level of health that can be attained through a concerted set of policies such as adequate health care and health promotion and ill-health prevention, education and social protection and general supportive social and environmental conditions.

BOX 5: Health care spending, health status and health inequalities

The health status of the EU population has improved considerably in recent decades. Life expectancy at birth increased by more than 30 years in the 20th century and infant mortality fell remarkably and is among the lowest in the world (Social Situation Report 2003; WHO European Health Report 2005). Healthy years of life have also increased and avoidable mortality has declined. Two broad developments are typically associated with a secular increase in life expectancy: improvements in overall living conditions and medical advances and more widely available medical care (i.e. a rising share of resources devoted to health and a more equitable distribution).

Measuring the effect of health care on health has received considerable attention in the past.[28] McKeown (1979), in a first influential study, suggests that better nutrition, hygiene and the use of immunisation and therapeutic interventions (emphasising the importance of preventive and primary care) explain the decline in death rates. A study in the Netherlands estimated that the contribution of health care to the mortality decline between 1850 and 1970 ranged from 4.7% to 18 %.[29] A pool of

[28] McGuire et al. 1994; Donaldson and Gerard, 1994; European Commission, 2005

[29] Mackenbach, J. P., Looman, C. W. N., Kunst, A. E., Habbema, J. D. F. and van der Maas, P. J. (1988). Post-1950 mortality trends and medical care: gains in life expectancy due to declines in mortality from conditions amenable to medical intervention in The Netherlands. Soc Sci Med 27: 889-9.

studies[30] shows that health care expenditure is associated with growth in life expectancy and disability-adjusted life expectancy and a decline in infant, child and maternal mortality. Other studies[31] confirm that healthcare interventions (i.e. treatment and preventive activities) have had a substantial effect on the decline in 'avoidable' mortality especially over the past 30 years. Moreover, the quality of a country's primary care system is negatively associated with all-cause mortality and premature mortality and cause-specific premature mortality in 18 wealthy OECD countries over three decades (WHO Health Evidence Network, 2006; Macinko et al. 2003). In Europe the SHARE study (2005) demonstrates that a 1% increase in health care expenditure is associated with a 4.2% increase in the proportion of very healthy respondents in SHARE countries. Nixon and Ulmann (2006) find that increases in health care expenditure are strongly associated with declines in infant mortality and increases in life expectancy in the EU, as in the studies they review.

Despite economic growth and increases in health care expenditure and population coverage, ***substantial inequalities*** in life expectancy, healthy life expectancy, mortality, avoidable mortality and specific mortality causes, self-perceived health and disability, and mental health ***continue to exist across population groups*** in all European countries and may have widened during the last decades of the 20th century.[32] People with less education, lower occupational class and lower income tend to die younger and have a higher prevalence of disease[33]. Differences in access to care and care utilisation (e.g. Van Doorslaer and Masseria, 2004) may explain part of the observed inequalities. Higher socio-economic groups may have taken up more effective health care interventions and may have higher survival rates because of better access, quality and compliance to treatments. Indeed, as highlighted in the 2007 Joint Report on Social Protection and Social Inclusion there are important barriers to access such as service availability and distribution, waiting times, financial costs of care, information.

Inequalities are also strongly associated to health-related behaviour (smoking and alcohol intake, nutrition, physical exercise), the environment (safe water, air and food, working conditions, adequate housing), economic and social conditions (income, education), gender and cultural values. Recent research also stresses the link between promoting active participation in employment and society (e.g. volunteer work) and health (e.g. SHARE, 2005; WHO European Health Report 2002). Hence, improving health status and reducing health inequalities requires a multi-sector approach, including equal access to timely and effective health care interventions (treatment and preventive care), pensions schemes that ensure an adequate income, policies that reduce social inequalities, poverty and social exclusion, a generally supportive social environment providing education opportunities and opportunities to participate in paid and unpaid volunteer work throughout life and adequate health promotion.

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30 See for example WHO World Health Report 2000; Evans et al. 2000, 2001; Hollingsworth and Wildman, 2002 and Gravelle et al., 2003; Gupta et al., 2002; Aakvik, 2004; World Bank, 2006.

31 See for example the Health Status and Living Conditions Report, Social Situation Observatory, 2005; European Commission 2005; Nolte and McKee, 2004; Levi et al., 2001; Nolte et al, 2000; Mackenbach et al., 1998; Velkova et al., 1997.

32 See "Health Inequalities: Europe in Profile", Mackenbach 2005 - UK Presidency; "Health Status and Living Conditions Report", Social Situation Observatory, 2005; WHO European Health Report 2005 for a good overview of the EU countries.

33 See SHARE, 2005; Wilkinson and Marmot, 2005; Newey et al., 2003; Mackenbach and Bakker, 2002; Evans et al., 2001.

2.3. The Lisbon Strategy and its Impact on Social Cohesion

The second overarching objective of the OMC for social protection and social inclusion is to promote effective, mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social cohesion, and the EU's Sustainable Development Strategy. While it is certainly too early to draw any firm conclusions about the effectiveness of this interaction in the Member States since the adoption of the revised objectives, the following chapter looks at the impact of employment growth on social inclusion and health and how far it benefits all households. Then it examines the impact of increased working lives on the adequacy and sustainability of pension systems. This is of course only a partial analysis of the interactions between the different objectives.

2.3.1 Employment and its impact on the poverty risk

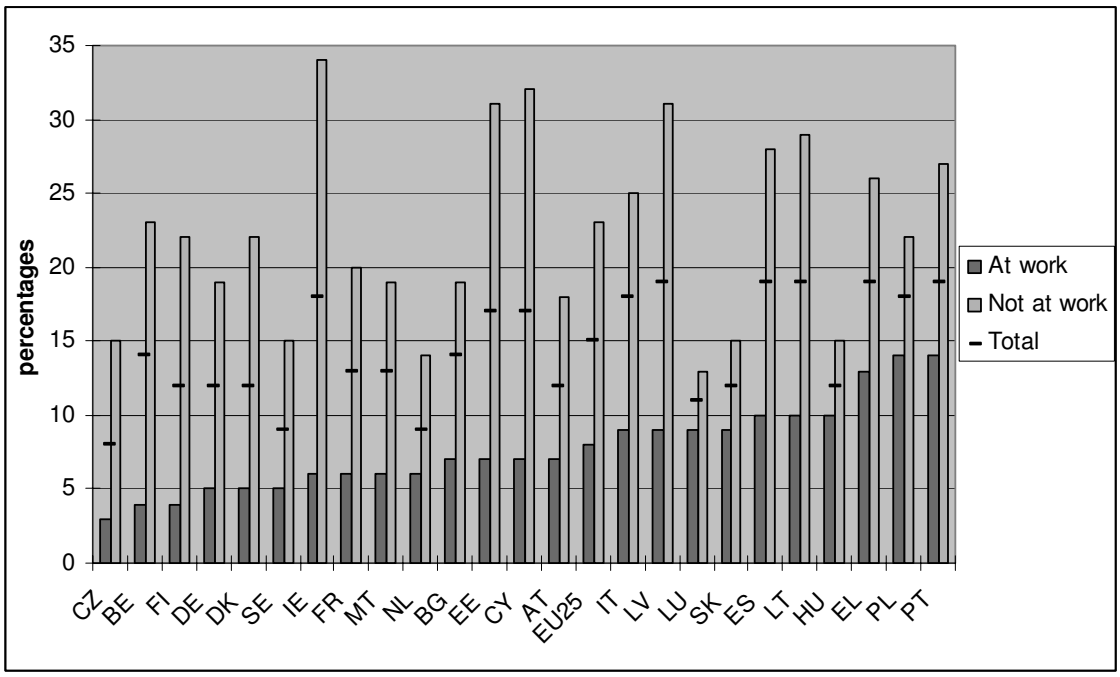
A job is the best safeguard against poverty and social exclusion…

Employment policies have a key role to play in promoting adequate living standards and greater social cohesion. In the EU as a whole, the risk of poverty is nearly 2.5 times greater for those who are not in work than for those who are.

…but a job does not guarantee a life free from poverty

However, the at-risk-of-poverty rate is still relatively high even for those in work. In the EU25 it stands at 8%, ranging from 3% in the Czech Republic and 4% in Belgium and Finland to 13% in Greece and 14% in Poland and Portugal. Furthermore, the proportion of those working within the income-poor population aged 16 or more is a significant 28%. Therefore, in order to achieve the objective stated by the Barcelona European Council of significantly reducing the number of people at risk of poverty and social exclusion by 2010, the problem of **in-work poverty** has to be addressed.

Figure 20:
At-risk-of-poverty rate by labour force status – individuals aged 18 and over - 2004.



Notes: provisional data for HU. Data for RO, SI and UK not available.
Source: Eurostat, EU-SILC (survey year 2005, income year 2004). National data source for BG (survey and income year 2004

In-work poverty is linked to low pay, low skills, precarious and often part-time employment.[34] Quality employment is essential to lift individuals out of poverty and "in order to promote [it] it is necessary to develop employability, in particular through policies to promote the acquisition of skills and life-long learning".[35] It is also necessary to put in place sound macroeconomic policies to facilitate employment creation and a stable economic climate conducive to higher investment in human capital on the part of employers.

The poverty risk increases when joblessness is combined with the presence of dependent children

But poverty risks are associated not only with the employment situation of individuals but also with the household type in which they live and with the economic status of those with whom they share the household. The incidence of poverty risk is broadly similar for households with or without children when all working age members of the household are in full-time work. However, the combination of care responsibilities *and* exclusion from the labour market for all household members[36] produces the highest risk of poverty, where as many as 64% of those living in jobless households[37] with dependent children are at risk of poverty in the EU-25. This percentage rises to just over 70% in Belgium and France, to 78%

[34] See Bardone L. and A. Guio, 2005,"In-work poverty", *Statistics in Focus 2/2005*, Eurostat.

[35] Quotes in this paragraph and in the following one are taken from Council of the European Union, 2002, "Fight against poverty and social exclusion: common objectives for the second round of National Action Plans", SOC 508.

[36] Of course, not only the presence of children is important but also the household size.

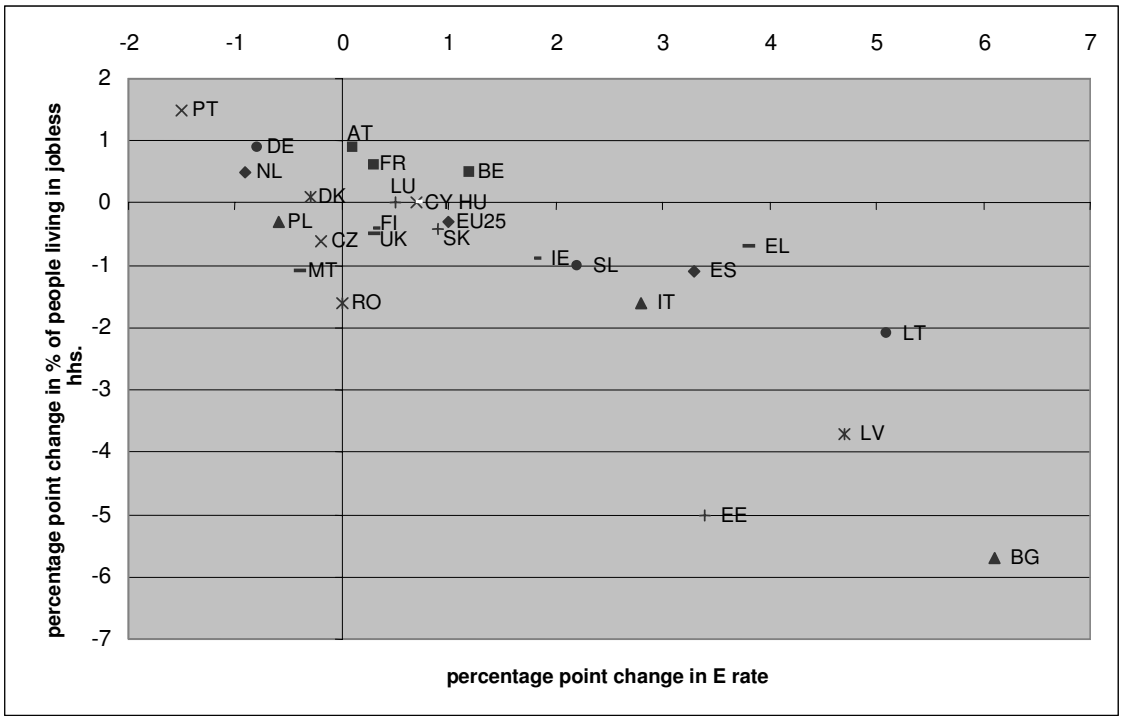
[37] Jobless households are defined here as households with a "work intensity" equal to zero, with work intensity defined as the number of months all working age household members have worked during the income reference year as a proportion of the total number of months they could have worked, with categories ranging from 0 (jobless household) to 1 (full work intensity).

in Belgium and the Czech Republic and 81% in Estonia and over 80% in the Baltic States. Low levels of labour market attachment can also be insufficient to safeguard individuals from poverty, especially in the case of households with dependent children. Households with a work intensity of less than 0.5 *and* dependent children have a particularly high incidence of poverty risk in Luxembourg (54%), Estonia (56%) and Lithuania (64%).

2.3.2. Employment growth and jobless households

Apart from the issue of in-work poverty, it is important to consider whether employment growth benefits all households, in particular those with the least attachment to the labour market. For example, is employment growth matched by a decrease in the proportion of jobless households, or is it concentrated on those households that already have a strong labour market attachment? In general, between 2001 and 2005, the proportion of jobless households remained roughly stable. Only the Baltic States, Bulgaria and to a lesser extent Italy and Spain, experienced a relatively sharp increase in the employment rate coupled with the largest decrease in the proportion of jobless households. Greece experienced a high rate of employment growth, equal to 3.8 percentage points, but a decrease in the proportion of jobless households of only 0.7 p.p. Seven Member States (Belgium, France, Cyprus, Luxembourg, Hungary, Austria and Finland) experienced a weak increase in the employment rate that did not translate into a decrease in the proportion of jobless households. In four countries - Denmark, Germany, the Netherlands and Portugal - the employment rate went down and at the same time the proportion of jobless households increased (in Portugal the percentage point change in employment was – 1.5 and that in jobless households + 1.5).

Figure 21: percentage point change in the proportion of individuals aged 18-59 living in jobless households and the employment rate of people aged 15-64, 2001 to 2005.



Source: Eurostat, Labour Force Survey - Quarter 2 results for jobless figures and annual averages for employment rates. 2002 jobless figures for DK, LV, LT and RO and 2003 figures for FI and HU. 2004 employment rates for DE and ES and 2002 figures (starting year) for RO.

2.3.3. Working longer and its impact on the adequacy and sustainability of pension systems

A significant factor in meeting the pension challenge and more generally meeting the challenge of an ageing society is to ensure that people work longer and that average effective retirement ages continue to increase. Extending working lives can strongly contribute to both the adequacy and the financial sustainability of pension systems. An extra 2 years of active life would translate into a corresponding increase in the theoretical replacement rate ranging from 5 to 10 percentage points depending on the Member States.[38] More in-depth analysis is nevertheless needed, in particular of the extent to which these increases in replacement rates associated with extending active life will change in the future.

While pension reforms can greatly contribute to increasing the employment rates of older workers, by strengthening incentives to work longer, it is essential to note that to deliver the expected outcomes, pension reforms need to be accompanied by positive developments in the labour market. People must be able to find adequate employment to be able to work longer, and this underlines the link with the question of employment and growth.

Importantly, early retirement is no longer seen as a way to make room for young people or reduce unemployment. Continued vocational training offers a tremendous opportunity for older workers to acquire new skills and to update qualifications throughout their professional lives. Furthermore, it is essential for Member States to provide suitable access for older workers to appropriate employment. Progress in this area is set out in detail in the 2007 Annual Progress Report on Growth and Jobs. The report provides evidence that comprehensive ageing strategies can achieve good results, though few Member States address ageing as an integral part of the lifecycle approach to work.

The potential increase in employment rates among older people is significant. The pace of the decline in employment rates at age 55 and 60 varies greatly among Member States (see figure 22 below).[39] While, on average, the employment rate of those aged 55-59 is 17 p.p. lower than that of those aged 50-54, the decrease varies from about 5 p.p. (Denmark and Sweden) to 25 p.p. or more (Belgium, Italy, Luxemburg, Slovenia, Austria, Poland and the Slovak Republic). A particular objective for all Member States is to reduce the extent of inactivity before retirement; for many Member States the main focus will be on the 55-59 age group, for whom the employment rate is already falling considerably (see figure 22), whilesome will also target earlier ages.

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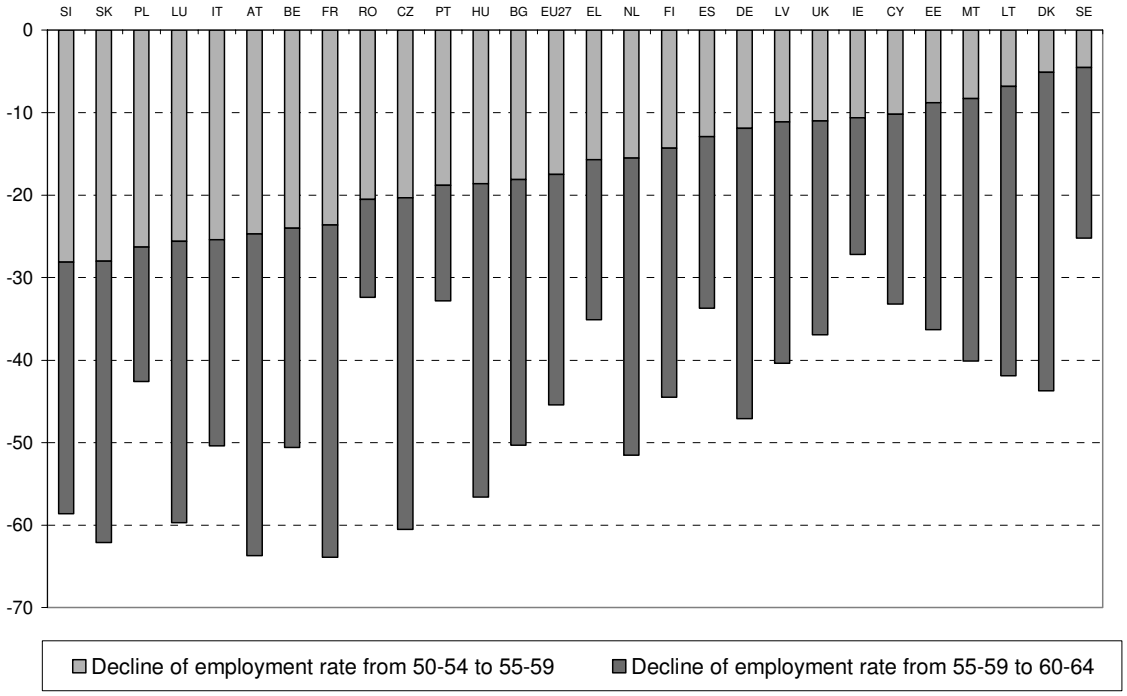
[38] See the 2006 ISG report on theoretical replacement rates.

[39] The recent labour market projections associated with the expenditures projections of the Ageing Working Group report indicate that the 60% Lisbon employment rate target for females is likely to be reached by 2010 and that the employment rate of older workers will sharply increase from around 40% in 2004 to 59% in 2025.

Figure 22: Pace of decline of the employment rate of older workers by age bracket, in percentage points (2006)



Source: Labour Force Survey, 2006 second quarter. Note: In some Member States the decline in employment rates with age can also be significant before 55.

If all Member States recorded a decline in the employment rate between the 50-54 and 55-59 age groups comparable with the levels of those Member States with the best records (about 5 p.p.), employment rates among people aged 55-59 would increase by about 10 p.p. If this could be maintained for the 55-59 to 60-64 cohorts, employment rates among the 55-64 age group would increase by about 10 p.p., going beyond the 50% objective. This shows that achieving an increase in the employment rate of older workers to meet agreed targets can be attained, on the whole, by reducing early exits from the labour market. However, this should be seen as the first step. Improving employment rates for those aged 60-64 will also be necessary in order to contribute to future adequacy and sustainability.

2.3.4. The impact of economic outcomes on health

Currently, the health and social sector employs a significant and growing proportion of the active population in the EU-15 many of whom are highly skilled: in 2003, the sector represented 10% of total EU employment, up from 9% in 1995. In some countries this proportion is even higher (11% in DE and 15% in the NL in 2003, up from 9% and 14% in 1995). An ageing population and important changes in society (e.g. smaller families, families living further apart) will potentially lead to further requirements in terms of care personnel and thus translate into more employment opportunities. As has been stated, health care and health policy (promotion, prevention and curative care) can make a positive contribution to employment and growth by ensuring that a working population is and remains healthy and highly productive over a lifetime.

It can also be shown that economic outcomes also matter for health, as highlighted by extensive academic literature in the area, the 2005 European Commission report *The Contribution of health to the economy in the European Union* and the 2001 WHO report by the Commission on Macroeconomics and Health. Sustained economic growth is typically associated with better living conditions (e.g. housing, sanitation, hygiene, nutrition) and fewer

living and occupational hazards. The positive impact of economic growth on health is particularly strong if growth is channelled into raising the incomes of the poor and increasing public expenditure, notably health care expenditure, social security and education. Thus, though GDP growth impacts positively on health, much depends on how the additional wealth is distributed and utilised.

Poverty also has a negative impact on health: living in poverty is associated with lower life expectancy, higher mortality (including infant mortality) and morbidity. Poverty is related to poor diet, sanitation and housing, higher prevalence of smoking, alcohol and drug use, greater violence and lack of access to care. Unemployment is a major cause of poverty and thus ill-health. Therefore, increasing employment and tackling poverty can improve the general health of the population.

More recently, employment and activity, notably in older ages, are also shown to contribute positively to health status. However, the quality of employment (e.g. jobs compatible with skills and expectations, matching reward and effort, control of work, exposure to risk and unsafe working conditions, job security, job turnover, flexibility, and social dialogue, amongst other things) is an important determinant of good health and well-being (e.g. SHARE, 2005; "Health and Quality in Work", 2005; WHO European Health Report 2002). Adapting work practices and working conditions – e.g. ending discrimination, creating barrier-free workplaces and promoting flexibility for employees – will help workers maintain their health.

3. PART TWO: THEMATIC ANALYSIS

3.1. Strategies for Social Inclusion

In September/October 2006, Member States adopted renewed National Action Plans for Social Inclusion under the new streamlined OMC as one chapter of the National Report on Strategies for Social Protection and Social Inclusion. They presented the key priorities in Member States efforts to promote greater social inclusion and make a decisive impact on the eradication of poverty and social exclusion. Member States have responded to the guidelines that they agreed, together with the European Commission, by selecting three or four key priorities that they consider to have particularly strong potential to make a real difference, rather than covering the full spectrum of relevant issues. The reports are thus more strategic than in previous years, and this assessment, which sets out to reflect Member States' choices, is therefore not exhaustive in its treatment of each specific theme. Nonetheless, Member States continue to recognise the multidimensional nature of poverty and exclusion, by tackling their priority issues from many angles.

This more focused and strategic approach, and the strengthened emphasis on policy implementation, will contribute to making further progress on the achievement of the three Common Objectives[40] relating to social inclusion which were adopted by the European Council in March 2006:

(d) access for all to the resources, rights and services needed for participation in society, preventing and addressing exclusion, and fighting all forms of discrimination leading to exclusion;

(e) the active social inclusion of all, both by promoting participation in the labour market and by fighting poverty and exclusion;

(f) that social inclusion policies are well-coordinated and involve all levels of government and relevant actors, including people experiencing poverty, that they are efficient and effective and mainstreamed into all relevant public policies, including economic, budgetary, education and training policies and structural fund (notably ESF) programmes.

As highlighted in the Joint Report some issues emerge clearly as the major priorities for Member States' efforts:

They have responded strongly to the Spring 2006 European Council challenge to reduce child poverty, with clear commitments to breaking the cycle of deprivation. Measure include facilitating parents' labour market participation, improving access to quality education and adequate housing and protecting children's rights.

Further, active inclusion emerges as a powerful means of promoting the social and labour market integration of the most disadvantaged. Increased conditionality in accessing benefits tends to be a major component, but this must not push those unable to work further into social exclusion.

Thirdly, considerable attention is given to further reinforcing governance of social inclusion policies.

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[40] Full set of Common Objectives for the OMC on Social Protection and Social Inclusion: http://ec.europa.eu/employment_social/social_inclusion/objectives_en.htm

3.1.1. Full participation in society requires access to resources, rights and services

Tackling child poverty

Some groups of people are more likely than others to have difficulties accessing resources, rights and services necessary for their full participation in society. So children face a higher risk of poverty than the average citizen in almost every Member States. In some, nearly every third child is at risk. Living in a lone-parent and/or jobless household or in a family with many children further compounds the risk. This is a clear threat to social cohesion and to sustainable development. Children growing up in poverty are less likely than their better-off peers to do well in school, enjoy good health, stay out of dealings with the criminal justice system, and – as young adults – to find a foothold in the labour market and in society more broadly. Member States recognise these facts; the vast majority have set as a key priority the need to develop a strategic, integrated and long-term approach to preventing and addressing poverty and social exclusion among children. Education tends to play a key role in this.

Member States approach the issue in different ways, but often with a mix of policies addressing the manifold dimensions of the problem[41] – increasing the family's income, improving access to services, including decent housing, or protecting the rights of children and their families. While the overall approach is universal, complementary measures targeting the most disadvantaged children and families are often part of the strategy. Two aspects stand out: ensuring equal opportunities with respect to education, including early intervention, and promoting parents' participation in the labour market.

Many Member States plan increased or more targeted financial support, but tend to see the *main route* out of poverty and exclusion in *eliminating any obstacles to parents'*, especially mothers'*, labour market participation*. Measures to facilitate reconciliation of work and family life are often highlighted, including but often going beyond improved access to quality child care (e.g. DE). However, broader gender equality issues, such as the need to promote a more equal sharing of domestic work and of care responsibilities, receive attention only in a few reports (AT, EL, HU, IE, LT, IT and PT), as does the potential role of ICT to facilitate reconciliation. IE is setting out to improve access to quality learning opportunities for those in low-skilled employment; MT is introducing new legislation on children and setting welfare standards and AT to provide job opportunities to women returning to the labour market. Some Member States address the issue of housing in relation to improved labour market access of adults in marginalised families (IE, HU, LV, LT, MT).

Since 1997, the **UK** has been tackling child poverty as a priority; the proportion of children living in low-income households has fallen from being among the highest in Europe with 27% in 1997/98 to 22% in 2004/05. Eliminating child poverty thus remains a challenge and is addressed via a combination of measures to ensure financial security of parents and break cycles of deprivation, with particular emphasis on early learning opportunities, childcare services and support for children's transition to adulthood.

HU envisages a comprehensive policy mix to tackle child poverty and is making full use of the Community funds available in its efforts. Measures include the promotion of parents' participation in the labour market and improvement of childcare services, and of equality of opportunities for all pupils/students, strengthening of the family benefit system, strong child welfare and child protection services, in particular for children with special needs, and better access to health care and other services relevant for the well-being of children.

[41] See 3 examples in the box below.

NL promotes participation by children, with interventions aiming to support families facing difficulties/problems, and measures to increase opportunities for children and young people from deprived families to participate in social life. Through combined state/municipal intervention, a customised approach is taken with a strong emphasis on results.

CY's *Educational Priority Zones*, implemented by the Ministry of Education and Culture in three school areas, is a measure aimed at combating school failure and illiteracy and achieving equality of opportunity in education. The criteria for creating an Educational Priority Zone include a high degree of school failure and dropouts, of functional illiteracy and of foreign or foreign-language speaking pupils. Specific actions include reducing the number of children per classroom; employing teachers speaking the mother tongue of foreign-language speaking pupils, and keeping schools in EPZs open all day, with extra-curricular activities offered. The pilot recorded a reduction in dropouts, absenteeism and failures.

In **IT** a mix of actions has been defined to promote rights of children and families, with specific attention to the reform of family support allowances, to increase of supply of childcare services, and to enhance measures aimed at reconciliating work and family life and increasing participation of women to the labour market.

In line with Member States' priority-setting, child poverty will receive particular attention in implementing the OMC in 2007. A Peer Review will be dedicated to the issue with the purpose of promoting mutual learning between the Member States. Furthermore, Member States and the Commission are committed to developing an indicator that better captures the notion of children's well-being, thereby allowing measures to be designed and progress to be monitored more efficiently.

Striving to make education systems conducive to social inclusion

The reports present measures on how *education systems* may *foster inclusion* rather than perpetuating exclusion: a new Education Act based on this principle (ES); considerations on social selectivity in education (DE); emphasis on the link between low socio-economic background and school failure (LU); linking education with employability and reducing illiteracy and school drop-outs (MT); and education and training policy aimed at fostering social equity (FI). Some Member States (BE, ES) set out to provide parents with the skills necessary to assume their role fully.

Adequate investment in *pre-primary education* is of particular importance for disadvantaged children and for those with a different mother tongue from the majority. Many reports focus on this issue, with a number of Member States (AT, DE, ES, HU, IE, LT, PT, LV, BE, SE) planning to develop capacity, and some specifically targeting the needs of children from areas of acute economic and social disadvantage (IE, CY for immigrant children, IT, CZ, LT, PL, RO for Roma, UK).

Variations in *quality of education* may translate into structural disadvantage for people from underprivileged areas. To tackle this, Member States support schools in disadvantaged areas and communities in order to achieve greater equality in terms of educational participation (IE); set out to improve quality, especially in relation to areas with a large Roma community (HU); or work on the principle of positive discrimination, based on the provision of different levels of funding to regions or to specific urban areas to compensate for inequalities (CZ, CY, FR and others).

Breaking the link between social origins and educational outcomes is crucial in order to prevent deprived children from becoming disadvantaged young people. The key is to tackle *early school leaving*, which increases the risk of exclusion from the labour market, of job insecurity and of low quality employment. On average, 15% of students leave school early, but in some countries more than a third of young people are affected. Member States have set a benchmark for reducing early school leaving in the framework of the Education and Training 2010 work programme, and almost all reports focus on the issue. Significant additional efforts are needed in order to reach this benchmark – no more than 10% early school leavers by 2010.[42]

A mixture of preventative and compensatory measures are envisaged: redesigning educational policies with a gender focus, as boys tend to leave school earlier than girls (IE); investing in second-chance schools (DE); action to prevent early school leaving and truancy among impoverished children (RO); ambitious targets for reducing school failure coupled with a set of preventive measures, such as establishing full-time school (longer school hours) (PT); a plan for reinforcement, guidance and support, and pedagogical improvements with particular focus on diversity (ES); introducing non-formal and informal learning as a preventative measure (MT); raising the school-leaving age (NL); grants and logistical support for disadvantaged pupils (PL, LT, HU); extension to upper secondary level of rights to student welfare and guidance (FI); and cooperation with NGOs in addressing early school leaving (CY). Developing these measures into comprehensive strategies will help Member States achieve significant results in tackling early school leaving.

In **FR** the programme for educational success (*Réussite educative*) is targeted at children experiencing hardship and/or living in deprived areas. The aim is to reinforce the capacity of the educational system and institutional partners to follow up personally 200,000 children over time from age 2 to 16. These actions will mobilise multi-disciplinary teams (teachers, social workers, psychologists, health workers, etc.). A strong monitoring system is in place and results are expected from 2007 on.
RO's *Gata, Dispus si Capabil* project involves the NGO *Associatia Ovidiu Rom* working in partnership with local government in three neighbourhoods to increase school attendance and performance among Roma children, and to help Roma mothers find jobs. Since 2001, 400 children have been helped to enrol in school, stay on longer at school or improve their school results, and 100 women have obtained and kept jobs.

In general, better *system flexibility* improves access to education and limits social exclusion by maximising the value of learning. So FR is promoting the validation of prior learning, with an ambitious target of 60,000 cases in 2006; DE is putting initiatives in place to improve mobility between education and training systems; and CZ refers to the adoption of a new Law on Recognition of the Results of Further Education and the creation of a National Qualifications Framework. The issue of equal opportunity of access to higher education, however, is addressed only by a small number of Member States (UK, CZ, SK, LT).

Ensuring access to lifelong learning

The importance of adult participation in lifelong learning is recognised in many reports. The focus is mainly on the acquisition of basic skills. A number of measures are planned to reconcile family responsibilities and participation in LLL activities (e.g. in DE: special aid programmes and adequate infrastructure). In IE, the Back to Education Allowance will facilitate access to education for disadvantaged groups and disadvantaged communities. In

[42] http://ec.europa.eu/education/policies/2010/doc/progressreport06.pdf

PT, an ambitious training and certification measure is also planned for adults with poor qualifications. EL is implementing legislation aimed at increasing participation in adult education, and is focusing on second-chance schools. MT is setting up lifelong learning community centres that encourage literacy and skills development.
Some recognition is given to the fact that, as Europe continues to move towards a "knowledge-based society", accessibility and usability of ICT products and services, coupled with the necessary digital skills are paramount to people's social and economic participation.
The significant contribution that guidance and counselling can make to social inclusion is often highlighted. Several reports state that the national guidance system should be reinforced. IT, in particular, refers to setting up a comprehensive, lifelong guidance system.

Ensuring access to services and upgrading their quality

Overall, Member States recognise the general need for access to quality services to allow participation in society, and to prevent and address exclusion. Many address access to different kinds of services separately (education, as outlined above, training, housing, health care, transport, ICT, financial services, etc.). But some (BG, FI, IE, IT, SK, UK) have highlighted as a cross-cutting priority the general improvement of access to essential services. RO is taking measures to address the problem that many Roma people do not possess identity cards, hampering their access to services. As to the social services system, some Member States (CZ, FI, DE, HU, IE, LT, PL, RO, SK, UK) give priority to better balancing income transfers and services, institutional care and community or home care, and to improved availability, quality, client orientation, and versatility.

EE's Community Services in a Village was initiated by the Estonian Village Movement Kondukant and ran from October 2005 to May 2006. The objective of the project was to create preconditions for a network of community services and to share experience in initiating community services in order to help people living far from centres to have access to local and flexible services, tailored to their needs. An assessment of service availability and financing options was compiled, service development training was provided and a service development guide was published. Cooperation contacts were established with 15 Finnish village societies that offer services.

Some Member States (EL, HU, LT, LV, MT, PT, SK) point out that the lack of provision of non-institutional social services makes it difficult to address the needs of various social groups and hampers full labour market participation by those taking care of dependent persons. In those countries, more innovative, community-based ways of providing social services have yet to be developed and attention has to be given to preventive and rehabilitation services targeting the most vulnerable. Some Member States, e.g. DE and MT, stress the priority of strengthening the role of NGOs, promoting voluntary work and encouraging self help. Most Member States recognise the need to take better account of developments such as ageing, changing family structures, female employment, migration and diversity, and to promote the involvement of users themselves, meet expectations of greater choice and strengthen personalised measures.

Increased spending on its own is not enough to ensure improvement. Other factors that emerge from the strategic reports include: the development of social care standards; quality assessment and control applicable to all providers of social services; the development of professional standards for social services employees; high-quality professional education; lifelong learning; supervision; a helpline offering advice to carers; and pressure from citizens (choice and voice).

Improving access to housing and fighting homelessness

Access to adequate housing is a particularly vital factor for social and labour market integration: almost all Member States consider it a key priority requiring more efforts. A number of them (BE, CZ, DK, FI, FR, HU, IE,PL, SE, UK) set out to address all dimensions: improving access to affordable housing, helping the most disadvantaged and their families to obtain housing suited to their specific needs, tackling the poor quality housing of people on low incomes, and tackling homelessness. Others (AT, CY, DE, EE, EL, ES, IT, LT, LU, LV, MT, NL, SK, SI, PT) present actions focused on specific groups or problems, such as improving access to housing for vulnerable groups, re-housing for people living in slums or shanties, housing refurbishment and the prevention of evictions.

Most Member States set out to address the shortage of affordable adequate housing, in particular in high-cost urban areas (BE, CZ, DK, EE, ES, FI, FR, HU, IE, LU, LV, PL, PT, SE, SK, SI, UK). Measures targeted at low-income groups include: new social housing units, rent subsidies, tax relief, favourable housing loans, earmarking of land or requirements that local authorities build new social housing, and state funds for housing development.

The need to increase the supply of adequate and reasonably priced independent homes for disabled people, people with health problems or social integration difficulties or with special needs is addressed in some reports (BG, DK, FI, HU, MT, SE, SK). This will help contain pressure on supported and service accommodation organised by social services. The transformation or the demolition of housing falling below the minimum standards of decency are also priorities highlighted by some Member States (BE, DK, FR, HU, MT, SL, PL, PT and UK).

With a view to halting the influx of disadvantaged people into the most deprived estates (and the corresponding exit of the most resourceful) and to curbing trends towards urban segregation, a few Member States (DK, FI, FR) plan measures such as: obligations on municipalities with a shortage to construct new social housing, tenants selection, the sale of social housing without efforts to re-let them first, removal support for disadvantaged residents in troublesome areas, more say for local authorities in allotting land to cater for social needs, specific integration initiatives in disadvantaged housing areas (e.g. special crime prevention activities, homework help, voluntary work and business start-ups).

Homelessness is an extreme example of social exclusion, usually indicative of shortcomings in a range of policy areas (for example, health, welfare, housing, employment and justice). Rather than focusing on homelessness only, Member States are increasingly adopting a structural approach to tackling housing exclusion. The growing issue of families with children without permanent homes is receiving more attention (e.g. SE). Some Member States set out to ensure that people leaving institutions find homes (CZ, ES, FI, NL). In addition to improving temporary housing, some Member States (BE, DK, IE, HU, NL, SE, FI, FR) are committed to ensuring alternative forms of housing for homeless people with multiple problems as well as opening up the housing market to those excluded from it. Some Member States (AT, FR, HU, SE, LV, NL, IT) are working on preventing eviction, often in relation to families with children or older people, and linking this to plans to address debt problems. Some countries have successfully implemented comprehensive strategies in recent years. In the UK, in 2005, the number of households becoming homeless fell by 27% compared with 2004; in DE, the number of homeless people fell from 530 000 in 1998 to 292 000 in 2004.

AT's *Länder* programmes to "prevent eviction" aim at durably reducing and preventing homelessness with a special focus on lone parents. The project aims at ensuring proper

cooperation between all stakeholders (landlords, communities, social services providers and courts) that can help prevent the multiple factors that lead to the risk of eviction. The specific objectives are, for instance, to prevent forced eviction, and provide integrated access to welfare structures (enhancing access to social services), as well as affordable housing for the most vulnerable. In the Vienna region, where they have long been implemented, the projects have produced positive and sustained outcomes.

Reducing health inequalities and ensuring equal access to health care

In all Member States there remain disparities in health status and inequalities in access to care between socio-economic groups, in addition to regional and/or urban/rural disparities. This occurs despite the fact that health care systems have been designed to ensure universal or close-to-universal coverage, and it jeopardises some people's chances of participating fully in society and in the labour market.

Most Member States are endeavouring to break the remaining barriers to access to healthcare. This entails reducing financial barriers for low earners by reviewing eligibility criteria for access to free or cheaper care (DE, FR, IE,CY), setting up specific schemes (BE, FR, LU) or abolishing fees for children (FI). Some Member States set out to enhance primary and preventive care provision (EE, EL, IE,HU, PT, SI, SK), to adapt services better to people with special needs (e.g. the disabled in CZ, ES, LT, PL, SI, FI; the mentally ill in EL, MT, SI, SE, children in FR, MT), to correct for territorial inequalities (EL, ES, HU, LT, PT, FI, UK, RO) or extend coverage in terms of types of services (e.g. dental care). The voluntary sector will be strengthened in MT. Some Member States focus on reducing waiting times (DK, IE,FI, MT), and a number also target measures at the most vulnerable in general (PT, BG, RO) or at particular sub-groups: children (DE, ES, FR, HU, LV, LT, MT, PT, UK, RO), the unemployed and minimum income beneficiaries (EE, FR), dependents (CZ, EL, ES, PT, FI), the homeless (CZ, IE,SI), the elderly (CZ, EE, EL, ES, LV, MT, PT), immigrants (EL, FR, MT, SI) (e.g. extend universal coverage to all non-accompanied foreign children under 18), and ethnic minorities (EL, BG, RO).

In most countries which require co-payments, the measures referred to above help to reduce their impact on the most vulnerable. This impact needs to be closely monitored, however, especially in countries that have just introduced such cost-sharing schemes.

Income disparities and differences in living conditions are the source of health inequalities, and are often compounded by lifestyles and risky behaviour. Therefore, most measures tend to be on promotion and prevention (see chapter 2.4.3). A number of Member States (DK, DE, FR, IE,CY, LV, LT, MT, NL, PT, FI, UK, BG) are attempting to mobilise a wide range of services (including education, housing and employment services), especially those close to the most vulnerable groups: children and minorities (e.g. breaking cultural health barriers in BG). Health prevention addresses eating habits, smoking, drinking, and drug abuse, for example. Screening campaigns are carried out at school (FR, NL, FI, UK), and NGOs contribute to the reintegration of young people (SE) and those in institutions (FR). Involvement of actors at all territorial levels is sought (CZ, ES, FR, FI, PT, UK), and some Member States target specific deprived areas (FR, UK).

Access to financial services and tackling over-indebtedness

Over-indebtedness, a growing problem in the EU, can jeopardise health, family life, access to housing and employment. It badly affects the living conditions of the families involved and the education of their children. A number of Member States (AT, DK, FR, HU, NL, UK) make over-indebted people a target group for their social inclusion strategies.

Action to prevent and combat financial exclusion includes measures to educate the young, who are particularly at risk (AT), making financial budgeting a compulsory subject of secondary education (NL), improved access to bank accounts and affordable credit for lower-income groups (FR, UK), a code of conduct to prevent the provision of excess credit including rules on advertising, and an obligation to assess creditworthiness (NL). Since *services offering guidance* to those affected are currently often stretched because of rising demand, some Member States plan to add resources to reinforce provision (FR, HU, UK).

FI's Social Credit Act gives local authorities responsibility, as a part of adult social work, for social lending to people on low incomes or lacking the means to solve problems arising from over-indebtedness and unemployment. Social lending has helped borrowers achieve sound financial management (by providing financial advice and guidance when the loan is granted and during repayment), broken debt cycles, promoted rehabilitation and employment, safeguarded accommodation, helped in managing social crises, and otherwise fostered independent life management. As a method of early intervention in the debt problems of young people, social credit has also helped them to start training and to find accommodation and employment.

With regard to *debt settlement*, NL is putting in place a comprehensive debt amnesty system and measures to strengthen the amicable settlement process.[43] DK is launching a pilot project on remission of public-sector debt for people who have been social assistance claimants for four years or more, provided that the person finds and keeps a job or subsidised employment, or starts a course of education or rehabilitation process.

Furthering territorial cohesion

Most of the larger Member States provide information about territorial disparities by referring to regions, to the urban/rural divide and/or to deprived/disadvantaged areas. However, given the efforts to select a small number of priority policy objectives, the regional or local dimension is less visible than in the previous generations of national action plans.

A number of Member States express concerns about rural poverty and different aspects of social exclusion, in particular as regards access to education/lifelong learning, to health/long-term care and quality social services, to housing and to transportation. HU envisages comprehensive territorial developments with the support of the Structural Funds. In Member States such as PL and RO, where a high proportion of the agricultural population lives from the subsistence economy, the ongoing economic transformation process needs to be taken into account in addition to the challenges common to all Member States exposed to 'normal' forms of rural exclusion. Self-employed or unpaid family workers who live from the subsistence economy are in some countries the most numerous sub-group of the working poor. The necessity of providing quality jobs for them, including support for mobility, seems widely overlooked in the strategic reports.

DE's *Handlungsprogram "Soziale Stadt NRW"* (Social City Action Programme in Nordrhein-Westfalen) is an interdisciplinary programme of action targeted at eradicating complex disadvantages in neighbourhoods. This programme has been running under the Urban Planning Ministry since 1993. The programme is currently supporting multi-objective projects in 37 neighbourhoods, combining town planning measures with social, housing and economic

[43] For details see http://www.peer-review-social-inclusion.net/peer-reviews/2006/amnesty-of-debts-a-three-step-solution.

and labour market policies. The local population participate in the renewal of their own neighbourhoods. Evaluation, conducted largely by the local authorities, has been standardised since 2003.

As mentioned above, Member States also highlight efforts to improve living conditions in certain urban areas (FR: 'quartiers périphériques'/'sensibles'/défavorisés'; EN: 'socially deprived areas', and IT, in particular inner cities in the South) and to fighting segregation in cities (DK) through urban development. In the EU-15, the perception of such challenges is often linked to the handling of diversity and the integration of immigrants, whereas in new Member States a general need for urban renovation tends to be acknowledged, linked in some cities to the specific problems affecting the Roma minority. The particular difficulties facing the outermost regions, including considerable problems in accessing both services and employment, are not covered in the reports.

3.1.2. Promoting active inclusion and fighting poverty

Employability and integration of people furthest from the labour market

A quality job is often said to be the best safeguard against poverty and social exclusion; the incidence of poverty among the working population is far lower than among the jobless population. A job provides an opportunity, ideally, for the individual to develop his or her potential and integrate into society. To be precise, employment is a *sustainable* way out of poverty and social exclusion when it lasts, when it pays sufficiently to lift workers out of poverty and when it has all those features, normally referred to as "quality in work", that promote the individual's future employment prospects, safeguard their health and safety, and enhance human and social capital.

Member States are increasingly adopting "active inclusion"[44] as the preferred route to promoting social and labour market integration. An element of this is the clearly discernible trend towards making access to benefits conditional on job searching and availability for the labour market. A balanced active inclusion approach requires this to be accompanied by opportunities to build human capital, including the acquisition of IT skills, and address any existing educational disadvantage, and by adequate counselling and guidance offered to the individual. Crucially, income support should be guaranteed at an adequate level, otherwise conditionality risks pushing the most disadvantaged even further to the margins.

In general, Member States give insufficient attention in their reports to the issue of minimum resources. Some Member States, however, point out that the balance between rights and responsibilities should be fairly assessed and that where conditionality has been strengthened safety nets also need to be more finely knit. This is not only an equity argument, limited to people who do not have the capacity to work. It is also an efficiency argument, as strong social protection improves the functioning of the labour market by supporting job search and re-skilling, thus enhancing versatility. In this vein, some Member States set out to improve the coverage and generosity of their benefit systems hand in hand with the focus on activation.

Member States acknowledge that universal employment policies are often not sufficient to reintegrate the most vulnerable. The people concerned often suffer from multiple disadvantages and a targeted approach needs to be put in place. In most Member States, reforms of the public employment services (PES) are centred on the development of personalised and customised approaches for specific groups of people.

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[44] For further details on the EU interpretation of this concept, see COM(2006) 44 final.

This is, for example, the case in ES with the creation of special employment centres for people with disabilities, facing special obstacles to labour market entry, and the implementation of personalised job search pathways for socially excluded people; in FR, with the creation of individualised social support and personalised projects to access employment; in DE, with targeted support for young people, through training, work opportunities, intense mentoring, and comprehensive assistance including looking for accommodation and offering debt and addiction counselling (covered by a budget of € 7 billion in 2005 supporting 550,000 people); in BE, with a focus on low-skilled individuals and the development and acknowledgement of their competencies; in SE, where PES are given overall responsibility for newly arrived immigrants; and in CY, with personalised assistance offered together with benefit registration.

FI's *Labour Force Service Centres* are an integrated, comprehensive approach to addressing the needs of the structurally unemployed in order to integrate them into the labour market as part of the reform of the public employment service. Funding is granted by the Ministry of Labour for centres if there are many clients in the area unemployed for at least two years. The Centres offer multi-occupational services under one roof – the client can start with a health survey, medical occupational rehabilitation and activating measures by social services, and then move onto training or wage-subsidised work.

Policies to support labour market integration operate from both sides of the labour market, i.e. the supply side and demand side. With respect to *supply*, the strategic reports recognise the need to equip individuals with the skills and knowledge required by today's labour market, to provide them with the right incentives to participate actively in society and to support them in their job search. This approach covers a set of policies in the following three areas:

Active Labour Market Policies to tackle lack of employability – in particular through investment in education and training and job counselling. Most of these policies are delivered by the PES, in partnerships with other social and economic actors. In order to promote the integration of people furthest from the labour market, education and training policies often address the need of specific groups of people over and above low-skilled individuals. These groups include older workers and young entrants into the labour market, migrants, women, the long-term unemployed, disabled people and those living in disadvantaged areas, including those affected by economic restructuring. Targeted human capital policies have been put in place in most Member States. Another important aspect is the certification of job-related competencies and the assessment of skills and qualifications for groups such as migrants to improve skills-matching and the employability of individuals concerned (NL, UK, FR and SE).

Most Member States stress increased efforts on job counselling programmes, to make them more efficient, timely and more regularly available. Some programmes highlight a more comprehensive approach to employability, covering issues such as the loss of accommodation (CZ) and transportation and accommodation allowances (EE). DK has put in place mentor schemes at drop-in shelters to reach out to the most socially disadvantaged groups.

"Make work pay" and financial incentives to work. The interaction between tax and benefits should provide the right incentives for people to enter and remain in the labour market without weakening support for those who are not in a position to do so. Policies that address this balance most effectively introduce (or expand) tax credits (e.g. UK, FR and NL), establish gradual withdrawal of benefits (IE, NL) and improve their administration (NL, SI, DE).

Non-financial incentives and social obstacles to entry into the labour market. Addressing poor employability and providing appropriate financial incentives are only two factors determining an individual's capacity for and decisions on labour market entry. Other social factors can represent serious obstacles to labour market integration. As mentioned above, several Member States stress the need to support the reconciliation of work and family life – for example by improving the availability of flexible and affordable child care (UK, LU, CY, NL, BE, HU), often with a view to meeting the needs of lone parents, too. FR presents a set of policies to address a number of obstacles to entering employment, including mobility, health, housing and over-indebtedness.

Labour force participation as an active jobseeker for someone previously inactive is only a first step to obtaining employment. Good quality jobs, that facilitate employment retention and progression, need to be available and an integrated approach to labour market integration should also focus on the *demand* side. Overall job creation and growth is necessary but not enough to include people furthest from the labour market, who are often at a marked disadvantage in a competitive economy. Member States' strategies centre on two issues:

Financial incentives for employers to hire. To boost recruitment of specific groups of disadvantaged people, Member States have introduced reductions in social insurance contributions, wage subsidies, subsidised employment and credit facilities (FI, SI, CY, RO, AT, ES, FR, DK, SE, DE, HU), often targeting certain types of enterprises. Reductions in the "tax wedge" on permanent employment contracts are also used to curb labour market segmentation (for example in ES and IT, where further targeted incentives are meant to promote women's employment in the south).

Anti-discrimination and labour law, together with social dialogue. Member States have reiterated their commitment to the appropriate legal framework and industrial relations to give everybody an equal chance in the labour market. In particular, some Member States have introduced legislation and enhanced social dialogue to increase labour market flexibility and address the needs of disadvantaged groups for which full-time or regular work is not always suitable. These measures include flexibility and availability of parental and child care leave; availability of care for children and other dependents; reduced working hours, longer holidays and adapted job content for senior workers; and teleworking. Discrimination is one of the main determinants of social exclusion and Member States have either enhanced their anti-discrimination legislation or reinforced their instruments to deal with it (e.g. funding for an Ombudsman, a code of practice for employers, and inter-ministerial working groups). Finally, raising awareness is seen as essential to the effective implementation of current legislation.

In **BE** the Walloon region's project "*management de la diversité*" aims at enhancing the integration into the labour market of people who are discriminated against on grounds of ethnic origin, age, gender or disability, through "positive discrimination" practices. The main thrust of this action is to foster social responsibility among employers by setting standards for "good management of diversity". It involves employees' organisations and both private and public sector employers. Integrating vulnerable groups is one of the key challenges of the Region's employment strategy, which sets out to give these groups priority access to measures such as sectoral agreements, job coaching and individual attention from employment and social services.

Many Member States recognise that those furthest from the labour market may need to be supported in getting a firm foot-hold in the labour market. Policy measures include providing in-job support, via employment retention and advancement projects, and promoting (including

by subsidising) on-the-job training. Several reports have underlined the need for interaction between PES and Social Services, together with the need for social support, especially for people with social problems that need a focused approach. NL highlights the role of the Social Support Act (WMO) in improving social cohesion and quality of life at local level, and enhancing social support for disadvantaged groups. Minimum wage provisions are important instruments in reducing the risk of poverty for workers, improving the quality of work and making work more attractive; some Member States have reported plans to increase the minimum wage level (UK, ES, CY, LT and LV). Policies addressed to individuals have been accompanied by those focusing on the environment and addressing the problems of deprived areas, both urban and rural (CZ, UK, BE, FR, SE, DE).

On active inclusion, the Commission is set to support Member States by following up on the consultation carried out in the first half of 2006.

The contribution of the social economy

The social economy is an important source of jobs and entrepreneurship, including for people with poor qualifications or whose capacity for work is reduced (see examples below). It can enable the most disadvantaged to exercise some kind of gainful activity or to create employment in areas without mainstream companies and employers (peripheral areas, remote rural areas). It also provides vital social services and assistance that are often overlooked in the market economy and plays a key role in involving participants and European citizens more fully in society since stakeholders, i.e. workers, volunteers and users, are as a rule involved in management.

Several Member States have highlighted its contribution to better governance in the field of social inclusion, and in social and economic regeneration. Nonetheless, programmes and policies vary in scope, quality and comprehensiveness and national approaches vary from strong policy support to an almost complete absence of support.

Examples of measures that help provide *job opportunities* for those furthest from the labour market include: support for activity cooperatives and reintegration enterprises, the creation of new jobs in community services and of social economy "guichets" (BE); the creation of a sustainable model for the development of social enterprises (BG); partnership between local authorities and local stakeholders to help mentally ill people into employment (DK); structures for the employment and economic integration of travellers (FR); priority in active labour market policy schemes for 'non-progression ready' unemployed (IE); reform of employment subsidies and the development of social enterprises (FI); encouragement to start up of cooperative enterprises (SE); and a social enterprise pilot project providing paid work experience placements for blind people (UK).

In **PL** the new social inclusion policy aims to reform vocational and social activation to enable regional and local governments to be more proactive in developing social services and the social economy. Specific attention is paid to the development of institutions: it is planned to establish a platform for cooperation between various public and non-public institutions active in the social economy. The social economy will also be supported through the development of advisory services and information for social economy initiatives, developing local loan funds and promoting education.

Measures to help meet needs for *social services and assistance* include: reinforced community-based social services for the most vulnerable (BG); investment subsidies for the construction of cooperative flats targeting Roma communities and vulnerable children (CZ);

involving voluntary social organisations in tackling substance abuse (DK); integrated services to support the immigrant population and involvement of third-sector associations in anti-discrimination activities (PT); joint efforts on a range of inclusion issues by local authorities, social organisations and foundations, and service companies (FI).

Addressing obstacles to young people's labour market entry

Youth unemployment, precarious jobs and the problems young people face in gaining a secure foothold in the labour market are concerns frequently cited in the strategic reports. All reports focus on vocational training, especially as a tool to support labour market entry or job retention by vulnerable groups including the young. There is a general commitment to reinforcing the role of PES in addressing the needs of young people at an early stage of unemployment. Many Member States are reinforcing their programmes to provide support for young people with difficulties in the transition from school to work, by providing individualised support, including counselling and suitable forms of further education and vocational training. FI, for example, is continuing to implement the 'Social guarantee for young people', launched in early 2005 in line with the EU target: after a continuous maximum period of unemployment of three months, young unemployed job-seekers under the age of 25 are offered an active alternative that furthers their position (training in job-seeking, preparatory or occupational labour market training, trial work placements, on-the-job training, preparatory training for working life, start-up grants, or wage-subsidised work).

HU's Study Hall ('Tanoda') Programme, implemented by the Ministry of Education and the Employment Office, addresses the need to encourage disadvantaged youth, in particular Roma, to complete elementary school and to increase their chances of attending secondary school and obtaining a school-leaving certificate. The goal of the programme is to provide extracurricular, accessible, effective learning programmes for disadvantaged students. The learning experience and good practice of the successful "study halls" is to be disseminated to the new study halls. The project has been run as part of the National Development Plan 2004–2006. In 2004, 23 study halls received operating subsidies in 2005, while in the second round 46 applicants received support for 2006-2007.

Beside the *Ausbildungspakt* and among other initiatives, DE is planning to continue with the 'Expertise Agencies', offering specific assistance for the social inclusion of particularly disadvantaged young people in socially deprived areas, and maintain the goal of ensuring that every young person interested in a vocational education who meets the entry requirements is given a chance of obtaining a professional qualification (*Ausbildungspakt*). LV has presented a list of measures for improving access for young people at risk of poverty and social exclusion, underpinned by output indicators designed to measure their effectiveness. In NL, educational reform will make it compulsory for young people without qualifications to participate in a work-study programme. AT is building on previous initiatives, e.g. Jobs4Youth, intended to enable all young adults (under 25) to participate in a training or re-entry programme. In some countries, efforts are being made to pay accommodation expenses for people attending training. In the UK, partnerships are being put in place by autumn 2006 to bring together schools, further education colleges and work-based training providers in order to improve education and training for 14-19 year olds and to improve its labour market relevance.

Immigrants, ethnic minorities and Roma

There remain gaps, often considerable, between immigrants and ethnic minorities and the rest of the population with respect to employment and unemployment, income, education, early

school-leaving, health and poverty. In recognition of this fact, most Member States have made the social inclusion of immigrants and ethnic minorities a priority.

As far as broader integration policies are concerned, the holistic approach taken in some countries to the various dimensions of the integration process (labour market participation and promotion of participation in social, cultural and political life, etc.) is a positive development, as is the focus on involving both immigrants and the host society.

The integration agenda that is presented in the **UK** report is based on a "virtuous triangle of equality (meaning non-discrimination), participation (of all communities in political and community decision making on all levels) and interaction (between all communities in various localities, such as schools and neighbourhoods)". Similar integrated plans have been drafted for Wales (Race Equality Scheme), Scotland (One Scotland Many Cultures campaign) and Northern Ireland (Racial Equality Strategy).

The draft strategic plan for citizenship and integration 2006-2009 presented in the **ES** report is an example of a comprehensive policy of integrating immigrants which aims to boost social cohesion through policies based on equal rights, duties and opportunities for all immigrants and Spanish citizens, by adapting services to the realities of a diverse society and by promoting understanding of the migration phenomenon within the host society and, at the same time, fostering a feeling among immigrants that they belong to the society they live in.

Some Member States (AT, BE, CY, DK, IE, NL) focus on labour market participation as a key element in integrating migrants into a new society which potentially brings benefits such as facilitating the acquisition of language skills and closer interaction with the host society. An increasing concern appears to be the acquisition of language abilities and civic orientation as means for successful integration. DE, for example, plans wide-ranging integration courses for newly arrived immigrants and for those already living in the country. FI and EE focus on the need for language training and NL is introducing pre-departure training. Other reports focus on issues such as improved access to services in general (EL) or better housing conditions (SI), while IE is taking measures to strengthen the labour market situation for female migrant workers. [45]

As regards social inclusion activities for ethnic minorities, only a few Member States provide information on measures for groups facing multiple disadvantages, e.g. special courses targeting women and girls from an immigrant background aimed at strengthening their self-confidence and offering them job prospects (DE); and measures to promote the emancipation of women of different ethnic origin to help their social inclusion (NL, DK).

Although a number of Member States have emphasised the importance of anti-discrimination policies to tackle social exclusion, with some exceptions (e.g. UK) there is little trace of measures to improve information on equal rights.

The lack of data on immigrants and ethnic minorities remains a problem[46] (UK, IE, DK, and NL are exceptions). As set out in the IE report, breaking down data between different ethnic groups would allow variations in the degree of social inclusion and vulnerability to be

[45] For details on trends in integration policies and measures, see the Second Annual Report on Migration and Integration SEC (2006) 892. The third Annual Report is forthcoming in 2007.

[46] See Commission Proposal for a Regulation on Community statistics on migration and international protection (COM(2005)375 of 14.9.2005).

documented. At present, the reports typically do not distinguish specific target groups (i.e. the immigrants/ethnic minorities concerned).

With respect to policies on the Roma population, CZ, HU, BG and RO provide for measures to tackle the disadvantages of Roma communities, with the main focus on education and living conditions.

In **CZ,** the city of Ostrava has launched an initiative to prevent multiple exclusion of Roma people from access to the labour market, to education and to social and health care services. Dedicated staff in the city council maintains permanent contact with public administration and local authority workers, regional and local NGOs, schools and health care providers. They are also in charge of monitoring the concrete outcomes of the project (50 jobs created, 31 Roma assistant teachers employed in schools, 16 mothers involved with their children in lifelong learning projects).

Inclusion of disabled people in society and in the labour market

Promoting the inclusion of disabled people is more extensively covered than in previous National Action Plans, with all Member States highlighting measures targeted at disabled people; AT, EL and PT have made it one of their priority objectives. Most Member States identify the need to mainstream disability issues into all relevant policies, but there are considerable variations in the degree to which they explain how this will be done in practice (HU, SE and IE present advanced mechanisms). The UK is introducing a new Disability Equality Duty requiring all public bodies to promote equality of opportunity for disabled people and to publish and implement Disability Equality Schemes.

For disabled people to live as independent a life as possible and to be socially included in their local communities, it is vital – and also cost-effective – to build up local services, which, to a large extent, can replace institutional care. A number of Member States (BG, CY, CZ, EL, LV, LT, MT, PL, RO, SI, SK) focus on measures to develop community-based services, i.e. to cater for ongoing deinstitutionalisation. DK, DE and UK are promoting independent living by introducing individual choice of service providers; DE has introduced personal budgets. FI, CZ, DK, IE, FR and AT are all taking measures to promote accessible housing. As further explained in the section on health care, e-Health can play an important role in making independent living possible.

Several reports refer to the elimination of barriers to education and training at all levels for disabled people and people with special educational needs (both through the elimination of physical barriers and through the provision of specific support). Many countries envisage specific support. The choice varies between special schools and special needs education in mainstream schools.

BG's National Programme for Employment and Vocational Training for persons with permanent disabilities is a programme to increase the employability of people with disabilities, to make employers aware of the possibilities of employing disabled people, and to raise public awareness and combat stereotypes. Motivational and vocational training is provided for disabled people, suitable sustainable employment is sought and financial support to employers who employ disabled people is provided. The outcomes are monitored via monthly Employment Agency statistics. To encourage good practice among employers, a symbol for a positive attitude towards people with disabilities has been introduced, which can be awarded to selected employers following certain evaluation criteria.

Most attention is given to measures promoting active labour market inclusion. AT, BE, DK, IE and LV are setting clear targets for increasing the employment rate among disabled people. In the UK, the New Deal for disabled people has helped almost 75 000 people into jobs, and the Pathways to Work programme will be extended to the whole country by 2008. DK has a funded action plan up to 2009 to bring more disabled people into work. In IE, public bodies are required to be proactive in employing disabled people. AT, CY, DE, IE, IT, PL and SE all have different forms of subsidy schemes, while FR and HU focus on measures to make workplaces and training accessible. EE and HU are introducing new employment rehabilitation/welfare systems in 2007. In CZ, the legal obligation to provide individual plans for vocational rehabilitation still remains to be implemented. LV is launching a National Programme to improve infrastructure, social care facilities and social rehabilitation institutions with EU co-financing. BE and DK are promoting diversity in the labour market (BE: an annual award to the best enterprise, DK: a network for raising awareness among municipalities and jobcentres). In all Member States there is still a long way to go, however, before access to the labour market is even remotely comparable to that of non-disabled people.

3.1.3 Strengthened governance of social inclusion policies

Mobilising stakeholders and raising awareness

The bulk of Member States have made progress, since the previous NAPs for inclusion, in mobilising and consulting those concerned. Among the arrangements for preparing the 2006-2008 National Strategy for Social Inclusion a number of new good practices have emerged, building on the experience gained so far in the OMC.

In many countries (DK, BE, CY, CZ, EE, ES, FI, FR, IE, LU, MT, NL, PT, SE, UK) the process of drafting the NAP was open, from the outset, to participation by NGOs and social services providers, allowing thorough discussion. Nonetheless, in all Member States there is scope for improving the quality of this involvement, ensuring that it actually impacts on policies and priorities, and for extending it beyond the preparatory phase.

Several methods of gathering the views of civil society are being tested. Some countries (AT, ES, MT, LV) used questionnaires to sound out NGOs, service providers/users and/or competent authorities at all levels of government, on access to essential services for vulnerable groups. NL put in place a facility for “interactive” consultation of small groups of stakeholders allowing them to give views on the categories of people most in need of measures, priorities and needs beyond existing policies, and the parties' own action. FR experimented with local forums bringing together people experiencing poverty and professionals expressing their views (supported by innovative facilitation techniques) on institutional arrangements and their impact on obstacles to full participation in society. In BE the report “Abolish Poverty” resulted from debates and ideas from consultative groups including people experiencing poverty.

In the **UK,** "Get Heard" is a toolkit enabling “grass roots” organisations to gather opinions on social inclusion. It has helped people experiencing poverty get involved in their local communities and to make a difference to policies and services which affect their lives, and those working in the voluntary and community sector to discuss what was working and what not in the anti-poverty strategy and possible solutions, and have their contribution better reflected in the national strategy. 146 "Get Heard" workshops have been held around the country. The project was funded by the EU and the UK Government.

While most Member States continued to involve relevant ministries and agencies through committees to coordinate and mainstream social inclusion policies, some tried to open up the process, setting up specific working groups to draw up the plan, with representatives of national, regional and local government and agencies, NGOs and in some cases social partners (BE, BG, CZ, EE, ES, LV, LT, PT, SL). Besides involving representatives of municipalities and regions in national consultative meetings or committees, some Member States (BE, CZ, FR, LV, SE, ES, IE) organised discussion seminars, forums or round tables at regional level, enabling local actors to participate directly in the design of national and regional social inclusion policies. In DE, the cooperation between federal government, *Länder* and NGOs has continuously improved since the preparation of the first NAP/Incl. in 2001.

While the key role played by regional and local authorities tends to be emphasised, only a few Member States (including RO and BG) reported on new or additional arrangements to better articulate the priorities set at national level with the responsibilities of regional or local authorities. Examples are: building on the experience of financially rewarding local authorities for their contribution to government outcomes (through local public service agreements (LPSAs)) by establishing Local Area Agreements setting multi-annual outcome targets for numerous national policy priorities (UK); developing a methodology for creating local and regional action plans for social inclusion by August 2007 (CZ); implementing Social Cohesion Urban Contracts (FR); improving information exchange between local/regional authorities and national government on the outcomes of social inclusion policies (BG, NL, SE, PT).

Cooperation needs to be further strengthened in many Member States to ensure genuine consultation; this raises issues of resources and capacity building. While administrative coordination across government ministries has been improved, and cooperation with stakeholders strengthened, there is still typically much to be done to embed the objectives of the EU social inclusion process fully into policy making systems. This should also involve the participation of people suffering exclusion themselves, both in the implementation and monitoring of the strategy and in steering future policy development.

As to arrangements for the implementation phase, some Member States plan to keep stakeholders involved through round tables, seminars, national or regional conferences, etc. to assess progress and to issue proposals for the way forward (BE, DK, CY, FR, LU, MT, ES). In AT, the two anti-poverty umbrella organisations have been commissioned by the Federal Ministry to consult their member organisations about areas in need of social welfare reforms. The UK is considering setting up a formal stakeholders group. In numerous Member States, the challenge is still to increase coordination, cooperation and the visibility of implementation of the NAP for inclusion across all relevant policy domains. Some Member States (BE, CZ, ES, FR, IE, LT, MT, SE, SI, UK) plan to review progress regularly and if necessary adjust the measures presented. BE and ES have set up a dedicated website with information on the measures and on the activities of the different implementation and monitoring bodies.

Mainstreaming social inclusion

A strong approach to consultation using the expertise of stakeholders is a vital element of social inclusion mainstreaming. All Member States' reports cover the issue (e.g. BE with on-the-spot mediators in poverty and social exclusion placed in 10 branches of the federal administration). Some Member States show a clear understanding that mainstreaming involves integrating social inclusion into all areas and levels of policy making, backed up by the drafting of plans/structures (IE, FR, HU, PT, BE, SE, UK, RO, BG). Some have relatively

long experience of implementing structures/tools, whereas others are at an early stage in designing new governance structures.

IE's policy coordination structure starts at political level with the Cabinet Committee on Social Inclusion, supported at administrative level by a Senior Officials Group which promotes and oversees policy initiatives of a cross-cutting nature. An Office is dedicated to promoting social inclusion, developing mainstreaming tools, and reporting, monitoring and evaluation of the national system of social protection (NSSP) for social inclusion and the social inclusion components of the National Development Plan. The Office has developed a poverty proofing exercise (Poverty Impact Assessment) designed to assess the impact of all policies from the policy formulation stage. Mainstreaming for other target groups is addressed through legislation (Disability Sectoral Plans); specialist expertise (local authority social inclusion units) and strategies such as the National Action Plan against Racism (mainstreaming intercultural issues into the formulation of policy).

The **FR** strategy comprises a political and administrative framework, a targeted approach, and cross-cutting policy objectives directly built into the budgetary process, with indicators to monitor progress. FR plans to draw on the expertise of people experiencing poverty. An interministerial committee (CILE) coordinating social inclusion policies is in place at political level, supported by a permanent committee with representatives of 13 ministries which prepares the work and promotes the implementation of CILE decisions in the relevant ministries. Key activities are national conferences to prevent and combat social inclusion (since July 2004), preceded by five thematic regional conferences and a regular report (DPT) setting out state funding for social inclusion, together with objectives and indicators. It includes cross-cutting objectives such as reducing child poverty, integrating young people, combating illiteracy, eradicating sub-standard housing, and mobilising both institutional stakeholders and sectoral stakeholders organised around the common objectives of the National Plan for Social Inclusion. [*]

In Member States where it has not become a cross-government policy or where policy coordination mechanisms are not fully developed, poverty and social exclusion are nevertheless addressed, but in a way that does not always ensure that the multidimensional nature of the issues is taken into account by the various competent ministries and agencies. A number of Member States tend to describe various components in isolation instead of interpreting mainstreaming as a holistic and strategic approach; for example, they stress commitment and participation (NL, LT, AT); describe advisory councils/collaborative committees (DE, DK); focus on creating more efficient social services (MT) or greater cooperation between various public bodies (MT, DK, ES, PL) or describe how structural funds will be spent on social inclusion (PL, LT). Developing this into fully fledged strategic approaches could reinforce the impact of mainstreaming. It could be a question of strengthening back-up by appropriate plans and structures, or addressing obstacles such as insufficient interdepartmental cooperation, lack of awareness of the issues or a concentration of attention to specific areas. Certain Member States have implemented practical tools to help integrate social inclusion issues in relevant public policy areas and ensure the monitoring of their implementation. So, for example, in PT "Focal Points" in each Ministry will assess the contribution to mainstreaming and train all governmental institutional actors on the importance of mainstreaming.

[*] CILE: Comité interministériel de lutte contre les exclusions; DPT: Document de politique transversale Inclusion Sociale

Certain Member States bring out the importance of not losing sight of specific target groups in implementing mainstreaming. HU, for example, has chosen to concentrate its mainstreaming strategy on the Roma and people with disabilities, and highlights equal opportunities and anti-discrimination as a strong theme (National Equal Opportunity Network charged with promoting the social inclusion of Roma, disabled, children, elderly, women and people living in disadvantaged areas). 16 Opportunity Centres have been set up to cooperate with the relevant organisations, promote dialogue between local governments, institutions and organisations and organise programmes and training courses.

However, ad hoc mainstreaming, with proposals to address certain governance issues, may be necessary to build up a more complete and integrated approach. For example, a key priority for MT and SK is to improve governance structures, which will enable better networking of the social welfare sector (MT) and better coordination of policies at national, regional and local levels to enable policies reach target groups (SK).

In Member States where mainstreaming has yet to be established, key components – improved coordination, strengthened mechanisms for stakeholder involvement, improved systems for delivery of social services, just to give a few examples – may indeed need to developed gradually. In general, mainstreaming needs to be better understood as a strategic tool that requires a wide variety of structures and processes to be in place in order to be used successfully. There is a balance to be struck between targeting vulnerable groups with specific actions, and ensuring that this special treatment does not result in further segregation, and consequently discrimination.

Gender mainstreaming

More gender awareness is demonstrated with respect to the social situation and social inclusion policies than in previous reports. Many Member States stress the importance of promoting equality between women and men, make a commitment to gender mainstreaming and/or refer to the government's gender equality programme (AT, CZ, DK, EE, ES, FI, FR, HU, IE, LT, MT, NL, PT, SE, SI, SK, UK, BG). A handful of Member States strive to adopt a consistent gender mainstreaming approach in the majority of priority policy objectives (EL, FR, IE, LT, LU and SE). For the bulk of countries there is considerable scope for developing this consistently across policies, e.g. by allowing available statistical information on gender inequalities to influence policy design more, and for providing more detail on how gender mainstreaming is implemented.

For **LT**, the gender aspect is consistently present in the social situation analysis and is mainstreamed into all policy priorities. The priority to integrate more people into the labour market, for example, acknowledges the difficulties faced by women with caring responsibilities. The proposed measures include an emphasis on changing traditional stereotypes on the role of women and men with a view to establishing gender equality on the labour market; on increasing the possibilities for women, in particular in rural areas, to start and develop businesses; and ensuring that activation measures reach disadvantaged women, such as victims of trafficking, pregnant women, and mothers of children under 8 or a disabled child under 18.

IE presents a consistent awareness of gender equality issues in all policy priorities. The measures under the priority to improve access to quality services, for example, include promoting gender equality across all government services, policies and programmes. This is to be achieved by developing, implementing and monitoring appropriate policies including programmes for *Positive Actions to Promote Gender Equality* (including the implementation

of the National Women's Strategy) and *Equality Proofing*. The National Women's Strategy, due to be published in the first semester of 2007, will be a cross-departmental strategy aimed at enhancing the socio-economic status of women, their well-being and their participation in decision-making and civil society.

Examples of gender mainstreaming are found in the majority of **EL** policy priorities. In education and training, for example, addressing disadvantage includes offering counselling and career guidance programmes based on a gender dimension, planning/revising curricula so as not to reproduce stereotypes, and producing education material to introduce gender equality issues. Positive action in favour of women is being promoted in higher education and lifelong learning via specific programmes and incentives such as scholarships to attract women into fields in which they are under-represented. An 'Equality in Education' Observatory is also planned.

A large majority of Member States are focusing on increasing labour market participation, and about one third (AT, CY, EL, ES, FR, HU, IE, LT, UK, IT) have signalled measures targeted specifically at women. Many are also providing assistance to families (CZ, DE, EE, FI, EL, FR, IE, LT, LV, NL, PL, SK) and most are committed to increasing child care provision and to promoting reconciliation of work and private life. The role of men in informal care is also addressed in some reports (CY, EL, HU, LT, LV). All these policies have an impact on gender equality and can be instrumental in promoting female employment and thereby in halting the trend towards the feminisation of poverty.

As highlighted above, a majority of Member States are setting out to tackle child poverty and some of them recognise the importance of the gender dimension in this respect (AT, EL, HU, IE, LT and PT). This includes measures such as providing opportunities for mothers to return to the labour market, supporting lone parent families, implementing reconciliation policies, increasing the availability of child care facilities, and encouraging men to take paternal leave. Some acknowledge the differences between girls and boys in early school leaving (EE, IE, LU, SE). A small number of the proposed education and training programmes aim explicitly at promoting greater gender equality (EL, ES, FR, LT).

In their policy priorities, some Member States address the specific problems faced by ethnic minority and/or immigrant women (DK, DE, EL, ES, FR, IE, NL, SE). Some include measures to improve the situation of women victims of trafficking and/or violence (AT, DK, EL, ES, FR, HU, LT, LV, MT, PT, SE, SI, SK, IT) or refer to the gender perspective in the design of measures targeting the homeless (BE, IE, NL, SE). A number of reports acknowledge the gender pay gap (AT, CY, DE, EE, ES, FI, FR, LT, MT, SK, UK).

Targets tend to be disaggregated by gender when looking at raising female employment (BE, CY, DE, ES, HU, IE, LU, MT, SE) but not in all areas where it would be relevant, except for SE. Monitoring targets broken down by gender and analyzing sex-disaggregated statistics, where possible, would help in making visible both positive and negative policy impacts on the respective situation of women and men.

A handful of Member States provided information as to whether gender equality units or women's organizations with specialised expertise in the field were among the stakeholders consulted.

Use of indicators, targets, monitoring and evaluation

The National Strategy Reports show how common EU indicators can be used to assess the situation in the wider EU context and in relation to all dimensions of the objectives. Most Member States draw on the *EU's lists of overarching and social inclusion indicators* to describe the social situation, often focusing on the key indicators that are most relevant to their strategy. A number of countries also base their assessment on a full review of the overarching and social inclusion indicators presented in an annex to this document. The EU-based indicators are often supplemented by *national outcome indicators*, used as an alternative to the EU measure, or to cover populations such as specific vulnerable groups (immigrants, ethnic minorities, the disabled, people living in deprived areas, the homeless), or to cover dimensions that are not yet covered by EU indicators (housing, persistent poverty, socio-economic gaps in life expectancy, etc). Member States also use *national input or output indicators* that are often more timely and directly related to specific policy measures, such as the number of child care places, the number or percentage of beneficiaries of a given programme, the number of homes built in the social housing sector, etc. In many cases, these policy-related indicators are accompanied by targets.

Some Member States have been more successful than others at pointing out how the quantitative assessment presented is used in policy making, in terms of identifying priorities, monitoring progress and, in some cases, setting targets. A number of countries have set up specific inter-ministerial indicator groups or bodies that are in charge of developing the indicators used and/or monitoring progress.

The **UK** report is an example of good practice on how indicators can be used for policy making in all three areas quoted above: in addition to the fact that monitoring on the basis of indicators and targets has been part of its social inclusion strategy since the late 1990s, the UK has made an effort to link its national monitoring exercise to a thorough assessment of the newly adopted EU indicators (including summary tables), thereby assessing the UK performance in the EU context.

The **FR** report is another good example of how common EU indicators and supplementary indicators can be used in policy making. National priorities are accompanied by the relevant indicator(s), both to justify their selection as priorities (outcome indicators) and to monitor progress (both outcome and input/output indicators). A nationally defined set of indicators consistent with the EU common indicators has been agreed to monitor social cohesion.

Monitoring and evaluation are greatly facilitated when plans are focused on clear political outcomes and contain quantified targets. There is some increase in the use of quantified targets, but there are important differences between Member States. Some of them either have put forward no targets at all or present so few targets that it seems unlikely that these will give meaningful direction to the plan. Several Member States, however, put forward a broader set of targets. Most systematic use of targets seems to be made in the reports from IE, UK, NL and PT. Across the board there is considerable scope to strengthen the use of targets.

One issue worth noting is the way in which strategies are formulated and targets are set in countries where regional and local authorities have considerable power in the field of social inclusion. In the UK, as indicated above, national targets are supplemented by targets for Scotland, Northern Ireland and Wales. In some cases local governments receive a financial reward if they commit themselves to targets for national priorities.

The need for effective monitoring and evaluation is acknowledged more than previously in the reports, and although often very little concrete information about the arrangements is provided, it can be concluded that there is a basis for mutual learning. Almost half the

Member States indicate that they have working NAP or social inclusion monitoring systems, and some others plan to develop them in the near future. In other Member States, implementation of the strategy on social inclusion is to be monitored as part of broader strategies or through other existing processes and reports (e.g. by statistical institutes). In addition, often specific monitoring systems exist for each policy priority. Many Member States provide a list of monitoring indicators for each political priority.

Typically, a social inclusion coordinating unit in the Ministry responsible is charged with coordinating monitoring activities. A number of Member States have appointed social inclusion liaison officers in the ministries and organisations involved (IE, PT) to facilitate the process. In some Member States, monitoring is the responsibility of the government alone, while in others a specific monitoring committee involving NGOs and social partners, for example, is in place to assist the government in developing the monitoring framework and to assess results. Where specific monitoring systems for each policy area have been developed, specific stakeholders are often involved. So in LU, for example, there is tripartite participation in monitoring labour market policies (government, unions and employers) and education (teachers, parents, pupils).

Sometimes annual monitoring reports are produced. A few countries have integrated monitoring of the resources invested in social inclusion policy in the budgetary process (e.g. FR, PT). The NL and UK produce easily accessible reports that show clearly whether they are on track or not. Some countries continually update indicators on a website.

Issues to be resolved include a lack of recent data, breaks in the time series and unavailable indicators. Clearly, countries need to invest in statistical and analytical capacity. Some Member States set out to address this through well developed data strategies (IE), making the provision of high quality and reliable data a political priority (SK), developing new data and information systems (e.g. EE: employment policy statistics, IE: data on migrants, LT: social assistance information system) to allow for more evidence-based planning. The annual reports of ombudsmen are cited in several cases as important sources of information.

On the issue of including regional and local levels of government in monitoring, NL provides an interesting example. Local authorities are responsible for the results of policies at their level, but the central government provides (national) benchmarking instruments on a website allowing local governments to compare the results of their policies. PT intends to link national and regional-local information systems for monitoring purposes.

Overall, there is very little information on evaluation arrangements. Sometimes an evaluation plan, report or conference is mentioned. Efforts will face the challenge of establishing the causal impact of an intervention. Evaluation tends to be scheduled at the end of the planning period to feed into the next strategic cycle. Different tools are used – surveys, conferences, seminars, consultation processes, etc. – and procedures may be formal or informal. Often stakeholders and independent experts are involved (more so than in the case of monitoring). Evaluation is sometimes mentioned in relation to monitoring bodies. Obviously, establishing the causal impact of policy interventions on outcomes represents an important challenge and progress in this field could be greatly facilitated if Member States' were more informed about each other's experiences.

For such mutual learning purposes Member States should be encouraged in future to provide more information on evaluation methods, the questions, the format and dissemination, the stakeholders involved, the availability of internal and independent expertise, and the financial and human resources devoted to evaluation.

As an example of ex ante evaluation, IE's Poverty Impact Assessment was referred to above. Some Member States apply the idea of systematically organising and evaluating smaller scale policy experiments before applying them on a bigger scale (e.g. the UK: employment retention and advancement project and pathways to work: testing innovative approaches).

Use of structural funds, in particular the European Social Fund

Member States have, to large extent, made progress towards better coordination between social inclusion measures and use of the Structural Funds, notably the European Social Fund (for example NL, DE, AT, SK). However, there is considerable room for improvement, particularly in increasing the visibility and importance of the ESF, as well as the ERDF, in achieving social inclusion. The new programming round (2007-2013) presents an exceptional opportunity for upgrading. Member States and Regions now have at their disposal a financial instrument which is both more precise and simpler to use.

Reinforcing the social inclusion of disadvantaged people with a view to lasting employment is now a specific priority for the ESF. Action to develop preventative and active policies to integrate or re-integrate the socially excluded into the labour market also can be supported under all ESF priorities for 2007-2013, underpinning the call for the mainstreaming of active inclusion policies in national policy-making.

Many of the National Reports stress that employment offers the main route out of poverty and consequently a pathway to social inclusion. It is appropriate, therefore, that ESF support should be concentrated on actions which are likely to help people back to work, such as education and training, employability and lifelong learning. It can also be used for measures aiming at the social inclusion of persons not yet ready to integrate in the labour market. However, employment in itself may be insufficient to secure social inclusion; other types of intervention allowing for the wider and gradual integration and empowerment of social groups should also play a role here.

The regulations call for action to be based on prior identification of needs by, for instance, using relevant national and/or regional indicators such as unemployment and participation rates, long-term unemployment rates, population at risk of poverty rates and levels of income. But attention should also be paid to the local level, where disparities may fail to be picked up by regional statistics.

In addition, visibility should be improved as to the scope for ERDF contributing to the improvement of infrastructure related to social inclusion and fighting urban deprivation. There will be scope under the 2007-2013 programmes to support human capital investment, promote awareness and improve awareness and access to start-up financing for entrepreneurship, including for the unemployed and ethnic minorities.

3.1.4. Annexes to section on social inclusion

ANNEX 1:GOOD PRACTICE EXAMPLES IN SOCIAL INCLUSION POLICIES IN THE 2006 NATIONAL REPORTS

The examples of good practice described below are taken from the many and diverse examples of good practices presented by Member States in their National Reports. In the *Guidelines for preparing national reports on strategies for social protection and social inclusion*, it was suggested that MS give examples of policies or projects that have been evaluated and shown to have important lessons for policy-making or cover a key institutional arrangement relevant to some aspect of the common objectives. The inclusion of specific monitoring/evaluation results is useful, inter alia, when disseminating good practice among other Member States. The examples selected below aim to cover key policy areas evenly, and to highlight projects with a comprehensive approach to tackling the multiple facets of social exclusion and the accumulation of disadvantages. The examples are of projects that have received a positive evaluation and would seem to have a lasting impact. Some examples of good practice provided by Member States are shown in boxes in the main text instead. These are listed at the end of this Annex for ease of reference.

Access to resources, rights and services for full participation in society

Tackling child poverty

UK – *Working for Families* is a funding stream of €50m for the period 2004 – 2008, allocated to certain local authorities under the auspices of the Scottish Executive, based on the number of children in households dependent on workless benefits. The principal aim is to ensure that access to affordable, flexible childcare is not a barrier preventing parents from client groups (lone parents, low income families, families with other stresses causing difficulties with sustaining employment) from accessing education, training or employment. Key workers assess an individual client's needs, and at the same time help the client to access, and sometimes pay for, appropriate childcare so that the client is not prevented from taking up the opportunity identified. Progress is measured using a range of hard and soft outcomes. Hard outcomes include full/part-time employment or entering or completing an educational or accredited vocational training course of 6 months or more. As at 31 March 2006, 6000 parents had engaged with Working for Families in the period 2004 – 2006, and 2600 of these had achieved a hard outcome.

MT's *NWAR Programme* is a family literacy programme set up by the Foundation for Educational Services in 2003, as part of a strategy to significantly reduce illiteracy in Malta. Specifically, the programme provides an after-school family literacy service to families where children are at severe risk of failure due to poor literacy skills. The service is offered twice weekly to both children and their parents. The second specific aim of the programme is to disseminate throughout the educational system those differentiated teaching methodologies which are found to be effective, in order to raise the level of acquisition of basic skills in Maltese schools. A Basic Skills Assessment Tool has been developed, which allows teachers to assess students' progress and adapt teaching methodologies accordingly.

Access to services

SI's *Residential Groups in the area of mental health* seek to provide accommodation and individualised care for persons with long-term or moderate mental disorders, who otherwise might only have recourse to institutional care. Residential groups provide 24-hour

accommodation in units of up to 7 or14 users, and provide greater privacy and independence for the user than institutions. Under the National Social Security Programme for 2006 – 2010, the network of residential groups is defined as one of the nine public programme networks. In 2006, the residential groups are being implemented by 6 non-governmental organisations and 1 public institution, with 174 users in 33 groups, accounting for 11% of the total population in social care institutions.

LV's *Improvement of infrastructure and equipment of social care and social rehabilitation institutions,* which was launched at the end of 2004, is an ERDF co-financed national programme aimed at modernising state social care and social rehabilitation institutions, so that persons not in need of institutionalised long-term care can obtain services tailored to enabling them to return to everyday life and, if possible, enter the labour market. There are 5 regional partnership projects between local governments and state social care institutions, which provide clients with additional services such as halfway houses, day-care centres, social rehabilitation, skills development, group apartments, etc. The total budget of the programme is €7.25 million.

Housing/homelessness

LU – *Renting of housing by NGOs***:** The Housing Fund (HF) is the largest public promoter in the country and provides social housing for rental, some of which it makes available permanently to NGOs who, in turn, rent this housing to the persons to whom they provide social assistance, also providing them with housing adapted to their specific needs (low income, disabled). They also carry out regular social supervision of the people in receipt of housing. Over the last 15 years, 22 associations have benefited from one or several of the 85 rental dwellings and all 85 units continue to be managed by the same NGOs without any major problems.

UK – *A New Approach to Homelessness* – Since March 2002, through the Homelessness Act 2002 and a number of strategy documents setting out the need for a coordinated approach to tackling homelessness, local authorities have been both required to and empowered (via statutory powers, increased funding) to tackle the problem of homelessness across the UK. Major successes have been recorded – annual figures for 2005 show a 75% reduction in rough sleepers in England since 1998; use of Bed and Breakfast accommodation for families with children for longer than 6 weeks has been outlawed; it is estimated that 73 884 households will have been prevented from becoming homeless in 2005/2006 through local authority prevention measures.

FR - The national "Eradiquer l'habitat indigne" plan is an inter-ministerial initiative designed to eradicate housing of unacceptable living standards. It provides a solid legislative framework to underpin the duties and powers of municipalities and other authorities responsible in identifying and rehabilitating poor housing in their areas. It also reinforces the duties of owners as well as the rights of tenants. The legislative framework is backed up by specific operational and financial tools to enhance the action of municipalities. The monitoring provides strong evidence of a significant increase in the rehabilitation of poor housing in both rural and urban France.

Migrants and minorities[47]

PT's *National Support Centres for Immigrants (NCSI)*, located in Lisbon and Oporto, and opened in 2004, provide integrated services to support the immigrant population in Portugal. The Support Centres were set up in response to the problems faced by a growing immigrant population, including too difficult access to dispersed services, linguistic and communication difficulties and no adequate answers to several questions raised by immigration. Socio-cultural mediators mostly from immigrant communities are involved, in an effort to generate trust with the target group. The NCSI have a monitoring system which enables them to collect data on the number of attendees and waiting periods. An external assessment by the International Organisation for Migration was undertaken in 2006.

Addressing financial exclusion and over-indebtedness

In June 2006, the **DK** parliament adopted an act on *Pilot Projects involving remission of public sector debt for socially disadvantaged groups.* The act sets up a four-year pilot project combining the need to remit the debt with incentives to involve the person in gainful activity. The target group is persons who have been in receipt of social assistance for four or more consecutive years. To qualify for the scheme, a person must find and retain a job or subsidised employment, start education or enter a rehabilitation process. DKK 25m per annum has been allocated for the period 2005 – 2008.

Labour market integration and fighting poverty

Employability and integration of people furthest from the labour market

AT's *"initiatives of the social partners to improve the labour market opportunities of disadvantaged groups"* project provides a consistent framework for measures taken together mainly by employers' and employees' organisations to combat youth unemployment, to encourage the employment of older workers, to integrate the disabled more into the labour market, and to create health-compliant workplaces and a suitable framework for individuals in precarious forms of employment. In addition to the groundwork done at company and public employment services level, the project also involves awareness-raising in the general public.

ES: The *multi-regional programme to fight against discrimination* was put in place in 2000 and aims to enhance the active inclusion of people most at risk of exclusion. The programme takes an integrated approach and mobilises all the relevant stakeholders in an effort to offer flexible and individualised paths of integration to people with specific disadvantages. A monitoring system provides evidence that over the last 5 years 64 342 contracts have been signed, 619 companies created, 44 863 persons trained, etc. The project also adds to the network of NGOs working with these target groups.

LT's *Programme on Professional Skills Training for Individuals Addicted to Drugs* is designed to motivate persons addicted to drugs to take an active role in the labour market and to receive legal income, and to receive training in the field of public catering services through their involvement in the *Mano Guru Salad Bar.* This project has been run since 2004 by the Social Aid division of Vilnius City Municipality and Vilnius Centre for Addictive Disorders. Since 2004, 29 people from six rehabilitation centres across Lithuania have participated in the

[47] For more examples of good practice in the area of integration, see 'Handbook on Integration for policy-makers and practitioners' http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/handbook_en.pdf: The second edition is due to be published in 2007.

programme, and 11 participants have successfully completed the programme and found new jobs. This programme obtained funding from EQUAL for further development of its activities.

NL *Amsterdam Form Brigade* – This initiative seeks to address people's lack of awareness of their social entitlements, and is also an active inclusion initiative. Almost every district in Amsterdam has 'Form Brigades', staffed by teams of volunteers (100 volunteers in all, themselves unemployed and on benefit for a long time) with the purpose of informing district residents of their rights, and helping them complete all sorts of forms related to social services and entitlements. The volunteers receive training and on-the-job mentoring. Each year more than 20% of them move on to a paid job.

Roma

SK's *Programme in support of the development of community social work in municipalities* is a comprehensive multi-dimensional approach designed to develop social work to assist groups most at risk of social exclusion. The programme targets the Roma community in particular. It aims to support the socially excluded in the field of employment, living conditions and housing, education, health care and social integration, and on specific problems experienced by individuals. Community social workers operate in 176 municipalities, in cooperation with local authorities which, for example, are obliged to provide office facilities for the administration of social work, and to provide a certain amount of co-financing. Detailed monitoring criteria have been worked out, and the programme will be evaluated in the second half of 2006. To date, 600 social work-related posts have been created, with spin-off as regards employment rates.

EL *Safeguarding – Promotion of Health and Social Inclusion of Greek Roma* is part of Greece's Integrated Action Plan on Roma. Since 2005, 18 medico-social centres have been in operation; these provide the first line health care, social care and social inclusion services, with plans for the establishment of a total of 37 centres. The medical aspect includes referrals to hospitals, vaccination of children, health education programmes and the keeping of medical history records. The social aspect includes communication with enterprises to find jobs for Roma, enrolment of Roma children in the 1st grades of primary and secondary school, intervention in the cases of school dropouts, cooperation regarding domestic violence, etc. There are also mobile units visiting remote communities. It has been noted that the target group's response has improved, and greater trust and cooperation has developed over the course of the project.

Governance

Mobilising stakeholders

SE – *University courses for student social workers and former clients together -*
Three university courses run by the Basta Work Cooperative and the Department of Social Work at Lund University under the EQUAL Programme. The courses, of 6 weeks duration, bring together students of social work and course participants who are either former social worker clients or marginalised and have no former university education. The aim of the courses is to give both groups an understanding of the working and living conditions of the other, to show how clients can be empowered to overcome social exclusion, and to demonstrate in what ways social work can contribute to this. All of the students are awarded 5 European Credit Transfer points at the end of the course, which is to be put on a permanent footing.

PL's *Civic Initiative Fund*, planned as a 3-year project, is a fund designed to stimulate and support the development of civic initiatives with the participation of non-governmental organisations. The fund's objectives are to support innovative projects by NGOs; partnerships between NGO and public sectors; cooperation between NGOs; and dissemination and promotion of good practices, as developed in particular within the CIF programme. Projects have to cover one of the following areas: social protection, social inclusion and activation, human/civic rights and freedoms, science, culture, education and care, public safety and public defence. The Fund is monitored through reports submitted by funded organisations.

IT - *Using the ESF to promote labour market insertion of disadvantaged groups through non-profit organisation.* Global grants in Objective 3 regions of Italy directly support non-profit organizations promoting employability of disadvantaged groups. Small grants ranging from 10,000 to 50,000 € were made available to non-profit organizations for projects promoting labour market insertion of disadvantaged groups in particular through the promotion of entrepreneurship and self-employment. Intermediary bodies provide organisational support and training. The scheme aims to build and strengthen networks of non-profit organisations active in regions of the Centre-North. In Lombardy 25% of the final beneficiaries were recipients of invalidity benefits and 10% recovering drug addicts

Mainstreaming

BE – *Insertion de médiateurs de terrain en pauvreté et exclusion sociale au sein de l'administration fédérale* sets out to promote the emergence of a new profession in the fight against poverty and social exclusion. Through the expertise of people knowing poverty from the inside, it seeks to ensure that there will be a greater emphasis on and a better understanding of poverty and social exclusion issues at the core of the federal administration. This project, administered by the *SPP Intégration Sociale,* involves the placement of 16 *médiateurs de terrain*, 8 French-speaking and 8 Dutch-speaking, in 10 federal public services, including 5 social security institutions. The specific tasks of the *médiateurs* in each service are constantly evolving, as part of dialogue between the *médiateurs*, the *SPP Intégration Sociale* and the specific services.

IE's *Disability Sectoral Plans,* which were launched in July 2006, are an example of using legislation as a mainstreaming tool to improve access to mainstreamed services for a specifically targeted vulnerable group. The Disability Act 2005 requires six Government Departments (Health and Children; Social and Family Affairs; Enterprise, Trade and Employment; Transport; Environment, Heritage and Local Government; Communications, Marine and Natural Resources) to develop Sectoral Plans to show how key issues relating to people with disabilities will be addressed. The Plans must give details on the level of access relating to the services specified in the Plan. The first three of the above-mentioned ministries must also give details on cross-Departmental cooperation to ensure coordinated service delivery for people with disabilities. The Act also requires people with disabilities to be consulted in the development of the plans. Progress reports on the Sectoral Plans will be prepared after 3 years.

List of examples of good practice highlighted in the main text

CY: *Educational Priority Zones*

FR: *Réussite Educative*

RO: *Gata, Dispus si Capabil*

EE: *Community Services in a Village*

AT: *Laender programmes to prevent eviction*

DE: *Handlungsprogram "Soziale Stadt NRW"*

FI: *Labour Force Service Centre*

BE: *Management de la diversité*

HU: *Study Hall "Tanoda" Programme*

CZ: *Comprehensive approach by the city of Ostrava to eradicate discrimination against socially excluded Roma and Roma at risk of social exclusion*

BG: *National Programme for Employment and Vocational Training of Persons with permanent disabilities*

UK: *Get Heard!*

ANNEX 2: LIST OF EXAMPLES OF GOOD PRACTICE IN THE FIELD OF SOCIAL INCLUSION BY COUNTRY.

Member State	Example
Austria	**Initiatives of the social partners to improve labour market opportunities of disadvantaged groups**
Austria	**Training support and assistance schemes under integration-type vocational training**
Austria	**Prevent eviction/retain lodging**
Austria	**Anti-poverty conference**
Belgium	**Management de la diversité**
Belgium	**Accès direct de la rue au logement pour les personnes sans abri**
Belgium	**Plan stratégique en matière d'intégration des technologies de l'information et de la communication dans les établissements scolaires de l'enseignement obligatoire de l'enseignement de promotion sociale**
Belgium	**Insertion de médiateurs de terrain en pauvreté et exclusion sociale au sein de l'administration fédérale**
Bulgaria	**Employment for the Roma**
Bulgaria	**National Programme for Employment and Vocational Training of persons with permanent disabilities**
Bulgaria	**Care Leavers Integration Programme**
Bulgaria	**Social Investments in Children**
Bulgaria	**Child Welfare Reform**
Cyprus	**Life Education Centres**
Cyprus	**Educational Priority Zones**
Czech Republic	**Comprehensive approach by the city of Ostrava to eradicate discrimination against socially excluded Roma and Roma at risk of social exclusion.**
Czech Republic	**Support from ESF for the provision of social services for the benefit of homeless persons**
Czech Republic	**Stop Social Exclusion Information Campaign**
Denmark	**Employment initiatives aimed at mentally ill people**
Denmark	**Programme board strategy against ghettoisation**
Denmark	**Debt Remission Pilot Project**
Denmark	**Alternative residential facilities**
Denmark	**Upper Secondary School Reform**
Denmark	**Combating men's domestic violence against women and children**
Denmark	**Employment, participation and equal opportunities for all**

Denmark	**Prostitution: a new life**
Denmark	**Speech recognition in Danish**
Estonia	**Pilot project of home care workers**
Estonia	**Training unemployed persons to become call centre operators**
Estonia	**Community Services in a Village**
Finland	**Social Guarantee**
Finland	**Labour Force Service Centre model**
Finland	**Social Credit**
Finland	**Advisory Board on Romani Affairs**
France	**Développer l'égalité salariale entre les hommes et les femmes**
France	**Création de l'Agence Nationale de Rénovation Urbaine**
France	**Eradiquer l'habitat indigne**
France	**Programme "réussite educative"**
Germany	**Betrieb und Schule**
Germany	**Handlungsprogramm "Soziale Stadt"**
Germany	**"Sozialrauemliche Familien- und Jugendarbeit"**
Greece	**Safeguarding – Promotion of health and social inclusion of Greek gypsies**
Hungary	**Integrated Roma Central Employment Programme**
Hungary	**Study Hall (Tanoda) Programme**
Hungary	**"Place of Correction" Attendance Centre**
Hungary	**Card Operated Consumption Meters**
Ireland	**Disability Sectoral Plans**
Ireland	**Social Inclusion Units in Local Authorities**
Ireland	**Poverty Impact Assessment**
Italy	**Local plans for social inclusion**
Italy	**ESF global grants for social inclusion**
Italy	**Database of social needs**
Italy	**Labour market insertion of people with disabilities**
Latvia	**Improvement of infrastructure and equipment of social care and social rehabilitation institutions**
Lithuania	**"Mano Guru" Bar**
Lithuania	**Elderly Women's Activity Centre**
Lithuania	**Window to the future alliance**
Luxembourg	**Location des logements par l'intermédiaire ONG**
Luxembourg	**Suive des décrocheurs scolaires**
Malta	**Social Policy Information Centre**
Malta	**Care and Repair Service**
Malta	**Home Support Service**
Malta	**NWAR Programme**
The Netherlands	**Synergy between Work and Social Assistance Act (WWB) and the Social**

	Support Act (Wmo) in neighbour home care service (Tilburg).
The Netherlands	**Poverty and health intervention by municipal health service in West Brabant**
The Netherlands	**Linking of databases for the Reimbursement of Exceptional Expenses Scheme**
The Netherlands	**De-bureaucratising in Houten**
The Netherlands	**The Amsterdam Form Brigade**
The Netherlands	**Work and Social Assistance Card**
Poland	**Social Employment**
Poland	**Civic Initiative Fund**
Poland	**System of Family Benefits**
Portugal	**National Support Centre for Immigrants**
Portugal	**Active Participation**
Portugal	**Methodology of the Integrated**
Romania	**"Gata, Dispus si Capabil"**
Romania	**Building a model of Integrated Community Support Services for young drug addicts**
Romania	**Samusocial din Romania**
Slovenia	**Activation and employment of Roma and people with disabilities**
Slovenia	**Residential Groups in the area of mental health**
Slovenia	**Foster Care**
Slovenia	**Temporary Housing Units**
Slovakia	**Programme in support of the development of community social work in municipalities**
Slovakia	**Increase of employability of groups affected and threatened by social inclusion through local social inclusion partnerships**
Slovakia	**Crisis intervention in Banska Bystrica city**
Spain	**Common Fund for Immigrants**
Spain	**Integrated Programmes in autonomous regions**
Spain	**The experience of private management of the Structural Funds in the fight against discrimination**
Sweden	**University course for student social workers and former clients together**
Sweden	**Komet programme – Social inclusion through prevention**
Sweden	**Good housing in Bergsjon – Project to prevent eviction**
United Kingdom	**A New Approach to Homelessness**
United Kingdom	**Child Poverty Accord**
United Kingdom	**Working for Families**
United Kingdom	**Get Heard!**

3.2. Strategies in Health Care and Long-Term Care

3.2.1. Introduction

This section reviews the 2006 national reports in relation to health care and long-term care as part of the first full coordination exercise under the streamlined OMC. Member States submitted national reports on social inclusion, pensions and, for the first time, health care and long-term care in September 2006. This chapter analyses the main challenges Member States face and their planned strategies to tackle these challenges in the fields of health care and long-term care in the light of the agreed common objectives (see below).

Common objectives for health care and long-term care

Member States are committed to ***accessible, high-quality and sustainable health care and long-term care by ensuring:*** (j) access for all to adequate health and long-term care and that the need for care does not lead to poverty and financial dependency; and that inequities in access to care and in health outcomes are addressed; (k) quality in health and long-term care and by adapting care, including developing preventive care, to the changing needs and preferences of society and individuals, notably by developing quality standards reflecting best international practice and by strengthening the responsibility of health professionals and of patients and care recipients; (l) that adequate and high quality health and long-term care remains affordable and financially sustainable by promoting a rational use of resources, notably through appropriate incentives for users and providers, good governance and coordination between care systems and public and private institutions. Long-term sustainability and quality require the promotion of healthy and active lifestyles and good human resources for the care sector.

The role of health care systems in combating the risk of disease and contributing to social cohesion and employment has been acknowledged for some time by the European Union. Thus, the April 2004 Commission communication (COM(2004)304) proposed to extend the OMC to the areas of health care and long-term care in order to establish a common framework to support Member States in the modernisation of their systems. This communication was endorsed by the Council in October 2004. The Council also stated that, in 2005, Member States were to present national preliminary statements regarding the challenges faced by their health care and long-term care systems, current reforms and planned policies. The resulting November 2005 Memorandum of the Social Protection Committee highlighted the main issues raised by those statements and contributed to the definition of the new streamlined common objectives.

In this section, chapters 2, 3 and 4 analyse in greater detail the specific challenges identified in the national reports in relation to access, quality and long-term sustainability, and describe associated policy measures. Chapter 5 looks at access, quality and sustainability in the specific field of long-term care. Chapter 6 concludes and identifies key issues for further work and best practice exchange under the OMC.

Importantly, the national reports show how strongly interlinked the above common objectives are. They emphasise the strong synergies between improving access, enhancing quality and ensuring sustainability in a number of policies. Thus, the reader will find the same issues addressed in more than one section, albeit from a different perspective to reflect these synergies.

3.2.2. Global challenges in the area of access and policies to address them

National reports show that all EU Member States are strongly committed to ensuring access for all, to adequate health care and long-term care. Solidarity and equitable financing (progressive financing through income-related taxation and contributions, risk pooling, risk selection prohibition and risk adjustment mechanisms) are principles inherent in health care systems. Moreover, by way of their design, Member States aim to ensure that access does not depend on ability to pay, income or wealth and that the need for care does not lead to poverty and financial dependency. Universal or near universal rights giving access to care can be found in all Member States, either through National Health Systems (NHS), providing access rights to all residents in a country, or through Social Health Insurance Systems, where access rights are typically granted to those making contributions (and their families) and the State (through taxation) ensures access for non-contributing individuals.

However, universal rights do not necessarily translate into universal access and there remain significant sources of inequalities in access that demand further attention. These include lack of insurance coverage, lack of coverage/provision of certain types of care, high individual financial costs of care and geographical disparities of supply. They also include lengthy waiting times for certain treatments, lack of knowledge or information and complex administrative procedures.

Moreover, whilst, according to most empirical findings, health care systems have largely contributed to significant improvements in health across the EU, there is considerable scope for improvement. All EU countries are faced with substantial inequalities in health within their populations, which have widened in the latter part of the 20th century (Mackenbach, 2005 for UK Presidency[48]). National reports document significant differences in the health outcomes within each country between different sections of the population based on socio-economic status, place of residence and ethnic group (e.g. Roma, travellers or migrants). On average, less advantaged groups have shorter lives, suffer more disease and illness and feel their health to be worse than more advantaged groups. A gradient exists for most health indicators in which those with higher levels of education or wealth, or those in professional employment, have better health on average than their counterparts.

These health inequalities arise because of systematic differences between people according to social group: in the quality of their physical and social environments (e.g. at home, school, workplace), material conditions (poverty and material deprivation, exclusion and marginalisation) and in their exposure to factors which influence health, such as quality of nutrition, level of physical activity, tobacco and alcohol use, sexual behaviour and psychosocial factors (negative life events and a combination of high effort and demands with low reward and low control). Addressing health inequalities requires action to increase social protection and tackle social exclusion, to ensure that socio-economically disadvantaged people are not subject to additional disadvantages in relation to access to health services, and to protect and promote health – particularly in specific disadvantaged groups.[49] Given its clear significance and implications for EU citizens, this is an area of potential EU level exchange. The OMC investigated how social protection systems – including access to care – contribute to reducing health inequalities by means of a peer review in January 2007.

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48 Department of Health, United Kingdom
http://www.dh.gov.uk/PolicyAndGuidance/International/EuropeanUnion/EUPresidency2005/EUPresidencyArticle/fs/en?CONTENT_ID=4119613&chk=Xa2sOh

49 The section regarding social inclusion highlights some of the action taken for the most vulnerable groups.

3.2.2.1. Lack of insurance coverage of the population

There have been consistent increases in health care and long-term care expenditure and Member States have made significant efforts to increase the proportion of their populations that are covered by health insurance. However, there are still some groups without insurance coverage of any sort. In Estonia, for example, 6% of the population only have access to emergency care, and in Slovenia up to 20 000 people are without health insurance owing to their lack of permanent residence or citizenship. In Greece, 3% of the population are not covered, whilst in Austria this proportion is around 2%. In Lithuania and in Belgium the figure is 1%, while it is 0.5% in Germany, 0.2% in Spain and 0.1% in France and in Luxembourg. NHS systems by definition provide coverage for all their resident population. This does not mean, however, that access to care under NHS systems is equal for all population groups.

In general, lack of insurance coverage relates to: a lack of permanent residency or citizenship, lack of official papers, a failure to register with the relevant authorities (often associated with a lack of understanding of how the system works, notably due to a lack of information regarding registration procedures - as is the case in Bulgaria and Romania). Further reasons for lack of insurance coverage include administrative hurdles when changing jobs or marital status. The long-term unemployed, those not receiving social security benefits, minorities (e.g. Roma), the homeless, illegal immigrants and asylum seekers are all particularly at risk.

Furthermore, insurance coverage is not generic for all groups: in many Member States the richest households typically acquire extra voluntary insurance that provides complementary or supplementary coverage. Certain Member States have specific arrangements: in Portugal, for example, distinct groups (e.g. civil servants) have double or triple coverage through both the NHS and their own social insurance system. In Ireland only 28.5% of the population receive a wide range of services for free (based on income and age).

Member States recognise the problem and many have implemented or plan to implement policies to enhance health care coverage. France has created the Couverture Maladie Universelle Complémentaire to cover the full costs of care of more vulnerable groups. This programme also provides financial aid to those on low incomes to help acquire complementary insurance. The Netherlands have introduced mandatory health insurance for the whole population[50] whereas Belgium is increasing risk coverage of the self-employed to align it with the rest of the population. Cyprus is to introduce universal residence-based coverage within the National Health Scheme. Estonia has recently extended coverage to those on unemployment benefits and is pursuing funding options to include those groups not currently covered. Germany has proposals for a new law that aims to ensure that all citizens are covered by health insurance and in Austria social assistance schemes under the responsibility of the Länder are used to pay for the costs of the non-insured. Despite such measures, in a large majority of EU countries much remains to be done in order to extend health insurance coverage to illegal immigrants and asylum seekers.

3.2.2.2. Lack of coverage of certain types of care and high direct costs of care

The objective in the health care systems of Member States is for access to health care not to depend on the ability to pay, income or wealth and for the need for care not to lead to individual poverty and financial dependency. It is striking therefore to observe that private health care financing has increased substantially throughout the EU, both in absolute and in relative terms. The growth in private expenditure (in part made possible by a general increase

[50] Although there are concerns that during a transition period a proportion of the population will not be covered.

in income and wealth) is related to increased cost-sharing51 for public benefit packages, growing out-of-pocket payments for services excluded from insurance packages and, to a lesser (but not negligible) extent, to premiums for voluntary private insurance with a complementary or supplementary role. Indeed, the large increase in health care expenditure in recent decades has led to fiscal pressure to control the costs of publicly covered or provided care. The bulk of cost-containment policies developed in the 1980s and 1990s included the prioritising of services and the exclusion or non-coverage of particular types of care. These measures were coupled with increased patient cost-sharing (co-payments or co-insurance). This had the dual aim of not only increasing funds to the sector but also improving patient cost awareness and incentivising a behavioural change with regard to the use of health care services. This was expected to reduce unnecessary consumption.

Dental, ophthalmic and aural care services are basic services typically not covered by NHS or social insurance systems in Member States, while co-payments generally apply to a)pharmaceuticals, b) specialist and home visits and hospital care (albeit to a lesser extent), and c) in some cases to primary or even emergency care. Informal (unofficial, under-the-table envelope) payments, though decreasing, add an extra cost to patients in various Member States (e.g. LT, LV, EE, PL, HU, EL, SK, BG, RO).

Table 1: Private health care expenditure as a percentage of total health care expenditure

	1990	1998	2004
EL	46		48.3
PT	35		30.3
NL	33		38.8
IE	28		21.5
AT	27		32.4
FR	23		23.4
ES	22		28.1
IT	21		23.6
DE	19		21.9
FI	19		23.2
DK	17		17.4
UK	16		14.1
HU	11		28.2
SE	10		14.6
PL	8		30
LU	7		9.8
CZ	5		9. 3
CY		59	52.2
LV		40	48.4
BE		30	29.1
LT		24	24.6
SI		24	22.8
MT		24	21.8
EE		14	24
SK		8	12

Source: WHO health for all database

According to OECD and WHO data (see Table 1), between 1990 and 2004 the share of private health care expenditure within total health care expenditure increased in almost all countries except DK (constant at 17%), UK, IE and PT. These countries showed a decrease from 16 to 14.1%, from 28 to 21.5% and from 35 to 30.3% respectively. In 2004, private

[51] Such as co-payments – a flat fee or charge per service or co-insurance – a percentage of the total charge

health care expenditure ranged from 9.8% (LU) and 9.3% (CZ) of total health care expenditure to about 48.3% (EL) and 52.2% (CY). The figure is more than 20% in all Member States except LU, CZ, DK, SE, UK and SK and at 30% or more in AT, BE, CY, EL, LV, NL, PL and PT.

These are significant shares of expenditure. High private health care expenditure per se may not be deemed a negative feature of the system (as it may relate to wealthier, richer societies). However, if cost-sharing, out-of-pocket and private health insurance schemes are not properly designed they can reduce the financial equity of the system (increase regressivity) and deter access to care, notably for the most vulnerable groups. There is a danger that charging may lead to a reduction in the seeking of appropriate medical care at the appropriate time. This could even result in a worsening of the general health of the population and in particular those in greatest need or the less-well-off, resulting in the receipt of belated care, often in emergency departments. In fact, international codes and regulations (e.g. European Code of Social Security of 1964 and the Revised Code of Social Security of 1990, plus ILO Conventions 102 and 130) reflect a compromise as regards the extent of private financing of health care: countries are allowed to introduce charges but in doing so these charges should be proportionate to and not prejudice medical and social protection objectives. It is therefore imperative to understand the impact that cost-sharing for public benefits, out-of-pocket payments for non-covered benefits and private health insurance premiums are having on household incomes, especially on those who are most vulnerable or in greater need of care. Given the negative implications private financing may have on access and its limited role in providing extra resources, it is a component of health care provision that must be carefully considered.

In this context, dental, ophthalmic and aural care are often means-tested and age-related. Social insurance or the state covers the costs associated with these types of care for particular groups such as children, the elderly, people with chronic disease or disabilities, people on low income or special groups (e.g. war veterans, pregnant women) (e.g. BE, CY, FI, IE, MT, UK, LV, SI, IT, PL, NL, RO). Free preventive care for all (e.g. BE, SI, SK, CZ) together with free primary health care is a further measure to ensure individuals receive appropriate early medical intervention.

Policies regarding cost-sharing (co-payments or co-insurance) include, for example, a basic free package of care for all (e.g. SI, PL, SK, RO) and free care, exemptions or reductions for certain groups such as children, the elderly, benefit recipients, those on low incomes, the disabled, the chronically ill and pregnant women (e.g. AT, FR, BE, DE, LV, SI, IE, HU, CY, IT, SK, SE, RO). Some countries operate a more favourable or complete reimbursement system of co-payments (e.g. BE, FR). Co-payment ceilings for special groups such as those who are chronically ill or applied universally are other measures used to ensure costs are contained for beneficiaries (e.g. FI, BE, DK, LV, DE, IT, IE, SE, HU). Expensive interventions are directly financed in part by social insurance in LU, FR and BE, whilst the Netherlands uses tax breaks when costs rise above a certain percentage of income. Some Member States impose limits on physicians' charges and equipment for low income groups (e.g. FR, DE) and some set a maximum NHS price for the private sector (e.g. UK). Other Member States provide financial aid to acquire complementary insurance to people on low incomes (e.g. FR). In SK, the Bureau of the Fight Against Corruption has been established to combat informal payments. It should be noted, though, that exemptions or favourable reimbursement rules can often be complex for those who could potentially benefit the most.

Pharmaceuticals are a major area of cost-sharing. Typically, a percentage of costs are charged to individuals, varying from nothing to up to 80% depending on the type and category of

medicine (MISSOC, 2005). Drugs used to treat life-threatening diseases or drugs with major therapeutic effects are typically subject to lower rates of cost-sharing than those offering only marginal improvements in quality of life. For pharmaceutical products in particular, methods of indirect cost-sharing can be found: the percentage of user charges is not based on actual prices, but rather on a reference price, or, reimbursement is based on generic substitutions. In this context, increased provision of generics and over-the-counter medicines (e.g. BE, PT, MT, FR, HU) are thought to reduce the individual costs of care. This is further aided by the provision of free or cheap medicines (or more favourable reimbursement of medicines) and equipment for the elderly, the chronically ill and those with disabilities in a large number of countries.

Long-term care has particularly limited coverage levels and is deemed to be a serious social protection issue. Member States have recognised that provision is insufficient both for existing needs and more chronically for future needs. Lack of public provision or insurance and the high costs associated with private provision impose a major financial burden on patients and their relatives. See chapter on long-term care for further details.

Finally, while solidarity and equitable financing are principles inherent in all NHS or social insurance systems, certain practices result in less solidarity and a reduced redistributive capacity. These can take the form of caps on income-related contributions/premiums, opting-out rules for the better-off, significant use of indirect (e.g. VAT) taxes and the co-existence of specific social insurance systems for particular groups in society. These may benefit richer and/or healthier citizens or result in pro-rich use of care via extended coverage.

3.2.2.3. Geographical inequity in access to care

Geographical variations in coverage and provision are a further barrier to access. Supply is typically greater in bigger cities and more densely populated areas, whilst there is a lack of GPs or family doctors and certain basic specialist services in small, rural and remote areas. Hospitals are often unevenly distributed and as a large proportion of medical staff is concentrated in hospitals this exacerbates geographical disparities. Geographical features (islands, mountains) may be an explanation for some Member States but in others (e.g. FI, ES, DK, IT) disparities are the result of a decentralised decision-making process giving regional and local authorities policy discretion and permitting regional differences in funding. While allowing services to adapt to local circumstances, local decision-making has led to varying treatment and coverage as well as to variations in staff levels. It should also be noted that care provision within cities can be equally mixed, exhibiting variations between richer and poorer neighbourhoods.

Member States have proposed a number of policies to counter these issues of inequality, including: better adjustment of resources to needs (FR, EL, CY, PT, BE, UK, CZ, EE, LT), a municipal reform that extends municipalities' population base (FI, DK), cooperation between municipalities (FI, AT, EE, HU) and cross-border agreements for the provision of care (e.g. FR, ES, BE, DE). Further policy measures outlined were the defining of a package of country-wide standardised services (e.g. ES, IT), the setting of regional targets for staff (e.g. SI) and the provision of incentives to work in areas where inequalities are most prevalent (e.g. SI, FR, DE, the latter involving a legal amendment governing contractual relationships for statutory health insurance physicians). An improvement of transport networks (e.g. SK, EE) and the creation of free or low-cost help lines (e.g. EE, FI, PT, UK, PL) are also expected to reduce geographical differences in access.

Significantly, ensuring regional equity of access bears a strong connection with ensuring better distribution of primary health care. More and better distributed primary care centres

(e.g. EL, CY, LV, LT, PT, CZ), ensuring a larger number of GPs or family doctors in areas poorly provided for (e.g. BE, CY, EE, EL, FR, AT, SI, DE, IE, LT, PT) and enabling the operation of smaller units (e.g. FI, PT) are some of the measures proposed. These measures are coupled with clear definitions of time and distance limits to access GPs (e.g. EE, NL) and a minimum basket of primary care services in all health centres (e.g. PT). Increasing the number of ambulances, dispatch and arrival centres and setting a maximum response time for ambulances (e.g. HU, PL, EL, SK, SK) are further policy solutions outlined. Additional hospital capacity in under-provided areas (e.g. EL, IE) and modernisation of local health infrastructure (e.g. SK) are measures reported to reduce observed differences.

Cohesion policy programmes have contributed and will continue to contribute to closing the gaps in health infrastructure, thus promoting the accessibility of health services in less prosperous Member States and regions. Some countries (e.g. EE, ES) do indeed report the use of European funds to help tackle geographical differences in provision.

3.2.2.4. Long waiting times and disparities in waiting times

Another matter of concern (often cited as an organisational barrier to access) is waiting times. Waiting times have been reported for visits to a GP or family doctor, for consultations with a specialist after a referral by a GP and, more substantially, for elective surgery (i.e. non-urgent non-life-threatening conditions such as eye cataracts, hip replacement). In some Member States waiting times were reported even for more urgent conditions. According to the OECD (OECD, 2003) mean waiting times are over 3 months in several Member States, although in some cases maximum waiting times can stretch for years. It should be noted, though, that they vary substantially across regions and specialties. Member States also acknowledge that a lack of public provision and coverage of long-term care services has resulted in substantial waiting times for existing care - particularly residential care - of up to several years.

Waiting times and waiting lists are the result of a combination of resource constraints and free care at the point of access (i.e. zero or low-cost sharing) so that rationing comes from a non-monetary mechanism in the form of waiting. Moreover, rapid technology development and implementation has increased the range of interventions available, resulting in a larger demand for surgery. Other reasons for waiting times include: their use as part of hospital planning and the lack of incentive by public sector physicians to perform more interventions in the public sector (where waiting times can induce greater demand for private practice). Waiting times generate dissatisfaction among patients and especially the public in general but interestingly there is little evidence (OECD, 2003) that health deteriorates as a result of a few months wait for elective (non-urgent) care. In fact, most patients can tolerate and even prefer short to moderate waits, a fact that contrasts with the general concern expressed over waiting times. This may be a reflection of the use of waiting lists as part of political campaigns.

A first step identified in addressing waiting times is to compile better data on the issue and continuously monitor and review existing lists - notably using on-line registries (e.g. EE, PL, IE, MT, SE). Policies proposed to reduce the wait for outpatient visits and surgery include increasing funding and capacity through extra beds or new hospitals (e.g. UK, MT, FI, IE, EL, PL, SI). They also include defining common basic requirements for waiting lists (e.g. ES) and nationwide legislation and guidelines for non-urgent medical specialties (e.g. FI); defining time frames (i.e. maximum waiting times) for primary care, specialist and hospital care (e.g. FI, UK, NL, IE, SE); and the running of an integrated country-wide system of waiting lists (e.g. PT, IT with a prioritisation system, MT). Some countries are using or plan to use hospitals in other areas or regions of the country (e.g. FI, DK, UK, IT), using private sector facilities (e.g. FI, IE, UK, NL, DK), or even facilities abroad (e.g. UK, SE) for those waiting longer than agreed time limits. Implementing staff incentives such as additional payments to

physicians to conduct extra interventions where waiting times are lengthy (e.g. UK, NL, SI) are further policy examples.

3.2.2.5. Lack of information

Other general barriers to access include the a) lack of information on basic rights and ways to access care, which results in lack of registration with the insurance system or with a GP, b) administrative hurdles that render registration with the insurance system difficult, and c) language and cultural barriers, which can play an important role in the way people access and use services. Several Member States stress the need to better inform potential users of the system. Examples provided are the use of explanatory guides, web portals, contact centres, walk-in centres, phone lines and intercultural mediators.

Global challenges in the area of quality

European citizens value health as a key factor in achieving a good quality of life. Monitoring and improving the quality of health care systems is therefore an essential part of social protection. Europeans expect their health to be protected, and to be provided with access to the best care possible by modern scientific standards.[52] Monitoring and improving quality also provides further potential benefits by increasing (cost-) effectiveness (it should be noted that the relation between quality and expenditure of health care is not necessarily directly proportional). Finally, only through the monitoring of the level of quality can policy-makers identify and avoid unwanted negative effects in policy implementation. In their reports, Member States present a valuable collection of tools that have been developed to increase and maintain high quality care. These can be categorised as effectiveness; evidence-based medicine; and integrated care.

3.2.3.1. Improving effectiveness

The National Strategy Reports acknowledge the priority all Member States attach to the *effectiveness* of their health systems. The WHO has defined effectiveness as the degree of convergence between outlined goals or standards and actual care provided.[53] Achieving a high level of care effectiveness is a complex task composed of several layers of interacting components. These are subject to regular updating in the light of both technological development and the evolution of demand. *Quality standards* define *what* "high" or "good" quality entails in relation to the requirements that should be met; they can be classified as structural, procedural or outcome-oriented standards. *Quality systems* relate to health care institutions introducing processes that describe *how* predefined standards are to be met and how they will be monitored and ensuring that appropriate action is taken to meet the objective of high quality care. Achieving and obtaining a high quality of care is an ongoing process of setting goals, taking action and evaluating results. Furthermore, it also provides a basis for programmes designed to ensure patient safety, including the facilitation of the reporting of problems, learning from mistakes and developing effective interventions to improve patient safety and quality of care overall.

Member States are addressing these important aims with a variety of specific policies or programmes, such as quality-assured treatment programmes for the chronically ill (e.g. DE, UK), a prioritised vaccination programme (e.g. LT, RO, BG), and a prioritised cancer screening programme (e.g. FR, UK, IE, LT). Owing to the complexity of the quality assurance task, several Member States are working to find the most efficient approach and are restructuring and consolidating the growing number of specific activities. Government framework laws are one such approach to implementation (e.g. CY, FR, NL, AT, DE, UK, IE, PT, DK, SK) while the creation of new agencies whose main responsibility is the development of quality standards and systems is another (e.g. FR, DE, AT, UK, IE, NL). Some Member States rely more heavily on external and independent reports and monitoring of quality (e.g. UK, IE, SE, FR, NL, LT), where

[52] See Eurobarometer 63 at http://ec.europa.eu/public_opinion/archives/eb/eb63/eb63_en.htm

[53] Arah et al., 2003, WHO 2000

others rely on health care providers self-reporting on the quality of the service provided. Furthermore, most Member States have created (or plan to create) national (or regional) accreditation institutes tasked with the setting of standards and the certification of hospitals and doctors who meet these standards (e.g. DK, LV, BG, CZ, FR). The National authorities of only a few Member States routinely plan inspection visits to health care institutions and providers to gain direct impressions of structures, procedures, hygiene, etc., and to provide direct feedback and guidance (e.g. UK, FR, PT).

The National Reports also highlight the importance of readily available and comprehensible information pertaining to the quality levels of specific health care providers. On one hand, this can be a strong motivator for the health care providers to increase their level of quality through the stimulation of competition for high quality, effective and efficient services without the need for regulator intervention. On the other hand, only well informed patients have the ability to make rational choices. Practical examples of information provided to patients can be found on the web-based information portals already available (and receiving a lot of media attention (NL)) or planned in some Member States (e.g. NL, SE, CZ).

3.2.3.2. Applying evidence-based medicine

Another subject receiving considerable attention within the Member States' reports is the development of evidence-based medicine and clinical guidelines. According to the Centre for Evidence-Based Medicine in Oxford, "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."[54] Health care authorities have started formulating guidelines for best practice to enable easier implementation of evidence-based clinical decisions for health care providers. The process of health-technology assessment is a useful tool for both policy-makers and health professionals to make evidence-based decisions on the utilisation of different treatments and technologies. In practice, when a product enters the market, all available scientific data (evidence) is collected and analysed to evaluate whether the intervention is medically justifiable and safe, whether it will have the intended clinical effect (effectiveness) and, finally, whether there are alternatives at a lower cost (efficiency). In particular, where *new* technologies that promise less intrusive, more effective and efficient treatment are available, this assessment process is key as the widespread introduction of new technologies has been identified as a central driver of increased costs, if they are not assessed properly (see also chapter 2.4 – sources of expenditure pressure). Health technology assessments help to increase care quality, improve financial sustainability and engender greater access to health systems. Finally, the patient safety perspective should not be overlooked when evaluating the introduction of new technologies.

As with quality standards and systems, some Member States are relying on designated national agencies to assess new - and in part, existing - health technology. Most Member States report the existence of health technology assessment agencies (e.g. DE, UK, SE, FI, and ES). The complexity and costs of these assessments are high and some Member States point out that they are already benefiting from international and European cooperation in this field (e.g. CZ, FI). For example, the Commission is facilitating cooperation between Member States by supporting the European Health Technology Assessment Network. Within this project, 24 Member States are working together to develop common activities and improve methodological approaches. To help carry out health technology assessments, clinical guidelines have been established on how to manage diseases and have proven their worth for several years in some Member States (e.g. SE, FI, UK). There have also been European-level projects on clinical guidelines (GIN network) but none of the Member States has reported on cross-European cooperation in this area. Nevertheless, most Member States have clinical guidelines in place and plan to (or have already begun) to build

[54] See Oxford Centre for Evidence-Based Medicine at http://www.cebm.net/glossary.asp

up guideline databases (e.g. DE, EE, BG, PT, FR, BE). Further evaluation is required to evaluate the extent to which these guidelines are used by, and are helpful for, health care professionals and the extent to which they improve the system's effectiveness. From a European perspective, this area may also provide elements for further cooperation between Member States.

Patient safety should be an essential factor when considering evidence-based medicine and overall quality of care. Patient safety means ensuring that safety forms an integral part within health care systems and processes. Member States across the European Union are implementing measures to reduce the level of unsafe care, e.g. reducing hospital-acquired infections is a target in many Member States. Reporting mechanisms and training provide the basis for developing effective patient safety and quality programmes. Several Member States, including FI, DK and the UK, have set up national reporting and training systems to identify adverse events in an attempt to establish an understanding of the causes and to develop solutions and interventions. The challenge at European level is to create mechanisms by which good practice in those areas is shared across Member States. Action on this front is currently being taken forward by the patient safety working group of the High Level Group on Health Care Services and Medical Care.[55] Reducing the rate of medical complications will not only improve the quality of care overall, it will also reduce costs and increase access by lowering the frequency and shortening the length of hospitalisations.

3.2.3.3. Developing better integration, choice and coordination of care

Member States underline in their reports the need for more free choice, integration and coordination of care. These three closely linked concepts describe different perspectives of the same clinical practices. To some extent interests of health care purchasers, providers and patients may be divergent and need to be well balanced.

For example, health care providers and purchasers have an interest in optimising care coordination. The coordination of different levels of care, the flow of information and efficiency can all be increased while improving access and financial sustainability. However, the majority of Member States raise concerns on the efficacy of their referral systems and as such are trying to establish the GP as a gatekeeper to other services (such as secondary care or social services (e.g. DE, FR, BE, HU)). However, in this context free choice of treatment is only preserved when patients can choose and change their GP freely and reasonably often and when they can freely choose providers of any necessary secondary care. Member States that have traditionally limited freedom of choice of health services (e.g. UK, LT, FI) are investing a lot of effort into increasing patient choice, in part to enable patient empowerment and more patient-centred care. The Netherlands pursue a different approach to applying the rules of a free market to their health care system. It is hoped that patients will make smart choices in terms of “value for money” and care pathways will be optimised by the health care providers without regulator interventions. However, in choosing health insurance the choice of contracted health care providers is subsequently limited.

Further measures aimed at improving care coordination include the concentration of specialised care within treatment centres. Through this approach Member States hope to increase quality of care whilst liberating resources for better primary and social care (e.g. SE, LV, CY, CZ), which is of particular importance due to the shortage of GPs in rural areas in most Member States. To address this, some Member States report the development of incentive schemes for GPs willing to practise in these areas (e.g. DE, LV, HU), whereas Spain reports that the strengthening of primary care has led to higher patient satisfaction. Furthermore, GP networks and primary care health centres have also been established in some Member States (e.g. DE, CY, UK) to ensure

[55] HLG/2006/8 FINAL at http://ec.europa.eu/health/ph_overview/co_operation/mobility/high_level_hsmc_en.htm

coordination of efforts without affecting patients' choice. Similarly, the introduction of electronic patient record systems is receiving great attention (e.g. AT, NL, SE, MT, UK). These systems aim to reduce bureaucracy, increase patient safety and care cooperation and simplify data collection for the monitoring of health care quality. If implemented correctly it is projected to play a central role in assuring quality, safety, access and financial sustainability of health systems. In order to achieve well coordinated and integrated care, health-related data should be accessible between the different services, standardised and ideally a part of a more general IT system.

Member States also underline in their reports the need for increased integrated care focusing on patients' needs. The term integrated care describes clinical practices that combine different types of care services within the health care system and address the overall needs of patients in a multidimensional and coherent manner. It aims to coordinate primary, secondary and tertiary care, on the one hand, and different forms of care (social, nursing, medical, long-term and palliative), on the other. For example, several measures have been taken to strengthen the role of social services within the patient-centred care system through higher investment in this area (e.g. UK, CZ) or through the introduction of a chief inspector of social services tasked to monitor quality (e.g. IE). The approach of integrated care is especially effective in the context of an ageing population with increased numbers of patients who need special attention, such as citizens with multiple and simultaneous illnesses, chronic illnesses and mental or physical disablement. If successfully implemented, integrated care increases the quality of care, patient safety and patients' (and their families') satisfaction. Some Member States have begun monitoring levels of patient satisfaction (e.g. MT, SE, HU, SK) and others have introduced "Patient Charters" (e.g. AT, CZ, FI, SK, BE, CY) to strengthen patients' rights in general. Furthermore, successful care integration can reduce overall administrative costs and effort, whilst helping people to live more independently and for longer, maximising their years of healthy and active living. Fewer inappropriate interventions, consultations and (re-)hospitalisations for individuals will also help to ensure accessibility and sustainability of the health system overall.

3.2.3.4. Summary of findings

In the National Strategy reports on Social Protection and Social Inclusion, Member States stress the importance of "high quality health care". Action has been taken to develop tools to meet the challenges and a lot of progress has been made in recent years. High quality care also supports financial sustainability and improves access to the health system. Well coordinated referral systems staffed with well trained health care professionals can lead to a higher rate of early diagnosis and therapy, with the subsequent costs and health care utilisation being reduced over time. The same is true for the development and implementation of best practice and clinical guidelines which reduce unnecessary diagnostic or therapeutic interventions. The risk of harm is reduced and the frequency and duration of cost-intensive hospitalisation can also be decreased.

Even though Member States act independently in organising their systems, there is much similarity between the different nations' policies, thereby underlining the scope for European cooperation. The new and acceding Member States have particularly benefited where quality standards and systems are taken into account right from the beginning of the reform process. However, there is still room for improvement. For example, quality standards are often set in relation to the performance level that health authorities or citizens are used to. This does not necessarily represent latest developments in technology or best practice. Similarly, actions with regard to health technology assessment, patient safety, along with greater sharing of quality standards and systems more generally, could benefit from greater cooperation at European level.

Global challenges in the area of sustainability

The sustainability of health care and long-term care systems both from a financial and a human resources perspective is an area requiring the full attention of Member States in both

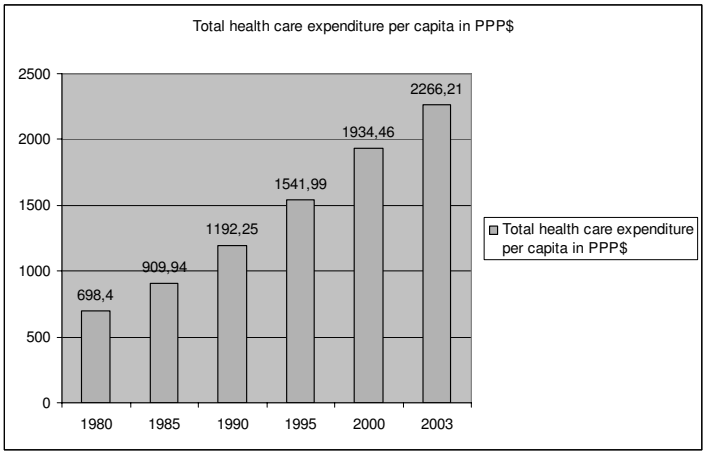
the short and long term. The increase in health care expenditure and its considerable share of public resources require Member States to place particular emphasis on the financial sustainability of health care systems. This is achieved through the promotion of a rational use of resources and good governance and coordination. Ensuring the necessary numbers of staff in the sector is another underlined goal, as is the need to improve health promotion and disease prevention mechanisms to reduce the financial burden of disease. This chapter looks at various dimensions of sustainability as identified in the reports. A first dimension (section 2.4.1) is financial sustainability. An analysis of the financial resources spent in the sector and Member States policies to attain better value for money is presented. A second dimension is staff (section 2.4.2). In the light of greater demand and potential staff shortages, a description of the policies to ensure sufficient and qualified numbers in what is a labour-intensive sector is provided. A third dimension is health promotion and disease prevention (section 2.4.3). The current pattern of disease and existing health inequalities that translate into premature and avoidable mortality suggests that there is a role, too, for effective promotion and prevention to enhance financial sustainability through the postponement and reduction of the overall costs of disease, with positive implications for employment and growth.

3.2.4.1. Financial sustainability

In general, **Member States spend significant amounts of financial resources** in these sectors: on average, EU countries spend around 8.8% of GDP (2004) on total health care expenditure, although some, such as FR and DE, spend up to 10% and 10.9% (2004) and others, such as EE (5.5%), LV (6.4%), LT (6.5%) and SK (5.8%), spend considerably less. A large part of this expenditure (on average more than 70% in EU countries) is paid out of public sources: public health care expenditure accounts for about 6.55% of GDP, in 2004 although, once again, variations can be observed with some Member States, such as SE and DE, spending 8.1% and 8.5% of GDP and others, such as CY (3%) and LV (3.3), spending half the EU average. For these the challenge may actually be adding extra and needed resources to the system whilst ensuring an efficient use.

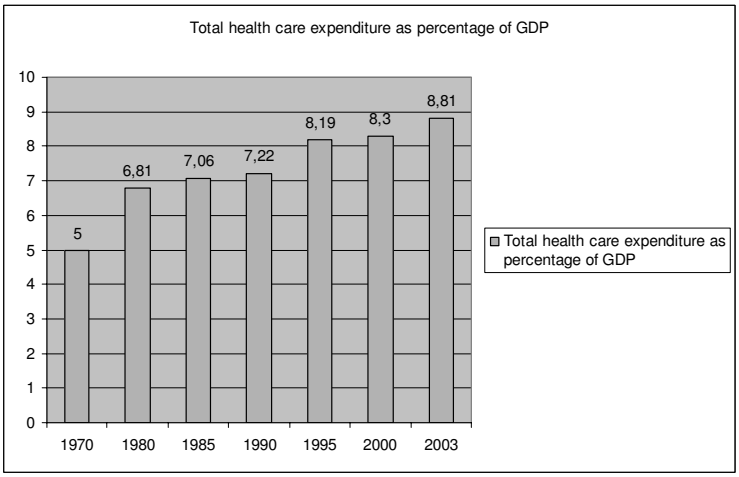
Moreover, **total health care expenditure has consistently increased** in the EU in recent decades (see Figures 1 and 2). On average, it was 698.4 per capita PPP$ in 1980 and 2376.33 in 2004. On average, it was about 5% of GDP in 1970 and 8.87% in 2004, i.e. a rise of more than 3 percentage points of GDP in three decades. In most countries it **has often increased at a faster rate than economic growth.** Different periods can be identified. In the 1970s, the large increase in total health care expenditure was due to increasing population coverage and thus rising public health care expenditure. In the 1980s and 1990s, the increase in total health care expenditure was related to an increase in private expenditure as a result of increases in per capita income, and the implementation of cost-containment policies (exclusion of some treatments from the public benefits basket and increased cost-sharing), which shifted the burden to private users in an attempt to control public expenditure. In the period 1992-1997 health expenditure and notably public expenditure grew at a similar or even slower rate than economic growth. In the late 1990s and early 2000s (1997-2003) public and private expenditure rose again (OECD, WHO data) with public expenditure increasing more quickly than economic growth. This was a period where health expenditure continued to grow while there was an economic slowdown; hence, the share of expenditure on GDP became higher (with some exceptions such as ES and FI). Data for some countries (e.g. DE) suggests that expenditure growth slowed down after 2003.

Figure 1



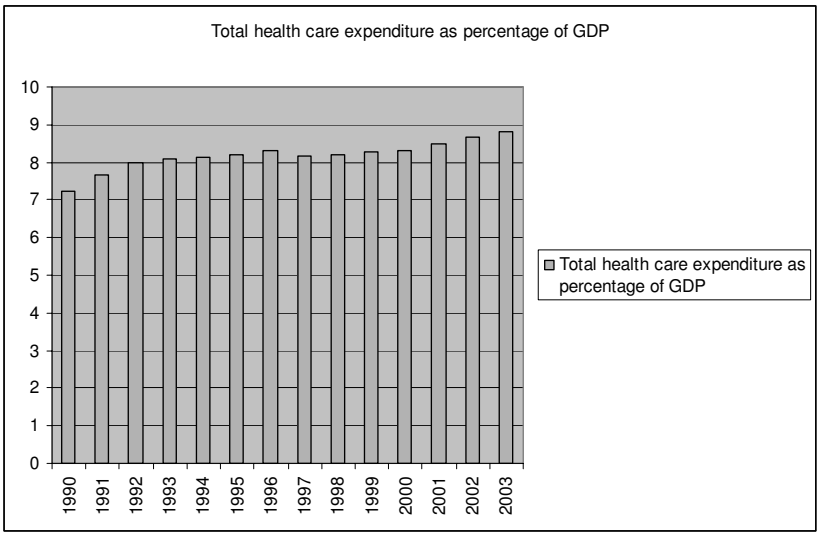
Source: WHO Health for all database. EU averages

Figure 2



Source: WHO Health for all database. EU averages.

Figure 3



Source: WHO Health for all database. EU averages.

Similar insights can be drawn from looking at price indices and their annual average rates of change. It can be seen (table 2) that for the EU and all years from 1997 to 2005 the health care

price index has consistently registered greater annual average rates of change than the general consumer price index, with the exception of the year 2001.

Table 2: Annual average rates of change of health care and consumer price indexes

1997	1998	1999	2000	2001	2002	2003	2004	2005
Annual average rates of change of health care price index								
6.3	5.6	5.6	3.6	2.0	2.9	2.5	6.7	2.4
Annual average rates of change of general consumer price index								
2.6	2.1	1.6	2.4	2.5	2.1	1.9	2.1	2.2

Source: ESTAT

These values do hide certain variations across countries with some countries showing very high annual rates of change for both general prices and for health care prices (above 10 and 20% respectively). Interestingly, some countries, such as BE or ES and to a lesser extent LU, PT and SI for the last 4 years, appear to have similar (or even lower) rates of growth for health care prices as compared to the rates of growth of general prices.

Differences across countries in the extent of their expenditure and the structure of relative prices raise interesting questions in relation to cost-containment policies: Is this a result of different staff and wage structures? Of more effective pharmaceutical price regulation or use of generics? Of different contract and payment systems? Of different structures of provision? Of more highly (or more effectively) regulated systems and widespread use of price controls? As will be seen in the remainder of this chapter, all Member States are implementing or planning a variety of measures to control expenditure growth and ensure better value for money. Overall, this suggests that financial sustainability is indeed an area to exchange best-practice experience under the OMC framework.

Sources of expenditure pressure

The main sources of expenditure pressures appear to be an ageing population, the continuous development and introduction of technology and patient expectations. Whilst **ageing** appears to have had a weak impact in the past (OECD 2005) it is probably fair to say that, as more people live longer and the baby boom generation reaches retirement age, ageing will have a greater impact on expenditure. This relates to the fact that ageing results in new patterns of morbidity (including multi-morbidity) potentially presenting themselves over a longer period of time, thus increasing the pressure on services to provide more care than is currently provided and to adjust current provision. Moreover, expenditure for the 65+ age bracket is greater than for the under 65s.[56] Ageing can also have other negative implications, such as reducing the supply of staff and increasing staff wages, thus resulting in higher production costs. Similarly, a smaller proportion of the working population may result in a lower contribution/tax base. According to the 2006 EPC/EC projections (see EPC/EC 2006), public health care expenditure in the EU is set to increase by 1.6 percentage points of GDP by 2050 (with ES, IE and CZ registering an increase of 2.2 and 2%) due to population ageing (and accounting for the general macroeconomic situation). The same projections predict an increase in public long-term care expenditure of 0.6 percentage points of GDP (with FI, SE and SI showing 1.8, 1.7 and 1.2 percentage increases), although the increases may be higher

[56] Expenditure is the highest the closest one is to death. As the probability of dying is larger in the 65+ than for younger groups, expenditure is larger for the 65+ age bracket.

as most Member States are only now developing comprehensive long-term care provision. OECD projections show an average increase of 0.8 percentage points of GDP for public health care (although PL and SK register 1.6 and 1.7% increases) due to ageing. A 1.5 percentage points of GDP increase for long-term care (although CZ, HU, PL, SK register a 2.3, 2, 2.4 and 3.2% of GDP increases) due to ageing is also projected for OECD Member States (OECD 2005).

Whilst **technological development** can bring about less intrusive and cheaper treatments, it contributes to rising the costs of care as it creates opportunities to cure or control more (not previously cured or controlled) diseases through new and often expensive interventions or by replacing old therapies with new more expensive ones, albeit safer or less intrusive with fewer side-effects. Thus, technology creates a demand for services not previously in place, which is supply-induced. Part of the progress in medical technology is the development of new, more efficient pharmaceuticals, which contributes to a large extent to increases in spending. Member States indeed refer to the large growth in pharmaceutical expenditure and the introduction and diffusion of new drugs as one of the main financial pressures they face. Drug spending has registered a rapid rise in recent years (more than 5% per year during the 1997-2003 period in the OECD area), growing faster than the rate of total health care expenditure, except for SE, LU, EL and CZ.

Table 3: Average real annual growth rates of total pharmaceutical expenditure for 1997-2003

IE	HU	SK	FR	NL	AT	SE	FI	DK	EL	ES	DE	IT	LU	CZ
11.3	8.3	7.7	5.8	5.4	5.3	4.9	4.6	4.3	4.2	3.7	3.7	3.3	3.2	1.7

Source: OECD health data 2005

In 2003, and for those countries for which information was available, pharmaceutical expenditure was more than 20% of total health care expenditure in CZ, EE, FR, HU, IT, SI, ES, SK and PL, whilst still a significant item in other countries.

Table 4: Pharmaceutical expenditure as a percentage of total expenditure

SK	PL	HU	CZ	EE	IT	ES	FR	SI	AT	FI	EL	DE	SE	IE	LU	NL	DK
39	30	28	26	24	22	22	21	21	17	16	16	15	13	11	11	11	10

Source: WHO health for all database

A large part (about 60%) of the expenditure is public expenditure. In this context, the OECD (OECD 2005) has estimated that technology was responsible for an average 1% annual growth in public health care expenditure from the 1980s to 2002. The OECD predicts an extra 1% of GDP increase in public health care expenditure until 2050 due to technology development.

Substantial differences in expenditure reflect differences in volume, price level and structure of consumption as well as the impact of pharmaceutical-related policies (reference pricing, generic use, coverage and reimbursement). As before, this highlights the potential benefit for Member States of exchanging information in this field.

Growing expectations, broadly related to changes in lifestyles, education, income, family structures and/or access to information, also play an important role in determining demand and supply of care. In general, countries with a higher GDP per capita tend to spend more on

health care. The desire for greater choice, more tailor-made treatment, for access to the newest technologies and wider ranges of treatment, and the enforcement of patient rights are some of the pressures policy-makers have to face and balance against existing resources. Again, different financing and organisational arrangements can be more or less able to control such expenditure pressures (OECD 2005). The OECD has estimated that income effects were responsible for an average 3.2% growth in public health care expenditure from the 1980s to 2002. The figures show that overall projections are quite sensitive to income elasticity: Income elasticity higher than 1 (1.2) can add a further 1.3 percentage points of GDP to the baseline scenario whereas income elasticity lower than 1 (0.8) can reduce expenditure projections by 1 percentage point of GDP. The EPC/EC report also projects significantly higher health care spending (2% of GDP) once income elasticity of demand is assumed to exceed unity (1.1 converging to unity by the end of the projection period).

The **general economic and social context** can also have a bearing on resources in that slow growth means fewer additional resources whilst high unemployment, poverty and social exclusion result in ill-health, greater use of resources and a smaller inflow of funds. Contribution evasion is also a challenge to resource availability.

Raising the effectiveness and efficiency of provision

In this context, maintaining the financial sustainability of systems is indeed a rational concern. Whereas in the 1980s and 1990s emphasis was placed on cost-containment measures, notably through budgetary caps and wages and price controls and through enhancing patients co-sharing of costs to raise awareness, reduce unnecessary consumption and adding funds to the sector, more recently Member States have emphasised the need to improve efficiency of care provision. Raising efficiency and effectiveness of care is to be achieved in various areas of provision, including primary care, hospital care and pharmaceuticals.

Encouraging the use of primary care and strengthening referral systems

All Member States strongly emphasise the need to make greater use of primary care vis-à-vis more expensive and unnecessary specialist care. Primary care is to be the first place of contact with the system and GPs/family doctors are to play a gatekeeping role: he/she provides all the necessary interventions and only if and when needed refers the patient to a specialist. The gatekeeping and referral system controls costs by regulating the number of interventions and avoiding duplication of treatments and misuse of the system. To ensure the referral system works effectively it is either made compulsory and becomes the only way to obtain free/almost free care or strong financial incentives are associated with its use, for example, by having reimbursement dependent on whether a GP/family doctor has been consulted. Referral systems are to be coupled with national (notably electronic) patient records to avoid duplication of care. To benefit from the advantages of primary care and referral systems, it is vital, however, to define clearly the tasks of primary and secondary care, to ensure sufficient numbers and appropriate training of staff, and the equipment needed to perform common interventions and minor surgery, and ensure good coordination between primary and specialist care. Note that Member States emphasise that a strong focus on primary care and referral systems also helps to maintain quality (notably patient safety), as described in the quality section, and to ensure access by providing professional guidance and easing the flow of patients through the system, with a possible reduction of waiting times and geographical inequities in access.

Enhancing ambulatory care/day case surgery

To improve efficiency Member States are also directing more services from inpatient to outpatient departments (e.g. EE, FI, HU, LT, SI, PL, SK, SE) and increasing the use of day case surgery (e.g. EE, HU, IE, LT, SI, DE, LV, PL, SE, SK) when technology is available. If properly handled, greater use of ambulatory and day case surgery can reduce the costs associated with hospital care (e.g. catering, accommodation) without necessarily reducing the quality of treatment and the health of the patient.

Reforming inpatient hospital care

Changes are also planned in the inpatient setting. Reducing the average length of stay (e.g. EE, HU, LT, PL, SI, DE, CZ), increasing bed occupancy rates (e.g. LT, SI), and reducing the number of beds (e.g. EE, HU, LT, LV, PL, SI, DE, IT, LV, CZ) are all measures designed to enhance the effectiveness and efficiency of hospital care. These are coupled with the creation of transition wards to prepare long-term care patients to be discharged from acute to long-term care facilities, thus reducing the use of more expensive care settings. Other measures include: hospital conglomerates (e.g. LV), hospital mergers (e.g. LU), division of tasks between hospitals in the same area to avoid duplications (e.g. LU, PT, LV, FI, HU) and the concentration of more specific and specialised services at regional or even national level, notably through centres of excellence (e.g. ES, FI, LU, DK, LV).

Care Coordination

Member States have also reported on the importance of improved coordination to the sustainability of their systems. Whilst ensuring greater quality of care by way of a correct care path and increasing patient safety through fewer and less harmful interventions (see chapter 2.3), Member States see care coordination as a means of achieving more cost-effective care provision and better value for the resources spent in the health care and long-term care sector. Care coordination implies better links between a) public institutions and its different levels (national, regional, local), b) types of medical care (primary care, secondary outpatient and inpatient, tertiary care), c) types of care (medical and social) and d) public health initiatives and sectors in an "health in all policies" approach. Such coordination can ensure complementarities and avoid duplication in provision; it can help to avoid duplication of interventions and ensure timely and thus often cheaper care. As mentioned above, task division between types of medical care, greater use of primary care and referral systems to secondary care are emphasised as means of reducing overuse (unnecessary use) of more expensive specialist care and hospital care. Collaboration and specialisation between hospitals in each region and the concentration of tertiary care in a small number of centres of excellence are designed to avoid excess and expensive overcapacity and associated running costs.

The creation of agencies responsible for coordinating between sectors and services, the introduction of ICT and e-health solutions, including electronic patient records, coordination between regions and between county/municipality levels, cooperation between municipalities, third sector organisations, voluntary workers and enterprises are policy examples reported in relation to improve care coordination.

Contracts and payments for providers

An important policy pursued/planned by some Member States is to separate the provision and funding role in this sector (creating a provider-purchaser split) and to have the funding authorities establish contracts with providers for the supply of health services (e.g. UK, CY, MT, NL, PT). Another policy is to establish new types of contracts in the hospital setting,

including prospective budgets (e.g. UK, BE, CZ, SK), activity-based financing (e.g. DK, FR, NL, LU, AT) and DRG-based payments (e.g. UK, BE, FR, HU, IE, LU, PT, DE, FI, SE, SK, EE). The purchaser-provider split and the new contracts aim to raise transparency and cost-awareness among providers and provide an incentive for providers to be efficient. It does however require an increased role of regulation.

Whilst capitation and salaries for staff are seen as more effective in controlling staff costs vis-à-vis a fee-for-service system, some element of activity-based remuneration is being added to the basic capitation or salary: of GPs to conduct preventive care services or of specialists to increase activity and attain greater value for money whilst helping to reduce waiting times. Fee negotiation and posting of fees for doctors (e.g. BE) are other means of controlling and ensuring the transparency of prices in a fee-for-service context. Competition between insurers (e.g. NL, DE) and in general (e.g. SK) is expected to lead to better and cost-saving contracts. In BE, insurers can turn surpluses into reserves and must use this to cover their debt as an incentive to control costs.

Controlling pharmaceutical expenditure

Controlling fast-growing pharmaceutical expenditure as described in section 2.4.1.1 is seen as a priority. In this instance, the variety of policies is large, including the establishment of joint procurement systems for medicines and material (e.g. ES, FI, LU, PT, IT, IE) and encouraging the use of generics (e.g. UK, FR, BE, IE, NL, LU, PT, AT, FI, SE) – notably through prescription by active ingredient (e.g. FI, PT), having pharmacies offer the cheapest product available (e.g. FI, DK, SE, NL), or reimbursing generics more favourably (e.g. BE, DK, FR, SI, PT, NL, AT). Policies also include promoting rational prescription and use of medicines (e.g. BE, EL, ES, FI, FR, LU, IT, PT, HU, SK) coupled with the use of indicative prescription targets for physicians (e.g. BE, IE) or even prescription limits (e.g. SK), evaluation of doctors' prescription behaviour (e.g. LU, UK, SK), the use of electronic prescribing (e.g. PL, PT) and reference prices (e.g. PL, PT). Allowing certain products to be sold over the counter and not just in pharmacies (e.g. PT, DK, UK, NL), agreements with the pharmaceutical industry (e.g. AT, PL, PT) and the growing use of technology assessment (e.g. BE, FI, FR, DE, SE, SI), notably as the basis of reimbursement to restrict expenditure to what is cost-effective, are other policies described. Again, a synergy can be identified between ensuring sustainability and enhancing quality: a growing use of evidence-based medicine and technology assessment can help countries to better manage the introduction of new health interventions – often identified as the central driver for increased costs if not assessed properly – ensuring not only greater quality but also greater value for money by restricting expenditure to what is safe, effective and cost-effective.

Extra funding

Several Member States wish to increase needed funding for the sector by: increasing contribution rates (e.g. HU, EE, PL, BG, SI for some population groups), broadening the contribution base (EE) and allocating additional tax funding from tobacco taxes (e.g. ES), VAT (e.g. MT) and general taxation (e.g. DE). Tackling tax evasion (e.g. SI) and establishing public-private partnerships (e.g. IE, UK) are other policies proposed.

3.2.4.2. Human resources for health

Human resources are an essential factor in the provision of health and long-term care, directly influencing access, quality and financial sustainability of health care and long-term care systems. Accessible care systems require well-trained and highly motivated physician and nurse workforces of an adequate size that are able to deliver safe, high quality medical and

nursing services. Health and social sectors in most of the EU countries have experienced or are undergoing considerable transformations, requiring their workforce to work on new skills with new technologies and to adapt to the increasing pace of change (ageing population, changes in the structure of provision, patient's expectations and resource constraints). Health care and long-term care employ a significant proportion of the population, many of whom are highly skilled. Numbers vary however between 3% and 10% of working age population. Although technology plays an important role, the sector is labour-intensive. Although it represents an opportunity for job creation it has often been seen as a recurring burden rather than a capital asset and an investment for the future. As a consequence, most countries face chronic problems caused by supply–demand imbalances, misallocation of health workers, skill imbalances and poor working environments; reflecting weak human resource management and regulation. While most of the national reports identify the challenges concerning medical staff in the long term, they do not specify what strategies they intend to employ to ensure adequate and sustainable care provision.

Main challenges

The delivery of health care and long-term care of appropriate quantity and quality requires, among other things, matching supply with the demand for doctors and nurses. Whilst ageing may induce a greater demand for services and thus staff – the most challenging common issue in all Member States – fewer people are entering the medical workforce. The social value attached in some Member States to doctors and nurses is low, a high range of professional opportunities are open to young people, migration of medical staff is a significant issue and as more and more professionals reach retirement age the pressure on hiring staff increases. Efforts are needed to retain existing staff and tackle the difficulties caused by an ageing medical workforce. Staff shortages pose a threat to access (resulting in a lack of staff in certain geographical areas or in some areas of care) and to the financial sustainability of the system (increasing wage costs and extra retaining costs). Various measures have been introduced by Member States to tackle these shortages although they rarely form part of a human resource development strategy. Some Member States have increased the training of medical staff (e.g. MT, FI, IE, EL, NL, CY, AT, PT) and have promoted post-graduate training and continuous professional development (e.g. MT, FI, LU, DE, NL).

To cover the expected increase of long-term care, a large number of Member States draw attention to the importance of enhancing home and community care services and making efforts to move away from institutional care. To address this issue the availability of a qualified workforce at an efficient level – as one of the main components – has been identified. As a consequence, authorities in most Member States put the emphasis on developing adequate training and lifelong learning schemes in geriatrics, increasing nursing staff (e.g. ES, FR, LT, SE, CZ) and taking initiatives to support informal carers, such as direct financial aid (e.g. AT, CZ, DE, EE, DK, HU, FR, ES, SK, FI, IT, IE, SE), tax exemptions (e.g. ES, DE, EL, FR, LU) and work leave to care for relatives (e.g. AT, ES, FI, DE, NL).

Another matter of concern reported by many Member States as a structural issue arises from an imbalanced staff structure, which often shows a small proportion of primary care physicians in relation to specialists and a significant lack of nurses, physiotherapists and geriatric doctors, while ensuring regional equity in access would require an increase in GPs and nurses and a better geographical distribution. To support the primary health care systems some authorities focus on training more staff and retraining existing staff to work as GPs (e.g. ES, EE, LT, LV, PT, HU, SE, SI), increasing the motivation of primary care staff through increased responsibility (e.g. LT, PT), improving their working conditions (e.g. SE) and introducing primary care courses as part of the medical curriculum (e.g. HU, PT). As

highlighted, a better distribution of primary health care can help to tackle geographical disparities.

Today, there are reports of nurse shortages in almost all EU countries. Nursing has been exposed to increasing pressure over the last 25 years. Health care systems have had to adjust to an economic environment focused on efficiency. This development has very often resulted in intensified work, increasing patient turnover and in deteriorating working conditions combined with an increase in demand for nurses. Providing more education facilities at nursing schools could be one way of addressing this issue, although it seems unlikely that an increase in provision of nursing training alone will solve the future demand for nursing staff. This is due, among other things, to the relative unattractiveness of the nursing professions for young people. The most effective way of ensuring nursing in the future, therefore, seems to be to promote the retention of existing nursing staff.

The clear gender perspective has to be mentioned when analysing nursing staff. It is still predominantly a highly gender-segregated profession.

Intra-Community mobility

Free movement of labour within the Union and the mutual recognition of qualifications have encouraged medical workforce mobility into certain regions. The movement of medical staff between countries was limited before the last (2004) enlargement of the EU but the context has started to change since, although the increase may be due to the greater opportunities for doctors and nurses from some Member States to migrate to those countries where working conditions for health professionals are more attractive. Remunerations, employment opportunities and long-term financial security remain a key factor in explaining the inclination to migrate, although there are major differences between occupations and countries. Linguistic and cultural barriers are the main reasons for the lack of mobility. The evaluation and follow-up of the effects of the directive on mutual recognition of professional qualifications, particularly concerning physicians and nurses, is a key issue for some Member States. Early identification of trends (e.g. increase in mobility of young graduates) can signal shortages in time for an adequate response. However, evidence of the scale and impact of this movement is limited. The need for staff retention policies is identified by some countries in the reports (e.g. EE, LT, LV, PL, SK). The impact of medical staff mobility on the health system depends nevertheless on a variety of factors, and the issue is widely addressed by the High Level Group on Health Professionals.

Socio-economic challenges

In addition to an ageing society and the structural changes needed in many countries, health workers within the general workforce are affected by the socio-economic changes that shape the economy and the general working conditions. Some countries (e.g. BE, LU, LT, LV) have introduced financial incentives such as wage increases to retain health professionals and others have also aimed at improving working conditions (e.g. facilitating a balance between work and family commitments, greater discretion in their work, providing opportunities for professional growth) to keep staff (e.g. MT, NL). Movement of medical staff from the health sector to other forms of employment or from public to private practice are other concerns related to countries' socio-economic situation.

Quality

Member States are committed to improving the quality of services provided in health care and long-term care. To ensure official state guarantees of care, most Member States aim to improve quality standards through the development or implementation of accreditation/certification of institutions and staff based on national sets of pre-determined standards. In some cases (e.g. FR, LV, DE, SE) accreditation is compulsory. Continuous staff training (e.g. BE, FR, FI, LU, HU, SE) via the establishment of a points system related to accreditation or a certification process are also emphasised in some reports.

3.2.4.3. Health promotion and disease prevention

The national reports and the 2006 in-depth review emphasised that the current pattern of multiple, chronic, non-communicable diseases and significant health inequalities across socio-economic groups amount to a significant financial burden. Moreover, both the EPC/EC and OECD projections highlight the fact that the impact of ageing very much depends on the health status of the elderly population. An improvement in the health status of the population, notably in later ages (i.e. we live longer but also more years in good health), could offset the financial pressure associated with ageing. In this context, it is argued that promotion and prevention can reduce the financial burden of disease although it may mean an increase in current costs. Promotion and prevention are seen as a means of reducing the overall costs of care through lower demand for care and the postponement of disease. Also, current large socio-economic differences in health, which translate into avoidable and premature mortality and disability, represent a loss of human and economic potential. Bringing the level of health of all social groups to closer to that of the most privileged would mean a huge improvement in health, a large reduction in the number of people lost to the labour market (directly or indirectly as family and relatives have to care for the ill), a rise in productivity and an overall increase in human capital.

In this context, it was argued that it was time to implement effective policy to improve general population status and reduce health inequalities. Whilst the national reports and the 2006 in-depth review stressed that equitable access by lower socio-economic groups to preventive and primary care and more specifically to effective prevention and treatment of cardiovascular diseases and cancer can help to reduce the gap and improve general health, it is also recognised that lifestyles, and thus effective health promotion and disease prevention programmes, can play a substantial role in determining health and health inequalities. A combination of general and targeted promotion and prevention policies directed at lower socio-economic groups is recommended in the reports and by academic studies. A comprehensive "health in all policies" approach that ensures coordination between different public institutions and sectors and the establishment of partnerships with businesses and community representatives is deemed the ideal approach.

The national reports present a variety of **promotion initiatives that relate to risks factors** such as tobacco use, obesity versus healthy diet, sedentary life versus physical activity, alcohol consumption, drug use and antibiotics use, lack of breast feeding and hazardous physical, chemical and biological factors. Various initiatives **are disease-specific**: cancer diseases, cardiovascular diseases, respiratory diseases, diabetes, mental health, HIV/AIDS, sexually transmitted diseases, accidents, particularly traffic accidents, work accidents, home accidents and suicide, tuberculosis, osteoporosis, Alzheimer's and rare diseases. **Disease prevention initiatives** include: implementing screening programmes for the early detection of diseases such as breast, cervix, prostate and colorectal cancer, cholesterol, sugar, and blood pressure, sometimes coupled with remuneration incentives to conduct such preventive care practices; ensuring vaccination of target groups; implementing home nursing visits where nurses have a prevention and health education role; provision of maternal and infant care; and developing/ strengthening systems of epidemiological surveillance and health alerts. These

initiatives include information campaigns, education, legislation, changes in health service provision or health at work policies. Importantly, Member States identified the **need to develop information systems and monitor data on health status**. Only in this way can it be established if and where there is a problem, its extent and the impact of policy.

3.2.5. Long-term care

National reports show that Member States are strongly committed to ensuring accessible, high quality long-term care and sustainable financing of the long-term care sector. Demographic developments increase the pressure on long-term care systems to provide more and better curative medical care but also more rehabilitative, nursing and social care. Population ageing results in an increasing share of old and very old people in the population, leading to new patterns of morbidity and mortality, such as an increase in (often multiple and reinforcing) degenerative and chronic diseases. In addition to the ageing population, socio-economic developments, such as changes in family structures (smaller and more disintegrated families) and the increased labour market participation of women, also impact on the provision of long-term care and the subsequent need to adapt long-term care services. Consequently, expanding long-term care in a financially sustainable manner is a major preoccupation for Member States.

The Luxembourg Presidency Conference "Long-term care for older persons", which was held on 12 and 13 May 2005, and the joint EU Commission and AARP Conference "The Cross Atlantic Exchange to Advance Long-Term Care" held in Brussels on 13 September 2006 also highlighted the fact that, given the extended longevity in the EU and the United States, an increasing demand for long-term care can be expected. This increased demand for long-term care services represents a policy challenge for many nations as current supply is considered to be insufficient and inadequate in terms of meeting current and especially future needs and thus ensuring decent living conditions. Recognition that there is no comprehensive system for the provision of long-term services in the US and in large parts of the EU was, however, coupled with a firm commitment on the part of EU countries to ensure universal access to quality care.

It is important to note that different definitions of long-term care coexist. Long-term care brings together a range of services needed for persons who are dependent on help with basic Activities of Daily Living[57] (ADLs) over an extended period of time. Elements of long-term care include rehabilitation, basic medical services, home nursing, social care, housing and services such as transport, meals, occupational and empowerment activities, thus also including help with Instrumental activities of daily living (IADLs).[58] Long-term care is usually provided to persons with physical or mental handicaps, the frail elderly and particular groups that need support in conducting their daily life activities. Long-term care needs are most prevalent in the oldest age groups, who are most at risk of long-standing chronic conditions causing physical or mental disability.[59]

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[57] ADLs: Activities of Daily Living are self-care activities that a person must perform every day such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions.

[58] IADLs: Instrumental activities of daily living are activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

[59] OECD 2005 Long-Term Care for Older People

Provision and financing of long-term care

Long-term care provision varies across Member States, both in terms of coverage of the population and extent of provision and also in terms of the schemes used. Countries use in-kind benefits or cash allowances and budgets or a mix of the two. Several countries have a mixed financing system (e.g. BE, FR, EL), combining resources from insurance schemes and taxes, with different budgets and institutions responsible for the provision and purchasing of long-term care. Some countries provide comprehensive public programmes financed through social insurance (e.g. DE, LU, ES), whereas others fund their programmes through taxation (Nordic countries, LT) or means-tested schemes (e.g. UK, CY).

3.2.5.1. Access to adequate long-term care

Throughout the national reports, Member States confirm their goal of ensuring universal access to adequate long-term care for their citizens. Many Member States recognise the inadequacy of their long-term care systems in the light of population ageing, socio-demographic developments and changing needs. Whilst committing themselves, to ensuring access, Member States identified that comprehensive and universal access to long-term care is effectively hindered through various obstacles that need addressing. Differentiated access to a range of long-term care services can be observed for various population groups, some of which are not yet fully covered by social insurance schemes. Indeed, long-term care presents an especially limited coverage.

One issue effectively acting as a barrier to access for long-term care is the citizens' ability to pay. High private costs, which are seemingly higher than in health care (out-of-pocket and voluntary private insurance), impose a major financial burden on users and their relatives and act as a barrier to access, particularly for low-income groups. This is associated with the use of private provision resulting from either the inadequacy of public provision/insurance and/or the country's organisational structure and financing: several countries have introduced co-payments, insurance premiums or have only means-tested long-term care provision (e.g. CY, EE, IE). Policies directed at reducing the individual direct costs of care include co-payment exemptions and co-payments based on income, extra financial aid/welfare benefits to the elderly dependent, disabled and chronically ill, state coverage of social long-term care for low-income households in a Social Assistance framework (e.g. FR, NL, BE, HU), nationwide standardisation of co-payments and state subsidies to use private services.

Moreover, the lack of public provision/coverage of long-term care services has resulted in substantial waiting times for existing care, particularly residential care. Uneven geographical (across regions, urban versus rural, within cities) provision can also be observed as social services are typically the responsibility of local authorities or regions. To tackle this, Spain, for example, is planning the implementation of a uniform basket of long-term care services across the autonomous regions. It has made long-term care system accessibility a social inclusion policy priority. The newly launched “Autonomy and Dependency Care System” was designed to guarantee care for dependents and promote their autonomy. It provides for a wide range of care services both at home and in care centres, and for financial and every day support to their families. 100% coverage by 2015 is the target.

In this context, Member States want to expand long-term care services. This includes increasing population and care coverage by the health insurance schemes and enhancing the availability of specialised services, home or community (close to home) care (medical, nursing and social care) and residential care when the alternative is no longer medically appropriate/adequate (e.g. BE, CZ, EL, HU, ES, LT).

Tailor-made community and home care services (provision)

The national reports and the EU/AARP conference underlined that countries are firmly focused on enhancing tailor-made home and community care services and moving away from institutional care (which has to be maintained for those with severe disabilities/conditions, for whom home care is no longer the most appropriate alternative). A variety of publicly funded schemes are being explored together with a public-private provision mix (without undermining private provision). Individual choice and flexible provision are strongly supported while keeping within the limits of resource availability. Home and community services typically include: a) home medical visits, home nursing, home assistance (e.g. cleaning, shopping, meals-on-wheels) and home adjustment (e.g. rails, walk-in baths), b) day or short-stay hospitals, day care and transport, night care centres, service housing (typically rented individual apartments with associated medical and social services) and c) tele-assistance. Geriatric, transition and rehabilitation wards are means of ensuring the transition from acute to home settings. The general trend is thus that, where available, home or community care is preferred to institutional care. This is not to say that institutional care provision should be dismantled, particularly as regards patients with severe disability/illness. Information and communication technology (e-health solutions such as tele-monitoring, tele-medicine and independent living systems) can help to ensure independent living and more user-oriented services. For example, ICT can offer better self-management of chronic conditions and can support informal carers in their role The goal is to help individuals to remain at home for as long as possible, whilst providing institutional care when needed. This also supports individuals' choice and preferences: in general people want to live for as long as possible in their own homes, close to their family and friends. It is also considered to be the cheapest or budget-neutral option on both sides of the Atlantic.

As highlighted in the reports, provision is to be expanded through coordination between national, regional and local levels of government and in partnership with the private and notably the voluntary sector. In Finland, the authorities also plan joint municipal level provision. In this context it is important to note that the 2005 Luxembourg Presidency Conference showed how important it is for national, regional and local authorities to learn from each other's solutions and experiences.

3.2.5.2. Quality of long-term care

Improving quality standards plays a major role in ensuring adequate care quality for dependent persons, whether for informal (family) care, formal home care services or in institutions. Efforts must be made to improve quality of care in this field, which is often considered to be poor and exhibits high within-country variations (e.g. HU, MT, PL, PT, EL). Several National Reports describe various quality improvement measures. Quality standards for structures, procedures and outcomes, as well as quality accreditation measures (e.g. NL, SK) coupled with quality monitoring systems (e.g. CY, EL, FR, NL), are just a few of the tools available to Member States for ensuring high quality long-term care. In the case of long-term care, more patient-centred patterns of care, including more tailor-made services with greater involvement of users in decision-making, also aim to enhance quality. A basic requirement for quality assurance, of particular relevance for long-term care, is the active deterrence of maltreatment or abuse. Uniform quality assurance mechanisms (e.g. CZ, EE, ES, SE, LT, LV, SE, SI, UK) can address regional inequalities in provision and deter arbitrary discretion application in users' needs assessment at local or regional level. Spain, for example, applies common standards throughout its territory. Several countries have made (e.g. BE, ES, FI) or are in the process of making efforts (e.g. HU, LV, MT, PL) to enhance and promote integrated long-term care provision, allowing uninterrupted care continuum for care users and evaluation and monitoring mechanisms by multidisciplinary teams (e.g. UK).

Care coordination

Care coordination is seen as crucial in enabling high quality (and efficient use) of services in an institutional or community setting and thus permitting an adequate continuum of care irrespectively of the different levels of long-term care provision (local, regional, national) and organisation. Coordination problems at the interface between medical, social services and informal care can indeed result in negative outcomes for users and in inefficient use of resources. Coordination problems refer to the financing of the system, on the one hand (coordination or lack of between the different budgets involved), and the organisation of service delivery, on the other (coordination or lack of between the different levels of organisation and between the various organisms involved (health versus social services)). Multiple and often reinforcing chronic ailments necessitate some degree of care integration, as they require the provision of different types of care and access to specialised treatments. Care professionals must ensure that patients follow a coherent path of care with the appropriate treatment provided in the appropriate setting irrespectively of the organisational features of the long-term care systems. Better coordination between health and social services can also avoid duplication of action and service provision. Liberating long-term care patients from acute care settings and ensuring that such care is provided in more appropriate settings can reduce the financial burden associated with expensive acute care while enhancing the quality of the care provided.

Policies to improve care coordination, particularly between health and social budgets, have been promoted (e.g. ES, FR, IE, LU, LV, PL, PT, ES). To improve the quality of long-term care in several countries (UK, IE, BE, DK, DE, EE, ES, SE, SK, FI, LV, PT, IT) there are plans to develop common assessment schemes and evaluation by multidisciplinary teams that would define the care plans to be followed by the care user. Similarly, the care coordinating role envisaged in the UK for community matrons is planned in the Italian context through the establishment of District Managers. Additionally, in addressing the trend towards deinstitutionalisation, many Member States have attempted to coordinate the provision of long-term care at local or regional level, with mixed outcomes (e.g. FI, ES, HU, LT, LV, SE) and consequences in terms of access to, and the quality of, long-term care. Addressing access and coverage of the population has important implications for the financing of the system and vice versa. For example, the decentralisation of long-term care service provision (e.g. BE, ES, DE, CZ, FI, SE, LT, LV, PT) and the promotion of care in a community setting (Most Member States) must be sustainable, thereby ensuring coordination of the system's financing between different budgets and different organisational levels (e.g. BE, CZ, DE, ES, FR, IE, LU, LV, PL).

This is an area where the national reports, and their best practice examples, give a good basis for mutual learning between Member States in the context of the OMC, due to the commonality of the challenges.

3.2.5.3. Sustainability of long-term care systems

Three dimensions of sustainability can be identified in the National Reports: financial sustainability, human resources, and health promotion and disease prevention in old age.

Financial sustainability

A shared perception that came to light in the national reports and the AARP conference is that long-term care expenditure will increase in the near and distant future in order to meet growing demand. For example, the 2006 EPC/EC projections predict an increase in public

long-term care expenditure of 0.6 percentage points of GDP (with FI, SE and SI showing a 1.8, 1.7 and 1.2 increase) due to population ageing. It must be noted, however, that this increase may be higher as the projections are based on current institutional and policy settings, whilst many Member States are only starting to develop a comprehensive framework for long-term care provision. In this context there is increasing recognition of the need to create a solid financing basis for long-term care and ensure the availability of much needed resources. Several Member States are moving in this direction, either through the establishment of dedicated additional and compulsory social insurance schemes and contributions (e.g. DE, PL, SI) or through taxation in order to put long-term care on a sound financial footing. Moreover, both the EU and the US recognise that it is necessary to find an adequate mix between public and private sources of finance. Independently of the country's public financial arrangement, private direct payments will also play a role, although EU Member States are committed to designing funding schemes that do not hinder universal and comprehensive access to quality long-term care. The 2005 Luxembourg Presidency Conference had already concluded that a social insurance or tax-based system appeared to be more efficient than private financing solutions. In terms of provision the national reports and both conferences point to a potential mix of public and private (notably social sector) provision.

Some Member States with developed long-term care systems have already taken important steps to ensure the financial sustainability of their systems. Examples include additional insurance-based schemes that would cover the long-term care needs of their population (e.g. DE, PL, BE). Although these innovative schemes often do not cover all foreseeable risks and the way they are organised varies (voluntary, mandatory), they can serve as examples to the other Member States, who will have to implement some form of support in the light of the changing long-term care needs of the population. France combines an additional insurance scheme and means-testing to meet the long-term care needs of its population and addresses in that sense the accessibility and solvability issues of long-term care with the recognition that the insurance principle can leave certain parts of the population without long-term care coverage. Similarly, in Spain, long-term care needs are met through the instigation of supporting mechanisms within a Social Assistance scheme. Long-term care provision is financed through central budgets and tax, leaving the insurance mechanisms aside, with individual co-payments and exemptions for vulnerable groups.

Human resources

The national reports and the EU/AARP conference underlined that countries are firmly focused on the need to develop a high quality workforce. This was identified as a key pillar for sustaining long-term care systems and adequate service provision. Given that the sector is labour-intensive, current and future shortages in the workforce need to be addressed through appropriate training (especially geriatric and gerontology), certification and evaluation mechanisms. Additionally, informal care provision will continue to play an important role that complements formal provision.

In view of the looming shortages in the trained medical (particularly nurses and geriatric doctors) and social workforce in the US and the EU, many Member States have introduced policies to increase nursing staff in order to deal with the increased demand for services in this field (e.g. ES, FR, LT, SE, CZ) and prevent their emigration because of better working conditions and better pay (e.g. PL, LV, EE). Also, how to keep good care workers is a common challenge. Continuous training and evaluation can be significant in maintaining quality of staff. Most Member states have introduced or are introducing training and lifelong

learning schemes in order to maintain the staff's expertise and enhance their capacity in dealing with specific long-term care specialties such as geriatrics.

Moreover, as stated in the national reports, at the 2005 Luxembourg Presidency Conference and at the 2006 EU/AARP conference, informal carers, usually family members and predominantly women, play a crucial role in the provision of long-term care. Both in the US and in the EU, care provided by family relatives and friends is a substantial part of the long-term care provision to those in need (even in countries where formal home and institutional care systems are available, such as Sweden). As informal care is to maintain an important role and given the strong focus on home provision, the national reports stress the need to develop structures that support informal caregivers. This was reiterated by the 2005 Luxembourg Presidency Conference and the 2006 EU/AARP conference, which both stressed the importance of ensuring smooth coordination between formal and informal care and of informal carers receiving appropriate support when pursuing their care activities.

Policy proposals related to informal care include: information, training, counselling, respite care (allow caregivers time off), financial aid to informal carers (e.g. AT, CZ, DE, EE, DK, HU, FR, ES, SK, FI, IT, IE, SE), tax credits and exemptions (e.g. ES, DE, EL, FR, LU), allowing informal caregivers to reconcile care provision and paid employment, notably through work leave to care for relatives (e.g. AT, ES, FI, DE, NL) and considering care periods as part of the contribution career for pension purposes, formalising their status and including them in social insurance schemes.

In view of the growing demand for services and thus carers in a labour-intensive sector, an interesting issue raised by the US representatives during the AARP conference, which is also of importance in the EU context, was the need to adopt an integrated immigration policy regarding the employment of the immigrant workforce in this sector.

Prevention and rehabilitation policies

Given the constraints on public finances allocated to long-term care and the difficulties experienced in raising additional resources through increased contributions and taxes, promoting healthy and active lifestyles (through healthy ageing, preventing obesity, smoking, alcohol and drug abuse throughout the lifecycle), health and safety at work and preventive care (screening, vaccination and immunisation) can make a positive contribution to improving the overall health status of the population. This point was also made at the 2005 Luxembourg Presidency Conference. Aside from the positive health outcomes (life and healthy life expectancy, mortality rates), promoting healthy ageing and preventive care policies also helps to increase labour market participation and productivity rates. Most Member States have generalised vaccination and screening programmes and campaigns to promote healthy ageing which are either being promoted or in place. One issue that often remained unaddressed in the national reports is the degree of efficacy of these campaigns and the degree of care coordination that exists amongst the different providers and levels of provision in promoting preventive care policies.

Similarly, rehabilitative care is to be promoted (e.g. PT, CZ, EL, FI, FR) with a view to restoring patients' skills and thus helping them to regain maximum self-sufficiency and to function in a normal or as near normal a manner as possible. Rehabilitative care can be provided in an institutional and a community setting. More importantly, rehabilitative services should be provided in order to help, where possible, the patient reintegrate in the labour market. The promotion of rehabilitative care depends to a large extent on the efficient use and promotion of ICT products and services for independent living. The Commission will address

the possible benefits the information society can have on the ageing population and its activation in a forthcoming Communication. The national reports and the EU/AARP conference highlighted the importance of active ageing, healthier ageing and the adjustment of the environment where people live. These are presented as necessary complements to long-term care provision from a service-user point of view.

3.2.5.4. Summary of findings

In the light of the ageing population and the socio-economic changes, most Member States recognise that formal long-term care provision is insufficient. Limited coverage and access to long-term care is viewed as a major challenge to social protection systems, particularly when considering the increasing demand for more formal medical, rehabilitative, nursing and social care. In addressing limited access and coverage to long-term care, the emphasis in all Member States is thus on enhancing formal home and community care to help individuals remain at home for as long as possible, to provide institutional care when the alternative is no longer adequate and to support informal caregivers. Some Member States have stepped up their support for formal and informal carers, helping them to integrate in social security schemes and formalising their employment status.

Member States attempt to support the coordination between health care and social services in an integrated manner and the coordination between the various organisational and financial features of their systems (different organisational level: national, regional, local and different budgets). Several countries have set up continuous monitoring of the costs of ageing, which is often accompanied by the creation of additional fund collection mechanisms oriented towards the long-term sustainability of the system. Given the great variation in terms of response and policy approaches to tackling the above problems of access and coverage throughout Member States, the exchange of best practice in this field is encouraged, particularly in the light of the multiplicity and complexity of the challenges faced and their interdependence and commonality at European level. The OMC can allow exchange of given practices when they have proved successful, making in that sense for mutual learning and exchange. Additional information is provided in Annex 2 on best practices.

3.2.6. Conclusions on health care and long-term care

In this first year of implementation of the OMC in the area of health care and long-term care, all Member States have reported on the common challenges of ensuring universal access to quality and sustainable health care and long-term care. The OMC has proved to be a good tool for the Union and its Member States to advance their understanding of health care reforms by defining common objectives, reviewing progress and promoting a learning process. The main points to emerge from the report are:

Member States identified as priorities within their health care systems the need to: ensure equal access for all; reduce health inequalities; guarantee the provision of safe and high quality care; and manage the introduction of new technology for healthy and independent living. More rational use of resources is an essential factor in rendering health care systems sustainable and maintaining high quality.

Solidarity and equitable financing are principles inherent in the systems and all countries pledge universal rights to access. However, these do not necessarily translate into universal access and significant inequities remain. All countries are firmly committed to ensuring access to adequate health care and long-term care for everyone and refuse any trade-off between access and sustainability.

Member States use a mix of tools to achieve and maintain high quality care across the system. These include: quality standards, such as minimum structural and procedural requirements for providers, quality assurance systems, e.g. accreditation or certification of providers, and quality monitoring systems based on reporting exercises, and inspections. Integration of medical, nursing, social and palliative care is expected to lead to better, more efficient patient flows throughout the system.

The issue of preventing costs growing substantially faster than GDP clearly emerges from the reports. The main pressures arise from an ageing population, the introduction of technology, worrying price trends in the sector and rising patient expectations. Most Member States have introduced cost containment measures, and some are looking for new sources of financing. More rational use of resources and improved coordination between levels (national, regional, local) and administrations (health, social services) is essential to render health care systems sustainable.

Human resources continue to warrant the full attention of Member States in both the short and the long term. Some countries may need to expand their financial and human resources to ensure adequate coverage of the whole population, and assess their human resource strategy in order to ensure sufficient recruitment, retention, skills and compensation.

- In most Member States, long-term care needs to be expanded and put on a sound financial footing. Stronger coordination between health care and social services, support for informal carers and exploiting new technology can help people to stay as long as possible in their own homes.

- Improved coordination, promotion of healthy lifestyles and prevention could be win-win strategies, contributing both to improved health status and to reduced expenditure growth.

While these are general messages that emerge from the reports, specific challenges for Member States differ greatly. Some need to devote more resources to health care and long-term care to ensure adequate coverage while improving efficiency, while in others efficiency itself will be the key to maintaining sustainable systems.

Future horizontal work within the OMC could follow two directions. On the one hand, many of the areas analysed would benefit from a stronger and more comprehensive analytical basis. This concerns in particular the determinants of health inequalities, factors of sustainability, rational use of resources and issues concerning care coordination. The development of statistical data and indicators in these areas is also crucial to moving the analysis forward.On the other hand, Annex 2 summarises an impressive list of proposals of good practices that Member States put forward in their reports. These could form the basis for an exchange of experiences and mutual learning. The Peer Review methodology successfully used in the social inclusion strand could also be applied for some of the priority topics. Three major areas can be identified:

- Varying solutions to solve the trade-off between access and sustainability: design of out-of-pocket payments, avoiding overuse and minimising disincentives for vulnerable groups.

- Long-term care: this is an area where Member States are finding their way; there is potential for mutual exchange both on systemic issues and on specific aspects (for example, the involvement of civil society).

- Improving the quality of services: this implies spreading high quality across the care system and the implementation of prevention and promotion programmes.

3.2.7. Annex to section on health and long term care: Best Practice Examples in health care and long-term care in the 2006 National Reports

The aim of this Annex is to provide a synoptic view of the best practice examples on health and long-term care reported by the Member States. They are all strategies, methods, processes, activities, incentives or rewards that the authorities have implemented in an effort to be more effective in delivering a particular outcome than any other technique, method, process, etc. An analysis of this impressive list of examples shows that the focus is on three major areas which are closely linked. Broadly speaking, their goal is to tackle inequities in access, to enhance the quality of services provided, to improve financial sustainability, to promote long-term care, to coordinate health and social care, to overcome discrimination and to increase the integration of people with disabilities, ethnic minorities, immigrants, the homeless, addicts and isolated older people. There is potential for mutual exchange, and further details can be found in the national reports. The examples for exchanges of experience are as follows:

- Varying solutions to solve the trade-off between access and sustainability: design of out-of-pocket payments, avoiding overuse and minimising disincentives for vulnerable groups.

Examples aiming to enhance access through cost-sharing policies (co-payments or co-insurance) include annual ceilings on co-payments for all (BE) to limit the health care costs of each person to a maximum amount per year, complementary insurance and access to an outpatient clinic free of charge for those around an income threshold (FR, AT). Methods for improving access: introduction of a GP consultation phone line when no other services are available, thereby also reducing unnecessary "emergency" calls (EE), special training programme for GPs designed to ensure a better distribution of primary health care in areas at a disadvantage (HU), provision of high cost and low patient volume treatments abroad in highly specialised centres (UK) under a bilateral health care agreement (MT). Some countries highlighted the policies/measures they have implemented to provide access to health care for immigrants and disadvantaged groups (IT, PT).

Control of fast growing expenditure is a priority for all countries: hence the examples of promoting rational use of pharmaceuticals (FR), encouraging use of generics (LU), introducing DRG-based payments (DE), developing pilot studies based on private-public partnerships (EL), making a hospital's departments accountable for their own budgets (MT). Measures to ensure an appropriate size of medical workforce are also underlined in the reports: strategies aimed at the development of human resources for health (LV), re-training of unemployed persons to work as home carers (EE).

- Long-term care: an area where Member States are searching for new ways, systemic issues and how to involve civil society.

Initiatives for enhancing long-term care, especially coordination between health and social care sectors: integrated coordination of health care and social services (CZ, DE, PT), agreement establishing the budgetary and organisational framework for long-term care between regions and communities (BE), provision of social services within a city for people with disabilities by way of support, self-actualisation and therapeutic functions (SK). Initiatives for promoting home care: ensuring conditions for assisted living (AT), long-term care insurance giving priority for assistance for care at home (DE), home support service offered by a foundation (MT), a 7 days/24 hours reachable phone line to help the elderly to stay in their homes (MT), development of new national services (home care, post-acute/rehabilitation care and long-term care), or care lines, aimed at offering responses adjusted to the needs of various elderly groups and others with dependency problems (PT). Examples on rehabilitation: provision of adequate care for patients in a persistent vegetative

state (BE), acute rehabilitation geriatric hospital incorporating an interdisciplinary team approach (MT), residential groups in the area of mental health in an effort to avoid repeated hospitalisations, institutional care or inadequate home care (SI). Involving civil society in addition to professional and family assistance arrangements: development of specialised individualised care – contact centre for the Alzheimer's society, volunteer hospice association, ensuring the accessibility and development of social services through community planning (CZ), promotion and establishment of voluntary new structures of cooperation between the state or social security and civil society for caring and supporting older people (DE). As for quality standards, an internal and external quality assurance system for long-term care (DE), the development of social care and social rehabilitation institutions infrastructure and equipment (LV) and the introduction of a new up-to-date approach in order to improve the quality of services provided for disabled patients living in a home centre (SK) are further highlighted examples of good practice.

- Improving the quality of services.

Member States are highly committed to increasing and maintaining high quality care and provided a valuable collection of tools implemented: uniform treatment criteria for access to non-emergency care (FI), affirmation of patients' rights to increase patient satisfaction and the level of quality (FR); development of evidence-based medicine for high cost and low patient volume treatments through the creation of a network of centres of excellence (FR); flexibility in community services by way of holistic care provided by multi-disciplinary teams (MT) and introduction of a quality assurance initiative – a merit award scheme – to reward good practice (MT).

The examples present a variety of health promotion initiatives aimed at reducing risk factors by raising awareness among adolescents of obesity versus healthy diet (AT), health promotion and drug education in primary and secondary education (CY), family/women health promotion care centres (IT), restriction on trade of unhealthy foodstuffs in educational establishments (LV), support and promotion of local community projects to improve health (UK), creation of a national network of hospitals promoting health (CZ), introduction of a health trainers programme aiming to help people improve their health (UK). Disease prevention initiatives include: breast screening policy (BE), national plans of active prevention (IT, SI), national vaccination systems (HU, BE).

Health inequalities associated with a range of factors are substantial across and within EU Member States. A national cross-governmental strategy (UK) has been reported as an example of how to address it.

3.3. Progress in the Field of Pensions since 2006

3.3.1. Introduction

The 2006 joint report reiterated the approach to the open method of coordination to be taken during 'light' years when Member States are not required to deliver National Strategies. In these years the OMC will concentrate on in-depth analysis of specific issues, dissemination of policy findings and ongoing assessments of indicators of progress towards the common objectives. In the field of pensions, 2006 was one such 'light' year, although it also coincided with the recalibration of the OMC into a new streamlined method of working, receiving National Strategy reports on social inclusion, and, for the first time, health and long-term care. National Strategy reports also contained a brief update on the key reforms to Member States' pension systems that had occurred in the previous year.

Therefore, the focus of OMC work in 2006 has been on points identified in the last joint report as areas warranting further analysis, together with ongoing work on the indicator of theoretical replacement rates. Studies, seminars and workshops were organised in 2006 on two issues: the design of minimum income provisions for older people and the link between flexibility in the age of retirement and longer working lives.

This section summarises the main work carried out in 2006 in the field of pensions in the light of the agreed common objectives (see below). Chapter 2 summarises recent developments to those Member States' pension systems which have undergone recent reforms. Chapter 3 is an overview of the findings and the work of the Indicator Sub-Group on replacement rates. Chapter 4 summarises the SPC study on minimum income provision for older people, while chapter 5 summarises the main messages emerging from a study on flexible age of retirement. Chapter 6 provides general conclusions and identifies the next steps.

Common objectives for pensions

The common objectives of the OMC in the field of pensions are to provide adequate and sustainable pensions by ensuring: (g) adequate retirement incomes for all and access to pensions which allow people to maintain, to a reasonable degree, their living standard after retirement, in the spirit of solidarity and fairness between and within generations; (h) the financial sustainability of public and private pension schemes, bearing in mind pressures on public finances and the ageing of populations, and in the context of the three-pronged strategy for tackling the budgetary implications of ageing, notably by supporting longer working lives and active ageing; by balancing contributions and benefits in an appropriate and socially fair manner; and by promoting the affordability and the security of funded and private schemes; (i) that pension systems are transparent, well adapted to the needs and aspirations of women and men and the requirements of modern societies, demographic ageing and structural change; that people receive the information they need to plan their retirement and that reforms are conducted on the basis of the broadest possible consensus.

Key issues from the 2006 Joint Report into adequate and sustainable pensions

The Synthesis report on adequate and sustainable pensions of 2006 reiterated that the three main objectives of pensions adequacy, sustainability and modernisation should continue to guide the reform strategies for meeting the European pensions challenge. It noted that Member States had made substantial reforms in recent years, partly to address key sustainability issues presented by ageing populations, but also to ensure that reforms provided adequate pensions for all citizens. The report also confirmed that the reform of pension

systems cannot be conducted within a vacuum and must be considered alongside labour market reforms and overall public spending plans.

The Synthesis report identified a number of key issues requiring careful monitoring. A first key issue is the need to promote more and longer working (in particular the mobilisation of previously less active members within paid work, such as women and older workers). A second issue is the need to adjust systems to changes in life expectancy and to promote a life-cycle approach into their design. A third is the need for pension systems to be modernised and take better account of the changing and more flexible nature of careers (reflecting the role of carers, periods of training and education and job mobility). A fourth key issue is to ensure future adequate minimum income provisions for pensioners, notably as regards indexation rules and possible disincentives to work or save. A fifth key issue is the financial sustainability of public pensions systems and monitoring of the effect on government budgets (including the impact private pension systems may have on public finances). The evolution and development of occupational and private funded pensions was also emphasised, reflecting Member States efforts to reform existing structures, or develop funded provisions for the first time. The report highlighted the positive contribution such systems can make to the outcome of older peoples' incomes, but sounded a note of caution as to the impact such systems have for those not engaged in formal or paid work and underlined the importance of ensuring security and equity The report also underlined the importance of enhancing transparency and promoting better education and understanding of pension issues among the public. Finally, the report emphasised that regular reviews and adjustment mechanisms are important innovations not only for adapting systems over time but also for promoting a better understanding of the need for reform in the face of demographic challenges.

3.3.2. Recent developments in pension reforms

Although Member States submitted National Strategy reports in 2005 outlining the progress of reforms since 2002, a number of them have reported examples of substantial reform in the last year (the most notable of which are proposals outlined in Portugal, UK, Denmark and Malta), while several of them have reported further refinements to existing strategies of reform.

The UK is undergoing a substantial reform of its state pension system in the wake of a report by an independent Pensions Commission. The UK government's reform proposals aim to provide a stable State pension, annually increased in line with the evolution of earnings and with broader coverage (with the specific intention of increasing provision for women and carers). The proposals also outline an innovative approach to significantly broaden and deepen the levels of supplementary pension saving, by means of 'auto-enrolment'. Individuals will either be automatically enrolled into existing occupational schemes or into new low-cost individual savings accounts that will be fully portable and include mandatory employer contributions. The proposed reforms also envisage a gradual increase of the State pension age to 68 by 2046.

Malta also undertook extensive pensions reforms in March 2006. These are designed to improve the adequacy of incomes for pensioners and to extend working lives through increasing the number of contributory years needed for a full state pension from 30 to 40 years. Furthermore, there will be a raising of the age at which a pension can be taken to 65. Both the Danish and German authorities have also proposed rises in the age at which an individual is entitled to a state pension, from 65 to 67, and both are pursuing measures designed to reduce instances of early retirement.

The Portuguese authorities have reached agreement with their social partners to reform their State pension system in order to improve equality and link benefits closer to contributions and the progression of life expectancy. These reforms are part of a strategy to increase the employment rates of older workers. Portugal has also recently introduced a new minimum income guarantee for the elderly: the "Solidarity Supplement for the elderly" was launched in 2006 and is designed to tackle older person poverty in Portugal.

Belgium, Germany, Spain and France have outlined more incremental changes aimed at increasing the numbers of older workers, and Spain and Austria have also made reforms to their minimum pensions systems. Poland and the Czech Republic have reported that reforms announced in the 2006 Joint Report have been delayed, or have made little progress.

The two new Member States submitted reports for the first time, outlining the key challenges of their pensions systems. Romania highlighted the need to increase the contributory base of its pension system, to extend working lives and to ensure that pensions are adequate in the coming years. Bulgaria also outlined the need to increase the employment rate of older workers and further develop provisions for the new supplementary components to their system.

3.3.3. Theoretical replacement rates and the long-term adequacy of pensions

This chapter reflects the current state of assessment of the future adequacy of pension systems within the Open Method of Coordination for pensions. Following the adoption by the European Council in March 2006 of the streamlined common objectives, a set of agreed indicators for pensions was adopted by the Social Protection Committee in June 2006. These included theoretical replacement rates to provide a prospective picture of adequacy of pensions.[60]

The long-term adequacy of pensions

The three streamlined objectives for pensions sketch out a strategy for reconciling adequacy and financial sustainability in the context of population ageing. However, they do not represent a blueprint for pension reform as these objectives can be achieved in different ways and what finally matters are outcomes.

A key dimension of pension systems is that they relate not only to the current situation of older people but also to future developments, which are influenced by enacted reforms. Theoretical replacement rates make it possible to highlight prospective trends for future pensions, in line with available expenditures projections. In view of the potential high costs implied by the ageing of populations, most Member States are engaged in significant reforms of their pension systems, which will clearly impact on future pension benefits. The 2005 national strategy reports showed that Member States are trying to maintain or even improve basic income protection (see section on minimum income provision for older people), while pension reforms also tend to reduce the level of replacement rates for a given career length and profile. This highlights that while many reforms can reduce the average level of pensions, Members States pay attention to guaranteeing a decent minimum to all.

Indeed, reforms are generally aimed at curbing the rise in pension expenditures. This is well reflected in the latest set of pension expenditures produced by the Economic Policy Committee's Working Group on Ageing (AWG), which show that drops in the benefit ratio[61]

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[60] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/indicators_en.pdf

[61] This corresponds to a decline of average pensions in relation to average wages, as the former are projected to increase at a slower pace than the latter.

play a major part in decoupling public pension expenditure growth from the increase in the old-age dependency ratio.

As underlined in the 2006 Synthesis report on pensions and in the 2006 Sustainability report, adequacy and sustainability of pensions cannot be achieved separately: they are mutually reinforcing in a virtuous or vicious circle. Indeed, achieving sustainability at the cost of a significant decline in the future relative level of pensions would put the reform strategy at risk of unexpected demands for revaluation of pensions. . By the same token, promises of pensions without sustainable financing raise questions as to the capacity of pension systems to effectively deliver.

Current and prospective theoretical replacement rates

The first three primary indicators on the adequacy of pensions provide information on the current income situation of older people, as regards monetary poverty (poverty risk of people aged 65+), and the relative income situation of older people. The latter can be assessed either on the basis of household income[62] (relative income) or on the basis of individual incomes (aggregate replacement rate). These indicators need to be complemented by another type of information, focusing more specifically on the pension systems themselves and their future evolution.

The Indicators Sub-Group of the Social Protection Committee responded to the need for prospective adequacy indicators by developing a methodological framework for calculating theoretical replacement rates. The first results of this work were presented to the Council in March 2003, while further refining of the methodology and a peer review in April 2005 helped to prepare a second wave of calculations that were used in the National Strategy reports and the Synthesis Report on adequate and sustainable pensions of 2006. These elements were synthesised in a report of the ISG of May 2006.[63]

Prospective theoretical replacement ratios describe the anticipated evolution of pension income, taking into account reforms introduced, for a person retiring at 65 after 40 years of work at the average wage (male if relevant). Theoretical replacement rates refer to the replacement of income obtained when people retire: at the moment of take-up, it is the ratio of pension income in the first year of retirement divided by work income during the last year before retiring.

These allow the adequacy of pensions to be assessed and take account of changes that have been adopted in many countries as a result of recent reforms. Comparisons between Member States of projected trends provide useful information on expected trends, but it should also be borne in mind that other factors are also at play, such as the expected evolution in employment or rates of returns, and the general development of pension expenditures.

Several factors will actually determine future adequacy, the replacement of previous income provided by public pension schemes being a determining factor, but not the only one. Future income replacement levels will depend first of all on the pace of accrual of pension entitlements, which is linked to developments in the labour market and to the actual coverage of pension schemes. Increased female labour force participation will lead to higher pensions

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62 Income data are assessed for households and then individualised using a general equivalence scale (although this equivalence of scale may be slightly different for elderly people). Thus, income data are not individual incomes of men and women or of older or younger people, but a share of the household income in which these individuals live.

63 http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf

for women, while longer careers (later retirement) should allow people to accrue more adequate pension rights. Supplementary private pensions may make a larger contribution to old-age income. Also, accumulated wealth – particularly home ownership – is a major determinant of living standards in old age. Unfortunately, it is not currently possible to assess the long-term overall impact of all these factors on the incomes of older people (and their distribution).

Representativeness, assumptions used and interpretation of results

Information on representativeness and on assumptions used is an essential guide for the interpretation of theoretical replacement rates as they show how the theoretical situation reflects actual outcomes.

The base case representativeness can differ considerably between Member States and it is essential to have information concerning representativeness.[64] Differences in the representativeness of the base case (Table A1) suggest that comparisons of levels of theoretical replacement rates among Member States should only be made with caution. For the sake of a more accurate interpretation of results, levels of theoretical replacement rates are thus not displayed (they are provided in country sections of the ISG 2006 report).

Theoretical replacement rates refer first and foremost to statutory pensions, i.e. classical pay-as-you-go schemes, but also, for some Member States, to the mandatory funded tier of the statutory scheme (EE, LV, LT, HU, PL, SK and SE). In some Member States, calculations also cover funded occupational and voluntary schemes (BE, DK, DE, IE, IT, NL, SE and UK), which can be either of a defined contribution type (DC) or of a defined benefit one (DB).

Results thus need to be accompanied by information on coverage of the various schemes, as the situation should also be reflected of people that are not covered by such schemes, but only by statutory schemes. Reflecting the universality of access to those schemes, coverage of first pillar schemes is generally close to 100% of the labour force, thus allowing good representativeness. However, this is not necessarily the case for occupational or voluntary schemes (current estimates of coverage range from 11% in IT to 90% in SE and 91% in NL).

Representativeness also depends on the average age at retirement and average seniority at retirement. In this regard, the assumption of an age of retirement of 65 is high in comparison to current levels (see Table 1), notably for women. Only a few Member States appear to currently have retirement ages close to 65 (IE, SE). Thus, in a number of Member States, calculations provide an overestimation of the current income situation of pensioners. Also, while the current levels of seniority appear to be generally close to 40 years, significant differences between Member States can be observed.

Information on assumptions used is also essential, in particular as regards contribution rates.[65] Total contribution rates used (Table A2) are generally in the range of 20 percentage points

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64 The following aspects were considered: age and seniority at retirement, coverage, percentage of the annual flow of new retirees receiving occupational pensions (or private in general), current overall contribution to the first pillar as a percentage of individual earnings for private employees, current overall contribution to occupational schemes as a percentage of individual earnings for private employees who are currently members of such a scheme, means-tested supplements and other social benefits, aggregate replacement rate, average pension relative to average wage.

65 The following aspects were considered: contributions by the employer and the employee to the different schemes included in the calculations (as well as the other social contributions, with the possible

(between 15 and 25). In some Member States, contribution rates can of around 30 percentage points (CZ, ES, IE, PT, SE) or between 35 and 40 percentage points (IT, PL, UK). Representativeness is well achieved as regards assumptions on levels of contributions to first pillar. For second pillar schemes, it should be noted that calculations generally rely on an assumption of increase of contribution rates for this type of pension provision (Table 2).

The general economic assumptions used have been chosen to be as consistent as possible with the AWG assumptions (see 2006 ISG report for detailed description of assumptions used). It should be noted that the common assumption used on long-run real rates of return is 2.5% (3% gross real rates of return minus 0.5% administrative charges; the NL and DK used 0.25% administrative charges, reflecting lower administrative costs enabled by large-scale pension schemes).[66]

Trend towards a decline in replacement rates at a given age

The work carried out on replacement rates by the Indicator Sub-Group highlights the fact that reforms of statutory schemes will often lead to a decrease in replacement rates at given retirement ages. Indeed, all types of pension provision have to adapt to the trend of increasing life expectancy at 60 or 65, be they pay-as-you-go or funded. It should be noted that the evolution of replacement rates is assessed for given retirement ages and given contribution length, while most pension reforms actually plan an increase in at least one or both of these parameters.

Results for the base case indicate that, for most Member States, overall replacement rates are projected to decline over the coming decades (see Table A3): net theoretical replacement rates are projected to decline in 12 Member States, while the situation would not change significantly in 8 other Member States (a change of +/- 3 percentage points) and an increase is projected for 6 Member States (only two where this exceeds 5 percentage points). Given that second pillar pensions generally do not have full coverage of the population, the decline is more significant when focusing on the evolution of gross replacement rates of first pillar statutory schemes: gross theoretical replacement rates are projected to decline in 14 Member States, while the situation would not change significantly in 8 other Member States (a change of +/- 3 percentage points) and an increase is projected for only 3 Member States.[67]

In addition, pensions in payment most often lag behind wages, as for the most part they are generally indexed on prices (on an aggregate of wages and prices, with various weights). This translates into a decrease in the level of theoretical replacement rates during the period of retirement (see last column of Table A3).

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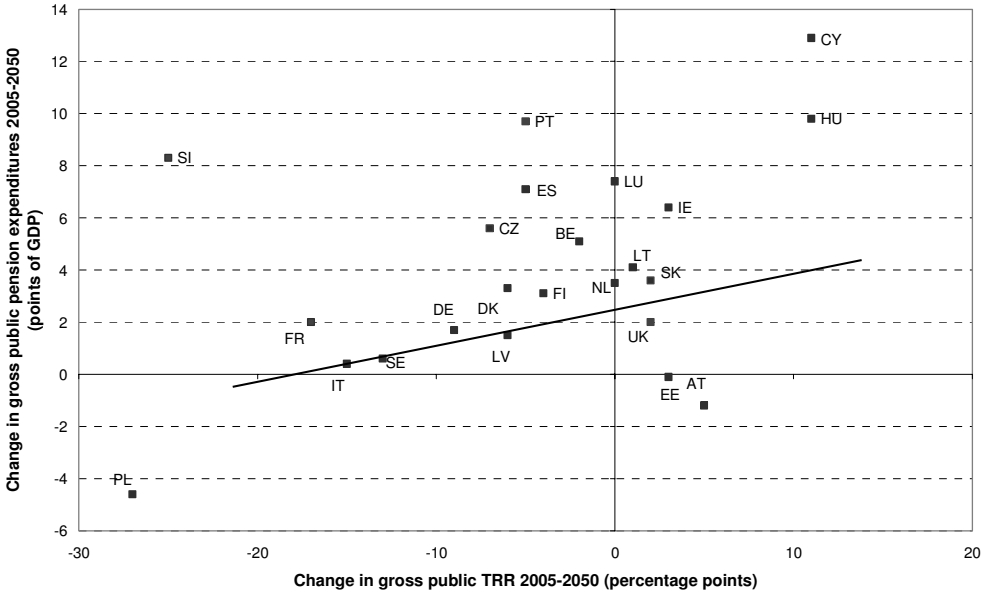
addition of any public contributions), and, where a Member States chooses to use a DB framework for 2nd pillar schemes, contribution rates assumed (both employee and employer contributions).

66 The assumption on contribution rates is linked for defined benefit schemes to the rate of return assumption. The common assumption of 2.5% for real long-run rates of returns (3% gross minus 0.5% administrative costs) may not necessarily reflect the circumstances of some countries, notably those with well-established pension industries. Member States have been asked to provide national variants when they wish to illustrate this. Some Member States used slightly different assumptions of rates of returns, which should be borne in mind when making comparisons of outcomes of funded schemes. The Finnish and Swedish calculations, for example, use a real net rate of return of 3%, while the Cypriot and Maltese calculations (in the variant 'some reform') use a higher real net rate of return.

67 Observing the evolution by measuring *relative* changes in theoretical replacement ratios allows differences in initial levels to be taken into account (as compared to the evolution in percentage points). In some Member States, the intensity of changes can differ (see ISG 2006 report).

Furthermore, the evolution of theoretical replacement rates is linked to the evolution of pension expenditures, as highlighted in Graph 1 for public (statutory) pensions. Member States with more positive developments of theoretical replacement rates appear to face more significant challenges as regards their future pension expenditures, and can be relatively less advanced in the process of pension reform (it should be noted that reforms up to 2004 have been taken into account and that some Member States introduced significant reforms since then). However, comparable evolutions of theoretical replacement rates can reflect significantly different situations as regards the evolution of pension expenditures; which also reflects different projected dynamics, notably as regards demography or employment.

Figure 1 – Projected evolutions of theoretical replacement rates (TRR) and pension expenditures for public pension schemes



Source: ISG and AWG projections (public pension schemes include the funded tier of statutory schemes).

The trend towards a drop in prospective replacement rates at a given age results in various adjustments not only in statutory schemes (pay-as-you-go and possibly including a funded tier) but also in private pension schemes in some Member States. In the latter case, this contribution will benefit people who are actually covered and thus a significant share of pensioners will rely only on the contribution provided by statutory schemes (see coverage levels, Table A 1).

Most Member States have statutory pension schemes providing earnings-related pensions. Benefits under these pension schemes are related to earnings, either during a specified number of years towards the end of the career or increasingly during the entire career. The contribution period taken into account in the calculation of pensions, the pace of revalorisation of past wages (no revalorisation, revalorisation on prices, on wages, or a mix) and the pace of indexation of current pensions vary appreciably among Member States and are generally the target of adjustments during reforms. Also, a significant development has been the introduction of a demographic adjustment factor in a number of Member States (DE, FR, AT, PL, SE, FI and LV and in all DC-funded schemes), which take account of future demographic trends and in particular of increases in life expectancy. They thus provide strong incentives for people to postpone retirement to match rising life expectancy and offer opportunities to achieve adequate pension levels.

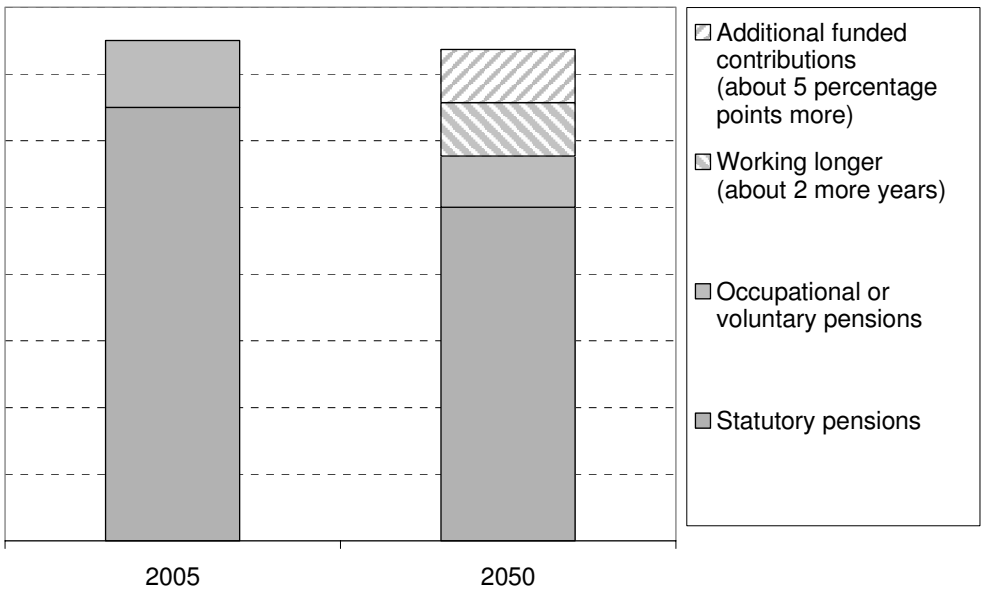
How can working longer and the development of privately managed pensions influence replacement rates ?

Two major axes have been developed by Member States to cater for this projected decline in replacement rates at a given age: incentives to work longer, on the one hand, and the development of private pensions (higher savings and contribution rates) on the other. It can also be noted that a number of Member States (such as Belgium and Denmark) have embarked on a strategy of public debt reduction, which can create room for manoeuvre for financing adequate pensions.

All Member States have increased the accrual of pension rights if people work longer and these should act as incentives to work longer, thus helping to offset the projected decrease in replacement rates. Moreover, in a number of Member States, the development of privately managed pension provision is projected to play a role in compensating for future decreases in replacement rates.

The orders of magnitude available indicate that an increase in the retirement age of about 2 years and an increase in contributions to funded schemes of about 5 contribution points will keep replacement constant (cf. 2006 ISG report on theoretical replacement rates).

Figure 2 – Evolution of theoretical replacement rates, working longer and privately managed pension provision



Source: Stylised illustration of ISG projections (statutory schemes also include where there is a the funded tier), based on 2006 ISG report on theoretical replacement rates.

Increasing incentives to work longer

A number of reforms have recently strengthened the benefit-contribution link of pension systems. In defined-benefit schemes, the link can been strengthened through a longer contribution period required for a full pension, while applying actuarial reductions for early pensions and increases in pension rights for deferred retirement (in a number of Member States, such as AT, FR, FI, while the link had already been strengthened by previous reforms in a number of Member States). Some Member States have pushed through major reform packages, and have changed their statutory schemes appreciably (DE, FR, AT, FI, IT).

Notional defined contribution schemes (such as in SE and PL) also build on a strong link between contributions and benefits. Since the end of the 1990s, a number of Member States have also introduced statutory funded pension schemes (e.g. PL, HU, EE, LV, LT, SK, SE).

Extending working lives by 2 years enables theoretical replacement rates to be increased by 5 to slightly more than 10 percentage points. Theoretical replacement rates calculated by the OECD also provide evidence of these incentives (notably at different wages levels and for different periods in time). Initial results indicate that incentives to work longer increase with age and that in some Member States they are still low after recent reforms, particularly among low wage careers.

Development of privately managed pension provision

In Member States where statutory pensions provide a relatively low income replacement for average wages earners and are geared more to the goal of poverty prevention, the ability to maintain one's living standard after retirement depends to a large extent on access to the funded tier of the statutory scheme, and to private occupational or personal pension provision (as in DK, NL, IE, UK). Moreover, in some Member States the funded tier of the statutory scheme is expected to contribute significantly to the future income of pensioners (PL, EE, LV, LT, HU, SK). A number of countries have increased provisions for occupational or private schemes that complement public pensions (DE, IT).

In these countries, achieving good coverage rates of such private schemes and adequate benefit levels are particularly important goals for policy-makers. It should be underlined that increasing reliance on private provision also has to be accompanied by appropriate coverage and contributions paid into these forms of pension provision.

The current coverage of the second pillar schemes taken into account varies, and this should be borne in mind when considering the contribution from these schemes to replacement rates results for the base case (current estimates of coverage range from 11% in IT to 90% in SE, see Table A2). As regards contribution rates, some Member States assumed in the calculations of theoretical replacement rates that workers will contribute more than 10% of their wage to private funds (DK, NL[68], SE) and in some cases more than 20% (IE, UK).[69] Furthermore, the assumptions used indicate that contribution rates are generally expected to rise in comparison to current levels to enable the projected levels of income replacement to be achieved (see Table A2).

In a number of Member States, the contribution of private pensions is thus expected to rise. This also includes Member States that are developing a funded tier within their statutory schemes (SE, EE, LV, LT, PL, HU, SK) where the first payments will be made at the end of the decade. For these Member States, it would be interesting to identify the contribution of the funded tier of statutory schemes. The development of occupational pension schemes (even in countries where the increase in coverage rates is still recent by the standards of pension systems) will also translate into an increase in the number of pensioners with entitlements for a complete career over the coming decades. Some countries plan to compensate partly for the decline in statutory replacement rates by the development of privately managed pension provision (in particular DE and IT), while in other Member States an increase in contribution rates to private pensions is projected in order to achieve future projected levels of replacement

[68] The level of contribution rates assumed in projections of theoretical replacement rates for NL depends on the actual level of indexation of benefits and of future real rates of return.

[69] In Ireland and in the UK, the vast majority of the assumed contributions in the base case are employer contributions.

rates of second pillar pensions (in particular in DK, NL and UK). In this regard, it should be stressed that, in order to deliver according to expectations, it is essential to monitor the evolution of coverage and contribution rates of these schemes.

Summary of findings

Theoretical replacement rates make it possible to monitor how enacted reforms will translate into changes in future pensions, for given situations and under given assumptions. The results indicate a trend towards a decline in replacement rates at a given age, which in part also reflects the trend towards an increase in life expectancy at 60 or 65. Indeed, all types of pension provision have to adapt to the trend of increased life expectancy (be they funded by a pay-as-you-go mechanism or through funded schemes). In this respect, longer working lives (and also higher savings and contributions to second pillar pensions in some Member States) appear to be the key to compensating for this projected evolution in theoretical replacement rates at a given age.

However, it should be stressed that trends in individual replacement rates will not directly translate into equivalent changes in future pensioners' household incomes. Rising female labour force participation in all Member States will result in higher average pensions. In southern or the new Member States, economic modernisation and corresponding employment changes will lead to better pension outcomes in the future. With these structural evolutions, the trend towards a reduction of benefits could be counterbalanced to a significant extent. Further analysis is needed in this area.

These results could usefully be underpinned by a more systematic assessment and a more in-depth analysis: the changing composition of pensions calls for a more detailed assessment of the contribution of the different types of schemes and a more in-depth analysis of incentives to work longer or of the balance between contributions and benefits. Cooperation with the OECD, which is also compiling estimates of theoretical replacement rates, will contribute to a better understanding of such issues (notably as regards the effective age of retirement, levels of earnings, length of contribution, real long-run rates of return, contribution rates, life expectancy, career breaks and differences between men and women).

3.3.4. Minimum income provision for older people

Background

This chapter examines the contribution made by minimum income provision for older people within the pension systems of the Member States. Work on this subject was carried out in 2006, in line with the commitment of the 2006 Synthesis report to focusing policy analysis and exchange of best practices on key issues during light years of the OMC. An analytical report of the SPC was completed based on responses to questionnaires sent to Member States and the findings of a special seminar into the issue of women's poverty and minimum income held in Belgium in June 2006.

The purpose of this work was to review and assess reforms and developments of minimum income provision for the elderly throughout the Member States, and the roles minimum incomes play in ensuring adequacy in retirement (and in particular alleviating old age poverty). It also looked at the sustainability of such systems and their likely evolution and interaction with Member States' reformed pension systems in general.

Design

The prime finding of the investigation into minimum incomes is the diversity of the types of provision that Member States reported. The main aims of such provision are to provide a set level of income for elderly citizens, in particular for those who may not have had the opportunity to accrue pension rights during working age.

Broadly speaking, minimum provisions can be divided into 3 types (although it should be noted that some systems combine parts of 2 or 3 of these broad categories): (i) minimum pensions within the earnings-related pensions systems that rely on contributions throughout a working life. These often offer a strong degree of solidarity, and are generally available with a fairly low threshold of contributory years and are subsequently almost universal in their coverage; (ii) Minimum pension schemes. They can provide flat-rate benefits for all older people, without regard to the accumulation of own pension rights. Usually, the residency for a certain period of time is the core criteria for receipt (for instance DK or NL). Other minimum pension schemes can guarantee a certain level of income to all elderly persons but are means tested against earnings related pensions, thus complementing earnings related pensions. Entitlement is usually based on residency test (for instance FI and SE) (iii) separate social assistance benefits for older people, usually paid to people who do not meet residence criteria and/or have made too few contributions to the general system and subsequently have little or no income in old age. Usually, these benefits are subject to some form of means testing, often broader than minimum pensions. They ensure that individuals have the basics for an adequate living. Sometimes the social assistance rate is higher for the elderly, and may be referred to as a minimum pension, or minimum income. Older people also generally enjoy other types of benefits, which make an important contribution to their living standards (in particular health care services, housing benefits).

Poverty

As minimum incomes are often utilised to alleviate poverty, the setting of these minimum levels and the subsequent indexation of the benefits in payment are an important aspect of the efficacy of the provision. These methods range from calculating rates in relation to consumption (often a basket of essential goods such as basic foodstuffs), as is the case in Estonia and Germany, to setting minimum incomes in line with national minimum wages (Netherlands, Portugal) and setting levels with regard to poverty levels (Austria combines this with price inflation). Indexation practices also differ widely, being either linked to price rises, to average wage increases or a mixture of the two or also ad hoc rises determined by Governments (though in recent years some Member States have increased minimum incomes more substantially than legislation calls for).

Also, minimum income provisions are not necessarily indexed in the same manner as general pension benefits and, in some Member States, minimum income provisions are based on more favourable or less favourable indexes. It should be noted that increasing minimum incomes by price inflation can be argued for on the grounds that the consumption needs of pensioners may be stable or even decline with age, and therefore retaining a price link is sufficient. However, this also ensures a worsening of the relative income situation of pensioners and particularly for those on the lowest incomes. This is also reflected in poverty levels among the oldest pensioners usually being higher than among their younger cohorts (although there are a number of other factors that contribute to this differential). Calculations of theoretical replacement rates by the ISG suggest that this effect can be substantial, as replacement rates for a standard career generally decrease by around 5 to 10 percentage points 10 years after retirement. People with little or no access to the general pension system are likely to be even more harshly affected, where reductions of 10% to a low income are less sustainable.

Reforms

A number of Member States have made reforms to their minimum income systems with the purpose of: increasing levels of benefits, making access to benefits easier or replacing existing benefits with new systems. This reflects the growing attention that minimum incomes have received in recent years, alongside reforms that many Member States have undertaken to their general pension systems. In a number of Member States, the level of minimum pensions has increased more rapidly than general indexation rules require (e.g. in BE, FR, FI), and some at a quicker pace than the general evolution of pensions or wages (e.g. in IE, ES, PT). Other Member States have introduced new benefits recently, such as the Pension Credit in the United Kingdom (2003), the Solidarity Supplement for the elderly in Portugal and the creation of a social assistance pensions in Lithuania (2006). Slovakia has adopted a new mechanism, which guarantees a minimum income for all retirees with pension benefits lower than a pre-set subsistence level. Other Member States have introduced supplements to existing benefits, as in Denmark (Supplementary Pension Benefit in 2003) and in Hungary (supplement for those aged 75 or more introduced in 2006), or made access to benefits easier (Basic Insurance for old age people in Germany).

These reforms are having, or have already had, an impact on poverty levels for the elderly, and, while in most Member States older people are more at risk of relative poverty than the rest of the population, it should be noted that the poverty gap of older people (i.e. income closer to the poverty line) in all but a few Member States is lower than the general population. This is due in part to the provisions of minimum incomes to the elderly on the whole being higher than similar provisions that are available for the general population (such as general social assistance).

Incentives

A further aspect of minimum incomes is their impact on supplementary savings and working patterns, on the premise that if minimum guarantees are too high, means-tested or paid at an early age, they remove incentives to work and save. Research into these factors is limited but Member States indicated that at present disincentives were at best minimal and less significant than other elements within pension systems. As large numbers of EU citizens begin to accrue private and occupational savings over the coming decades and incentives to retire early are removed from pension systems, minimum income disincentives should be closely monitored.

Future

The expected evolutions of the demand for minimum income provision within pension systems are uncertain (except in Member States with universal coverage through flat-rate pensions, where coverage should remain comprehensive, as in NL or DK). Member States lacked detailed projections on the future role of such benefits, either on the likely number of future recipients or on the likely potential levels of expenditure. Clearly, assessing this is fraught with practical difficulties, such as estimating future employment rates, returns on private savings and developments in pensions systems. However, as a large number of Member States are set to see falls in replacement rates from traditional state pension systems over the coming years and greater reliance is transferred to occupational or private saving (which will be inherently more unpredictable in terms of income outcomes and also offer less solidarity for people with broken work records), greater attention should be paid to this issue, with more emphasis placed on what minimum incomes are likely to deliver and for whom.

Summary of findings

Minimum incomes across much of the EU have grown in importance in recent years, as countries reform their systems and focus more closely on the adequacy of their poorest pensioners. How they are designed varies, reflecting the multiplicity of pension systems, which subsequently contributes to the varying importance placed on them by the Member States. However, there is greater emphasis in some countries, which place a high premium on private and occupational saving.

The effects of minimum incomes are reflected in the generally lower poverty gaps of older people in comparison to the general population, although relative poverty is still more likely among the elderly than among their younger counterparts. The conclusion can be drawn that minimum incomes are effective in alleviating relative poverty but not necessary in eliminating it altogether. Therefore, consideration should be given to the levels of minimum incomes and their adjustment mechanisms to the rises in prices and living standards. . Evidence suggests that in some Member States reliance on such provision is declining, reflecting the maturation of earnings related pension systems. There is clear tendancy that the need for minimum incomes will decrease, as, more women (who traditionally have been the main recipients of such benefits) are entering the labour market and accruing future pension rights. On the other hand, in particular for those with broken work records and part-time or low paid jobs, the development of stricter rules on the accrual of pension rights and tighter access to or actuarial reductions for early retirement is likely to result in lower retirement incomes. The uncertain outcome of recent pension reforms makes it essential to develop tools to monitor future developments of minimum incomes and their interaction with the wider pension system, through, for instance, theoretical replacement rates or dynamic (panel) micro-simulation models.

3.3.5. Flexibility of retirement age

The 2006 Synthesis report on adequate and sustainable pensions identified policies to provide for flexibility of retirement age as an issue for further analysis and for exchange of practices between Member States. Ten Member States presented and discussed their approaches and programmes at a workshop organised jointly by the Spanish Ministry of Labour and Social Affairs and the Commission. The general conclusion seems to be that more flexible retirement provision can help to adjust pension systems to demographic ageing and to provide more freedom for the retirement decision of workers within the constraints and trade-offs inherent in social retirement systems.

Most Member States are reforming their legislation on retirement age. While the legal retirement age can be uniformly increased, some Member States are also introducing more flexibility of retirement age, thus giving individuals more choice in their retirement decisions. This can be done either by introducing windows within which a person can retire or by making it possible to cumulate pensions and earnings, either through partial retirement or through the option of cumulating earnings and pension benefits.

Three key questions were identified at this stage: the definition of appropriate incentives for flexibility in retirement, the design of conditions for cumulating pensions and earnings, and further improvement of information and understanding of pension systems by individuals.

A first key question for the design of flexibility in retirement age is the strength of incentives. In this context, a benchmark for earlier/later retirement could be the concept of actuarial equivalence, which would also ensure a sustainable financing of the system. However, incentives to postpone retirement appear to differ significantly between Member States, being sometimes below actuarial equivalence. If incentives to retire later are too low, this can be

seen as encouragement to retire earlier. Conversely, high bonuses can involve dead-weight costs by subsidising individuals who would in any case have postponed retirement. Elements of evaluation available suggest that incentives to postpone the age of withdrawal from the labour market beyond the legal retirement age generally amount to an increase in pensions of between 5 and 10% per year (depending on age, careers and mortality tables).

Furthermore, it is essential to note that the strength of incentives can also directly impact on adequacy, as an increase of a few years in retirement age can translate into substantial differences in pension levels. For lower wage earners in particular, incentives have to be reviewed and linked to the interaction between minimum incomes for pensioners and standard earnings-related schemes. The strength of incentives also needs to be considered in respect of different eligibility criteria. In particular, it is essential to set a minimum retirement age, as well as to take into account of the length of contributions (for instance, the strength of incentives can depend on the length of contributions).

Another key issue for the design of flexibility of retirement age are the conditions for cumulating pensions and earnings and accruing additional pension rights. In general, these arrangements currently concern a small fraction of pensioners, at most 10% before the age of 65 and no more than 1% around the age of 65. In this respect, it is important not to mix the possibilities of drawing a partial pension with early retirement paths, as partial retirement can sometimes have been used for the different purpose of earlier exits from the labour market. In general, far more scope is provided for cumulating a pension (possibly partially) and earnings for ages close to the standard retirement age, while conditions are stricter for earlier ages (there is often no scope for cumulating earnings and early retirement). Furthermore, the progressive phase-out of pensioners from the labour market also depends on labour market conditions, and in particular on the possibility of part-time work for older workers.

A third key issue identified is the extent to which individuals understand fairly complex retirement rules. This is a difficult question that requires long-term efforts. Experience suggests that even when individuals are provided the information on their pension entitlements, they do not necessarily understand the consequences of different retirement choices in a context of changing rules. It is essential to provide broad information on the effects of reforms for individuals and on the potential impact of their choices. Experience also raises doubts as to how far a policy can build on the assumption that people are fully aware of the consequences of their decisions and whether flexibility does not need to be complemented by minimum/maximum provision, which ensures adequate retirement incomes and restricts the scope for choice.

The workshop also highlighted the fact that other factors than the rules of the pension system are at play. In particular, the ability of the labour market to respond to changes in retirement provisions is essential, notably as regards part-time work. Only if labour markets are open for older workers can flexibility of rules give real choices to people. One aspect in this respect are the costs and incentives for employers to hire or lay off staff.

Finally, it was noted that not many evaluations were available and more investment on evaluation tools is needed, based on an empirical assessment of the impact of reforms and not only *ex-ante* evaluations based on simulations, particularly as regards the induced effects on employment paths of older workers and on the composition of incomes.

3.3.6. Next steps within the Open Method of Coordination

2006 was a productive year for conducting in-depth analyses on issues such as minimum income provision for older people and flexibility of retirement age, and for continuing work

on replacement rate indicators. New approaches to working were trialled in 2006, with two successful 'peer review' style seminars held, and the use of more traditional working methods such as questionnaires to Member States and reports to the SPC. As identified in the 2006 Joint Report, further work into specific issues during 'light' years will continue and work in 2007 will centre on investigations into the development of funded schemes across the EU (notably as regards the payout phase), alongside continuing work on increasing employment opportunities for older workers and reducing incentives for early retirement.

3.3.7. Annex to section on pensions– Result tables on theoretical replacement rates

Table A1 - Background information regarding coverage, average age of retirement and seniority at retirement

	Coverage rate (%)				Age at retirement of new flows of retirees - total (men/women)	Seniority (including non-contributory periods) at retirement of new flows of retirees - total (men/women)
	Statutory pensions	Type of statutory scheme (DB, NDC or DC)	Occupational and voluntary pensions	Type of supplementary scheme (DB or DC)		
BE	68	DB	40-45	DC	Nd (64/61.6)	Nd (42.6/30.5)
CZ	100	DB	/	/	58 (60.2/56.3)	41.6 (44.4/39.6)
DK	100	DB	78	DC	62.1 (62/62.3)	27.7 (35.7/20.3)
DE	Nd	DB	70	DC	Nd	Nd
EE	100	DB and DC	/	/	60.3 (61.5/59)	43.7 (45.6/42.9)
EL	Nd	DB	/	/	60.4 (61.4/58.6)	25.1 (27.5/20.8)
ES	89	DB	/	/	63.7 (63.5/64)	38 (40.3/30.4)
FR	Nd	DB	/	/	Nd (60. 6/60.5)	Nd (33.2/34)
IE	100	DB	52	DB	65	Nd
IT	100	DB and DC	11.4	DC	59.7 (59.8/59.6)	32.1 (34.9/27.9)
CY	86	DB	/	/	62.7 (Nd/Nd)	Nd
LV	100	NDC and DC	/	/	60.3 (61.4/58.3)	30 (30/29)
LT	83	DB and DC	/	/	60 (61.4/58.4)	35.8 (37.5/34.2)
LU	92	DB	/	/	Nd (60.3/62.4)	Nd (44.2/39.1)
HU	100	DB and DC	/	/	58.5 (59.7/57.3)	39.1 (40.3/37.9)
MT	Nd	DB	/	/	60.8 (61.5/60.5)	26.3 (29.1/23.5)
NL	100	DB	91	DB and/or DC	65 (65/65) *	Nd
AT	100	DB	/	/	60.4 (62.7/58.9)	Nd
PL	77	NDC and DC	/	/	57.8 (60.5/56.4)	34.9 (37.3/33.9)
PT	82	DB	/	/	64.2 (63.7 / 64.8)	27.3 (31.4/21.8)
SI	100	DB	/	/	63.2 (63.7/62.7)	28 (30/24)
SK	Nd	DB and DC	/	/	58.5 (61.4/56.8)	Nd
FI	100	DB	/	/	59.1 (59/59.2)	29.6 (30.9/28.6)
SE	100	NDC and DC	90	DB	64.7 (64.8/64.7)	28 (30/24)
UK	100	DB	56	DB	62.3 (62.7/61.9)	35 (42/26)

Note: The first four columns provide background information on current coverage levels, thus giving elements on the representativeness associated with the base case. Coverage rates refer to the coverage of the labour force; in some cases (notably for occupational and voluntary pensions), this can refer to the coverage of the employees in the private sector. Occupational and voluntary pensions included: BE (occupational pensions), DK (occupational, SP and ATP schemes), DE (occupational or Riester Pensions), IE (occupational pensions), IT (DC occupational pension funds, financed through the diverting of employees' TFR deferred wage component), NL (occupational pensions, results presented refer to the case of indexation of 80% on wages), SE (occupational pensions) and UK (occupational pensions). Information is provided on the type of scheme taken into account (DB, defined benefit, DC, defined contribution, NDC Notional defined contribution). The last two columns refer to the average age at retirement and seniority at retirement for new flows of retirees and thus provide elements on the representativeness associated with the base case, related to the assumptions of retirement at 65 with 40 years of seniority. Figures are for 2004 except 2005 for age of retirement in ES (*) This refers to the age at retirement of new flows of retirees for the first pillar; the actual exit age in the second pillar is not available.

Table A2 – Assumptions and representativeness of contribution rates (contribution rates in percentage points)

	Statutory pensions (or in some cases social security)	Occupational and voluntary pensions		Total contribution rate used as assumption
		Estimate of current levels (2002)	Assumption used	
BE	46.3[a]	Nd	4.25	50.55[a]
CZ	28	/		28
DK	0.9[b]	8.8	12.7	13.6
DE	19.5	Nd	4	23.5
EE	22	/		22
EL	20	/		20
ES	28.3	/		28.3
FR	20	/		20
IE	9.5	10-15	20.7	30
IT	32.7	5.7	6.91	39.6
CY	16.6[c]	/		16.6
LV	20	/		20
LT	26	/		26
LU	24[d]	/		24
HU	26.5	/		26.5
MT	30[e]	/		30
NL	7	9.8	11.5 -12.5	21-22
AT	22.8	/		22.8
PL	36.9[f]	/		36.9
PT	32.6[g]	/		34.75
SI	24.35	/		24.3
SK	Nd	/		Nd
FI	21.6	/		21.6
SE	17.2	13.7	13.7	30.9
UK	14.75 – 10.9	16.6	23.7	34.6 – 38.4

Note: The first two columns provide information on contribution rates used for statutory schemes and also eventually occupational or private schemes included in the base case, thus giving elements on the representativeness associated with the base case. Contribution rates correspond to overall contribution rates as a share of gross wages (from employees and employers) used as assumptions for the calculation of theoretical replacement rates. Contribution rates may differ from current levels, reflecting, for instance, projected increases in contribution rates, in particular as regards assumptions used for second pillar schemes. Contribution rates are not always directly comparable as they can refer to different fields.

(a) For Belgium, this refers to the overall Social Security contribution rate, due to its global management.
(b) For Denmark, this refers to contributions, to the ATP (statutory Supplementary Labour Market Pension, though it should be recalled that the financing of the first pillar mainly comes from the general budget.
(c) For Cyprus, a quarter (4%) comes from the general State budget.
(d) For Luxembourg, one third (8%) also comes from the general State budget.
(e) For Malta, this amounts to 10% from the employee, 10% from the employer and 10% from the State.
(f) For Poland, this amounts to old-age contributions (19.52 per cent of wage) and disability and survivors contribution (13 per cent of wage).
(g) For Portugal, this is a general estimate (ratio between overall contributions and aggregate wages declared to social security). The total contribution rate used as an assumption in simulations is 34.75 (legal statutory contribution rate).

Table A3 - Evolution of theoretical replacement rates from 2005 to 2050

	Change in theoretical replacement rate 2005-2050 (in percentage points)						**Change in pension expenditures 2005-2050** (in percentage points of GDP)		**Variation of replacement rate, 10 years after retirement** (in percentage points)	
	Net (Total)	Gross replacement rate								
		Total	Statutory pensions (DB, NDC or DC)		Occupational and voluntary pensions (DB, NDC or DC)		Statutory pensions	Occupational pensions	Net	Gross
BE	6	4	-2	DB	6	DC	5,1	/	-4	-5
CZ	-9	-7	-7	DB	/		5,6	/	-13	-10
DK	5	15	-6	DB	21	DC	3,3	/	-3	-1
DE	4	5	-9	DB	15	DC	1,7	/	0	-2
EE	2	3	3	DB and DC	/		-0,1	/	-2	-3
EL	-9	-11	-11	DB	/		/	/	-16	-19
ES	-6	-5	-5	DB	/		7,1	/	-10	-9
FR	-17	-17	-17	DB	/		2,0	/	-12	-10
IE	0	0	3	DB	-3	DB	6,4	/	-4	-4
IT	4	1	-15	DB and DC	16	DC	0,4	/	Nd	-12
CY	18	11	11	DB	/		12,9	/	-7	-6
LV	-6	-6	-6	NDC and DC	/		1,5	/	Nd	7
LT	-4	2	2	DB and DC	/		3,6	/	-6	-1
LU	1	0	0	DB	/		7,4	/	1	0
HU	-4	11	11	DB and DC	/		9,8	/	-14	-9
MT	-54	-41	-41	DB	/		-0,4	/	0	0
NL	-2	-2	0	DB	-2	DB	3,5	4,1	-5	-4
AT	4	5	5	DB	/		-1,2	/	-10	-10
PL	-33	-27	-27	NDC and DC	/		-4,6	/	-26	-21
PT	1	-5	-5	DB	/		9,7	/	-10	-10
SI	-22	-25	-25	DB	/		8,3	/	-10	-4.5
SK	1	1	1	DB and DC	/		4,1	/	Nd	Nd
FI	0	-4	-4	DB	/		3,1	/	-8	-8
SE	-15	-12	-13	NDC and DC	1	DB	0,6	0,3	-10	-9
UK	3	3	2	DB	0	DB	2,0	/	-6	-5

Source: Member States' calculations of theoretical replacement rates.

Reading: the first four columns provide the evolution of theoretical replacement rates in percentage points from 2005 to 2050, for a worker retiring at 65 after 40 years with average earnings: net or gross, total, and contributions from statutory schemes, from occupational or individual schemes, be they defined benefit (DB), notional defined contribution (NDC) or defined contribution (DC) schemes. The next two columns refer to projections of pension expenditures, as calculated by the AWG. The last column indicates the decline in the replacement rates after 10 years of retirement and in percentage points in the base case for a worker retiring in 2005.

4. ANNEXES

4.1. Annex IA – Overarching Indicators

BACKGROUND

In December 2001, the Laeken European Council endorsed a set of 18 indicators of social exclusion and poverty, organised in a two-level structure of primary indicators – consisting of 10 leading indicators covering the broad fields considered to be the most important elements leading to social exclusion – and 8 secondary indicators – intended to support the leading indicators and describe other dimensions of the problem.

After the Laeken European Council, the Indicators Sub-Group has continued working with a view to refining and consolidating the original list of indicators. It has also worked at developing indicators to support the OMC on adequate and sustainable Pensions and more recently the OMC on health care and long-term care.

In June 2006, the Social Protection Committee adopted the report on indicators to be used in the context of the streamlined OMC on social protection and social inclusion70. The adopted set of indicators consists of a portfolio of 14 overarching indicators (+11 context indicators) meant to reflect the newly adopted overarching objectives (a) "social cohesion" and (b) "interaction with the Lisbon strategy growth and jobs objectives"; and of three strand portfolios for social inclusion, pensions, and health and long-term care.

In this context, the ISG confirmed the Laeken criteria for the selection of indicators and agreed on a new typology of indicators:

– Commonly agreed EU indicators contributing to a comparative assessment of MS's progress towards the common objectives. These indicators might refer to social outcomes, intermediate social outcomes or outputs.

– Commonly agreed national indicators based on commonly agreed definitions and assumptions that provide key information to assess the progress of MS in relation to certain objectives, while not allowing for a direct cross-country comparison, or not necessarily having a clear normative interpretation. These indicators should be interpreted jointly with the relevant background information (exact definition, assumptions, representativeness).

– Context information: Each portfolio will have to be assessed in the light of key context information, and by referring to past, and where relevant, future trends. The list of context information proposed is indicative and leaves room to other background information that would be most relevant to better frame and understand the national context.

The report also contains a streamlined list for each of the individual processes of social inclusion and pensions and a preliminary list for health and long-term care.

70 http://ec.europa.eu/employment_social/social_inclusion/docs/2006/indicators_en.pdf

DEFINITION OF THE OVERARCHING INDICATORS

Title	*Definition*
OVERARCHING INDICATORS	
At-risk-of-poverty rate + Illustrative threshold value	Share of persons aged 0+ with an equivalised disposable income below 60% of the national median equivalised disposable income Equivalised disposable income is defined as the household's total disposable income divided by its "equivalent size" to take account of its size and composition.. Value of the at-risk-of-poverty threshold (60% median national equivalised income) in PPS for an illustrative household type (e.g., single person household) Source: EU-SILC
Relative median poverty risk gap	Difference between the median equivalised disposable income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of poverty threshold. Source: EU-SILC
S80/S20	Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income. Source: EU-SILC
Healthy life expectancy	Number of years that a person at birth, at 45, at 65 is still expected to live in a healthy condition (also called disability- free life expectancy). To be interpreted jointly with life expectancy Source: Eurostat
Early school leavers	Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training attained is 0, 1 or 2 according to the 1997 International Standard Classification of Education – ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS
People living in jobless households	Proportion of adults (aged 18-59 and not students) and children living in jobless households, expressed as a share of all people in the same age group . This indicator should be analysed in the light of context indicator: jobless households by main household types Source: LFS
Projected Total Public Social expenditures	Age-related projections of total public social expenditures (e.g. pensions, health care, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50) Specific assumptions agreed in the AWG/EPC. See "The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies" http://ec.europa.eu/economy_finance/epc/documents/2006/ageingreport_en.pdf Source: EPC/AWG
Median relative income of elderly people	Median individual pension income of retirees aged 65-74 in relation to median earnings of employed persons aged 50-59 excluding social benefits other than pensions, based on gross income Source: EU-SILC
Aggregate replacement ratio	Median **individual** pensions of 65-74 relative to median individual earnings of 50-59, excluding other social benefits Source: EU-SILC
Employment rate of older workers	Persons in employment in age groups 55 - 59 and 60 – 64 as a proportion of total population in the same age group Source: LFS
In-work poverty risk	Individuals who are classified as employed (distinguishing between “wage and salary employment plus self-employment” and “wage and salary employment” only) and who are at risk of poverty This indicator needs to be analysed according to personal, job and household characteristics. It should also be analysed in comparison with the poverty risk faced by the unemployed and the inactive. Source: EU-SILC
Activity rate	Share of employed and unemployed people in total population of working age 15-64 Source: LFS
Regional disparities – coefficient of variation of employment rates	Standard deviation of regional employment rates divided by the weighted national average (age group 15-64 years). (NUTS II) Source: LFS

Title	*Definition*
SELECTED HEALTH INDICATORS	
Total expenditure on health	Sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices. It comprises the outlays earmarked for health maintenance, restoration or enhancement of the health status of the population, paid for in cash or in kind. It is expressed in $PPP. International dollars are derived by dividing local currency units by an estimate of their Purchasing Power Parity (PPP) compared to US dollar, i.e. the measure which minimizes the consequences of differences in price levels between countries. Source: NHA (WHO)
General government expenditure on health as a % of Total health expenditure	Comprises the direct outlays earmarked for the enhancement of the health status of the population and/or the distribution of medical care goods and services among population by the following financing agents: central/federal, state/provincial/regional, and local/municipal authorities; extrabudgetary agencies, social security schemes; parastatals and public firms. Expenditures on health include final consumption, subsidies to producers, and transfers to households (chiefly reimbursements for medical and pharmaceutical bills). It includes both recurrent and investment expenditures (including capital transfers) made during the year. Besides domestic funds it also includes external resources (mainly as grants passing through the government or loans channelled through the national budget). Source: NHA (WHO)
Private health expenditure as a % of total health expenditure	Sum of expenditures on health by the following entities: - Prepaid plans and risk-pooling arrangements: the outlays of private insurance schemes and private social insurance schemes (with no government control over payment rates and participating providers but with broad guidelines from government) - Firms' expenditure on health: the outlays by private enterprises for medical care and health enhancing benefits other than payment to social security or other pre-paid schemes. - Non-profit institutions serving mainly households: outlays of those entities whose status do not permit them to be a source of financial gain for the units that establish, control or finance them. This includes funding from internal and external sources. - Household out -of-pocket spending: the direct outlays of households, including gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services. This includes household direct payments to public and private providers of health care services, non-profit institutions, and non-reimbursable cost sharing, such as deductibles, co-payments and fee for services. Source: NHA (WHO)
CONTEXT INDICATORS	
GDP growth	Growth rate of GDP volume - percentage change on previous year Source: Eurostat STRIND
Employment rate, by sex	The employment rate is calculated by dividing the number of persons aged 15 to 64 in employment by the total population of the same age group. Source: LFS
Unemployment rate, by sex, and key age groups	Unemployment rates represent unemployed persons as a percentage of the labour force. The labour force is the total number of people employed and unemployed. Unemployed persons comprise persons aged 15+ who were: a. without work during the reference week, b. currently available for work, i.e. were available for paid employment or self-employment before the end of the two weeks following the reference week, c. actively seeking work, i.e. had taken specific steps in the four weeks period ending with the reference week to seek paid employment or self-employment or who found a job to start later, i.e. within a period of, at most, three months. Source: LFS
Long term unemployment rate, by sex and key age groups	Long-term unemployed (12 months and more) persons are those aged at least 15 years who are without work within the next two weeks, are available to start work within the next two weeks and who are seeking work (have actively sought employment at some time during the previous four weeks or are not seeking a job because they have already found a job to start later). The total active population (labour force) is the total number of the employed and unemployed population. The duration of unemployment is defined as the duration of a search for a job or as the length of the period since the last job was held (if this period is shorter than the duration of the search for a job). Source: LFS
Life expectancy at birth and at 65	LE at birth: The mean number of years that a newborn child can expect to live if subjected throughout his life to the current mortality conditions (age specific probabilities of dying). LE at 65: The mean number of years still to be lived by a person who have reached 65, if subjected throughout the rest of his life to the current mortality conditions (age specific probabilities of dying). Source Eurostat – Demography
Old age dependency ratio, current and projected	Ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64). Source Eurostat – Demography

Title	*Definition*
Distribution of population by household types, incl. collective households	Number and % of people living in private resp. collective households. Source Eurostat - Census 2001 data collection
Public debt, current and projected, % of GDP	Government debt is the consolidated gross debt of the whole general government sector outstanding at the end of the year (in nominal value). These data are reported to the European Commission in the framework of the Excessive Deficit Procedure (EDP). Projections are produced by the Commission Services in the context of the assessment of the long-term sustainability of the public finances based on the 2005/06 updates of Stability and Convergence Programmes (SCPs). http://ec.europa.eu/economy_finance/publications/european_economy/2006/ee306_en.pdf
Social protection expenditure, current, by function, gross and net (ESPROSS)	Total social protection expenditures broken down in social benefits, administration cost and other expenditure. In addition, social benefits are classified by functions of social protection. Net expenditures are not presented here since they are not available in ESSPROS yet. Source: Eurostat – ESSPROS
Jobless households by main household types	Breakdown of jobless households by main household types Source: EU-SILC
Making work pay indicators (unemployment trap, inactivity trap (esp. second earner case), low-wage trap.	Unemployment trap: Marginal effective tax rate (METR) on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from unemployment to a job with a wage level of 67% of APW. Inactivity trap: METR on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job while previously inactive. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from inactivity to a job with a wage level of 67% of APW. Low wage trap: METR on labour income taking account of the combined effect of increased taxes on labour and in-work benefits withdrawal as one increases the work effort (increased working hours or moving to a better job). Calculated as the ratio of change in personal income tax and employee contributions plus change (reductions) in benefits, divided by increases in gross earnings, using the "discrete" income changes from 34-66% of APW. Breakdown by family types: one-earner couple with two children and single parent with two children. Source: Joint Commission -OECD project using tax-benefit Models
Net income of social assistance recipients as a % of the at-risk of poverty threshold for 3 jobless household types	This indicator refers to the income of people living in households that only rely on "last resort" social assistance benefits (including related housing benefits) and for which no other income stream is available (from other social protection benefits – e.g. unemployment or disability schemes – or from work). The aim of such an indicator is to evaluate if the safety nets provided to those households most excluded from the labour market are sufficient to lift people out of poverty. This indicator is calculated on the basis of the tax-benefit models developed jointly by the OECD and the European Commission. It is only calculated for Countries where non-categorical social benefits are in place and for 3 jobless household types: single, lone parent, 2 children and couple with 2 children. This indicator is especially relevant when analysing MWP indicators. Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat (see Chapter I and Annex I)
Change in projected theoretical replacement ratio for base case 2004-2050 accompanied with information on type of pension scheme (DB, DC or NDC), and change in projected public pension expenditure 2004-2050. (results should systematically be presented collectively in one table).	Change in the theoretical level of income from pensions at the moment of take-up related to the income from work in the last year before retirement for a hypothetical worker (base case), percentage points, 2004-2050, with information on the type of pension scheme (DB, DC or NDC) and changes in the public pension expenditure as a share of GDP, 2004-2050. This information can only collectively form the indicator called Projected theoretical replacement ratio. Results relate to current and projected, gross (public and private) and total net replacement rates, and should be accompanied by information on representativeness and assumptions (contribution rates and coverage rate, public and private), and calculations of changes in replacement rates for 1 or 2 other cases, if suitable (e.g. OECD) Specific assumptions agreed in the ISG. For further details, see 2006 report on Replacement Rates. http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf Source: ISG and AWG

4.2. Annex IB - Data Sources – specific notes

INDICATORS OF INCOME AND LIVING CONDITIONS: *EU-SILC*

For the first time this year, EU-SILC data is available for 25 EU Countries. The newly implemented reference source of statistics on income and social exclusion is the European Survey on Income and Living Conditions (EU-SILC) framework regulation (No.1177/2003). Technical aspects of this instrument are developed through Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys following the transitional arrangements agreed by the European Statistical System[71].

The EU-SILC definition of total household gross and disposable income and the different income components keep as close as possible to the international recommendations of the UN 'Canberra Manual'. A key objective of EU-SILC is to deliver timely, robust and comparable data on total disposable household income, total disposable household income before transfers, total gross income and gross income at component level (in the ECHP, the income components were recorded net). This objective will be reached in two steps, in that Member States have been allowed to postpone the delivery of gross income at component level and of total household gross income data until after the first year of their operations.

Although certain countries (eg. Denmark) are already able to supply income including imputed rent - i.e. the money that one saves on full (market) rent by living in one's own accommodation or in accommodation rented at a price that is lower than the market rent -, for reasons of comparability, **the income definition underlying the calculation of indicators currently excludes imputed rent**. This could have a distorting effect in comparisons between countries, or between population sub-groups, when accommodation tenure status varies. This impact may be particularly apparent for the elderly who may have been able to accumulate wealth in the form of housing assets. In the statistical annex, data for Denmark are therefore shown both with and without imputed rent, as an illustration of the impact of this income component on the results. Once imputed rent is taken into account, the at-risk-of-poverty rate is reduced for people aged 65 and over, the inactive other than pensioners and those living in owner-occupied accommodation.

It should also be noted that the definition of income currently used excludes non monetary income components, which include the value of goods produced for own consumption[72] and non-cash employee income. This component will be available for all countries from the SILC(2007) exercise onwards, and therefore included in the indicators that will be published in January 2009.

The reference year for the data is the year to which information on income refers (i.e., the "income year"), which in most cases differs from the survey year in which the data have been collected. Namely, 2004 data refer to the income situation of the population in 2004, even if the information has been collected in 2005. EU aggregates are computed as population-weighted averages of available national values.

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[71] National data sources are adjusted ex-post and as far as possible with the EU-SILC methodology. Whilst the maximum effort is made to maximise consistency of definitions and concepts, the resulting indicators cannot be considered to be fully comparable to the EU-SILC based indicators.

[72] Before the introduction of EU-SILC in the New Member States, the value of goods produced for own consumption was included in the calculation of the EU indicators estimated on the basis of national sources. This transitory agreement was made to take account of the potentially significant impact of this component on the income distribution in these countries.

Note on trends

During the transition to EU-SILC income based indicators were calculated on the basis of available national sources (household budget survey, micro-censuses, etc.[73]) that were not fully compatible with the SILC methodology based on detailed income. Following the implementation of EU-SILC in a given country, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. This is why no trends in income based indicators are presented in this year's report.

Limitations

The limited sample size of certain data sources used for the collection of income data and the specific difficulties of collecting accurate information on disposable income directly from households or through administrative registers raise certain concerns as regards data quality. This is particularly the case for information on income at the two ends of the income distribution.

Furthermore, household surveys do not cover persons living in collective households, homeless persons or other difficult-to-reach groups.

It must also be acknowledged that self-employment income is difficult to collect, whatever the data source. It must also be kept in mind that the difficulty in recording income from the informal economy can introduce a bias in the income distribution as measured by surveys.

Finally, whilst it is considered to be the best basis for such analyses, current income is acknowledged to be an imperfect measure of consumption capabilities and welfare, as, among other things, it does not reflect access to credit, access to accumulated savings or ability to liquidate accumulated assets, informal community support arrangements, aspects of non monetary deprivation, differential pricing, etc. These factors may be of particular relevance for persons at the lower end of the income distribution. The bottom 10 per cent of the income distribution should not, therefore, necessarily be interpreted as having the bottom 10 per cent of living standards. This is why reference is made to the "at-risk-of-poverty" rate rather than simply the poverty rate.

AGE-RELATED EXPENDITURE PROJECTIONS

Long-term budgetary projections were prepared in 2006 by the Economic Policy Committee and the European Commission (DG ECFIN) - see European Policy Committee and European Commission (2006), "The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050)", European Economy, Special Report No.1/2006.

The projections are made on the basis of a common population projection and agreed common underlying economic assumptions that have been endorsed by the EPC. The projections are made on the basis of "no policy change", i.e. only reflecting enacted legislation but not possible future policy changes (although account is taken of provisions in enacted legislation that enter into force over time). The pension projections are made on the basis of legislation enacted by mid-2005. They are also made on the basis of the current behaviour of economic agents, without assuming any future changes in behaviour over time: for example, this is reflected in the assumptions on participation rates, which are based on the most recently observed trends by age and gender. While the underlying assumptions have been made by applying a common methodology uniformly to all Member States, for several countries adjustments have been made to avoid an

[73] See specific footnotes in each country profile

overly mechanical approach that leads to economically unsound outcomes and to take due account of significant country-specific circumstances. The pension projections were made using the models of national authorities, and thus reflect the current institutional features of national pension systems. In contrast, the projections for health care, long-term care, education and unemployment transfers were made using common models developed by the European Commission in close cooperation with the EPC and its Working Group on Ageing Populations. The projection results show the combined impact of expected changes in size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in health status of the population in each Member State of the European Union.

PENSION EXPENDITURE

The "pension expenditure" aggregate according to the ESSPROS definition, goes beyond that of public expenditure and also includes expenditure by private social protection schemes. "Pension expenditure" is the sum of seven different categories of benefits, as defined in the 1996 ESSPROS Manual: disability pension, early retirement benefit due to reduced capacity to work, old-age pension, anticipated old-age pension, partial pension, survivors' pension and early retirement benefit for labour market reasons. Some of these benefits (for example, disability pensions) may be paid to people who have not reached the standard retirement age.

REPLACEMENT RATES

The figures for current and prospective pension replacement rates are based on the methodology developed by the Indicators Sub-Group of the Social Protection Committee. The results are based on the baseline assumption of a hypothetical person (male if gender matters), retiring at the age of 65 after a 40 years full-time work career with a flat earnings profile at average earnings with contributions to the most general public pension scheme as well as to occupational and private pension schemes for some Member States.

The replacement rate represents the individual pension income during the first year of retirement relative to the individual income received during the year preceding retirement. Calculations were conducted by the Member States.

HEALTHCARE EXPENDITURE – WHO-health for all database (www.who.int\nha)

This information is based on national health accounts (NHA) collected within an internationally recognised framework. NHA are a synthesis of the financing and spending flows recorded in the operation of a health system. In the future the System of health accounts (SHA) will contain uniform data for Eurostat, the OECD and the WHO. In the meantime, the WHO database is the only one to cover all Member States.

About 100 countries either have produced full national health accounts or report expenditure on health to the OECD. Standard accounting estimation and extrapolation techniques have been used to provide time series (1998-2004). Ministries of Health have responded to the draft updates sent for their inputs and comments. The principal international references used are the International Monetary Fund (IMF), Government Finance Statistics and International Financial Statistics; OECD health data; and the United Nations National Accounts Statistics. National sources include: national health accounts reports, public expenditure reports, statistical yearbooks and other periodicals, budgetary documents, national accounts reports, central bank reports, non-governmental organisation reports, academic studies, reports and data provided by central statistical offices and ministries and statistical data on official websites.

4.3. Annex 1C: Statistical tables – Overarching indicators

1a At-risk-of-poverty rate by age and gender SILC(2005) - Income reference year 2004

		EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total population			16	15	15 i	10b	12	10	13b	18	20	20	20	13	19	16b	19b	21b	13	13pb	15b	11b	12	21b	20	18 i	12pb	13b	12	9	19pb
Children aged 0-17			19	19	22 i	18b	10	11	14b	21	23	20	24	14	24	13b	22b	27b	19	20pb	21b	15b	15	29b	24	25 i	12pb	19b	10	9	22pb
People aged 18+	Total		15	14	14 i	9b	12	10	13b	18	19	19	19	13	18	17b	19b	19b	11	12pb	13b	9b	12	18b	19	17 i	12pb	12b	12	9	18pb
	Men		14	12	12 i	8b	12	10	11b	16	17	18	17	12	16	15b	17b	18b	11	12pb	12b	9b	11	19b	19	17 i	10pb	11b	11	9	16pb
	Women		16	15	17 i	10b	13	11	15b	19	20	21	20	13	20	19b	20b	19b	12	12pb	14b	10b	13	17b	20	17 i	14pb	12b	13	10	19pb
People aged 18-64	Total		14	12	14 i	9b	11	11	12b	17	16	17	16	12	16	11b	18b	19b	12	13pb	12b	10b	11	20b	17	17 i	10pb	13b	11	9	15pb
	Men		13	11	13 i	9b	11	10	11b	17	15	16	15	11	15	10b	18b	20b	11	13pb	11b	10b	11	21b	17	17 i	10pb	13b	11	9	15pb
	Women		15	13	14 i	10b	11	11	14b	17	17	18	17	12	18	13b	18b	18b	13	13pb	13b	10b	11	20b	17	16 i	10pb	13b	10	8	16pb
People aged 65+	Total		19	21	16 i	5b	18	9	15b	20	33	28	29	16	23	51b	21b	17b	7	6pb	15b	5b	14	7b	28	17 i	20pb	7b	18	11	27pb
	Men		16	19	5 i	2b	17	8	12b	10	30	25	26	15	19	47b	12b	6b	9	4pb	15b	5b	10	5b	28	12 i	11pb	3b	11	6	24pb
	Women		21	22	23 i	7b	18	9	18b	26	36	30	32	18	26	53b	26b	22b	5	8pb	15b	6b	17	9b	28	21 i	26pb	10b	23	14	29pb

At-risk-of-poverty threshold (illustrative values), PPS (Income reference year 2004)

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
- One-person household			9410	2033 i	4662b	9581	9699	9891b	2869	9004	6518	7035	8720	8263	8787b	2402b	2341b	16375	3379pb	6498b	9688b	10562	2877b	4993	1504 i	7047pb	3118b	8501	8582	10652pb
- Two adults with two dep. children			19761	4269 i	9791b	20119	20368	20770b	6025	18909	13687	14774	18312	17352	18453b	5044b	4916b	34387	7095pb	13646b	20345b	22181	6041b	10486	3158 i	14799pb	6548b	17851	18021	22370pb

1) Including imputed rent. See methodological note for an explanation; b: break in series; p: provisional

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005); * BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005 (age brackets 0-15, 16+, 16-64).

1b Relative median at-risk-of-poverty gap by gender and selected age group (Income reference year 2004)

		EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total population			22	19	19 i	18b	16	18	20b	24	20	24	25	17	24	19b	27b	28b	18	19pb	18b	21b	15	30b	27	22 i	19pb	23b	14	19	21pb
Children aged 0-17			22	21	24 i	18b	18	15	18b	30	23	23	29	15	28	17b	31b	30b	18	19pb	21b	21b	14	33b	28	23 i	17pb	24b	11	17	19pb
People aged 18+	Total		22	19	18 i	18b	16	19	21b	22	18	24	25	17	23	21b	26b	28b	20	18pb	17b	22b	15	29b	26	21 i	20pb	23b	14	19	22pb
	Men		23	20	20 i	19b	14	17	22b	29	19	24	26	17	24	18b	33b	32b	18	20pb	18b	23b	17	30b	26	21 i	21pb	25b	16	23	24pb
	Women		21	18	17 i	17b	16	19	20b	19	17	24	24	17	22	22b	22b	24b	20	18pb	17b	20b	15	28b	26	21 i	19pb	23b	13	17	21pb
People aged 18-64	Total		24	21	20 i	19b	22	23	22b	29	22	24	29	17	27	19b	33b	31b	20	20pb	18b	22b	18	30b	29	22 i	19pb	25b	17	23	24pb
	Men		25	21	21 i	19b	22	24	23b	31	22	24	29	19	27	17b	36b	33b	20	21pb	18b	26b	19	31b	30	22 i	22pb	26b	18	26	26pb
	Women		23	20	20 i	19b	22	22	22b	28	22	24	28	17	28	21b	30b	30b	20	19pb	18b	20b	17	30b	29	22 i	17pb	24b	17	20	22pb
People aged 65+	Total		17	15	13 i	8b	8	5	18b	11	10	24	22	15	18	21b	11b	13b	13	9pb	14b	12b	14	17b	17	19 i	20pb	16b	10	10	19pb
	Men		17	17	8 i	25bu	7	5	19b	13	12	22	23	13	16	20b	13b	11bu	16u	8pbu	16b	11bu	12	19b	16	16 i	17pb	23bu	9	9u	19pb
	Women		17	13	14 i	6b	9	4	17b	11	10	25	20	17	19	23b	10b	13b	13u	11pb	13b	12b	15	16b	19	20 i	20pb	16b	11	11	20pb

1) Including imputed rent. See methodological note for an explanation; b: break in series; p: provisional

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005); * BG National HBS 2004, income data 2004 and RO National HBS 2005, income

2 Inequality of income : S80/S20 income quintile share ratio (Income reference year 2004)

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
S80/S20		4,9	4,1	4.0 i	3.7b	3,5	3,5	4.1b	5,9	5,0	5,8	5,4	4,0	5,6	4.3b	6.7b	6.9b	3,8	4.0pb	4.2b	4.0b	3,8	6.6b	8,2	4.9 i	3.4pb	3.9b	3,6	3,3	5.6pb

1) Including imputed rent. See methodological note for an explanation; b: break in series; p: provisional

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005); * BG National HBS 2004, income data 2004 and RO

3a. Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - EU values

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
life expectancy at birth - males	**eu25**	72,8	73,2	73,5	73,5	73,8	74,4	74,7	75	75,1	:	75,8
life expectancy at 45 - males	**eu25**	**:**	**:**	**:**	**:**	:	31,8	32,1	32,2	32,3	:	:
life expectancy at 65 - males	**eu25**	:	:	:	:	:	15,7	15,9	16	16,1	:	:
life expectancy at birth - females	**eu25**	79,7	79,9	80,2	80,2	80,4	80,8	81,1	81,2	81,2	:	81,9
life expectancy at 45 - females	**eu25**	:	:	:	:	:	37,2	37,4	37,5	37,4	:	:
life expectancy at 65 - females	**eu25**	:	:	:	:	:	19,4	19,6	19,6	19,6	:	:
life expectancy at birth - males	**eu15**	73,9	74,2	74,6	74,6	74,9	75,4	75,7	75,9	76	:	:
life expectancy at 45 - males	**eu15**	31,5	31,7	32	:	:	32,6	32,9	33	33,1	:	:
life expectancy at 65 - males	**eu15**	15,3	15,4	15,6	:	:	16,1	16,3	16,4	16,4	:	:
Disability free life expectancy at birth - males	**eu15**	:	:	:	:	63.2 e	63.5 e	63.6 e	64.3 e	64.5 e	:	:
life expectancy at birth - females	**eu15**	80,4	80,6	80,9	80,9	81,1	81,4	81,7	81,7	81,7	:	:
life expectancy at 45 - females	**eu15**	36,9	37,1	37,3	:	:	37,7	37,9	38	38	:	:
life expectancy at 65 - females	**eu15**	19,1	19,2	19,4	:	:	19,7	20	20	20	:	:
Disability free life expectancy at birth - females	**eu15**	:	:	:	:	63.9 e	64.4 e	65.0 e	65.8 e	66.0 e	:	:

Source: Eurostat - Demography; e: estimate

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**BE**	73,4 (p)	73,8 (p)	74,1 (p)	74,3	74,4	74,6	74,9	75,1	75,9
life expectancy at 45 - males	**BE**	31,1	31,4	31,6	31,7	31,7	32	32,3	32,3	:
life expectancy at 65 - males	**BE**	14,8	15	15,2	15,2	15,4	15,5	15,8	15,8	:
Disability free life expectancy at birth - males	**BE**	63,3	64,1	66,5	63,3	66	65,7	66,6	66,9 (e)	67,4 (e)
Life expectancy at birth - females	**BE**	80,2 (p)	80,5 (p)	80,6 (p)	80,5	80,8	80,8	81,1	81,1	81,7
life expectancy at 45 - females	**BE**	36,8	37	37,1	37	37,2	37,3	37,5	37,4	:
life expectancy at 65 - females	**BE**	19,1	19,2	19,4	19,3	19,4	19,5	19,7	19,7	:
Disability free life expectancy at birth - females	**BE**	66,4	68,5 (e)	68,3	65,4 (e)	68,4	69,1	68,8	69,0 (e)	69,2 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**BG**	67,1	67,1	:	:	68,3	68,2	68,5	68,9	68,9
Life expectancy at birth - females	**BG**	74,6	74,3	:	:	75,1	75,3	75,3	75,6	75,9

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**CZ**	69.7	70.4	70.5	71.1	71.4	71.6	72.1	72.1	72.1
life expectancy at 45 - males	**CZ**	27,6	27,9	28,1	28,5	28,8	28,9	29,3	29,3	29,3
life expectancy at 65 - males	**CZ**	12,7	13,1	13,2	13,4	13,6	13,7	13,9	14	13,9
Disability free life expectancy at birth - males	**CZ**	:	:	:	:	:	:	:	62,8 (p)	:
Life expectancy at birth - females	**CZ**	76.6	77.3	77.5	78.1	78.2	78.4	78.5	78.7	78.7
life expectancy at 45 - females	**CZ**	33,3	33,8	34	34,4	34,4	34,6	34,7	34,9	34,8
life expectancy at 65 - females	**CZ**	16	16,4	16,6	16,9	16,9	17,1	17,2	17,4	17,3
Disability free life expectancy at birth - females	**CZ**	:	:	:	:	:	:	:	63,3 (p)	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**DK**	72.7	73.1	73.6	73.9	74.2	74.5	74.7	74.8	75.1
life expectancy at 45 - males	**DK**	30,2	30,5	30,9	31,1	31,3	31,6	31,7	31,8	32
life expectancy at 65 - males	**DK**	14,1	14,4	14,6	14,8	14,9	15,2	15,2	15,4	15,5
Disability free life expectancy at birth - males	**DK**	61,6	61,7	61,6	62,4	62,5	62,9	62,2	62,8 (e)	63,0 (e)
Life expectancy at birth - females	**DK**	77.8	78.2	78.4	78.8	79.0	79.3	79.3	79.5	79.9
life expectancy at 45 - females	**DK**	34,3	34,7	34,9	35,2	35,2	35,5	35,7	35,7	36
life expectancy at 65 - females	**DK**	17,5	17,8	17,9	18,1	18,1	18,3	18,4	18,3	18,6
Disability free life expectancy at birth - females	**DK**	60,7	61,1	60,7 (e)	61,3 (e)	60,8	61,9	60,4	61,0 (e)	60,9 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**DE**	73.3	73.6	74.0	74.5 (e)	74.7	75.0	75.5	75.4 (p)	75.7 (e)
life expectancy at 45 - males	**DE**	30,7	30,9	31,3	31,6	31,9	32,1	32,4	:	32,6
life expectancy at 65 - males	**DE**	14,7	14,9	15,2	15,3	15,5	15,7	16	:	16,1
Disability free life expectancy at birth - males	**DE**	60	60,8	61,9 (e)	62,1 (e)	62,3 (e)	63,2 (e)	64,1 (e)	64,4 (e)	65,0 (e)
Life expectancy at birth - females	**DE**	79.7	79.9	80.3	80.6 (e)	80.7	81.0	81.3	81.2 (p)	81.4 (e)
life expectancy at 45 - females	**DE**	36,2	36,3	36,7	36,8	37	37,2	37,5	:	37,5
life expectancy at 65 - females	**DE**	18,5	18,6	18,9	19	19,2	19,4	19,6	:	19,6
Disability free life expectancy at birth - females	**DE**	64,3	64,5	64,3 (e)	64,3 (e)	64,3 (e)	64,6 (e)	64,5 (e)	64,5 (e)	64,7 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**EE**	61.9	64.7	64.8	64.6	65.5	65.6	64.9	65.3	66.0
life expectancy at 45 - males	**EE**	23,5	24,6	25,1	24,5	25,3	25,3	24,8	25,2	:
life expectancy at 65 - males	**EE**	12	12,2	12,6	12,4	12,6	12,7	12,6	12,7	:
Disability free life expectancy at birth - males	**EE**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**EE**	74.5	75.7	76.1	75.6	76.3	76.4	76.4	77.1	76.9
life expectancy at 45 - females	**EE**	32,5	33	33,3	33	33,5	33,6	33,6	34	:
life expectancy at 65 - females	**EE**	16,1	16,4	16,8	16,4	17	16,9	17,2	17,3	:
Disability free life expectancy at birth - females	**EE**	:	:	:	:	:	:	:	:	:

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**IE**	72.9	73.1 (p)	73.3 (p)	73.4	73.4	73.9	74.5	75.2	75.8
life expectancy at 45 - males	**IE**	30,2	30,5	30,7	30,8	30,8	31,4	31,9	32,3	32,9
life expectancy at 65 - males	**IE**	13,6	13,8	14	14,1	14,1	14,6	15	15,3	15,7
Disability free life expectancy at birth - males	**IE**	63,2	64	63,2	64	63,9	63,3	63,3	63,5 (e)	63,4 (e)
Life expectancy at birth - females	**IE**	78.4	78.7 (p)	78.6 (p)	79.0	78.8	79.1	79.6	80.3	80.7
life expectancy at 45 - females	**IE**	34,9	35	35,1	35,3	35,2	35,5	36	36,6	36,8
life expectancy at 65 - females	**IE**	17,3	17,3	17,5	17,6	17,5	17,8	18,2	18,6	18,9
Disability free life expectancy at birth - females	**IE**	:	:	:	:	67,6	66,9	66,5	65,9 (e)	65,4 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**ES**	74.3	74.4	75.0	75.1	75.1	75.8	76.1 (e)	76.2 (e)	76.9 (e)
life expectancy at 45 - males	**ES**	32,3	32,4	32,7	32,6	32,5	33,1	33,3	33,4	:
life expectancy at 65 - males	**ES**	16	16,1	16,2	16,1	16,1	16,6	16,8	16,8	:
Disability free life expectancy at birth - males	**ES**	64,2	65,1	65,5	65,2	65,6	66,5	66	66,6 (e)	66,8 (e)
Life expectancy at birth - females	**ES**	81.5	81.7	82.0	82.1	82.1	82.5	82.8 (e)	82.9 (e)	83.6 (e)
life expectancy at 45 - females	**ES**	38,1	38,2	38,4	38,4	38,4	38,8	39,1	39,1	:
life expectancy at 65 - females	**ES**	19,8	19,9	20,1	20,1	20,1	20,4	20,7	20,7	:
Disability free life expectancy at birth - females	**ES**	67,7	68,4	68,2	68,2	69,5	69,3	69,2 (e)	69,9 (e)	70,2 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**FR**	73.9	74.1	74.6 (p)	74.8 (p)	75.0	75.3	75.5	75.8 (p)	75.9 (p)
life expectancy at 45 - males	**FR**	31,9	32	32,3	32,4	32,5	32,8	33	33,1	:
life expectancy at 65 - males	**FR**	16,1	16,1	16,3	16,4	16,5	16,7	16,9	17,1	:
Disability free life expectancy at birth - males	**FR**	60	59,6	60,2	59,2	60,1	60,1	60,5	60,4 (e)	60,6 (e)
Life expectancy at birth - females	**FR**	81.8	82.0	82.3 (p)	82.4 (p)	82.5	82.7	82.9	83.0 (p)	82.9 (p)
life expectancy at 45 - females	**FR**	38,5	38,6	38,8	38,8	38,9	39,1	39,3	39,3	:
life expectancy at 65 - females	**FR**	20,6	20,7	20,8	20,9	20,9	21,2	21,3	21,4	:
Disability free life expectancy at birth - females	**FR**	62,4	62,5	63,1	62,8	63,3	63,2 (e)	63,3	63,7 (e)	63,9 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**IT**	74.9	75.3	75.7 (e)	75.7	76.1	76.6	76.7 (e)	76.8 (e)	76.8 (e)
life expectancy at 45 - males	**IT**	32,5	32,7	32,9	32,9	33,1	33,5	:	:	:
life expectancy at 65 - males	**IT**	15,8	16	16,1	16	16,2	16,5	:	:	:
Disability free life expectancy at birth - males	**IT**	66,7	67,4	68	67,9	68,7	69,7	69,8	70,4 (e)	70,9 (e)
Life expectancy at birth - females	**IT**	81.3	81.4	81.6 (e)	81.8	82.2	82.5	82.8 (e)	82.9 (e)	82.5 (e)
life expectancy at 45 - females	**IT**	37,7	37,9	38	38,1	38,4	38,6	:	:	:
life expectancy at 65 - females	**IT**	19,6	19,8	19,8	19,9	20,1	20,4	:	:	:
Disability free life expectancy at birth - females	**IT**	70	70,5 (e)	71,3	71,3	72,1	72,9	73,0 (e)	73,9 (e)	74,4 (e)

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**CY**	75.3	:	75.0	75.3	75.3	:	76.1 (e)	:	77.0 (e)
life expectancy at 45 - males	**CY**	33,1	:	32,7	:	:	:	:	:	:
life expectancy at 65 - males	**CY**	16,3	:	15,6	:	:	:	:	:	:
Disability free life expectancy at birth - males	**CY**	:	:	:	:	:	:	:	:	68,4
Life expectancy at birth - females	**CY**	79.8	:	80.0	80.4	80.4	:	81.0 (e)	:	81.4 (e)
life expectancy at 45 - females	**CY**	36,5	:	36,5	:	:	:	:	:	:
life expectancy at 65 - females	**CY**	18,6	:	18,4	:	:	:	:	:	:
Disability free life expectancy at birth - females	**CY**	:	:	:	:	:	:	:	:	69,6

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**LV**	60.3	63.3	64.2	63.8	64.7	65.0	64.8	64.8	65.7
life expectancy at 45 - males	**LV**	22,3	24,2	24,7	24,5	24,9	25,1	25	25	25,4
life expectancy at 65 - males	**LV**	11,5	11,9	12,1	12,3	12,4	12,5	12,4	12,5	12,7
Disability free life expectancy at birth - males	**LV**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**LV**	73.1	74.9	75.2	74.9	75.3	76.0	75.9	76.0	75.9
life expectancy at 45 - females	**LV**	31,6	32,8	33,1	32,8	33,2	33,5	33,4	33,4	33,2
life expectancy at 65 - females	**LV**	16	16,5	16,5	16,3	16,7	16,9	16,8	16,9	16,7
Disability free life expectancy at birth - females	**LV**	:	:	:	:	:	:	:	:	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**LT**	63.3	64.7	65.5	66.0	66.4	66.8	66.0	66.3	66.5
life expectancy at 45 - males	**LT**	24,5	25,3	26	26,2	26,4	26,7	26,2	26,2	26,2
life expectancy at 65 - males	**LT**	12,8	13,1	13,2	13,4	13,4	13,6	13,5	13,3	13,3
Disability free life expectancy at birth - males	**LT**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**LT**	75.0	75.8	76.6	76.6	76.9	77.4	77.5	77.5	77.7
life expectancy at 45 - females	**LT**	33	33,5	34	34	34,3	34,7	34,6	34,6	34,7
life expectancy at 65 - females	**LT**	16,8	17	17,2	17,3	17,4	17,8	17,8	17,7	17,9
Disability free life expectancy at birth - females	**LT**	:	:	:	:	:	:	:	:	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**LU**	73.0	73.3	74.1	73.7	74.6	74.8	75.2	74.9	75.0
life expectancy at 45 - males	**LU**	30,5	30,7	31,2	31,2	31,9	32	32,6	32,4	32,1
life expectancy at 65 - males	**LU**	14,7	14,8	14,8	15,1	15,3	15,5	16	15,9	15,5
Disability free life expectancy at birth - males	**LU**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**LU**	80.2	79.9	79.8	80.5	81.1	81.1	80.7	81.5	81.0
life expectancy at 45 - females	**LU**	36,8	36,9	36,5	36,9	37,3	37,4	37,3	37,7	37,1
life expectancy at 65 - females	**LU**	19,2	19,2	19	19,2	19,5	19,7	19,4	19,9	19
Disability free life expectancy at birth - females	**LU**	:	:	:	:	:	:	:	:	:

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**HU**	65.3	66.1	66.4	66.1	66.4	67.4	68.1	68.4	68.4
life expectancy at 45 - males	**HU**	24,5	24,9	25,1	:	24,9	25,8	26,2	26,4	26,3
life expectancy at 65 - males	**HU**	12,1	12,1	12,2	12,2	12,2	12,7	13	13,1	13
Disability free life expectancy at birth - males	**HU**	:	:	:	:	:	:	:	:	53,5 (p)
Life expectancy at birth - females	**HU**	74.5	74.7	75.1	75.2	75.2	75.9	76.4	76.7	76.7
life expectancy at 45 - females	**HU**	31,9	32,1	32,3	:	32,2	32,9	33,3	33,6	33,4
life expectancy at 65 - females	**HU**	15,8	15,6	15,9	16	15,9	16,5	16,7	17	16,9
Disability free life expectancy at birth - females	**HU**	:	:	:	:	:	:	:	:	57,8 (p)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**MT**	74.9	74.9	74.9	74.4	75.1	76.2	76.1	75.9	76.7
life expectancy at 45 - males	**MT**	32,4	32,2	:	:	:	32,6	32,9	32,5	33,4
life expectancy at 65 - males	**MT**	15,3	14,7	:	:	:	15,2	15,3	14,9	15,8
Disability free life expectancy at birth - males	**MT**	:	:	:	:	:	:	:	65,1 (p)	:
Life expectancy at birth - females	**MT**	79.5	79.8	80.1	80.1	79.3	80.3	80.9	81.0	80.7
life expectancy at 45 - females	**MT**	35,6	36,6	:	:	:	36,5	36,7	37,2	36,7
life expectancy at 65 - females	**MT**	17,5	18,5	:	:	:	18,5	18,4	19	18,4
Disability free life expectancy at birth - females	**MT**	:	:	:	:	:	:	:	65,7 (p)	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**NL**	74.6	74.7	75.2	75.2 (e)	75.3	75.5	75.8	76.0	76.2 (p)
life expectancy at 45 - males	**NL**	31,5	31,6	32	32	32,1	32,3	32,6	32,7	32,9
life expectancy at 65 - males	**NL**	14,7	14,8	15	15,1	15,1	15,3	15,5	15,6	15,8
Disability free life expectancy at birth - males	**NL**	61,1	62,1	62,5	61,9	61,6	61,4	61,9	61,7 (e)	61,7 (e)
Life expectancy at birth - females	**NL**	80.4	80.3	80.5	80.6 (e)	80.5	80.5	80.7	80.7	80.9 (p)
life expectancy at 45 - females	**NL**	36,8	36,8	36,9	36,9	36,8	36,9	37	37	37,2
life expectancy at 65 - females	**NL**	19	19	19,2	19,2	19,1	19,2	19,3	19,3	19,5
Disability free life expectancy at birth - females	**NL**	62,1 (e)	61,5	61,4	61,1 (e)	61,4	60,2	59,4	59,3 (e)	58,8 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**AT**	73.3	73.7	74.1	74.5 (e)	74.8	75.1	75.6	75.8	75.9
life expectancy at 45 - males	**AT**	30,9	31,1	31,3	31,7	32	32,4	32,8	32,9	:
life expectancy at 65 - males	**AT**	14,9	15,1	15,2	15,4	15,6	16	16,3	16,3	:
Disability free life expectancy at birth - males	**AT**	60	62,3	62,2	63,4	63,6	64,6	64,2	65,6 (e)	66,2 (e)
Life expectancy at birth - females	**AT**	79.9	80.1	80.5	80.8 (e)	80.8	81.1	81.5	81.7	81.6
life expectancy at 45 - females	**AT**	36,3	36,4	36,8	37	37,1	37,3	37,7	37,8	:
life expectancy at 65 - females	**AT**	18,6	18,7	18,9	19,1	19,2	19,4	19,8	19,7	:
Disability free life expectancy at birth - females	**AT**	:	:	:	:	:	68	68,5	69,0 (e)	69,6 (e)

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**PL**	67.6	68.1	68.5	68.9	68.2	69.7	70.2	70.4	70.5
life expectancy at 45 - males	**PL**	26,7	26,9	27,1	:	27,1	27,9	28,2	28,4	28,4
life expectancy at 65 - males	**PL**	12,9	12,9	13,1	:	13,2	13,6	13,9	14	13,9
Disability free life expectancy at birth - males	**PL**	:	59,9	:	:	:	:	:	62,5	:
Life expectancy at birth - females	**PL**	76.4	76.6	77.0	77.3	77.2	77.9	78.3	78.7	78.8
life expectancy at 45 - females	**PL**	33,6	33,7	33,9	:	34,1	34,6	34,9	35,2	35,3
life expectancy at 65 - females	**PL**	16,6	16,5	16,8	:	17	17,3	17,6	17,9	17,9
Disability free life expectancy at birth - females	**PL**	:	66,8	:	:	:	:	:	68,9	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**PT**	71.6	71.4	72.0	72.2	72.6	73.2	73.5	73.8	74.2
life expectancy at 45 - males	**PT**	30,6	30,4	30,9	31	31,2	31,6	31,8	31,9	31,9
life expectancy at 65 - males	**PT**	14,6	14,5	14,8	14,8	14,9	15,3	15,6	15,6	15,6
Disability free life expectancy at birth - males	**PT**	59,6	58,2	59,3	59,1	58,8	60,2	59,5	59,7 (e)	59,8 (e)
Life expectancy at birth - females	**PT**	78.7	78.8	79.0	79.3	79.5	80.0	80.3	80.5	80.5
life expectancy at 45 - females	**PT**	35,7	35,7	36	36,2	36,2	36,7	36,9	37	37
life expectancy at 65 - females	**PT**	17,8	17,8	18,1	18,2	18,3	18,7	18,9	19	18,9
Disability free life expectancy at birth - females	**PT**	63,1	60,5	60,4	61,1	60,7	62,2	62,7	61,8 (e)	61,8 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**RO**	65,3	65,2	65,5	65,5	67,1	67,7	67,6	67,5	67,8
Life expectancy at birth - females	**RO**	73,1	73	73,3	73,3	74,2	74,6	74,9	74,9	75,3

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**SI**	70.3	70.8	71.0	69.9	71.8	72.3	72.3	72.6	72.6 (e)
life expectancy at 45 - males	**SI**	28,4	28,7	28,9	:	29,4	29,6	29,9	30,1	29,9
life expectancy at 65 - males	**SI**	13,5	13,6	13,8	13,3	14,1	14,2	14,5	14,5	14,4
Disability free life expectancy at birth - males	**SI**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**SI**	77.8	78.3	78.6	77.8	79.3	79.7	80.3	80.5	80.4 (e)
life expectancy at 45 - females	**SI**	34,5	34,7	35	:	35,6	36,1	36,3	36,5	36,6
life expectancy at 65 - females	**SI**	17,1	17,3	17,6	17,1	18,1	18,5	18,8	18,9	18,8
Disability free life expectancy at birth - females	**SI**	:	:	:	:	:	:	:	:	:

3b: Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2003 - National values

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003
life expectancy at birth - males	**SK**	68,4	68,9	68,9	68,6	69	69,1	69,5	69,8	69,9
life expectancy at 45 - males	**SK**	26,7	27	27,1	:	27,1	27,1	27,3	27,6	27,7
life expectancy at 65 - males	**SK**	12,7	12,9	12,9	:	13	12,9	13	13,3	13,3
Disability free life expectancy at birth - males	**SK**	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**SK**	76.3	76.8	76.7	76.7	77.2	77.4	77.7	77.7	77.8
life expectancy at 45 - females	**SK**	33,2	33,6	33,5	:	33,9	33,9	34,1	34,3	34,4
Disability free life expectancy at birth - females	**SK**	16,1	16,4	16,4	:	16,6	16,5	16,8	16,9	16,9
Disability free life expectancy at birth - females	**SK**	:	:	:	:	:	:	:	:	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003
life expectancy at birth - males	**FI**	72,8	73	73,4	73,5	73,8	74,2	74,6	74,9	75,1
life expectancy at 45 - males	**FI**	30,4	30,6	31	30,9	31,2	31,6	32	32,1	:
life expectancy at 65 - males	**FI**	14,5	14,6	15	14,9	15,1	15,5	15,7	15,8	:
Disability free life expectancy at birth - males	**FI**	:	54,6	55,5	55,9	55,8	56,3	56,7	57,0 (e)	57,3 (e)
Life expectancy at birth - females	**FI**	80.2	80.5	80.5	80.8	81.0	81.0	81.5	81.5	81.8
life expectancy at 45 - females	**FI**	36,5	36,8	36,9	37,1	37,2	37,3	37,6	37,6	:
life expectancy at 65 - females	**FI**	18,6	18,7	18,9	19,1	19,2	19,3	19,6	19,6	:
Disability free life expectancy at birth - females	**FI**	:	57,7	57,6	58,3	57,4	56,8 (e)	56,9	56,8 (e)	56,5 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**SV**	76.2	76.5	76.7	76.9	77.1	77.4	77.6	77.7	77.9
life expectancy at 45 - males	**SV**	33	33,2	33,4	33,5	33,7	34	34,2	34,3	34,4
life expectancy at 65 - males	**SV**	16	16,1	16,2	16,3	16,4	16,7	16,9	16,9	17
Disability free life expectancy at birth - males	**SV**	:	:	62,1	61,7	62	63,1	61,9	62,4 (e)	62,5 (e)
Life expectancy at birth - females	**SV**	81.4	81.5	81.8	81.9	81.9	82.0	82.1	82.1	82.5
life expectancy at 45 - females	**SV**	37,5	37,6	37,9	37,9	37,9	37,9	38,1	38,1	38,4
life expectancy at 65 - females	**SV**	19,6	19,7	19,9	19,9	19,9	20	20,1	20	20,3
Disability free life expectancy at birth - females	**SV**	:	:	60	61,3 (e)	61,8	61,9	61	61,9 (e)	62,2 (e)

		1995	1996	1997	1998	1999	2000	2001	2002	2003
Life expectancy at birth - males	**UK**	74.0	74.3	74.7 (e)	74.8 (e)	75.0	75.4	75.7 (p)	75.9	76.2 (e)
life expectancy at 45 - males	**UK**	31,2	31,5	31,8	31,9	32,1	32,5	32,8	32,9	:
life expectancy at 65 - males	**UK**	14,6	14,8	15,1	15,2	15,3	15,7	15,9	16,1	:
Disability free life expectancy at birth - males	**UK**	60,6	60,8	60,9 (e)	60,8 (e)	61,2 (e)	61,3 (e)	61,1 (e)	61,4 (e)	61,5 (e)
Life expectancy at birth - females	**UK**	79.2	79.5	79.6 (e)	79.7 (e)	79.8	80.2	80.4 (p)	80.5	80.7 (e)
life expectancy at 45 - females	**UK**	35,6	35,9	36	36,1	36,2	36,6	36,8	36,8	:
life expectancy at 65 - females	**UK**	18,2	18,3	18,4	18,5	18,5	18,9	19,1	19,1	:
Disability free life expectancy at birth - females	**UK**	61,2 (e)	61,8 (e)	61,2 (e)	62,2 (e)	61,3 (e)	61,2 (e)	60,8 (e)	60,9 (e)	60,9 (e)

4 Early school-leavers (% of the total population aged 18-24 who have at most lower secondary education and not in further education or training)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000	total	17,6e	17,3e	12,5	:	:	11,6	14,9	14,2	:	18,2	29,1	13,3	25,3	18,5	:	16,7	16,8	13,8	54,2	15,5	10,2	:	42,6	22,3	:	:	8,9b	7,7	18,4
	female	15,6e	15,2e	10,2	:	:	9,9	15,2	12,1u	:	13,6	23,4	11,9	21,9	13,9	:	14,9	17,6	13,2	56,1	14,8	10,7	:	35,1	21,3	:	:	6,5b	6,2	17,9
	male	19,7e	19,5e	14,8	:	:	13,4	14,6	16,3	:	22,9	34,7	14,8	28,8	25	:	18,5	15,9	14,3	52,5	16,2	9,6	:	50,1	23,3	:	:	11,3b	9,2	19
2004	total	16,1	15,6	11,9b	21,4	6,1	8,5	12,1	13,7	12,9p	14,9	31,7	14,2	22,3	20,6	15,6	9,5b	12,7	12,6	42b	14	8,7i	5,7b	39,4b	23,6b	4,2u	7,1	8,7	8,6	14,9i
	female	13,7	13,1	8,3b	20,7	6,5	6,7	11,9	:~u	9,7p	11,6	24,6	12,3	18,4	14,9	10,7	7,4u	12,7	11,4	39,5b	11,9	7,9i	3,7b	30,6b	22,4b	2,6u	6,4	6,9	7,9	14,2i
	male	18,5	18	15,6b	22,1	5,8	10,4	12,2	20,5	16,1p	18,3	38,5	16,1	26,2	27,2	20,5	11,6u	12,6	13,7	44,2b	16,1	9,5i	7,7b	47,9b	24,9b	5,8u	7,8	10,6	9,3	15,7i
2005	total	15,6	15,2	13	20	6,4	8,5	13,8	14	12,3p	13,3	30,8b	12,6	21,9	18,1	11,9	9,2	13,3	12,3	41,2	13,6	9	5,5	38,6	20,8	4,3u	5,8	9,3	11,7b	14
	female	13,6	13,1	10,6	20,6	6,6	7,5	14,1	10,7u	9,6p	9,2	25b	10,7	17,8	10,6	8,2	6,2u	9,6	11,1	39,3	11,2	8,5	4	30,1	20,1	2,8u	5,7	7,3	10,9b	13,2
	male	17,6	17,3	15,3	19,5	6,2	9,4	13,5	17,4u	14,9p	17,5	36,4b	14,6	25,9	26,6	15,5	12,2u	17	13,5	43	15,8	9,4	6,9	46,7	21,4	5,7u	6	11,3	12,4b	14,7
2006	total	15,4	15,1	12,6	18	5,5	10,9	13,8	13,2	12,3	15,9	29,9	13,1	20,8	16	19p	10,3	13,3	12,4	41,6	12,9	9,6	5,6	39,2p	19	5,2u	6,4	10,8p	12	13
	female	13,2	12,8	10,2	17,9	5,4	9,1	13,6	:~u	9	11	23,8	11,2	17,3	9,2	16,1p	7u	9,6	10,7	38,9	10,7	9,8	3,8	31,8p	18,9	3,3u	5,5	9p	10,7	11,4
	male	17,5	17,4	14,9	18,2	5,7	12,8	13,9	19,6u	15,6	20,7	35,8	15,1	24,3	23,5	21,6p	13,3u	17	14	44,4	15,1	9,3	7,2	46,4p	19,1	6,9u	7,3	12,6p	13,3	14,6

u = data lack reliability due to low sample size / : = not available or unreliable data / b = break / p = provisional

In DK, LU, IS, NO, EE, LV, LT, CY, MT and SI, the high degree of variation of results over time is partly influenced by a low sample size.

In CY, the reference population (denominator) excludes students abroad. In DE (2004), participation to personnel interest courses is excluded

Source : Eurostat, Labour Force Survey - Quarter 2 results

5 People living in jobless households: children (0-17 years) and prime-age adults (18-59 years), selected years (% of population in the relevant age group)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2001	Children		9,5e	12,9	19	8	:	8,9	11,2	10,4	5,3	6,4	9,2	7	3,9	10,7	:	3,4	13,5	7,9	6	4,1	:	3,6	6,8	3,8	9,3u	:	:	16,9
	Adults (18-59)																													
	Total		10,1e	13,8	17,3b	7,9	:	9,7	11	8,8	8,8	7,4	10,3	10,8	4,9	12,8	10	6,7	13,2	7,8	6,9	7,9	13,8	4,3	8,7	8,2	10	:	:	11,2
	Men		8,8e	11,5	16,8b	6,2	:	8,9	10,9	7,4	6,4	6,6	8,9	9,1	3,4	12,3	10,1	5,3	12	5,7	5,4	6,2	12,9	3,7	7,7	7,1	9,6	:	:	9,1
	Women		11,4e	16,2	17,8b	9,5	:	10,5	11,1	10,2	11,2	8,3	11,6	12,4	6,3	13,2	10	8,1	14,3	9,9	8,5	9,6	14,7	4,9	9,6	9,4	10,5	:	:	13,2
2002	Children		9,8e	13,8	18,7	7,6	5,6	9,3	10,1	10,8	5,1	6,6	9,6	7,2	3,9	10,6b	8,4	2,8	14,3	7,6	6	4,4	:	4,2	9,8b	3,8	12,1	:	:	17,4
	Adults (18-59)																													
	Total		10,2e	14,2	16,6	7,3	7,6	10	10,8	8,5	8,9	7,3	10,4	10,2	5,3	10,5b	9,1b	6,3	13	7,2	6,7	7,5	15,1	4,6	11,3b	8	10,9	:	:	11,3
	Men		8,9e	11,9	16,1	5,6	7,2	9,4	10,6	7,3	6,5	6,6	9,1	8,6	3,9	10,7b	8,5b	5,6	12	5,8	5,3	6,2	14,1	3,9	10,1b	7	10,4	:	:	9,2
	Women		11,4e	16,6	17	9,1	8	10,7	10,9	9,7	11,2	8	11,8	11,8	6,5	10,3b	9,7b	7	14	8,6	8,1	8,8	16,1	5,2	12,5b	8,9	11,4	:	:	13,3
2003	Children		9,8e	13,9	16,6	8,4	5,7	10,3	9	11,8	4,6	6	9,5	7	3,4	7,2	6,1	3,9i	12,6b	8	7	4,3	:	5	10,2	4	11,8	5,7	:	17
	Adults (18-59)																													
	Total		10,2e	14,4	15,3	7,7	8,6	10,6	10,9	8,9	8,5	7,2	10,6	9,7	5,2	8,7	7,4	7,5i	11,6b	7,9	8	7,4	14,8	5,5	11,1	8,7	10,1	10,9	:	10,9
	Men		9e	12,7	14,7	5,8	7,8	10	11,3	7,6	6,2	6,5	9,5	8,1	4,3	8,9	7,4	6i	10,9b	6,2	6,7	6,1	13,7	4,8	9,8	7,8	9,3	11,6	:	8,9
	Women		11,3e	16,2	15,8	9,7	9,3	11,2	10,5	10,2	10,8	7,8	11,8	11,3	6,1	8,6	7,4	9i	12,2b	9,7	9,3	8,6	15,9	6,1	12,4	9,6	10,9	10,3	:	12,9
2004	Children		9,8i	13,2	15,6	9	6	10,9	9,6	11,8	4,5	6,3	9,6	5,7	2,6	7,2	6,5	3,4	13,2	9,2	7	5,6i	:	4,3	11,1	3,8	12,8	5,7	:	16,8
	Adults (18-59)																													
	Total		10,3i	13,7	13,7	8	8,5	11,1	9,5	8,6	8,5	7,3	10,8	9,1	5	7,8	8,1	7,1	11,9	8,6	8	8,8i	15,8	5,3	11,1	7,5	10,8	11	:	11
	Men		9,3i	11,3	13,2	6,4	8,3	10,8	10,2	7,2	6,2	6,7	9,5	7,9	3,8	7,1	8,3	5,7	11,1	6,8	6,7	7,6i	14,8	5	10,4	7	10	11,2	:	9
	Women		11,4i	16	14,2	9,6	8,8	11,4	8,7	10,1	10,7	7,9	12,1	10,4	6,1	8,4	8	8,5	12,7	10,4	9,3	10i	16,8	5,7	11,7	8	11,6	10,9	:	13
2005	Children		9,7e	12,9	14,5	8,1	5,7	11,1	9,1	12	4,1	5,4	9,5	5,6	3,5	8,3	6,2	2,7	14,2	8,9	7	6,3	:	4,3	10,4	2,7	13,8	6,6	:	16,5
	Adults (18-59)																													
	Total		10,2e	13,5	13	7,4	7,7	11,1	8,5	8,4	8,5	6,7	10,7	9,5	5,2	8,1	6,6	6,7	12,3	8,2	8	8,7	15,3	5,5	10,4	6,7	10,2	10,5	:	11
	Men		9,3e	11,6	12,6	5,8	7,7	10,9	10,2	7,2	6,4	6,2	9,6	8,3	4,2	8,7	6,9	5,4	11,6	6,5	6,9	7,7	14	5,1	9,4	6,3	9,5	11	:	9,2
	Women		11,2e	15,4	13,5	9	7,8	11,3	7	9,8	10,7	7,2	11,8	10,8	6,2	7,6	6,4	8,1	13,1	9,9	9	9,6	16,6	5,8	11,3	7,1	10,9	10	:	12,8
2006	Children		9,5e	13,5	14,5	8,2	5,7p	10,5	8,2	11,3	3,6	5,1	9,5	5,4	3,9	7,1	5,3	2,7p	13,3	8,2	6,2	7,2	11,2	4,7	10	3,6	11,8	6,6p	:	16,2
	Adults (18-59)																													
	Total		9,8e	14,3	11,6	7,3	7,7p	10,6	6	7,9	8,1	6,3	10,9	9,2	4,9	6,8	7	6,7p	11,6	6,7	7,4	8,8	13,5	5,8	9,7	7,2	9,6	10,5p	:	10,7
	Men		8,8e	12,3	11,1	5,8	7,7p	10,4	6,1	6,5	6,1	5,8	9,9	7,8	3,7	7,5	7,2	5,4p	10,6	5,2	6,2	7,8	12,3	5,3	8,8	6,6	9	11p	:	8,8
	Women		10,8e	16,4	12	8,8	7,8p	10,9	5,8	9,3	10,1	6,8	12	10,6	5,9	6,2	6,9	8,1p	12,6	8,2	8,6	9,8	14,6	6,4	10,6	7,8	10,2	10p	:	12,5

u = data lack reliability due to low sample size / : = not available or unreliable data / b = break / p = provisional

In DK, LU, IS, NO, EE, LV, LT, CY, MT and SI, the high degree of variation of results over time is partly influenced by a low sample size.

In CY, the reference population (denominator) excludes students abroad. In DE (2003 and 2004), participation to personnel interest courses is excluded

Source : Eurostat, Labour Force Survey - Quarter 2 results

6 Projected total public social expenditures

Total age-related public spending: pension, health care, long-term care, education and unemployment transfers (% of GDP) – baseline scenario

http://ec.europa.eu/economy_finance/epc/documents/2006/ageingannex_en.pdf p.7

http://ec.europa.eu/economy_finance/epc/documents/2006/ageingreport_en.pdf p.11

	EU25	BE	CZ	DK	DE	EE	IE	EL*	ES	FR	IT	CY	LT	LV	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
2004	23,4	25,4	19,3	26,8	23,7	17,1	15,5	8,9	20,1	26,7	26,2	16,4	16	17,5	19,5	20,7	18,2	20,9	25,2	23,7	23,8	24,2	16,2	25,4	29,6	19,6
Change 2004-2010	-0,7	-0,3	-0,5	0,2	-1,2	-0,6	-0,1	-0,2	-0,4	0	-0,5	0,1	-0,7	-2,9	-0,1	0,3	0,9	-0,3	-1	-3,5	0,4	-0,2	-0,8	0,2	-1,4	-0,2
Change 2004-2020	-0,2	1,2	-0,1	1,8	-0,8	-2	1,6	-0,2	0,3	0,9	-0,3	1,2	-0,9	-2,9	2,1	1,6	2,2	1,5	-1	-5,8	2,5	1,3	-0,9	2,3	-1	0,3
Change 2004-2030	1,5	4,5	1,7	4	1	-2,3	3,3	0,2	3,3	1,9	1,1	4,1	0,3	-1,5	5,5	2,8	1,8	3,8	0,8	-6,1	4,2	4,4	0,3	4,7	1,3	2,2
Change 2004-2040	3	6,2	4,8	5,3	2	-2,8	5,2	0,8	7,2	2,9	2,5	7	0,8	-1,3	7,9	5,7	1	5,3	0,9	-6,4	7,3	7,5	1,5	5,3	2,3	3,3
Change 2004-2050	3,4	6,3	7,1	4,8	2,7	-2,7	7,8	1,3	8,5	2,9	1,8	11,8	1,4	-1,3	8,3	7	0,3	4,9	0,1	-6,7	9,8	9,6	2,9	5,2	2,2	4

1) Total expenditure for GR does not include pension expenditure. The Greek authorities have agreed to provide the pension projections in 2006. In the context of the most recent assessment of the sustainability of public finances based on the Greek stability programme, public spending on pensions was projected to increase by 10.3% of GDP between 2004 and 2050.

2) Total expenditure for: GR, FR, PT, CY, EE, HU does not include long-term care

3) The projection results for public spending on long-term care for Germany does not reflect current legislation where benefit levels are fixed. A scenario which comes closer to the current setting of legislation projects that public spending would remain constant as a share of GDP over the projection period.

Note: these figures refer to the baseline projections for social security spending on pensions, education and unemployment transfers.

For health care and long-term care, the projections refer to "AWG reference scenarios"

7a Relative income of people aged 65+ (relative to the complementary age groups) (%)

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total		0.85 s	0,73		0.83 b	0,70		0.92 b	0.73	0.65	0.79	0.75	0.9	0.84 b	0.57 b	0.75 b	0.81 b	0.97	1.01 b	0.87 b	0.88 b	0.95	1.09 b	0.78		0.87 pb	0.85 b	0.75	0.8	0.72 bp

1) Including imputed rent. See methodological note for an explanation; b: break in series; p: provisional

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005);

* BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005

7b Aggregate replacement ratio (%)

These data are currently being checked by Estat and will be available within the coming weeks

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total		0.54 s	0.42		0.51 b	0.35		0.45 b	0.47	0.43	0.49	0.56	0.66	0.58 b	0.28 b	0.61 b	0.47 b	0.63	0.61 b	0.55 b	0.43 b	0.67	0.59 b	0.63		0.42 pb	0.55 b	0.46	0.58	:

1) Including imputed rent. See methodological note for an explanation; b: break in series; p: provisional

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005); * BG National HBS 2004, income data 2004 and RO National

8 Inequalities in access to health (not yet agreed upon)

9 At-risk of poverty rate anchored at a point in time

Not available yet

10 Employment rate of older workers (% of people aged 55-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	35,8	22,9	:	37,1	52	37,7	50,2	41,7	39	35,1	28,3	27,7	:	36,3	39,5	25,1	17,3	:	33,9	28,4	32,1	49,6b	51,5	23,9	22,8	36,2	63	49
	male	:	46,6	32,1	:	53,2	61,3	47,2	62	60,2	56	52,6	32,5	41,4	:	48,1	54,4	35,2	27	:	47,5	40,5	41,5	62,9b	59,5	31,8	39,1	38,4	66,1	59,1
	female	:	25,5	14	:	22,9	42	28,3	41,6	23,1	23,5	18,8	24,4	15	:	27,5	28,3	15,5	9,6	:	20,3	17,1	24,1	38b	44,5	16,1	9,4	34,1	60	39,2
2000	total	36,9	36,6	26,3	20,8	36,3	55,7	37,6	46,3	45,3	39	37	29,9	27,7	49,4	36	40,4	26,7	22,2	28,5	38,2	28,8	28,4	50,7	49,5	22,7	21,3	41,6	64,9	50,7b
	male	47,1	46,9	36,4	33,2	51,7	64,1	46,4	55,9	63,2	55,2	54,9	33,6	40,9	67,3	48,4	50,6	37,2	33,2	50,8	50,2	41,2	36,7	62,1	56	32,3	35,4	42,9	67,8	60,1b
	female	27,4	26,9	16,6	10,3	22,4	46,6	29	39	27,2	24,3	20,2	26,3	15,3	32,1	26,7	32,6	16,4	13,3	8,4	26,1	17,2	21,4	40,6	43,8	13,8	9,8	40,4	62,1	41,7b
2002	total	38,5	38,7	26,6	27	40,8	57,9	38,9	51,6	48	39,2	39,6	34,7	28,9	49,4	41,7	41,6	28,1	25,6	30,1	42,3	29,1	26,1	51,4	37,3b	24,5	22,8	47,8	68	53,4
	male	48,4	48,8	36	37	57,2	64,5	47,3	58,4	65	55,9	58,4	38,7	41,3	67,3	50,5	51,5	37,7	35,5	50,8	54,6	39,6	34,5	61,9	42,7b	35,4	39,1	48,5	70,4	62,6
	female	29,1	29,2	17,5	18,2	25,9	50,4	30,6	46,5	30,8	24	21,9	30,8	17,3	32,2	35,2	34,1	18,4	17,6	10,9	29,9	19,3	18,9	42,2	32,6b	14,2	9,5	47,2	65,6	44,5
2004	total	40,6	41	30	32,5	42,7	60,3	41,8	52,4	49,5	39,4	41,3	37,3	30,5b	49,9	47,9	47,1	30,4	31,1	31,5	45,2	28,8b	26,2	50,3	36,9	29	26,8	50,9	69,1	56,2
	male	50,3	50,7	39,1	42,2	57,2	67,3	50,7	56,4	65	56,4	58,9	41	42,2b	70,8	55,8	57,6	38,3	38,4	53,4	56,9	38,9b	34,1	59,1	43,1	40,9	43,8	51,4	71,2	65,7
	female	31,6	31,7	21,1	24,2	29,4	53,3	33	49,4	33,7	24	24,6	33,8	19,6b	30	41,9	39,3	22,2	25	11,5	33,4	19,3b	19,4	42,5	31,4	17,8	12,6	50,4	67	47
2005	total	42,2	42,5	31,8	34,7	44,5	59,5	45,4b	56,1	51,6	41,6	43,1b	37,9	31,4	50,6	49,5	49,2	31,7	33	30,8	46,1	31,8	27,2	50,5	39,4	30,7	30,3	52,7	69,4b	56,9
	male	51,5	51,8	41,7	45,5	59,3	65,6	53,5b	59,3	65,7	58,8	59,7b	40,7	42,7	70,8	55,2	59,1	38,3	40,6	50,8	56,9	41,3	35,9	58,1	46,7	43,1	47,8	52,8	72b	66
	female	33,5	33,7	22,1	25,5	30,9	53,5	37,5b	53,7	37,3	25,8	27,4b	35,2	20,8	31,5	45,3	41,7	24,9	26,7	12,4	35,2	22,9	19,7	43,7	33,1	18,5	15,6	52,7	66,7b	48,1

(b) break in data series

Source : Eurostat - Labour Force Survey, Annual averages.

11 At-risk-of-poverty rate by most frequent activity status and by gender (Age 18+)

			EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
-	Total	Total	15	14	14 i	8b	12	10	12b	17	18	19	19	13	18	17b	19b	19b	11	12pb	13b	9b	12	18b	19	:	12pb	12b	12	9	:
		Men	14	13	12 i	8b	12	10	11b	15	17	18	17	12	16	15b	17b	18b	11	12pb	12b	9b	10	19b	19	:	10pb	11b	10	8	:
		Women	16	15	17 i	9b	12	11	14b	19	20	21	20	13	20	19b	20b	20b	11	12pb	14b	9b	13	17b	20	:	14pb	12b	13	10	:
-	At work	Total	8	4	7 i	3b	5	5	5b	7	6	13	10	6	9	7b	9b	10b	9	10pb	6b	6b	7	14b	14	:	5pb	9b	4	5	:
		Men	9	5	7 i	3b	5	5	5b	7	6	14	11	7	11	6b	9b	10b	9	10pb	7b	6b	7	15b	14	:	5pb	9b	4	6	:
		Women	7	3	6 i	4b	5	5	6b	8	5	12	9	5	6	7b	9b	10b	9	9pb	3b	5b	6	12b	12	:	4pb	9b	4	5	:
-	Not at work	Total	23	23	19 i	15b	22	18	19b	31	34	26	28	20	25	32b	31b	29b	13	15pb	19b	14b	18	22b	27	:	19pb	15b	22	15	:
		Men	22	24	15 i	15b	24	19	18b	30	37	25	28	19	23	33b	32b	28b	14	14pb	22b	15b	17	23b	26	:	17pb	16b	20	13	:
		Women	23	23	22 i	15b	21	17	19b	31	32	26	28	20	27	31b	31b	29b	13	15pb	18b	13b	18	21b	27	:	21pb	15b	23	16	:
	* Unemployed	Total	40	31	34 i	51b	26	25	42b	60	47	32	35	29	44	37b	59b	63b	46	48pb	48b	27b	48	46b	28	:	25pb	39b	36	26	:
		Men	44	30	36 i	57b	39	37	41b	62	53	38	41	34	50	46b	64b	65b	45	52pb	55b	27b	53	48b	33	:	24pb	41b	39	33	:
		Women	38	32	32 i	47b	14	14	44b	58	35	28	31	25	39	31b	53b	60b	48	45pb	23bu	27b	42	43b	24	:	26pb	38b	31	19	:
	* Retired	Total	17	18	15 i	6b	16	8	14b	23	30	25	25	13	16	49b	24b	17b	6	10pb	17b	5b	12	11b	25	:	17pb	7b	17	10	:
		Men	16	19	7 i	4b	15	8	12b	11	30	22	25	13	15	46b	19b	8b	7	9pb	17b	4b	10	11b	25	:	11pb	4b	11	7	:
		Women	18	18	20 i	7b	16	8	16b	28	30	29	23	14	17	51b	26b	22b	4	10pb	12b	5b	14	10b	25	:	21pb	8b	21	13	:
	* Other inactive	Total	25	26	17 i	16b	31	28	18b	31	34	25	28	27	28	19b	31b	29b	14	17pb	18b	19b	22	26b	29	:	22pb	19b	27	26	:
		Men	25	26	13 i	17b	33	28	19b	35	38	26	25	25	25	16b	31b	26b	19	12pb	19b	26b	26	25b	25	:	23pb	18b	29	26	:
		Women	25	25	21 i	15b	30	28	18b	29	32	25	29	28	29	21b	31b	31b	13	20pb	18b	16b	21	27b	30	:	21pb	19b	25	26	:

Distribution of at-risk-or-poverty population

			EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
-	Total	Total	100	100			100	100	:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	:	100	100	100	100	:
		Men		44			43	47	:	41	39	46	45	45	45	42	42	40	42	48	47	46	49	44	50	46	:	41	45	42	45	:
		Women		56			57	53	:	59	61	54	55	55	55	58	58	60	58	52	53	54	51	56	50	54	:	59	55	58	55	:
-	At work	Total	28	14			23	23	:	20	24	18	33	29	26	23	22	27	28	46	46	20	36	32	34	40	:	19	41	17	35	:
		Men		9			13	13	:	10	11	11	21	19	16	17	13	13	15	28	26	17	22	20	20	23	:	11	21	9	21	:
		Women		5			10	11	:	10	13	7	12	9	10	6	10	13	14	18	21	3	15	12	14	17	:	7	20	8	15	:
-	Not at work	Total	72	86			77	77	:	80	76	82	67	71	74	77	78	73	72	54	54	80	64	68	66	60	:	81	59	83	65	:
		Men		35			30	34	:	31	28	35	23	25	29	26	30	27	27	20	21	29	27	24	29	23	:	30	23	33	24	:
		Women		51			46	42	:	48	48	47	43	46	45	52	48	47	44	34	32	51	36	44	36	37	:	52	35	50	40	:
	* Unemployed	Total	15	21			38	9	:	21	19	11	8	13	14	14	5	22	27	8	17	10	17	9	29	8	:	4	26	19	8	:
		Men		11			18	7	:	10	12	8	4	6	8	7	3	12	15	4	8	9	7	5	15	4	:	2	13	12	6	:
		Women		11			20	3	:	11	7	3	4	8	6	7	3	9	11	4	8	1	10	4	14	4	:	2	13	7	3	:
	* Retired	Total	27	29			20	29	:	31	30	15	28	20	28	18	47	34	22	8	28	18	10	27	17	28	:	42	16	39	31	:
		Men		13			5	12	:	13	4	11	14	14	13	10	20	9	3	6	10	16	4	11	7	13	:	11	4	11	9	:
		Women		16			15	17	:	18	26	3	15	6	15	9	26	26	19	2	18	2	6	17	10	15	:	31	12	28	22	:
	* Other inactive	Total	29	36			19	38	:	28	27	57	31	38	32	45	26	17	23	38	9	53	37	31	20	25	:	35	17	24	26	:
		Men		11			7	16	:	8	11	15	6	6	8	8	6	5	9	9	3	5	16	8	7	6	:	17	7	10	10	:
		Women		25			12	23	:	19	16	41	25	32	24	36	19	11	14	28	6	48	20	23	13	19	:	18	10	15	16	:

1) Including imputed rent. See methodological note for an explanation

Source: SILC(2005) Income data 2004; except for UK, income year 2005 and for IE moving income reference period (2004-2005); * BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005.

p = provisional. s = estimated by Eurostat. u = result based on small sample (20-49 observations)

12 Activity rates (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	68	63,5	:	72	79,7	70,8	72,2	65,6	63,2	63	68,4	59	:	69,8	72,1	62,1	58,7	:	73	71	65,7	70,6b	68,9	68,2	69,3	72,3	76,2	75,4
	Male	:	77,4	72,8	:	80	83,8	79,2	79	78,2	77,6	77,3	75,2	73,6	:	76,4	78,2	75,9	66,6	:	82,6	80,3	72,8	79,3b	75,7	72,6	77,2	75,6	79	83,2
	Female	:	58,7	54	:	64	75,6	62,2	66,4	52,9	49	48,9	61,9	44,6	:	63,9	66,5	48,1	51,2	:	63,2	61,7	58,8	62,3b	62,3	63,6	61,7	69,1	73,5	67,4
2000	Total	68,6	68,7	65,1	60,7	71,3	80	71,1	70,2	68,2	63,8	65,4	68,7	60,1	69,1	67,2	70,8	64,1	60,1	58	75,2	71	65,8	71,4	68,4	67,5	69,9	74,5	77,3	75,4b
	Male	77,1	77,4	73,7	66,2	79,1	84,2	78,9	75,6	79,9	77,4	78,8	75,2	74,1	81,4	72,7	74,5	76,3	67,9	80,5	84,1	80,1	71,7	79,2	75	71,9	76,8	77,2	79,8	82,8b
	Female	60,1	60	56,4	55,6	63,6	75,6	63,3	65,3	56,3	50,5	52	62,4	46,3	57,7	62,1	67,3	51,6	52,7	35,2	66	62	59,9	63,9	61,9	62,9	63,2	71,9	74,8	68,2b
2002	Total	68,6	69	64,8	61,9	70,6	79,6	71,7	69,3	68,6	64,2	66,2	69,1	61,1	71,2	68,8	69,6	65,2	59,7	58,5	76,5	71,6	64,6	72,7	63,4b	67,8	69,9	74,9	77,6	75,2
	Male	76,8	77,3	73,2	66,4	78,6	83,6	78,8	74,6	79,2	77,6	79,1	75,5	74,3	81,3	74,1	73,6	76,7	67,1	80,1	84,5	79,6	70,6	80	70,4b	72,5	76,7	77	79,4	82,3
	Female	60,5	60,7	56,3	57,5	62,7	75,5	64,4	64,4	57,8	51	53,1	63	47,9	61,8	63,9	65,8	53,6	52,7	36,7	68,3	63,7	58,7	65,6	56,6b	63	63,2	72,8	75,8	68,3
2004	Total	69,3	69,7	65,9	61,8	70	80,1	72,6	70	69,5	66,5	68,7	69,5	62,7b	72,6	69,7	69,1	65,8	60,5	58,2	76,6	71,3b	64	73	63	69,8	69,7	74,2	77,2	75,2
	Male	77	77,5	73,4	66,4	77,9	84	79,2	74,4	79,9	79	80,4	75,3	74,9b	83	74,3	72,8	75,6	67,2	80,2	83,9	78,5b	70,1	79,1	70	74,5	76,5	76,4	79,1	82
	Female	61,6	62	58,2	57,2	62,2	76,2	65,8	66	59	54,1	56,8	63,9	50,6b	62,8	65,3	65,6	55,8	54	36	69,2	64,2b	57,9	67	56,2	65	63	72	75,2	68,6
2005	Total	69,7	70,2	66,7	62,1	70,4	79,8	73,8b	70,1	70,8	66,8	69,7b	69,5	62,5	72,4	69,6	68,4	66,6	61,3	58,1	76,9	72,4	64,4	73,4	62,3	70,7	68,9	74,7	78,7b	75,3
	Male	77,3	77,8	73,9	67	78,4	83,6	80,6b	73,6	80,6	79,2	80,9b	75,1	74,6	82,9	74,4	72,1	76	67,9	79,1	83,7	79,3	70,8	79	69,4	75,1	76,5	76,6	80,9b	81,9
	Female	62,1	62,5	59,5	57,3	62,4	75,9	66,9b	66,9	60,8	54,5	58,3b	64,1	50,4	62,5	65,1	64,9	57	55,1	36,9	70	65,6	58,1	67,9	55,3	66,1	61,5	72,8	76,3b	68,8

Source : Eurostat - Labour Force Survey, Annual averages.

(b) break in series

13 Dispersion of regional employment rates*, selected years (%)

	EU 25	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SL	SK	FI	SE	UK
1999	13,4	8	5,6	-	5,4	-	-	5,2	10,7	7,1	17,4	-	-	-	-	9,1	-	2,3	2,3	4,8	2,6	-	8,1	6,7	5	7,1
2004	12,2	8,7	5,6	-	6,2	-	-	4,1	8,7	7,1	15,6	-	-	-	-	9,4	-	2,3	3,5	6,4	3,5	-	9	5,5	4,4	5,8

* Coefficient of variation of employment rates across regions at NUTS2 level

e = estimate; p = provisional figure

Source : Eurostat - Labour Force Survey, Annual averages

Context indicators

Context 1: Growth rate of GDP at constant prices (2000) - percentage change over previous year

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2004	2,4	2,4	3	5,6	4,2	2,2	1,2	8,1	4,3	4,7	3,2	2,3	1,1	4,2	8,6	7,3	3,6	4,9	0,8	2	2,4	5,3	1,2	8,4	4,4	5,4	3,5	4,1	3,3
2005	1,7	1,7	1,1	5,5	6,1	3	0,9	10,5	5,5	3,7	3,5	1,2	0	3,9	10,2	7,6	4	4,2	2,2	1,5	2	3,5	0,4	4,1	4	6	2,9	2,9	1,9
2006	2,9	2,9	2,7 f	6,0 f	6,0 f	3,0 f	2,5	10,9 f	5,3 f	3,8 f	3,8 f	2,2 f	2	3,8 f	11,0 f	7,8 f	5,5 f	3,9	2,3 f	3,0 f	3,1 f	5,2 f	1,2 f	7,2 f	4,8 f	6,7 f	4,9 f	4,0 f	2,8

Context 1a: GDP per capita in Purchasing Power Standards (PPS), (EU-25 = 100)

	EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1996		100	118,1	:	70,0 (e)	123,8	118,1	34,8 (e)	69,8	87,0	112,9	102,3	115,6	79,6 (e)	30,2 (e)	34,7 (e)	196,7	48,5 (e)	:	119,2	126,5	42,1 (e)	74,9	69,0 (e)	:	45,5 (e)	103,9	115,7	109,1
2000		100	116,5	26,5	64,7	126,0	111,7	42,1	126,1	72,7	92,1	113,3	113,1	82,2	35,3	37,9	222,0	53,9	78,0	124,0	125,5	46,7	80,3	24,9	72,7	47,4	114,0	118,8	111,8
2004		100	119,4	31,8	72,1	120,1	111,1	53,4	135,7	81,4	96,6	107,7	103,0	87,7	43,6	49,0	240,8	61,3	71,3	124,7	123,4	48,7	71,8	32,6	79,9	54,4	110,8	115,4	118,0
2005		100	118,1	33,0	73,7	122,1	110,0	59,8	138,9	84,1	98,0	108,2	100,4	88,9	48,0	52,1	251,2	62,5	70,5	125,6	123,1	49,8	71,1	34,1	81,9	57,1	110,7	114,8	117,6
2006		100	118,1 f	34,2 f	76,1 f	122.4 f	110,2 f	65,0 f	139,2 f	84,9 f	98,0 f	107,3 f	99,6 f	88,3 f	52,3 f	55,0 f	257,1 f	63,6 f	69,7 f	126,1 f	123,2 f	51,1 f	69,8 f	35,8 f	83,6 f	59,4 f	112.9 f	116,0 f	117,3 f

f = forecast r = revised value e = estimate

Source : Eurostat, Structural indicators database

Context 2a: Employment rate (% of population aged 15-64)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	total	:	61,2	57,4	:	67,3	75,1	63,9	64,6	60,6	56	51,3	60,2	51,9	:	59,9	62,3	60,5	53,7	:	70,2	67,9	59	66,8b	64,2	62,9	60,6	64,6	70,3	70,5
	male	:	70,6	67,1	:	76	79,9	71,9	69,6	72,1	71,7	66,8	67,4	66,8	:	65,1	66,2	74,5	60,5	:	80,2	77	66,5	75,9b	70,4	67,2	67,8	67,8	72,8	77,3
	female	:	51,8	47,6	:	58,7	70,2	55,8	60,3	49	40,5	35,8	53,1	37,3	:	55,1	58,6	46,2	47,2	:	60,1	58,8	51,7	58,2b	58,2	58,6	53,5	61,2	67,9	63,6
2000	total	62,2	62,4	60,5	50,4	65	76,3	65,6	60,4	65,2	56,5	56,3	62,1	53,7	65,7	57,5	59,1	62,7	56,3	54,2	72,9	68,5	55	68,4	63	62,8	56,8	67,2	73	71,2b
	male	70,8	71,2	69,5	54,7	73,2	80,8	72,9	64,3	76,3	71,5	71,2	69,2	68	78,7	61,5	60,5	75	63,1	75	82,1	77,3	61,2	76,5	68,6	67,2	62,2	70,1	75,1	77,8b
	female	53,7	53,6	51,5	46,3	56,9	71,6	58,1	56,9	53,9	41,7	41,3	55,2	39,6	53,5	53,8	57,7	50,1	49,7	33,1	63,5	59,6	48,9	60,5	57,5	58,4	51,5	64,2	70,9	64,7b
2002	total	62,3	62,8	59,9	50,6	65,4	75,9	65,4	62	65,5	57,5	58,5	63	55,5	68,6	60,4	59,9	63,4	56,2	54,4	74,4	68,7	51,5	68,8	57,6b	63,4	56,8	68,1	73,6	71,3
	male	70,3	71	68,3	53,7	73,9	80	71,8	66,5	75,4	72,2	72,6	69,5	69,1	78,9	64,3	62,7	75,1	62,9	74,7	82,4	76,4	56,9	76,5	63,6b	68,2	62,4	70	74,9	77,6
	female	54,4	54,7	51,4	47,5	57	71,7	58,9	57,9	55,4	42,9	44,4	56,7	42	59,1	56,8	57,2	51,6	49,8	33,9	66,2	61,3	46,2	61,4	51,8b	58,6	51,4	66,2	72,2	65,2
2004	total	62,9	63,3	60,3	54,2	64,2	75,7	65	63	66,3	59,4	61,1	63,1	57,6b	68,9	62,3	61,2	62,5	56,8	54	73,1	67,8b	51,7	67,8	57,7	65,3	57	67,6	72,1	71,6
	male	70,3	70,9	67,9	57,9	72,3	79,7	70,8	66,4	75,9	73,7	73,8	69	70,1b	79,8	66,4	64,7	72,8	63,1	75,1	80,2	74,9b	57,2	74,2	63,4	70	63,2	69,7	73,6	77,8
	female	55,4	55,7	52,6	50,6	56	71,6	59,2	60	56,5	45,2	48,3	57,4	45,2b	58,7	58,5	57,8	51,9	50,7	32,7	65,8	60,7b	46,2	61,7	52,1	60,5	50,9	65,6	70,5	65,6
2005	total	63,4	63,8	61,1	55,8	64,8	75,9	65,4b	64,4	67,6	60,1	63,3b	63,1	57,6	68,5	63,3	62,6	63,6	56,9	53,9	73,2	68,6	52,8	67,5	57,6	66	57,7	68,4	72,5b	71,7
	male	70,8	71,3	68,3	60	73,3	79,8	71,2b	67	76,9	74,2	75,2b	68,8	69,9	79,2	67,6	66,1	73,3	63,1	73,8	79,9	75,4	58,9	73,4	63,7	70,4	64,6	70,3	74,4b	77,6
	female	56	56,3	53,8	51,7	56,3	71,9	59,6b	62,1	58,3	46,1	51,2b	57,6	45,3	58,4	59,3	59,4	53,7	51	33,7	66,4	62	46,8	61,7	51,5	61,3	50,9	66,5	70,4b	65,9

Source : Eurostat - Labour Force Survey, Annual averages.

(b): break in series

Context 2b: Unemployment rate (% of labour force aged 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	9,3	9,3	:	6,4	4,9	8,8	9,2	7,5	10,8	15	11,1	11,3	:	14,3	13,2	2,7	8,4	:	3,8	4,5	10,2	5,1	5,4	7,4	12,6	11,4	8,2	6,1
	Males	:	8	7,7	:	5	3,9	7,1	9,9	7,7	7	11,2	9,5	8,8	:	15,1	14,6	1,9	9	:	3	3,8	8,5	4,1	5,5	7,3	12,2	10,9	8,4	6,8
	Females	:	11,2	11,6	:	8,1	6	11,1	8,3	7,3	16,7	21,1	12,9	15,4	:	13,6	11,7	4	7,8	:	5	5,4	12,2	6,3	5,3	7,5	13,1	12	8	5,3
2000	Total	8,7	8,6	6,9	16,4	8,7	4,3	7,2	12,8	4,2	11,2	11,1	9,1	10,1	4,9	13,7	16,4	2,3	6,4	6,7	2,8	3,6	16,1	4	7,2	6,7	18,8	9,8	5,6	5,5
	Males	7,5	7,4	5,6	16,7	7,3	3,9	6	13,8	4,3	7,4	7,9	7,6	7,8	3,2	14,4	18,6	1,8	7	6,4	2,2	3,1	14,4	3,2	7,8	6,5	18,9	9,1	5,9	6
	Females	10,1	10,2	8,5	16,2	10,3	4,8	8,7	11,8	4,2	17,1	16	10,9	13,6	7,2	12,9	14,1	3,1	5,6	7,4	3,6	4,3	18,1	4,9	6,4	7	18,6	10,6	5,3	4,9
2002	Total	8,9	8,7	7,5	18,1	7,3	4,6	8,2	10,3	4,5	10,3	11,1	8,7	8,6	3,6	12,2	13,5	2,7	5,8	7,5	2,8	4,2	19,9	5	8,4	6,3	18,7	9,1	4,9	5,1
	Males	8	7,8	6,7	18,9	5,9	4,3	7,1	10,8	4,7	6,8	8,1	7,8	6,7	2,9	13,3	14,2	2	6,2	6,6	2,5	4	19,1	4,1	9,1	5,9	18,6	9,1	5,3	5,6
	Females	10	10	8,6	17,3	9	5	9,4	9,7	4,1	15,6	15,7	9,8	11,5	4,5	11	12,8	3,7	5,4	9,3	3,1	4,4	20,9	6	7,7	6,8	18,7	9,1	4,6	4,5
2004	Total	9,1	9,1	8,4	12	8,3	5,5	9,5	9,7	4,5	10,5	10,6	9,6	8b	4,6	10,4	11,4	5,1	6,1	7,4	4,6	4,8b	19	6,7	8,1	6,3	18,2	8,8	6,3	4,7
	Males	8,2	8,1	7,5	12,5	7,1	5,1	8,7	10,4	4,9	6,6	8	8,7	6,4b	3,6	10,6	11	3,7	6,1	6,6	4,3	4,4b	18,2	5,8	9,1	5,8	17,4	8,7	6,5	5
	Females	10,1	10,2	9,5	11,5	9,9	6	10,5	8,9	4,1	16,2	14,3	10,6	10,5b	6	10,2	11,8	7,1	6,1	9	4,8	5,3b	19,9	7,6	6,9	6,8	19,2	8,9	6,1	4,2
2005	Total	8,7	8,8	8,4	10,1	7,9	4,8	9,5b	7,9	4,4	9,8	9,2	9,7	7,7	5,2	8,9	8,3	4,5	7,2	7,3	4,7	5,2	17,7	7,6	7,2	6,5	16,3	8,4	7,8p	4,8
	Males	7,9	7,9	7,6	10,3	6,5	4,4	8,8b	8,8	4,6	6,1	7	8,8	6,2	4,3	9,1	8,2	3,5	7	6,5	4,4	4,9	16,6	6,7	7,8	6,1	15,5	8,2	7,9p	5,1
	Females	9,7	9,8	9,5	9,8	9,8	5,3	10,3b	7,1	4,1	15,3	12,2	10,7	10,1	6,5	8,7	8,3	5,8	7,4	9	5,1	5,5	19,1	8,7	6,4	7	17,2	8,6	7,7p	4,3

Source: Eurostat - Harmonised unemployment series, Annual average

Context 2c: Youth unemployment rate (% of labour force aged 15-24)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	19,5	22,1	:	12,8	7,3	15	15,2	11,3	29,9	33,1	25,6	29,9	:	26,8	25,5	6,9	15	:	7,6	6,4	22,5	10,7	15,8	17,8	25,1	23,5	16,1	13,1
	Males	:	17,7	20,2	:	11,5	7,1	12,3	16,7	11,6	21,3	25,9	23,3	25,4	:	27,4	30,1	6,5	16,6	:	7,4	5	20,2	8,5	15,6	16,9	26,6	22,8	16,4	14,8
	Females	:	21,6	24,5	:	14,4	7,4	17,9	13,1	11	40,2	42,4	28,3	35,5	:	26	18,4	7,3	13	:	7,9	7,9	25,1	13,2	16,1	18,8	23,4	24,3	15,8	11,3
2000	Total	17,9	17,6	16,7	33,7	17,8	6,2	10,6	23,9	6,8	29,1	24,3	20,1	27	10,1	21,4	30,6	7,1	12,4	13,7	5,7	5,3	35,1	8,8	20	16,3	36,9	21,4	10,5	12,6
	Males	16,7	16,2	14,5	36,1	18,5	6,6	9,4	23,8	6,8	21,5	18,1	18	23,1	6,9	21,2	32,3	6,5	13,6	14,9	4,9	4,7	33,3	6,6	22,2	14,6	39,7	21,1	11	13,7
	Females	19,3	19,3	19,5	30,7	17	5,7	11,9	24,1	7	38,1	32,5	22,5	31,9	13	21,6	28,3	7,9	10,8	12,3	6,5	6	37,2	11,5	17,2	18,3	33,8	21,6	9,9	11,4
2002	Total	18,9	18,5	17,7	37	16,9	7,4	14,2	17,6	8,5	26,8	24,2	19,7	23,1	8,1	22	22,5	7,7	12,7	17,1	5	6,7	42,5	11,6	23,2	16,5	37,7	21	11,9	12
	Males	18,1	17,5	17,2	40,1	16,6	7,3	13	14,3	9,3	19,9	19,2	18,2	19,4	7,9	20,4	22,6	6,1	13,2	17,6	5,2	6,4	41,9	9,8	24,3	15	39,5	21,2	12	13,7
	Females	19,8	19,6	18,3	33,2	17,2	7,5	15,4	22,5	7,6	35,3	31,1	21,7	27,8	8,3	24,3	22,2	9,6	11,9	16,7	4,8	7,1	43,3	13,9	21,8	18,6	35,5	20,9	11,8	10,2
2004	Total	19,2	19	21,2	25,8	21	8,2	15	21,7	8,9	26,9	23,9	21,8	23,5b	10,5	18,1	22,7	16,8	15,5	16,8	8	9,4b	39,6	15,3	21,9	16,1	33,1	20,7	16,3	12,1
	Males	18,7	18,4	20,2	27	22,2	8,9	15,2	21,2	9,3	19,1	19,4	20,8	20,6b	9,4	16	22,5	12	16,2	16,3	7,9	9b	37,7	13,5	24,2	13,9	34,7	22	15,7	13,4
	Females	19,8	19,7	22,4	24,3	19,5	7,4	14,8	22,4	8,5	36,3	30,1	23	27,2b	11,6	21,3	22,9	22,3	14,4	17,4	8,1	9,8b	41,9	17,6	18,9	19,2	31	19,4	16,9	10,7
2005	Total	18,6	18,5	21,5	22,3	19,2	8,6	14,8b	15,9	8,7	26	19,7	22,7	24	13	13,6	15,7	13,7	19,4	16,4	8,2	10,3	36,9	16,1	20,2	15,9	30,1	20,1	22,6p	12,9
	Males	18,4	18,2	21	23,4	19,3	8,6	15,4b	16,6	9,2	18,7	16,7	21,3	21,5	11,9	11,8	15,9	11,7	19,6	16,8	8	10,5	35,7	13,6	21,6	14,5	31	20,6	23p	14,5
	Females	18,9	18,9	22,1	21	19,1	8,6	14,1b	14,9	8,1	34,8	23,5	24,4	27,4	14,2	16,2	15,3	16,2	19	16	8,4	10,1	38,3	19,1	18,4	17,8	28,8	19,5	22,1p	11,1

Source: Eurostat, Harmonised unemployment series - Annual average

Context 2d: Long-term unemployment rate by gender, selected years (% of the labour force 15+)

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
1998	Total	:	4,4	5,6	:	2	1,3	4,5	4,2	3,9	5,8	7,5	4,5	6,8	:	7,9	7,5	0,9	4,2	:	1,5	1,3	4,7	2,2	2,3	3,3	6,5	4,1	2,6	1,9
	Males	:	3,6	4,5	:	1,5	0,9	3,4	4,4	4,7	3,1	4,9	3,8	5,3	:	8,3	7,9	0,7	4,5	:	1,3	1	3,5	1,7	2,2	3,3	6	4,3	3,2	2,4
	Females	:	5,5	7,1	:	2,6	1,7	6	4,1	2,8	10	11,6	5,3	9,1	:	7,5	7	1,1	3,8	:	1,8	1,8	6,3	2,8	2,5	3,3	7,1	3,9	1,8	1,2
2000	Total	4,1	3,9	3,7	9,4	4,2	0,9	3,7	5,9	1,6	6,2	4,6	3,5	6,3	1,2	7,9	8	0,6	3,1	4,4	0,8	1	7,4	1,7	3,5	4,1	10,3	2,8	1,4	1,4
	Males	4,2	3,3	3	9,6	3,5	0,8	3	6,7	2	3,6	2,8	2,9	4,8	0,5	8,3	9,4	0,5	3,5	4,5	0,6	0,9	6	1,4	3,6	4,1	10,3	2,8	1,7	1,9
	Females	4	4,8	4,6	9,2	5,2	1,1	4,6	5	1	10,2	7,4	4,3	8,4	2,2	7,5	6,5	0,6	2,5	4,2	1	1,2	9,1	2	3,4	4,2	10,2	2,7	1	0,9
2002	Total	4,6	3,9	3,7	12	3,7	0,9	3,9	5,4	1,4	5,3	3,7	3,1	5,1	0,8	5,5	7,2	0,7	2,5	3,3	0,7	1,1	10,9	1,7	4	3,5	12,2	2,3	1	1,1
	Males	4,6	3,3	3,2	12,5	3	0,7	3,3	6,3	1,8	3,1	2,3	2,6	4	0,5	6,4	7,6	0,6	2,8	3,5	0,6	1	9,7	1,4	4,1	3,4	11,9	2,5	1,2	1,4
	Females	4,5	4,6	4,3	11,4	4,6	1	4,8	4,4	0,8	8,6	5,9	3,5	6,9	1	4,6	6,8	0,9	2,2	2,4	0,9	1,2	12,3	2,1	4	3,6	12,5	2	0,8	0,7
2004	Total	4	4,1	4,1	7,2	4,2	1,2	5,4	5	1,6	5,6	3,4	3,9	4b	1,2	4,6	5,8	1,1	2,7	3,4	1,6	1,3b	10,3	3	4,5	3,2	11,8	2,1	1,2	1
	Males	4,3	3,6	3,7	7,3	3,4	1,1	4,8	5,6	2	3	2,2	3,5	2,9b	0,9	4,8	5,5	0,8	2,8	3,7	1,5	1,3b	9,6	2,6	5,2	3,1	11,3	2,3	1,4	1,2
	Females	3,6	4,7	4,7	7	5,3	1,3	6,1	4,4	1	9,4	5,1	4,3	5,5b	1,6	4,3	6,2	1,4	2,6	3	1,6	1,4b	11	3,4	3,6	3,4	12,4	2	1	0,6
2005	Total	3,8	3,9	4,4	6	4,2	1,1	5b	4,2	1,5	5,1	2,2b	4	3,9	1,2	4,1	4,3	1,2	3,2	3,4	1,9	1,3	10,2	3,7	4,4	3,1	11,7	2,2	1,2p	1
	Males	3,9	3,5	3,8	6	3,4	1,1	4,7b	4,2	1,9	2,6	1,4b	3,5	2,9	0,8	4,4	4,2	1,2	3,2	3,4	1,9	1,2	9,3	3,2	4,7	2,9	11,2	2,4	1,4p	1,3
	Females	3,7	4,5	5	6	5,3	1,2	5,4b	4,2	0,8	8,9	3,4b	4,6	5,2	1,8	3,7	4,5	1,2	3,2	3,2	1,9	1,4	11,4	4,2	3,9	3,3	12,3	1,9	1p	0,7

Source : Eurostat - Labour Force Survey, Annual averages

Context 4: Old age dependency ratio (current and projected) - ratio between the total number of people aged 65 and over and the number of persons of working age (from 15 to 64)

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2005	24,9	26,3	24,9	19,8	22,6	27,8	24,1	16,5	26,8	24,5	25,3	29,4	17,7	24,1	22,5	21,2	22,8	19,2	20,7	23,6	18,7	25,2	21,1	21,7	16,3	23,7	26,4	24,4
2010	26,3	26,4	25,6	21,9	24,8	31	24,7	17,5	28	25,4	25,9	31,3	19,1	25,2	23,4	21,6	24,3	20,4	22,2	26,3	18,8	26,5	21,2	23,6	16,9	25,4	28	25,1
2020	32,1	32,2	33,0	31,8	31,2	35,1	28,7	22,5	32,5	30	33,2	36,6	25,5	28	26	24,7	31,2	30	29	30,3	27,1	31,5	25,1	30,8	23,5	37	34,4	30,3
2030	40,3	41,3	40,4	37,1	37,1	46	33,4	28,3	39,1	38,9	40,7	45,2	32,9	33,4	33,4	31,5	35,1	36	36,7	40,8	35,7	39	29,6	40,4	31,7	45	38,5	37,4
2040	48,5	47,2	48,8	43,8	42,1	54,6	36,6	35,9	49,8	54,3	46,9	59,8	36,1	37,4	39,3	36,7	40,3	35,9	41,6	50,4	39,7	48,9	39,6	47,7	38,1	46,1	41,5	43,8
2050	52,8	48,1	60,9	54,8	40	55,8	43,1	45,3	58,8	67,5	47,9	66	43,2	44,1	44,9	36,1	48,3	40,6	38,6	53,2	51	58,1	51,1	55,6	50,6	46,7	40,9	45,3

Source : Eurostat - EUROPOP2004 Trend scenario - baseline variant

Context 5a: Distribution of households by age and household type (private/institutional)

		EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Total	Total ('000)	441467	10296	7904	10230	5349	82277	1370	10628	40847	58514	3852	56996	690	2377	3484	440	10198	0	15986	8033	38230	10356	21681	1964	5379	5181	0	58789
	Private households (%)	98,7	98,6	99,3	99,3	98,7	99,0	98,8	96,6	99,4	97,8	98,4	99,3	99,4	99,0	99,3	98,3	97,5	-	98,6	98,9	98,9	99,0	98,5	99,3	98,4	98,1	-	98,2
	Institutional household (%	1,3	1,4	0,7	0,7	1,3	1,0	0,9	3,4	0,6	2,2	1,6	0,7	0,6	1,0	0,7	1,7	2,4	-	1,4	1,1	1,1	1,0	1,5	0,7	0,8	0,7	-	1,8
Children	Total ('000)	90525	2162	1531	2057	1161	15251	312	2011	7341	13426	1009	9833	180	541	846	98	2087	0	3532	1639	8851	2053	4847	376	1277	1135	0	13346
(0-17)	Private households (%)	99,4	99,9	97,9	99,8	99,4	99,7	99,2	97,8	99,9	99,2	99,6	99,9	99,9	99,4	99,3	99,0	96,9	-	99,7	99,7	99,2	99,5	98,3	:	98,3	99,1	-	99,3
	Institutional household (%	0,6	0,1	2,1	0,2	0,6	:	0,6	2,2	0,1	0,8	0,4	0,1	0,1	0,6	0,7	1,0	3,1	-	0,3	0,3	0,8	0,5	1,7	:	0,4	0,4	-	0,7
18-64	Total ('000)	279593	6390	5586	6759	3396	52516	852	6824	26547	35788	2420	36517	428	1485	2148	281	6565	0	10279	5152	24522	6610	15420	1299	3444	3269	0	36103
	Private households (%)	99,0	99,5	99,4	99,5	98,9	99,6	98,9	96,0	99,7	98,2	98,9	99,5	99,7	99,0	99,4	99,0	97,7	-	99,4	99,4	98,8	99,6	98,0	:	98,7	98,4	-	98,5
	Institutional household (%	1,0	0,5	0,6	0,5	1,1	:	0,9	4,0	0,3	1,8	1,1	0,5	0,3	1,0	0,6	1,0	2,2	-	0,6	0,6	1,2	0,4	2,0	:	0,6	0,3	-	1,5
65+	Total ('000)	71306	1744	1322	1411	792	14510	205	1792	6974	9299	423	10646	80	352	489	61	1546	0	2174	1242	4853	1693	3050	289	611	777	0	9341
	Private households (%)	96,4	93,9	99,6	97,7	96,7	96,3	98,1	97,5	97,7	94,3	92,8	97,9	96,4	98,7	98,9	93,7	97,5	-	93,5	95,8	98,8	96,4	99,6	:	97,0	95,1	-	95,4
	Institutional household (%	3,6	6,1	0,4	2,3	3,3	:	1,7	2,5	2,3	5,7	7,2	2,1	3,6	1,3	1,1	6,3	2,5	-	6,5	4,2	1,2	3,6	0,4	:	2,7	3,1	-	4,6
75+	Total ('000)	30917	774	481	570	379	6191	75	642	3036	4133	184	4762	34	126	178	25	619	0	972	582	1841	701	1063	110	238	340	0	4405
	Private households (%)	93,3	88,4	99,3	95,7	94,2	92,5	96,9	96,7	96,1	89,5	87,6	96,5	92,7	98,1	98,3	87,0	95,8	-	87,2	92,4	98,1	93,1	99,4	88,4	95,4	90,8	-	91,5
	Institutional household (%	6,7	11,5	0,7	4,3	5,8	7,5	2,9	3,3	3,9	10,5	12,4	3,5	7,3	1,9	1,7	13,0	4,2	-	12,8	7,6	1,9	6,9	0,6	5,3	4,2	6,0	-	8,5
	Hospitals (%)	19,9	5,3	14,0	4,9	:	:	3,6	20,4	12,5	13,8	27,8	1,5	5,8	2,0	5,2	9,8	11,8	-	20,8	19,4	18,5	3,3	30,7	:	13,3	27,9	-	44,6
	Old people's homes (%)	68,0	85,1	83,8	86,3	:	:	95,4	34,3	56,6	79,5	56,4	73,2	91,0	97,7	89,1	69,2	83,4	-	75,9	76,3	65,8	85,8	59,4	:	75,1	58,5	-	46,0

Source: Eurostat Census data collection 2000-01

Context 5b: Population living in private households by household type, 2005 (percentage of total population)

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
- Single adults, no children	14,6	12,5		10,3	14,9	17,2	9,7	9,9	5,8	13,1	7,6	11,4	5,1	7,8	8,5	7,7	9,7	4,2	14,1	14,9	0,0	5,9	9,1	5,5	15,7	:	13,5
of which:																										:	
- Single men	6,1	5,4		3,8	7,7	7,3	3,9	3,7	2,4	5,3	3,4	4,4	1,6	2,8	2,4	3,2	3,0	1,6	6,4	6,3	0,0	2,0	3,1	1,6	6,9	:	6,0
- Single women	8,5	7,1		6,5	7,2	9,8	5,8	6,1	3,4	7,8	4,2	7,1	3,5	4,9	6,2	4,5	6,7	2,6	7,8	8,6	0,0	4,0	6,0	3,9	8,9	:	7,5
																										:	
- Under 65	8,8	7,7		5,3	12,0	10,6	6,7	5,4	2,7	7,8	4,1	5,2	2,8	4,5	3,6	4,3	4,4	1,6	9,3	9,6	0,0	2,4	4,2	2,3	12,0	:	7,9
- 65 and over	5,9	4,8		5,0	2,9	6,5	3,0	4,5	3,0	5,2	3,6	6,3	2,2	3,3	4,9	3,4	5,3	2,6	4,9	5,3	0,0	3,5	4,9	3,2	3,7	:	5,6
- Single parents	4,5	6,6		4,6	4,9	4,4	6,4	1,6	1,9	5,3	3,4	2,0	2,1	4,8	4,2	3,3	3,8	1,8	3,5	3,8	0,0	2,5	2,3	2,4	2,4	:	8,4
- 2 adults below 65, no children	14,4	14,1		13,6	21,7	16,9	11,5	10,3	9,2	14,7	11,4	9,1	10,3	9,6	6,8	12,1	11,5	7,1	18,6	13,8	0,0	8,4	8,9	7,3	17,8	:	16,7
- 2 adults, at least one aged 65+, no children	11,5	11,3		9,6	9,7	12,9	11,0	12,5	9,3	10,9	6,6	11,0	9,5	9,2	7,2	9,7	9,4	8,3	9,7	9,2	0,0	10,3	8,8	7,1	10,3	:	10,6
- 3 or more adults, no children	14,9	10,3		13,5	6,3	9,7	11,6	20,0	23,0	7,2	25,8	19,2	15,5	17,4	11,7	9,3	14,6	21,3	10,9	14,1	0,0	19,8	21,7	17,4	13,0	:	11,3
- 2 adults, 1 child	12,4	10,5		12,5	10,2	11,5	14,3	11,2	12,2	12,4	6,8	13,3	10,6	11,0	10,7	12,6	11,4	10,1	9,2	11,0	0,0	16,7	10,9	8,7	9,6	:	9,6
- 2 adults, 2 children	17,1	16,9		20,0	17,8	14,3	16,1	18,6	17,3	18,9	10,8	17,2	16,8	10,8	15,4	23,0	15,8	18,4	16,6	14,2	0,0	15,7	17,0	15,9	13,2	:	13,8
- 2 adults, 3 or more children	7,4	10,0		5,5	8,2	6,1	5,5	5,4	4,1	11,0	9,9	5,2	12,3	4,9	5,8	12,5	8,1	8,5	8,3	5,9	0,0	4,0	5,0	8,7	9,0	:	7,7
- 3 or more adults, with children	12,4	7,8		10,4	6,4	7,0	13,8	10,5	17,2	6,5	17,6	11,7	17,9	24,6	29,6	9,7	15,6	20,2	9,1	13,2	0,0	16,7	16,3	27,1	9,0	:	8,4

EU aggregates based on available country data

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for DK and FI.

Context 6a: General government debt - General government consolidated gross debt as a percentage of GDP

	EUR-25	BE	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
2000	62	107,7	18,5	51,7	59,7	5,2	37,8	111,6	59,2	56,7	109,1	59,5	12,3	23,7	6,4	53,4	55,4	53,8	65,5	35,9	50,4	27,6	50,2	43,8	52,3	41,2
2001	61,1	106,3	25,1	47,4	58,8	4,8	35,5	113,2	55,5	56,2	108,7	61,4	14	22,8	6,5	50,7	61,3	50,7	66	35,9	52,9	28,3	48,9	42,3	53,8	38
2002	60,5	103,3	28,5	46,8	60,3	5,6	32,2	110,7	52,5	58,2	105,6	64,7	13,5	22,2	6,5	55,6	60,1	50,5	65,8	39,8	55,5	29,1	43,3	41,3	52	37,5
2003	62	98,6	30,1	44,4	63,9	5,7	31,1	107,8	48,7	62,4	104,3	69,1	14,4	21,2	6,3	58	70,2	52	64,6	43,9	57	28,5	42,7	44,3	51,8	38,9
2004	62,4	94,3	30,7	42,6	65,7	5,2	29,7	108,5	46,2	64,4	103,9	70,3	14,5	19,4	6,6	59,4	74,9	52,6	63,8	41,8	58,6	28,7	41,6	44,3	50,5	40,4
2005	63,3	93,2	30,4	35,9	67,9	4,5	27,4	107,5	43,1	66,6	106,6	69,2	12,1	18,7	6	61,7	74,2	52,7	63,4	42	64	28	34,5	41,3	50,4	42,4
2006	*62,2*	*89,4*	*30,9*	*28,5*	*67,8*	*4*	*25,8*	*104,8*	*39,7*	*64,7*	*107,2*	*64,8*	*11,1*	*18,9*	*7,4*	*67,6*	*69,6*	*50,5*	*62,1*	*42,4*	*67,4*	*28,4*	*33*	*38,8*	*46,7*	*43,2*
2007	*61,1*	*86,3*	*30,8*	*24,5*	*67,7*	*2,7*	*24,4*	*101*	*37*	*63,9*	*105,9*	*62,2*	*10,6*	*19,6*	*7,3*	*70,9*	*69*	*47,8*	*60,9*	*43,1*	*69,4*	*28*	*31,6*	*37,3*	*42,6*	*44,1*
2008	*60,1*	*83,2*	*31*	*22*	*67,3*	*2,1*	*23,6*	*96,4*	*34,7*	*63,3*	*105,7*	*59,6*	*10,3*	*19,8*	*7,1*	*72,7*	*68,6*	*45,4*	*59,8*	*42,7*	*70,7*	*27,6*	*31*	*35,8*	*38,7*	*44,7*

Source: Eurostat - General Government data (2000 to 2005) and ECFIN forecasts (2006-2008)
http://ec.europa.eu/economy_finance/indicators/general_government_data/government_data_en.htm

Context 6b: Projected evolution of debt levels up to 2050 (in % of GDP)
http://ec.europa.eu/economy_finance/publications/european_economy/2006/ee306_en.pdf p.60

Programme scenario

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
2005	-	94.3	:	37.4	36.8	67.3	4.6	28.0	107.9	43.1	65.8	108.5	70.5	13.1	19.2	6.4	57.7	76.7	54.4	63.4	42.5	65.5	:	29.0	33.7	42.7	50.9	43.3
2010	-	75.3	:	39.6	21.5	65.6	2.5	24.6	91.0	31.5	61.1	99.1	51.5	11.7	18.0	8.9	62.5	60.6	50.0	54.9	51.3	64.4	:	28.4	35.9	37.3	39.0	44.4
2030	-	36.1	:	79.0	-15.1	57.9	-28.2	36.7	122.0	9.6	64.2	51.4	70.6	-0.4	19.9	20.9	76.0	-1.8	88.6	15.0	6.2	89.2	:	76.3	48.1	38.8	9.6	54.0
2050	-	63.5	:	280.2	-37.3	99.4	-93.2	156.2	346.0	95.8	121.2	30.7	189.5	11.1	69.8	109.7	119.3	-106.3	218.1	-21.2	-76.3	262.5	:	302.7	130.4	117.3	52.0	110.3
2005 budget scenario																												
2010	-	73.4	:	43.2	14.4	73.6	0.9	13.6	96.9	25.7	69.2	108.9	64.3	13.0	22.4	11.5	76.1	80.2	44.2	58.9	53.2	76.3	:	25.1	38.7	23.7	30.3	47.0
2030	-	33.6	:	95.7	-61.2	116.2	-39.3	7.9	165.2	-13.5	132.8	127.6	116.3	14.9	46.7	56.1	143.6	92.9	67.8	54.9	20.0	195.4	:	68.5	66.8	7.9	8.0	90.1
2050	-	60.2	:	320.3	-135.5	232.4	-117.0	100.4	451.3	42.6	269.9	208.9	269.9	49.6	135.7	179.1	247.6	79.6	177.7	67.5	-42.5	517.4	:	287.2	176.9	61.6	58.8	186.7

* Adjusted gross debt.

Source: Commission services, 2005/06 updated stability and convergence programmes.

Context 7a: Social protection benefits by group of functions (as a percentage of total benefits) - 2004

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Old age and survivors benefits	45,9e	44,1	:	41,1p	37,2	43,5p	43,7	43,6p	23,3	50,9	43,7p	61,3p	48,3	50p	47,3p	36,5p	42,5	51,2	41,6p	48,2	60,1p	47,2p	:	44,7p	40,1p	36,9	40,1p	44,6e
Sickness, health care	28,3e	27,7	:	35,3p	20,6	27,2p	31,5	30p	42,1	26,5	30,8p	25,9p	24,1	24,5p	29,5p	25p	29,5	27	30,4p	25	19,5p	30,4p	:	32,7p	30,1p	25,5	25,4p	30,4e
Disability	8,1e	6,8	:	7,9p	13,9	7,7p	9,1	5,8p	5,3	5	7,5p	6,1p	4,3	9,8p	10,2p	13,5p	10,3	6,7	10,9p	8,3	11,5p	10,4p	:	8,1p	9,6p	13,2	14,8p	9,2e
Unemployment	6,5e	12,5	:	3,9p	9,5	8,6p	1,6	7,8p	8,3	5,9	12,9p	2p	4,9	3,4p	1,6p	4,7p	2,9	6,9	6,3p	6	3,5p	5,7p	:	3,1p	6,2p	9,8	6,2p	2,6e
Family and children	7,8e	7,1	:	8,4p	13	10,5p	12,7	8,5p	15,5	6,9	3,5p	4,4p	11,4	10,5p	8,8p	17,4p	12,1	5,2	4,8p	10,7	4,6p	5,3p	:	8,6p	10,7p	11,5	9,6p	6,7e
Housing and social exclusion n.e.c.	3,4e	1,8	:	3,4p	5,8	2,5p	1,5	4,4p	5,5	4,7	1,7p	0,3p	6,9	1,8p	2,6p	2,9p	2,6	2,9	6p	1,8	0,8p	1p	:	2,8p	3,3p	3,1	3,9p	6,4e

e: Eurostat estimate; p: provisional

Context 7b: Social protection benefits by group of functions (as a percentage of GDP) - 2004

	EU	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
Total	**26,2e**	**27,9**	**:**	**18,9p**	**29,7**	**28,4p**	**13,3**	**16,3**	**25,2**	**19,5p**	**29,4p**	**25,1p**	**17,6**	**12,2p**	**12,8p**	**22p**	**20,3**	**18,5**	**26,7p**	**28,2**	**19,7p**	**23,2p**	**:**	**23,7p**	**16,5p**	**25,9**	**31,6p**	**25,8e**
Old age and survivors	12e	12,3	:	7,8p	11,1	12,4p	5,8	3,8	12,8	8,5p	12,8p	15,4p	8,5	6,1p	6,1p	8,1p	8,6	9,5	11,1p	13,6	11,8p	11p	:	10,6p	6,6p	9,6	12,7p	11,5e
Sickness/Health care	7,4e	7,7	:	6,7p	6,1	7,7p	4,2	6,9	6,7	6p	8,8p	6,5p	4,2	3p	3,8p	5,5p	6	5	8,1p	7,1	3,8p	7,1p	:	7,8p	5p	6,6	8p	7,8e
Disability	2,1e	1,9	:	1,5p	4,1	2,2p	1,2	0,9	1,3	1,5p	1,7p	1,5p	0,8	1,2p	1,3p	3p	2,1	1,2	2,9p	2,3	2,3p	2,4p	:	1,9p	1,6p	3,4	4,7p	2,4e
Unemployment	1,7e	3,5	:	0,7p	2,8	2,4p	0,2	1,3	1,5	2,5p	2,3p	0,5p	0,9	0,4p	0,2p	1p	0,6	1,3	1,7p	1,7	0,7p	1,3p	:	0,7p	1p	2,5	2p	0,7e
Family/Children	2,1e	2	:	1,6p	3,9	3p	1,7	2,5	1,7	0,7p	2,5p	1,1p	2	1,3p	1,1p	3,8p	2,5	1	1,3p	3	0,9p	1,2p	:	2p	1,8p	3	3p	1,7e
Housing and Social exclusion n.e.c.	0,9e	0,5	:	0,6p	1,7	0,7p	0,2	0,9	1,2	0,3p	1,3p	0,1p	1,2	0,2p	0,3p	0,6p	0,5	0,5	1,6p	0,5	0,2p	0,2p	:	0,7p	0,5p	0,8	1,2p	1,7e

e: Eurostat estimate; p: provisional

Context 8a: Adults aged 18-59 living in jobless households by household types, 2005, in % of total number of adults living in jobless households

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone without children	25,9	30,5	:	23,8	:	38,4	24,8	19,1	12,4	27,7	:	17,6	17,4	21,4	17,8	29,8	15,9	7,3	40,6	35,5	16,0	13,6	:	31,2	9,7	47,7	:	27,9
Alone with child(ren)	9,7	13,2	:	11,6	:	10,4	13,1	3,2	4,5	9,8	:	3,2	8,5	9,0	8,1	7,0	6,0	7,2	11,3	5,4	3,8	5,8	:	4,7	4,2	4,1	:	24,1
Couple without children	21,2	23,9	:	25,1	:	17,8	12,9	27,2	14,4	27,0	:	18,4	29,1	12,5	10,3	39,0	21,6	22,3	26,4	26,8	28,5	20,8	:	27,3	16,6	26,1	:	16,3
Couple with child(ren)	14,6	12,6	:	13,9	:	13,8	11,7	12,0	18,8	18,0	:	15,2	15,8	11,3	14,0	11,4	20,7	24,2	14,4	13,9	9,0	14,1	:	7,0	16,7	11,5	:	15,5
Other households without childr	21,6	14,2	:	18,7	:	14,4	29,8	32,4	38,6	12,6	:	36,1	24,4	33,8	31,0	10,3	22,8	29,3	6,0	13,2	34,6	35,0	:	24,8	25,1	10,0	:	11,7
- without elderly (65+)	11,1	8,6	:	8,2	:	9,2	10,6	13,4	13,9	6,6	:	17,2	12,5	14,5	8,4	5,0	9,8	13,8	3,8	6,0	19,5	14,6	:	8,5	12,6	4,3	:	6,9
- with at least 1 elderly (65+)	10,6	5,6	:	10,5	:	5,2	19,2	19,0	24,7	5,9	:	18,9	11,9	19,3	22,7	5,3	13,0	15,5	2,1	7,2	15,0	20,4	:	16,3	12,5	5,7	:	4,8
Other households with child(ren)	6,9	5,6	:	6,9	:	5,2	7,8	6,1	11,4	5,0	:	9,4	4,7	12,1	18,9	2,5	12,9	9,7	1,3	5,1	8,1	10,7	:	5,0	27,8	0,7	:	4,5
- without elderly (65+)	5,4	5,0	:	5,7	:	4,8	5,1	3,1	7,1	4,2	:	7,3	3,2	4,2	8,4	1,7	10,5	5,4	1,1	3,7	6,1	7,0	:	4,5	22,4	0,5	:	3,5
- with at least 1 elderly (65+)	1,5	0,6	:	1,1	:	0,4	2,7	3,0	4,2	0,8	:	2,1	1,6	7,9	10,5	0,8	2,4	4,3	0,2	1,5	2,0	3,8	:	0,5	5,4	0,2	:	1,0
Total number in 1000	24.629,2	758,2	:	443,6	:	5.023,3	61,2	490,2	1.636,2	3.403,3	:	3.004,9	20,9	102,2	120,8	16,3	679,4	18,3	733,6	395,7	3.202,6	315,7	:	78,9	322,6	306,5	:	3.494,8

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for FI.

Context 8b: Children aged 0-17 living in jobless households by household types, 2005, in % of total number of children living in jobless households

	EU25	BE	BG	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Alone with child(ren) - no elderl	41,3	55,5	:	47,9	:	48,6	48,3	25,7	25,2	43,3	:	20,4	41,7	34,7	32,5	60,3	22,8	38,5	52,1	33,3	:	28,4	:	42,4	12,3	35,3	:	66,7
Alone with child(ren) - at least 1	0,3	0,6	:	0,4	:	0,2	4,0	0,3	0,6	0,3	:	0,3	1,0	0,0	2,4	0,0	0,1	0,0	0,2	1,0	:	1,3	:	0,0	0,0	0,1	:	0,4
Couple with child(ren) - total	34,9	32,6	:	38,9	:	39,0	33,6	56,3	51,8	47,4	:	59,2	43,6	27,0	32,1	36,1	51,3	42,3	44,4	54,3	:	46,9	:	36,4	41,7	62,3	:	26,0
- without elderly (65+)	33,9	31,4	:	38,7	:	38,2	33,6	51,4	48,5	46,1	:	57,5	42,4	27,0	31,5	35,4	50,8	38,7	43,3	53,5	:	40,7	:	32,9	40,9	62,0	:	25,1
- with at least 1 elderly (65+)	1,0	1,2	:	0,2	:	0,7	0,0	4,9	3,2	1,3	:	1,6	1,2	0,0	0,6	0,7	0,5	3,6	1,1	0,8	:	6,2	:	3,5	0,8	0,3	:	0,8
Other households with child(ren)	7,8	10,0	:	9,9	:	10,8	8,4	5,6	10,4	6,5	:	11,9	7,9	18,7	14,8	2,1	20,1	8,8	2,6	6,9	:	12,3	:	19,3	36,7	1,6	:	4,9
- without elderly (65+)	7,8	10,0	:	9,9	:	10,8	8,3	5,4	10,3	6,5	:	11,8	7,8	18,5	14,6	2,1	20,1	8,7	2,6	6,9	:	12,2	:	19,3	36,6	1,6	:	4,9
- with at least 1 elderly (65+)	0,0	0,0	:	0,0	:	0,0	0,1	0,1	0,1	0,0	:	0,1	0,1	0,2	0,2	0,0	0,1	0,1	0,0	0,0	:	0,1	:	0,0	0,1	0,0	:	0,0
Total number in 1000	8510,94	278,6	:	149,74	947,2	1579,9	24,581	75,568	396,62	1262,5	123,69	545,12	6,2511	34,278	42,297	2,6934	265,85	8,387	248,19	98,13	:	81,444	:	9,4717	159,55	70,899	:	2100

Source : Eurostat - European Labour Force Survey 2005, Spring results. Annual averages for FI.

Context 9.a Unemployment traps, 2004

For unemployed persons (previous work at 67% of APW, full-time) returning to full-time work at 2 different wage levels. Including social assistance where applicable.

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of APW	50	67	50	67	50	67	50	67
Belgium	96%	88%	83%	79%	82%	76%	81%	77%
Czech Republic	79%	65%	71%	69%	97%	78%	78%	65%
Denmark	105%	89%	98%	89%	86%	89%	103%	92%
Germany	100%	87%	100%	93%	100%	84%	114%	98%
Greece	96%	76%	106%	83%	106%	83%	70%	56%
Spain	97%	80%	100%	79%	100%	78%	100%	81%
France	100%	82%	100%	90%	99%	90%	101%	82%
Ireland	88%	73%	-3%	12%	94%	87%	59%	52%
Italy	67%	59%	63%	54%	63%	52%	84%	74%
Luxembourg	99%	85%	103%	88%	103%	104%	100%	82%
Hungary	77%	66%	86%	68%	86%	68%	80%	63%
Netherlands	93%	87%	90%	85%	92%	88%	86%	76%
Austria	87%	73%	98%	81%	100%	96%	88%	75%
Poland	99%	83%	83%	73%	100%	95%	85%	78%
Portugal	110%	87%	95%	97%	82%	82%	110%	85%
Finland	88%	80%	92%	86%	92%	94%	89%	76%
Slovak Republic	56%	43%	45%	34%	46%	31%	62%	47%
Sweden	105%	87%	103%	91%	100%	100%	105%	87%
United Kingdom	78%	71%	55%	64%	67%	73%	70%	61%

1 The wage level of the second earner is fixed at 67% of the APW.

Context 9b. Inactivity Trap at 67% of APW,

with and without childcare costs,

Lone parents and two-earner couples with two children, in percent

	Lone Parents with two children, no childcare	Lone Parents with two children, with childcare	Two-earner Couple with 2 chdren, no childcare	Two-earner Couple with 2 children, with childcare
Austria 2001	82%	95%	24%	62%
Belgium 2002	76%	82%	50%	64%
Denmark 2001	88%	93%	69%	90%
Finland 2001	78%	81%	55%	80%
France 2002	99%	112%	24%	59%
Germany 2001	85%	88%	50%	59%
Greece 2001	16%	21%	16%	27%
Hungary 2001	49%	67%	62%	80%
Ireland 2001	54%	131%	24%	106%
Netherlands 2001	80%	85%	33%	58%
Portugal 2001	70%	95%	17%	82%
Slovak Republic 2001	123%	141%	64%	121%
Sweden 2002	59%	64%	28%	42%
United Kingdom 2002	59%	84%	25%	89%

Transition for lone parent is from non-UB recipient to full-time employment at 67% of APW. Transition for married couple is from a family with one full-time earner employed at 67% of APW to two full-time earners, each at 67% of APW. Both family types are assumed to have two children, **aged 2 and 3**, and are assumed to use full-time childcare after transition. Childcare in public or publicly sanctioned facilities, where applicable.

Calculations for Finland, Hungary, and the Slovak

Source: Joint Commission -OECD project using tax-benefit Models

Context 9c. Inactivity traps

For inactive persons entering work at 2 different wage levels [1], 2004

	Single person, no children		Lone parent		One-earner couple, 2 children				Two-earner couple, 2 children			
moving to % of APW	50		67		50		67		50		67	
Belgium	66%		66%		75%		73%		70%	*66%*	67%	*66%*	38%		45%
Czech Republic	66%		56%		71%		69%		97%		78%		44%		39%
Denmark	103%		88%		90%		84%		90%	*95%*	92%		63%	*95%*	61%
Germany	89%		79%		90%		85%		90%		76%		49%		49%
Greece	16%		16%		16%		16%		16%		16%		16%		16%
Spain	47%		42%		63%		52%		69%		54%		16%		19%
France	80%		67%		87%	*58%*	81%		100%	*55%*	90%		28%	*54%*	27%
Ireland	88%		73%		-3%		12%		94%	*45%*	87%		30%		30%
Italy	14%		19%		-10%		0%		-17%	*0%*	-8%		39%	*-4%*	41%
Luxembourg	89%		76%		85%		83%		75%		84%		48%		40%
Hungary	51%		47%		51%		42%		51%		42%		13%		13%
Netherlands	93%		87%		83%		79%		93%		89%		40%		42%
Austria	87%		73%		98%		81%		100%		96%		22%		25%
Poland	70%		61%		54%		51%		100%		95%		47%		50%
Portugal	54%		45%		56%		55%		74%		70%		63%		50%
Finland	81%		75%		62%		63%		92%		94%		35%		36%
Slovak Republic	27%		28%		37%		35%		52%		42%		20%		22%
Sweden	98%		83%		68%		65%		100%		100%		37%		36%
United Kingdom	78%		71%		55%	*79%*	64%		67%	*57%*	73%	*65%*	60%	*70%*	53%

1 In Italics are indicated values of the METR for entering half time work when they differ from the METR for full-time work at 50%

Context 9d. Low wage traps - 2004

METR as wage increases by 33% of the APW wage level from two starting low wages

	from 33 to 67% of APW				*from 67 to 100% of APW*			
Income ranges:	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children	Single person, no children	Lone parent	One-earner couple, 2 children	Two-earner couple, 2 children
Belgium	58%	57%	43%	59%	57%	57%	50%	55%
Czech Republic	33%	39%	57%	30%	28%	52%	54%	34%
Denmark	81%	72%	89%	58%	52%	62%	59%	43%
Germany	75%	86%	69%	50%	53%	52%	51%	52%
Greece	16%	16%	16%	16%	18%	16%	16%	16%
Spain	24%	18%	15%	19%	29%	26%	24%	29%
France	37%	59%	75%	22%	40%	40%	40%	32%
Ireland	47%	53%	74%	25%	30%	84%	48%	30%
Italy	29%	0%	-12%	50%	42%	52%	60%	47%
Luxembourg	74%	94%	110%	14%	33%	14%	67%	20%
Hungary	32%	20%	20%	13%	39%	28%	28%	39%
Netherlands	76%	59%	79%	37%	47%	60%	64%	48%
Austria	47%	63%	92%	33%	45%	45%	45%	45%
Poland	65%	41%	91%	56%	35%	115%	47%	35%
Portugal	15%	92%	82%	12%	24%	20%	91%	23%
Finland	62%	60%	100%	32%	43%	59%	68%	43%
Slovak Republic	22%	25%	39%	31%	30%	29%	14%	30%
Sweden	66%	45%	100%	33%	36%	57%	52%	36%
United Kingdom	62%	77%	76%	51%	33%	73%	79%	33%

Context 10: Net income of social assistance recipients as % of the at-risk of poverty rate threshold for 3 jobless households types

	HU	PT	ES	CZ	BE	LU	FR	AT	PL	SE	UK	FI	DE	IE	DK	NL
Single person	35,0	42,7	57,3	66,6	76,6	76,8	78,6	84,0	88,5	93,6	97,3	98,3	103,2	104,8	118,2	118,7
Lone parent, 2 children	40,9	73,0	57,7	89,1	89,9	76,1	81,7	89,6	100,6	82,9	104,3	96,0	99,3	93,2	121,3	101,3
Married couple, 2 children	29,1	76,0	48,1	85,9	68,5	74,4	69,9	79,2	103,5	76,4	90,5	88,2	80,7	90,0	91,8	81,5

Source : Joint EC-OECD project using OECD tax-benefit models, and Eurostat (see Chapter I and Annex I).

Context 11: At-risk-of-poverty rate before social transfers by gender and selected age group (income reference year 2004)

Before all social transfers except old-age/survivors' pensions

	EU27	EU25	BE	BG*	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO*	SI	SK	FI	SE	UK
Total population		26	28	:	21b	31	30	24b	24	32	23	24	26	24	22b	26b	26b	23	29pb	21b	22b	24	30b	26	:	:	22b	28	29	:
Children aged 0-17 years		34	33	:	34b	26	27	31b	31	40	23	29	34	31	20b	31b	34b	35	44pb	30b	28b	36	39b	32	:	:	30b	31	35	:
People a Total		24	26	:	18b	32	30	22b	22	30	23	23	24	22	22b	25b	24b	20	26pb	18b	20b	21	27b	25	:	:	20b	27	27	:
Men		23	25	:	17b	31	29	20b	20	27	21	21	23	20	20b	22b	23b	20	26pb	17b	20b	20	29b	24	:	:	19b	26	24	:
Women		25	28	:	20b	33	32	24b	24	32	24	25	25	24	24b	26b	25b	20	25pb	19b	20b	23	26b	25	:	:	20b	29	29	:
People a Total		25	27	:	20b	29	29	24b	23	28	20	21	25	21	17b	25b	25b	22	30pb	18b	22b	23	31b	24	:	:	22b	27	28	:
Men		23	25	:	19b	28	28	22b	22	25	19	20	24	20	15b	24b	25b	22	30pb	17b	21b	22	32b	23	:	:	21b	27	27	:
Women		25	28	:	21b	31	31	26b	23	29	21	22	25	22	18b	24b	24b	23	29pb	19b	23b	23	30b	24	:	:	22b	27	29	:
People a Total		23	25	:	11b	43	35	17b	22	44	32	32	21	25	54b	27b	20b	10	11pb	21b	10b	16	11b	30	:	:	12b	27	23	:
Men		20	24	:	7b	45	37	14b	11	38	29	29	19	21	51b	15b	8b	12	7pb	20b	10b	11	8b	30	:	:	8b	19	13	:
Women		26	26	:	14b	41	33	19b	28	48	35	35	22	28	57b	32b	26b	9	14pb	21b	10b	20	13b	30	:	:	15b	32	30	:
Before all social transfers including old-age/survivors' pensions																														
Total population		43	42	:	39b	39	39	44b	39	40	39	39	45	43	29b	40b	42b	40	50pb	36b	37b	43	51b	42	:	:	40b	40	42	:
Children aged 0-17 years		36	34	:	35b	26	27	32b	34	41	25	32	36	34	21b	35b	38b	38	48pb	33b	28b	39	46b	35	:	:	35b	32	36	:
People aged 18 + Total		45	44	:	40b	42	42	46b	40	39	42	40	47	45	32b	42b	43b	41	50pb	37b	39b	44	52b	43	:	:	42b	43	44	:
Men		42	40	:	36b	39	39	44b	36	36	40	37	44	41	29b	38b	40b	38	48pb	34b	36b	40	51b	41	:	:	38b	40	40	:
Women		48	47	:	43b	46	45	49b	43	42	45	43	50	49	34b	44b	46b	43	53pb	39b	43b	48	54b	45	:	:	45b	46	47	:
People aged 18-64 Total		33	32	:	30b	30	30	33b	29	30	31	29	35	33	22b	32b	33b	31	41pb	27b	28b	33	45b	33	:	:	33b	31	30	:
Men		31	29	:	27b	28	28	29b	28	28	29	27	33	31	20b	31b	33b	29	40pb	25b	25b	30	45b	31	:	:	30b	30	28	:
Women		35	35	:	32b	32	32	36b	30	33	32	31	36	36	24b	33b	33b	33	42pb	30b	30b	36	45b	34	:	:	35b	31	32	:
People aged 65 + Total		90	92	:	88b	94	93	92b	83	88	83	83	96	85	88b	79b	86b	87	90pb	79b	95b	87	88b	82	:	:	91b	92	94	:
Men		89	92	:	91b	92	90	91b	83	87	81	84	96	83	87b	78b	85b	88	90pb	79b	95b	86	88b	83	:	:	88b	89	90	:
Women		90	91	:	87b	96	96	92b	83	88	85	83	95	86	88b	79b	87b	86	90pb	79b	95b	87	88b	82	:	:	93b	94	97	:

1) Including imputed rent. See methodological note for an explanation

Source: SILC(2005) Income data 2004; except for UK, income year 2005; * BG National HBS 2004, income data 2004 and RO National HBS 2005, income data 2005.

p = provisional. s = estimated by Eurostat. u = result based on small sample (20-49 observations)

Context 12: Theoretical replacement rates (see point 3.3 of the report)

Additional table: Employment gap of migrants

1. Employment rate gap by country of birth, 2005, annual averages

2005	Employment rate gap between persons born in country and …			Employment rates by country of birth (age group 15-64)			Distribution of the population aged 15-64 (by country of birth)		
	...born outside the country	...born in another EU25 country	...born outside the EU25	Born in the country	Born in another EU25 country (1)	Born outside the EU25 (1)	Born in the country	Born in another EU25 country	Born outside the EU25
BE	12,5	5,2	18,5	62,7	57,5	44,2	87,1	5,8	7,1
BG	17.1u		15.1u	55,8	0,0	40,7 u	99,8		0,2
CZ	3,4	5,9	-2,4	64,9	59,0	67,2	98,1	1,4	0,6
DK	13,6	4,6	16,8	76,9	72,2	60,1	93,1	1,8	5,1
DE	14,2	1,9	20,2	66,9	65,0	46,7	89,5	3,4	7,0
EE	-5,3	-0,4	-5,6	63,7	64,1	69,3	85,6	0,9	13,5
IE	-1,7	-5,7	7,7	66,9	72,7	59,3	88,7	7,9	3,4
EL	-6,4	4,6	-8,3	59,6	55,0	67,9	92,0	1,2	6,9
ES	-6,8	-1,7	-7,8	62,5	64,2	70,2	88,0	1,9	10,1
FR	7,9	0,5	10,6	64,1	63,5	53,5	88,3	3,1	8,5
IT				0,0	0,0	0,0			
CY	-2,2	10,7	-7,7	68,1	57,4	75,8	82,9	5,1	12,0
LV	-4,2	6,7	-5,6	62,8	56,1	68,4	88,0	1,4	10,7
LT	-5,1		-6,2	62,4	0,0	68,7	96,3	0,2 u	3,5
LU	-9,4	-10,9	-0,1	59,8	70,7	60,0	59,7	34,6	5,8
HU	-5,8	3,7	-7,7	56,8	53,1	64,5	98,2	0,3	1,5
MT	-4,1	4.8u	-8,3	53,7	48,9 u	61,9	95,3	1,5	3,2
NL	14,5	5,0	16,7	75,2	70,2	58,5	86,9	2,5	10,7
AT	7,7	4,5	8,9	69,9	65,3	61,0	83,7	4,7	11,5
PL	22,9	23,2	22,8	52,9	29,8	30,1	99,4	0,3	0,4
PT	-5,4	2,0	-7,4	67,1	65,1	74,5	92,9	1,5	5,6
RO				0,0	0,0	0,0			
SI	-1,3	6,4	-2,0	65,9	59,4	67,9	92,1	0,6	7,2
SK	6,4	8,8	-3,8	57,8	49,0	61,6	99,1	0,7	0,2
FI	11,7	3,4	17,9	68,8	65,4	50,8	96,9	1,3	1,8
SE	13,8	2,5	19,5	74,3	71,8	54,8	86,4	4,6	9,0
UK	7,7	0,4	10,3	72,5	72,1	62,2	88,9	3,0	8,2
EU-27	4,9	-0,5	6,8	64,9	65,4	58,1	90,8	2,5	6,7
EU-25	5,0	-0,3	7,0	65,1	65,4	58,1	90,6	2,6	6,8
EU-15	7,2	1,2	9,5	67,3	66,1	57,8	88,9	3,0	8,1

2. Distrbution of the population by age and country of birth

2005	Born in the country			Born in another EU25 country			Born in outside the EU25		
	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64
BE	19,4	53,3	27,3	8,3	54,1	37,6	14,2	67,4	18,4
BG	19,8	52,1	28,1						
CZ	18,9	51,8	29,3	6,7	50,7	42,6	13,3	71,0	15,7
DK	16,7	52,6	30,6	12,1	55,7	32,3	16,8	68,9	14,3
DE	17,7	53,7	28,7	13,3	59,4	27,3	19,5	61,2	19,3
EE	25,6	52,0	22,4				3,4	47,8	48,8
IE	23,3	52,8	23,9	16,5	68,8	14,7			
EL	17,1	55,0	27,9	19,2	66,9	13,9	18,4	67,4	14,2
ES	17,6	56,8	25,7	7,8	69,4	22,8	19,6	71,3	9,1
FR	20,5	53,0	26,5	6,4	50,2	43,4	10,7	56,6	32,8
IT									
CY	19,5	53,4	27,1	14,2	61,1	24,8	16,9	72,0	11,1
LV	25,2	52,6	22,2	11,3	38,7	50,0	3,4	45,3	51,3
LT	23,2	53,2	23,5				5,7 u	55,4	39,0
LU	21,5	52,2	26,4	9,7	64,9	25,3	14,8	70,4	14,7
HU	18,8	52,1	29,2	12,2 u	40,9	46,9	12,0	63,9	24,1
MT	22,5	50,4	27,1						
NL	18,4	52,7	28,9	8,9	60,8	30,3	13,1	66,2	20,7
AT	18,4	55,0	26,6	12,0	55,9	32,1	16,2	62,5	21,3
PL	22,6	51,7	25,7				5,8 u	27,6	66,6
PT	18,6	54,3	27,2	22,3	70,5	7,2	15,4	72,2	12,3
RO									
SI	20,2	54,0	25,8	6,3 u	53,1	40,6 u	5,0	58,0	37,0
SK	23,0	53,2	23,8						
FI	18,1	50,0	32,0	24,1	61,0	14,8	22,1	64,6	13,3
SE	19,7	49,8	30,5	4,8	48,3	46,9	18,7	63,6	17,7
UK	19,4	52,3	28,3	15,8	59,5	24,7	14,4	64,8	20,8
EU-27	19,3	53,2	27,5	11,2	57,4	31,4	15,6	63,4	21,0
EU-25	19,3	53,3	27,5	11,2	57,4	31,4	15,6	63,4	21,0
EU-15	18,7	53,6	27,8	11,3	58,1	30,5	16,0	63,9	20,1

3. Distribution of the 15-64 by sex and country of birth

2005	Born in the country		Born in another EU25 country		Born outside the EU25	
	Men	Women	Men	Women	Men	Women
BE	49,5	50,5	51,6	48,4	50,8	49,2
BG	50,5	49,5			55,4 u	44,6 u
CZ	49,9	50,1	49,6	50,4	45,8	54,2
DK	49,3	50,7	45,2	54,8	55,7	44,3
DE	49,8	50,2	47,5	52,5	49,1	50,9
EE	51,6	48,4	52,7	47,3	57,1	42,9
IE	49,8	50,2	48,1	51,9	48,3	51,7
EL	50,1	49,9	62,0	38,0	49,2	50,8
ES	49,4	50,6	53,2	46,8	50,1	49,9
FR	50,5	49,5	53,2	46,8	51,0	49,0
IT						
CY	50,1	49,9	53,3	46,7	60,6	39,4
LV	51,2	48,8	57,2	42,8	56,5	43,5
LT	51,7	48,3			53,9	46,1
LU	49,2	50,8	49,6	50,4	53,4	46,6
HU	51,1	48,9	56,3	43,7	53,3	46,7
MT	49,7	50,3	53,0 u	47,0 u	47,7	52,3
NL	49,3	50,7	56,1	43,9	50,1	49,9
AT	49,8	50,2	57,5	42,5	50,5	49,5
PL	50,5	49,5	46,8	53,2	53,8	46,2
PT	50,5	49,5	52,1	47,9	52,4	47,6
RO						
SI	49,2	50,8	54,9	45,1	49,0	51,0
SK	50,3	49,7	53,3	46,7	53,9	46,1
FI	49,7	50,3	48,3	51,7	53,8	46,2
SE	48,9	51,1	53,0	47,0	50,5	49,5
UK	50,6	49,4	53,1	46,9	51,6	48,4
EU-27	50,1	49,9	51,6	48,4	50,6	49,4
EU-25	50,1	49,9	51,6	48,4	50,6	49,4
EU-15	50,0	50,0	51,6	48,4	50,5	49,5

Source: EU labour Force Survey, quarter 2. Data marked 'u' lack reliabilty due to small sample size. Empty cells correspond to data not avaialble or not reliable due to smal sample size

(1) In case "born in another EU25 country" is not reliable due to small sample size, the cell "Born outside the EU25" refers to "Born outside the country".

(2) Country of birth is not available for BG, DE and RO. Nationality is used instead.

COMMISSION STAFF WORKING DOCUMENT

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Joint Report on Social Protection and Social Inclusion

COUNTRY PROFILES

1. INTRODUCTION

These 27 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. They are based on the integrated National Strategies for social protection and social inclusion that Member States have presented in 2006 for the first time. They complement the 2007 Joint Report on social protection and social inclusion [COM(2007) 13 final].

Each profile identifies those aspects of performance deserving to be highlighted in the context of the Open Method of Co-ordination 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 that will be undertaken in the context of the implementation of the National Action Plans for inclusion 2006-2008. The section on pensions draws upon the national strategy reports on pension reform presented in 2005 and their summary (Synthesis report on adequate and sustainable pensions, SEC(2006)304 of 27 February 2006). The section on health and long term care is based on the sectoral plans that the Member States presented for the first time in 2006. The concluding 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 on the basis of the National Strategies. All sections have benefited from bilateral exchanges with the Member States.

The country profiles also make reference to the implementation reports that Member States presented in the framework of the Strategy for growth and jobs. These analyses should be considered in connection with the corresponding country chapters of the Annual Progress Report on the implementation of the Lisbon strategy.

Annex 1A to this document explains the overarching indicators which Member States have agreed to use in the context of the OMC on social protection and social inclusion. Annex 1B provides details on the data sources used.

BELGIUM

1. Situation and key trends

Belgium's economic growth slowed down to 1.2% in 2005 but is expected to strengthen in 2006 to 2.7%. While 39 000 new jobs were created, the unemployment rate remained at 8.4% in 2005 (8.8% in the EU 25). Significant regional disparities still exist in both employment[74] (64.9% in Flanders, 56.1% in Wallonia, 54.8% in Brussels) and unemployment[75] (5.4% in Flanders, 12.1% in Wallonia, 15.9% in Brussels). Youth unemployment has continued to rise (21.5% in 2005). The employment of older people (50-64) has improved over the last five years from 26.3% in 2000 up to 31.8% in 2005 but remains low and significantly below the EU average (42.5% in 2005). This increase mainly results from the 33.1% rise in female employment within this age group over the last five years. The total female employment rate has increased since 2000 from 51.5% to 53.8% in 2005, while the male employment rate decreased slightly over the same period (69.5% in 2000 compared to 68.3% in 2005).The at-risk-of-poverty rate was 15% in 2005, though with significant regional differences (11% in Flanders, 18% in Wallonia and an estimated 27% in Brussels). Life expectancy at birth (76.7[76] and 82.4[77] years for males and females respectively) is close to the EU average. However, Belgium has a higher healthy life expectancy than the EU average both for males (67.4 compared to 64.5[78] years) and for females (69.2 compared to 66[79] years). The fertility rate of 1.72[80] is above the EU average (1.52). The old-age dependency ratio was 26.3 in 2005 and is expected to increase to 41.3 by 2030. Total gross social protection expenditure has risen since 2000 and accounted for 29.3% of GDP in 2003. Pensions and health represent the bulk (44.1% and 27.7% respectively) of social protection expenditure.

2. Overall strategic approach

The report emphasises the rise in employment and job creation as main factors in helping to safeguard the future of social security. The strategy is based around three objectives: first of all, to secure in a structural manner the financial equilibrium of the social security system by maintaining a high level of social protection and linking social benefits (including pensions) to the development of well-being; secondly, to step up interaction between social inclusion policies and the development of employment, in particular through activation measures in favour of risk groups; and finally, to offer affordable quality healthcare.

The measures described in the report are closely linked to the priorities and objectives identified in the National Reform Programme (NRP) 2005-2008 with a view to achieving the aims of the Lisbon Strategy and the WTO's social objectives. Although the strategy proposed by Belgium presents numerous similarities with previous plans, it reflects a good understanding of the multidimensional nature of social exclusion.

Gender mainstreaming is lacking in the report despite the availability of statistics broken down by sex. However, more women than men are likely to benefit from the measures

[74] 2005 figures (source: FPS Economy - Directorate-General Statistics Belgium)
[75] 2004 figures (source: FPS Economy - Directorate-General Statistics Belgium)
[76] 2005 provisional estimate (source: Eurostat)
[77] 2005 provisional estimate (source: Eurostat)
[78] EU 15 figure (source: Eurostat)
[79] EU 15 figure (source: Eurostat)
[80] 2005 provisional estimate (source: Eurostat)

proposed under the priority policy objectives, as they tend to be overrepresented among the target groups.

The preparation of each of the pillars of the report has seen consultation and coordination among the competent legislative authorities at all levels and has involved a wide range of stakeholders, including the social partners and associations of people living in poverty and social exclusion. However, cooperation between players from the three pillars remains limited, as a result of which the links between the pillars are inadequate. Better coordination and exchange of information between these players represents a challenge for future plans, in order to improve coherence and the "interrelatedness" aspect.

3. Social inclusion

3.1. Key trends. The at-risk-of-poverty rate after social transfers was 15% in 2004 with a higher risk for older persons (21%), single persons (21%), tenants (27%), persons living in a single-parent household (36%) and the unemployed (28%). The overall in-work poverty rate of 4% is well below the 8% EU average. Social transfers continue to play an important role, as they reduce by 46% the at-risk-of-poverty rate, which before social transfers (except old-age pensions) was 28% in 2004. The net income of social assistance recipients as a percentage of the poverty threshold is 76.6% for a single person, 68.5% for a married couple with two children and 89.9% for a lone parent with two children. The proportion of children aged 0-17 living in a jobless household decreased from 13.8% in 2002 to 13.5% in 2006 (9.5[81]% EU average). Only marginal progress has been made on early school leaving (13% in 2005), with an important gender gap (15.3% for males and 10.6% for females). While 81.8% of people aged 20-24 had completed at least upper secondary education in 2005, youth unemployment continued to rise to 21.5%, which is above the EU average (18.5%). Another important issue is the unemployment rate gap between non-EU and EU nationals (25.4% in 2005), which is three times higher than the average across the EU.

3.2. Key challenges and priorities. The 2006 plan, the result of a broad consultation process, focuses on three priorities, namely to ensure decent and affordable housing for everyone, to develop activation and diversity in employment and social integration, and finally to tackle child poverty. The first two challenges, already identified in the previous Inclusion NAPs, still require more political and financial commitment.

Despite the efforts of the Regions to increase the availability of social housing, the supply is still not enough to meet demand. Furthermore, the weakest social categories are still forced to spend too much of their household budget on housing.

The need to increase participation in the labour market by certain groups is still an essential challenge. The long-term unemployment rate for lone parents (14%), people from outside EU˙25 (20%) and the disabled and low-skilled (8%) requires specific measures to help people into employment. The unemployment rates for both older and young people remain a cause for concern in Belgium. The risk of child poverty in Belgium is below the EU average (17% as against 19%), but the children of lone parents and those living in households where no one is employed are particularly at risk (36% and 70% respectively). These priorities correspond to the challenges identified in the 2006 Joint Report, and the primary objectives are to increase participation in the labour market, ensure access to the resources and services people

[81] 2006 estimate (source: Eurostat)

need in order to be able to live a dignified life, to prevent discrimination and to eliminate child poverty.

3.3. Policy measures. The first priority is to ensure decent and affordable housing for everyone. This policy will consist in improving the supply of modest housing, not only by increasing the availability of social housing, but also by stepping up checks and compliance with stricter quality standards. The aim would be for social housing for rent as a percentage of the total number of private households to rise from 6.3% in 2004 to 8% in 2010, an ambitious objective given that this figure has remained constant at around 6.3% since 1995. Financial measures such as the simplification of the rent allowances procedure and fine-tuning of a system for the payment of rent guarantees will make it easier for the most deprived to gain access to inhabitable and up-to-standard social housing. Another objective is to extend the right to energy by improving the supply of and access to gas, electricity and water, so as to improve protection for the most deprived. The budget of the social housing agencies will also be increased so that they have more scope for action and promotional activities as well as renovation or restoration work. Measures to help the homeless are also planned, with a view to integrating them by providing housing. Finally, cooperation will be established among the various bodies in order to increase awareness of the housing problem in Belgium. Most of these measures are not particularly innovative, and the report remains fairly discrete on how they will be implemented and financed. There is no mention of the gender perspective, with the exception of a wish to increase the number of accommodation places for homeless women in Brussels.

The second priority is to develop activation and diversity in employment and social integration. The goal of activation and diversity is to increase the employment rate and create jobs by devoting special attention to specific target groups, such as people from outside the EU, low-skilled and poorly educated people, and the disabled. The results aimed at by this measure are taken from the NRP and are consistent with the objectives laid down for 2010 by the Lisbon Strategy for the employment rate (70%), participation in lifelong learning (12.5%) and a reduction in early school-leaving (10%). The employment rate for women should also reach the Lisbon objective of 60% by 2010. Finally, the Belgian authorities are aiming to reduce the unemployment rate for people from outside the EU to the same level as for Belgian workers. In view of the scale of the problem (which is compounded if we take account of people of foreign origin who have taken Belgian nationality, for whom participation in the labour market remains difficult) and the ambitious objective that has been mapped out, it would have been appropriate for the problem of immigrant integration to be the subject of an overall approach under a specific measure. At federal level, a working group on discrimination ensures efficient harmonisation of the different employment measures designed to foster equal opportunity in access to employment for risk groups. Flanders devotes nearly €8 million a year to a number of diversity initiatives designed to prevent exclusion of older people, persons of foreign origin and the disabled from the labour market and grants an employment premium for the recruitment of people over the age of 50. The three Regions are intending to increase the availability of childcare facilities so that parents who want to work can gain access to the labour market. Several initiatives and instruments will be developed to promote employment for the target groups by offering them personalised guidance towards integration. The ESF will play an important part here. Development of the social economy and neighbourhood services will continue in both Flanders and Wallonia and will be accompanied by other, not necessarily professional, activities. In addition to various research projects and studies which will be launched in order to assess the impact of activation measures, means of registering and monitoring will be harmonised and improved with regard to diversity.

The objective of the third priority is to tackle child poverty by breaking the poverty cycle. The emphasis placed on this target group in Belgium's policy on poverty is new. The aim is to reduce the percentage of children under 16 at risk of poverty to 12% by 2010 (compared with 17% in 2003) and to cut the proportion of children (aged up to 17) living in households where no one is in paid employment from 12.9% in 2005 to 7% in 2010. If these levels are to be achieved throughout Belgium, a considerable effort will be needed, in view of the regional differences. Nevertheless, a set of measures has been introduced. In addition to financial measures under the other two policies mentioned, the employment bonus system and the new family allowance at the start of the school year (introduced in August 2006) will contribute towards increasing families' incomes. The Belgian authorities will focus on measures to stop children leaving school early and encourage the participation in society of all children from a very young age. In the field of education, efforts will be made to reduce parental contributions to the cost of schooling and to diversify school attendance populations. Links between families and schools will be strengthened, and the involvement of parents in an educational role will be encouraged. Finally, the policy on special assistance for youth, including unaccompanied foreign minors, will be improved by various measures.

3.4. Governance. The plan was drawn up by two working groups on "actions" and "indicators" acting in close cooperation and coordinated by the Public Planning Service for Social Integration. The groups include representatives from the federal level and the various Communities and Regions, as well as delegates from other (primarily local) authorities (Union of Towns, Cities and Municipalities), the social partners (National Labour Council), experts and associations of persons living in poverty and social exclusion. The two working groups have been enlarged to take in representatives from all parts of civil society. In developing indicators and identifying targets, the "indicators" group has also made extensive use of the results of debates, research and reports. The plan will be implemented through coordinated federal and regional action plans. Monitoring of progress towards meeting targets will be the responsibility of the working groups, but the various competent authorities will themselves be able to enter data on the website of the Public Planning Service for Social Integration so that the implementation of their respective activities can be followed. In 2007 a public forum on the plan will be organised with a view to formulating recommendations for the future.

4. Pensions

In 2004, older people had a living standard of 3% of the general population, which is relatively low compared to other Member States, while the poverty risk among older people (21%) is estimated to be significantly higher than for the Belgian population below the age of 65.

In spite of recent increases, the employment rate among older workers remains low. The 2006 Sustainability Report assessed Belgium as a medium-risk Member State as regards the sustainability of public finances, due notably to the very high level of public debt. Belgium is facing substantial budgetary pressures due to an ageing population: according to the AWG projections in 2005, public pension expenditure will rise from 10.4% to 15.5% of GDP between 2004 and 2050.[82] According to ISG projections, the net theoretical replacement rate in the statutory scheme (for a worker retiring at 65 after 40 years of employment on the

[82] National projections included in the 2006 National Strategy Report on Social Protection and Social Inclusion and reflecting recent reforms and different methodology choices indicate that the increase in pension expenditure from 2005 to 2050 would represent 3.9% of GDP.

average wage) is expected to decrease slightly from 63% in 2004 to 61% in 2050, while the overall net replacement rate is expected to rise from 67% to 74%, thanks to contributions of 4.25% of gross wages to occupational schemes (currently about 40-45% of the employed population are covered by occupational schemes).

Ensuring an adequate and sustainable strong public scheme is a main preoccupation of the Belgian pension policy. The 2006 Joint Report underlined the importance of improving the employment situation among older people in order to ensure adequate and sustainable pensions. The report at the same time highlighted efforts made to improve the adequacy of pensions (in particular, minimum pensions and occupational pensions). The Belgian Government has taken further steps to enhance the adequacy of pensions notably for women, through further increases in the minimum income for pensioners (*GRAPA*) to the at-risk-of-poverty level, the introduction of a mechanism to adjust pension benefits to welfare developments and better account taken of part-time work in determining minimum retirement income. The harmonisation of the statutory retirement age for salaried workers by 2009 for men and women is ongoing.

A reform of early retirement provision was adopted at the end of 2005, and should contribute to adequacy and financial sustainability in encouraging a higher labour-force participation among older people under what is termed the "*pact between the generations*", notably by raising the age for early retirement from 58 to 60 and strengthening incentives to work beyond 62 for a career of at least 44 years ("*bonus pension*"). However, further increases in the employment of older workers are of key importance.

Moreover, the strategy for securing financial sustainability continues to rely strongly on the global management of social security and on the reduction of public debt. Furthermore, the savings are transferred to a reserve fund (by the end of 2005, reserves amounted to 4.5% of GDP) and are thus earmarked for future expenditure on ageing-related needs.

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 supplementary pension schemes, further efforts to ensure a high coverage of the working population (especially women) by occupational pension schemes might be needed.

5. Health care and long-term care

5.1. Health care

Description of the system. The Belgian healthcare system is based on a compulsory health insurance scheme which is an integral part of the social security system and covers 99% of the population. Around 70% of funding comes from the public sector (contributions plus State funding and taxes), 22% directly from families ("out of pocket"), and the rest is covered by supplementary insurance schemes. These remain marginal, and there is a consensus on the need to further consolidate the public compulsory insurance scheme in order to ensure its continuity. Patients have freedom of choice of care provider and direct access to specialists. Care providers are essentially paid directly by the patient on the basis of tariffs agreed between the social partners, mutual insurance funds and care providers. Patients then receive a reimbursement of around 75% from their mutual insurance fund (except in the case of hospitalisation, where the fund covers the costs directly). The range of healthcare services is extensive, and there are no waiting lists. The Federal State has sole responsibility for the compulsory healthcare insurance

scheme, which is an integral part of the social security system. By contrast, the Federal State and Regions are jointly responsible for healthcare services and public health. Belgium's strategy is to lighten the financial burden for the poorest patients, improve the quality of care by making it user-focused and ensuring its continuity, and rein in the increase in costs by improving the cost/efficiency ratio.

Access. Although the Belgian healthcare scheme covers 99% of the population, the authorities fear that the contributions which patients are asked to pay for certain services (21.5% direct payments by households in 2004, a figure which is relatively high, although it has fallen in recent years) are likely to weigh heavily on the budgets of the most vulnerable social groups. To limit this risk, the authorities have adopted a range of measures, which include annual ceilings ("*maximum to be billed"*), a higher rate of reimbursement and free preventive care for all. The "*maximum to be billed"* is the basic tool for ensuring the financial accessibility of healthcare, given its very wide application. 500 000 Belgian households (11%) benefited from it in 2005, and its scope will be extended further. Several measures are envisaged in order to reduce the cost of medicines to patients (compulsory price reductions, incentives to use generic products, extension of reimbursement to certain innovative medicines). There are no problems as regards equality of access throughout the country. Attempts are being made to optimise the geographical distribution of healthcare availability, at hospital level by introducing "care areas" and at general practitioner level through premiums for doctors establishing a practice in an area where there is a shortage.

Quality. As regards the quality of service providers, the system is traditionally based on healthcare institution recognition standards. An agency analyses clinical practices, develops best practices and evaluates medical technologies. A peer review system is being developed, e.g. comparison of hospitals on the basis of a series of indicators allowing them to define their own objectives for improvement. In order to achieve a steady improvement in healthcare quality, the authorities plan to guarantee user-oriented benefits (geared to their needs) based on the continuity of healthcare, in particular by giving priority to primary care, prevention policies, patients' freedom of choice, and availability of information. Several vaccines which are free of charge are easily obtainable through preventive healthcare centres for children.

Long-term viability. Total healthcare spending, which amounted to PPP$ 2 922 per capita (9.3% of GDP) in 2004, is relatively high, having increased sharply in recent years. According to the Ageing Working Group's projections, public healthcare spending is likely to rise by 2.4 percentage points, while national projections foresee an increase of 3.7 percentage points by 2050. The Government plans to meet the challenge of rising healthcare costs by different approaches. At macro-economic level it will set a standard for the growth of public healthcare spending (4.5 % per annum, before inflation), broken down into partial budgetary objectives based on main headings (medical and paramedical). Continuous monitoring arrangements are being put in place to ensure compliance with the standard. At micro-economic level, Belgium has opted for policies designed to make all healthcare players take responsibility: patients' contributions, flat-rate amounts for certain hospital services (so as to discourage over-use), distribution of part of the budget among mutual insurance funds on the basis of "theoretical expenditure" (i.e. as a function of the health risk profiles of insured persons).

Improving healthcare coordination and the rational use of resources are of major importance in improving the cost/efficiency ratio. Priority is therefore given to primary care and the use of patients' medical records. Other measures include technology assessment, a higher reimbursement rate for generic medicines, and better prescription practices. In 2005 and 2006

he annual budgetary objective of 4.5% growth in real terms was achieved. The development of health promotion policies and healthy lifestyles is also a priority for all authorities.

5.2. Long-term care

Description of the system. Long-term care can be provided by hospitals, specialised services, specialised institutions or at home. Despite the relatively high cost, the number of old people in institutions is also relatively high (6-7% of over-65s). The Communities and Regions have many responsibilities, and the services they offer therefore vary. Coordination takes place between federal, Community and regional levels, and also between general and long-term healthcare services, e.g. through integrated home-care services making it possible to exploit complementarity between different care providers and assistance services.

Access. The challenge to improve long-term care is linked to the priority given to keeping people at home. To achieve it, the principle of continuing care is being developed, together with day-care centres and short stays in institutions. However, keeping people at home also entails costs for the individual, such as transport to day-care centres or the need to continue to pay rent during a short stay in an institution. Special attention has been devoted in the Belgian report to the different services taking account of mental illness in a suitable and targeted manner. A recent development is a care circuit for patients in a persistent neurovegetative state, an attempt to respond to the lack of adequate facilities for this type of patient.

Quality. In the field of long-term care, accreditation, peer review (e.g. the geriatrics group) and the development of appropriate professional skills also guarantee the quality of the services offered. Special importance is attached to coordination in order to enable integrated, ongoing and multidisciplinary care and aid services to be provided, in line with the person's needs. The coming years will be devoted, among other things, to the development and implementation of care pathways for chronically ill patients.

Long-term viability. Many risks specific to long-term care are insured through the compulsory healthcare insurance scheme, which means that the challenges as regards ensuring financial viability are the same as for health care. One of those challenges for the coming years is to ensure the deployment of human resources, taking account of population ageing. Efforts will be made to strengthen the position of primary care providers and to ensure that there are sufficient aid and care providers by giving them an attractive status. It will also be necessary to develop different forms of care, taking account of people's degree of dependence (residential care, day care, night care, short stays in an institution). To this end, a multiannual protocol was concluded between the different competent authorities in 2005.

6. Challenges ahead

To raise employment rates, especially among older workers, young people, migrants and non-EU nationals and improve access to the labour market for the long-term unemployed, unqualified workers and single parents;

To step up efforts to bring affordable and decent housing within reach of more people;

To guarantee the sustainability and adequacy of pension schemes by further reducing the public debt and to continue making second-pillar pension schemes more accessible, especially to women;
To manage growing healthcare expenditure by improving the cost/efficiency ratio while guaranteeing access for vulnerable groups;

BELGIUM : data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.7	116.5	**2000**	60.5	69.5	51.5	29.1	26.3	**2000**	6.9	5.6	8.5	16.7
2002	1.5	117.6	**2002**	59.9	68.3	51.4	29.4	26.6	**2002**	7.5	6.7	8.6	17.7
2004	3.0	119.4	**2004**	60.3	67.9	52.6	27.8	30.0	**2004**	8.4	7.5	9.5	21.2
2006	2.7f	118.2f	**2005**	61.1	68.3	53.8	27.5	31.8	**2005**	8.4	7.6	9.5	21.5

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65 (2003 instead 2005)		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.4	80.2	14.8	19.1	63.3	66.4	5.9	**1995**	8.4	69.5	-	na	na
2000	74.6	80.8	15.5	19.5	65.7	69.1	4.8	**2000**	8.5	69.3	24.6	99	57.5a
2004	76.7ps	82.4sp	na	na	67.4e	69.2e	4.3	**2004**	9.3	70.9	21.5	na	na

s: Eurostat estimate; p: provisional **THE Total Health Expenditures* ***PHI Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age related projection of expenditure (AWG)					
Eurostat	Total expenditure* (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in 2004 and changes since 2004			
										Total social expend.	Public pensions	Health care	Long-term care
1995	27.4	43.1	23.6	13	8.8	2.7	8.8	**2005**	26.3	25.4	10,4	6,2	0,9
2000	26.5	44.1	24.2	11.8	8.8	1.8	9.3	**2010**	26.4	-0,3	na	na	na
2004	29.3	44.1	27.7	12.5	7.1	1.8	6.8	**2030**	41.3	4,5	4,3	0,9	0,4
								2050	48.1	6,3	5,1	1,4	1

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate						Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	15	19	14	12	21	19	21	19	21	15	**Total**	4,1
Male	14	-	12	11	19	21	-	20	21	17	**Male**	-
Female	15	-	15	13	22	19	-	18	20	13	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	11.3b	13.0b	11.2b	14.8b	**1999**	4,8	4,0	5,9	**1999**	15.2b	17.7b	12.7b
2004	13,2	13,7	11,3	16,0	**2004**	4,1	3,7	4,7	**2004**	11.9b	15.6b	8.3b
2006	13,5	14,3	12,3	16,4	**2005**	4,4	3,8	5,0	**2005**	13,0	15,3	10,6

**: excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0,732	0,744	0,734	***Aggregate replacement ratio***	0,418	0,446	0,464

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions (or Social Security)	Occupational & voluntary pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
6		4	-2	DB	6	DC	68	40	45	46.3	Nd	4.25

** (DB / NDC/ DC); ** (DB / DC)*

BULGARIA

1. Situation and key trends

GDP has remained steady in recent years, well above the EU average: between 1998 and 2004, real GDP growth averaged 4.4% a year, reaching 5.6% in 2004, while inflation was contained to single-digit levels. Growth is expected to remain at levels of 5.5% to 6% throughout 2006-2008. However, these figures do not take account of informal economic activity. The total employment rate, which remains among the lowest 10 in the EU, increased from 54.2% (2004) to 55.8% (2005), with increases in rates for both women and men from 50.6% and 57.9% (2004) to 51.7 % and 60% (2005) respectively. In the 55-64 age group, the employment rate rose from 32.5% (2004) to 34.7% (2005). In the 15-24 age group, however, employment rose only from 21.5% (2004) to 21.6% (2005). Over the period 2004-2005, total unemployment decreased from 12% to a record of 10.1%. Female unemployment decreased from 11.5% (2004) to 9.8% (2005) while male unemployment decreased from 12.5% to 10.3%. A negative rate of population growth (-5.4% in 2005) and continuing out-migration contribute to one of the most challenging demographic situations in Europe: the share of persons aged 0-14 was 13.6% in 2005 and the age dependency ratio was 44.5% (2005).[83] Life expectancy at birth in 2004 was 76.2 (women) and 69 (men), thus showing large gaps with the EU benchmarks. Infant mortality is (11.6 in 2004) above the 2004 EU average of 4.5 but shows a significant decrease from 27.3 in 1970. Perinatal mortality is also high, at 12.21 in 2004.

2. Overall strategic approach

The National Report on Social Protection and Social Inclusion adopts the key challenges identified in the Joint Inclusion Memorandum (JIM). Providing equal opportunities for all to use the benefits of economic growth is the key principle driving the overall strategic approach. The opportunities of disabled persons, children, young people and of the elderly are highlighted, as is the multidimensional nature of social inclusion challenges. Gender equality underpins the overall approach, together with the establishment of sustainable and efficient social protection and inclusion systems. It is acknowledged that social protection and policies for economic growth and more and better jobs guide the formulation of policies and programmes, as well as steering budgets. The National Strategic Report is an important step towards setting up strategic priorities for social protection and inclusion policies. Efforts, however, should continue to improve coordination of the sequencing, financing and monitoring arrangements under each policy priority. The Bulgarian Government shows its awareness of the importance of effective links between the Lisbon objectives and its social protection and social inclusion policies, but further efforts are needed to illustrate mutually reinforcing actions more effectively. Although the overall strategic approach does not specifically refer to the Roma population, subsequent sections of the report and other strategic documents indicate awareness and commitment to the inclusion challenges of ethnic minorities. In terms of governance, priority is given to consultation and early involvement of stakeholders. Consultation, however, needs to be meaningfully used as an instrument for reaching out to civil society and generating public ownership and adherence to policies. While acknowledging the added value of the JIM and the support granted by PHARE, additional efforts are needed to further develop the strategy for the use of ESF.

[83] National Statistical Institute available at : http://www.nsi.bg/Population/Population.htm (September, 2006)

3. Social inclusion

3.1 Key trends

Despite falling overall unemployment, employment rates remain low. At the end of 2005, the employment rate (15-64) was 55.8%, with a gender gap of 8.3 percentage points. Intervention measures, such as the lowering of the pension contribution rate and the increased control of labour inspectorates, were effective in reducing unregistered labour and contributed to improvements in the employment rate. Long-term duration is a distinctive feature of unemployment in Bulgaria: unemployed persons with no job for more than a year accounted for 59.8% of all unemployed in 2005. Over the two years 2004-2005, the percentage of early school-leavers (total) slightly improved (21.4% - 20% respectively), against 15.1% in the EU (2005). In terms of living conditions, GDP per capita (in PPP) rose from 26.5% (2000) to 31.8% (2004) of the EU-25 average. In 2004, the at-risk of poverty rate[84] stood at 15%. In 2005, the poverty line moved upwards and reached €936 annually, or €78 per month. Women account for 17% (2004) of persons with disposable income below the at-risk-of-poverty rate. Their share increases to 23% in persons aged 65+. The at-risk-of-poverty rate among people 65+ increased to 16% (2004) while it was 14.1% (2003). At the end of 2005, there were 2.3 million persons living on pensions. A higher poverty incidence is also found in the Roma community.

Thus, the percentage of those at-risk-of-poverty remains stable despite increased economic opportunities. Seen in this light, social transfers play an important role in reducing both relative and absolute poverty. Even though the average pension was increased from €41 (2000) to €69 (2005), pensions continue to have a low nominal value and yet contribute to poverty reduction: national data show that the poverty rate of 39.1% (2005, before social transfers) is reduced to 17.2% when pensions are included, and to 14.2% after inclusion of all other transfers. The income quintile share ratio for 2004 is 4. According to the National Strategic Report, social security and social assistance expenditure make up 13.4% of GDP (national figure 2005).[85] Particularly vulnerable to poverty and exclusion are: a) children (particularly those from ethnic minorities and those living in single parent family households); b) persons employed on low wages and unemployed (low wage workers and unemployed account for 55% of people living in poverty); and c) elderly persons, particularly those above 75 years of age.

3.2 Key challenges and priorities

Four main policy objectives are identified for the period 2006-2008: i) equal labour market participation of groups at-risk-of-poverty and social exclusion; ii) ensuring equal access to services designed to prevent social exclusion and its consequences; iii) social inclusion of vulnerable ethnic minorities; iv) poverty reduction among groups beyond working age, particularly among children and elderly persons. These policy objectives are linked to twelve key targets set for 2008 that can be grouped as follows:

Employment: i) activity rate (age group 15-64) of 65.6%; ii) unemployment rate below 9%; iii) increase of employment rate (age group 15-64) up to 59.2%; iv) increase of number of persons from vulnerable groups included in vocational training by 20%. Education: v)

[84]Data for all income based indicators ((at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) is based on the national household budget survey that is adjusted ex-post to the EU harmonised SILC methodology but is not fully compatible the SILC detailed definition income.

[85]Ministry of Finance, Consolidated budget

decrease of 10% in the number of children of mandatory school age dropping out of school compared to the 2005 rate; vi) increase by 15% in the number of children with special educational needs integrated in mainstream and professional schools; vii) increase in the number of Roma schoolchildren taken out of segregated schools by 10%. Social protection: viii) decrease in the number of persons on social assistance by 5%; ix) decrease in the number of persons in specialised institutions by 10%; x) increase in the number of persons from vulnerable groups using social and health services within the community by 20%. Overarching: xi) at least a 15% increase in total household income; xii) nominal growth of income from pensions of more than 5% per annum.

These targets correspond to key trends and challenges and are linked to a wide range of strategic documents in the areas of social protection and inclusion. They complement the strategic approach and mirror the seven key inclusion policy priorities. While these targets build on the JIM, their quantitative expression is innovative. Although target (x) contains a health dimension, the overall health challenges of Bulgaria require better policy coordination between the OMC strands. Access to health care services remains a critical issue for persons who have not paid their health insurance contributions. Particular attention needs to be paid to access to health care services and to the removal of financial and other barriers impeding access, particularly for people living in rural areas and for those outside the scope of social assistance programmes.

3.3 Policy measures

For each of the four policy objectives above, detailed policy measures are envisaged together with a set of indicators for further follow-up. The gender perspective appears as a horizontal issue, as a draft Law on equal opportunities has to be voted on by Parliament. The policy objective of *equal labour market participation of the groups at-risk-of-poverty and social exclusion* will be achieved by combining existing measures with new policy measures such as encouraging active behaviour on the labour market of the long-term unemployed through the payment of a "bonus" for getting a job, promoting employment tailored to the needs of vulnerable groups and promoting social economy. *Ensuring equal access to services designed to prevent social exclusion and its consequences* relies on measures aimed at securing respect of social rights and on new policy measures (streamlining of cooperation with local districts and civil society organisations, increasing financing for community-based services, development of social services aiming at deinstitutionalisation, reduction of drop-out rates and support for mainstream education of children with special educational needs). The policy objective of *social inclusion of vulnerable ethnic minorities,* in addition to current measures, entails measures such as improving of the capacity of Roma representatives for full-scale involvement, setting up a database for the Roma integration process, improving of the multi-ethnic cultural environment, and introducing measures to reduce the infant and maternal mortality rate among Roma. The policy objective of *poverty reduction among groups beyond working age* combines measures focusing on two particular groups: children and the elderly. These measures include normative approval of an official poverty line, the development and expansion of social services for both target groups, and the establishment of a monitoring mechanism for child poverty. In total, for the period 2006-2008 some 60 new measures will target the four key policy objectives. The state budget is the main financial source for these measures, together with the municipal budgets. The ESF and state guaranteed loan from the World Bank will complement the financing. However, there are no precise resource allocations per group of measures to evidence their budgetary feasibility and overall commitment to them. A limited number of more focused and adequately funded priorities with precise monitoring arrangements, including intermediate targets and an impact

assessment, would be preferable to a large range of actions whose implementation could go beyond available administrative capacity, particularly at local level.

3.4 Governance

The Ministry of labour and social policy is the main coordinating body at central level. The national legislation provides for consultation of stakeholders. This is achieved through a network of consultative bodies, such as the National Council for Tripartite Cooperation, the National Council for Integration of People with Disabilities, the National Council for Coordination of Policies and Programmes aimed at the Reduction of Poverty and Social Exclusion, the National Council for Cooperation on Ethnic and Demographic Issues, the National Association of Municipalities, and other consultative bodies. In the field of protection against discrimination, the Commission for protection against discrimination was established in 2005 following the entry into force of the Law on protection against discrimination. Transparency in decision-making and the involvement of all stakeholders are presented as key factors for better governance. It is therefore necessary to further improve the policy and inter-institutional coordination and the measures for active involvement of stakeholders. As regards the social inclusion of ethnic minorities, it is vital to continue and increase the involvement of civil society organisations representing their concerns. Sustained efforts are also needed to fight against informal payments in health and education.

4. Pensions

As outlined in section 3.1, Bulgaria has made progress in pensioner poverty alleviation. However, 23% of women over the age of 65 are at-risk-of-poverty compared to only 5% of their male counterparts. Projections for Bulgaria's future old-age dependency ratio are significantly higher than the EU average (60.9% compared to the EU average of 53.2% in 2050), which will have a significant impact on the long-term sustainability of pensions. Replacement rate projections made in 2005 show that the average net replacement rate for pensions from the solidarity pay as you go (p-a-y-g) pillar will amount to 44% in 2030 and about 42% in 2050. Supplementary pension schemes are expected to have a positive impact on pensioners' incomes, increasing the total net replacement rate to 52% in 2030 and 57% in 2050. Long-term projections on public pension expenditure illustrate that the actuarial balance of public p-a-y-g funds will remain negative (4% in 2030 and 9% in 2050). However, public pension expenditures are projected to be about 7.3% of GDP in 2050.

Bulgaria made significant changes to its pension system in 2000, introducing a funded component to its first pillar system and reforming its pay as you go scheme. A rise in the retirement age, currently being debated, will have an impact on long-term sustainability. Concerns remain as regards the adequacy of pensions for persons who have not made sufficient contributions, and those on low earnings. The decision to link pension indexation to a mix of wages and prices will help future sustainability, but may result in poorer pensioners the further from retirement they are. The development of a funded tier of the first pillar and the promotion of other voluntary saving should provide good incentives for work and for working longer. However, it will be important to develop suitable mechanisms for the payment of pensions from these systems that are sustainable and contribute to improvements in replacement rates. Furthermore, extending working lives through incentives, or by linking contributions more closely to benefits, needs to go hand in hand with improved employment opportunities for older workers. Increases in employment and in particular in employment rates of older workers are steps forward, as are improvements in revenue collection and adequacy of pensions. In addition, individuals are able to save via the two funded components

of the system. However, improvements in employment rates still have a long way to go to reach the EU average and provide a solid, sustainable base.

5. Health and long-term care

5.1 Health care

Description of the system. Overall health indicators in Bulgaria show significant gaps vis-à-vis the EU averages. Following the introduction of mandatory health insurance (Health Insurance Act, 1998), the National Health Insurance Fund (NHIF) collects health insurance contributions from employers and employees set at 6% of wages. It contracts general practitioners, specialists in outpatient services and hospitals. General practitioners are paid by the NHIF on a capitation basis for the services provided, with regional compensation to offset geographical disparities. Outpatient care specialists are paid on a fee for service basis. Contributions for the unemployed, the poor, pensioners, students and other vulnerable groups are covered by the state and municipal budgets. The Ministry of Health is in charge of the overall health policy and management of the health care system. It is responsible for emergency care, vaccination and immunisation, psychiatric care, state sanitary and food control and health promotion. Hospital care is provided by acute care hospitals, specialised and long-term care establishments which can be jointly owned by the Ministry of Health and the municipalities, only by the municipalities or only by the state. Hospital treatment is covered by the NHIF on the basis of clinical paths for diagnosis. Reimbursement of pharmaceuticals varies. Life-saving drugs and the treatment of certain diseases such as cancer, diabetes and genetic diseases are free of charge. Hospital stay and treatments without prior referral require payment under fixed and uniform tariffs. Additional revenue for practitioners and hospitals is provided by patients' mandatory fees for visits (1% of the minimum wage) and for hospital stay per day (2% of the minimum wage). There are exemptions from payment of such fees for a large group of patients.The share of voluntary health insurance in health care purchase and provision is limited.

Accessibility. The state provides free, universal access to emergency health care and to all services paid for by the state budget. Access is impeded due to various reasons: geographical distribution of practices, transport problems, non-registration with a GP and non-payment of health insurance contributions of registered patients. Despite the reforms, a small percentage of the population are still not registered with a GP. This could impact negatively on their access to health care services. Although vulnerable groups' contributions are paid for by the state, limited access to health care services remains a problem due to a lack of information on patients' rights and responsibilities, exemptions and regulatory procedures. The state budget also provides a specific health benefit for hospital admission of vulnerable groups. A remaining problem is the fragmented access to primary health care services of some ethnic minorities, particularly in rural areas, resulting from non-registration and non-contribution with the health insurance fund. The level of reimbursement for certain pharmaceuticals and medical devices effectively hinders access to health care services. Similarly, co-payments (fees for non-referred services for the insured and those entitled to free care) and persistent informal payments negatively impact on access.

Quality. In recent years, 25 medical standards have been introduced in various medical specialities. The accreditation mechanism for health establishments has been expanded to include not only hospitals but also outpatient units. Rules for good medical practice are to be prepared and introduced. Establishing effective quality control and evaluation mechanisms of the health care services remains a challenge for the authorities. Although preventive policies

and immunisation campaigns are well established, their quality and quantity vary. Even though patients enjoy free choice of GP, the referral process to specialised care is hindered by the low quality and availability of these services (geographical disparities and transport issues). The authorities recognise that the introduction of accreditation and quality management systems, together with rules for medical practice, will help to increase the quality of medical services and equity in health. The authorities agree that further action designed to improve the quality of care and services is needed.

Long-term sustainability. In 2004, total health care expenditure amounted to 7.7% of GDP. The share of public health expenditure was 55.8% of total health care expenditure, with official out-of-pocket payments standing at 43.5% of total health expenditure. The authorities recognise the need to increase public funding for health care and improve the mandatory health insurance scheme. Since 2006, the NHIF share in hospital financing has increased and gradually replaced the share of state and municipal funding. In addressing the financial sustainability of the system, the authorities state that the funds specifically allocated for vulnerable groups' medical care will remain in place.

5.2. Long-term care

Description of the system. Long-term care is provided in both an institutional and a community setting. The authorities recognise the need to expand social services to offset demographic developments. This is in line with the overall tendency towards deinstitutionalisation and prioritised development of community-based care. The management of social services is the responsibility of municipalities, with both state and municipal budgets used to finance the social services provided. To guarantee financial sustainability and to support the municipalities in their new responsibilities in social services development, the state provides funding for a number of social services (day care centres, protected homes, centres for social rehabilitation and integration, specialised institutions, etc.). Social services can also be financed by private entities. Private providers have to be registered with the Social Assistance Agency. Social services are provided in return for fee payments or by way of agreements between the users and providers. Some groups are subsidised through the state budget (children under 16, persons with no income or savings, shelters residents). Social services use is voluntary and there is a free choice of provision. Institutional care is provided when community-based care is unavailable. The authorities plan to develop LTC services through complete implementation of the new legislation and the encouragement of public-private partnerships (2003 social services legislative reform).

Accessibility. For persons requiring mental care, the aim is to provide deinstitutionalised care with the appropriate integration mechanisms for their return into the community. For the elderly, however, there are plans to increase and expand social services, especially services provided in a community setting. Fees are low and do not impede access to LTC services. Measures are in place to guarantee free access to social services for vulnerable groups.

Quality. Despite the existence of legal norms regarding the obligations of LTC providers, including the possibility to close down institutions, improving physical conditions of accommodation continues to be a serious challenge. Besides state control, the social services are also subject to civil control (public councils, trustees, etc.). The authorities recognise the need to expand the range of services provided and improve the quality of existing services.

Long-term sustainability. The ageing of the population will require increased resources to be allocated to LTC for the elderly in particular. Although the recognised strategy of increased

deinstitutionalisation will curb some of the financial burden on the state budget, adequate community-based care alternatives are needed and will incur additional costs, particularly for vulnerable groups without means.

6. Challenges ahead

To combat long-term unemployment and poverty, particularly in areas of multiple deprivations, through an active approach linking decisive actions on health and education in order to enhance individual capacities for labour market integration.

To break the intergenerational transmission of poverty and improve the chances of young people, in particular those from vulnerable groups and in underdeveloped regions and cities, by addressing the mismatch between skills and labour market requirements, reducing early school-leaving and providing social services and social housing.

To amplify efforts on the inclusion of vulnerable groups and ethnic minorities, focusing on the need for public anti-discrimination policies and awareness-raising actions.

To ensure that sufficient resources are available to provide access to health care and adequate social protection benefits for all (notably pensions) and to improve the poverty reduction effectiveness of the social protection system. To increase employment rates, in particular among older workers, and to improve contribution collection in order to ensure the sustainable financing of social protection and health care services.

To accelerate the implementation of the LTC reform through increased provision of social services, continued deinstitutionalisation and the expansion of adequate community-based care, without however neglecting the need for quality improvements in existing care institutions.

BULGARIA data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.4	26.5	**2000**	50.4	54.7	46.3	19.7	20.8	**2000**	16.4	16.7	16.2	33.7
2002	4.9	28.3	**2002**	50.6	53.7	47.5	19.4	27.0	**2002**	18.1	18.9	17.3	37,0
2004	5.6	31.8	**2004**	54.2	57.9	50.6	21.5	32.5	**2004**	12.0	12.5	11.5	25.8
2006	6.0f	34.2f	**2005**	55.8	60.0	51.7	21.6	34.7	**2005**	10.1	10.3	9.8	22.3

*** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	67.1	74.6	12.5	15.2	na	na	14.8	**1995**			-		
2000	68.4	75.1	12.8	15.4	na	na	13.3	**2000**	6.2	59.2	40.4		
2004	69.0sp	76.2sp	13.2sp	16.2sp	na	na	11.6	**2004**	7.7	55.8	43.5		

** Total health expenditure* ** Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio	expenditure (% of GDP) level in **2004** and changes since 2004			
										Total social expend.	Public pensions	Health care	Long-term care
1995	na	na	na	na	na	na	na	**2005**	na	na	na	na	na
2000	na	na	na	na	na	na	na	**2010**	na	na	na	na	na
2004	na	na	na	na	na	na	na	**2030**	na	na	na	na	na
								2050	na	na			

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
HBS income 2004	Total	Children 0-15	16+	16-64	65+	Total	Children 0-15	16+	16-64	65+		S80/S20
Total	15	22	14	14	16	19	24	18	20	13	**Total**	4
Male	13	-	12	13	5	20	-	20	21	8	**Male**	-
femal	17	-	17	14	23	18	-	17	20	14	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	na	na	na	**1999**	na	na	na
2004	15.6	13.7	13.2	14.2	**2004**	7.2	7.3	7.0	**2004**	21.4	22.1	20.7
2006	14.5	11.6	11.1	12.0	**2005**	6.0	6.0	6.0	**2005**	20.0	19.5	20.6

** excluding students*

HBS income 2004	Total	Male	Female	HBS income 2004	Total	Male	Female
Relative income of 65+	na	na	na	***Aggregate replacement ratio***	na	na	na

Change in theoretical replacement rates (2005-2050)

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
na	na	na	na	na	na	na	na	na	na	na	na

**(DB / NDC/ DC); ** (DB / DC)*

CZECH REPUBLIC

1. Situation and key trends

Economic growth has been robust in recent years, accelerating to 6% in 2006, and GDP per capita has increased to 76.1% of the EU-25 average. Employment rates have started to increase after slight decreases in the previous years. In 2005, the total employment rate (64.8%) stayed above the EU-25 average, along with the employment rate of older workers (55-64), which increased significantly (44.5% against 42.7% in 2004). The employment rate among women (56.3%) was equal to the EU-25 average. On the other hand, the employment rate in the 15-24 age group continued to decrease (27.5%). There have been slight decreases in unemployment rates (7.9% overall, 9.8% for women). Youth unemployment has fallen more significantly (19.2%). In 2005, long-term unemployment remained at 4.2%. The at-risk-of-poverty rate[86] is one of the lowest in the EU-25 (10% in 2004). The population is ageing and the fertility rate of 1.2 is one of the lowest in the world. The Czech Republic is projected to face rapid ageing in the coming decades: the old-age dependency ratio was 19.8 in 2005 and is projected exceed 50% by 2050. Life expectancy at birth (72.6 for males and 79.2 for females in 2004) is somewhat below the EU-25 average[87], but has consistently increased over the last decade. Healthy life expectancy (62.8 and 63.3 in 2002) is not far below the EU-15 average. The infant mortality rate (3.7 in 2004) is one of the lowest in the EU and has seen a consistent decrease since 1960 (20). The perinatal mortality rate (4.3 in 2003) is also low by EU standards. Social protection expenditure is steadily increasing, reaching 19.6% of GDP in 2004 (EU-25 – 27.3%). Expenditure on pensions was 8.5% of GDP in 2005) and is projected to rise to 14% in 2050; total health expenditure was 7.2% of GDP in 2004.

2. Overall strategic approach

The main challenges presented in the Report are "achieving a sustainable standard of social protection", "sustaining adequate pensions and a decent living standard for pensioners", "preventing and tackling inter-generational social exclusion", and "increasing the participation of people at risk of social exclusion in the labour market". The Czech social protection system has been successful in decreasing poverty and preventing social exclusion, but needs to be adapted to ensure its sustainability and to tackle social benefit dependency. Social cohesion will therefore be pursued in particular through measures aimed at enhancing the degree of economic and social self-sufficiency of the population, while maintaining the basic standard of living of the population. The intention is also to prevent the intergenerational transmission of deprivation by focusing on the protection of families and children, ensuring equal access to education and vocational training. However, the Report does not present enough synergies between social inclusion and labour market participation and does not mention the issue of 'flexicurity'. Regarding pensions, the emphasis will be on postponing retirement and supporting complementary pension systems. Health and long-term care policy should contribute to social cohesion by focusing on the prevention of illnesses, raising public awareness of the need to avoid overuse of health services to ensure their sustainability, and increasing the quality and accessibility of health and long-term care. The Report refers to the Lisbon National Reform Programme (NRP) and its priorities and

[86] Following the implementation of EU-SILC in 2005, the values of all income based indicators for 2004 (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition from ECHP to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national micro-census survey that was not fully compatible with the SILC methodology based on detailed income data.

[87] EU-25 average of 75.8 and 81.9 for males and females in 2004

highlights the need to ensure the long-term sustainability of social protection systems in order to guarantee economic growth and competitiveness.

As regards governance, this is addressed differently in the three strands. The Committee on Social Inclusion created by the Ministry of Labour and Social Affairs (MPSV) has been coordinating the social inclusion strategy and also worked on the health and long-term care part of the Report (a special sub-group was created). A special team of experts was established by agreement of the political parties to work on the proposals for pension reform, while in the field of health and long-term care standard structures such as expert and working committees and doctor and patient organisations already exist. Regarding implementation, the emphasis is on mainstreaming social inclusion but this is still not applied as a general principle.

As an example of mutual strengthening, the educational measures for Roma children were singled out: these aim to overcome their disadvantages due to low education through preparatory classes, teacher's assistants, and support programmes for secondary education. Relevant statistics are not yet available, but it may be presumed that these measures are helping these children finish basic education and enter secondary school. This will also have a positive effect on their entry into the labour market. However, gender mainstreaming is not evident within the Report. The structural funds and especially the European Social Fund are viewed as important tools for implementing the social inclusion strategy in particular.

3. Social inclusion

3.1 Key trends

The Czech Republic has one of the lowest at-risk-of-poverty rate in EU-25 (10% in 2004). The role of social transfers in decreasing poverty is significant: without them, 39% of the population would fall under the poverty line. Pensions reduce the percentage from 39% to 21% and other social transfers to 10%. There is a very low proportion of poor pensioners due to the regular adjustment of pensions. Women (11%) are more at risk of poverty than men (10%), and the difference increases with age (in the 65+ age group, W= 7%, M=2%). The groups most at risk of poverty are the unemployed (51%), single-parent families with at least one child (41%) and households with three or more children (25%). The net income of social assistance recipients was 66.6% of the at-risk-of-poverty threshold for single persons, 89.1% for lone parents with 2 children and 85.9% for married couples with 2 children[88].

Child poverty is lower than the EU-25 average but is still quite high (18%). The youth unemployment rate is high (19.2% in 2005) but is starting to decrease. Educational attainment amongst 22-year-olds is one of the highest in EU-25, with 90.3% having completed secondary school in 2005 (M = 90.8%, F = 89.8%), though this represents a slight decrease (91.8% in 1999). The number of early school-leavers is very low (6.4% in 2005), although increasing (5.5% in 2002) and lower for men (M = 6.2%, F = 6.6%). The percentage of people living in jobless households (8.2% for children aged 0-17 and 7.3% in the 18-59 age group) is lower than the EU-25 average. The rate of in-work poverty (3% in the 18+age group) is significantly lower than the EU-25 average (8% for the 18+ age group).

The Czech social protection system is successful in protecting people from falling below the poverty line. On the other hand, it does not sufficiently motivate some population groups to enter the labour market. The unemployment trap was 78% for a one-earner + 2 children family in 2004. Recently, new measures have been implemented or approved to support

[88] Figures on the net income are not based on the EU-SILC but on the previous 2002 Microcensus survey.

making work pay, together with a comprehensive reform of the social benefits system to encourage higher activation. The reform aims to motivate people to enter the labour market by financially benefiting those actively trying to solve their situation and penalising persons refusing to cooperate with the labour and social affairs offices. To supplement the current minimum subsistence amount, which is the criterion for social benefit entitlement, a new concept, the existence minimum amount, will be introduced to ensure a basic living standard for the population. This will be accompanied by reform of the social services.

3.2 Key challenges and priorities

The Czech Republic chose to limit its previous multi-dimensional approach to social inclusion to a targeted approach focused on the most disadvantaged groups and families. The objectives are in line with the main features of the country's situation, in particular the fact that the rate of poverty is very low and concentrated among some population groups. An effort to involve regional and local levels in the strategy will aim to overcome the hitherto rather administrative and formal approach to implementing and mainstreaming social inclusion and will also endeavour to tackle regional disparities. In comparison to the last NAP/incl., which stressed employment as the most important way out of poverty, the current strategy focuses more on social services development and considers employment only in relation to the NRP 2005. The synergies between social policies and employment are thus less evident. This is particularly regrettable given the high unemployment rate among young people, which exposes them to the risk of poverty. A coherent approach in line with the European Youth Pact is needed.

The 2006 Joint Report identified two challenges for the Czech Republic regarding social inclusion: to support the implementation of social inclusion policies at regional and local level and to improve the situation of vulnerable groups (for example the Roma) and disadvantaged regions. Concerning the most vulnerable groups, progress is particularly evident as regards the Roma. The Concept of Roma integration has been amended and the Czech Republic has joined the Decade of Roma Inclusion 2005-2015. To eliminate the disadvantages in access to education, the numbers of preparatory classes and teacher's assistants have increased. A successful programme of outreach work in excluded Roma communities is being implemented and strengthened, and the complex 'Analysis of the Socially Excluded Roma Communities' has been produced. Progress has also been achieved with homeless people. The Report listed as one example of best practice a project financed by the ESF aiming to ensure systematic delivery of high-quality social services to the homeless. If more capacity were available for housing and individualised help, this could be successful in promoting social inclusion. To improve the situation of the most disadvantaged regions with over 14% unemployment, an additional investment incentive programme, which also finances training, was introduced in June 2004.

3.3 Policy measures

The first priority, which is to strengthen the integration of socially excluded persons or persons at risk of social exclusion and eliminate the barriers to entry and retention on the labour market for such persons, strongly builds on the previous NAP/Incl. and on the findings of the implementation report. It is to be pursued in particular by the social services in line with the new Act on Social Services to come into force in January 2007. The Act aims at facilitating access to social services and increasing their quality and will introduce personal benefits and a set of compulsory quality standards. The first priority covers most disadvantaged groups, including the long-term unemployed, people with disabilities, older people, excluded Roma communities, the homeless, immigrants, victims of domestic

violence, ex-prisoners, persons leaving institutions, etc. Social inclusion is also to be enhanced by support for the social economy and social field work. There are many useful measures proposed, such as: introducing a uniform and complex approach to dealing with the problems of socially excluded Roma communities; creating a complex system of preschool education and supporting special programmes for the transition to secondary school and courses for early school-leavers. Regarding children with disabilities, the stress is on eliminating the regional differences in educational and counselling offer and transforming the special schools into integrated support centres. Significant attention is paid to the prevention of social pathological phenomena both in socially excluded communities and in weak families in order to protect children. Also positive is the increased attention paid to young persons leaving institutions: plans for their development are to be prepared before they leave their institutions and there will be programmes to support their independent living. On the other hand, several issues require more attention: the need to increase employment, the prevention of housing loss (according to the Strategy, a concept and system will be developed for social housing, but more clarification would be useful), and the situation of older persons.

The second priority, which is to strengthen the cohesion of the family and awareness of its importance, the awareness of intergenerational solidarity and the rights of the child, will be promoted by supporting the existing social services and developing the new services in cooperation with the NGOs. To tackle regional differences in the accessibility of services, their availability and quality will be surveyed. Special attention will be paid to families at risk of poverty and to supporting intergenerational cohesion. Also stressed is the prevention of pathological phenomena in families. A concept of caring for at risk children and children living outside their own families was to be produced in 2006. Attention will be paid to the rights of children and to foster care (including complex social services for families). The second priority will cover all families with a special focus on the disadvantaged, which indicates the increased importance given to family policy.

The third priority is intended to support decision-making processes at local and regional level and the development of partnership in social inclusion policy. In fact, however, it focuses mostly on the system and delivery of social services. The stress on quality is evident, and particular attention is paid to the education and training of social workers and service providers. The MPSV is to support the regions and towns in preparing their medium-term plans for the development of social services and motivate them to use a community planning method. Further, they are to be given support to modernise and humanise residential facilities, especially in developing alternative non-residential and field social services. Two measures with a broader social inclusion aspect were mentioned: developing tools to assess the status and efficiency of activities implemented at local, regional and national levels, and raising awareness of active social policies to motivate municipalities to adopt a more sensitive approach to prevent social exclusion and support the integration of Roma communities.

No targets are set, but national policy-related input and output indicators are used, such as the volume of funds spent, the number of supported persons/entities/families, the number of programmes/plans in place, the number of newly provided services, the number of users, the number of children placed in foster care and institutional care, the number of persons who have completed an educational program, the number of municipalities involved in community planning, etc. While the Czech Republic is performing well on most of the EU-agreed outcome indicators, little use is made of them in monitoring policies. The gender perspective is not sufficiently taken into account. As regards the budget, the scale of resources allocated to the priorities is unclear, as no figures are given. In general, the aim is to finance implementation from the state budget and the structural funds. The role of the ESF in promoting social inclusion has been growing (it is making an important contribution to

specific groups and the disadvantaged regions). In the next programming period, it should help create mechanisms to solve the problems of the excluded communities by the systemic way.

3.4 Governance

The social inclusion part of the Report was prepared by MPSV together with the Committee on Social Inclusion (CSI), which was created in 2003 to draft the Joint Inclusion Memorandum. It consists of representatives of ministries, governmental, regional/local authorities, social partners, NGOs, and experts. Preparation started in autumn 2005 at two regional conferences where the main social exclusion issues were discussed. The social inclusion part also builds on some of the new research reports. Coordination is primarily at national level and is not fully developed at regional and local levels. Nevertheless, work began in 2005 on the methodology for creating regional and local plans (by August 2007). In addition to the CSI, the "Stop Social Exclusion" project serves as an information tool for the social inclusion strategy. One of its targets to involve people experiencing poverty has not been fully achieved so far (however, they are included in decision-making on social services in regions and municipalities that implement community planning). Implementation will be monitored by the MPSV in conjunction with the CSI. The MPSV will prepare the implementation report each year in October and submit it to the CSI. The report will then be published on the internet. The intention is to produce the Final Implementation Report as well. Indicators for monitoring progress are included in all priorities.

4. Pensions

In 2004, older people had a relative standard of living quite close to that of the general population (83%), while the poverty risk among older people (5%) is estimated to be lower than for the population below the age of 65.

The Czech Republic is facing rapidly growing budgetary pressures of a significantly higher magnitude than in most Member States, and the 2006 Sustainability Report assessed the Czech Republic as a high-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005, spending on public pensions is expected to increase from 8.5% of GDP in 2004 to 14.0% of GDP in 2050 (a rise of 5.6 p.p.). According to ISG projections, theoretical replacement rates for a worker retiring at 65 after 40 years of employment on the average wage are projected to decline by about 10 p.p. by 2050 (both gross and net), reaching 70% net (53% gross) in 2050.

The 2006 Joint Report noted that while the Czech Republic has managed to ensure the adequacy of pensions over the last decade, the pension system is facing growing pressures. The Report stressed the need for continuous reforms, in particular to improve the employment situation of older workers. While the Czech Republic currently has a low rate of poverty among older people, replacement rates are projected to decline and future adequacy needs to be carefully addressed. In spite of recent improvements, further increases in the employment rate of older workers are needed. Incentives to work longer need to be strengthened and the creation and take-up of jobs for older workers should be further encouraged so as to help balance financial sustainability and pension adequacy.

Further measures were suggested by an expert team (changing the calculation of benefits, further increasing the retirement age to 65, creating a reserve fund and increasing state support for private pensions, especially for annuities instead of lump-sums), though no agreement on reform has yet been reached at this time. There is a need for the new

government to move on with further steps in reform in order to help strengthen the sustainability of pensions while securing adequacy.

5. Health and long-term care

5.1. Health care

Description of the system: Compulsory universal health insurance provides comprehensive health care coverage for all permanent residents. The General Health Insurance Agency (VZP) has a leading role among health insurance funds covering 70% of the population. There is a clear separation between financing and provision. Provision is decentralised and comprises a public-private mix. Service providers are independent and operate on the basis of contracts negotiated with insurance funds while the Ministry of Health regulates price ceilings. Primary health care (PHC) is organised by municipalities and delivered in municipal health centres, polyclinics or the private premises of general practitioners (GPs), dentists and gynaecologists. About 95% of PHC is private. A GP referral gives access to specialists, polyclinics and hospitals (outpatient and inpatient departments). 75% of specialist outpatient facilities are private whereas hospitals are public. GPs are paid on a capitation basis in the public sector and on a fee-for-service basis in the private sector. Specialists are paid a salary in hospitals and a fee-for-service in the private sector. Compulsory health insurance is financed primarily through an earmarked payroll tax on employees, employers and self-employed and by state budget contributions. Co-payments apply to certain services but are limited. Voluntary private insurance is negligible. In the light of health inequalities and barriers to access for some socio-economic groups, the government is aiming to improve the quality of healthcare services, to improve general health and reduce health inequalities, to ensure homogeneous geographic availability and to provide more easily accessible and equitable services that are better organised and integrated with social services, while maintaining the principles of solidarity, equality and availability of the system and current coverage. In addition, the government is also focusing on increasing the number of health workers and emphasising promotion and prevention as a means to improve long-term health.

Accessibility: The package of services available within the public system is very broad and only a limited number of services are excluded from coverage. The level of out-of-pocket payments is considered low (8.6% of total health expenditure in 2004) with the exception of dental care. Full payment for at least one medicine in each of the basic therapeutic groups is legally guaranteed. The report does not perceive regional inequalities in access to health care services. Nevertheless, unequal access is an important issue for some socio-economic groups (i.e. the homeless and people with disabilities). The report underlines that a stronger PHC, better coordination and the restructuring of the network of health care facilities is needed in order to improve access for patients to different types of care.

Quality: Authorities emphasise the need to develop a national quality assurance system based on international standards and plan to introduce a state-guaranteed accreditation programme for providers. At present, an independent accreditation agency is responsible for the external evaluation of the quality of healthcare in hospitals according to standards accredited by an international society. The report pinpoints the importance of a good information system (e.g. on activity and performance) to ensure quality and financial sustainability. The establishment of a national register to provide information on projects supporting security and quality in healthcare facilities is planned by the government. Patients in the Czech Republic have the right to choose their own health insurance company, doctor and healthcare facility. The establishment of a national agency for patients is envisaged by the government.

Long-term sustainability: Total health care expenditure (7.2% of GDP and 1333 per capita PPP$ in 2004) is below the EU-25 average in GDP terms[89] but noticeably higher than in the other new Member States. It has been constant over the decade in GDP terms. The annual growth rate of per capita expenditure is one of the highest within the EU (9.1% in 2002/2003). Public expenditure as a share of total health expenditure (90.7% in 2004) is the EU highest. Ageing (according to the 2006 EPC/EU projections public health care expenditure is projected to increase by 2 percentage points of GDP by 2050 due to population ageing) and technological developments are emphasised in the report as the main long-term challenges. Expenditure on pharmaceuticals is particularly high (27.5% of total health expenditure in 2004). The government is attempting to stabilise and then reduce these costs through new legislation and via changes in the mechanism of payment for pharmaceuticals to manufacturers and suppliers. The report highlights the overuse of specialist and hospital care (the number of acute hospital beds is still one of highest in the EU). To improve efficiency the authorities are planning to reinforce PHC, concentrate highly specialised healthcare providers in a few centres throughout the country and shorten the average hospital stay (very high by Western Europe standards). It should be noted that the general conditions for improving the equity of financing and the financial sustainability of funds may not be fully met. Improving risk-adjustment across funds by basing resource allocation not just on age but also on other elements may reduce the financial difficulties of some insurance companies, especially of the VZP. The report highlights some imbalances in the structure of human resources. The government also emphasises the need for stronger promotion and prevention to address risk factors and specific diseases and ensure health-supporting environments that facilitate healthy choices. On promotion and prevention, several programmes have been launched in recent years (e.g. the Long-term Programme for Improving the Health of the Czech Population - Health for All in the 21st Century) under the auspices of the WHO.

5.2 Long-term care

Description of the system: Long-term care facilities vary in nature and financing, and involve primary, home and day care services (nursing activities, hygiene, shopping, meals-on-wheels, washing, leisure activities, and rehabilitation), assisted housing, residential services (pensioners homes and boarding houses for pensioners) and sheltered housing. The regional authorities and municipalities are responsible for organising the provision of long-term social care financed from the state budget (only long-term medical care is paid by health insurance). Clients and their families also contribute to the costs of institutional care. Some services (particularly out-patient) are provided through NGOs, financed mostly by public grants. As a result of ageing and societal changes, the government's strategy is to increase the provision of home care services and shift from institutional to primary and home care. A multi-source financing of social services is the recently declared central principle. Monitoring the impacts of the new Act on Social Services is also a priority for the authorities.

Accessibility: The report highlights that the current supply is insufficient, waiting times for placement in public long-term care facilities (e.g. pensioners' homes) varies from several months up to several years and regional inequalities (availability, waiting times, financial costs) are high. Moreover, due to co-payment obligations, a financial barrier to access exists. The strategies to tackle these issues differ from region to region depending on local government performance. Some municipalities are introducing new care paths to replace institution-based care with home-care, while others are extending nursing care or modernising facilities. However, the health and social care sectors are not fully integrated. The report underlines that the capacity of hospices has increased in recent years but is still insufficient.

[89] 8.87% and 2376.33 per capita PPP$ in 2004.

The government intends to encourage cooperation between stakeholders to tackle social exclusion and create a network of geriatric outpatient and community gerontology centres. The provision of adequate long-term care is a key priority in the coming decade.

Quality: A new Social Services Act defines the conditions for the registration of social service providers and is expected to improve the current fragmented framework. Social Services quality standards set basic levels for personnel training and procedural and operational aspects regarding the provision of social services. The importance of improving coordination between health and social care is emphasised in the report.

Long-term sustainability: Stronger coordination between the health and long-term care sectors is planned by the government through the introduction of a joint-financial (multi-source) model for the "institute of the social – health-care bed". Within this new system healthcare facilities will be able to integrate nursing care units with medical facilities or transform acute care beds into aftercare beds. The government considers the development of and access to long-term care to be their main priority in terms of ageing and socio-economic policy. According to the 2006 EPC projections, expenditure is projected to increase by 5.6 percentage points of GDP by 2050 due to population ageing.

6. 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 address pension reform and encourage the creation and take-up of jobs for older workers so as to help balance financial sustainability and pension adequacy;

Improve efficiency and reduce waste through a more rational use of resources (notably through a stronger focus on PHC while reducing the high dependency on specialist and hospital inpatient care) and by adjusting staff numbers;

To improve risk-adjustment across funds to improve equity of financing and the financial sustainability of funds;

To enhance coordination between health and social care and between different stakeholders and to improve access to long-term care services.

Czech Republic: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,6	64,7	**2000**	65,0	73,2	56,9	36,4	36,3	**2000**	8,7	7,3	10,3	17,8
2002	1,9	67,7	**2002**	65,4	73,9	57,0	32,2	40,8	**2002**	7,3	5,9	9,0	16,9
2004	4,2	72,1	**2004**	64,2	72,3	56,0	27,8	42,7	**2004**	8,3	7,1	9,9	21,0
2006	6.0f	76.1f	**2005**	64,8	73,3	56,3	27,5	44,5	**2005**	7,9	6,5	9,8	19,2

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth*		Infant mortality rate	WHO	Total Health exp %GDP	Public Health Exp % of THE**	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI*** % of pop
	male	female	male	female	male	female							
1995	69.7	76.6	12.7	16,0	na	na	7.7	**1995**	6.9	92.7	-		
2000	71.6	78.4	13.7	17.1	na	na	4.1	**2000**	6.6	91.4	8.6	100	negligible
2004	72.6sp	79.2sp	14.3sp	17.7sp	62.8p	63.3p	3,7	**2004**	7,2	90,7	8,6		

**data for 2002* ***THE: Total Health Expenditures* ****PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	17,4	39,7	37,2	2.3	11,9	1.3	7,6
2000	19,5	43,3	33,7	3,5	8,4	3,3	7,8
2004	19,6	41,1	35,3	3,9	8,4	3,4	7,9

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio	expenditure (% of GDP) level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health Care	Long Term care
2005	19.8	19.3	8.5	6.4	0.3
2010	21.9	-0,5			
2030	37.1	1.7	1.1	1.4	0.2
2050	54.8	7.1	5.6	2	0.4

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	10b	18b	9b	9b	5b	18b	18b	18b	19b	8b	**Total**	3.7b
male	10b	-	8b	9b	2b	19b	-	19b	19b	25b	**male**	-
femal	11b	-	10b	10b	7b	18b	-	17b	19b	6b	**female**	-

	People living in jobless households				Eurostat	Long Term Unemployment rate			Eurostat	Early school leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	7.2	7.2	5.6	8.8	**1999**	3.2	2.4	4.2	**1999**	na	na	na
2004	9,0	8,0	6.4	9.6	**2004**	4.2	3.4	5.3	**2004**	6,1	5,8	6,5
2006	8,2	7,3	5.8	8,8	**2005**	4.2	3.4	5.3	**2005**	6.4	6,2	6,6

** excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0,828b	0,854b	0,808b	***Aggregate replacement ratio***	0,506b	0,485b	0,576b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
-9	-7	-7	DB	…	…	100		…	28	…	…

**:(DB / NDC/ DC); ** (DB / DC)*

DENMARK

1. Situation and key trends

The Danish economy has been characterised by strong activity in recent years with GDP growth estimated to reach 3.0% in 2006. Denmark continues to record employment rates well above the EU targets (75.9% in 2005), particularly for women (71.9%) and older workers (59.53%). Unemployment has decreased significantly and is expected to reach a historical low of 3.9% in 2006. Long-term unemployment (1.1%) and unemployment among young people are decreasing and are among the lowest in the EU. Denmark performs well as regards the risk of financial poverty (12% in 2004 – 10% including imputed rent). Immigrants, students and the unemployed are overrepresented in the lower income brackets. The social protection system is based on the principle of universality with all citizen guaranteed fundamental protection against social risks such as unemployment, sickness or dependency. There is a strong involvement of social partners, local authorities and other stakeholders. Danish expenditure on social protection ranks as one of the highest in the EU (30.7% of GDP in 2004). The ratio of persons aged 65 and above to 15-64 year olds will increase from the present 22.6% (2005) to 37.1% in 2030 and 40% in 2050 (significantly below the EU-25 average of 52% in 2050). Male life expectancy is average (75.4 years in 2004) but is below average for women (80.1 years). Infant mortality (4.4 in 2004) is near the EU average. Perinatal mortality is also about average (4.4 in 2001) and has constantly declined since 1960 (26.2).

2. Overall strategic approach

The overall strategic approach to social protection and social inclusion is to develop an inclusive labour market by increasing the labour market participation of vulnerable groups. Key challenges are 1) to increase the employment rate of vulnerable groups, 2) to ensure that all citizens have equal access to a high- quality, efficient health care system and 3) to establish the budgetary conditions for maintaining the present universal pension system. Denmark has addressed all three overarching objectives of the Open Method of Coordination.

On social cohesion, Denmark has recently taken steps to safeguard its social protection system in the long term through a newly adopted welfare agreement, which is expected to address a large part of the long-term welfare challenges caused by ageing. The long-term focus of the social inclusion strategy is on breaking the vicious circle of deprivation. The short-term focus of the social inclusion strategy is on vulnerable, disadvantaged and already socially excluded groups. The weakness of the social inclusion strategy is that, so far, it has lacked an analysis of the background for the various initiatives and particularly the social situation of certain target groups. Together with relatively few targets and indicators to help monitor the activities, there is a risk of limited evaluability, fragmented management and blurred accountability. The Government has recently taken steps to develop analysis, evaluations and indicators within its social inclusion strategy, notably in the framework of the new action programme "Our Collective responsibility II".

There is an effective and mutual interaction between the strategy on social inclusion and the Lisbon Strategy. Both the National Strategy Report on social inclusion and social protection and the National Reform Programme are drawn up in close cooperation with all the ministries involved. Social inclusion policies are presented as an integral part of the Danish Lisbon strategy, and the measures are seen as key elements in pursuing the targets of this strategy.

Examples are the employability of vulnerable groups and improving the flexibility of employees.

On governance there has been extensive involvement of key stakeholders in the preparation of the social inclusion strategy, including social partners, civil society, evaluators, regional authorities and relevant ministries. Denmark has a very long tradition of cooperation between NGOs and the public sector in implementing social policy.

3. Social inclusion

3.1 Key trends

Denmark has one of the lowest levels of income inequalities in the EU, despite a slight widening in the late 1990s. However, the share of people living in jobless households decreased from 8.5% in 2004 to estimated 7.7% in 2006 for adults and from 6.0% to 5.7% for children.

According to ESSPROS data, Denmark spends 30.7% of its GDP on social protection, compared to the EU15 average of 28% (2004 data). Measured as expenditure per capita in Purchasing Power Standards (PPS), the Danish expenditure on social protection, at 8 115 PPS, is one of the highest in the EU. According to the 2003 EU-SILC data, 12% of the Danish population lived on an income of less than 60% of the median income (10% when including imputed rent). This rate is one of the lowest in the EU, largely reflecting a relatively even income distribution.

Immigrants, students and the unemployed are over-represented in the lower income brackets. The employment rate of people with ethnic minority background remains significantly below the average of the population.

3.2 Key challenges and priorities

The overall strategic approach for social inclusion policies in Denmark is the assumption that a strong and competitive society requires social cohesion without too many social and economic differences. The key priority for Denmark for obtaining an inclusive society is therefore through intensive involvement of and dialogue with social partners and key stakeholders to ensure that vulnerable and marginal groups also have sufficient access to the labour market. This strategic approach can be seen as bridging well the three strand objectives for social inclusion.

In the 2006 Joint Report, two challenges were identified for Denmark. As regards "safeguarding the current high level of protection while satisfying increasing demands for health and welfare services in view of the ageing population", Denmark has made good progress. The far-reaching welfare agreement reached in June 2006 is expected to address a large part of the long-term welfare challenges caused by ageing. Concerning the second challenge of "developing labour market tools designed to improve integration of ethnic minorities within the labour market", participation rates have improved only moderately over the past year. More substantial effect from new measures adopted by the welfare agreement has to be seen.

A major challenge of the social inclusion strategy is to establish analysis of the impact of policy initiatives on the situation of vulnerable groups. In particular, the social situation of

certain immigrants especially affected by reduced social allowances in recent years - has been highlighted regularly by key stakeholders, such as the Government's independent "Council of Socially Marginalised People". Within the action programme *Our collective responsibility II*" the Government has now taken first steps to address this.

The ESF is contributing to Denmark's social inclusion policies through the Objective 3 programme, but the funding is negligible in comparison to the total expenditure on social inclusion in Denmark.

3.3 Policy measures

In order to pursue its key priorities for vulnerable groups, the government has launched in August 2006 a new phase in its action programme *"Our Collective Responsibility II"* with an estimated budget of €83 million . The main focus of this phase is 1) to strengthen outreach and support services, 2) to create more openings to the labour market, and 3) to improve social administration.

In 2006, the Government launched a new strategy to break the vicious circle of deprivation. A new reform aims at strengthening early preventive activities for disadvantaged children and young people and their families, while also improving casework in local authorities. The reform also puts greater emphasis on the school attendance of children and young people in care, thus helping to break the vicious circle of deprivation. Another crucial element is the existence of day-care facilities, for which €268 million has been allocated over a four-year period mainly to help support children. The newly adopted welfare agreement contains ambitious targets for increasing the share of pupils with upper-secondary education to 95% in 2015. Special efforts are being made to address the challenges faced by immigrants, including pilot projects for "whole-day-schools" to provide additional support.

The new welfare agreement contains concrete measures to strengthen the adult and vocational training system in Denmark. This is the result of the work of the Tripartite Committee for Lifelong Upgrading of Skills and Education, which concluded that while activities are already extensive when compared internationally, too many adults still have problems with basic school-level skills. This group also participates relatively little in vocational training. Some of the main measures will be to increase the number of participants in Preparatory Adult Education (basic skills in literacy and innumeracy) to a yearly number of 40.000. An additional 2.000 adult apprenticeships will be established, and there is also a strong emphasis on enhancing the motivation for lifelong learning.

A number of activities have been launched to boost employment among vulnerable groups. About €67 million has been allocated to activate the long-term unemployed with a target of doubling the participation rate within 2 years. In the National report several activities for people on the fringes of the labour market are mentioned: the *pool for social activation* with about 7.2 million, a *special mentor scheme* with around €5.3 million and a *temporary working scheme* with about €2.7 million. Finally, an annually €3.3 million has been allocated for the period 2005-2008 to a debt remission pilot project targeting socially disadvantaged groups. A 2005-2009 action plan for people with disabilities with a budget of €11 million has been launched with the aim of increasing their employment yearly by 2000 and the share of enterprises employing the disabled by 1 percentage point. Finally, about €43 million has been allocated to help mentally ill people enter the labour market.

On housing, anti-Ghetto measures will be continued with the aim of stopping the flow of vulnerable groups into these areas and retaining the more well-off residents. New rules will permit the municipalities in 25 special areas to reject house seekers receiving social assistance but at the same time will oblige them to offer replacement housing within six months. The anti-Ghetto measures also allow for businesses to be set up in buildings that were assigned to social housing. In 2006-2008, an additional €5 million has been allocated to establish protected houses for the homeless and socially vulnerable. Finally, about €32 million is allocated yearly to housing renovation and €7 million to urban renewal.

On integration, the newly adopted welfare agreement contains a number of new measures for immigrants. Apart from a tightening of rights and obligations for activation, these new measures also contain yet to be tested initiatives, including the creation of partnerships with large enterprises and the introduction of wage subsidies. About €40 million has been allocated over a four-year period to a special counselling scheme aiming to assist immigrants in their job search and job applications. Finally, a new quadripartite agreement has been reached in order to introduce special access packages etc.

Special attention is still being given to trafficking in women and to address the growing need for informing ethnic minority women about their rights in Denmark. It is estimated that there are about 4000-5000 prostitutes in Denmark of which almost half are foreigners. Many of them are believed to be the victims of trafficking. Increased cooperation with the Baltic countries is being envisaged to prevent recruitment for trafficking. An action plan aims at improving outreach work, and a protected shelter/hostel has been established to help women out of their situation. Finally, a €135.000 information campaign has been launched to raise awareness of trafficking and have cases reported to a special "hotline".

3.4 Governance

The involvement of stakeholders has been extensive during the preparation of the National Strategic Report. A national conference took place in April 2006 with the participation of a large spectrum of key stakeholders, including social partners, civil society, evaluators, regional authorities and relevant ministries. Based on contributions from various ministries, a first draft of the National Strategic Report was then submitted to a hearing procedure for all participants at the initial national conference. The policies for social inclusion and social protection are presented as an integral part of the Danish Lisbon strategy, and the measures are seen as key elements in pursuing the targets of this strategy. Denmark has a very long tradition of cooperation between NGOs and the public sector in social matters. This is one of the strongest points in the Danish policy on social inclusion, and makes an important contribution to Denmark's successful and inclusive society.

The Danish Government has recently taken steps to improve the monitoring and evaluation of the social policies.

4. Pensions

The income of people aged 65+ relative to the 0-64 age group stands at 71%, which is lower than in most other member states, while the risk of poverty for the elderly population remains at a moderate level (17%), but higher than for the 0-64 age group (10%).[90]

The 2006 Sustainability report assessed Denmark as a low risk Member States as regards the sustainability of public finances. According to AWG projections, public pension spending will grow between 2004 and 2050 from 9.5% to 12.8% of GDP[91]. A major increase is also expected in expenditure on occupational pensions, as these schemes will mature and contribute significantly to future pensions. According to ISG projections, total gross theoretical replacement rates for a worker retiring at 65 after 40 years on the average wage is expected to increase from 49% in 2005 to 64% in 2050 (from 71% to 76% in net terms), despite a decrease in the gross replacement rate for the first pillar (including ATP) from 45% to 39%, reflecting the expected increase in occupational pensions from 4% to 25% (current coverage of those schemes is close to 80%), assuming contribution rates of 12.7%).

The 2006 Joint Report underlined that the Danish strategy for ensuring the adequacy and sustainability of public pensions seems appropriate. It stressed that the maturation of occupational pensions should contribute to the future adequacy of pensions and would benefit from periodic reviewing. It also noted that despite good employment records, further measures to improve employment rates among older people would be required, in particular as regards early retirement schemes.

A budget policy leading to quick debt reduction has already been sustained for some years, and should result into substantially lower levels of public debt by 2010. With the development of occupational pension schemes, replacement rates are expected to rise significantly and reduce the current relative income gap between people aged 65 and over and people below the age of 65. The first pillar will nevertheless continue to play a dominant role in pension provision.

Under the welfare agreement of June 2006, retirement ages will increase from 60 to 62 for early retirement schemes (from 2019 to 2022) and from 65 to 67 for old age pensions (from 2024 to 2027), while from 2025 they will be indexed to life expectancy at 60. Though the phasing in of these measures appears to be particularly long, they should make a substantial contribution to long-term future adequacy and sustainability.

[90] Accumulated wealth, which is higher for older people, should also be considered when comparing living standards across generations, but due to data limitations this is unfortunately not possible for all countries. These figures do not include as income negative capital income and imputed rent from private housing, or in kind benefits or services (such as as home-help or health care), and possibly some specific in cash benefits (such as heating benefits), which gives an incomplete picture of the income situation, in particular for older people. When taking into account this more comprehensive definition of income, the risk of poverty in Denmark for elderly people is fairly the same as in the rest of the population (8.7% for people aged more than 65 and 10.6% for people aged more then 75, compared to 9.8% for 0-64 aged people).

[91] Excluding the effects of the Welfare Agreement reached in June 2006

5. Health and long-term care

5.1 Health Care

Description of the System: Denmark has a tax-based, decentralised health care system that provides universal coverage for all Danish citizens. Primary care and hospital care are free at the point of use. Health care has to day been primarily funded and provided by the counties. However, The Local Government Reform of 1 January 2007 introduces five new, larger regions to replace the counties, which will now be mainly responsible for hospitals and psychiatric treatment. The new regions can no longer levy taxes, but will be financed from the tax-based state (around 80%) and the local authority budgets. The ninety-eight new local authorities will assume a wider responsibility and a reinforced role in the health area, especially for prevention and rehabilitation but specialised outpatient rehabilitation will still be provided in hospitals. The reform aims to ensure cohesive patient treatment across administrative borders especially for disadvantaged persons and simplified access to prevention, examination, treatment and care. It allows local authorities to develop new organisational solutions to improve quality, interdisciplinary activities and staff recruitment.

Accessibility: All citizens in Denmark are entitled to free and equal access to health care and rehabilitation as well as to prevention and health promotion services. Citizens have a free choice of public hospitals in the country, and in July 2002 the Government guaranteed all citizens the right to opt for publicly financed treatment at a private or foreign hospital if waiting times for public hospitals are more than two months (from 2007 the limit is one month).From July 2002 to July 2006 nearly X% of the patients have used this guarantee, almost entirely in the form of treatments at private domestic hospitals. Hospital treatment for non-emergency cases requires referral from a doctor, usually the patient's general practitioner. Private out-of-pocket payments accounted for 16% of total health expenditure in 2004, in the form of as co-payments for e.g. physiotherapy, dental care, spectacles and pharmaceuticals as well as contributions to voluntary health insurance schemes. About 30% of the population purchase such insurance to cover statutory co-payments.[92] From 2002 to 2006, average waiting times for 18 selected treatments fell by 22%, from 27 weeks to 21 weeks. Almost 96.000 (approx. 20%) more operations were performed in 2005 than in 2001. Waiting times are considered to reflect the organisational quality of the hospitals.

Quality: The Danish quality model, which aims to promote and improve the quality and delivery of treatment, will be developed over a period of time. The initial aim is to accredit all public hospitals under the model by the end of 2008. Subsequently this will be gradually expanded to cover the entire health sector. The quality model must be based on standards with measurable indicators for clinical quality (e.g. treatment of lung cancer) and on standards for organisational quality (e.g. hygiene and patient information). A Danish quality institute was set up in 2005 with the task of ensuring the implementation of the Danish quality model.. In recent years a number of initiatives have been launched with the primary aim of increasing quality in cancer treatment. To help reducing the total waiting times the Government has recently announced further measures to help guiding patients. The Government is ensuring more openness and transparency in hospital treatment, for instance by introducing a website in October 2006 to publish comparable information on quality and service at individual hospitals.

[92] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

Long-term Sustainability: Total healthcare expenditure (9.0% of GDP and PPP$2763 per capita in 2003) was just above the EU average as a percentage of GDP (8.8% and PPP$2266 in 2003). The share of GDP was 9% in 1980-1983, declining to 8.2% in 1997 before rising again to the current level. The share of public healthcare expenditure[93] decreased from 88% in 1980 to 83% in 2002. Public healthcare expenditure grew from 6.9% of GDP 1998 to 7.4% in 2004. According to the 2006 EPC/EC projections public health care expenditure will increase by 0.8 percentage points of GDP by 2050 due to population ageing, whereas a national projection show a 1.1% increase. Increased free choice for patients have led to increased transparency in the use of resources. Local government reform is expected to promote better coordination of competences and responsibilities at different levels thereby ensuring more efficient use of resources. The local government reform will also mean that prevention at local level will have a higher priority, and should help ensure greater coherence between care actions at different organisational levels. The five new regions should provide a stronger basis for centralising more treatments, taking better advantage of specialisation and ensuring optimum resource utilisation.

5.2 Long-Term Care

Description of the system: Legislation defines the overall rights to receive long-term care. The local authorities (local council) are responsible for providing the various forms of long-term care services. The costs are financed through local taxes and grants from the state and the local authority always decides on the assistance to be granted, irrespective of whether it is provided within the public or private sector. Local authorities are obliged to ensure assistance with the necessary personal care and practical tasks in the homes of individuals unable to take care of themselves on their own. Assistance is granted following an individual assessment of the recipient's functional abilities and needs, and is planned in cooperation with the recipient on the local council's adopted service level. Assistance aims at activation, by enabling the recipient to perform as many tasks as possible by themselves. Almost half of all older people over 80 receive permanent home-help services. A basic principle of this policy is that the type of home should not dictate what care services are offered, but that the needs of older individuals should steer such decisions. Since 1987, Denmark has only built special housing for older people with living quarters separated from where care is provided. Local authorities continue to convert old care homes into such 'close-care accommodations'.

Accessibility: Danish care for the elderly rests on the basic principle that all residents of Denmark have free and equal access to various services, where temporary or permanent physical or mental impairment prevents them from handling such tasks on their own. In principle, permanent personal care and practical help is free. Some fees are charged for temporary help, except for citizens on the lowest incomes. For permanent help, local councils may charge payment for non-staff expenses. Fees may be charged for meal schemes. However, such fees account for only a small part of total care expenditure on older people. Residents in social housing for the elderly pay monthly rent corresponding to the costs of running the housing area, and may have access to general housing benefits depending on income. Residents of conventional care homes pay rent related to the costs of running the care home, with possible deductions based on the resident's financial situation.

Quality: Legislation directs local authorities to establish quality standards containing a description of the service level determined by the local council and to prepare quality standards for personal and practical help. As of 2001, local authorities are obliged to prepare

[93] As a percentage of total health care expenditure

quality standards for rehabilitation that must state what help citizens are entitled to. The content, scope and performance of services must be precisely described and quality targets set. Local authorities must adopt quality standards once a year and follow them up regularly. An initiative has been taken recently to create more openness regarding care home quality by enabling user information to be compared within and across local authority borders. The local council must offer respite care (outside the home) or relief (in the home) for family carers. For several years, activities have been undertaken to train, educate and upgrade the qualifications of staff and managers in the care sector. It is felt that the recruitment of nurses may become increasingly problematic as the profession is associated with low salary levels, a heavy workload and poor working conditions.[94]

Long-term Sustainability: The Government attaches great importance to offering citizens free choice as part of its strategy towards older people. Healthy competition can improve quality and efficiency, and encourages suppliers to better meet recipients' expectations. All persons deemed eligible for special housing are entitled to choose such housing freely within the local authority as well as across local authority borders. Moreover, elderly and disabled people are entitled to choose between various home-help suppliers. In 2005, 160.000 persons receiving home help were entitled to choose between suppliers of that service. Of these, some 15% used this option to choose a private supplier. The Government wants to provide further options for free choice. A new bill will thus be introduced to provide a framework for ensuring greater freedom of choice for citizens, allowing the private sector to establish and operate free retirement housing in competition with retirement housing run by local authorities. According to the 2006 EPC/EC projections, public long-term care expenditure will increase by 1.1 percentage points of GDP by 2050 due to population ageing (from 1.1% of GDP in 2004), which corresponds to the national growth projection.

6. 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 further develop labour market tools to improve the integration of ethnic minorities within the labour market.

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

- To take the necessary steps to further improve the quality, effectiveness and efficiency of the Danish health care system, including measures to improve the organisation and performance of cancer treatments.

- To take more actions to recruit people to work in the care professions and improve the working conditions.

[94] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

DENMARK

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.5	126,0	**2000**	76.3	80.8	71.6	66,0	55.7	**2000**	4.3	3.9	4.8	6.2
2002	0.5	121.4	**2002**	75.9	80,0	71.7	63.5	57.9	**2002**	4.6	4.3	5,0	7.4
2004	2.2	120.1	**2004**	75.7	79.7	71.6	62.3	60.3	**2004**	5.5	5.1	6,0	8.2
2006	3.0f	122.6f	**2005**	75.9	79.8	71.9	62.3	59.5	**2005**	4.8	4.4	5.3	8.6

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65 (2003 instead of 2004)		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.7	77.8	14.1	17.5	61.6	60.7	5.1	**1995**	8.2	82.5			
2000	74.3	79.0	15.2	18.3	62.9	61.9	5.3	**2000**	8.4	82.4	16	100	28
2004	75.4sp	80.1sp	15.9sp	18.9sp	63.0e	60.9e	4.4	**2004**	9	82.6	16.1	100	

*s: Eurostat estimate; p: provisional; e: Estimate; *THE: Total Health Expenditures **PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	31.9	37.7	17.8	14.8	12.4	6.8	10.6
2000	28.9	38.1	20.2	10.5	13.1	6.1	12
2004	30.7	37.2	20.6	9.5	13	5.8	13.9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2005	22.6	26.8			
2010	24.8	0.2			
2030	37.1	4			
2050	40	4.8			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate ***					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	10	12	11	18	16	18	16	22	8	**Total**	3.5
Male	12	-	12	11	17	16	-	14	22	7	**Male**	-
Female	12	-	13	11	18	16	-	16	22	9	**Female**	-

*** Without imputed rent

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	1.1	1.0	1.3	**1999**	11.5	14.2	9.1
2004	6,0	8.5	8.3	8.8	**2004**	1.2	1.1	1.3	**2004**	8.5	10.4	6.7
2006	5.7p	7.7p	7.7p	7.8p	**2005**	1.1	1.1	1.2	**2005**	8.5	9.4	7.5

**: excluding students; p:provisional*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.7	0.718	0.695	***Aggregate replacement ratio***	0.353	0.325	0.388

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Current estimate (2002)	Assumption
5	15	-6	DB	21	DC	100	78		0.9	19:12	12.7

**:(DB / NDC/ DC); ** (DB / DC)*

GERMANY

1. Situation and key trends

Against the background of increasing GDP growth (estimated at 2.5% in 2006 as against 0,9% in 2005), the total employment rate started picking up in 2006 after a long period of stagnation but remains well below the Lisbon target (65.4% in 2005). The unemployment rate started decreasing after reaching a peak of 9.5% in 2005. The youth unemployment rate has been rising over the past years and stabilised at 14,8% in 2005. Following a steady trend since 2001, the employment rate among older workers rose to 45.4% in 2005, but remains below the Lisbon target of 50%. A steady rise in long-term unemployment can be observed, the rate reaching 5% in 2005. The at-risk-of-poverty rate stood at 13% in 2004[95].

Total social expenditure as a percentage of GDP in 2004 was 29,5% above the EU average (28%). Total expenditure on families and children, at 10.5% of GDP, is one of the highest in the EU and contrasts with a very low birth rate and an at-risk-of-poverty rate of 14% for children in 2004.

Demographic trends will result in a significant increase in the old-age dependency ratio, from 27,8% in 2005 to 52%[96] in 2050, and total age-related public social expenditure is projected to rise from 23.7% in 2005 to 26.4% in 2050. Pension expenditure amounted to 12.4% of GDP in 2004. Life expectancy at birth (76.5 and 81.9 years for males and females in 2004) is slightly above the EU average for men[97]. It has risen about 2 years over the last decade (from 73.3 and 79.7 in 1995). Infant mortality (4.1 in 2004) is low, the EU value being 4.5. Perinatal mortality is also low (5.8 in 2003) and has constantly declined since 1960 (34.9).

2. Overall strategic approach

Enhancing the sustainable functioning of the pension, accident insurance, health care and long-term care system is identified as a priority. Improving the labour market prospects of young people, older people, immigrants and people with disabilities also remains a political priority.

In relation to social inclusion, the report highlights the situation of children and families, the position of immigrants and access to the labour market for women. Concerning pensions, Germany is consolidating the first pillar and supporting the second and third pillars of the pension system through attractive incentives. As in health and long-term care, the main objective is to secure the efficiency and quality of the system in view of the demographic challenges.

The gender dimension is more visible in the policy process than in previous reports, especially as regards raising the participation rate of women, broadening their occupational choice,

[95] Following the implementation of EU-SILC in 2005, the values of all income based indicators for income year 2004 (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. Due to 2002 and 2005 break in time series the large year to year differences that can be noted are therefore not significant. During the transition from ECHP to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the German Socio-Economic Panel that was not fully compatible with the SILC methodology based on detailed income data.

[96] Calculated on the basis of the ad hoc scenario.

[97] The EU average was 75.8 and 81.9 years for males and females in 2004.

tackling the gender pay gap, and increasing their self-employment and career opportunities through an increase in child care facilities and the introduction of a new parental allowance.

The report notes that improving general labour market participation and sustaining the social protection system directly contribute to the Lisbon objectives of economic growth and greater social cohesion. The report also identifies economic growth and more employment as essential conditions for achieving an adequate level of social protection and equal opportunities. Adequate governance of social policies is ensured through regular and institutionalised consultation of all relevant stakeholders. Hearings are regularly held in the process of adopting social protection laws. This broad participation of relevant stakeholders is also ensured in the preparation of reports, such as the national strategy report and the report on poverty and wealth, a comprehensive reporting tool.

While the report encompasses many important and relevant policy fields, the three strands of the strategy remain however largely disconnected from one another.

3. Social inclusion

3.1 Key trends

Long-term unemployment stood at 5% in 2005, compared to 3.9% in the EU-25. National data show that from September 2005 to September 2006, the number of long-term unemployed increased by 5.3%, to 1.6 million people. Long-term unemployment is a major poverty risk and could have longer-term implications when the people concerned enter pension age.

The strong correlation between parental socio-economic status and the educational attainment of children has been confirmed by recent studies. Children from a higher socio-economic background are 3.1 times more likely to enter secondary education than children from lower strata of the population. An OECD study of May 2006 shows in particular that the educational attainment prospects of children of immigrant background (i.e. second- and third-generation) are only 50% of those of comparable native children. In 2005, the early school-leaving rate was 13.8%, lower than the EU-25 rate of 15.1.

The overall at-risk-of-poverty rate stood at 13% in 2004. According to national data, there is a strong disparity between East (17.3%) and West (12%). Certain groups were more exposed, for example single parents with dependent children (30%). In July 2006, 2.1 million children (0-17) were living on the social allowance level. The unemployed had an at-risk-of-poverty rate of 42% (EU-25 40%) in 2004. For immigrants, the rate was 24% (2003), thus significantly higher than for German citizens. In-work poverty stood at 5%. The at-risk-of-poverty rate for the 65+ age group stood at 15% in 2004, but with a strong gender disparity (18% for women and 12.0% for men).

3.2 Key challenges and priorities

The 2006 joint report identified as the main challenges for social inclusion the need to ensure that the labour market reform does not adversely affect the social and economic integration of groups at risk, and to ensure the sustainable integration of immigrants.

This report responds to these challenges while taking a broader approach. It identifies seven political priorities for 2006-2008, namely enhancing labour market participation, reducing

disadvantages in education and vocational training, modernising child and family policies to eradicate child poverty, improving the integration of immigrants, fighting discrimination against disabled people, strengthening the role of social services and civil society and improving governance.

With these priorities, the proposed strategy should help improve access to resources, rights and services for all, which constitutes one of the Common Objectives for social inclusion. In the field of education and training, for example, the report describes numerous initiatives at different government levels to improve access.

The continued emphasis on labour market participation will also contribute to the second Common Objective for social inclusion. Concerning the coordination of social policies at all levels — the third Common Objective — the report demonstrates good progress in comparison with former National Action Plans. It draws a clear picture of the division of tasks in the field of social inclusion between the Federal government, *Länder* and the local authorities.

Based on the 2006 National Strategic Reference Framework, the ESF will shift its focus from the integration of disadvantaged groups within the labour market to adaptability and human capital. While social inclusion is not identified as a separate priority within the forthcoming ESF programmes, a number of relevant actions will be supported, in particular for young people, such as improvements in the education and training system and the integration of immigrants into the labour market.

The general approach of the inclusion strand consists in providing equal opportunities for all and ensuring a fair balance between solidarity and individual responsibility. While the choice of priorities in the report seems fully justified, targets for inclusion are seldom defined.

3.3 Policy measures

In order to enhance the labour market participation of low-qualified workers, immigrants, older workers and young people, a number of measures are planned or already partially implemented. In 62 regions, for example, the employment of older workers is to be boosted through the programme “Perspektive 50 plus”. This aims at raising the effective labour market exit age, which stood at 61.3 in 2005. This is in line with the policy of raising the pension age to 67 by 2029. However, the 2005 Hartz IV reform package is not yet fully implemented. The new administrative structures responsible for supporting the long-term unemployed (ARGEs) have not been delivering a satisfactory level of service, as a recent report by the Federal Court of Auditors has revealed. In reaction to the report, the Federal Labour Ministry in cooperation with the Federal Employment Office has issued new guidelines to improve the functioning and level of services provided by the ARGEs. Additional training for case managers and recommendations for better integration services have been provided. Financial and administrative incentives for the low-qualified to enter the labour market, on the one hand, and the availability of job opportunities for this group, on the other, merit further attention. The Government is planning an initiative to improve labour market prospects for the low-qualified.

Improving equal opportunities in education for all strata of the population by supporting children from disadvantaged families at a very early stage is pursued by a package of measures in cooperation with the *Länder*. The programme “FörMig” aims to improve the reading and writing skills of children. For the transition from school to the labour market, the

recently introduced Federal programme, EQJ, helps disadvantaged young people to qualify for an apprenticeship. As this tool has proved to be successful, the number of available places has been significantly increased for 2006 and 2007.

To ease the situation of families, a package of financial and support measures has been put in place. Here, the emphasis is on support measures — rather than increased financial transfers — for families in need, such as the expansion of care services and comprehensive counselling services. However, the effectiveness of these measures will depend on the resources of the local authorities, which carry the main responsibility for financing measures for children and families.

The language courses for newly arrived immigrants will be continued in the reporting period and given an added value by revising the system of immigrant counselling agencies. Individual migrants have access to these services for the first three years after arrival in Germany.

The four European Antidiscrimination Directives were transposed into German law in 2006. This should improve the opportunities for people with disabilities to participate in social and working life. The compulsory implementation of a personal budget in 2008 for each person in rehabilitation empowers disabled persons to organise their personal pathways back into society through appropriate measures. The success of this new approach has been confirmed recently by the published results of pilot projects.

As regards the last priority, strengthening the role of social services, the report is somewhat limited but does announce an improvement in the tax regime for NGOs, which should help with their activities.

3.4 Governance

From the first NAP/Incl. in 2001, the cooperation between federal government, *Länder* and NGOs has continuously improved. This improvement is largely attributable to the parallel process for producing the Federal Poverty and Wealth Report. A "Permanent Advisory Workgroup on Social Inclusion", representing 35 important stakeholders, has been established. This workgroup was also consulted on the National Strategy Report. A stakeholder hearing on the first draft of the report took place in May 2006. In order to report on the social inclusion process in a more detailed way, some *Länder* produce their own social situation reports. With a view to improving the circulation of best-practice information within Germany, the Government has launched the project "Info-exchange: Participation and social integration". It will produce a structured web-based database on projects in the field of social inclusion.

4. Pensions

Older people have a standard of living close to that of the general population (92%). The poverty risk among older people (15% in 2004)[98] is slightly higher than that of the population below the age of 65.

[98] These income figures do not include negative capital income, imputed rent from private housing, or in-kind benefits or services, and possibly ignore some specific in-cash benefits, which gives an incomplete picture of the income situation, in particular for older people. Accumulated wealth, which is higher for older people, should also be considered when comparing living standards across generations, but due to

Despite recent increases, the employment rate among older workers, standing at 45.4% in 2005, remains below the Lisbon target of 50%. Despite the current weak budgetary situation, the 2006 Sustainability Report assessed Germany as a medium-risk Member State as regards the sustainability of public finances, notably on account of the effects of the pension reforms enacted. According to the 2005 AWG projections, public spending on pensions will increase from 2004 to 2050 by 1.7 p.p. of GDP. According to ISG projections, the gross replacement rate of statutory pensions for a worker working for 40 years on the average wage and retiring at 65 will decrease from 43% in 2005 to 34% in 2050. The overall gross replacement rate is projected to increase from 43% to 48% by 2050 (63% to 67% net), with the decline in statutory pensions of 9 p.p. being offset by an increase of up to 15 p.p. in the private pension replacement rate (these schemes currently cover around 70% of the employed, with contributions assumed to be 4% of wages).

The 2006 Joint Report underlined the key importance of further improvements in the employment situation of older workers and improved coverage of private pensions to ensure future adequacy. In 2006, the new Government decided to increase the retirement age gradually from 65 to 67 (from 2012 until 2029 by one month a year and then two months a year, the first generation to be affected being those born in 1947). People with more than 45 validated insurance years (including validated periods of child care) will still be allowed to retire at 65 without reductions. Germany is terminating early retirement paths within a fairly short transition period and is focusing on improving employment among older workers with the programme "Initiative 50plus".

As people take advantage of the opportunities for supplementary provision, it is expected that the replacement rate can be kept more or less constant for a given age and that the increase in the employment of older workers will enable them to accrue higher pensions. In order to help ensure future adequacy, voluntary private provision, either through occupational or personal pension schemes, is strongly subsidised through tax allowances and direct public grants, especially for low-income groups and for people raising children. For the latter, further increases in incentives are to be introduced from 2008, while a general information campaign will be launched in early 2007. The future adequacy of overall pension provision will depend on the take-up rates of these new opportunities and on the improvement in the employment of older workers. The Federal Government will report every four years on trends in the adequacy and sustainability of the pension system as well as the employment of older employees.

5. Health and long-term care

5.1 Health Care

Description of the System: The health care system is decentralised, characterised by federalism and delegation to self-administered non-governmental bodies, which are the main actors in the social health insurance system: The sickness funds and their associations on the purchaser side, and the physicians' and dentists' associations on the provider side. Hospitals are on the other hand represented by organizations based on private law. These actors are organised at both federal and regional (*Land*) level. The 253 health funds (2006) collect contributions for the statutory health care and long-term care insurances, and negotiate contracts with the health or long-term care providers. The Ministry of Health proposes health legislation that, when passed by parliament, defines the legislative framework for the social

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data limitations this is not possible for all countries. As from 2008, EU-SILC is expected to include imputed rents in the definition of income.

health insurance system. It also supervises the non-governmental bodies and, with the assistance of subordinate authorities, undertakes various licensing and supervisory functions, scientific work and information services. The range of services available under statutory health insurance is laid down by the legislator and further defined by the self-administration of the health insurance providers and service providers in the Joint Federal Committee. The catalogue of services is largely uniform and applies across all types of insurance providers. Services are not divided into basic and optional services. However, individual options are offered by health insurance providers for separately defined areas of services. Since 1996, almost all insured persons have had the right to choose a health fund freely, while funds are obliged to accept any applicant.

Accessibility: The 2006 National Strategy Report states that 74% of German citizens have mandatory health insurance. Another 15% are voluntarily insured with a statutory health insurance provider. The spouses and children of people with statutory health insurance are also insured without having to pay contributions under certain conditions. Some 10% of the population have private health insurance, of whom approximately half are civil servants who have only a proportion of their sickness costs covered by private insurance. However, a small but growing number of citizens have been found to be outside the insurance systems and have problems to (re)enter them. The currently proposed new law aims to ensure that all citizens are covered by health insurance. A need for action has been seen with respect to the nation-wide distribution of physicians[99], especially general practitioners. Thus the law governing the contractual relationships between physicians and the statutory health insurance has been liberalised in order to give incentives for a better distribution of physicians, especially in the new *Länder* and rural areas.

Quality: There is a legal requirement making quality assurance obligatory for all service providers in out-patient and in-patient provision, which expressly gives them responsibility for the quality and efficiency of their services, including regularly certified further training for doctors. The law requires statutory doctors, hospitals and out-patient and in-patient preventive and rehabilitation facilities to set up internal quality management systems. This internal quality assurance is coupled with external quality and effectiveness assurance, so that quality can also be assessed in comparison with others and any quality deficits can be recognised and remedied. Hospitals are required by law to write a structured quality report every two years, enabling interested parties to ascertain the type and number of services provided in the hospital and the quality improvement measures carried out. An agency (DIMDI) has set up and operates a database information system to evaluate the efficiency and effectiveness of health technologies. Integrated care is promoted by GP networks, health centres, the opening of hospitals for out-patient care as well as bonus programmes for health-conscious behaviour. An electronic patient card will be introduced gradually.

Long-term sustainability: Total healthcare expenditure in 2004 was 10,6 % of GDP and 3043 PPP$ per capita, above the EU average (8.87% and 2376) and the highest in EU as a % of GDP.[100] The share of GDP was 8.5% in 1990 and 10,3 % in 2000. The share of public healthcare expenditure as a percentage of total health care expenditure decreased from 81,5 % in 1992, after reunification, to 76,9 % in 2004. According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.2 percentage points of GDP by 2050 due to population ageing. The 2006 National Strategy Report notes that Germany has a

[99] National Reform Program Germany 2005 – 2008, Implementation and progress report 2006.

[100] WHO Regional Office for Europe, European health for all database (HFA-DB), updated June 2006. (The OECD Health Data 2006, updated 10 Oct, reports for Germany in 2004: 10.6% of GDP and 3043 PPP$).

high ratio of health expenditure to GDP, which is seen as an expression of comprehensive health care provision, but - on the other hand – raise questions as to the efficiency of the health system. The poor development of wages combined with continuing high unemployment has led to reduced contribution payments to statutory health insurance in recent years and contributes to a structural income weakness in statutory health insurance. The 2006 implementation and progress report on Germany's National Reform Programme 2005 – 2008 reports on the reform concept for the sustainable financing of statutory health insurance and for further quality and efficiency improvements. With some of the social tasks of statutory health insurance being financed from the federal budget, the resources of statutory health insurance will be placed on a more stable, more equitable and employment-promoting basis in the long run. A grant of €2.5 billion will be made available from the 2007 budget, and is to be increased in the following years. The financial reforms to be initiated this year will also be linked with the reform of health care structures in order to ensure that the funds available will be used more efficiently and more effectively in the future. On 25 October 2006, the federal government adopted a proposal for an extensive law to strengthen competition in statutory health insurance (GKV-WSG), which will now be debated in the Bundestag with the aim of having it come into force on 1 April 2007.

5.2 Long-term care

Description of the system: The public long-term care insurance scheme, introduced in 1995 as the fifth pillar of the social security system, covers the risk of needing permanent, extensive care. Insurance is mandatory in line with the principle that long-term care insurance follows health insurance. Consequently, almost the entire population is insured against the risk of needing (non-medical) long-term care. All insured in a statutory health insurance scheme are members of the related long-term care insurance scheme. All persons with private health insurance, or in a special system, are members of a private long-term care insurance scheme. The benefits are fixed by law and identical in both systems. They depend on the extent of the need for care, but are granted as a lump sum irrespective of age, income or wealth. Long-term care benefits are separate from other insurance entitlements that are related purely to illness and thus come under health insurance (e.g. entitlement to a home help or a district nurse in the event of illness or to prevent a hospital stay). In addition, supplementary general care services are often available to those in need of care and to their family members. These are mainly provided by local authorities and charities.

Accessibility: Access to the services of long-term care insurance is possible for all insured people in the Federal Republic of Germany if the requirements under insurance law are met. This means that almost the whole population is included in the protection of social long-term care insurance and private long-term care insurance. While this ensures universal coverage, there is debate in Germany on how to ensure access in future, including the specific contributions that the long-term care insurance can or should make towards the total cost of care, notably in cases of intensive care needs.

Quality: Because of demographic developments, the number of people needing care is expected to increase. Against this background, ensuring the provision of high-quality care in future requires that (1) an appropriate number of adequately trained personnel, (2) internal measures in the care institutions to ensure and develop quality and (3) appropriate contractual agreements with insurance funds to enable the care institutions to meet their responsibilities. Well trained, skilled specialist staff is essential to ensure appropriate care quality. The new professional regulations in the Act on the Care of the Elderly and the Nursing Act therefore aim to improve training in the care professions and increase their attractiveness. The

development of modules for culture-sensitive care for the elderly and in nursing, and including them in training, will help to improve the quality of care for immigrants, as will training for people from immigrant backgrounds in the care professions. These new provisions are a response to the debate on the quality of care and the questions raised in a number of cases regarding respect for the rights of those receiving care.

Long-term Sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is projected to increase from 1.0 % of GDP in 2004 to 2 % of GDP by 2050 due to population ageing, if benefits rise in line with GDP per worker. According to an alternative scenario, expenditure will stay constant at 1.0 % of GDP assuming that benefits rise in line with the general inflation rate[101]. A legislative proposal for sustainable and fair financing will also be presented for long-term care insurance, in 2007. Among other things, it should take account of the need to supplement the system with capital-covered elements such as a demographic reserve and to harmonise the different risk structures of social and private long-term care insurance schemes. The proposal will also depend on the final form of the new legislation for the health insurance system.

6. Challenges ahead

To ensure that the continued implementation and revision of the 2005 labour market reforms effectively supports the long-term unemployed and people furthest away from the labour market.

To promote the sustainable and active social inclusion of immigrants and persons of immigrant background (second and third generation) into society, in particular through adequate access to education and vocational training and measures to support their integration on the labour market.

To break the intergenerational transmission of poverty by increasing educational opportunities at all levels for disadvantaged groups and securing early intervention services for disadvantaged families.

To ensure the adequacy and the long-term sustainability of pensions, notably by further promoting longer working life and increased participation in supplementary pension provision.

To finalise a sustainable reform for the health care system, improving financing and efficiency while maintaining high quality standards, and implement this reform in 2007, and to finalise in 2007 a similar reform for the long-term care insurance system.

To improve the geographical distribution of physicians, especially outpatient general practitioners in the new *Länder* and some rural areas, e.g. by successful implementation of the amended law that governs the contractual relationship between physicians and the statutory health insurance.

[101] This scenario has been developed by the EPC to better reflect the German system of long term care with nominally fixed benefits that have not been amended since the introduction of long term care insurance in 1995. A future dynamic sampling of the benefits in line with the general inflation rate is discussed as an element of the forthcoming reform.

Germany : data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,2	111,7	**2000**	65,6	72,9	58,1	47,2	37,6	**2000**	7,2	6,0	8,7	10,6
2002	0.0	108.5	**2002**	65.4	71.8	58.9	45.7	38.9	**2002**	8.2	7.1	9.4	14.2
2004	1.2	111.1	**2004**	65.0	70.8	59.2	41.9	41.8	**2004**	9.5	8.7	10.5	15.0
2006	2.5	110.1	**2005**	65.4b	71.2b	59.6b	42.0b	45.4b	**2005**	9.5	8.8	10.3	14.8

** Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); b: break in data series*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	73.3	79.7	14.7	18.5	60.0	64.3	5.3	**1995**	10.6	80.5	-		
2000	75.0	81.0	15.7	19.4	63.2e	64.6e	4.4	**2000**	10.6	78.6	10.6	90.9	18.2
2004	76.5sp	81.9sp	16.7sp	20.1sp	65.0e	64.7e	4.1	**2004**	10.9	78.1	10.5		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio**	expenditure (% of GDP) Level in **2004** and changes since2004			
										Total social expend.	Public pensions	Health care	Long term care ***
1995	28.2	42.7	31	9	7.5	2.9	6.8	**2005**	27.8	23.7	11.4	6.0	1
2000	29.2	42.4	28.3	8.4	10.6	2.6	7.8	**2010**	30.7	-1.2	- 0.9	0.3	0
2004	29.5	43.5	27.2	8.6	10.5	2.5	7.7	**2030**	44	-1	0.9	0.9	0.4
								2050	52	2.7	1.7	1.2	1

** including administrative costs* *** based on the ad hoc scenario*
****Under the assumption that benefits are dynamised in line with general inflation, the expenditure level stays unchanged in 2030 and 2050.*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13b	14b	13b	12b	15b	20b	18b	21b	22b	18b	**Total**	4.1b
male	12b	-	11b	11b	12b	21b	-	22b	23b	19b	**male**	-
femal	14b	-	15b	14b	18b	20b	-	20b	22b	17b	**female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	9.5	10.5	9.5	11.4	**1999**	4.1	3.2	5.2	**1999**	14.9	14.2	15.6
2004	10.9	11.1	10.8	11.4	**2004**	5.4	4.8	6.1	**2004**	12.1	12.2	11.9
2006	10.5	10.6	10.4	10.9	**2005**	5.0b	4.7b	5.4b	**2005**	13.8	13.5	14.1

**: excluding students; b: break in data series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.92b	0.93b	0.90b	***Aggregate replacement ratio***	0.45b	0.44b	0.48b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Estimate of current (2002)	Assumption
4	5	-9	DB	15	DC	Nd	70		19.5	Nd	4

** (DB / NDC/ DC); ** (DB / DC)*

ESTONIA

1. Situation and key trends

Estonia is expected to achieve a 10.9% growth in total output in 2006 (2005: 9.8%, EU25 1.6%). GDP per capita rose to 57.3% of the EU average in 2005 and is predicted to reach 65% in 2007. The relative poverty rate was 18% in 2004 (EU-25 16%). Both real wages and productivity have increased rapidly, the former more than the latter. The inflation rate of 4.1% exceeded the EU average of 2.2% in 2005. Employment growth in 2006 is projected to be strong at 3.2% (2005: 2.0%, employment rate 64.4%, activity rate 70.1%), but is expected to slow down to 1.8% in 2007. In 2005, the employment rate for females was 62.1% (EU-25 56.3%), among 55 to 64-year-olds it was 56.1% (EU-25 42.5%) and for 15 to 24-year-olds 29.1% (EU-25 36.8%). The unemployment rate, which decreased from 9.7% in 2004 to 7.9% in 2005 (8.8% for males), is projected to fall further to 6.8% in 2006 and to 6% in 2007. Youth unemployment fell down from 21.4% in 2004 to 15.9% in 2005. Long-term unemployment has decreased, but was still higher (4.2%) than the EU-average (3.9%) in 2005.

The share of GDP spent on social protection was 17.1% in 2004. 39% of the total was for pensions (6.7% of GDP in 2004, projected to fall to 4.8% by 2030) and 32% for health care (5.4% of GDP in 2004, projected to rise to 6.2% by 2030). Life expectancy (66.5 and 77.9 years for males and females in 2004) is the second lowest in the EU. For men, it is 9 years less than the EU average[102]. It has increased about 4 years for men and 2.5 for women in the last decade (61.9 and 74.5 in 1995), a considerable improvement following the 1989-1994 decrease. Healthy life expectancy is low at 52.5 years for women and 49.2 years for men in 2004. Low fertility rates and increases in life expectancy will increase the old-age dependency ratio from its present 24% to 31% by 2025 and to 43% by 2050. The infant mortality rate (6.3 in 2004) is one of the highest in the EU[103] though it has seen a substantial decrease since 1960 (31.1) and in the last decade (14.9 in 1995). Perinatal mortality is high at 8, but has been consistently decreasing since 1960 (22.5).

2. Overall strategic approach

The NRS for 2006-2008 aims to support the strategic objective of achieving rapid, socially and regionally balanced and sustainable economic development. In this context, social protection systems should secure the ability of an individual to cope where social risks emerge. The strategy emphasises the primacy of work and equal opportunities for all in the prevention of poverty and social exclusion. Gender mainstreaming remains declarative.

Promoting social cohesion: The main priorities for 2006-2008 are preventing and reducing long-term unemployment and inactivity, alleviating the social exclusion of families with children, ensuring an adequate level of pensions, maintaining the financial stability of the health care services and health insurance system by widening the tax base, promoting healthy lifestyles and improving public health services, and improving life-long learning systems.

Relationship with the Lisbon Strategy. As with the NRP, the NRS is based on the State Budget Strategy and was prepared in co-operation with all the relevant Ministries, social

[102] EU average of 75.8 and 81.9 years for males and females in 2004.
[103] EU average of 4.5 in 2004.

partners and civil society. The NRS refers to the NRP 2005-2007 and notes that it has a more in-depth analysis of how social protection policies support growth and jobs and vice versa. The NRP underlines e.g. the importance of policies aimed at bringing the at-risk groups into employment with a view to reducing the pressure on the state budget resulting from the high level of social benefit payments.

Governance: The main stakeholders participated in a steering group for the preparation of the NRS. In addition, civil society in a wider sense had the opportunity to provide input. More partners are gradually becoming involved, but many still lack the competence and knowledge to take part in the process. The NRS notes the aim is to increase administrative capacities in order to support the integrated design and implementation of policies in different fields. The NRS also calls for the establishment of a permanent forum involving the steering group and NGOs to improve coordination and monitoring of the implementation of the NRS. In order to promote the more effective participation of the social partners and NGOs in this forum, it could be useful to make competence development measures available for them as well.

3. Social inclusion

3.1 Key trends

Relative poverty was 18% in 2004, the threshold value being the third lowest in the EU after LT and LV (2869 PPS in 2004). As a result of the growth in Estonians´ real income, the share of the population living in absolute poverty (the line is defined at national level in terms of minimum consumption and adjusted annually in accordance with the consumer price index) has decreased considerably in recent years (national data: adults from 32.8% in 1998 to 17% in 2004; children from 40.4% in 1998 to 25.3% in 2004).

Unemployment, in particular long-term unemployment, and economic inactivity, remain major causes for exclusion and are often connected with other risk factors. In 2004, the relative poverty rate among the unemployed was 60% and among the inactive 31%. A major part of unemployment is structural in nature, relating to skills mismatches. Long-term unemployment is more common among the over-50 and young people. The at-risk groups with difficulties in integrating within the labour market include: those with only a basic education and/or skills that do not match market needs; ethnic minorities; young people; disabled persons; and the inactive wanting to have work (7% of the working age population in 2005).

The at-risk-of-poverty rate was also higher than average among one-person households (36%) and single parents (40%) in 2003. In-work poverty at 7% was slightly lower than the EU average (8%) in 2004, and their share of the population below the relative poverty line was 28% (EU 27%). Households with dependent children accounted for 55% of the at-risk-of-poverty population and their relative poverty rate of 18% in 2004 was the same as the national average. 8.2% of all children lived in jobless households in 2006 and children comprised one fifth of the at-risk-of-poverty population in 2004. Children's at-risk-of-poverty rate was 31% before and 21% after social transfers in 2004. Social transfers excluding pensions also reduce the overall risk-of-poverty rate by six percentage points compared to the EU average of ten points.

Youth educational attainment declined from 82.3% in 2004 to 80.9% in 2005 (EU benchmark: min. 85% in 2010). The share of early school-leavers increased slightly in 2005 to 14% (EU

benchmark: max. 10% in 2010). The adult participation rate in life-long learning was 5.9%, half the EU-average in 2005.

3.2 Key challenges and priorities

The key policy challenges highlighted in the NRS are increasing labour market participation and eliminating child poverty, which reflect the challenges identified in the 2006 Joint Report for Estonia. The priority objectives for 2006-2008 for increasing social inclusion are the prevention and reduction of long-term unemployment and exclusion from the labour market; and the prevention and alleviation of poverty and social exclusion among families with children. Estonia provides a reasonably multi-dimensional synthesis of the situation and main trends to justify focussing on reducing structural unemployment and supporting children in the context of the family, although the experience of implementing the 2004 NAP/inclusion is not reported. The approach chosen is nevertheless quite compatible with the common objectives under the social inclusion strand.

Estonia has not only made extensive use of indicators to support their selection of main priorities, but has also set clear and quantified interim targets for the period covered by the plan. A multi-faceted set of measures has been outlined to achieve both strategic objectives. The budgetary impact or equivalent as well as the responsible authorities have normally been specified for the measures. The contribution of the Structural Funds, especially the ESF, to supporting the NRS objectives will be significant, in particular for active labour market measures, where the majority of funding will come from the ESF.

3.3 Policy measures

The priority objective of increasing labour market participation is supported with the following measures and targets:

Existing measures include the Strategy for Labour Market Measures approved in 2004 and the Labour Market Services and Benefits Act adopted to implement the principles of the strategy. The Act came into force on 1 January 2006. It provides for: an internship system, identifying young people and the long-term unemployed as focus groups; work practice and services for disabled people; improved access to active measures; the introduction of case management; and the principle that the unemployed must under certain conditions accept suitable work. The NRS reports that 0.12% of GDP was spent on the implementation of labour market policy in 2005, of which 74% or 0.09% of GDP was spent on active measures (Eurostat: ALMP expenditure in EE was 0.04% of GDP and the number of participants in LMP measures was 0.6 per 100 persons wanting to work in 2004).

New measures include the increase in the level of passive measures (e.g. the monthly unemployment allowance will rise to €69 in 2007 from the present €25) to motivate and support the unemployed in seeking work. The planned increase in the State budget is 90% in 2006 and 23% in 2007. A system of in-service retraining and a single system of professional and career counselling will be created; employment services will be extended to working people; and a service to respond to collective redundancies will be tested as part of an ESF project. The planned amount for ALMP in 2006 is €20.5m (115% increase) of which €12.1m from ESF. In 2007, the amount will be €17.2m (16% decrease), of which €9.1m will be from the ESF. In addition to labour market measures, the intention is to encourage flexible forms of work (only 16.5% of employees were in non-standard employment or self-employed, compared with the EU average of 39.6% in 2005), to encourage a more employee-friendly

working environment, to develop welfare and other public services supporting employment, and to utilise opportunities provided by information and communication technology.

Targets for 2008 are: an employment rate of 69% (2005: 64.4%); an activity rate of 73.1% (2005: 70.1%); a long-term unemployment rate of 2.7% (2005: 4.2%); and the number of long-term unemployed cut to 18 500 (national data 2005: 27 900).

Best practices include two ESF projects: The 'Pilot Project of Home Care Workers' targeted to 100 unemployed persons from ethnic minorities with the aim of training them to return to the labour market as home care workers. 88 passed the training and the objective is to have 60 home care workers employed by local authorities. The other project, 'Training Unemployed Persons as Call Center Operators', involved 390 persons, and 95% of them are now employed.

The priority objective of eliminating child poverty is supported with the following measures and targets:

Existing measures are based on the Child Welfare Strategy adopted in 2004. In 2006, the duration of parental benefit was extended to 455 days (100% of average monthly pay during the previous year); the quarterly benefit for families with three children was increased to €19 and with four or more children to €29; the childbirth allowance and adoption allowance were raised to €320. In addition to the financial support there are a number of measures that have an important role in addressing social inclusion risks: rehabilitation plans for disabled children and delinquent children; an agreed method for calculating maintenance costs; support persons; free phone line; and training to develop networks around an abused child. An increase in the ratio of child protection officials in local authorities is also planned.

New measures comprise: upgrading child benefit from €19 to €57; improving counselling services; training in social and parenting skills; strengthening of co-operation networks; enhancing the housing conditions of families with children; creation of equal opportunities to obtain good education; improving development opportunities for children belonging to specific risk groups; and addressing children's special needs e.g. intervention strategies for school violence and improving leisure opportunities.

Targets for 2008 comprise: reducing the number of children living below the relative poverty line by 2% compared to 2005 (2004: 21%); the difference between the absolute poverty rate among children (0-15 years) and that of total population being 7.9% (national data 2004: 8.3%); increasing the number of child protection officials to one per 1000 children (baseline not given); and increasing the participation of children with special development needs in kindergartens or pre-school classes (not quantified). A further target is to increase the ratio of child care staff per child to 1:6.

3.4 Governance

A steering committee involving the ministries and social partners and a representative of the NGOs was convened to ensure the inclusion of stakeholders in the preparation of the NRS. In addition, an informal umbrella organisation was established to allow the third sector to participate in a more meaningful way. For better coordination and monitoring of the implementation of the NRS, the Ministry of Social Affairs will call upon a permanent round table consisting of the steering committee and NGOs. This will be a useful contribution to strengthening the monitoring of the process, although the NRS could also have outlined the

extent to which independent evaluation will be used to feed into the process. All in all the governance arrangements nevertheless appear slightly stronger than before.

4. Pensions

Older people have a standard of living relatively close to that of the general population (73% in 2003), while the poverty rate among the elderly is currently 20% (gender differences are high: 10% for men and 26% for women), slightly higher than for the 0-64 population.

The 2006 Sustainability Report assessed Estonia as a low-risk Member State as regards the sustainability of public finances. According to the AWG 2005 projections, Estonia will see a noticeable fall in spending on public pensions (from 6.7% of GDP in 2004 to 4.2% in 2050), linked to the diversion of part of the social security pension contributions into privately funded schemes (for the mandatory funded system, pension expenditure will stay stable from 6.7% in 2004 to 6.6% in 2050). According to ISG calculations, the theoretical net replacement rate was 41% in 2005 (gross replacement rate 33%) and is projected to remain roughly constant until 2050. This reflects a steady decrease in the replacement rate provided by the first tier of the first pillar (from a 33% gross replacement rate in 2005 to 15% in 2050), while the contribution of the funded tier is projected to reach a gross replacement of 13% in 2030 and 21% in 2050. These replacement rates are predicated on a worker contributing for 40 years, but with the higher reliance on funded provision inherent in the reformed system, those with interrupted work patterns are less likely to achieve these levels.

The Joint Report of 2006 highlighted the financial sustainability of the overall Estonian pension system, and the success in achieving high employment rates for both women and older people. However, the challenges facing the system were the adequacy of current pensions and the possibility of further declines in the future. The report also noted the availability of early retirement schemes. On this last point, the updated report mentions the possibility of reducing access to such schemes, though it gives no indication of how or when this will be achieved.

The reform of the 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 has 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 is the future adequacy of pensions, as current replacement rates are already rather low and projected to decline even further. Although the employment rate among 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 arrangements for paying out benefits from 2009 onwards.

5. Health and long-term care

5.1. Health care

Description of the system: The Estonian Health Insurance Fund (EHIF) purchases and reimburses care for about 94% of the population based on residence and group membership (e.g. the unemployed, children, pensioners, full-time carers). Provision is decentralised and

mostly public, though private provision is increasing. Residents register with primary health care (PHC) doctor, who provide general medical care and health promotion and prevention services and play a gate-keeping role for specialist and hospital care. Ambulatory specialist care is provided in health centres, hospital outpatient departments and specialists' own practices. Inpatient care is provided in regional, central and local hospitals (mostly owned by municipalities or the state). Outpatient and inpatient care providers (either private or public) enter into contracts with the EHIF. The EHIF pays family doctors on a capitation basis plus fees for home visits. Other staff are salaried. The system is financed primarily through an earmarked payroll tax on employees (in practice employers) and the self-employed and through taxation (that pays for ambulance and emergency care and promotion and prevention). Co-payments apply to home and outpatient visits, hospital stay and drugs. Adult dental care is not covered by EHIF. Out-of-pocket payments are paid to any non-EHIF contracted provider. Recognising as challenges the low health status of the population, access barriers and the clear need for resources, the authorities are aiming to improve population health through more promotion and prevention activities, to ensure an homogeneous geographic availability of services, to extend population coverage, to implement a well-functioning PHC sector and to allocate additional resources to the sector, while maintaining the sustainability of the system in both financial and human resources terms.

Accessibility: The report states that though population coverage is high, 6% of the population is not insured. The authorities, who have already extended coverage to those on unemployment benefits, are considering ways (e.g. local government insurance) to extend coverage to other groups now only covered for emergency care. The authorities argue that PHC accessibility is good with 99.8% of patients able to see a family doctor within the prescribed 3 days (the number of GPs per 100 000 inhabitant is one of the highest in the EU: 95.1). To tackle geographic disparities in access (e.g. the uneven distribution of important specialities), the authorities are planning a PHC network with services close to the patient's place of residence. A free 24-hour phone line has also been set up. They also want to ensure that everyone can reach special medical care within an hour. The report indicates that to better organise waiting lists hospitals are providing information to the NHIF, which publishes it on line (and which is to also allow patients greater hospital choice in future). It also notes that to tackle long waits there are national/ central waiting lists for certain services and extra funding has been allocated to the specialties with the longest lists. Data show that private spending is high (out-of-pocket payments were 21.3% of total health expenditure in 2004) due to increasing co-payments and an increasing number of treatments being excluded (e.g. dental care) from the benefits package. This may place a financial burden on more vulnerable groups and indeed there are socio-economic (income) differences in the use of health services. The authorities wish to improve access with the planned increase in the sector's funding.

Quality: According to the report, to the improve quality of care specific requirements for providers are being set up, whereby the Health Care Board (HCB) licenses and controls the providers, clinical guidelines (best practice) are being implemented and the EHIF together with the WHO have started to develop a system of hospital quality indicators. The authorities see the greater use of ICT and eHealth solutions as a means to improve access by filling service gaps in certain areas, but also and importantly as a way to improve standardised data gathering for monitoring and planning, to offer better information for providers on standards and guidelines and to improve coordination between providers and services. They also emphasise patient choice and involvement as a quality dimension. Hence, patients can choose and change their family doctors at any time and can choose any specialist within a region and, in the future, in any region. Patient complaints are dealt with by the HCB, patient associations are now included in some national disease strategies and in certain committees, and

satisfaction surveys were launched. The government expects digital patient information to reduce complications and lead to better diagnosis and treatment. Cooperation networks (i.e. family doctors, nurses and some specialists) are seen as a way to improve the offer of integrated care. Guidelines and multidisciplinary teams are envisaged in the rehabilitation field.

Long-term sustainability: Total health expenditure (5.5% of GDP and 776 per capita PPP$ in 2004) is the EU lowest and well below the EU average[104]. It has decreased in GDP terms in the last decade though it has increased in per capita terms. GDP growth may partly explain this trend. The share of public expenditure in total expenditure (76% in 2004) has decreased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.1 percentage points of GDP by 2050. Hence, it may be feasible to increase state expenditure notably to enhance effective promotion and prevention, to increase coverage and to reduce financial barriers to access. The authorities are planning to widen the (earmarked payroll) tax base (increasing the rate of tax and extending the population base) to add resources to the sector. To enhance efficiency they want to continue reducing the number of beds (which stills exceeds targets) and average hospital stay while increasing the proportion of outpatient and day-case care and PHC (ensuring an effective referral system). These measures are to be coupled with cost-based prices and DRG-based payment for inpatient care. The authorities see maintaining sufficient human resources as a serious challenge due to the migration of qualified staff to Western Europe (staff numbers dropped by 24% during the 1990s) and shortages of nursing personnel. A voluntary re-registration system and an additional fee-for service payment for GPs for preventive care services are seen as means to motivate personnel. They also highlight the need for stronger promotion and prevention to address risk factors (tobacco, alcohol, drugs, diet, exercise, environment) and specific diseases and to ensure health-supporting environments that facilitate healthy choices. Specific strategies include: Heart and Physical Activities, School Health Care, HIV/AIDS and tuberculosis. Cooperation is sought with the private and social sector. Strong emphasis is placed on extending the coverage of occupational health and the availability of related services (e.g. medical buses in rural areas).

5.2. Long-term care

Description of the system: The health care system provides medical care, nursing care in institutions or hospitals, geriatric assessment, home PHC and home nursing care. These services are paid by the EHIF. The welfare system provides care in institutions, day care centres, home care, housing services (e.g. house adjustment, cleaning, food) and other social services. The municipalities are responsible for providing these services or purchasing them from state and local agencies and the private sector. Caregivers receive an allowance to reimburse care costs or alleviate their care burden. A social worker together with the family doctor or a geriatric team considers and chooses between forms of care based on the person's needs and financial situation. The authorities put emphasis on: developing home-based care that helps people remain in their homes for as long as possible, developing institutional care for when necessary, developing human resources and promoting healthy ageing.

Accessibility: Institutional and community services have been increasing. Acute hospital capacity is to be transformed into nursing care beds. Local authorities should pay for the full costs of institutional care for those on low incomes. The authorities want to concentrate on enhancing home-based services to improve access (and reduce costs) through additional

[104] EU average of 8.87% and 2376.33 in 2004.

sector funding. Home care is still not provided by 30% of local authorities. The reduced availability of services forces people to use institutional care (also more expensive for the state). It also makes it easier for richer vis-à-vis poorer households to find private solutions which can impose an excessive financial burden on poorer households.

Quality: County governors monitor the quality of social services and deal with patient complaints. To enhance quality, the authorities plan a set of uniform minimum standards to replace the current very general standards that resulted in different geographic service quality. This is to be coupled with workers registration and the licensing of provision. Recognising that the separation between health and welfare services does not always ensure the quality of services and patient flows across services, the authorities are defining levels of care under an integrated care structure with multifunctional institutions and a multidisciplinary team assessment.

Long-term sustainability: The joint municipal provision of services and cooperation between local authorities and different stakeholders are seen by the government as ways to reduce costs or provide extra care in an efficient manner. They regard the number of nursing personnel and therapists as insufficient to ensure care provision. Estonia is also focusing on healthy and active life-styles and equal opportunities for the elderly.

6. Challenges ahead

To continue increasing labour market participation of at-risk groups, through a combination of properly financed active labour market policies and effective monitoring of the increased participation of disadvantaged groups, as well as by promoting flexible forms of work.

To reduce the high risk of poverty among families with children by focusing on the income, housing, educational and social needs of disadvantaged families.

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

To improve the population and geographical coverage of care, reduce patient's financial burden of care, to tackle long waiting times and enhance the provision of home and community-based long-term care services.

To allocate additional and needed resources to the sector in view of the low health status of the population and existing access barriers while improving the efficiency and coordination of services and improving health status through promotion and prevention strategies.

Estonia: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	10.8	42.1	**2000**	60.4	64.3	56.9	28.3	46.3	**2000**	12.8	13.8	11.8	23.9
2002	8.0	46.8	**2002**	62.0	66.5	57.9	28.2	51.6	**2002**	10.3	10.8	9.7	17.6
2004	8.1	53.4	**2004**	63.0	66.4	60.0	27.2	52.4	**2004**	9.7	10.4	8.9	21.7
2006	10.9f	65.0f	**2005**	64.4	67.0	62.1	29.1	56.1	**2005**	7.9	8.8	7.1	15.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate		Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	61.9	74.5	12.0	16.1	n/a	n/a	14.9	**1995**	5.9		-		
2000	65.6	76.4	12.7	16.9	n/a	n/a	8.4	**2000**	5.5	77.5	19.9		
2004	66.5sp	77.9sp	13.0sp	17.8sp	n/a	n/a	6.3	**2004**	5.5	76.0	21.3		

s: Eurostat estimate; p: provisional ** Total Health Expenditure* ** Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	14.0	45.3	32.1	1.3	11.9	2.7	6.6
2004	13.4	43.7	31.5	1.6	12.7	1.5	9.1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	24.1	17.1	6.7	5.4	
2010	24.7	-0.6			
2030	33.4	-2.3	-1.9	0.8	
2050	43.1	-2.7	-2.5	1.1	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	18	21	18	17	20	24	30	22	29	11	**Total**	5.9
Male	17	-	16	17	10	29	-	29	31	13	**Male**	-
femal	19	-	19	17	26	21	-	19	28	11	**Female**	-

	People living in jobless households				Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female	Total	Male	Female
1999	10.2	10.4	10.5	10.4	**1999**	5.0	5.5	4.5	14.0	19.0	9.2
2004	9.6	9.5	10.2	8.7	**2004**	5.0	5.6	4.4	13.7	20.5	na
2006	8.2	6.0	6.1	5.8	**2005**	4.2	4.2	4.2	14.0	17.4u	10.7u

** excluding students* *u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.728	0.757	0.698	***Aggregate replacement ratio***	0.467	0.402	0.54

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	pensions: Current estimate (2002)	pensions: Assumption
2	3	3	DB / DC			100		22		

**(DB / NDC/ DC); ** (DB / DC)*

IRELAND

1. Situation and key trends

GDP growth of 4.7% in 2005 ensured that the economy continues to grow appreciably above average EU rates (1.6%). Forecasts for 2006 estimate an increase in GDP growth of 5.3%, although there are concerns that there is an over-reliance on the construction sector. Employment rates continue to grow and, if current trends are sustained, IE is likely to achieve all quantitative Lisbon targets on employment. The overall employment rate in 2005 stood at 67.6 %, the male employment rate was 76.9% and female employment 58.3%.Employment amongst those aged 15-24 (48.7%) and employment amongst those aged 55-64 (51.6%) are both above EU averages.

IE unemployment remains low and stable at 4.4% (2005).While overall activity rates (70.8%) now exceed the EU averages (70.2% in 2005), there are continuing constraints, notably in relation to care services, which limit the capacity of some categories – e.g. families with children (particularly lone parents) - to participate in the labour market.

At 20% in 2004, the at-risk-of-poverty rate remained substantially above the EU average (16% in 2004). At-risk-of-poverty rates are particularly high amongst older people living alone and lone parents, though more recent national data from 2005 indicate that at-risk-of-poverty rates for these categories have been significantly reduced, reflecting the impact and focus of the Irish social security system on people on the lowest incomes.

Life expectancy at birth (75.8 and 80.7 for males and females in 2003) is about the EU average. It has increased by about three years for men and two years for women over the last decade (72.9 and 78.4 in 1995). It has risen consistently since 1970 (68.54 and 73.19). Healthy life expectancy (63.4 for males and 65.4 for females) is slightly below the EU15 average (64.5 and 66 respectively) but it has not changed much for men since 1995 and it shows a small reduction for women (67.6 in 1999). The infant mortality rate (4.9 in 2004) is about the EU average and shows a large reduction since 1960 (29.3) though it decreased more slowly in the last decade (6.4 in 1995). Perinatal mortality is however rather high (9.2 in 2001).

The current old-age dependency ratio (16.5 in 2005) is considerably below the EU average, but is projected to increase significantly to reach 45.3 by 2050.

Gross social protection expenditure amounted to some 17% of GDP in 2004, which is substantially below the EU average (27.3%). The very significant growth in GDP, however, means that the very significant real increases in benefit rates and child income support introduced in recent years is somewhat masked. Further explanatory factors for the lower levels of social protection expenditure in IE include the lower proportion of pensioners and the reliance on private pension provision to supplement flat-rate State pensions; and lower spending on unemployment benefits in the light of sustained low unemployment figures.

2. Overall strategic approach

The Irish National Strategy Report can generally be said to contain a coherent strategic approach which builds upon the achievements of the earlier National Anti-Poverty Strategy and the National Plan against Poverty and Social Exclusion 2003-05. Mirroring the outcome

of the negotiations on a new Social Partnership Agreement, *Towards 2016*, it adopts a lifecycle approach which makes for a cogent analysis of the issues being addressed in tackling social exclusion.

The four priorities identified - child poverty, access to quality employment, integration of immigrants, and access to quality services – are appropriate and consistent with EU priorities and in most cases clear, ambitious but achievable targets are included, again drawing to a considerable extent from *Towards 2016*. A notable weakness, however, is the absence of any explicit targets in relation to poverty reduction. It is important to note that IE will shortly complete a separate new National Action Plan for Social Inclusion in parallel with, and complementary to, the forthcoming National Development Plan 2007-13. While a certain caution towards the setting of poverty reduction targets (even in relation to the national consistent poverty measure) can be discerned in the Strategy Report, it is expected that this new Plan will clearly address this issue. At a wider level, the streamlining of Action Plans on Poverty and the NDP must be viewed as a positive step, since it should facilitate greater coherence in policy development and more effective mainstreaming of poverty and social exclusion issues across all policy domains.

The linkages with the National Reform Programme will be addressed within the context of the Steering Group, chaired by the Secretary-General of the Department of the Taoiseach (Prime Minister) and representing the Government and the Social Partners, charged with overseeing the implementation of *Towards 2016*. This Group will periodically review progress in implementing key strategies including the NSSPI, the NAP/Inclusion 2006-08, the National Development Programme 2007-13 and the National Reform Programme.

3. Social inclusion

3.1 Key trends

The economic background in Ireland remains positive with strong GDP growth and a vibrant labour market predicted to continue over the coming years. There are concerns however that growth is excessively linked to domestic consumption and notably to the construction sector, and there is some concern too at the relatively high levels of inflation currently being experienced. Of particular significance is the net migration experienced in recent years with population growth, largely fuelled by immigration, of 8.1% being recorded between 2002 and 2006. This presents a new set of challenges to be faced in terms of integration and service provision.

While the latest figures for the national 'consistent poverty' measure show positive results, down from 8.8% (2003) to 6.8% in 2004, it is not possible to measure trends over the longer term owing to methodological issues associated with the change from the ECHP to the EU-SILC.

IE argues that the high levels of people at risk of poverty (20% in 2004) is attributable primarily to an increase in the median income driven by a significant shift from one to two income households (itself a consequence of increased female workforce participation). While the impact of rapid economic growth and associated household structural changes over the past decade does tend to mask the very significant investment in welfare benefits over the same period, the underlying high proportion at risk of poverty also reflects the structure of the Irish welfare system (based on flat-rate benefits) and points to a continued level of inequality in Irish society which must be a matter for concern. Expenditure on public social expenditure

in Ireland (15.5% in 2004) is considerably below the EU average (23.4%). Families with children (particularly lone parents), older people living alone and people with disabilities are particularly vulnerable to being at risk of poverty. It is notable also that there is an increasing prevalence of people in employment who are at risk of poverty, reflecting primarily those who are engaged in low-paid and/or part-time work.

3.2 Key challenges and priorities

The strategic approach can be viewed as a further development of the strategy followed in Ireland to date in the National Anti-Poverty Strategy and the previous NAP/inclusion and sets out the intention to continue reform of the social welfare system, to address access to the labour market, enhance employability and improve access to better quality education, health and other services. The strategic framework adopted mirrors that contained in the recently concluded social partnership agreement – *Towards 2016. T*he major innovation in *Towards 2016* in relation to social policy is its adoption of a life cycle approach. This divides up the population into three groups: children, people of working age and older people, (although it continues to identify people with disabilities as a separate category) and includes a set of policy goals in relation to each group, together with priority actions.

IE places a strong emphasis on the provision of enhanced services and reiterates commitments to continued investment in welfare provision.

As regards active social inclusion, the Strategy again reflects the tenor of *Towards 2016* which seeks to be more explicit than in the past in identifying the complementary relationship between social policy and economic policy. This can be seen as reflecting also the greater visibility of flexicurity as a policy driver insofar as the Strategy identifies the importance of effective interaction between social protection and growth and employment. (The creation of the new Office of the Minister for Children is also a significant development in terms of structures designed to facilitate effective implementation of the lifecycle approach.) Overcoming educational disadvantage is also taken up as one of the challenges ahead for Ireland.

As regards policy co-ordination and the involvement of all actors, there are further welcome developments in the IE approach. *Towards 2016* provides for instance that a 'streamlined national social inclusion report' will be prepared annually by the Office for Social Inclusion, with the purpose of monitoring and reviewing progress at each stage of the life cycle. This development is welcomed and should help to ensure that social inclusion issues receive due weight in policy development and implementation.

The challenges identified in the 2006 Joint Report related firstly to the need to sustain investment in service provision, notably in relation to childcare and elder care; and IE can be regarded as having responded positively in this area (e.g. through the Childcare Investment Programme). The second area related to the need to address the high proportion at risk of poverty and the high level of income inequalities. While significant investment in income supports has been sustained in recent Budgets, including the 2006 Budget, the absence of an explicit commitment to setting poverty reduction targets gives some cause for concern. As noted earlier, the finalisation of a new NAP/inclusion will provide a clearer picture of IE's intentions in this regard.

3.3 Policy measures

The following four priority areas are selected: child poverty; access to quality work and learning opportunities (activation measures); integration of immigrants; and access to quality services. While by definition, identifying priority areas means that some other worthy issues are overlooked, it is perhaps regrettable that the approach adopted has the perceived effect of diminishing the priority accorded to vulnerable groups, such as Travellers, in earlier NAPs/inclusion. In general, however, the areas identified are all in need of significant attention and fit well with EU priorities.

Notwithstanding the absence of explicit child poverty reduction targets, the Report identifies a wide range of targets that will impact on child poverty in the areas of income support, childcare, tackling early school leaving, addressing educational disadvantage (notably through the implementation of the 'Delivering Equality of Opportunity in Schools' programme), and improving health outcomes. A review of child income supports is to be completed within a year. This is a critical area, given the emphasis on improving access to employment opportunities, since there is evidence to suggest that disincentives to employment within the welfare system have re-emerged as a serious issue. The key targets identified are by and large quantitative, time-limited and demonstrate an integrated approach to addressing child poverty.

The second objective focuses on increasing employment participation and access to education among marginalised groups, notably lone parents, people with disabilities, older workers and the unemployed through the removal of barriers to employment on one hand and the implementation of a new case active management service for all social welfare customers on the other. If it is to succeed, this approach will demand a more flexible response in the area of training and education provision if the needs of the target groups are to be adequately addressed (e.g. in terms of affordable and accessible childcare and the removal of rigidities in the scheduling of training). The targets set relate primarily to literacy, employment rates and investment in the Back to Education Initiative and are relatively clear and time-limited. No targets are included however in respect of the adoption of a case management approach for all social welfare customers. In 2006, substantial investments were made in employment and training supports for the unemployed and the economically inactive and programmes aimed at facilitating access to learning opportunities for low skilled disadvantaged workers.

The third objective – integration of immigrants – is clearly an area of increasing relevance in IE, given the scale of inward migration in recent years. The approach outlined is wide-ranging covering service provision, active integration and anti-racist initiatives, but there is an absence of clear targets (other than to increase the number of language support teachers in schools) with continuing data shortages being advanced as the key explanatory factor. While the NSSPI does indicate that this issue is being addressed as part of the data strategy of the Office for Social Inclusion, it is important that data deficits are not allowed to become a barrier in themselves to effective early actions to address the needs of migrants and to ensure their integration into society.

The final objective relates to access to quality services and the approach outlined represents a substantial development on earlier Plans. An impressive range of policy domains - income support, health, long term care services, transport, accessible ICT, housing and accommodation, improving local environments, and investing in local infrastructure – is covered and clear targets relating to housing, health and transport are included.

The approach taken to gender issues is mixed. A gender perspective is systematically included within the discussion of each policy objective, an approach which demonstrates an increased awareness of the particular issues facing men and women. This does not however translate into gender-specific targets. The adoption of the life cycle approach, mirroring that set out in the *Towards 2016* Agreement can be characterised as 'gender-blind' with the result that the visibility of gender mainstreaming is diminished considerably.

While budgetary allocations are provided in respect of some specific actions (e.g. the National Childcare Investment Programme), and current (2006) expenditure levels are broadly outlined, the Report indicates that future proposed resource allocations will be contingent on the completion of the National Development Plan 2007-13 and on the annual budgetary process. No reference is made in the report on the possible future role of the ESF in supporting actions planned under the Strategy.

3.4 Governance

IE continues to demonstrate a clear commitment to wide-ranging consultation in the preparation of its inclusion strategy. An extensive consultation process was undertaken, including a public call for submissions, regional public consultations, a meeting of the Social Inclusion Forum and consultation with the local authorities. (There is a commitment now to establish Social Exclusion Units in half of all local authorities by end-2008, a welcome – albeit limited – development which will help to embed social exclusion-related activities more concretely within local communities.) Other seminars were run by the Combat Poverty Agency and by various community and voluntary organisations. The direct involvement of stakeholders is more limited in the areas of implementation, monitoring and evaluation although the social partners will have an oversight role through their participation in the Steering Group for the Social Partnership Agreement.

The Strategy envisages a more streamlined approach in the future to the monitoring and evaluation of social inclusion issues. The role of the Office for Social Inclusion has been enhanced under *Towards 2016* and the Office is now charged with monitoring progress on the implementation of the NSSPI, the forthcoming NAP/Inclusion and the social inclusion elements of the new National Development Plan. A single annual Social Inclusion Report will be published, commencing in June 2007. Given that a key message emerging from the consultation process centred on the need to address the 'implementation gap' in existing legislation, policy programmes and task force recommendations, it is to be hoped that the more streamlined monitoring process will in turn underpin a more rigorous implementation of commitments and the achievement of targets. In this regard, also, the recent overhaul of the poverty proofing process, now known as Poverty Impact Assessment, is a positive step.

4. Pensions

Pensioner incomes in Ireland are among the lowest in the EU-25, relative to the overall population (65% of those aged 0-64), and persons aged 65+ are more at risk of being in poverty than those aged 0-64 . In 2004, 33% were at risk of poverty (men 30%, women 36%), meaning that poverty rates of older people in Ireland remain amongst the highest in EU-25, in spite of the fact that State pensions have been increasing at a faster rate than either prices and earnings.

The 2006 Sustainability Report assessed Ireland as a medium-risk Member State as regards the sustainability of public finances, notably due to the high cost of ageing and despite the

current strong budgetary position. According to the AWG 2005 projections, public spending on first-pillar pensions (including public service pensions) is set to rise from 4.6% of GDP in 2004 to 11.1% in 2050. The rise is relatively continuous and stable over the whole period. Theoretical pension replacement rates are expected to stay stable until 2050 (78% total net and 67% total gross – of which 31% from public pensions; currently only about 50% of the employed population is covered by occupational schemes).

Ireland has made progress in making provision for increasing the adequacy of pensions, and further steps have been announced recently by the Government which will have a particular impact on the poorest older pensioners, the majority of whom are women. Nevertheless, as set out in the 2006 Joint Report, extended coverage of supplementary pension provisions is important to ensure the effectiveness of the income replacement function of pension systems. Evidence suggests that despite Government initiatives, levels of supplementary pension coverage are at best static. Although Ireland has made good progress in increasing its older workforce, early retirement is still common, in particular for reasons of illness or disability. Further strengthening of incentives to work longer would contribute to ensuring future adequacy and sustainability. The Irish Government's commitment to allow a pension to be drawn, whilst continuing to work, could help improve flexibility in retirement.

The Irish 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, in the face of significant projected pensions expenditures in the future. Recent returns of the reserve fund (19.5% in 2005) are impressive and have taken the value of the fund to 11% of GDP. The commitment to monitoring the adequacy of contribution rates through regular actuarial reviews should help to react to any signs of adjustments being needed, and thus help to keep the system on a sustainable footing. A pensions green paper is expected in early 2007 setting out further possible steps for pension reform. A consultation process will follow the publication of the green paper and the Government will respond to these consultations by producing a framework for long-term pensions policy.

5. Health and long-term care

5.1. Health care

Description of the system: A National Health Service (NHS) provides care to all residents some of whom (medical card holders) are entitled to free care (primary, secondary, dental, ophthalmic, aural, maternal and infant care, medicines) based on income and age (70+). Non-medical card holders are subject to charges for consultations, inpatient, outpatient and emergency care and are not covered for dental, ophthalmic and aural care. The NHS is a mix of public and private provision. Primary health care (PHC) is delivered in health centres on the one hand, and in the private premises of general practitioners (GPs), pharmacists, dentists and optometrists, on the other. A GP referral gives access to specialist and hospital care which are available in hospitals' outpatient and inpatient departments. Public sector specialists also conduct private practice for outpatients. Most hospitals are publicly owned but private care can be provided in public hospitals. GPs are paid on a capitation basis for medical card patients and a fee-for-service for all others, whereas specialists' pay is salary based in hospitals and fee-for-service in the private sector. The NHS is mainly financed through general taxation. Private health insurance (duplicate, complementary and supplementary), mostly community-rated and run by the Voluntary Health Insurance Board (80% of market), covers 43.8% of the population. Highlighting health inequalities and barriers to access as serious challenges, authorities have goals to improve general health and reduce health

inequalities through health promotion and to provide more easily accessible and equitable services that are better organised and integrated with social services, whilst enhancing system responsiveness and performance.

Accessibility: Data show that individual financial costs of care are rather high (private health care expenditure was 21.5% of total health care expenditure in 2004). To tackle this (over and above medical cards and an annual cap on hospital charges for all), authorities are extending free GP services to those around a threshold income. Moreover, they are introducing new legislation changing income guidelines and bringing further funding into the sector to increase the numbers of medical and free GP visit card holders. However, data show that GP numbers (3.1 per 100 000 inhabitants in 2004) are well below all other EU countries (e.g. 80.8 in England), which is clearly an obstacle to achieving appropriate and accessible PHC. The Irish authorities' response to this is the planned training of more GPs and expanding GP geographical coverage (including GP out-of-hours cooperatives), with 300 PHC teams expected by 2008. To address acute care shortages authorities are allocating funding to open new acute hospital beds and to contract with private facilities. The report highlights that appropriate long-term care outside the acute care setting can free additional beds. Emergency, renal and organ transplantation services will also receive additional funding. To reduce waiting times, the Irish authorities have set up the National Treatment Purchase Fund that collects data and pays for those waiting too long to be treated in private hospitals. A strong concern expressed in the report relates to substantial health inequalities: mortality was 3.5 higher in the lowest occupational class, chronic physical illness 2.5 times higher among the poor, infant mortality 3 times higher in poorer families, and travellers live 10-12 years less than the general population. Indicators are being defined for vulnerable groups and by socio-economic status (see further).

Quality: To improve quality the authorities are implementing quality standards together with a regulation and inspection regime. Legislation will establish the Health Information and Quality Authority (HIQA) and, to provide quality assurance, authorities will run a continuous accreditation system conducted by the Accreditation Board and a staff registration system. A national health information strategy is currently being implemented to develop standardised data sets and comparable indicators (on health status, health determinants, sector activity and financing) which authorities hope will support the planning and evaluation of services. In order to support the information system more emphasis will be placed on ICT. Authorities have allocated additional funding to the health research board to pursue research and evidence-based decision making. The HIQA will evaluate health technology. A customer charter and a complaints framework are planned, patients will be offered a choice of provider wherever possible, and an electronic health care record is planned. According to the report various fora (e.g. national consultative forum, regional health forums) are to provide opportunities for users, providers and staff to give feedback and be involved in decision making. To improve coordination between services and reduce fragmentation of management and delivery of care, the Health Service Executive was created, merging 11 previously separate and specialised agencies. ICT will support the links between services.

Long-term sustainability: Total health expenditure (7.2% of GDP and 2619 per capita PPP$ in 2004) is slightly below the EU average in GDP terms. It varied little throughout the decade, probably due to high GDP growth. Per capita expenditure increased rapidly between 1998-2002 (showing real rates of growth of between 9.8 and 11.2%). The share of public expenditure (78.5% of total expenditure in 2004) is around the EU average having increased in the last decade. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 2.0 percentage points of GDP by 2050. In this context, extra resources can be

used to improve access and increase promotion and prevention activities whilst still achieving efficiency gains. The Irish authorities emphasise the need to enhance the use of PHC and daycase surgery while improving DRGs definition and DRG payment as a means of controlling costs and enhancing efficiency. They expect that the new organisational structure and various plans will improve governance and accountability. Public-private partnerships are seen as opportunities to bring extra funding (capital investment) into the sector. With regards to health workers, a skills' monitoring report was published which authorities hope will help in the the long-term planning of the work force. Further developments have been the introduction of a health care-assistant training programme and an increase in the numbers of trained therapists, paramedics and nurses. New midwifery and children's nursing places are also planned to open. Highlighting the need to improve general health and reduce health inequalities, the authorities are implementing various promotion strategies addressing risk factors and specific diseases (e.g. smoking, alcohol, diet, exercise, cancer, drugs, aids, obesity, breastfeeding, suicide, mental health). Health promotion is to be implemented in a comprehensive manner using health impact assessment in all sectors, legislation, environment, education, health sector (e.g. access, immunisation, screening), inclusion/ anti-poverty, income, employment, and supply side (drinking and food industry) policies. It is to be conducted in different settings (e.g. schools, workplace).

5.2. Long-term care

Description of the system: Services include, alongside PHC and hospital care: home nursing, home help and care attendants, day centres, grants to adapt homes, meals-on-wheels, nutrition advice, therapy and rehabilitation, day hospitals, public residential care and private nursing homes. Services are provided in partnership with users, families and carers and a range of statutory, non-statutory, voluntary and community groups. Access is based on needs. Care in public facilities is free or almost free while a means-tested subvention is given to patients to pay for private nursing home care. There are some financial schemes for carers such as the carer's allowance for low income carers and the respite care grant. Care in the community is considered the preferred option by authorities both for the individual and on economic grounds. The goal is to maintain people in dignity and independence at home in accordance with their wishes; to support family, neighbours and voluntary bodies; and to provide hospital and residential care once this is no longer appropriate. Healthy ageing (promotion and prevention at older ages) is also a stated aim.

Accessibility: The report argues that public supply may be insufficient and private care may impose large financial burdens on patients and their families. Hence, to ensure equal access, authorities want to run a national standardised needs assessment with appropriate levels of co-payments and provide additional funding to expand the home care package and contract private services. Home care grants have been piloted as an alternative to residential care.

Quality: To ensure quality the report suggests that the HIQA will set national quality and safety standards for public services and a regulatory framework will define the standards in private nursing homes. Inspections are to be carried out, nurses will have full training and attendants will receive informal training. The report indicates that the National Council on Ageing and Older People advises on issues relating to older people with particularly regards to health care. The report also describes a number of databases and indicators related to disability and those at particular risk such as the 65+ and 75+ (influenza vaccination rates, waiting lists for certain procedures, and rates of residential care and home care use) A survey and report on long-stay care is conducted annually. Authorities expect that multidisciplinary teams will ensure integrated care.

Long-term sustainability: The 2006 EPC/EC age-related projections show an increase in public expenditure of 0.6 percentage points of GDP by 2050. Several reports have been looking at ways of financing long-term care. A combined system of taxation, co-payments and social insurance or pre-funding mechanisms is one possibility.

6. Challenges ahead

To ensure that the investment in services is sustained, delivered in an integrated manner along with welfare reforms and that it leads increasingly to more accessible and more flexible delivery attuned to the needs of those groups at greatest risk of poverty and exclusion, in particular to break the cycle of deprivation.

To continue to promote active inclusion to ensure that the range of issues, including the necessary adaptation of services, associated with the significant ongoing levels of migration are effectively addressed.

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 a significantly wider coverage of supplementary private schemes, while taking due account of the long-term sustainability of public finances.

To implement the set of measures that tackle major barriers to access (e.g. financial burden of care and long waiting times) and ensure more equitable access notably through enhancing nationwide availability of PHC, acute care, emergency and long-term care services; improve care coordination and integrated care.

To achieve efficiency gains in service delivery whilst improving the health of population and reduce substantial health inequalities.

<<IRELAND>>: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	9.4	126.1	**2000**	65.2	76.3	53.9	50.4	45.3	**2000**	4.2	4.3	4.2	6.8
2002	6.0	132.3	**2002**	65.5	75.4	55.4	47.6	48,0	**2002**	4.5	4.7	4.1	8.5
2004	4.3	135.7	**2004**	66.3	75.9	56.5	47.7	49.5	**2004**	4.5	4.9	4.1	8.9
2006	5.3f	139.2f	**2005**	67.6	76.9	58.3	48.7	51.6	**2005**	4.4	4.6	4.1	8.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality	WHO	Total health exp %GDP	Public health exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.9	78.4	13.6	17.3	63.2	na	6.4	**1995**	6.8	71.6	-		
2000	73..9	79.1	14.6	17.8	63.3	66.9	6.2	**2000**	6.2	73.9	13.6	100	43.8
2003	75.8	80.7	15.7	18.9	63.4e	65.4e	4.9	**2004**	7.2	78.5	13.6		

e: estimate **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total | ***Age-related projection of expenditure (AWG)***

Eurostat	Total expenditure* (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health Care	Long-term care
1995	18.8	26.5	36.2	15.3	12	5.2	4.8	**2005**	16.5	15.5	4.7	5.3	0.6
2000	14.1	25.1	41	9.5	13.6	5.6	5.2	**2010**	17.5	-0.1			
2004	17	23.3	42.1	8.3	15.5	5.5	5.3	**2030**	28.3	3.3	3.1	1.2	0.1
								2050	45.3	7.8	6.4	2	0.6

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2005	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	23	19	16	33	20	23	18	22	10	**Total**	5,0
Male	19	-	17	15	30	21	-	19	22	12	**Male**	-
femal	21	-	20	17	36	19	-	17	22	10	**Female**	-

	People living in jobless households				***Long-Term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*			% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female		Total	Male	Female
1999	11.7	9.8	8.5	11.1	2.4	3,0	1.6	**1999**	na	na	na
2004	11.8	8.6	7.2	10.1	1.6	2.0	1	**2004**	12.9p	16.1p	9.7p
2006	11.3	7.9	6.5	9.3	1.5	1.9	0.8	**2005**	12.3p	14.9p	9.6p

** excluding students* p: provisional

SILC income 2005	Total	Male	Female	SILC income 2005	Total	Male	Female
Relative income of 65+	0.654	0.663	0.647	***Aggregate replacement ratio***	0.426	0.382	0.506

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or social security)	Current Estimate (2002)	Assumption
0	0	3	DB	-3	DB	100	52	9.5	10-15	20.7

**:(DB / NDC/ DC); ** (DB / DC)*

GREECE

1. Situation and key trends

Real GDP growth has remained at high levels in recent years, despite the slowdown in the world economy. Even though a decline in the annual real GDP growth has been observed (from 4.7% in 2004 to 3.7% in 2005), the real GDP growth rates outstrip, by far, the respective EU-25 averages (2.3% in 2004 and 1.7% in 2005). Moreover, the projections for 2006-2007 indicate that growth will remain high (3.5% and 3.4% Eurostat).

The strong domestic economic activity has not led, however, to the expected gains in employment. The total employment rate has shown a gradual increase over the last few years, but in 2005 it continued to lag behind the EU-25 average by 3.7 percentage points (60.1% against 63.8%). The gap is greater for young people's and women's employment rates (25% in 2005 against 36.8% and 46.1% against 56.3% respectively), while the older workers' employment rate, is near the EU-25 average. After reaching a peak of 12% in 1999, the unemployment rate fell to 9.8% in 2005 but remains higher than the EU-25 average. Moreover, unemployment continues to affect mainly young persons and women, whose unemployment rates remain significantly higher than the EU-25 averages. Similarly, despite its modest downward trend over recent years, the long-term unemployment rate remains higher than the EU-25 average.

Total social protection expenditure as a percentage of GDP reached the EU-25 average in 2001 and, though slightly decreasing since, remains close to the EU-25 average, at 26% against 27.3% in 2003. Nevertheless, in 2004, Greece posted an at-risk-of-poverty rate after social transfers of 20% against a 16% EU-25 average, while the disparity for the 65+ age group was even stronger (28% against 18%). Expenditure on pensions was slightly above the EU-25 average, at 12.9% of GDP in 2004, but is projected to increase sharply until 2050. Greece's old-age dependency rate will grow from a moderate 26.8% in 2005 to 58.8% in 2050, among the highest in the EU.

In 2004, life expectancy at birth in Greece was 76.6 years for males and 81.5 for females, among the highest in EU-25 and showing a significant increase since 1995. Healthy life expectancy was above the respective EU-25 averages, 66.7 years against 64.5 years for males and 68.4 against 66 years for females. Infant mortality was below the EU-25 average, at 3.9% against 4.5% in 2004. At the same time, total health expenditure, as a percentage of GDP, seems to have stabilised in recent years and in 2004 was above the EU-25 average, 9.8% against 8.87% (WHO-HFA database). On the other hand, per capita spending on health in purchasing power parity is below the EU-25 average, at 2,011 in 2003 against 2,266, while the high level op private health care expenditure – accounting for almost half of the total expenditure (48.3% in 2004 against 24.1% EU-25 average) – may signal inequities in access for vulnerable groups.

2. Overall strategic approach

Over recent years, there has been recognition of the need for social policy adjustments. Consequently efforts have been under way to improve the social protection system and specifically the ability to meet existing and emerging needs of all those citizens at risk of social exclusion and poverty. The strategy announced in the National Report on Strategies follows the rationale of the previous NAP inclusion, is based on specific national challenges and takes into consideration the input of the reports on pensions and health and long-term

care. Within this framework, three strategic priorities are identified, namely a) improving governance, b) promoting employment and fighting unemployment among vulnerable groups by upgrading their abilities and c) securing a dignified socioeconomic standard of living and ensuring high-quality social services for all, especially with regard to education, health and social security and protection systems. The strategic approach and the key challenges identified are steps in the right direction. However, the links between the strategic priorities and the proposed interventions are not always sufficient. Moreover, further efforts are needed towards the adoption and implementation of a strategy addressing fully and comprehensively all three overarching objectives of the Open Method of Coordination for social protection and social inclusion. The willingness to address the governance objective is noticeable; nevertheless the implementation of the presented interventions had already been announced in the previous NAP and seems to encounter delays. On the other hand, the National Report provides links with the Lisbon strategy and puts emphasis on improving the employability of socially vulnerable groups. Moreover, efforts are under way in order to better address the question of immigrants' integration. An integrated approach has for the first time been adopted, which, if rapidly and fully implemented is expected to contribute to smooth progress in immigrants integration. Furthermore, there is a notable attempt to link the National Report with the interventions presently carried out and co-financed by ESF. The role of this contribution to achieving the overarching objectives looks indisputable. Yet, the link with the National Strategic Reference Framework (NSFR) 2007-2013 could benefit from more clarity, because many of the envisaged interventions will solicit ESF co-financing.

3. Social Inclusion

3.1 Key trends

Recent strong economic growth has not led to the expected gains in employment, but sustained high growth combined with structural reforms is expected to make a positive contribution. The total employment rate increased gradually over recent years, but in 2005 it continues to lag behind the EU-25 average by 3.7p.p. The gap is much greater for women and young people. The total unemployment rate has been declining in recent years, but remains higher than the EU-25 average (9.8% in 2005 against 8.8%). In 2005, the youth unemployment rate was 26% against 18.6% EU-25 average, while the unemployment rate for women was 15.3% against 9.9%. Similarly, despite a modest decrease in recent years, the long-term unemployment rate remains higher than the EU-25 average (5.1% against 3.9% in 2005).

Regarding education and lifelong learning, in 2005, persons with low educational attainment were 23.1% among the 25-34 years old, against an EU-25 average of 22%, while the gap for older generations is much higher (83% against 66.1% for the 65+). The percentage of low-achieving 15-year-olds in reading literacy was one of the highest in EU, at 25.2% against 19.8% in 2003. On the other hand, the total early-school-leavers rate was lower than the EU average in 2005, 13.3% against 14.9%. Participation in lifelong learning is very low, 1.8% against 11% EU-25 average. Given that spending on education remains lower than the EU-25 average, investing in education, including a drive to boost participation in lifelong learning, seems a priority.

Over the last decade, efforts to improve and extend the social protection system, in terms of both quantity and quality, are evident and partly reflected in the increase in social protection expenditure as a percentage of GDP, which reached the EU-25 average in 2001. Despite a moderate downturn since, it remains close to the EU-25 average, standing at 26% against

27.3% in 2003. Nevertheless, its impact on the relative reduction of the at-risk-of-poverty rate has been limited, only 3 p.p. against 9 p.p. EU-25 average. In 2004, the at-risk-of-poverty rate after social transfers was 20% against 16% EU-25 average, while the relative median at-risk-of-poverty gap was 25%. Greeks aged 65+ faced an at-risk-of-poverty rate after social transfers well above the EU-25 average, 28% in 2004 against 18%, while the rates for those at work and not at work were respectively 13% and 26%, against the 9% and 23% EU-25 averages. It should be noted that these percentages would probably be lower if the considerable level of owner-occupied housing among those at-risk-of poverty was taken into account. Greece exhibits one of the most unequal income distributions among the EU-25 (s80/s20 quintile share ration: 6.0 in 2004). Moreover, it should be noted that Greece has adopted neither an official poverty line, nor a universal minimum income scheme. The existent income support schemes target specific groups considered at greater risk.

3.2 Key challenges and priorities

The social inclusion strategy identifies four strategic priorities, namely a) strengthening employment, especially for women, young people, the long-term unemployed and vulnerable groups; b) tackling the disadvantaged position of persons and groups with regard to education and training; c) reinforcing the family and supporting the elderly; and d) promoting social inclusion of the disabled, immigrants, and persons and groups with cultural and religious particularities. Although the identified priorities point in the right direction, further efforts are needed towards the adoption of an integrated and streamlined strategic approach. The links between the strategic priorities and the proposed interventions are not always sufficient, while the social inclusion objective of Governance is only partly addressed. With the notable exception of three specific targets to be achieved by 2010 (employment rate of 64.1%, poverty gap rate at 20% and the rate of early school leavers below 10%), the plan lacks further concrete targets. Besides, it fails to refer to the availability of budgetary and human resources considered necessary for its successful implementation and does not provide any pre-assessment. Consequently, although the main challenges are well identified, the social inclusion part of the report could become more operational, if the spelled out priorities and measures were better associated with specific targets and concrete means. This would also have facilitated the ex-ante and ex-post evaluation of the strategy.

Referring to the challenges identified in 2006, the limited number of actions undertaken towards improving governance and mobilising all stakeholders has not yet had satisfactory results. The weaknesses in coordinating, monitoring and evaluating social policy interventions have so far rendered their effectiveness and efficiency rather limited. On the other hand, an increase in the number of structures providing social support and care services throughout the country has been observed. Moreover, some progress towards the integration of immigrants and the promotion of multiculturalism has been made through the adoption of a new law. Nonetheless, prompt and effective implementation is crucial if this is to succeed. Upgrading and extending the provision of services to the most vulnerable groups constitutes the prevailing concern. In this respect, increasing the efficiency of social protection expenditure is crucial. Some challenges, such as extending a “safety net” for all groups experiencing poverty and developing an integrated approach on child and in-work poverty remain to be adequately addressed. Finally, linkage with the intervention of the Structural Funds in the future period could benefit from more clarity, given that many of the envisaged interventions in the field of social inclusion will solicit ESF co-financing.

3.3 Policy measures

Over recent years, active employment measures for vulnerable social groups have been on the increase, while a number of integrated action plans for particular social groups are under way. Further restructuring of the public employment services by transforming them into one-stop shops, along with stronger active policies better geared to sectoral needs and the needs of vulnerable groups, receive a high priority. The creation of a Social Solidarity Fund to provide financial support and encouragement to the reintegration into the labour market of older unemployed persons, mainly victims of restructuring, is currently the subject of dialogue between the social partners. Moreover, the report expresses a willingness to promote policy planning focused on local needs and the particularities of regional labour markets.

In the wider framework of improving planning and implementation of educational and training policies, and making them better targeted and adapted to the needs of vulnerable groups, interventions such as “Supportive Classes” and "Intercultural Schools" will continue, and extra efforts will be dedicated to primary and secondary education. Adult’ education will be further promoted by the creation of at least one Second Chance School and one Adult’ Education Centre in each municipality.

Progress regarding support for the family and the elderly accelerated through the creation, at municipality level, of structures providing social care and accompanying services, especially to groups in need. The institutionalisation of specific schemes of social support, such as “Help at Home” and “Child Care”, along with the ESF co-financing, facilitated better provision of such services. Nonetheless, securing their financial sustainability remains a challenge. In relation to gender mainstreaming, certain priority criteria for women’s participation have increasingly been applied in recent years, though there is still room for progress. Furthermore, the report refers vaguely to the political will to implement interventions for households with no working members.

Over recent years, income support measures have been extended to cover more socially vulnerable groups, providing a categorical income support, which is gradually being improved. However, it continues to fall short of forming a "safety net" for everyone in need, while no national guaranteed minimum income scheme exists. Furthermore, bottom-up and user-oriented approaches, open procedures and social dialogue that would enhance the participation of stakeholders are still not being adequately developed in the context of poverty and social exclusion.

The selected intervention, aiming to promote health and social inclusion of Greek Roma, is indeed a good example of an integrated, and thus innovative, action plan. Yet, given the scarcity of evaluations of the impact of the implemented measures, and knowing that in reality a lot remains to be done to adequately address the issue of improving the situation of Greek Roma, to consider this specific intervention a good practice seems debatable.

Despite the positive steps, social policy adjustments carried out so far have failed to address effectively the multidimensional problems and needs in the area of poverty and social exclusion. The majority of undertaken measures appear to be fragmented as the appropriate institutional mechanisms to facilitate the adoption of an integrated approach are still at an early stage of development. The presented key policy measures go in the right direction and are well targeted. However, the report fails to set quantitative targets and lacks information on associated resources and their availability. Synergy and close interaction between the various measures, as well as coordination between the competent bodies, need to be further

strengthened. The willingness to commit to and keep up the efforts for ensuring an efficient and equitable social protection system is apparent in the plan which, if fully implemented, could contribute to alleviating poverty and social exclusion.

3.4 Governance

The National Report on Strategies was prepared under the coordination of the Minister of Employment and Social Protection, which had set as a priority the involvement of all relevant bodies. At the first stage of preparation of the report, survey questionnaires were sent to all relevant actors. Subsequently round tables with the Social Partners, NGOs and civil society were organised, before the draft report was presented by the Secretary General of the Ministry of Employment to the National Economic and Social Committee. Before its finalisation, the report should ideally have been discussed within the National Social Protection Committee, while the launch of broad social dialogue following the presentation of the draft would have been welcomed.

Identifying the need to improve governance, as an overall strategic priority, is a good starting point for developing an integrated social inclusion policy. Yet, delivery remains the core challenge. The creation of a National Council for Social Protection to formulate proposals on social protection policy planning issues, to monitor and evaluate the undertaken actions and to provide annual studies on the social situation, is a step in the right direction. However, concerns arise as its implementation seems to delay.

4. Pensions

Older people enjoy a living standard relatively close to that of the general population (79% in 2004), while according to SILC figures for 2004 (income year 2003), the poverty rate of people aged 65 or more stands at 28% (but with very low gender difference), about 10 p.p. higher than the poverty risk of people aged 0-64.

The 2006 Sustainability Report assessed Greece as a high-risk Member State regarding the sustainability of public finances, notably due to the high projected increase in age-related expenditure and a high level of debt. According to the budgetary projections made by the AWG in 2001, expenditure on pensions is projected to almost double, reaching a level of 24.8% of GDP in 2050. ISG projections for workers with a complete career record of 40 years of contributions show that the total net replacement at age 65 is projected to decline by 9 p.p. by 2050, from a net 115% (gross 105%) to 106%, still above 100%. If instead of 40 years of contributions, the current weighted average of 25 contribution years is taken into account, and instead of the 65 retirement age the current weighted average retirement age of 60 is considered, the replacement rate for the primary pension is 33%. In this case, a proportional fall is also computed for the auxiliary pension amount.

The 2006 Joint Report highlighted that implementing 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 recently launched social dialogue, 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. The latest update mentions the further

development of occupational pension schemes, which could help improve adequacy and help incentives for working longer. 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. Apart from this, the overall efforts with a view to ensuring viability should continue at a faster pace.

5. Health and long-term care

5.1 Health care

Description of the system: The Greek healthcare system is based on the coexistence of the National Health Service (NHS), a compulsory social health insurance and voluntary private health insurance schemes. Universal coverage of the population is provided by the NHS and a variety of social insurance funds (35). 8% of the population maintains complementary private voluntary health insurance coverage. The provision of health care consists of NHS units, insurance funds' units and private sector units contracted by the insurance funds. A legal reform resulting in NHS decentralisation along regional lines has been remodelled. The original Administrative Health Regions (PESYs) which were not given individual budgets have been replaced by Managerial Regional Health Units (DYPE). Primary Health Care (PHC) is delivered through PHC centres, hospital ambulatory (outpatient) services that belong to the NHS, and PHC units that belong to the largest social insurance fund (IKA). Secondary and tertiary care is provided in general and specialised hospitals. Health services are funded almost equally by public and private sources. Public expenditure is financed by taxes and compulsory social health insurance contributions. Voluntary payments by individuals or employers represent a high percentage of total health expenditure (48.3% in 2004). The NHS budget is set annually. Taxes provide approximately 70% of all hospital funding, and the remaining 30% is a public/private mixture combining social security and out-of-pocket payments. The national strategy aims at improving the efficiency and effectiveness of both healthcare and LTC systems by extending the scope of PHC. Both healthcare and LTC appear mutually dependent, with coordination problems in one system negatively affecting the other.

Accessibility: Universal access is guaranteed by law and the population coverage is high. Despite the legal provision of non-discrimination, access problems remain, due to geographical disparities and an uneven distribution of facilities and medical staff. Efforts to ameliorate patients' access include the modernisation-supplementation of medical-technological equipment, the creation of new specialised departments (intensive care and dialysis units) and efforts to improve the staffing of the healthcare system. Extra funding has been allocated to increase capacity and service distribution (including primary care centres and hospital care). This increased health expenditure, combined with the absorption of the allocated Structural Funds (3rd CSF), resulted in the creation of new hospitals and the addition of beds to the NHS. These measures aim at improving general access to health services whilst dealing with regional disparities, due to the geographical peculiarity of numerous islands. High and increasing private health care expenditure – almost half of the total – signals inequities in access for vulnerable groups. A legislative reform with an emphasis on PHC, the structural inclusion of family doctors and the inclusion of social insurance healthcare entities into the PHC system is ongoing.

Quality: The authorities acknowledge the need to institutionalise a comprehensive and uniform framework for quality control. Problems of poor effectiveness and efficiency concern mainly the hospital sector. One priority covers the generalised use of ICT, improved data gathering and exchange of information. To tackle the low level of computerisation, the setting

up of a National Health Information System (ESPY) for data collection is receiving support. A legislative proposal aimed at establishing quality control mechanisms, accreditation, inspection of facilities, the enforcement of patient rights (Ombudsman) and the promotion of preventive measures is to be adopted.

Long-term Sustainability: Total health expenditure as a percentage of GDP (9.8% in 2004) is above the EU average[105], whilst expenditure has stabilised in recent years. The public share of total health expenditure is 51.7% in 2004, originating from the state budget and social security. The remaining 48.3% of total health expenditure originates from private payments, with 46% of total health expenditure consisting of out-of-pocket payments. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.7 percentage points of GDP by 2050 due to population ageing. The mixed financing system (state, health insurance, private) operates with differentiated funding rates according to whether care is closed, open-ended and to the legal status of the care provider. Private expenditure appears very high for a mainly public healthcare system. The deficient and segmented PHC system is under review with the aim of fully integrating the role of the General Practitioner and bringing the insurance institutions into PHC. High private expenditure indicates access and service use inequities. Despite increased total health expenditure, health status indicators have not improved. Relatively low public expenditure raises concerns of severe under-financing of the system. There is no uniform price for acute bed use between public and insurance hospitals. Tax revenue is often used to fill the gap between the official funding level and the actual cost of hospital care. Despite the law on PHC centres (2004) assuring their financial and administrative autonomy, they are still financed through hospital budgets. Apart from high private expenditure, the system's financial sustainability is also undermined by excessive medicine and technology use and supply driven demand for health services. Modernisation efforts emphasise efficient ICT use, rational medicine and technology prescription, prevention-based policies and active ageing promotion.

5.2 Long-term care

Description of the system: The LTC system is mixed, including direct social services provisions, care needs coverage through insurance funds and tax exemptions for indirect care provision. LTC services for the elderly are provided by the State, private non-profit organisations and private for-profit organisations. These services have been supplemented by open care and home care services leading to a reduction in the use of hospital or institutional care. After the successful evaluation of the "Care at Home" Programme, there is planning for the development of day care centres for the elderly in order to allow working women with dependent family members to adequately cover their working hours. The National Direct Social Aid Centre (EKAB) is being reinforced.

Accessibility: The general aim is to favour care at home for the elderly. Service providers are concentrated in urban centres. Often the connective family network has to meet the needs of the elderly in semi-urban and rural areas. Focusing on home and close to home day care centres, supporting informal carers, will bring quality gains and more efficient use of resources. One priority is the development of more specialised, post-hospital support services (as well as infrastructure in particular for mental patients). The authorities plan to establish a National System of Social Solidarity based on a White Paper on Governance, pilot programmes aimed at combating social exclusion of particular groups, flexible and individualised needs-based LTC services and the modernisation of welfare institutions.

[105] EU average of 8.87% and PPP$ 2376.33 per capita in 2004

Quality: An independent Patients Rights Protection Agency covering LTC recipients' rights is in operation. Vocational Training Centres are in operation for the training of carers for the elderly. Evaluation is carried out by the Association of Inspectors of Health and Welfare Services. The authorities are aiming to achieve a uniform provision of LTC services. The legislative framework for the accreditation and evaluation of NGOs and voluntary organisations in the provision of LTC is in place. Implementation gaps and insufficient LTC health professionals (rural areas) are a challenge to uniform provision and to the level of quality of services.

Long-term sustainability: It is difficult to assess total LTC expenditure due to the multiplicity of providers and the forms of provision. A large part of LTC is informal, family provided and hence hard to assess in cost terms. The mixed financing system of formal long-term care is further complicated by differences in the financing rates, which vary according to the type of care and the provider's legal status. Cost-controlling mechanisms are weak and there is no comprehensive framework for cost evaluation.

6. Challenges ahead

To promote the active social inclusion of the most vulnerable social groups by upgrading and extending the provision of services and the financial "safety net" (minimum incomes) and by developing multidimensional policy approaches to the wider social inclusion of persons and groups with special characteristics and needs such as immigrants, disabled people, Roma and other vulnerable groups.

To improve governance and to promote the mobilisation and full participation of all relevant stakeholders, in order to strengthen implementation, monitoring and evaluation and also to increase the efficiency of social expenditure.

To increase efforts to ensure adequacy and long term sustainability of the pension system, notably by increasing employment and promoting longer working careers, so as to broaden the contribution base.

To enhance, better integrate and distribute PHC services to improve access, combat high costs, inequalities and tackle the high financial burden of care on vulnerable groups in order to curb the over-consumption and wastage of resources.

To modernise the management of the system through structural changes (in LTC the aim is to move away from a 'clinical' model and to adopt a 'social' model, mainly developed at the local level) and the development of a comprehensive framework for evaluating the quality of the services provided.

GREECE: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.5	72.7	**2000**	56.5	71.5	41.7	27.6	39,0	**2000**	11.2	7.4	17.1	29.1
2002	3.8	77.2	**2002**	57.5	72.2	42.9	26.5	39.2	**2002**	10.3	6.8	15.6	26.8
2004	4.7	81.4	**2004**	59.4	73.7	45.2	26.8	39.4	**2004**	10.5	6.6	16.2	26.9
2006	3.8f	84.9f	**2005**	60.1	74.2	46.1	25,0	41.6	**2005**	9.8	6.1	15.3	26,0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total Health exp. %GDP	Public Health Exp. % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop.	Pop. Covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	75,0	80.3	16.1	18.4	65.8	69.2e	8.1	**1995**	9.6	52	-	:	:
2000	75.6	80.5	16.3	18.3	66.3	68.2	5.9	**2000**	9.9	52.6	44.9	100	
2004	76.6sp	81.5sp	16.9sp	19.1sp	66.7e	68.4e	3.9	**2004**	9.8	51.7	46	100	8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditure **PHI: Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	22.3	52.1	26	4.5	8.8	3.8	4.8
2000	25.7	49.7	26.5	6.2	7.4	5.4	4.8
2004	26	50.9	26.5	5.9	6.9	4.7	5

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health Care	Long-Term Care
2005	26.8	8.9	5.1	5.1	:
2010	28	-0.2		5.4	:
2030	39.1	0.2	0.8	5.9	:
2050	58.8	1.3	1.7	6.8	:

*** total social expenditure for GR does not include pension expenditure. The Greek authorities have agreed to provide the pension projections in 2006.*

4. Social inclusion and pensions adequacy - Eurostat

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	20	19	17	28	24	23	24	24	24	**Total**	5.8
Male	18	-	18	16	25	24	-	24	24	22	**Male**	-
femal	21	-	21	18	30	24	-	24	24	25	**Female**	-

	People living in jobless households					Long-Term Unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	5.2	9.6	7.0	12.1	**1999**	6.5	3.8	10.7	**1999**	18.6	22.1	15.4
2004	4.5	8.5	6.2	10.7	**2004**	5.6	3.0	9.4	**2004**	14.9	18.3	11.6
2006	3.6	8.1	6.1	10.1	**2005**	5.1	2.6	8.9	**2005**	13.3	17.5	9.2

** excluding students*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.79	0.83	0.78	***Aggregate replacement ratio***	0.49	0.56	0.47

Change in theoretical replacement rates (2005-2050) - Source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
-9	-11	-11	DB	:	:	Nd	:	20	:	:

** (DB / NDC/ DC); ** (DB / DC)*

SPAIN

1. Situation and key trends

Economic growth accelerated to 3.5 % in 2005, above the EU average (1.6%). The debt ratio is low (43.1%, 63.4% in the EU, 2005). Both activity and employment rates, although significantly increasing since 2001, continue to be somewhat below EU averages: the activity rate stood at 69.7% in 2005 (70.2% in the EU); the employment rate at 63.3% (EU: 63.8%). The unemployment rate declined to 9.2% in 2005 (8.7% in the EU). The increase in employment rates has mainly benefited women (+15.4 percentage points between 1998 and 2005), but there is a clear need for further effort (the total female employment rate in 2005 stood at 51.2%, in the EU: 56.3%). With the employment rate of people aged 55-64 standing at 43.1%, Spain is marginally above the EU average (42.5%). However, the rate of employment for women aged 55-64 is substantially lower than the EU average (27.4% in Spain, 33.7% in the EU). The labour market is highly segmented, with a fixed-term employment rate of 33.3% in the second quarter of 2005, affecting particularly women, young people and low-skilled workers. Low productivity growth and high inflation hamper competitiveness. The substantial growth in the Spanish economy and in employment in recent years has directly benefited the social security system. The age structure of the population has changed significantly (with the number of people aged 65+ projected to grow from 17% in 2005 to 33.5% in 2050). The population increase, as a result of migration flows (more than 3 million people between 1998 and 2005), will play an important role in the sustainability of the system in the short and medium term. It will also positively influence the old-age dependency ratio, which is expected to grow from 25% in 2004 (close to EU average) to 67.5% in 2050 (EU: 52%). The effective labour market exit age in 2005 was one of the highest in the EU: 62.2 years, 60.7 years EU average. Although economic growth has accelerated in recent years, there is no significant improvement in terms of the number of people at risk of poverty: 20% of the Spanish population was below the at-risk-of-poverty threshold in 2004 (16% in the EU). People aged 65+ are particularly at risk (29% in Spain, 19% in the EU). Spain continues to be significantly below the EU average regarding social expenditure as a percentage of GDP (20% compared to 27.3% in the EU in 2004) and has one of the highest rates of early school leavers in the EU (30.8% in 2005, more than twice the EU average), particularly among men (36.4%, while the rate is much lower among women: 25%). Life expectancy at birth (76.9 and 83.6 for males and females in 2003) is above the 2003 EU average[106] showing a 2-year increase in the last decade (74.3 and 81.5 in 1995). Healthy life expectancy (66.8 and 70.2) is also above the EU average[107]. The infant mortality rate (3.5 in 2004) is one of the EU's lowest[108], a decrease from 35.4 in 1960. Perinatal mortality (5.3) is average, having decreased from 42.8 in 1960.

2. Overall strategic approach

The Spanish report has improved its strategic character in relation to previous years. Its main aim is to combine and mutually reinforce economic convergence with employment, sustained growth and social welfare, taking into account the reduction of territorial disparities and the overall objective of preventing social exclusion. The report identifies several key challenges related to social protection and social inclusion issues, in the light of the two major objectives included in the National Reform Programme: full convergence in per capita income with the

[106] EU average of 75.1 for males and 81.2 for females in 2003
[107] EU average of 64.5 and 66 for males and females in 2003
[108] EU average of 4.5 in 2004

EU and a total employment rate of 66% in 2010. The strategy plan is fully consistent with the analysis and challenges identified by the NRP, such as halving the alarmingly high early school drop-out rates to 15% in 2010. The Agreement for the Improvement of Growth and Employment, signed this year by the Government and the social partners, introduces important measures to tackle the excessive segmentation of the labour market. It will certainly have positive effects in the short term, although diminishing the structural segmentation of the labour market will require sustained and comprehensive efforts. The report foresees the modernisation and consolidation of the Spanish social model. In relation to social protection, the Government and the social partners signed in July an Agreement on Social Security Measures. The Agreement aims to modernise the system, while ensuring financial sustainability, as well as addressing adequacy and the contributions/benefits balance. Very important measures pertaining to social security and inclusion objectives concern the increase in the minimum wage (to rise to € 600 / month in 2008) and in the lowest pensions (a 26% increase between 2004 and 2008). Regarding other social inclusion objectives, the report lists measures relating to the integration of immigrants (Draft Strategic Plan on Citizenship and Integration 2006-2009), to guarantee the provision of care services to dependent persons (Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency, which will be implemented in 2007-2015), and to enhance equitable treatment regarding education. The adoption of the draft Equality between Women and Men Act regarding employment should help reduce the gender pay gap and improve women's access to employment. In order to address the specific needs of vulnerable groups, the report lists a series of measures for the elderly, people with disabilities, young people, children, families, Roma, migrants and the homeless. The Quality Plan of the National Health System has among its objectives to ensure a more rational use of resources, and to guarantee access to the same range of services for all citizens.

The preparation of the report, coordinated by the Ministry of Labour and Social Affairs, involved all relevant ministries and non-governmental stakeholders. The intention is to maintain this involvement through the implementation and follow-up phases. The report mentions a number of coordination measures involving the national, regional and local administrations.

3. Social inclusion

3.1 Key trends

As a result of strong job creation, the employment rate has increased significantly (up to 63.3% in 2005), but remains below the Lisbon objectives, especially for women. The high rate of fixed-term contracts is one of the major problems of the Spanish labour market, especially for women (also facing a high rate of unwanted part-time contracts), young people and low-skilled workers. 20% of the Spanish population was at risk of poverty in 2004 (EU: 16%), with higher rates for some traditional risk groups such as the elderly (29% for persons aged 65+, rising to 47% if living alone), children aged 0-17 (24%), single parents (37%) and the unemployed (40%). Access to housing is difficult for new entrants; often it is only possible through a high level of indebtedness. Young people face difficulty in accessing stable employment and housing; immigrants face difficulties regarding an adequate integration in the school system, and have some housing-related problems, especially for the newly arrived, and the Roma, despite a general improvement in their living conditions, still face inequalities in the fields of health, employment, housing and household income. Spain faces one of the highest rates of early school leavers of 18 to 24 years in the EU, 30.8% in 2005 (with

differences among Autonomous Communities), though the educational level of the population and the schooling rate have improved (81% at the age of 17).

3.2 Key challenges and priorities

The report outlines five overall strategic objectives, connected to some extent with the challenges identified in the 2006 joint report. The overall strategic objectives have been translated into specific targets and actions designed for its achievement. All objectives are mutually reinforcing, linked to the Lisbon objectives and focus on combining economic growth with social welfare, while reducing inequalities and preventing social exclusion.

One objective refers to enhancing access to the labour market, focusing specifically on women and other vulnerable groups, such as people with disabilities, victims of gender-related violence or people facing social exclusion. Another objective refers to the need to guarantee minimum resources, with special emphasis on vulnerable groups, such as recipients of low wages and pensions. An important target group are immigrant female workers, most of them working in the informal labour market for very low wages.

The third objective is to ensure equal treatment and non-discrimination regarding education options. The report sets out a range of specific targets, such as increasing the rate of pupils who attend the class that corresponds to their age up to 95% by 2010 (in 2005, this rate oscillated between 84.3% for the 12-year olds and 58.4% for the 15-year olds), increasing the supply of places for 0-3 year-old children by 2% annually (rising to 27% by 2008), guaranteeing free schooling in the second cycle and 100% schooling of 3-6 year-old children by 2010, and further developing a specific plan to reduce school failure, so that it covers 2000 schools by 2010.

The large number of immigrants has highlighted the need for a sound and comprehensive integration policy. The fourth objective therefore concerns the integration of immigrants and provides for a comprehensive approach, including such core areas as education, employment, housing, social services and health, while taking into account the more specific needs of youth and women.

The fifth objective addresses the increasing potential demand for social support services and benefits by the dependent population, as a result of social and demographic trends. According to national statistics, the estimated number of dependent people (more than 1.1 million persons in 2005) will increase by 250 000 in 2015. Currently, the dependent person's relatives are the main providers of basic care and support. The total public spending allocated to dependent people, which amounts currently to 0.32% of GDP, will rise to 1% of GDP after the implementation of the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency.

The report highlights the significant contribution of the ESF to inclusion policies. It includes an annex on co-financed measures, and another one setting out best practices regarding social inclusion, such as the functioning of the Fund for Reception and Integration of Immigrants and their educational support, and the national OP "Fight against discrimination", co-funded by ERDF and ESF (€ 345 million).

3.3 Policy measures

The report lists a whole range of new measures, mainly related to the five overall objectives identified in the report. Many of these measures include quantified targets. Many of the

actions from the previous plan have been extended and updated in the 2006-2008 NAP. In the context of the five overall strategic objectives identified in the report, two significant policy measures are those aimed at reducing fixed-term employment (Decree Law 5/2006) and increasing the female employment rate (draft Equality between Women and Men Act regarding employment, complemented by some specific actions to promote and support the reconciliation of work and personal life). A similar range of actions will be put in place for some other vulnerable groups (design of employment pathways for women with disabilities, immigrants, etc.). In order to facilitate access to training for the most disadvantaged groups, a new system of vocational training has been devised, unifying the two existing systems: training for the unemployed and training for people in employment.

The report provides for measures such as increasing the minimum wage up to € 600 / month in 2008 and the lowest pensions by 26% between 2004 and 2008 (thereby reducing the gap with the EU15 average).

A key tool for promoting equity in education is a recently approved Law, aiming to ensure an equitable education system for all students and a significant reduction in early school leaving. It sets out to establish specific programmes in schools located in areas where remedial schooling is considered necessary, and to guarantee grants and other educational assistance to needy students. Addressing the concentration of immigrant children in the public school system is also considered in the Law. The Law includes significant financial commitments, and concrete measures in relation to equity in education listed in the social inclusion strand of the report.

The draft Strategic Plan for Citizenship and Integration 2006-2009 (main objective: coordination of measures implemented by the various public administrations involved) and the Fund for Reception and Integration and educational support are the most important instruments for the integration of immigrants. The integration process will also be boosted by the funding of local innovative projects, and financial assistance to NGOs and bodies working in this area. Finally, the creation of a monitoring centre for equal treatment and non-discrimination based on race or ethnic origin should be also mentioned.

The needs of dependent people are addressed mainly by the Law on the Promotion of Personal Autonomy and Care for People in a Situation of Dependency (2007-2015), which sets out to prevent poverty and social exclusion for both the carer and the dependent person. The law will be implemented with the creation of the National Dependency System, aiming to provide support to dependent persons, mainly people aged 65+ and people with disabilities. The potential beneficiaries of the Autonomy and Dependency Care System will number some to 1.5 million by 2015. The financing of the system in 2007-2015 will amount to more than € 25 000 million. for all public administrations. The report also details other measures in the areas of health, social services, housing, justice and information society. Women's specific needs will be addressed by the implementation of the Law on Equal Opportunities between women and men. The NAP lists a series of measures for the elderly (Action Plan for the Elderly 2003-2007), people with disabilities (Action Plan for people with disabilities 2003-2007 and the National Plan on Accessibility 2004-2012), young people, children, families, Roma (constitution of the National Roma Council and creation of the Institute on the Roma culture).

3.4 Governance

The report was written with the participation of all relevant stakeholders, both public and private. The Ministry of Labour and Social Affairs coordinated the process of drawing up the national action plan. It is important to highlight the increasing importance of NGOs and social partners in drawing up, implementing and monitoring the plan. The explicit mention of a number of coordination measures among the national, regional and local administrations, which takes into account the decentralised structure of Spain, should also be noted.

4. Pensions

The income of people aged 65+ is relatively close to that of the 0-64 age group (75%), while the risk of poverty for the elderly population (29% in 2004) is significantly higher than that of the 0-64 year-olds. In spite of recent increases in the employment rate of older workers and a slightly higher rate than in the EU, further progress is needed to achieve the 50% Lisbon target for 2010.

Spain faces a major challenge with regard to financial sustainability due to demographic trends. Nevertheless, the 2006 Sustainability report assessed Spain as a medium-risk Member States as regards the sustainability of public finances, notably due to the high cost of population ageing and despite the current strong budgetary position. According to the 2005 AWG projections, public spending on pensions is set to increase from 8.6% to 15.7% of GDP, far more than the EU average. Due to Spain's relatively late ageing profile, nearly all the pension expenditure increase is projected to occur after 2015, and the reserve fund would enable deficits to be delayed until 2020. According to ISG projections, the theoretical replacement rate provided by the earnings-related scheme for average-earning workers retiring at 65 after 40 years should decrease by 6 p.p. by 2050, reaching a level of about 85% of gross replacement rate in 2050 (92% of net replacement rate).

The 2006 Joint Report underlined that the increase in employment rates and the reforms already enacted, in particular the strengthening of 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 a reduction of gender differences in living standards and poverty risks. It also stressed the importance of further reforms to secure both future adequacy and sustainability, in particular through a higher rate of participation in the labour market, especially for women and older people.

Thanks to sustained economic growth and fiscal discipline, Spain has made major efforts to achieve balance in public finances. Moreover, the national social security system has been showing surpluses since 1999 (1.1% of GDP in 2005, more than 1% GDP expected in 2006).

An Agreement between Government and Social Partners was signed in July 2006. Together with measures already adopted for increasing minimum pensions, it reaffirms the process of separating sources of financing for top-ups of minimum pensions, which will also be extended to include some pending specific categories of permanent invalidity pensions, and restructures widows' pensions. It also develops the rationalisation of the social security system, incorporating self-employed workers under the agricultural special schemes in the self-employed scheme, while salaried agricultural workers will be members of the general scheme. Furthermore, incentives to work longer are strengthened, notably for partial pensions (available from 61 instead of 60) and for deferment of retirement above the age of 65. This new agreement will improve future sustainability and adequacy, though it remains to be seen

whether further measures will be needed to achieve sufficient increases in the employment rates for older workers.

5. Health and long-term care

5.1 Health care

Description of the system: A National Health System (NHS), defined as the mix of central government and regional government services, provides universal coverage. It is a decentralised system with 17 autonomous regions running the health care services for their populations, the Ministry of Health having a monitoring role and ensuring the equity of the system, and the Interterritorial Council of the NHS (ICNHS) having a coordination role. Primary health care (PHC) is publicly managed and delivered in health centres. Patients register with a general practitioner (GP). GPs refer patients to specialists, who refer them to hospital care. Outpatient ambulatory centres provide outpatient specialist care ,and inpatient care is provided in hospitals which are publicly owned. The NHS also contracts services from private non-profit providers. PHC staff are paid a salary with some capitation, and hospital doctors are paid a salary. It is a tax-based system, free at the point of access. Co-payments apply to pharmaceuticals. Private voluntary complementary insurance covers 10% of the population. Civil servants can opt for one of the three publicly funded mutual funds (70% state funding and 30% contributions) and can choose between public and private provision. Authorities identify as goals the need to ensure countrywide equitable access to high quality care (notably by ensuring specific protection for disadvantaged groups) and the need to improve population health and reduce premature mortality and the burden of disease.

Accessibility: Though care is free at point of access except for pharmaceuticals, data show that private, notably out-of-pocket expenditure is high (23.3% of total expenditure in 2004), which may denote a financial burden for more vulnerable groups. Authorities highlight that whilst decentralisation can ensure more adaptability to local needs it has resulted in regional differences in provision. To prevent such differences they have established a portfolio of common standardised services for the NHS countrywide and will use social cohesion funds to compensate some regions. Another concern which has been voiced relates to the length of the waiting lists (partly due to having one of lowest number of beds – 358 per 100 000 inhabitants – in the EU and still a strong use of hospital care vis-à-vis PHC as GP numbers are low in EU terms). Thus, the Ministry of Health has established criteria indicators and minimum basic and (countrywide) common requirements for waiting lists for specialists, diagnostic and therapeutic trials and surgery.

Quality: A quality plan for the NHS has been drawn up to guarantee maximum levels of quality in healthcare in all regions on an equal basis. It involves developing strategies with all stakeholders (e.g. staff and patients) to ensure clinical excellence, for example. Strategies include greater use of ICT. Authorities are devising a plan to gather and monitor data on effectiveness. Patients can choose their GP within their area of residence.

Long-term sustainability: Total healthcare expenditure (7.8% of GDP and 1908 per capita PPP$ in 2004) is below the EU average[109] and has been more or less constant over the past decade. Public expenditure in 2004 corresponds to 71.9% of total health care expenditure, showing a decrease over time. It thus appears financially feasible to spend more on improving access and quality of health and long-term care without endangering the sustainability of

[109] 8.87% and 2376.33 in 2004.

public finances. Indeed, recognising insufficient health care finance, authorities are allocating additional resources to the sector, increasing revenues to the regions from taxes on tobacco and allowing regions to obtain further revenues. Authorities see ageing as a major challenge to service provision and sustainability (the 2006 EPC/EC age-related projections foresee an increase in public expenditure of 2.3 percentage points of GDP by 2050). To improve system efficiency the report focuses on enhancing the use of PHC vis-à-vis the overuse of unnecessary hospital or emergency care, on ensuring the rational use of technology and medication, on developing incentives for staff, on centralising and standardising the procurement of health products and equipment and centralising highly specialised services. A serious concern stressed in the report is the financing of care for foreign patients as Spain is an important provider of services for people insured under other countries' regimes. The Ministry of Health together with the National Institute for Social Security and the autonomous regions are trying to increase revenue for this item from € 32 to 60 million. A number of initiatives are planned for promoting healthy life styles and preventing avoidable death (focusing on tobacco, obesity, traffic accidents, and exercise) and for strengthening disease surveillance systems.

5.2 Long-term care

Description of the system: Traditionally the family had the main role in care giving but ageing and socio-demographic changes (increased female labour participation) are making the provision of long-term care services an ever more pressing concern for authorities. Hence, various laws have been extending the range of services in this area over the past decade. They now include: PHC at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers. Services to help those in a dependency situation are mostly organised by autonomous regions though sometimes they are jointly organised by the central government, regions and local authorities. They are part of the Social Security System.

Accessibility: Despite significant growth in services in recent years, authorities point to deficiencies in supply in view of the demand from dependents and from carers: e.g. only 3.5% of those 65+ received home help, 2.84% received telecare and 0.54% had a place in a day centre while 3.9% received residential care. They recognise that decentralised responsibilities have led to an uneven provision across regions. In this context, authorities have launched a major plan, the Autonomy and Dependency Care System, intended to increase coverage of all people in a situation of dependency (from disabled children to adults to the dependent elderly, some 650 000 people) by 2015 through a large boost in provision. The plan aims to ensure equity of access by using a common dependency scale and by defining a standard catalogue of services (wide range of home care, assistance and adjustment, day centres, night centres, residential care). It also aims to improve the integration of health and social services. Services may be supplied by public or private providers and each region organises service supply. Financial benefits will be allowed and family carers will enter the social security system and attend training courses when as caregivers. User charges are to be based on income and income brackets. The government recognises that this process will take some time and effort to accomplish.

Quality: A range of service charters, accreditation systems and quality indicators are being gradually adopted. The need for coordination between health and social care has been identified and several regions already have coordination plans.

Long-term sustainability: Current funding comes from regions, municipalities and central government. It is considered scarce in view of the needs. It is about 0.32% of GDP, and the 2006 EPC/EC age-related projections foresee an increase in 0.2 percentage points of GDP by 2050, without taking them into account in the financial impact of the new Law on the Promotion of Personal Autonomy and Care for People in a Situation on Dependency. Note, however, on the basis of the financial report of the Law that authorities are allocating an extra € 4,500 million to the sector in the near future and expenditure is expected to increase to 1% of GDP by 2015. Within the new plan the central government, regions, local authorities and users are to share the cost. Authorities highlight that this should also be seen as investment as it increases employment (300 000 new jobs), tax revenue and quality of life.

6. Challenges ahead

To break the intergenerational transmission of poverty, in particular by reducing the high rate of early school leavers. The new Education Law sets out to address this issue, but reaching the 2010 target will require sustained and comprehensive efforts.

To continue efforts to promote the active inclusion of vulnerable groups, such as the immigrant population and young people, and of women by reducing persistent inequalities in income, access to education and labour integration and to promote affordable housing through an appropriate and long-term public and rental housing policy.

To facilitate a higher level of participation, notably of women and older workers, in the labour market; this would help secure the sustainability and adequacy of the pension system.

To tackle regional differences in provision, reduce long waiting times and enhance the provision of long-term care and to improve efficiency, notably through an increased use and distribution of PHC and a rational use of services, technology and medication.

Spain: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5,0	92.1	**2000**	56.3	71.2	41.3	32.5	37,0	**2000**	11.1	7.9	16,0	24.3
2002	2.7	95.2	**2002**	58.5	72.6	44.4	34,0	39.6	**2002**	11.1	8.1	15.7	24.2
2004	3.2	96.6	**2004**	61.1	73.8	48.3	35.2	41.3	**2004**	10.6	8,0	14.3	23.9
2006	3.8f	98.1f	**2005**	63.3b	75.2b	51.2b	38.3b	43.1b	**2005**	9.2	7,0	12.2	19.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b: break in series*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total Health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	male	female	male	female	male	female							
1995	74.3	81.5	16,0	19.8	64.2	67.7	5.5	**1995**				99.8	
2000	75.8	82.5	16.6	20.4	66.5	69.3	4.4p	**2000**	7.4	71.6	23.6	(1997)	13
2004	76.9	83.6	17.2sp	21.2sp	66.8e	70.2e	4.0p	**2004**	7.8	71.9	23.3		

e: estimate; s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	21.6	43.9	28.6	16.5	2	1.6	7.4
2000	19.7	46.2	29.4	12	2.9	1.5	7.9
2004	20	43.7	30.8	12.9	3.5	1.7	7.5

** including administrative costs*

Age related projection of expenditures (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health Care	Long Term care
2005	24.5	./.	8.6	6.1	0.5
2010	25.4	-0.4	./.	./.	./.
2030	38.6	3.3	3.3	1.2	0
2050	66.8	8.5	7.1	2.2	0.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	24	19	16	29	25	29	25	29	22	**Total**	5.4
male	19	-	17	15	26	28	-	26	29	23	**male**	-
female	21	-	20	17	32	24	-	24	28	20	**female**	-

	People living in jobless households					***Long Term Unemployment rate***				***Early school leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	7.3	8.5	7.7	9.3	**1999**	5.7	3.6	9,0	**1999**	29.5	35.3	23.6
2004	6.3	7.3	6.7	7.9	**2004**	3.4	2.2	5.1	**2004**	31.7	38.5	24.6
2006	5.1	6.3	5.8	6.8	**2005**	2.2b	1.4b	3.4b	**2005**	30.8b	36.4b	25.0b

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.754	0.773	0.756	***Aggregate replacement ratio***	0.561	0.615	0.6

Change in theoretical replacement rates (2005-2050)

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates	
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Estimate of current (2002)	Assumption
-6	-5	-5	DB			89		28.3		

**:(DB / NDC/ DC); ** (DB / DC)*

FRANCE

1. Situation and key trends

GDP growth, which was modest in 2005 (1.2%), increased substantially in 2006 and was estimated to be 2.2%, with increased creation of jobs in the market sector. However, this development includes a surge in low-quality jobs, temporary work, fixed-term contracts or apprenticeships, traineeships and subsidised contracts (accounting for 13.6% of wage and salary earners in 2005). The number of poor workers was 1.933 million in 2003. The employment rate (63.1% in 2005) has hardly risen since 2002 and even declined slightly for men between 2002 (69.5%) and 2005 (68.8%). Only the rate of female activity, which has been steadily rising (57.6% in 2005), is approaching the Lisbon objectives. At the two extremities of the age pyramid, the main improvement concerns the 55-64 age group, whose employment rate (37.9% in 2005) has increased substantially since 2000 (+8%), mainly for demographic reasons, whereas the employment rate of young people (30.1% in 2005) has risen only marginally over the period (+1.5 percentage points). France's unemployment rate is still high (9.7% in 2005), even though it fell steadily between June 2005 and July 2006 to reach 8.9%. The unemployment rate among women is about 2% higher. The long-term unemployment rate is broadly the same as in 1999 (4% in 2005). 13% of the total population are at risk of poverty. The share of GDP accounted for by social security expenditure is stable (31.2% in 2004), with large proportions being spent on pensions (43.6% of the total) and health (30%). French demography is marked by a relatively high fertility rate (1.92) and life expectancy at birth above the Community average (76.7 years for men and 83.8 years for women in 2004), whereas life expectancy in good health is below the EU average[110] (60.6 years for men and 63.9 years for women in 2003). Infant mortality was 3.9/1000 in 2004, which is below the EU average, and has been falling steadily since 1970 (18.2). The old-age dependency ratio should rise less sharply than the European average from 25.3% in 2005 to 47.9% in 2050.

2. Overall policy approach

The report highlights the French social model, in which high-quality full employment and greater social cohesion are considered to be indispensable to growth. Its strategic dimension is far more marked than in previous plans, with three major thrusts consistent with the European overarching objectives: to improve the financial position of the social security schemes in order to make the French social model sustainable over the long term and maintain a high level of social protection; to enhance the quality and accessibility of health care and long-term care and ensure that they are adapted to needs; to pursue a global and integrated strategy of social inclusion based essentially on employment (with the emphasis on the integration of target groups, especially young people), housing and equal opportunities (over-arching approach). The interaction between social protection and social inclusion policies and the development of growth and employment is mentioned, whether for the measures in favour of the employment of the least-skilled workers, older people or women or for the extension of working life which the 2003 pension reform is seeking to achieve. The emphasis is placed on developing the governance of social policies and mainstreaming. In a context marked, in terms of equal opportunities, by the problem of unemployment and the exclusion of the visible minorities, equal opportunities for men and women is not in itself a policy priority. Nevertheless, this topic is dealt with more extensively than in previous plans and the statistical data in the annex are provided by sex in most cases.

[110] EU average of 64.5 years for men and 66 years for women in 2003.

3. Social inclusion

3.1 Key trends

The poverty rate for the population as a whole was 13% in 2004 (14% for children and women). This rate rises to 26% before transfers (44% excluding pensions and survivor's benefits). Net income from social assistance amounts to 78.6% of the poverty threshold for a single person, 81.7% for a single parent with two children and 69.9% for a couple with two children. According to national sources, administrative poverty (recipients of minimum social income) increased in 2004 and 2005 with the rise in the number of people receiving minimum income benefit (RMI) and the fall in the number of people leaving the scheme in recent years. Unemployment remains a major problem, especially for two categories: the 15-24 age group (22.7% of unemployed people in 2005) and the immigrant population (15% for men and 22% for women, with far higher levels for immigrants from non-Community countries, even when they have the same characteristics as the rest of the population). In 2005, 10.9% of adults (9.5% of children) lived in jobless households. There was a school drop-out rate of 12.6% (14.6% for boys) in 2005.

3.2 Main challenges and priorities

The report identifies three priorities, which are consistent with the European objectives and the main challenges identified in the 2006 Joint Report: access and return to employment of people who are the furthest removed from the labour market, the social and occupational integration of young people, especially those affected by problems of discrimination, subsidised housing and the provision of accommodation. The last two issues have been the main social issues in the news since the autumn of 2005. The contribution of the social cohesion plan is underlined, especially in terms of employment, with the restructuring of the public employment service, the enhanced accompanying measures, the focus on apprenticeship or the root-and-branch reform of subsidised contracts, which have made a major contribution to the fall in the employment rate over the past year. However, several measures have been introduced too recently for their lasting contribution to the objectives to be assessed. Mention is also made of the success of the new recruitment contract (*contrat nouvelles embauches* = CNE) and the boom in personal service jobs, but they are marred by a substitution effect for the former and involuntary part-time working for the latter.

The systems of monitoring and evaluation have been strengthened, especially by grouping bodies together in order to improve synergies and by establishing agencies, making it possible to create new partnerships: the *Agence nationale pour la rénovation urbaine* (national agency for urban renovation = ANRU) is one of the good practices presented, and its social counterpart will be the *Agence nationale pour la cohésion sociale* (national agency for social cohesion) in 2007. The State's overall funding of social inclusion policies is estimated to be over €33 billion per year in 2006 and 2007. The report occasionally refers to the ESF contribution. Work is currently under way to establish numerical objectives and objectives by sex to be attained in the work to combat poverty and exclusion. At this stage, the report includes several results to be achieved, most of which relate to the creation of systems rather than the expected effects. Mention should be made, however, of the clear objective of increasing the employment rate of older workers by 2 percentage points a year to reach 50% in 2010.

3.3 Policy measures

Promoting the return to the labour market of those people furthest removed from it is the first priority with three thrusts, primarily the development of the supply of jobs through traditional measures such as reductions in employers' social security contributions (their abolition in 2007 at the level of the minimum wage (SMIC) for enterprises with fewer than 20 workers). It would be worthwhile evaluating the results in relation to the costs. The schemes that have been started are being continued, such as the CNE, encouragement of employment in certain sectors, the validation of experience acquired (VAE) or the new subsidised contracts. While the last-named have definitely been a success, it would seem that this has mainly been the case in the non-market sector. Necessary work on training through these schemes will be carried out. Work will also be done on VAE in order to ensure that it too benefits the people who are furthest removed from the labour market. There is also a focus on the integration by economic activity (which received €30 million per year from the ESF in the period 2000-2006). The scheme to encourage business creation will be strengthened (with particular reference to women) in terms of the support provided after the start of the activity. The plan for the employment of older workers 2006-2010 (with a budget allocation of €10 million) is the real innovation in this range of measures. The development of equality of remuneration is still a declared objective. An evaluation is planned for 2008. However, little attention is paid to the professionalisation of personal services jobs. The second focus is to help people to reduce their dependence on assistance and to return to employment with the readaptation of profit-sharing schemes and the employment premium, which was considerably increased in 2006 and 2007 but whose impact on return to activity is apparently very limited. The third focus concerns the removal of obstacles to access to employment. Here the emphasis is placed on existing support measures (with ESF participation for individually tailored social assistance of €12 million per year in the period 2000-2006), the reorganisation of the employment services, priority access for recipients of the minimum income to childcare facilities, measures to combat illiteracy, to promote health and to combat poor housing, over-indebtedness and employment discrimination based on sex, age, disability or ethnic origin. Cooperation is planned between the care services for immigrants and the ANPE.

The second priority is the social and occupational integration of young people, with measures to avert failure at school by providing assistance to 200 000 children and adolescents who are experiencing serious difficulties (the educational success programme, which is mentioned as a good practice, is an objective at this stage), the doubling of the number of mediators between families and State institutions, the strengthening of the schemes for the provision of advice at school and university and new grant and mentoring schemes. Secondly, to develop the range of employment opportunities on offer: the existing schemes (contracts for young people in enterprises, specific mechanisms for entry into the civil service, the results of which remain very limited) will be supplemented by greater use of employment policy resources to assist the least-skilled young people in disadvantaged neighbourhoods. The third focus is designed to promote apprenticeship and the development of integration programmes: an increase in the number of young people in work-linked training in enterprises of over 250 employees, a "junior" apprenticeship for the 14-16 year age group, the pursuit of the professionalisation contracts and the contract for integration into the life of society (CIVIS), which was extended in 2006 to new graduates who are furthest removed from the labour market, and voluntary civil service focused on occupations with spare capacity. Finally, the removal of obstacles to integration also involves legal information measures and access to housing, health care and leisure. Few measures specifically incorporate the gender dimension, even though a higher proportion of girls are unemployed. The only genuinely gendered measures are access to

apprenticeship and diversification of school guidance choices. However, no impact study seems to have been conducted on previous measures of this type.

Developing the supply of subsidised housing and quality accommodation is the third priority of the social cohesion plan and the national housing pact. While there is no denying the boost to construction (with an objective of 100 000 subsidised housing units in 2006 and 500 000 in the period 2005-2009), associations fear that this will mainly benefit the middle classes. Several measures should make it easier for people to find housing and to stay in it. The enforceable right to housing, which is something that associations have been advocating for a long time, will be tested at local level in conurbations with more than 50 000 inhabitants under arrangements that are not specified. The combating of accommodation unfit for habitation, which is cited as a good practice, is an objective that has started to be implemented. It is reinforced with the creation of an emergency rehousing assistance fund (€20 million over five years). It is planned to develop adapted types of housing and the system for assisting the most vulnerable groups, and the issues of travellers and immigrant women are taken into account. Double discrimination is dealt with in terms of access to separate housing in order to facilitate the separation of polygamous households, the granting of family allowances to the mother and access to training.

3.4 Governance

The report is essentially an interministerial effort. Mention is made of three bodies consulted, including the National Council for Combating Poverty and Social Exclusion (CNLE) and the National Council for Integration through Economic Activity. It was preceded by a national conference (April 2006) prepared by subject-based territorial meetings involving many players. The renewal of the State's steering work is continuing with ambitious objectives for the period 2006-2008. Systematic evaluation of the new measures is announced, as are the creation of a monitoring group for the 2006-2008 report at the CNLE and the continuation of the work under way on monitoring indicators, which are already very exhaustive. It is planned to hold a parliamentary debate on the inclusion plan, which is not widely known, and to disseminate it to the players. Evaluation by users will be developed, and the integrated approach will be strengthened through the existing mechanisms at interministerial level and the overarching policy document, the continuation of a national conference and meetings in the regions. The most innovative area of work is the announcement of the approximation of local-level systems with the committees of the Departments which are to have a coordinating role and be involved in the drafting, implementation and monitoring of the plan's objectives and indicators. This concern for consistency can also be seen in the wish to incorporate the integration and inclusion measures into local projects for sustainable development.

4. Pensions

In 2004, older people enjoyed a relative living standard close to that of the general population (90%), while the poverty risk among older people (16%) was slightly higher than for the population below the age of 65. The increase in the employment rate of older workers has slowed down, and remains relatively low at 37.9% in 2005.

The 2006 Sustainability Report assessed France as a medium-risk Member State as regards the sustainability of public finances, notably due to the current weak budgetary situation, but also reflecting the effects of enacted pension reforms. According to AWG projections, public spending on pensions is expected to increase by 1.9 p.p. between 2004 and 2050, while under ISG projections theoretical replacement rates are expected to decline in the future. For a

worker retiring at 65 after 40 years working for the average wage, the net replacement rate will decrease from 80% in 2005 to 63% in 2050 (gross replacement rate from 66% to 49%). In order to maintain adequate replacement rate levels, the reform nevertheless aims at increasing the insured period beyond 40 years, in accordance with increases in life expectancy.

The 2006 Joint Report highlighted recent progress in pension reform, while underlining the key importance of further improvements in the employment situation of older workers.
The 2003 reform has significantly improved the financing of the pension system for the decades ahead, thus preserving the basic architecture of the current system, while contributing to more equitable treatment of members of different schemes. 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 thus have to be monitored attentively, in particular for the most vulnerable groups of the population. But a net replacement rate of 85% has been fixed from 2008 as an objective for the lowest pensions (careers on minimum wage) and will be re-examined in 2008.

Incentives to work longer have been further strengthened in 2006 under a national action plan for older persons' employment (notably *surcote* and better possibilities to combine employment and pensions), this being a further step towards putting the pension system on a financially sustainable footing in the long run. In spite of recent increases, the employment rate of older workers remains low, and further measures will be necessary, in particular to reduce early exits from the labour market. Current reforms will only be fully successful if they are accompanied by a sustainable strategy to increase the participation of older workers in the labour market and to raise employment in general. The 2003 reform provides for quadrennial reviews, the first one being in 2008, which is projected to lead to a further one-year rise in the number of contributory years required for a full pension, from 40 to 41 years between 2009 and 2012 for employees in the public and private sectors.

5. Health and long-term care

5.1 Health

Description of the system: The French health system is based on principles of solidarity and universal access: it covers the entire population on a basis that is primarily occupational and that, since 2000, has secondarily been residential. The basic schemes, which are financed in a mixed manner (social security contributions and taxation), cover approximately 3/4 of healthcare expenditure but offer better coverage for persons with long-term disorders. Disadvantaged people enjoy supplementary health cover free of charge (CMUC). A considerable proportion of the population (92%) has contracted occupational or individual supplementary insurance. The basic principle is to reimburse insured persons for the healthcare costs that they have incurred, but direct billing (the "third party pays" principle) by sickness insurance funds or supplementary insurance funds is possible and is the rule for hospitalisation. The National Union of Sickness Insurance Funds (UNCAM), bringing together the main pre-existing sickness insurance schemes (general scheme, agricultural scheme and self-employed scheme), was set up in 2004. It is responsible for setting the reimbursement rates within the range set by the State and for deciding which treatments and care are eligible for reimbursement. The sickness insurance funds are involved in setting the annual objectives for expenditure that are adopted by Parliament and, to this end, they submit annual forecasts for expenditure and income that are taken into account in setting the national objective for sickness insurance expenditure. The State generally sets the prices, especially

the tariff structure for health establishments and reimbursable medicines. Health establishments and self-employed doctors are paid on an "activity-based tariff scale". Doctors employed in State hospitals are paid through a salary.

Access: Persons on low incomes benefit from supplementary instruments, such as full coverage of all healthcare costs without the need to pay for health care initially, under the CMUC. Households whose resources are slightly above the limit for entitlement to the CMUC are granted assistance towards the payment of supplementary health insurance in the form of a tax credit, the threshold for which will be increased from 15% to 20% of the CMU ceiling in 2007 in order to increase the number of beneficiaries. However, there are still major differences between social groups in terms of access to care, especially specialist treatment, medical auxiliaries, eye care and dental treatment. Geographical disparities in the provision of care can be seen at local level. Specific measures, such as bonuses to encourage general practitioners to work in areas with insufficient doctors, have been taken. Since 2004, greater patient responsibility has been introduced: in order to improve the coordination of care and to avoid superfluous medical treatment, people have an incentive to designate their own general practitioner and a computerised personal medical file is gradually being created with penalty clauses (lower coverage of costs for treatment outside a person's treatment programme, for failure to submit the personal medical file or for doctors' fees exceeding the limit) have been introduced. The proportion of healthcare expenditure payable by patients (not covered by the basic scheme or by the CMUC or by supplementary insurance schemes) in the form of a "patient's contribution" represents about 10% of total expenditure.

Quality: The assessment of the quality of practices and strategies in diagnosis and treatment has been strengthened and is the responsibility of the *Haute authorité de santé* (HAS). Its main tasks are to bring together knowledge on evaluation (technological evaluation, occupational practices, clinical audit training, etc.) and to draw up recommendations (recommendations for clinical practice, medical references, consensus conferences on major clinical, diagnosis or treatment topics). The HAS is also responsible for the accreditation procedure for healthcare establishments (procedure renewable at least every five years). The formalisation of public health strategies through national subject-based plans with regional variants (for cancer, chronic diseases, etc.) helps to improve quality standards. Patients are free to choose healthcare providers, including specialists, and there are few waiting lists. Patients' rights have gradually been improved (especially the right to freedom of consent with a knowledge of the facts and direct access to one's medical records) through legislative reforms comprising measures designed to improve the quality of the system (compulsory continuing training for doctors, evaluation of occupational practices, improvement of the functioning of the tribunals of the associations of the medical professions, and development of health networks). Prevention systems have been strengthened in order to promote a culture of public health and prevention.

Long-term viability: The main challenge is the gap between health income and expenditure. With expenditure rising faster than income, the measures taken to reduce the deficit of the National Sickness Insurance Scheme (CNAM), which amounted to €11.6 billion in 2004, started to bear fruit in 2005 (reduction to €8 billion). A monitoring committee has been set up in order to monitor compliance with the national expenditure objective. If it looks as though expenditure will exceed the objective by more than 0.75%, the committee will alert the authorities and the national funds so that remedial action is taken. Total expenditure on health accounted for 10% of GDP (or PPP$ 3 016 per capita) in 2004. In that year, the State accounted for 76.5% of this expenditure. According to the 2006 projections of EPC/EC, public expenditure on health and care should rise by 1.8% of GDP between now and 2050 as

a result of population ageing. Since control of expenditure by the patient's contribution can be lessened by the very extensive use of supplementary health insurance, more "medicalised" systems of regulation have been set up (assessment of the "medical service rendered" having an effect on the reimbursement rate, promotion of proper use of care, with positive effects on the consumption of antibiotics and greater use of generic medicines). The prices of medicines are regularly revised, and generic medicines are promoted. The 2005 medical agreement aimed to save €1 billion, especially in the areas in which consumption is far higher than in other countries (psychotropic medicines, antibiotics). A flat-rate contribution to treatment has been introduced. In hospitals, efforts to save money mainly take the form of a rationalisation of purchasing policy.

5.2 Long-term care

Description of the system: The system is based on double financial coverage. On the one hand, health insurance finances the care provided by institutions to their disabled or dependent residents, long-term care units (hospital services for patients who cannot live independently) and nursing care for people at home. The costs of care are paid directly by the sickness insurance funds through the "direct billing" system. Since the cost of care is covered by sickness insurance, the cost of accommodation is payable by the person concerned or by social security if he has insufficient resources. Sickness insurance is the only financer of socialised coverage of long-term care (8% of total sickness insurance expenditure). On the other hand, two schemes mainly financed by the State and local authorities provide benefits as a contribution towards the costs of loss of autonomy at home or in an institution: disability compensation benefit (*prestation de compensation du handicap* = PCH), personalised independence allowance (*allocation personnalisée d'autonomie* = APA) for dependent elderly people. Benefits to cover the cost of home help are also paid as part of the social action of the old-age pension insurance funds. Elderly or disabled people also use the ordinary care system, thus benefiting from the same services as other insured people. The *Caisse nationale de solidarité pour l'autonomie* (CNSA) pools the funds collected from the solidarity-based contribution for autonomy (*contribution de solidarité autonomie*) and the funding allocation of sickness insurance laid down in the national objective for sickness insurance expenditure. The CNSA pays the Departments a contribution towards the funding of the APA and the PCH, thus spreading the national solidarity effort between regions and Departments. The Departments finance the dependency component of the amount charged by establishments and generally provide compensation for loss of autonomy through benefits (APA, PCH).

5.2.2 Access: Recent reforms are designed to develop structures that provide appropriate health care by the end of 2007. A plan for the medicalisation of institutions for the elderly or dependent persons has been launched. In order to ensure access to long-term care, efforts have been made to structure financial assistance for autonomy, with positive results (financial assistance, reductions in taxation, choice of benefits in kind or in cash, financial assistance to cover the cost of home help, etc.), thereby reducing the costs of care at home and in institutions. However, there is still a problem of solvency and efforts need to be made to improve coordination of sources of funding in order to ensure uniform provision of services. The financing of assistance to cover the costs of home help by municipalities and old-age pension insurance funds, where a person's level of dependence is below that required to receive the APA, and the universal service employment voucher (CESU), which makes potential users of services at home more solvent and can be pre-financed by direct billing, are examples of the efforts made to help disabled or dependent people.

Quality: Medico-social establishments and services that are financed by sickness insurance must be jointly authorised in advance (State, Department). Their care budgets and their scales of charges are negotiated annually. Users' rights have been enhanced (welcome brochure, contract for a person's stay, work plan for an establishment). Quality policy is supported by voluntary guidelines (i.e. personal services at home). Increased training and the validation of experience, which is a key plank of the professionalisation of these occupations, address the growing need for qualified staff. The authorities wish to increase the coordination of the health sector and the medico-social sector by launching a new plan entitled "*solidarité grand âge 2007-2012*" (2007-2012 plan of solidarity with the very elderly), which will be designed to encourage alternatives to hospital care and to improve the structure of the provision of care in the regions, with geriatric medicine coordinating the various players. Family support leave, offering carers a protective legal framework for their jobs but no compensation, will be introduced in 2007.

Long-term viability: The funding allocated by sickness insurance to long-term care has increased at a rate of more than 7% in recent years (which is higher than the increase in the income of sickness insurance). New resources are allocated to the funding of the CNSA: the solidarity-based contribution for autonomy (0.3% on wages and salaries in return for an unpaid additional day of work) and an additional contribution of 0.3% to the social security charges levied on certain income from assets and investments. Part of these resources will supplement the contribution from sickness insurance to the financing of medico-social structures. The expenditure payable by residents of institutions is correlated with changes in the cost of the accommodation component. Since the development of expenditure (costs and wages/salaries) is limited by the national objective for expenditure on sickness insurance and the CNSA, the increase in resources is limited.

6. Challenges

to promote active inclusion, in particular access and lasting return to the labour market of persons who are the furthest removed from it, with particular attention being paid to effective, occupational and socio-economic integration of visible minorities, especially young people;
to deal with the housing crisis, especially in the urban areas with the greatest problems;
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 consolidate the financial sustainability of the healthcare system by further development of reforms to ensure better coordination and integration of the programme of care through steering by a person's chosen general practitioner, which could lead, among other things, to rationalisation of consumption of medicines and more direct involvement of all players in the more efficient use of resources;

for long-term care, to ensure coordination of the various funding bodies in order to reduce the remaining cost payable by individuals, thus providing greater equality of access to long-term care and guaranteeing the long-term solvency of the system, the costs of which will necessarily increase due to demographic change, population ageing and medical and technological progress.

France: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.0	113.3	**2000**	62.1	69.2	55.2	28.6	29.9	**2000**	9.1	7.6	10.9	20.1
2002	1.0	112.0	**2002**	63.0	69.5	56.7	29.9	34.7	**2002**	8.7	7.8	9.8	19.7
2004	2.3	107.7	**2004**	63.1	69.0	57.4	30.4	37.3	**2004**	9.6	8.7	10.6	21.8
2006	2.2f	107.3f	**2005**	63.1	68.8	57.6	30.1	37.9	**2005**	9.7	8.8	10.7	22.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.9	81.8	16.1	20.6	60.0	62.4	4.9	**1995**	9.5	76.3	-		
2000	75.3	82.7	16.7	21.2	60.1	63.2e	4.4	**2000**	9.3	75.8	10.5	99.9	86
2004	76.7sp	83.8sp	17.7sp	22.1sp	60.6e	63.9e	3.9	**2004**	10	76.5	10.1		

e: estimate; p: provisional; s: eurostat estimate **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	30.3	43.5	28.3	7.9	10	4.5	5.9
2000	29.5	44.4	28.8	7.2	9.1	4.7	5.9
2004	31.2	43.6	30	7.8	8.5	4.4	5.8

** including administrative costs*

Age- related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	expenditure (% of GDP) Level in **2004** and changes since			
		Total social expend.	Public pensions	Health care	Long - term care
2005	25.3	26.7	12.8	7.7	
2010	25.9	0			
2030	40.7	1.9	1.5	1.2	
2050	47.9	2.9	2	1.8	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13	14	13	12	16	17	15	17	17	15	**Total**	4.0
Male	12	-	12	11	15	17	-	17	19	13	**Male**	-
Female	14	-	13	12	18	16	-	17	17	17	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	9.9	11.3	10.1	12.5	**1999**	4.1	3.4	4.9	**1999**	14.7	16.0	13.4
2004	9.6	10.8	9.5	12.1	**2004**	3.9	3.5	4.3	**2004**	14.2	16.1	12.3
2005	9.5	10.9	9.9	12.0	**2005**	4.0	3.5	4.6	**2005**	12.6	14.6	10.7

** excluding students*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.899	0.930	0.881	***Aggregate replacement ratio***	0.663	0.723	0.601

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or Social Security)	pensions Current estimate (2002)	Assumption
-17	-17	-17	DB			Nd			20		

**:(DB / NDC/ DC); ** (DB / DC)*

ITALY

1. Situation and key trends

Following a period of poor economic trends, in 2005 Italy's GDP remained stable, along with the employment rate (but forecasts for 2006 show a 1.7 percentage points growth). The labour market experienced a slight improvement, with modest job creation and a reduction in unemployment between 2004 and 2005 (from 8% to 7.7%). This last outcome is due to some extent to a discouragement effect among the young and among women (especially southern women); in fact, between 2003 and 2005 the general activity rate decreased (-0.5%) and the female activity rate, after a long-term increasing trend, reversed from positive to negative in 2004, followed by a small contraction in 2005 (from 50.4% to 50.3%). The total employment rate has increased over recent years, but at 57.6% in 2005 is still well below the Lisbon targets. The situation is especially bad regarding older workers (aged 55-64), where in spite of recent increases, the employment rate of 31.4% in 2005 contrasts with the Lisbon target of 50%. Significant gender gaps and territorial imbalances still characterise the Italian labour market, as well as increasing flexibility – especially for younger generations – and the persistently high presence of irregular jobs.

In 2004 Italy's at-risk-of-poverty rate[111] was 19%, and national data show that it has remained relatively stable over recent years. According to the latest available Eurostat data (2004), Italy spends 26.1% of its GDP on social protection; such expenditure is primarily devoted to old age and survivors[112] (61.3%) and sickness and health care (25.9%), while unemployment, housing and social inclusion functions are chronically underdeveloped. Due to ageing and a low fertility rate (1.33 in 2004) Italy is expected to face strong adverse demographic trends over the coming decades: the old-age dependency ratio (29.4 in 2005) is expected to rise to 66 by 2050, with projected growth of social expenditures of 1.8 points. Life expectancy (77.1 for men and 82.8 years for women) and healthy life expectancy (70.9 and 74.4 years respectively) are high and above the EU average. Infant mortality, at 4.1 per 1000 in 2004, is slightly below the EU average.

2. Overall strategic approach

A new strategic approach is quite evident in this report: social inclusion and social protection policies seem to have gained in importance in the government agenda. Frequent references to gender issues are made throughout the text, and attention to and visibility of gender equality can be considered adequate. Good strategic guidelines represent the main strength of the document but, on the other hand, despite recent progress, too few objectives are clearly targeted.

The main challenge identified in the Italian report is related to ensuring long-term sustainability of public finances while promoting stronger economic growth and higher social

[111] Please note that due to a methodological improvement in the EU-SILC implementation in 2005 which affected in different way different groups of the population and caused a large increase in the at-risk-of-poverty relative threshold, data shown for income year 2004 cannot be compared to the values published last year (2004 SILC exercise for income year 2003). In particular, large year to year differences (as for the values of elderly poverty indicators - at-risk-of poverty rate of the 65+, relative income of the 65+, aggregate replacement ratio, etc) cannot be considered significant. In the near future, data for 2004 SILC exercise will be retrospectively corrected in order to allow year to year comparisons.

[112] It should be noted, however, that in Italy benefits such as the TFR (trattamento di fine rapporto, sort of firm-based compulsory saving scheme) are classified under the old age function, but partly come under unemployment expenditure. These benefits represent some 5% of total social benefits.

cohesion and equity. In order to face this challenge Italy has selected four main priorities for action: 1. to reduce poverty; 2. to develop the pension system in order to ensure both its financial sustainability and adequacy; 3. to provide for accessible, more efficient and adequate health care services; 4. to reduce regional disparities.

In this way all three overarching objectives of the new OMC are addressed, but the result is not always satisfactory. The report is rich in references to priorities and measures able to meet the first objective (social cohesion, inclusion, protection, equal opportunities), and the third objective (governance) is explicitly mentioned, but not sufficiently developed. The second objective (integration with Lisbon and Gothenburg strategies) becomes more explicit in the text of the social inclusion strand, where it is illustrated through a concrete example regarding a labour-related tax reduction scheme; unfortunately no mention is made of the EU Sustainable Development Strategy.

3. Social inclusion

3.1. Key trends

The total at-risk-of-poverty rate after social transfers in 2004 is 19%, but as high as 24% for children under 18. The number of children in jobless households has declined steadily over recent years, down to 5.4% in 2006 (- 2.9% compared to 1999); also the number of people in jobless households decreased over the same period down to 9.2% in 2006. According to the national official statistics the overall poverty rate has remained relatively stable over recent years. However, it should be noted that Italy assesses poverty on the basis of consumption expenditure, which is influenced by the national consumption average; this means that when general living conditions are worsening, the value of the expenditure-based poverty line is consequently reduced and some areas could appear statistically less poor than they are in reality. The Italian national indicator tends, in fact, to reduce the population at-risk-of-poverty rate by nearly 6 percentage points compared with the EU indicator based on income.

The profile of poverty has not changed significantly: it is overwhelmingly concentrated in the south and affects mainly large households, households whose head is unemployed, a woman or with a low educational level, and in general families with three or more minors. The at-risk-of-poverty rate increases quite dramatically with the number of dependent children: from 15% (1 child), to 22% (2 children), to 35% (3 or more children). In general women record a higher at-risk-of-poverty rate, and the difference increases with age (up to 7 percentage points higher for people in old age).

Youth employment rates are particularly low in Italy, among the lowest in the EU; but these do not reflect high schooling rates or high educational attainment levels. In fact, youth educational attainment levels are low compared to other EU countries, though on the increase. The percentage of early school-leavers, although decreasing, is still high and well above (+6.8%) the EU average (21.9% in 2005) and with a substantial gender gap (17.8% for females and 25.9% for males). The poor performance in terms of educational attainment levels and employment rates signals the difficulties young people meet in the transition from school to work. These difficulties are evidenced by the concentration of unemployment among young people (over 50% of total unemployment) and by the long unemployment spells (long-term unemployment remains particularly high among the young).

3.2 Key challenges and priorities

The social inclusion strand of the Italian National Strategy Report is based on a multidimensional approach, and efforts to enhance the integration of policy fields and different government levels are clearly pursued. The report focuses on five national priorities for action: improved access to rights and services; reducing poverty, with particular reference to child poverty; strengthening the social inclusion of migrants and disabled people; increasing labour market participation, especially for women, young people and older workers; and reducing regional imbalances.

As far as the key challenges identified in the 2006 Joint Report are concerned, the most relevant progress concerns Italy's employment performance, but we are still a long way from achieving the Lisbon targets.

The importance of the ESF is stressed in relation to the financing of specific studies at national level.

3.3. Policy measures

The measures identified in the NRS under the five selected priorities, if properly implemented, could contribute to reducing poverty and social exclusion. However, the frequent lack of a sound analytical background and impact assessment of previous policies and the weakness in terms of targets and indicators make it difficult to judge their adequacy. The measures will be mainly funded from the national budget and SF, but the allocation of financial resources to specific measures is not always clear. There is a foreseeable risk of fragmented management and difficult evaluability.

The first priority (better access to rights and services) will be pursued mainly by making new efforts to define, through enhanced cooperation with the regions, the basic levels of social services, as required by the national reform of 2000 but still missing. Moreover, great attention is paid to the need for better monitoring and evaluation of the overall welfare system in order to target action and resources where most needed, and to reduce regional disparities. Concern is expressed about the persistent lack of care services for children and elderly people, and provision is made for specific measures and resources. Basic levels of benefits and services to be guaranteed all over the national territory will be defined starting from these two priority areas. A new National Fund for not-self-sufficient persons has just been created, according to the provisions contained in the budget law for 2007; implementing legislation will probably follow during the year. A special plan for increasing accessibility to child-care services for children aged 0-2 will be promoted (+ 6% in the next five years), but stronger efforts need to be made as Italy is still far removed from the target of 33% (9.9% in 2005).

As far as the second priority is concerned (reducing poverty), Italy is committed to reducing its at-risk-of-poverty rate to the EU average by 2010 (according to the latest available Eurostat data it is 3 percentage points higher). This priority will be pursued mainly through a fiscal reform that favours low-income and large families through the combined effects of tax rates, deductions and family allowances. There is also a specific undertaking by the Government to introduce a minimum income scheme, but no details of the practical arrangements are given. A national public housing plan for disadvantaged households and persons is announced, and the need to collect up-to-date data on homelessness briefly mentioned.

The third priority is related to two specific target groups: immigrants and disabled people. The political change arising from last spring's general election is particularly evident in the field of immigration policies, where recent years' restrictive approach is gradually moving towards a more open and multidimensional framework. National acts have been enforced and a bill presented in order to better meet labour market needs and tackle illegality and undeclared work. Significant changes are also expected concerning citizenship rules. A new National Fund for the social inclusion of migrants, addressing in particular social and housing difficulties, is provided for in the budget law for 2007. Finally, at a national level, appropriate financial resources are dedicated to the integration of foreign minors in school, and specific attention is given to minors from ethnic minorities. The report stresses the importance of mainstreaming disability policies, mainly through new forms of coordination between central and local authorities, with the active participation of social partners and NGOs. Measures are envisaged in the education and employment fields as well as initiatives to strengthen and simplify social protection-related procedures and to make the overall legal framework more coherent and clearer.

Regarding the fourth priority (increasing labour market participation), significant changes are expected in order to limit job insecurity and fragmentation, with particular attention being given to the North-South divide and equal opportunities. The most important measure presented in the report is the 5% reduction in labour-related taxation for permanent contracts; the reduction is even higher for employers based in the South of Italy who hire women. Incentives managed through collective bargaining agreements to transform temporary jobs into permanent jobs are being introduced. Some extensions of unemployment and social benefits to temporary and atypical workers are envisaged, but the provision of a more systematic and coherent reform of the overall "shock-absorbing" system is unfortunately still lacking. New mechanisms to fight undeclared work are being introduced and increased resources allocated to positive action in favour of female employment. To make it easier for young people to access employment, credit, housing and culture, Italy will adopt a National Youth Plan which will devote particular attention to education and training policies. Issues such as early school-leaving, apprenticeship and guidance are explicitly addressed, and a new dedicated National Fund has already been created. Specific measures to increase older workers' employment rate are envisaged, such as the "welfare to work" services for 3.000 redundant older workers introduced by law 202/2006, lifelong learning initiatives for 50.000 "over 50" employees over the next two years and a new experimental intergenerational solidarity agreement foreseen by the 2007 budget law.

The fifth and last priority is devoted to reducing regional disparities. As already mentioned above, tax advantages for female employment are foreseen for the South of Italy, together with a tax credit system for innovative investments in underdeveloped areas. A relevant financial effort will be devoted to the development of southern areas, according to the 2007 budget law which provides the stabilization of the FAS (Found for underdeveloped areas) for a seven-year period in accordance to the Structural Funds Regulations 2007-2013. In this new framework social inclusion is one of the priorities and, in particular, special attention is devoted to the development of care services for children and the elderly people. Furthermore, initiatives aiming at enhancing social development in the area have been launched also in the non-profit sector, such as the new "Foundation for the South" aimed at promoting and strengthening social infrastructure.

3.4. Governance

The new government seems intent on re-launching the approach introduced by the 2000 national reform, characterised by an institutional framework based on subsidiarity principles. A large number of governance instruments are mentioned, such as permanent conferences, programming agreements, co-decision mechanisms, monitoring systems and consultation bodies. For preparation of the NSR there was little opportunity to involve many stakeholders (mainly due to the limited time available since the formation of the new government), but some attempts were made to adopt a more systematic and coherent method. Hopefully there will be stronger involvement at the monitoring and implementation stages.

4. Pensions

In 2004, older people enjoyed a relative living standard which was close to that of the general population (84%), while the poverty risk among older people (23%) is estimated to be slightly higher than for the population below the age of 65. In spite of recent increases, the employment rate of older workers (aged 55-64) remains low, at 31.4% in 2005.

Despite unfavourable demographic trends, Italy is, as a result of the pension reforms undertaken since 1992, expected to face only small additional budgetary pressures due to ageing populations. The 2006 Sustainability Report assessed Italy as a medium-risk Member State as regards the sustainability of public finances. According to the budgetary projections made by the AWG in 2005, public expenditure on pensions will increase only marginally, from 14.2% of GDP in 2004 to 14.7% in 2050, and all age-related expenditure from 24.7% to 25.7% of GDP. Both trends are considerably slower than the EU average. According to ISG calculations, for a worker contributing 40 years on average earnings and retiring at 65, the gross replacement rate will decline from 79% today to 64% in 2050 (including the projected contribution of 6.91% to TFR, currently covering some 11% of the employed population). For people retiring at 60 after a career of 35 years, the decline in replacement rates is even more pronounced (about 20 p.p. between 2005 and 2050). For the self-employed, due to a lower level of pension contributions, the decline in the replacement rate is likely to be even sharper.

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 in minimum pensions in 2002, new measures introduced in 2004 have strengthened these reforms and also affect those who still have the right to retire early under the old rules. New discussions with the social partners planned in 2007 should not undermine previous structural reforms.

As mentioned in the 2006 report, raising employment rates, particularly for women and older workers, remains crucial for meeting future challenges, and continuing the process aimed at harmonising the effective retirement age for men and women would help to reduce the gender gap in pension entitlements and would also help boost the employment rates of older workers. Future pensions adequacy will also depend on 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 July 2007) to private pension schemes (except where the employee refuses) could do a lot to help develop supplementary pensions. The possibility of accumulating pension entitlements from different funds in order to have a single pension, and the increase in pension contributions for

the self-employed and atypical workers included in the 2007 budget proposal, should lead to improved pension rights for atypical workers.

5. Health and long-term care

5.1. Health care

Description of the system: There is a public National Health Service (NHS), financed via general taxation. Since 2001, responsibility for local governance of healthcare has been devolved to the regions. The NHS retains the authority to define the framework of strategies and national policies, together with the basic benefit package (Livelli Essenziali di Assistenza, LEA) that must be provided uniformly throughout the country. Regions have responsibility for the organisation and administration of the healthcare system. Local health authorities, both community and hospital authorities, are responsible for the delivery of health care services. Coordination and the achievable degree of uniformity are set through coordination between the central government and the regional administrations, and also with local authorities whenever social matters are on the agenda. Funds are distributed from the central budget to the regions according to a series of parameters (population, frequency of health utilisation by age and sex, territorial epidemiological indicators); nonetheless, health spending per capita still varies substantially from region to region. Some regional taxation also helps to finance the system. There are co-payments but no pre-payments in the NHS. 16% of the population has complementary private health insurance either individually subscribed to or offered by employers, representing 23.6% of total health expenditure.

Primary health care is provided by general practitioners and paediatricians, who are independent contractors of the NHS. Patients can choose the place and professional to whom to address themselves (as long as the GP has not reached the maximum allowed number of patients), and generalists have a gate-keeping function. GPs are part of the network of services provided by the Health District, the basic community structure of the public health system.

District and hospital staffs are public sector employees. The reform of 2001 aimed to introduce elements of privatisation into the system (possibility to purchase services from outside the NHS) and to improve the management of the healthcare system resources. The real impact of these measures is still under evaluation.

Accessibility: The only category not covered by the NHS is illegal immigrants. Out-of-pocket payments covering cost-sharing for public services, pharmaceuticals and private healthcare services amounted to 19.6% of health expenditure in 2004. Since 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 (municipalities) take charge of the institutional care costs of people on low incomes. There are still long waiting lists for hospital and specialised care. By contrast, there is a national plan for tackling waiting lists which should help to prioritise patients in order of urgency. There are differences in the quality of services offered between regions. This problem has been further exacerbated since 2001 and has lead to patients migrating to obtain highly specialised care from the best regions. A system of interregional financial compensation, for care provided to non-residents, allows citizens to choose services without geographic limitations.

Quality: A set of measures has been adopted to promote quality. These 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. A new National Health Information System (NSIS), based on individual records, is under construction, with the aim of both assuring better quality of care and helping to get expenditure under control. It should also be noted that health staff in all public services are obliged to follow, yearly, a certain number of refresher courses, in order to update their professional experience.

Long-term sustainability: Total health expenditure is around the EU average at 8.7% of GDP in 2004, but up from 8.1% in 2000. It is slightly below average at 2424 per capita PPP$ in 2004. Public health care expenditure as a share of total health care expenditure was about 76.4% in 2004. According to the 2006 EPC/EC projections public health care expenditure is expected to increase by 1.3 percentage points of GDP by 2050 due to population ageing. The main increases in expenditure are on pharmaceuticals, personnel and purchasing of goods and services. There were 6.1 physicians per 1000 population, among the highest ratios in Western Europe. The number of nurses was among the lowest in the EU at 3.0 per 1000 population in 1989 (Source: WHO-European Observatory). The national plan aims to improve efficiency and reduce waste. To this end it identifies the following measures: to impose stronger control on regional expenditures and on regions overrunning their budgets; to increase incentives for GPs to improve their prescription practice; to improve coordination between GPs to assure round the clock availability; to reduce the number of hospital beds aiming at 4.5 beds per 1000 inhabitants and to convert small hospitals into residential structures; to generally use resources more rationally (the compulsory introduction of district budgets is still experimental in some regions); to centralise public procurement. Cross-region comparisons across a series of indicators exist and are aimed at identifying and promoting the best national practices, and in controlling demand (for example identifying excessive use of certain procedures etc.).

There is a national plan of active prevention which is proposed as best practice. It aims to go beyond compulsory interventions (such as vaccinations and screening), by promoting active healthy behaviour and lifestyles on the part of citizens. It is carried out in collaboration with other ministries (Employment, Education, etc) as well as the regions. It gives high importance to prevention measures designed to change unhealthy habits in the population (tobacco, alcohol, nutrition, prevention of road and occupational accidents, etc).

5.2. Long-term care

Description of the system: The supply of long term care is based on a system combining integrated home assistance and residential care. Responsibility rests with the regional and local authorities, both health and social, depending on the specific kind of service provided. The government recognises that it is still insufficient for an ageing population and there are significant geographical disparities in supply and quality.

Accessibility: The general goal is to enable the elderly to remain in their home. People in need can obtain a large number of benefits, among which there are: direct free services, vouchers to buy services from accredited institutions, untied financial aid, which is mainly used to purchase the help, at home, of immigrant workers, and financial support for various degrees of invalidity. Better care coordination will be enhanced via the family doctor and the "Custode Sociale", who looks at the healthcare and social needs of elderly dependent people and drafts a patient care plan.

Quality: There is a lack of general standards for the quality of social care, both at home and in institutions. The (national) definition of essential levels of social service provision and quality (LIVEAS) – awaiting official approval – should help to address regional differences in standards, following the model already in use in the health sector (LEA). In this light, State, regions, autonomous provinces and local authorities are to plan and work together on the definition and provision of services and establish their respective responsibilities.

Long-term sustainability: Long-term care is financed both from the NHS and from the social policy fund, distributed from central Government to local levels. However, there is a clear recognition that given the trend of demographic developments, the resources are insufficient. According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.7 percentage points of GDP by 2050 due to population ageing. The government also recognises, as a major issue, the need to improve coordination between health and social services. The first step is to move towards a more integrated approach between the regional and local levels. Some regions have instituted a dedicated fund for ageing people in dependency situations, aimed at financing services and allowances, within the framework of the essential levels of health services. A similar measure has recently been approved by the Parliament at national level (National Fund for not-self-sufficient persons).

6. Challenges ahead

To reduce regional disparities through improved co-ordination between national and sub-national measures;

To increase the level of participation on the labour market, especially for young people, women and older workers, in order to meet future challenges arising from demographic trends, and ensure adequacy of pensions and the long-term sustainability of public finances;

To ensure a more coherent and comprehensive coverage of the "shock absorbing" system;

To improve efficiency and reduce waste through the more rational use of resources, and to improve health and LTC service organisation and coordination whilst reducing geographic differences in provision.

In long-term care, to focus on community and home services as an alternative to residential and hospital care by moving towards an integrated approach between regional and local levels.

Italy: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.6	113.1	**2000**	53.7	68,0	39.6	26.4	27.7	**2000**	10.1	7.8	13.6	27,0
2002	0.3	110,0	**2002**	55.5	69.1	42,0	25.8	28.9	**2002**	8.6	6.7	11.5	23.1
2004	1.1	103,0	**2004**	57.6b	70.1b	45.2b	27.6b	30.5b	**2004**	8,0	6.4	10.5	23.5
2006	1.7f	99.4f	**2005**	57.6	69.9	45.3	25.7	31.4	**2005**	7.7	6.2	10.1	24,0

*:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b:break in series

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth(2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	male	female	male	female	male	female							
1995	74.9	81.3	15.8	19.6	66.7	70,0	6.2	**1995**	7.3	71.9	-	100 (1997)	
2000	76.6	82.5	16.5	20.4	69.7	72.9	4.5	**2000**	8.1	73.5	22.8		15.6 (1999)
2004	77.1sp	82.8sp	16.8sp	20.6sp	70.9e	74.4e	4.1	**2004**	8.7	76.4	19.6		

s: Eurostat estimate; p: provisional; *THE: Total Health Expenditures; **PHI: Private Health Insurance

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	24.2	63.4	23.2	3	3.2	0.1	7
2000	24.7	63.2	25.1	1.7	3.8	0.2	6
2004	26.1	61.3	25.9	2	4.4	0.3	6.1

* including administrative costs

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	29.4	26.2	14.2	5.8	1.5
2010	31.3	-0.5			
2030	45.2	1.1	0.8	0.9	0.2
2050	66	1.8	0.4	1.3	0.7

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64	65+
Total	19	24	18	16	23
male	17	-	16	15	19
female	21	-	20	18	26

Poverty risk gap

Total	Children 0-17	18+	18-64	65+
24	28	23	27	18
25	-	24	27	16
24	-	22	28	19

Income inequalities

	S80/S20
Total	5.6
male	-
female	-

People living in jobless households

	Children	% of people aged 18-59*		
	Total	Total	male	female
1999	8.3	11.7	9.8	13.5
2004	5.7	9.1	7.9	10.4
2006	5.4	9.2	7.8	10.6

Long-term unemployment rate

	% of people aged 15-64			
	Total	male	female	
1999	6.7	5.2	9,0	**1999**
2004	4,0	2.9	5.5	**2004**
2005	3.9	2.9	5.2	**2005**

Early school-leavers

% of people aged 18-24		
Total	male	female
27.2	30.3	24.2
22.3	26.2	18.4
21.9	25.9	17.8

*: excluding students; p: provisional; b: break in series

SILC income 2004	Total	male	female
Relative income of 65+	0.844	0.871	0.835

SILC income 2004	Total	male	female
Aggregate replacement ratio	0.583	0.639	0.492

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
										Occupational & voluntary pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or social security)	Current estimate (2002)	Assumption
4	1	-15	DB & DC	16	DC	100	11.4		32.7	5.7	6.91

*(DB / NDC/ DC); ** (DB / DC)

CYPRUS

1. Situation and key trends

Cyprus continues to return a satisfactory economic and labour market performance. GDP growth remained buoyant at 3.8 percent (2005), and the fiscal deficit declined (from 4.1% in 2004 and a troublesome 6.3% in 2003) to 2.5% in 2005, better than expected. Consistent with the GDP growth, the employment rate was sustained at good levels (68.5% in 2005). Unemployment rose to 5.2% in 2005 but remains low in comparison to the EU average (8.8%). The employment rate for older workers (50.6%) is above the Lisbon target. The female employment rate, at 58.4%, is close to the EU target, despite a minor drop from previous years. On the other hand, youth unemployment, at 14%, shows a clear upward trend. Additionally, it is higher for women and includes a large share of persons with higher education.

The risk of poverty[113] for the general population was 16% in 2004, comparing well with the EU average. For the age group over 65, the risk of poverty (51%) remains troublesome[114]. It is as high as 73% for single elderly people.

According to the latest available Eurostat data (2004), social protection expenditure as a percentage of GDP stood at 17.8%. Total pension expenditure is set to rise from 6.9% of GDP in 2004 to 19.8% in 2050, causing serious concern as regards the financial sustainability of the system.

It is expected that the old-age dependency ratio will more than double between 2004 and 2050 from the present very low 17% to 43% (but still well below the EU25 average of 52% in 2050). Life expectancy (76.8 years for males and 81.9 years for females in 2004) is above the EU average[115], showing a 2-year increase since 1995. Healthy life expectancy (68.4 for men and 69.6 for women in 2003) is well above the EU average[116] and the second highest in the EU. Infant mortality (3.5 in 2004) is below the 2004 EU average of 4.5, continuing a consistent decrease from 26 in 1970. The gender pay gap, although on a somewhat downward trend over recent years, remains high at 25%. As a response to labour shortages, foreign workers have entered the local job market on a temporary basis, their numbers being roughly estimated at 14% of the workforce. There is no reliable estimate for the number of undeclared workers.

2. Overall strategic approach

The overall strategic approach of Cyprus, in line with its National Reform Programme, is concerned with embedding in the country the conditions for improving social cohesion, for the most part through the active inclusion of vulnerable groups into employment. The priorities selected respond to the main challenges faced by the country.

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[113] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national family expenditure survey that was not fully compatible with the SILC methodology based on detailed income data.

[114] Provident funds (lump sum benefits in case of retirement, death, invalidity, or termination of employment) are not included in the calculation of retired people's income

[115] 75.1 and 81.2 for males and females in 2003

[116] 64.5 and 66 for males and females in 2003

The priorities set by the Commission in 2005 for inclusion are addressed in the report, although analysed in different degrees of detail. Thus, the eradication of child poverty, flexibility in the labour market, longer working lives, the integration of migrants, improving access and tackling inequalities in health care, bettering the position of persons with disabilities, modernising the social protection system and tackling educational disadvantages, all receive attention. Access to housing for low-income families is also touched upon.

In the field of social inclusion, the main priorities for action concern the reduction of the risk of poverty for the overall population, and in particular for the high-risk group of persons aged 65 or more, the integration of vulnerable groups into the labour market and the prevention of exclusion for children. The development of human capital, with a focus on those groups who are most exposed to risk, remains a key challenge.

Modernisation of the social protection system is treated as an immediate priority, with a view to rendering it more efficient, and principally to ensuring its financial sustainability. The importance of social dialogue for reaching consensus on introducing changes to the pensions system features prominently in the report.

The main policy aim in the field of health and long-term care is to maintain and improve the standard of living of the population. Key consideration is given to ensuring access to health for all, and on eliminating inequalities in terms of financing the system. Furthermore, the agenda takes on board measures to modernise the organisation of government institutions and public health service providers. Emphasis is also placed on strengthening structures developed by local government and voluntary organisations. The inter-linkages between the Lisbon objectives for greater economic growth and employment, and the policy objectives reflected in the strategy report are apparent. The detailed description of the interventions of the ESF makes clear the role that the European Social Fund ('ESF') plays in the country's development strategy, and thereby in pursuing the Lisbon agenda.

The broad consultation process on the various aspects of the strategy confirms the existence of a long tradition of social dialogue. The upgrading of the functions of the Pancyprian Volunteerism Coordinative Council adds to the involvement of those more directly concerned by social exclusion, while the reported establishment of a monitoring and evaluation committee will help maximise the involvement of stakeholders.

The issue of gender equality is primarily addressed in the framework of employment. Despite a set of positive developments, and the adoption of measures promoting gender equality, a true gender mainstreaming approach is not evident in all policies.

3. Social inclusion

3.1 Key trends

Economic disparities and poverty are not widespread in Cyprus. In 2004, the risk of poverty for the overall population was on a par with the EU average, and remains very high for persons over 65 (51%), for persons living in single-member households (48%) and for single-parent families (35%). Inequality of income distribution (S80/S20) was 4.3 in 2004. The rate of childhood poverty was 13% in 2004, below the EU average (19% in 2004). 3.9% of children lived in a jobless household in 2006.

Social transfers reduce the overall at-risk-of-poverty rate from 29% to 16%. Access to decent housing is not considered to be a challenge for the overall population. In 2003, 91% of the population lived in owner-occupied or rent-free houses. Nevertheless, problems of access to decent housing may be faced by groups of persons such as foreign workers from third countries living temporarily in Cyprus on a contract basis.

Cyprus can boast high levels of educational attainment. Nonetheless, youth unemployment is both on an upward trend (14% in 2005 as compared to 11.3% in 2004) and more than twice the overall unemployment rate (5.2%: 2005). It is to be noted that a large proportion of the young unemployed are tertiary education graduates.

Persons with disabilities face a multitude of problems, the greatest being that of effectively entering the labour market.

3.2 Key challenges and priorities

Ensuring an adequate standard of living for disadvantaged and vulnerable groups and facilitating their integration into the labour market are key issues in Cyprus' efforts to enhance social cohesion. The modernisation of the social protection system, in order to enhance its effectiveness and respond to high pressure as regards its financial sustainability, is also a key priority. Nonetheless, the modernisation agenda remains open-ended and subject to social partner consultation. The main challenges identified for Cyprus in the 2006 Joint Report on social protection and social inclusion remain pertinent, and are indeed addressed in the 2006-2008 report. The government's approach is in line with the three overarching objectives for social protection and social inclusion.

The priorities for social inclusion have been structured around three main pillars. A first priority concerns reducing the risk of poverty for the general population, and in particular for the age group of 65 and older. A number of interventions are of relevance to this.

Secondly, priority is given to the integration of vulnerable groups into the labour market. In this respect, particular importance is placed on increasing access to employment of women, older persons, persons with disabilities, public assistance recipients, young persons and unemployed persons in general. In relation to the above, furthering the development of human capital and eliminating gender inequalities are key policy aims.

A third priority relates to preventing exclusion of children, which though lower than the EU equivalent, is considered important in preventing social exclusion in the next generation.

Other key priorities relate to safeguarding access to services, including education and health for all. Providing access to care services for children, older persons and other dependent persons also receives attention.

Finally, the contribution of the Structural Funds, and particularly of the ESF, in supporting the National Strategic Report objectives is clearly indicated in the report.

3.3 Policy measures

The strategy adopted by Cyprus focuses strongly on access to the labour market for vulnerable groups. It aims to increase flexibility in the labour market, to further develop human capital though vocational training activities and to manage economic migration

(especially for third-country workers). Additionally, the strategy prioritises the reduction of poverty for the overall population, and provides for specific measures for the population aged 65 and above, and for children.

The integration of vulnerable groups into the labour market is pursued mainly through active policies, the focus being on such target groups as women, older persons, public assistance recipients, persons with disabilities and young persons. The provision of a personalised approach to the unemployed by the Public Employment Services and the promotion of flexible forms of employment are complemented by better care services for children and other dependent persons.

Several quantified targets are set, amongst them an employment rate for women of 63% by 2010 (58.4% in 2005), an employment rate for older women of 32% by 2006 (31.5% in 2005) and for 6,000 unemployed persons to be employed by 2008. Quantified targets are also set for the reduction of child poverty and for the increase of the minimum wage to reach 50% of the median national wage by 2008.

It is noted that Cyprus does not have a statutory national minimum wage, with the minimum wage rate applying only to a small sector of the labour market. In relation to the set target, the effects of the increases in the minimum wage should be monitored, to ensure that they do not have an adverse impact on employment.

Moreover, incentives are offered to recipients of public assistance in order to encourage them to take up employment, such as the continuation of public assistance to long-term unemployed persons for up to one year after taking a job and the availability of unemployment benefits to those receiving training to help them enter or re-enter the labour market. In addition, incentives exist for postponing retirement in the form of reasonable increases in pension benefits[117].

Young persons are clearly identified as a target group. Measures to help them include the modernisation of the apprenticeship scheme, schemes to raise their employability and a scheme for providing financial assistance for the re-integration of people with addiction problems. In addition to the latter, a coordination committee for health education and citizenship has been set up within the Ministry of Education and Culture, in order to promote programmes for the prevention of drug dependency. It is worth noting that the government had been criticised in the past for its modest support to persons dependent on drugs, a problem which has been rising fast. On the use of ICTs in education, the report displays a somewhat simplistic approach.

Although the reduction of youth unemployment is not mentioned as a target per se, the National Reform Programme deals with that issue in more detail. Moreover, progress on modernising the apprenticeship scheme and reforming secondary vocational education has been slow.

Quite a few measures have been put in place to assist persons with disabilities, mainly in the form of facilitating their integration into the labour market, improving their accessibility and improving financial assistance offered to them. This approach is solid, given the extent of the

117 a) For every postponed month after the age of 65, pensions increase by 0.5 % with a maximum at age 68 b) The payment of a pension is not conditional on retirement from regular employment and c) A 'Self-employment scheme' provides grants to people over 63 in order to support them being actively involved in economic activity as self-employed

problems faced by persons with disabilities, in terms of their integration in the labour market and in society at large. A close monitoring of interventions should be put into practice.

Although women benefit from a series of measures, which aim primarily at their integration into the labour market, a true gender mainstreaming policy is to some extent lacking. Amongst other measures, support is offered to enhance women's employability. Other issues, for example violence in the family, are not touched upon. The issue of reconciliation of work and family life is adequately dealt with.

On the issue of reducing child poverty, emphasis is placed on educational support, with supportive teaching programmes, literacy programmes and support to children with special needs. The creation of 'educational priority zones' recognises the particular needs of children with a different cultural background, and is seen as a positive step in embedding a true policy of integration for these individuals.

The resources allocated to the achievement of the identified priorities are not consistently indicated. ESF funds in support of policies are visibly set. Changes to schemes providing financial assistance are also clearly indicated.

Although most challenges are adequately addressed, and progress can already be observed in terms of implementation, the policy on some key challenges, for example regarding the management of economic migration, remains general and vague. Other issues, such as reducing the gender pay gap, are only implicitly addressed.

Moreover, despite a clear policy line on reforming the health and long-term care systems (for example the reorganisation of public hospitals or the issue of de-institutionalisation), the timeframe and the budgetary implications of these operations are left open. Regarding social protection (pensions), the government has reported its commitment to adopting the necessary reform measures by the end of 2006. Nevertheless, these reforms also depend on the outcome of social dialogue. Both these issues are directly linked to the social inclusion strand.

3.4 Governance

The NSR was adopted by the Council of Ministers. The Social Welfare Services (SWS) of the Ministry of Labour and Social Insurance have the coordinating role in drafting the NSR. In this capacity, the SWS received contributions from other government departments, and held meetings with representatives of local authorities, social partners and NGOs.

Progress has been made on the issue of monitoring and evaluation of policies, with efforts being deployed to assume a comprehensive approach, even though monitoring and evaluation arrangements remain stronger for some policies and weaker for others, with the policies supported by the ESF receiving a better follow-up. In this context, a proposal to set up a monitoring and evaluation committee has been put forward. Proceeding with this arrangement would politically strengthen the social inclusion policy.

The clear setting of targets in the report will inevitably facilitate the monitoring of the situation. Nevertheless, lack of know-how and limited human resources, such as in the case of NGOs involved in the area, sometimes hinder this process.

4. Pensions

Pensioner incomes in Cyprus are among the lowest in the EU-25, relative to the overall population (57% of those aged 0-64), and the risk of poverty in the 65+ age group in Cyprus is the highest among all Member States (51% in 2004). The highest incidence of poverty occurs amongst persons living in single-adult households, though the gender disparity is less pronounced (47% for men and 53% for women).

The 2006 Sustainability Report assessed Cyprus as a high-risk Member State as regards the sustainability of public finances, notably due to the high projected increase in age-related expenditures and the high level of debt. According to the AWG projections, Cyprus is expected to increase its spending on public pensions (including public sector employees' pensions) from 6.9% of GDP in 2004 to 19.8% of GDP in 2050. The projected growth of 12.9 percentage points of GDP is the largest in the EU-25 and will exhaust the reserve fund by about 2040. According to ISG projections, theoretical replacement rate calculations put the gross replacement rate from the statutory pillar at 46% (net 52%) in 2005, increasing to 57% (net 66%) by 2030 and 57% (net 70%) by 2050.

Cyprus faces considerable challenges as identified in the 2006 Joint Report, chief of which is to ensure the adequacy of its pension system and to reduce the poverty levels of those over 65[118]

The value 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 the re-examination of pension entitlement between the ages of 63 and 65.

To tackle the problem of pensioner poverty, the Cypriot Government intends to carry out a study in 2007 on the possibility of fixing a minimum income targeted at those households at most risk of poverty, replacing the current inefficient supplementary Special Allowance Scheme to pensioners. A further study on the possibility of developing a second pillar, with defined contribution provision for those not covered by occupational pensions, is also envisaged in 2007.

5. Health and long-term care

5.1 Health care

Description of the system: Health care is provided by the Public Health Services (PHS) and the private health sector. The PHS, financed out of general taxation, co-payments and fees paid, covers 65-70% of the population, free of charge, and 5-10% at reduced fees. Free of charge health care is provided through the PHS to public sector employees irrespective of income. The remainder of the population is classified into two categories: those entitled to free of charge care (families with four or more children, severely disabled, the poor, etc), and those entitled to care at reduced fees (according to income level and number of family members). Private health services are financed by patients' out-of–pocket payments or through occupational medical funds. Treatment in emergency cases is free of charge for all

[118] The level of social insurance pension is still influenced by the insurance time completed under the scheme in force before October 1980.

residents at public hospitals. Coverage is not universal and the health care provided benefits are means-tested (except for the above-mentioned categories). Individuals who are not entitled to either free care or at reduced fees care, purchase private health services and pay out-of-pocket. There is no gate-keeping system at the moment and thus patients are free to choose the physician of their choice. Maternal and child health services are available to everyone, free, at the point of use. Public sector physicians are salaried employees, whereas physicians in the private, largely unregulated, sector are paid on a fee-for-service basis.

Awareness of serious organisational and financing difficulties of the health care system has led to the enactment in 2001 of a National Health Scheme (NHS) with an implementation target for 2008. The main characteristics of the reform are:
-Universal residence-based coverage of the population
-Financing through an insurance scheme based on earnings-related tripartite contributions
-Freedom of choice of provider between the private and public sector
-Separation of provision from financing of healthcare
-Management of the NHS by an independent public law Health Insurance Organisation
-Introduction of a referral system and obligatory enrolment with a GP to strengthen PHC
In 2006, the Health Insurance Organisation (HIO) worked on formulating a strategy and proceeded with the implementation phases of the National Health Scheme (NHS).

Accessibility: Despite the fact that the PHS covers the majority of the population (free of charge or at reduced fees), its capacity is limited and results in an increasing use of private health services paid on an out-of-pocket basis. Lower-income households have a higher burden of payment for private health services (between 4.6% and 6.4% of household income as opposed to 4% for median income households). Additionally, inequities in access result from the varying qualifying conditions for PHS coverage (free care without income test for some and means-testing for others). The introduction of the NHS will address these access inequities (universal coverage) and end differentiated care provision through the free choice of provision. Geographical disparities exist and also explain the increased use of private health services, which cover most of primary health care needs of the population. The authorities have strengthened primary care facilities to increase overall supply and address geographical disparities.

Quality: There is no comprehensive quality assurance system. Introducing an integrated quality assurance system is a priority for the authorities. The implementation of the reforms will address purchase management (largely uncoordinated) in both public and private sectors. Patient rights legislation has been enacted by Parliament, and patients participate in decision-making through the Patients Welfare Committees set up at each hospital. Patient choice of doctor and hospital, currently limited to the public sector, will be addressed by the introduction of the NHS, with free choice of GP in either public or private hospital, subject to referral. There is no use of technology assessment. Specific action plans for disease prevention are in place (e.g. cancer screening, infectious disease control network).

Long-term Sustainability: Total health expenditure (6.2% of GDP and 972 per capita PPP$ in 2004) is one of the lowest in the EU[119] despite a consistent increase over time. The public share of health spending (47.8% of total health expenditure in 2004) is the EU's lowest despite a substantial increase in the last decade. In 2004, the private share of health spending was 52.2% of total expenditure funded mainly through out-of-pocket payments. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.1 percentage

[119] EU average of 8.87% and 2376.33 in 2004

points of GDP by 2050 due to population ageing. The relatively low share of public health expenditure is expected to rise with the introduction of the NHS and the creation of a medical school. The high level of private health expenditure is due to under-resourced PHS and a lack of coordination between the private and public sectors of health provision. The reform and introduction of the NHS is expected to resolve problems of governance and strengthen the role of PHC. A unitary system of family doctors with gate-keeping and referral functions paid on a capitation basis, to be introduced, would address the problems of coordination between the competing sectors if accompanied by freedom of provider choice with regulated uniform pricing. Additionally, the reform will introduce a single Health Insurance Organisation (HIO), a financing agency, which will assure equal footing pricing between private and public providers, coordination between the sectors and will effectively consolidate a purchaser/provider split. The public sector dominates in the number of nurses and the private sector in the number of doctors. The reform is intended to address this problem with the new payment method for medical staff. Emphasis is placed on health promotion and disease prevention, through the creation of an integrated PHC system.

5.2 Long-term care

Description of the system: LTC services include residential care, home care and day care. LTC is available to residents who are unable to secure it by their own means. It is provided directly by governmental, community and private institutions with state financing. State subsidies are provided for public assistance recipients and in support of government, community and private carers as well as for house adjustments costs to promote home care. The private sector dominates LTC provision (residential care mainly available in privately-run homes, home care private carers) with state subsidies for vulnerable groups. Hence the state, in addition to direct provision of services, subsidises voluntary and private organisations that provide LTC. Co-payments by persons in care depend on household income. NGOs have a growing role in LTC provision.

Accessibility: The authorities' overall aim is to keep elderly and dependent persons in home care and/or within the family. This is the main mechanism for ensuring access to LTC services. A family member can be a home carer and will be financially supported if not in employment. Home care will be further enhanced through specific measures aimed at providing information for people who are not in receipt of public assistance. In terms of LTC for the mentally ill, measures are in place to upgrade and expand LTC in this area (institutional, non-institutional and creation of a National Mental Health Centre). In residential care, the limited supply of services by the state and the community is tackled by using private homes facilities with state subsidies (to reduce waiting lists).

Quality: Minimum quality requirements, registration and regular inspections in residential and day care in private and community homes are guaranteed by law. A law is expected to be enacted to regulate the provision of LTC (home care) by private and non-governmental organisations and to set standards for carers' qualifications. Institutionalisation is used as a last resort in cases where the family is unable to meet the care needs of a member, with an emphasis on home and community care.

Long-term sustainability: Steps have been taken to ensure the requisite coordination for promoting financial sustainability in LTC (Social Welfare Services, the Pancyprian Volunteerism Coordinative Council and local authorities), aimed at the rational distribution of subsidies between the various private and voluntary organisations and local authorities and the efficient use of resources. Additionally, in view of demographic developments, a plan to

integrate geriatric services at all levels of health provision and promotion of prevention policies is being implemented. The authorities have opted to target resources to the neediest and to support home care rather than institutionalisation as the way to promote the financial sustainability of LTC.

6. Challenges ahead

To continue to improve the position of vulnerable groups in society, by strengthening steps towards active inclusion in terms of pathways to employment and equal access to all services.

To continue efforts to improve governance by supporting the institutional capacity and involvement of local authorities, NGOs and social partners and by strengthening the development, implementation, monitoring and evaluation of policy interventions.

To address the long-term sustainability of pensions, notably by increasing incentives to work longer, while addressing the high risk of poverty among people aged 65 and over.

– To accelerate the process of reform to guarantee universal comprehensive care coverage and equitable financing through increased funding and efficient service provision.

To establish good coordination between the public and private sectors, to further the decentralisation process with the focus on improving the institutional capacity of local authorities, NGOs and social partners, and to enhance monitoring and quality assurance mechanisms.

Cyprus: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.0	82.2	**2000**	65.7	78.7	53.5	37,0	49.4	**2000**	4.9	3.2	7.2	10.1
2002	2.0	82.6	**2002**	68.6	78.9	59.1	37,0	49.4	**2002**	3.6	2.9	4.5	8.1
2004	4.2	87.7	**2004**	68.9	79.8	58.7	37.5	49.9	**2004**	4.6	3.6	6,0	10.5
2006	3.8f	88.3f	**2005**	68.5	79.2	58.4	36.7	50.6	**2005**	5.2	4.3	6.5	13.0

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	75.3	79.8	16.3	18.6	n/a	n/a	9.7	**1995**	n/a	n/a	-	n/a	n/a
2000	n/a	n/a	n/a	n/a	n/a	n/a	5.6	**2000**	5.8	41.6	55.7		
2004	76.8sp	81.9sp	16.7sp	19.4sp	68.4	69.6	3.5	**2004**	6.2	47.8	50		

**THE: Total Health Expenditure* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	14.8	48.8	27.2	7.2	6.3	7.1	3.4
2004	17.8	48.3	24.1	4.9	11.4	6.9	4.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public Pensions	Health Care	Long-Term Care
2005					
2010	19.1	n/a	n/a	n/a	n/a
2030	32.9	n/a	n/a	n/a	n/a
2050	43.2	n/a	n/a	n/a	n/a

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	16b	13b	17b	11b	51b	19b	17b	21b	19b	21b	**Total**	4.3b
Male	15b	-	15b	10b	47b	17b	-	18b	17b	20b	**Male**	-
femal	18b	-	19b	13b	53b	21b	-	22b	21b	23b	**Female**	-

	People living in jobless households					***Long-Term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	n/a	n/a	n/a	n/a	**1999**	n/a	n/a	n/a	**1999**	17.5	24.6	12.3
2004	2.6	5,0	3.8	6.1	**2004**	1.2	0.9	1.6	**2004**	20.6	27.2	14.9
2006	3.9	4.9	3.7	5.9	**2005**	1.2	0.8	1.8	**2005**	18.1	26.6	10.6

** excluding students; b: break in data series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.57b	0.59b	0.55b	***Aggregate replacement ratio***	0.28b	0.34b	0.34b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
								pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Estimate of current (2002)	Assumption
n/a	n/a		n/a		n/a	n/a		n/a	n/a	

** (DB / NDC/ DC); ** (DB / DC)*

LATVIA

1. Situation and key trends

High GDP growth rates continued in 2006 (around 11%). The overall employment rate reached 63.3% in 2005 (EU-25:- 63.8%). Employment for older workers (49.5%) and women (59.3%) was above the EU-25 average, while male employment, although growing, remained relatively low (67.6%). In a labour market, tightened by outward labour migration and a decreasing working age population, the unemployment rate continued to fall (8.9%), but remained slightly above the EU average (8.7%). Long- term unemployment (4.1%) has decreased at a slower rate. Although female unemployment (8.7%) was below the EU average, male unemployment (9.1%) was relatively high. Youth unemployment dropped to 13.6%. There was a slight decrease in the overall activity rate (69.6%), which now stands below the EU average (70.2%). The share of undeclared work in Latvia is high. Labour shortages have emerged and productivity remains the lowest in the EU.

Average living standards, although growing fast, are still low (GDP per capita in PPS stands at 52% of the EU average in 2006). High inflation (6.6%) erodes the income of low and average wage earners and household debt is rising. Income inequalities persist, as evidenced by a Gini coefficient of 36 in 2004. There are considerable regional disparities and a rural-urban divide. The at-risk-of-poverty[120] rate was 19%. Poverty risk for some population groups (like single pensioners, single-parent families) increased. Early school leaving (11.9%) is very much a male problem (15.5%, the female indicator being 8.2%). The share of persons with low educational attainment in the age group 25-34 is a concern for a country aiming at creating a knowledge-based economy (20.1% total, 24.6% for males and 15.6%- for females), while older cohorts up to 54 have performed much better (6.8% in the age group 35-44).

Population numbers have been decreasing since 1991, and are projected to decrease further over the coming decades, yet absolute decline in the population size is accompanied only by moderate increases in the old- age dependency ratio (from the current 24.1% to 44.1% in 2050). Total social protection expenditure as a percentage of GDP in 2004 was low (12.6%) and on a declining trend. Life expectancy at birth is among the lowest in the EU (67.1 years for males and 77.2 for females in 2004; almost 10 years lower than the EU average for males), but it has increased substantially since 1995. Infant mortality rates, although consistently falling (from 26.9 in 1960), remain high (at 9.4 in 2004, infant mortality was the highest in the EU and more than twice the average). Perinatal mortality, at 9.9 in 2005, is also among the highest. Total health expenditure as a percentage of GDP was 6.4% in 2004 (public expenditure accounts for about half of this).

2. Overall strategic approach

The Latvian National Report on Strategy for Social Protection and Social Inclusion 2006-2008 (NRS) emphasises the importance of integrated and mutually supportive policies in the fields of social inclusion, pensions, health and long-term care. Latvia, striving to ensure flexicurity, focuses on the social protection system's ability to react to population ageing, a shrinking labour force and to adequacy of benefits. An inclusive labour market is being developed. There is a strong focus on health care, preventive measures and healthy lifestyles. Latvia also puts emphasis on promoting education and a family-friendly environment. The reduction of social exclusion risks for

120 Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

pensioners is among the national priorities. Overall social inclusion issues raised in the NRS include barriers faced by at-risk groups in access to resources, education, quality jobs, social care and health care, ICT and housing. As regards its strengths, the NRS demonstrates that the choice of new inclusion priorities is a result of analyses of the current situation and wide consultations.

Latvia recognises the need to give attention to the adequacy, modernisation and financial sustainability of the social protection system, particularly pensions and health. The approach to a substantially different demographic situation is stressed. Pensions receive considerable attention, even though the reform has been completed. Latvia is confident about its pension policy, seeing it as progressive, modern and financially stable in the long term. Latvia is currently raising the retirement age for women (to 62, the same as the male retirement age). Poverty for the elderly is relatively low; however, the gender gap in poverty risk remains high. Latvia has indicated the need for a Reserve Fund for pensions (because of the demographic load). This is important to guarantee pension system financial sustainability, therefore measures relating to the fund should be reflected in greater detail. Latvia intends to reform its health care system in order to improve its long-term sustainability, raise its quality and enhance access to health care services. The programmes for modernising the emergency medical service and optimising the structure of health-care service providers should contribute to this. Particular emphasis should be placed on better integrating Primary Health Care. To improve general coverage of services and geographic access (through expanding emergency care), it is necessary to reduce the individual financial burden and address the human resources issues. The latter will be achieved through an increased allocation of public resources to the health sector and the development of training and staff retention policies (to be achieved through the Structural Funds). However, access by the poor is not sufficiently elaborated in the NRS.

When translating the strategies into action to be taken in the field of social inclusion, the NRS concentrates on a life cycle approach and on some family types. The NRS identifies three broad priorities for action to improve access to services and resources: (a) education and jobs for children and youth at risk of poverty and social exclusion; (b) resources and services for families, in particular large and lone-parent families; and (c) resources and services for pensioners at risk of poverty, in particular single pensioners. However, the NRS mentions also other numerous at- risk groups, but does not tackle the issues further. On the whole, the NRS provides a summary of actions, but is not always underpinned by a clear and coherent strategy. Being a forward- looking document, the Latvian NRS regrettably does not discuss to what extent the 2004 -2006 targets were achieved or the impact of past policies. Shortcomings remain in the NRS, regarding targets and indicators for monitoring the 2006-2008 period and this aspect needs to be strengthened significantly. As clear targets relating to poverty reduction are not included, some social inclusion commitments from the Lisbon NRP (such as lowering the at-risk-of-poverty rate to 11% by 2008) have disappeared from the agenda. The role of Structural Funds support in implementing the priority measures is not sufficiently highlighted, and details of funding are lacking. This adds to concerns that social inclusion and human resource development goals might not receive the attention they deserve. The three examples of good practice do not exactly correspond to the four selected areas, and are neither fully implemented nor evaluated.

3. Social inclusion

3.1 Key trends

Recent developments in Latvia include enhanced social security benefits for families with children and introduction of new support measures. Lower pension amounts have been are increased. In 2005 the tax-free personal income threshold was increased (and will be

increased again in future) and the guaranteed minimum income benefit was also increased. Possibilities to lower the personal income tax rate (currently 25%) are being looked into. A decision was taken to substantially increase the minimum wage as of 2007 (by more than 30%). As the poorest households spend a large share of their income on housing and food (41% in 2004), inflation erodes efforts to improve their situation. Increases in the prices of education (+10.3% in the current academic year, according to national statistics) health care services, food, housing, heating and transport all negatively affect the situation of medium wage earners as well. Household debt is rising and there is a need for advice about the consequences of taking on heavy financial commitments.

Although the average wages are growing rapidly and disposable income is increasing for all types of households, considerable income disparities remain between rural and urban areas and between Riga and other regions. The Gini coefficient decreased only in Riga. The relative poverty line in 2004 was EUR €110 per month. Owing to a dynamic income growth for higher wage earners and inflation, poverty risk for several groups, like single pensioners, single-parent families and for large families with dependent children remains high. Taxation on low-wage earners and the unemployment trap are also high (41.1% and 87.10 % in 2004). Educational attainment for young people is 81.8% (the female indicator being 86.6%). According to the NRS, numbers of drop-outs grew recently, both in vocational and in comprehensive day schools. The scope of Latvian language training has been increased, but lifelong learning is a concept still to be implemented, while 2005 has already seen a decrease in adult participation in education and training. Several policy documents benefiting vulnerable groups (Roma, the disabled, ex-convicts and the poor) were elaborated during 2006, but their impact will depend on resources allocated for achieving the objectives.

3.2 Key challenges and priorities:

Efforts are made to have an impact on the eradication of poverty and social exclusion by improving access to basic resources and social services. Still, the needs of Latvian society are huge. Social inclusion policies involve all government levels; however, there is a need to improve their efficiency, effectiveness and mainstreaming in relevant public policies and Structural Funds programmes. As regards the two social inclusion challenges presented by the 2006 Joint Report on Social Protection and Social Inclusion, they remain valid (development of a coherent strategic approach to promoting social inclusion, and introducing more targeted measures for vulnerable groups).

Considerable efforts are made to better include relevant actors, and to accommodate the needs of local governments and at-risk groups; still, the issue of tackling regional differences remains important. Actions taken and planned fall short of fully addressing the problems identified. Unfortunately, research and statistical data reveal no significant progress in reducing risks of poverty and social exclusion for vulnerable groups, neither by region, nor by gender. Inflation growth has eradicated the attempts of government to help lower income groups, while inequality in income distribution has not been tackled. The new priority actions will mostly target the at-risk groups by offering the same approach for both genders and all regions and territories. The needs of other groups at risk (like the homeless, the long-term unemployed, addicts, victims of trafficking) will also have to be addressed and lifelong learning will be important to achieve the social inclusion goals. As regards positive developments, the ESF has enabled Latvia to increase the numbers of those benefiting from active labour- market policies and the gender dimension has become more visible. The NRS only mentions the SF and EQUAL contribution as supportive to key policy objectives and ERDF support is reflected in best practice examples.

3.3 Policy measures

Education and jobs for children and youth at risk of poverty and social exclusion:
Action taken under this priority is aimed at increasing the efficiency of the teaching process in basic education, and reducing numbers of early school leavers and low performing students. Better opportunities to enrol in catch-up and remedial teaching programmes will be offered. Assistant teachers will be available, as well as consultations. ICT support and skills will be improved. Children with special needs will be integrated into the general education system and labour market. Problems faced by young offenders will be tackled and action taken to help the Roma children. Better access to vocational education for at-risk groups is envisaged, as well as overall improvements in vocational guidance and career development support. Improvements in job- related skills benefiting young people are planned.

Resources and services for families, in particular large and lone-parent families:
There is an intention to further reduce the tax burden, increase benefit amounts and improve the benefit system by making it more family- friendly. Tax exemptions will be offered for the households purchasing ICT. Improvement of access to housing is planned. Health improvement measures include free lunch in primary schools, testing of pregnant women to reduce the numbers of HIV/AIDS- infected newborns and establishing two mobile palliative care teams (comprising a psychologist, a social and medical worker and chaplain). Alternative social care and social services will be further promoted, including child-care services. Support to families in critical situations will be improved and family- friendly environments and infrastructure promoted. 900 social workers in municipalities will receive wages paid partially from the central budget.

Resources and services for pensioners at risk of poverty, in particular single pensioners:
To reduce the poverty and social exclusion that pensioners are facing, basic benefit amounts will be increased, lower pensions go up, supplements to benefits introduced, non-taxable minimum incomes increased. Access to housing, health care and social services will improve. New initiatives to be introduced will promote the access to cultural events and ICT.

NRS targets and indicators still need to be strengthened, to allow measuring the effect on Latvian society (including differences between genders and regions). In combination with scarce information on timeframes, the finances allocated for implementing NRS priorities, weaknesses in target setting and use of indicators do not allow the possible impact of proposed actions to be evaluated. The overall policy measures seem realistic, but, in the light of socio- economic developments in Latvia, higher ambitions reflected in specific targets for tackling poverty and social exclusion would have benefited the NRS. Latvia addresses gender issues by stressing the need for of better reconciliation of work and family life and increased prevention of the risk of discrimination. It mentions the national action to ensure such reconciliation via a state support system to families during the child care period, when one of the parents receives a child care allowance. Considering that usually women take care of children, this provides an opportunity to retain professional qualifications and labour market competitiveness. Latvia states the importance of developing short-term alternative child care centres and nursing services. However, there is an urgent need for decisive state support to develop these services. Current action at national level to create such services is mostly limited to encouragement for employers and local governments, methodological recommendations and campaigns. The NRS also sees the need to increase the role and responsibility of the father and to develop day care centres for the elderly and disabled.

3.4 Governance

There have been efforts to achieve better governance, transparency and involvement of stakeholders. To better target the needs of social risk groups in all regions, an extensive consultation was carried out, first with local governments and NGOs. It was followed by wider public consultations. In the end 101 proposals were put forward. Involvement of relevant actors in drafting of the NRS was ensured by establishing a representative working group. The monitoring mechanism for the next implementation period will be similar to the current one: a Monitoring Committee and an implementation report. The NRS envisages (in 2007) promoting social cohesion and gender equality by mainstreaming social inclusion policy in relevant policy fields and by identifying and implementing best practices from other Member States. These possible developments are most welcome. Concerns remain as there are huge social inclusion needs in the country, numerous proposals coming from NGOs and local governments and only few priorities selected, concentrating very much on family structure and age. Concerns relate to adequate financing for social inclusion activities, especially in the period 2007-2013. Also, in preparations for the next SF planning period, Latvia acknowledges a "lack of in-depth research" on implementation of the National Action Plan on Eradication of Poverty and Social Exclusion 2004-2006. The lack of such information can undermine the success of the current NRS.

4. Pensions

Pensioner incomes are relatively close to those of the overall population (75% of those aged 0-64 in 2003) and the risk of poverty among the 65+ age group 21% (in 2005) is slightly higher than that of the general population, but the gender gap is significant (12% for men and 26% for women). The 2006 Sustainability Report assessed Latvia as a low-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005, Latvia forecasts a decrease in public pension expenditure from 6.8% to 5.2% between 2004 and 2009 and thereafter a marginal increase from 5.2% to 5.6% of GDP over the period 2009-2050, an overall fall of 1.2 p.p. in public pension spending over the period 2004-2050. Taking into account pension expenditures from the mandatory funded scheme, expenditures are projected to increase from 6.8% of GDP in 2004 to 8.3% of GDP in 2050. ISG projections for the net replacement rate show a fall from 78% in 2005 to 67% in 2030 and then increase to 72% in 2050 (gross replacement rates are projected to decline from 61% in 2005 to 51% in 2030 and then increase to 55% in 2050).

The 2006 Joint Report set out the challenges that Latvia faces, namely the necessity of reducing the informal economy, to ensure individuals are contributing to the pensions system, and to ensure that those on low incomes are protected in retirement, particularly as Latvia increases the link between contributions made and benefits paid. One key development in meeting the latter of these challenges has been the significant increase in the guaranteed minimum pension, paid to those with low incomes or shorter time spent in paid work. The national pension system was transformed into a 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. Regarding the impact of ageing on pensions, the policy objective is a balanced budget position in the long term. The government expects the decline in the rate of contributions to the NDC scheme to be compensated by increased employment and an increase in declared work. The early retirement option is to be eliminated by 2008 under present plans. The risk of poverty among the 65+ age group is currently only slightly higher 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, particularly women.

5. Health and long-term care

5.1 Health care

Description of the system: The Health Compulsory Insurance State Agency (HCISA) provides coverage to all citizens. The HCISA, through the regional sickness funds (5), purchases care for their respective populations on the basis of contractual agreements. The range of primary and secondary services included within statutory provision is determined annually in the Basic Care Programme. Primary healthcare (PHC), provided in single or joint practices of general practitioners (GPs) and nurses, plays a central role. GPs are independent contractors and act as gatekeepers to specialist and hospital care. The costs of healthcare services that are not included in the Basic Care Programme must be covered by the patient. During the interim implementation period for the PHC system, patients' first registration can take place in various outpatient institutions. Most specialist and hospital care provision is public (some state and mostly municipal). Dental practices and pharmacies have been privatised. GPs are paid on a mixed capitation basis while hospital physicians are paid on a fixed salary plus a points system. The HCISA administers the tax-based health care budget, allocating it to the regional HCISA offices, which then allocate resources to primary, secondary and tertiary care, and emergency medical assistance. Patients have to pay a patient contribution in order to receive health care, while patients' co-payments apply to partly refunded pharmaceuticals. Out-of-pocket payments including informal payments constitute a large part of private expenditure on healthcare. National policy aims at concentrating resources of inpatient care, decentralising resource allocation for outpatient care, promoting cooperation in outpatient care and establishing a network of secondary care providers according to population needs.

Accessibility: Although coverage is universal, the services available totally free of charge are limited (e.g. emergency care) and individuals experience difficulties in access. Services unavailability is a major issue in PHC led systems, due to the remoteness of healthcare facilities in rural regions. This results in significant socio-economic and regional (urban/rural) access disparities. Several categories (1/3 of the total population) are exempted from patient contributions (disabled, mental patients, children, poor persons etc). Similarly, in emergency care, which is to be developed, patients do not have to pay a contribution. In order to tackle high patient costs that hinder access to health services, the authorities have introduced a "ceiling" for patient contributions, which if reached triggers exemption of payment of additional costs. Drug reimbursement procedures have been changed but resource allocation for reimbursement remains low. In PHC, the low number of GPs, their concentration in urban centres and the low ratio of nurses to doctors has severe consequences for the establishment of strong PHC teams and thus results in long waiting times for inpatient healthcare services and problematic access (related to insufficient specialised institutions, the referral process and the GP workload and payment method). The authorities recognise that the low number of physicians and the small share of public resources allocated to healthcare hinder universal access of the population.

Quality: Special supervisory bodies in charge of quality control are the Quality Control Inspectorate on Medical Care and the Health and Working Capacity Medical Experts Commission. In order to ensure quality, medical staff have to recertify every five years.

Patients can choose their GP and reregister up to twice a year. They can choose the hospital if it is contracted by the HCISA. Patients' rights are being consolidated and patients' awareness of their rights increases annually (increased number of complaints and petitions). The authorities state that outdated technology, difficulties in certifying institutions and closure of uncertified institutions, inadequate training/qualifications of staff and lack of coordination between PHC, specialist and hospital care providers constitute remaining problems. Preventive health care is being promoted with the involvement of NGOs, extended use of ICT, a free telephone information line and population education on healthy living.

Long-term Sustainability: Total health expenditure (6.4% of GDP and 751 per capita PPP$ in 2004) is below the EU average[121]. In 2004, public health expenditure stood at 51.6% and private health expenditure at 48.4% of total health expenditure. In 2004, out-of-pocket payments represented 45.9% of total health expenditure. According to the 2006 EPC/EC projections public healthcare expenditure is set to increase by 1.1 percentage points of GDP by 2050 due to population ageing. These numbers demand attention especially with regard to population health status and facilities' need for resources. The authorities recognise the need to increase public expenditure to finance effective prevention, reduce the financial burden of care, increase hospital supplies and reimburse sickness funds. The system appears underfinanced in comparison with neighbouring Member States. To achieve cost-efficiency, hospital care dependency is being reduced with plans to use hospital resources more effectively (hospital conglomerates, better coordination and concentration) and to build new PHC centres. The number of acute hospital beds[122] is declining and several hospitals have been transformed into LTC facilities. Staff and hospital payments (introduction of a GP referral and gate-keeping role) have been shifting to create incentives for PHC provision and reduce unnecessary specialist and hospital care. The authorities are concerned about potential staff shortages due to low pay, difficult working conditions and the retirement of the majority of acting physicians. The adopted strategy aims to increase wages and provide professional guarantees with the development of health education programmes.

5.2. Long-term care

Description of the system: Long-term care is provided on the basis of individual needs' and means assessment by municipal social workers. The evaluation assesses firstly whether residential or home care is a possibility and if not refers persons to the LTC institutions. LTC is financed from state and municipal budgets. Patients have to pay for LTC unless they belong to exempted groups. Municipalities are responsible for LTC provision and finance persons without means. National policy aims to develop care provision that is adjusted to each patient needs and economically justified including alternatives to institutional care.

Accessibility: Authorities emphasise the provision of alternatives to institutional care to meet LTC needs. The municipalities are responsible for providing adequate care services to elderly and disabled people. The finances of the municipality, which are exacerbated by regional (rural/urban) disparities, determine the availability of LTC institutions and hence access. A particular concern is the long-waiting times to enter facilities. Long queues for institutional access are due to the lack of LTC alternatives for particular groups (mental patients) and to insufficient municipal resources. Although home or residential care is favoured, lack of coordination between municipal and state budgets results in a growing but poor provision of these alternatives to institutional care. The state budget co-finances day care centres for the first 4 years, after which they fall under municipal responsibility. Authorities wish to develop

[121] EU average total health expenditure: 8.87% of GDP and 2376.33 per capita PPP$ in 2004
[122] though still above the EU average (555.7 in 2003)

service apartments and group houses[123] without however allocating the necessary funds towards this end.

Quality: Quality standards and a supervisory system have been developed. A social work coordinator post has been introduced at regional level. Cooperation with the PHC centres and physicians is promoted for the continuation of care and care programmes development. The quality of LTC services is hampered by the unsatisfactory finances of municipalities, low staff salaries and poor conditions in care facilities.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.3 percentage points of GDP by 2050 due to population ageing. To provide adequate care and achieve cost efficiency, the strategy focuses on limiting the overuse of expensive institutional care and on stimulating the development of alternative care. The authorities recognise the need to address the problem of negative effects of decentralisation such as the arbitrariness of municipalities in setting up criteria for social benefits and their tendency to place patients in state care facilities to reduce the local costs. This requires the creation of vertical and horizontal control mechanisms and stronger coordination. Delays in the implementation of the administrative reforms impair the long-term sustainability of the system.

6. Challenges ahead:

To develop a coherent strategic approach to promoting social inclusion and breaking the cycle of deprivation, especially for families, including quantified targets, which take into account regional and gender dimensions;

To promote targeted active inclusion measures for the full range of vulnerable groups, by addressing the adverse effects of inflation on low and medium income groups and enhancing associated services and employment opportunities;

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

To improve general coverage of health services, geographic access to care and reduce the individual financial burden of care, address human resources issues, continue deinstitutionalisation of LTC services and increase the resources allocated to this sector;

To finalise the reform of PHC, reduce hospital care dependency and improve care coordination in order to have a properly functioning referral process in a system that emphasises PHC and preventive care;

To clarify competencies and responsibilities between the state and the municipalities in terms of financing and organisation of healthcare and LTC, in order to enhance quality and uniformity of provision and put an end to discretion and discrepancies, particularly in LTC.

[123] Separate apartments for people with mental disorders and individual support. As of 1st January 2007, the state requires a 50% co-payment.

LATVIA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	6.9	35.3	**2000**	57.5	61.5	53.8	29.6	36,0	**2000**	13.7	14.4	12.9	21.4
2002	6.5	38.7	**2002**	60.4	64.3	56.8	31,0	41.7	**2002**	12.2	13.3	11,0	22,0
2004	8.6	43.6	**2004**	62.3	66.4	58.5	30.5	47.9	**2004**	10.4	10.6	10.2	18.1
2006	11.0f	52.3f	**2005**	63.3	67.6	59.3	32.6	49.5	**2005**	8.9	9.1	8.7	13.6

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	60,3	73.1	11,7	15,8	n/a	n/a	18.8	**1995**	4.2	95	-	:	:
2000	65.0	76.0	11,9	17,6	n/a	n/a	10.4	**2000**	6	55	45	:	:
2004	67,1	77,2	12.6sp	17.2sp	n/a	n/a	9.4	**2004**	6.4	51.6	45.9	:	:

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	15.3	57.1	16.7	3.8	10.2	1.4	10.7
2004	12.6	50	24.5	3.4	10.5	1.8	9.8

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long term care
2005	24.1	:	:	:	:
2010	25.2	(-) 2.9	:	:	:
2030	33.4	(-)1.5	(-)1.2	0.8	0.1
2050	44.1	(-)1.3	(-)1.2	1.1	0.3

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	19b	22b	19b	18b	21b	27b	31b	26b	33b	11b	**Total**	6.7b
Male	18b	-	17b	18b	12b	33b	-	33b	36b	13b	**Male**	-
Female	20b	-	20b	18b	26b	23b	-	22b	30b	10b	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	12.0b	14.9b	13.4b	16.4b	**1999**	7.6	7.6	7.6	**1999**	na	na	na
2004	7.2	7.8	7.1	8.4	**2004**	4.6	4.8	4.3	**2004**	15.6	20.5	10.7
2006	7.1	6.8	7.5	6.2	**2005**	4.1	4.4	3.7	**2005**	11.9	15.5	8.2

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0,746b	0,777b	0,735b	***Aggregate replacement ratio***	0,61b	0,52b	0,7b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	Pension (or Social Security)	Current estimate(2002)	Assumption
(-)6	(-)6	(-)6	NDC, DC			100		20		

**(DB / NDC/ DC); ** (DB / DC)*

LITHUANIA

1. Situation and key trends

GDP growth in Lithuania remains one of the highest in the EU (7.8% in 2006). GDP per capita in PPS has also increased rapidly but is still just about half of the EU average (55% in 2006). The rapid GDP growth has been driven mainly by the growth of exports, productivity and internal consumption in different time periods, while employment is growing at a slower pace. The employment rate was 62.6% in 2005 (men 66.1%; women 59.4%). A sharp drop in unemployment (to 8.3% in 2005 from 16.4% in 2000) is only partly mirrored by employment growth, largely due to movement of the labour force out of Lithuania (the migration saldo was -2.6 of population in 2005, the highest in the EU). However, LT registers a relatively high employment rate among older workers (49.2%, almost reaching the EU target). Long-term unemployment (4.3%) and youth unemployment (15.7%) have fallen but remain relatively high. The at-risk-of-poverty rate[124] after social transfers was relatively high in 2004 (21%).

Life expectancy is low for men (66.3 years; 77.7 years for women in 2004). Owing to high emigration, ageing and a low fertility rate (1.27 in 2005) the old-age dependency ratio (22.5 in 2005) is projected to double by 2050 (44.9). Total expenditure for social protection as a percentage of GDP (13.3% of GDP in 2004) was amongst the lowest in the EU and yet shows a declining trend (although the total amount is increasing in absolute terms). Pensions (47.3%) and health care expenses (29.5%) claim the biggest shares of social expenditure.

2. Overall strategic approach

The overall strategic approach to social protection and social inclusion is to promote social integration through employment of all those able to work and to ensure efficient and adequate social protection for those who are unable. The National Strategy Report on social protection and social inclusion identifies five key challenges: (1) to increase the activity rate of vulnerable groups; (2) to use the means available to the social protection system more efficiently and fairly; (3) to ensure the rights of children and youth; (4) to create more possibilities of social integration for vulnerable groups; and (5) to mainstream gender equality. Lithuania has addressed all three overarching objectives of the OMC.

On social cohesion, Lithuania aims to develop adequate, accessible and efficient social protection systems and social services. Another specific focus of the National Strategy Report is on support to families, children and youth. There are also some elements of gender mainstreaming. The streamlined National Strategy Report has become more focused in terms of priorities but lacks analytical background for the various initiatives and multifaceted strategy, most of the targets are not measurable, and there are very few arrangements for monitoring and none at all for evaluation.

[124] Following the implementation of EU-SILC in 2005, the values of all indicators related to income and living condition (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data. The most important factors having an impact on the poverty indicators between HBS 2004 and EU-SILC 2005 are the derogations on income from employment in kind and social benefits in kind.

The National Strategy Report interacts with the Lisbon objectives. Its focus on employability and activation of vulnerable groups, and the declared intentions to increase the average exit age from the labour market and to improve social, health and long-term care services should contribute to one of the key Lisbon challenges for Lithuania on increasing the supply of the labour force. Equally, social inclusion policies are presented as an integral part of the Lithuanian National Reform Programme. However, effectiveness of this mutual interaction could be further strengthened by addressing attractiveness of employment for vulnerable groups.

Efforts have been made to promote good governance. A partnership-based group was established to draft the National Strategy Report and a similar group is intended to be used for monitoring the Strategy. Those groups could benefit from strengthening of their administrative and representative capacity and more transparency. The significance of mainstreaming of social policies is recognised but the concrete tools are still to be developed.

3. Social inclusion

3.1. Key trends

Relative poverty after social transfers was relatively high in 2004 (21% and 16% in the EU) the threshold value being the lowest in the EU[125]. The at-risk-of-poverty rate before social transfers was at the EU average (26%) indicating lower efficiency of the social benefits. Although the population is getting richer as a whole, gains in wealth are unevenly spread and the income inequalities were considerably higher than the EU average (6.9 and 4.9 in the EU). National statistics reveal the increasing rural/urban divide.

The at-risk-of-poverty-rate is considerably higher among certain population groups, such as the unemployed (63%), single parents with dependant children (48%), families with three and more children (44%), single adult households (32%, higher for men) and tenants (33%). The in-work poverty risk was also relatively high in 2004 (10% and 8% in the EU). Working poor comprised 28% of the total at risk of poverty population. One third of the Lithuanian population is rural. National statistics reveal that the rural population was three times more at risk of poverty compared to the urban population of the five largest cities in 2005 and highly dependent on social benefits (29% of the total disposable income in 2005).

The at-risk-of-poverty rate for children is higher than the average for the population as a whole, standing at 27% after and 34% before social transfers (19% and 34% in the EU). 66% (57% in the EU) of jobless households had dependent children in 2004. The NRS reveals that the highest risk of poverty is amongst children 3-5 years old. Early school leaving was relatively low at 9.2% (15.2% in the EU) in 2005 (6.2% female, 12.2% male). The educational attainment level was relatively high (85.2% of 22-year olds had at least upper secondary education in 2005).

3.2 Key challenges and priorities

The social inclusion strand of the National Strategy Report focuses on four national priorities for action: increasing labour market participation; improving access to quality services; eliminating child poverty and enhancing assistance to families and tackling disadvantages in education and training. The relevance of the selected priorities is indisputable and the Strategy

[125] 1235 EUR in 2004

is more focused thanks to the prioritisation. However, the analytical justification for their choice over the other three priorities is not given. To some extent that may be due to the broader nature of the selected priorities and their partial coverage of the ones left aside (such as housing). The integration of a relatively small but socially disadvantaged Roma community is not addressed.

In the 2006 Joint Report, two challenges were identified for Lithuania. The challenge of developing and implementing a comprehensive regional policy to tackle regional imbalances and rural poverty is recognised in the National Strategy Report but the policy response has remained fragmented and lacks prioritisation, clear targets and guidelines for implementation, monitoring and evaluation. National statistics reveal an increasing rural/urban divide. Limited progress has been achieved as regards the second challenge on better governance which is analysed in section 3.4.

3.3. Policy measures

The NRS identifies a number of measures under the four selected priorities which can greatly contribute to reducing poverty and social exclusion if properly implemented. However, it is difficult to judge their adequacy due to the insufficient analytical background presented for the various measures and the social situation of certain vulnerable groups and the lack of an assessment of the impact of previous policies (which is expected to be done later). Many of the measures are target group and activity specific and the multifaceted approach is therefore fragmented. The scope of the many measures is not defined and there are very few measurable targets. There is therefore a risk of limited evaluability and fragmented management. The measures will be mainly funded from the national budget and Structural Funds (ESF, ERDF and EAGGF). The list indicating the resources allocated to measures has not been submitted.

The measures under the first priority, *to increase labour market participation*, are intended to serve two important tasks, namely to promote social integration through quality employment and activation of the disadvantaged groups and to increase the labour supply in the context of declining availability of the labour force. While there is an improvement in the variety of the activation measures and the coverage of the targets groups, the focus on the efficiency and quality management of the measures is not sufficient. The entrepreneurship measures are intended to promote self-employment of youth, disabled and unemployed persons, and the microcredit system which is currently under development can contribute greatly to that if provided with adequate resources. Promotion of subsidised employment is foreseen for the most vulnerable groups. Specific support for the rural population at high risk of poverty is basically limited to the EAGGF measures, which include various subsidies to farmers and support for the diversification of rural economies. The measures under the first priority should take better account of the relatively high in-work poverty most relevant to the disadvantaged groups and the high share of working poor in the overall at-risk-of-poverty population. The attractiveness of employment, support for the transition to work as well as remaining and progressing in employment should be further addressed. As regards the funding of these measures, the ESF will be an important financial instrument for the ALMP.

The second priority, *to improve access to quality services*, covers measures addressing social, legal and cultural services. The main focus is on social services, which reflects the new Law on Social Services in force since July 2006. The quality of social services should be improved by setting standards for all providers and creating quality control mechanisms. As regards the provision of services, the disabled receive particular attention. Regional availability and

variety of social services should be increased by the creation and implementation of the Programme for Development of Social infrastructure 2007-2009. Advanced social services can contribute to the first priority of increasing labour market participation through family/working life reconciliation measures and provide better social integration possibilities for those incapable of working. This link is obvious but not elaborated. The provision of some social services is to be supported by the ESF.

The measures under the third priority, *to eliminate child poverty and enhance assistance to families*, focus on the prevention of poverty and social exclusion among children and support for families with children to break the intergenerational transmission of poverty. In many cases this is still at the conceptual level. The National Programme on assistance to parents before and after child birth until the start of school (to be prepared by 2007) can have a significant impact on the well-being, health and education of preschool age children, if properly implemented and accessible to all. The strategy on decentralisation and non-institutionalised child care is being developed. The planned development of day care centres for children and youth and specific funding of projects presented by disadvantaged youth can increase their empowerment. The balance between planned monetary and in-kind benefits for families would need further elaboration in respect of potential work disincentives. Important plans for housing are announced as well.

The measures under the fourth priority should help *tackle disadvantage in education and training*. Many measures under this priority are of a mainstream nature such as the development of vocational training and LLL systems. Specific measures are also tailored for children from families at risk. Preschool age children should benefit from the education measures of the programme on the assistance to parents before and after child birth until the start of school, already mentioned under the third priority. Development of the specific programme to prevent non-attendance of school is planned. Students should benefit from the intended revision of the law regulating funding of studies. An important set of measures aimed at the development of civil society is also presented.

3.4. Governance

The Ministry of Social Security and Labour has overall responsibility for development and implementation of the NRS. The Ministry was assisted in the drafting process by a joint task group comprising representatives from governmental institutions, social partners, NGOs and the Association of Municipalities. It is also planned to establish a wide partnership-based NRS Monitoring Group to take over the tasks of the current NAP Monitoring Group during the period 2006-2008. While the strengthening of partnership is a very positive development, the criteria for the stakeholders' selection in the groups and their roles are not defined, while the activities of the groups lack visibility. This undermines to the groups' representative capacity to some extent. More active involvement of the most senior level government officials (for ensuring political commitment), social partners (especially regarding measures to increase labour market participation) and municipalities (having a key role in addressing regional imbalances) would be beneficial.

The National Strategy Report contains strong statements of intent to further develop the existing social assistance information system and e-services in the social sector. However, no specific measures have been planned to strengthen the capacity for monitoring and evaluating implementation of the Strategy or to enhance visibility of the social inclusion policy, although these areas were highlighted as a key challenge for Lithuania in the 2006 Joint Report. It is also important that the intentions to mainstream social inclusion policies result in concrete

measures such as impact assessment of legislation on poverty and establishing principles for adequate and effective funding.

4. Pensions

Pensioner incomes in Lithuania are close to those of the overall population (81% of those aged 0-64 in 2004). The poverty risk of the elderly (17% in 2004) is slightly lower than that of the general population, but the gender difference is significant (for older men it was 6% and 22% for women).
The 2006 Sustainability Report assessed Lithuania as a low-risk Member States as regards the sustainability of public finances. According to the AWG projections of 2005, Lithuania is projecting a moderate 1.9p.p. of GDP increase in public pension expenditure (3.7% of GDP when taking into account the funded tier of the statutory scheme) over the period 2004-2050 The State social insurance fund is expected to be in balance or surplus up to 2020. Thereafter, a deficit is anticipated, peaking at 0.7 % of GDP in 2030. ISG projections for net replacement rate show a slight decline from 55% in 2005 to 51% in 2050 (gross replacement rates are projected to increase slightly from 40% in 2005 to 42% in 2050).

The challenges identified in the 2006 Joint Report, raised issues of increasing employment and ensuring adequacy, as pension incomes especially social assistance pensions, are low in comparison with other Member States. Recent increases in the social assistant pension may go some way towards addressing this last challenge. However future adequacy should be closely monitored.

Since the 2004 reform, the State-managed statutory pay-as-you-go pension scheme has been supplemented with a privately managed funded pension scheme. This scheme cover gainful employment (although significant portions of the population are not covered), while a social assistance pension provides a minimum retirement income for those not entitled to a social insurance pension, including farmers and some categories of 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 raise the retirement age (including equalising statutory retirement ages for men and women) would contribute to both 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 with the general trend.

5. Health and long-term care

5.1. Health care

Description of the system: The Lithuanian National Health System (LNHS) provides healthcare services organised at three levels (municipal, county and national). Provision is decentralised and mostly public. Completely or partly free care is provided to the compulsorily insured population through the statutory health insurance system, which covers all contributing residents and certain groups (children), achieving 99% coverage. Primary care (PHC) is delivered in health centres, GPs' own surgeries, community posts, ambulatories and polyclinics by a variety of staff. GPs have a gate-keeping role (with an extra cost for non-

referral visits) with regard to specialist and hospital care but many specialist consultations take place without a referral. Specialist ambulatory care is provided in polyclinics and hospital outpatient departments. Inpatient care rests with general and specialised hospitals. Health care providers operate on the basis of contract with the statutory health insurance funds. Private provision of outpatient specialist care, notably by public hospital specialists, is growing. GPs are paid a salary, although an additional fee-for-service payment for preventive care and specialist services is being introduced. Whereas PHC is financed on a capitation basis according to the number of GP referrals, secondary care, in-patient and other services are financed on a capitation basis according to the number of residents and a rural/urban model. The LNHS is financed by compulsory insurance contributions, taxation revenues (from the state budget and municipalities) and direct patient payments to service providers. Statutory health insurance funds are transacted through the State Patients' Fund (SPF) and its regional branches: the Territorial Patients' Funds (TPFs). TPFs contract with care institutions for service provision and reimburse the insured (medication and added costs). Funds are allocated to TPFs on the basis of the proportion of residents in the county and service use. Co-payments apply for a variety of services (visits, hospital stays, drugs, dental services) and informal payments are common. The authorities wish to promote better accessibility to healthcare and social services, particularly in rural areas.

Accessibility: Free emergency care is provided by law to the entire population. Although services and population coverage is high some regional inequalities in distribution of health care services exist: health care facilities are concentrated in the major cities, certain specialties are lacking in rural areas and there are differences in hospital capacity. Also, out-of-pocket payments are high (24.2% of total health spending in 2004), particularly for pharmaceuticals, while informal payments appear to be decreasing. The authorities acknowledge that stronger PHC (including use of private providers) and better coordination of health care institutions can bring patients better access to different types of care. The financing structure aims to address regional inequalities of access by targeting funding according the medical needs of the population. Although the number of GPs and of PHC units has increased substantially, the system is still under-resourced and oriented towards acute and hospital care. The authorities recognise that the sector suffers from a lack of resources as well as a lack of cooperation between primary care, hospital and other services. Reforms are aimed at developing private provision (insurance and care institutions).

Quality: The authorities have identified quality limitations, including the poor conditions of buildings and equipment. TPFs carry out quality controls. The authorities are seeking to introduce modern medical technologies and to improve the qualifications and remuneration of staff. An information system based on comparable indicators is under development. Patients are free to choose the PHC facility, the GP within this and the hospital provider. Lithuania aims to improve the legal framework for quality assurance of the system. In addition to large-scale immunisation and vaccination programmes, introduction of the 2005 WHO International Health Regulations and intensification of preventive healthcare are planned.

Long-term sustainability: Total healthcare expenditure (6.5% of GDP and 816 per capita PPP$ in 2004) is below the EU average (8.87% and 2376.33 in 2004) despite having increased throughout the 1990s. The share of public health care expenditure[126] has decreased and stood at 75.4% in 2004 with private health expenditure representing 24.6% of total health expenditure. Out-of-pocket payments in 2004 represented 24.2% of total health expenditure. According to the 2006 EPC/EC projections public health care expenditure is set to increase by

[126] As a percentage of total health care expenditure

0.9 percentage points of GDP by 2050 due to population ageing. The authorities expect public expenditure to increase in view of economic growth while ageing and demographic changes are seen as a challenge to service provision and sustainability. The authorities have identified the clear lack of resource allocation to the healthcare system, and its orientation towards hospital and specialised provision, as a problem. In addressing these challenges, the reforms aim to reduce the weight of specialist and hospital care while strengthening PHC, outpatient care and day case surgery, reducing length of hospital stay and increasing bed use (which has been rising). The number of acute hospital beds in Lithuania has decreased over time, but is still above the EU average127. The development of quality healthcare human resources is seen as a priority. Although the increased number of GPs has contributed positively to the development of PHC, staff migration remains a serious problem and the authorities have put a staff retention policy in place. Improving the health status of the population and tackling health inequalities through an active health policy based on promotion, prevention and inter-sectoral collaboration is the adopted strategy. Developing an integrated and efficient PHC infrastructure as well as the integration of various entities dealing with LTC, at municipal level constitute a priority for the authorities.

5.2. Long-Term Care

Description of the system: Social care institutions vary in nature and financing. There are county, municipal and non-governmental institutions financed by the state (county), municipal and private (municipal and welfare funds) budgets respectively. LTC is provided in in-patient institutions and nursing services are provided both in in-patient and out-patient institutions. Funding for social services is provided by the municipal budgets and target subsidies from the state budget. Some social care is provided in nursing hospitals. More recently community-based non-institutional care has started to develop, including home nursing, home assistance and housekeeping services provided by carers and social workers. Most community care is, however, provided by families and relatives. Developing long-term care services, currently deemed insufficient, constitutes a priority for the authorities.

Accessibility: Despite the fact that the number of long-term care beds increased by 12.2% in 2004 compared to 2002, there are still problems of access, with an underdeveloped structure for care at home or within the community. Queuing for institutional care is still the norm. In addressing these issues, the authorities are looking to develop nursing services (payment, nurses' qualifications) and promote home care. Additionally, legislation is in preparation for integrating social and healthcare services in order to ensure access to LTC for residents. Although legally there is no discrimination in access to LTC services, the uneven location and provision of LTC institutions creates geographical inequalities. The allocation of subsidies to municipalities for the provision of LTC has been formalised, allowing municipalities to purchase services even in localities that lack the necessary services. In addressing this, new legislation provides for the establishment of a prior individual needs assessment for the provision of LTC as well as validating and formalising new types of LTC (day care, palliative care).

Quality: The aim is to move away from institutional care towards home-provided care. Targets for bed reduction in institutional care, development of nursing services, establishment of universal quality standards and licensing are legally entrenched and will take effect in January 2007. The establishment of private social care institutions and of a private market in LTC is being encouraged.

[127] 579.9 per 100.000 inhabitants

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.4 percentage points of GDP by 2050 due to population ageing. In addition to the (needs based) budget allocated from municipal sources, out-of-pocket payments will be calculated from the individual's various resources (property has been added). Individuals are required to contribute partially towards the costs of their LTC. The authorities view the development of appropriate day social care services and home care as necessary for reducing the financial costs of LTC institutions.

6. Challenges ahead

To combat child poverty, in particular by focusing on assistance to parents of pre-school age children and by opening up educational opportunities;

To combat rural poverty by promoting active inclusion, enhancing local development opportunities together with local partners and accessibility of quality social services;

To improve governance by developing, in partnership with all the relevant stakeholders, monitoring, evaluation and mainstreaming systems;

To ensure wider coverage of the population by the statutory pension system and longer working lives;

To ensure the availability of adequate pensions from the modernised pension system, as well as address transition costs beyond 2020;

To reinforce PHC, address geographic disparities in PHC supply and reduce the financial burden of care for vulnerable groups, enhance the provision of community long-term care services and support to informal carers, develop a human resources strategy;

To improve basic quality of facilities, implement information and monitoring systems and allocate additional resources to the sector, whilst ensuring more efficient provision (reduce high dependency on specialist and hospital inpatient care and improve the population health status through effective health prevention and disease prevention), given the low population health status and access problems.

Lithuania: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.1	37.9	**2000**	59.1	60.5	57.7	25.9	40.4	**2000**	16.4	18.6	14.1	30.6
2002	6.9	41.9	**2002**	59.9	62.7	57.2	23.8	41.6	**2002**	13.5	14.2	12.8	22.5
2004	7.3	49,0	**2004**	61.2	64.7	57.8	20.3	47.1	**2004**	11.4	11,0	11.8	22.7
2006	7.8f	55.0f	**2005**	62.6	66.1	59.4	21.2	49.2	**2005**	8.3	8.2	8.3	15.7

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	63.3	75,0	12.8	16.8	n/a	n/a	12.5	**1995**	4.9	86.3	-	:	:
2000	66.8	77.4	13.6	17.8	n/a	n/a	8.6	**2000**	6.5	69.7	26.1	:	:
2004	66.3sp	77.7sp	13.5sp	18sp	n/a	n/a	7.9	**2004**	6.5	75.4	24.2	:	:

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	15.8	47.8	29.8	1.8	8.8	3.4	8.4
2004	13.3	47.3	29.5	1.6	8.8	2.6	10.2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP)Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	22.5	16	6.7	3.7	0.5
2010	23.4	-0.7	:	:	:
2030	33.4	0.3	1.2	0.7	0.2
2050	44.9	1.4	1.8	0.9	0.4

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	21b	27b	19b	19b	17b	28b	30b	28b	31b	13b	**Total**	6.9b
Male	20b	-	18b	20b	6b	31b	-	32b	33b	11b	**Male**	-
Female	21b	-	19b	18b	22b	26b	-	24b	30b	13b	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	8.8	9,0	8.5	**1999**	5.3	6.1	4.4	**1999**	na	na	na
2004	6.5	8.1	8.3	8,0	**2004**	5.8	5.5	6.2	**2004**	9.5b	11.6u	7.4u
2006	5.3	7	7.2	6.9	**2005**	4.3	4.2	4.5	**2005**	9.2	12.2u	6.2u

**: excluding students; b: break in series; u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.81b	0.90b	0.76b	***Aggregate replacement ratio***	0.47b	0.50b	0.45b

Change in theoretical replacement rates (2005-2050) - source ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	Current estimate (2002)	Assumption
-4	2	2	DB and DC	/	/	83	/	26	/	/

** (DB / NDC/ DC); ** (DB / DC)*

LUXEMBOURG

1. Situation and key trends

The Luxembourg economy is still registering a much higher growth than neighboring countries (3.6% of GDP in 2004). After noticeable decreases in 2002 and 2003, there has been healthy growth in internal employment (2.3% in 2004, 3% in 2005), particularly among women. Internal unemployment, while relatively low from the outset, has fallen only moderately (5.1% of the working population in 2004 and 4.5% in 2005). The overall employment rate has only improved marginally since 2000 (63.6% in 2005, close to the EU average but still well below the Lisbon targets). The situation is especially bad regarding older workers (31.7% in 2005 - in spite of recent increases -, which is way below the EU target of 50%) and among young people (24.9% in 2005; 36.8% in the EU). The risk-of-poverty rate is low (13% in 2004128), but nearly identical to the EU average among the children from 0 to 17 years (19% as against 20%). Life expectancy (75 and 81 years for males and females in 2003) is close to the EU average. The level of expenditure on social welfare was equal to 22.6% of GDP in 2004. Total health expenditure was 6.9% of GDP in 2004, below the EU average, in spite of a steady increase in recent years, while per capita spending on health in PPP$ (3190) is the EU's highest. Luxembourg is expected to experience major demographic developments over the coming decades, due in particular to net migration inflows among the highest in the EU-25. The old-age dependency ratio (21% in 2004 and 36% in 2050) is already somewhat lower than the EU average of 24% and is projected by 2050 to become by far the lowest in the whole European Union (36%, compared to 52% as expected for EU as a whole).

2. Overall strategic approach

Emphasising the need to adapt the social inclusion and protection system (owing to the evolution of the family model, the increasing share of crossborder workers and the growth in unemployment) and the will to maintain the viability of this system, the strategic approach chosen reaffirms five principles of system management: (1) free access to services, appropriate level of benefits, promoting social cohesion, (2) quality of the services and individualised follow-up, 3) financial sustainability of the social protection system, (4) priority to integration through work and (5) maintaining the social dialogue.

Following consultation of stakeholders, six policies are presented, four of which (called "priority policy objectives", hereafter: "objectives") cover the Inclusion chapter: restoring full employment; preventing school failure and increasing the level of skills; reconciling family life and working life; and access to housing. The two additional policies are: "access to quality health care" and "maintaining a viable and sustainable statutory pension scheme".

The strategic choices and the objectives (although the issue of access to housing did not appear in the NRP) are in line with the Lisbon strategy, with the priorities established in the Luxembourg NRP and with the challenges formulated in the 2006 JR. With respect to governance, the system presented provides the means for a wide consultation process, enabling the stakeholders to propose measures to the Government and taking the local dimension (municipalities) into account.

[128] SILC(2005) income reference year 2004

The gender dimension is examined throughout, with special reference to an objective linked to the question of equality of men and women and the participation of women in working life.

The report does not always establish an explicit linkage between the diagnosis formulated in the first part (evaluation of the situation) and the selected policies, nor between the strategic approach and these policies.

3. Social inclusion

3.1 Key trends

In 2004[129], the at-risk-of-poverty rate in Luxembourg was 13%, well below the EU25 average (16% in 2004). Luxembourg reports a growing unemployment (from 2.7% in 1998 to 4.5% in 2005), especially among young people (from 6.9% in 1998 to 13.7% in 2005) and, to a lesser extent, the long term unemployed (from 0.7% to 1.2% between 1999 and 2005). For reasons which should be examined, the at-risk-of-poverty rate is much higher among children: (19% in 2004 against 11% for the rest of the population). The percentage of early school leavers grew slightly between 2004 and 2005 (+ 0.4 pt); one out of 5 early school leavers still becomes inactive. The retention rate for young people between 15 and 24 years old remains much lower than in the EU (40.8% as against 56.4% in 2000; 44.4% as against 60.5% in 2004). To face the problem of current and future internal unemployment, the Luxembourg authorities aim to mobilise their "residents' reserves", while the share of cross border workers in the internal labour market keeps increasing (from 29.8% in 2000 to 35.1% in 2005). The priorities are therefore to encourage labour market inclusion of women, young people or people over 55 years old (the latter also to reinforce the viability of the retirement system), and also to strengthen the fight against long-term unemployment. Luxembourg wants to combat intergenerational transmission of poverty by raising the skills level as from the earliest age, improving educational performance and offering an alternative to early school leavers; it also aims to tackle child poverty in particular by developing child care facilities to encourage parents' participation in the labour market.

3.2 Key challenges and priorities

The strategic approach related to inclusion policies is included in the 5 general "priority policy objectives" presented here above.. The four objectives (restoring full employment; preventing school failure and increasing the level of skills; reconciling family life and working life; and access to housing) build to a large extent on the 2006 challenges: by focusing on residents furthest from the labour market and on a policy aimed at maintaining employment, the higher rate of unemployment has been taken into account; on the other hand, the effort to raise the employment rate among the over-55 is too briefly considered, as the measures presented are merely statements of intent, similar to those formulated in the 2005 NRP. The evolution of childhood poverty should, however, be addressed in more detail and the fourth objective should be more clearly focussed on populations in need.

The systematic fixing of indicators, for each objective, as well as the description of the envisaged follow-up methods must be welcomed. Moreover, the effort by Luxembourg authorities to concentrate on a restricted number of major issues is worth mentioning, too; but this selection of objectives, although appropriate, should be explained in more detail.

[129] SILC(2005) income reference year 2004

The links with the ESF are simply mentioned twice, regarding the objective "Restoring full employment" and the objective "Reconciling family life and working life".

3.3 Policy measures

Most of the policies implemented aim to encourage maintenance on (or entry or return to) the labour market of people excluded or likely to be excluded: women finding it difficult to work because of care responsibilities, older workers put prematurely into retirement, young people leaving school without qualifications. They mainly target groups particularly at risk of poverty (single-parent households, large families, jobless households, young people without qualification) and aim to anticipate to a certain extent the risks of persistence of poverty (children under 15). However, certain groups of marginalised persons with social problems regardless of professional inactivity, e.g. drug addicts are treated in specific sectoral plans. Access to basic services and infrastructures is primarily the subject of the objective relating to access to housing (tenants also tend to be particularly at risk of poverty).

The measures submitted for each of the 4 objectives are consistent and show continuity with the previous report. New measures are limited following up on the objective "Restoring full employment". The report rather tends to confirm the targeting at persons furthest from the labour market and the will to apply the common labour law scheme to them (the draft law on "social unemployment" is redefined from this perspective). The report also develops the direction taken by the tripartite agreement of April 2006, which decided to give priority to measures promoting maintenance in employment. The rest of the measures are directed at young people and over-55 year old; for the latter, the ambitions (at the level of simple intentions) seem insufficient, while the average age of labour market exit fell between 2003 and 2004 and the rate of employment of older workers improved only marginally. "Preventing school failure and increasing the level of qualifications" is implemented by several measures, some of which are new: this is the case of the rapidly described process of identifying pupils at risk (leaving school before the end of compulsory education, or after but without qualifications) and of a project to take these in charge ("voluntary guidance service"). While more than one young person out of 5 having left the school system prematurely remains inactive, coercive measures previously envisaged are abandoned in favour of a new approach, where assistance and incentive prevail: a new draft law tabled in June 2006 provides for aid for training people under 18 years old and for paying a training allowance to people between 18 and 25 years old. According to the latest OECD study on education in Luxembourg, the performance gap between children of nationals and children of immigrants has been reduced at primary-school level: several measures taken in recent years have helped limit the adverse effect of immigrant or lower socio-economic backgrounds on PISA results to around the OECD average. But in secondary education, some problems still remain (which are not always questioned in the report) like the high proportion of pupils in vocational training channels (45%) or the low share of certified teachers (75%). "Reconciling family life and working life" is pursued by continuing or developing the actions listed in the last Inclusion NAP (and in the NRP): a new draft law is to organise parental assistance work. Within the framework of the objective "Access to housing", the Plan on housing is to be re-examined (establishing the legal framework for State assistance to the municipalities), as already described in the 2005 NAP but not specifically devoted to low-earnings populations; the report also presents a policy programme providing instruments for land price control, one of the measures of which is targeted at low-cost housings.

3.4 Governance

In order to prepare and draft the report, the Government and its acknowledged stakeholders (Ministerial Committees and NGO involved in the inclusion policy) met regularly between December 2005 and June 2006. The authorities involved in the coordination and implementation of the social inclusion policies are presented. But the efficiency of the whole mechanism should be evaluated further.

For each objective, reference indicators are specified together with, in general, the targeted figures ("Lisbon targets"); however, the indicators relating to the increase in places in childcare facilities are not harmonised with those specified in the 2005 NRP. But in spite of the specification of indicators and the presence of clearly identified steering committees, the report does not give enough quantitative estimates of the populations targeted by each objective and measure nor does it provide details of a fully adapted monitoring system.

4. Pensions

On the basis of 2004 figures, older people enjoy a living standard among the highest in EU-25 and virtually equal that of the general population, while the poverty risk among older people (7%) is significantly lower than for the population below the age of 65.

The 2006 Sustainability Report assessed Luxembourg as a medium-risk Member State as regards the sustainability of public finances, owing in particular to the high cost of ageing and despite the current strong budgetary position. Luxembourg is facing substantial budgetary pressures due to ageing populations. According to "Ageing Working Group" 2005 projections, public pension expenditures show a large increase of 7.4 p.p. of GDP, from 10% of GDP in 2004 to 17.4% of GDP in 2050, if according to ISG projections, the theoretical replacement rate will remain at current levels (about 90% in gross terms and 100% in net terms).

The 2006 Joint Report highlighted the fact that the Luxembourg pension system is based on a strong political consensus and ensures a high level of adequacy, but that its financial sustainability would be reinforced by an increase in employment rates among the resident population and in particular women and over-55 year olds.

The financial sustainability of the pension system depends not only on relatively high rates of economic growth in the future, but also on a very large contribution to the Luxembourg economy and pension schemes by non-resident workers. Despite the existence of a reserve fund, the fact remains that in the event of a decline in the employment of non-residents, an ageing population would then have to finance not only resident pensioners' pensions, but also those of a large number of pensioners outside Luxembourg.

5. Health and long-term care

5.1 Health care

Description of the system: Compulsory health insurance provides coverage to 99.9% of the population. The standard contribution rate is set by the Union of Sickness Funds (UCM) which, together with nine other profession-based funds, manage and provide statutory health insurance. Civil servants and employees of European and international institutions have their own health insurance funds. Health care providers are usually contracted out. Any level of

care provision that is chosen is eligible for reimbursement. Preventive services are the responsibility of the Ministry of Health. Healthcare is provided by public services, private practitioners and not-for-profit associations paid from the Ministry's budget. Luxembourg imports all pharmaceutical products and bases most retail prices on those determined in the country of origin. The healthcare system is mainly publicly financed through social health insurance. Health professionals' payments are based on a fixed statutory fee level (payment for a service which is then reimbursed), whilst hospitals are financed through annual budgets negotiated with the UCM. 75% of the population purchases complementary health insurance coverage, in order to pay for services that are categorised as non-essential under the compulsory schemes. Generally, however, complementary health insurance has always played a limited role. The national strategy is focused on the financial sustainability of the system and is aimed towards cost containment and better use of resources. Additionally, common drug and technology purchasing is envisaged (single hospital purchasing centre) with a view to achieving efficiency gains and moving towards a higher use of generic medicines.

Accessibility: Irrespective of someone's income, all insured persons benefit from the same service coverage and the same reimbursement conditions. For vulnerable groups, however, the sickness insurance funds provide both favourable rates of reimbursement and pre-financing of healthcare services. Ongoing extra investment in capacity is aimed at improving general access to health services. In terms of invalidity, a new framework facilitates appropriate resource allocation and service provision for the incapacitated (choice between sickness insurance, invalidity pension and professional training), thereby improving the management of long-term work incapacity.

Quality: The establishment of best practice guides and scientific recommendations has helped in assuring a high level of quality in health care. In terms of quality assurance, there are several consultative bodies that evaluate and monitor the quality of the services provided (a quadripartite committee, a scientific council, a standing hospital committee). There is a free choice of provision for the insured and providers must comply with the fixed set of fees for services. The authorities are encouraging hospitals and healthcare units to establish synergies and to collaborate with other healthcare providers at the wider regional level. The aim is to increase the quality of care through the creation of specialised care centres. In order to maintain a good standard of quality, health professionals have signed agreements with the UCM aimed at improving their qualifications through their participation in seminars (continuous training).

Long-term sustainability: Total health expenditure was estimated to be 6.9% of GDP in 2004. Public sources were estimated to account for 90.2% of total health expenditure in 2004, with the private share of total health expenditure standing at 9.8%. Out-of-pocket payments in 2004, represented 6.8% of total health expenditure In the same year, total healthcare expenditure per capita calculated in PPP$ was 3992. According to the 2006 EPC/EC projections, public health care expenditure is set to increase by 1.2 percentage points of GDP by 2050 due to population ageing. The concentration and grouping of low-activity care units is planned with a view to more rational and efficient use of these resources. Extensive hospital planning, based on periodic evaluations, makes for efficient use of resources and the non-proliferation of specialised services in more than one hospital or health centre. The reforms in the 1980s and 90s focused mainly on attaining financial stability for the sickness funds. The main measures introduced during this period were an increase in co-payments, the establishment of the Union of Sickness Funds' reserve for dealing with any budget imbalance and the transfer of responsibilities from individual sickness funds to the UCM. In 1995 a change in the payment system was introduced in response to spiralling hospital costs: a tariff

scheme with global prospective budgets negotiated annually between the individual hospitals and the UCM. Measures aimed at financial stabilisation and controlling costs have been introduced. They relate to evaluating doctors' prescription behaviour, controlling antibiotic overuse, encouraging the use of generics, as well as hospital collaboration and the designation of centres of excellence, the development of new management practices and centralised procurement of medicines. Strong health promotion and prevention policies (e.g. screening, immunisation, AIDS, TB, nutrition and physical activity campaigns), pursued on a multidisciplinary basis, are intended to improve the long-term financial sustainability of the system.

5.2 Long-term care

Description of the system: Long-term care has been identified by the authorities as a risk to the social security system. As a result, LTC services are provided in a social security framework. A compulsory social contribution based on various revenue sources has been established allowing access to long-term care services on the basis of need, independently of the ability to pay. In the case of home care, there is a possibility for the recipient of care to receive a cash payment that would allow the person to receive care from an informal carer. The cash payment is equivalent to half the cost of the service provided. This cash payment is regulated and limited to 10.5 hours a week for the informal carer in order to guarantee follow-up by the formal care services. The informal carers also benefit from specific insurance coverage. Palliative care is under the responsibility of the hospitals. The authorities intend to promote palliative care outside the hospitals and to ensure that it is financed through the social security system.

Accessibility: A comprehensive and obligatory (insurance) framework is in place for long-term care. For persons in need of additional care who are not covered by the dependence insurance, the state provides a form of co-payment (reimbursing the difference between the payment by the beneficiary and the actual cost of additional care) to the providers of these additional services, since the costs incurred by the beneficiary of these additional services are determined by a social tariff.

Quality: For the elderly, greater emphasis has been placed on geriatric care, gerontology education and the establishment of requirements for facilities and staff. In order to improve the quality of the long-term care provided, measures regarding the definition of clinical practice recommendations based on assessment and evidence-based studies have been introduced. In palliative care, specific training programmes have been introduced in order to meet the changing needs and demands in this specialised area.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.6 percentage points of GDP by 2050 due to population ageing. Preventive care programmes have been strengthened and are co-financed by the social security system. In addition to the fund reserve (which cannot be lower than 10% of annual expenditure for the LTC scheme), there is a 1% contributory rate (1.4% since January 2007) applicable to the total income of the insured population and a state contribution in order to maintain the financial sustainability of the LTC scheme.

6. Challenges ahead

To ensure better control and coordination of the inclusion strategy and to improve the mechanism for monitoring and evaluation;

To perform an analysis of the social implications of the relatively high level of unemployment in general and of long term unemployment;

To raise the employment rate of the resident young people and of the resident population aged 55-64 and to address the long-term sustainability of the pension system so as to make the system sustainable also in circumstances of low economic growth.

To address the financial sustainability of LTC and improve the quality of LTC services through the integration of the various LTC services with health care services in order to ensure continuation of care at home and in the institutional setting.

To limit the overuse of antibiotics and improve the use of generic medicines (quality and financial sustainability).

Luxembourg: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	FeMale				Total	Male	FeMale	
2000	8.4	222.0	**2000**	62.7	75.0	50.1	31.9	26.7	**2000**	2.3	1.8	3.1	7.1
2002	3.8	220.7	**2002**	63.4	75.1	51.6	31.2	28.1	**2002**	2.7	2.0	3.7	7.7
2004	3.6	240.8	**2004**	62.5	72.8	51.9	23.3	30.4	**2004**	5.1	3.7	7.1	16.8
2006	5.5f	257.1f	**2005**	63.6	73.3	53.7	24.9	31.7	**2005**	4.5	3.5	5.8	13.7

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality rate	WHO	Total health exp. %GDP	Public health Exp % of THE*	Out-of-pocket pay-ments % of THE	Public System covera-ge % of pop.	Pop covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	73.0	80.2	14.7	19.2	na	na	5.6	**1995**	5.7				
2000	74.8	81.1	15.5	19.7	na	na	5.1	**2000**	6.0	90.3	7.0		
2004	76sp	82.3sp	16.6sp	20.5sp	na	na	3.9	**2004**	6.9	90.2	6.8		

s: Eurostat estimate; p: provisional **THE: Total health expenditure* ***PHI: Private health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	20.7	45.1	24.9	3.1	13.1	1.2	12.7
2000	19.6	39.9	25.4	3.2	16.6	1.5	13.4
2004	22.6	36.5	25.0	4.7	17.4	2.9	13.5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2004	21.2	19.5			
2010	21.6	-0.9			
2030	31.5	5.5			
2050	36.1	8.3			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13	19	11	12	7	18	18	20	20	13	**Total**	3,8
Male	13	-	11	11	9	19	-	18	20	16	**Male**	-
Female	13	-	12	13	5	18	-	20	20	13	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	4.0	6.7	5.1	8.4	**1999**	0.7	0.6	0.9		**1999**	19.1b	18.9b	19.4b
2004	3.4	7.1	5.7	8.5	**2004**	1.1	0.8	1.4		**2004**	12.7	12.6	12.7
2006	2.7p	6.7p	5.4p	8.1p	**2005**	1.2	1.2	1.2		**2005**	13.3	17.0	9.6

**: excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.967	0.955	0.988	***Aggregate replacement ratio***	0.625	0.561	0.596

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates	
									pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or Social Security)	Current estimate (2002)	Assumption
1	0	0	DB			92		24		

**:(DB / NDC/ DC); ** (DB / DC)*

HUNGARY

1. Situation and key trends

Although the Hungarian economy continued to expand at a rate (4% in 2006 is the Eurostat forecast) well above the European average, the stagnation of employment persisted (56.9% in 2005). The overall rate reflects an enduring negative trend in the youth employment rate (down from 23.6% in 2004 to 21.8% in 2005) which was counteracted by a further increase in the employment of older people (from 31.1% in 2004 to 33% in 2005 which contrasts however with the 50% Lisbon target). The most serious problem of the labour market, however, continued to be the very low level of activity, despite the rising trend (up by 0.8 percentage points to 61.3% in 2005). Growth in activity has been followed by an increase in unemployment to 7.2 % (2005), although this is still relatively low in the light of the high level of inactivity. Unemployed and jobless households are the most exposed to poverty; both joblessness and poverty continue to be strongly correlated with educational, health, territorial and ethnic factors. The employment level of low-skilled people is only one third of high-skilled (28.4% vs. 82.4% in 2003). The health status of the population remains a real concern, with important implications for labour market performance. The old-age dependency ratio is projected to rise from 23% in 2004 to 48% in 2050, close to the EU average. Regional labour market differences are the second highest in the Union, and are marked by even more serious sub-regional differences. In addition to employment opportunities, territorial differences are equally important in terms of access to public services. All these disadvantages are affecting the Roma community especially. Nevertheless, poverty has remained at a relatively moderate level (a 13% at risk of poverty rate in 2004[130]), but children are exposed to a higher risk (20%) especially in lone parent families. Notwithstanding this social context, total social expenditures as a percentage of GDP have fallen (from 21.4% in 2003 to 20.7% in 2004). Social benefits for old-age make up the most important share in the expenditures, with 42.5%; these are followed by health-related spending (29.5%), family and children (12.1%) and disability benefits (10.3%) (2004).

Life expectancy (68.7 years for men and 77.2 years for women in 2004) is one of the lowest in the EU[131]. It has increased by 3.4 years for men and 2.7 years for women since 1995, a remarkable rise after the 1988-1994 decreases. Healthy life expectancy (53.5 and 57.8 years in 2004) remains well below the EU15 average (by more than 10 years)[132].The infant mortality rate is one of the highest in the EU (6.6‰ in 2004 against the 2004 EU average of 4.5‰), though it has improved considerably (47.6‰ in 1960 and 10.7‰ in 1995). Perinatal mortality is also high at 9.1‰ in 2003, although significantly lower than the 1960 figure of 35‰, having remained stable since 1995 (9‰).

2. Overall strategic approach

The report demonstrates a significant strengthening of strategic orientation since the 2004 National Action Plan on Social Inclusion. To a large extent the strategy builds on the overall

[130] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data

[131] EU average of 75.8 and 81.9 years for males and females in 2004.

[132] EU average of 64.5 and 66 years for males and females in 2003.

reform agenda of the government across the three strands, and is consistent with the National Reform Programme. At the same time, the NSR addresses most of the main elements of the three overarching objectives. The linkages between the National Strategic Report and the strategy of growth and jobs are strong (feeding-in), - especially as regards attracting people to employment and active inclusion, as well as through pension and health care reform. On the other hand, while the analysis shows that increasing economic competitiveness should deliver greater social cohesion, it does not allow for the necessary conditions to make this happen. Important policies necessary for the social inclusion priorities, such as incentives to mobility for tackling territorial disparities, are not accentuated enough (feeding-out).

While initiating broad reforms the strategy also shows continuity with the previous National Action Plan in focusing on children, disabled persons and the Roma. At the same time the main priorities of the strategy also build to a large extent on the previous strategic approach and interventions, especially in the area of access to employment (active inclusion) and tackling child poverty. In the priority of decreasing regional and territorial disparities the plan focuses on the poorest areas of the country where all social disadvantages, especially in terms of poor access to services are concentrated. The complex problems of these areas and the focus groups will be addressed through programmes carrying out integrated policy mixes (so-called complex programmes) according to the NSR. The intervention logic of coordinated efforts via a range of interventions from different sectors, involving the increased complexity of funding from numerous sources (from both Structural Funds eventually) remains to be seen.

The Government plans to use cohesion policy sources to a large extent in the implementation of the NSR. However, at this stage of planning detailed information on the modalities of structural programming has not been provided. Because of the deficits in monitoring results, the effectiveness of European funding in delivering the interventions of the 2004-2006 NAP is not clearly visible either. Nonetheless the drawing up and submission of a report on the implementation of the previous action plan is a welcome step. With the launch of the new plan, follow-up is to be supported by a better coordinated monitoring system that encompasses all relevant measures of the social inclusion strategy. Social partners and a wide range of civil society stakeholders have been intensively involved in the preparation of the plan. On the other hand, no information has been given concerning their role in implementation and monitoring of the priorities.

3. Social inclusion

3.1 Key trends

Although increasing activity creates a favourable context for the strategy, stagnating labour demand remains an obstacle to attaining the objective of better access to employment. In addition to jobless growth, a detailed analysis of the poverty rate also seems to indicate that the gains economic development are not reaching all segments of society. In terms of segmentation, low-skilled people, the Roma, children of lone parent families, large families, women lone parents and disabled persons are the most exposed to poverty. The child poverty rate, for instance, is 7 p.p. higher than the average.

In view of the very low employment and activity rate, attracting more people to the labour market through active inclusion will continue to be a main challenge. Although nominal inactivity or unemployment traps are not high, making work pay could be strengthened in the

lower wage segments. In this respect the review of access to and the design of social benefits, especially disability pensions, has a very important role.
The new system of family allowances, in which tax credits - available only to those with taxable income - have been replaced by an increase in the universal allowance, has been successful in reaching the needy more effectively. However, in addition to better targeted income redistribution, it is also important to prevent the intergenerational transmission of poverty. Although the proportion of school drop-outs is below the EU average (12.3%), early school leaving affects the young Roma disproportionately (around 20% of Roma pupils do not complete elementary schooling, another 20% complete their basic education late and a further 40-50% terminate their studies immediately after the elementary level or drop out from secondary school). This reflects the inequalities in access to quality primary education and the lack of basic competencies demonstrated by large groups of pupils. According to the PISA 2000 survey, the gap between the performance in reading and maths of 15-year-old pupils living in small settlements and those from major cities was almost four-times the OECD average.

There are very significant regional differences in terms of income, labour market situation, and access to services and housing. The dispersion of regional employment rates (9.4% in 2004) is the second largest in the EU and sub-regional differences are manifold. The risk of poverty strongly correlates with growing segregation and the overrepresentation of Roma people in disadvantaged areas.

3.2 Key challenges and priorities

The overarching objective of the social inclusion strand is the prevention of further increases in social inequalities, the strengthening of social inclusion and the compensation of disadvantaged people in the period of budgetary adjustment. However the third element has only received limited attention in the priorities. For the rest, the specific objectives correspond to the priorities: active inclusion, tackling child poverty and helping the most disadvantaged areas to catch up. Better monitoring of social inclusion through the establishment of an integrated system is an additional objective, in reaction to the lack of any systematic follow up of social inclusion interventions so far. The mainstreaming of inclusion policies is mainly demonstrated by multi-dimensional (“complex”) programmes that bring together various sectors in the implementation of a project.

In line with the challenge identified by the 2006 Joint Report of *improving employment performance and addressing inactivity, including the review of benefit systems* the first priority targets labour market inclusion in a manner that is consistent with the NRP. This is based on the "work first" principle without, however, limiting the scope of benefits and services. The interventions address crucial elements of the interaction between the social and the employment spheres, such as the redesign of the rehabilitation services and disability benefits. On the other hand, *resources dedicated to fighting poverty and exclusion, in particular among the Roma minority* are unlikely to be increased in the context of budgetary restraint. Considerable efforts have been made *to improve cooperation among the relevant governmental bodies and to better mobilise civil society in the preparation of policies*, however their role in *implementation* and monitoring is not visible.

3.3 Policy measures

The promotion of labour market integration and decreasing inactivity is based on active inclusion policies in line with the NRP. The priority lists a number of (context) target

indicators on overall, females and older people employment rate, on overall activity and gender disaggregated activity rates; early school leaving, LLL participation and active age population living in jobless households. The employment targets appear optimistic in view of the substantial job cuts in the public sector. The targets in the field of education are not underpinned by far-reaching interventions. The policy mix of the priority is mainly made up of fiscal incentives to work and the promotion of more active job search. In spite of the Government's austerity measures, tax wedge reduction programmes targeted at young labour market entrants, parents returning to the labour market and the long-term unemployed over 50 will be continued and expanded. Measures to promote active job search contain the most important reform initiatives in the social strand of the National Strategic Report. These concern the services and benefits that jobless people, and particularly disability pensioners, receive. With intensive support from the ESF, an integrated system of social and employment services based on PES will be established. Employment rehabilitation will also be reshaped with a view to placing greater emphasis on labour market outcomes. At the same time, for those, who have not completely lost the ability to work, the disability pension will be replaced by a transitional benefit attached to rehabilitation services leading to the labour market. Old age pensions will also be reviewed, so that those taking early retirement and those working longer receive financial incentives for higher effective exit ages through actuarially proportionate pensions. These policies are complemented by actions that try to make better use of alternative employment opportunities (e.g. social economy). On the other hand, lifelong learning measures and plans to eliminate obstacles to employment and, in particular, to overcome the constant mismatch between the outcomes of the education and training system and labour market demand, do not seem to reflect a coherent approach. Moreover, there are hardly any initiatives promoting geographical mobility.

The original target on the priority tackling child poverty was to reduce the child poverty rate to the 2003 overall average level (i.e. to 12%) by 2013. This is due to be revised as the child poverty rate is higher in 2004 than 2003 owing to the new methodology. An output target is also set for to pursuing better reconciliation of work and family life (namely a 6% increase in the capacity of child care facilities for 0-3 year olds, which is a more modest objective than the unachieved 10% target of the previous plan). The most important initiatives concern prevention of intergenerational transmission of poverty, as well as tackling poverty through better targeted income redistribution and better access to child welfare services in small settlements and disadvantaged areas. Breaking the cycle of poverty transmission needs to focus on pre-education and public education. In this context, the plan to establish integrated institutions providing services for children in both the 0-3 and 4-6 age groups in small settlements where the number of children is decreasing is welcome. Concentration of schools in small settlements with a view to abolishing segregated, poor quality education would be an important reform step towards tackling segregation and also towards ensuring more equal quality education in public education. However, the plan for the revision of school districts in order to avoid segregation still does not seem to have been properly thought out. In addition to the better targeted family allowances system, the new calculus for regular social assistance on the basis of consumption units also serves the interest of children. Better and more equal access is promoted through the encouragement of integrated services for children (e.g. through the setting up of child welfare centres in towns with more than 40 000 inhabitants or in the cooperation between smaller municipalities and the dissemination of the Sure Start programme, which complements the coordination of child services by the development of local community support for children's education). Moves to provide better access to these institutions, to increase the capacity of crèches and to tackle family violence reflect the higher priority being given to gender mainstreaming in comparison to the previous NAP.

The priority to reduce territorial and housing disadvantages has set a number of specific, quantified output and result targets. The plans to improve the territorial accessibility of social services are welcome. The reform of personal care services by introducing a management system to allocate capacity more rationally allocation according to local needs and the quality of service providers is especially encouraging. To this end, service provision will be monitored and measured by standard quality protocols. Furthermore, the NSR is continuing on good initiatives from the previous NAP to tackle indebtedness and to address homelessness, although these are still on a rather limited scale in terms of their budget. Finally, interventions aimed at helping disadvantaged regions to catch up seem unable to overcome immense regional differences.

3.4 Governance

Hungary has made a significant effort to involve all relevant actors in the preparation of the new social inclusion strategy. Consultation should, however, be better coordinated and it should ensure that genuine account is taken of the views of stakeholders concerned. Exactly how stakeholders are to be involved in implementation has not yet been worked out. Although the Government plans to set up an integrated monitoring system to follow up all social inclusion measures, its planning is at an early stage at the moment. Such a system could also enable a more extensive collection and use of gender-specific statistics.

4. Pensions

In 2004 the relative living standard of older people was nearly equal to that of the 0-64 population. Hungary's poverty rates are relatively low and slightly lower for the 65+ cohort (6%)[133].

The 2006 Sustainability Report assessed Hungary as a high-risk Member State as regards the sustainability of public finances, in particular due to the high cost of ageing. The projected increase in pension spending is well above the EU average, rising by 6.7% points of GDP between 2004 and 2050. According to ISG calculations, prospective theoretical replacement rates (including the two tiers of the mandatory scheme) are expected to remain more or less constant for workers at the average wage (about 100% as a net replacement rate for a 40-year career retiring at 65, and about 80% for a 38-year career retiring at 62).

The 2006 Joint Report outlined the challenges faced by the Hungarian system, namely ensuring adequate coverage for all workers within the state system - in particular farmers - and improving employment, especially for older workers. Although no major reforms have been instigated in recent years, the Hungarian authorities report that steps have been taken to include private farmers within the insurance system. Similarly the employment of older workers remains low, but has seen a marked increase of more than 10 percentage points since 2000, including a 2% increase in the last year.

The Hungarian pension system has been in the process of reform since 1997, involving an overhaul of the public pension scheme and the introduction of a mandatory funded scheme; a voluntary funded pillar was established in 1993. The introduction of the funded tier has led to transition costs which will pose a major challenge to the sustainability of public finances. Further reforms will be needed in order to limit the scope for early retirement, as 94% of the

[133] Source: SILC 2004 income year. The Hungarian authorities however, feel that the poverty rate for older people may be considerably higher than the SILC data shows. Separate national surveys give a relative poverty rate of 13% for the over 65s.

working population retired before the official retirement age (in 2004). The Hungarian administration has reported initiatives to combat this, which will require close monitoring. The introduction of linear accrual rates in the pension formula in 2013 will provide greater incentives to longer working lives and fairness, although this process could be accelerated.

Older people in general enjoy incomes almost comparable to those of the active population. However, under the reformed system contributions are more closely linked to benefits; thus, high levels of unemployment, as well as incomplete work records, together with the fact that a significant proportion of the contributors are low wage earners (30% of all contributions derive from minimum wages) suggest that adequacy issues are likely to arise in the future, beyond 2010.

5. Health and long-term care

5.1 Health care

Description of the system: A mandatory health insurance scheme administered by the National Health Insurance Fund (NHIF) – the main purchaser of care – gives universal access to comprehensive care. Municipalities and local governments are responsible for providing primary health care (PHC) and specialist care, and they own most PHC sites, polyclinics and hospitals. They can contract out services to private providers. Both private and public outpatient and inpatient care providers enter into contracts with the NHIF, which meets all operational costs but not running costs. General practitioners (GPs) are independent contractors, typically renting accommodation and equipment from municipalities, who define their client catchment areas. Mother and child health services are provided by qualified nurses. School health services represent a special form of medical care. A GP referral is needed to access specialist and hospital care, but the gate-keeping system is often bypassed. Specialist and hospital care is provided in hospitals and polyclinics. GPs are funded through an adjusted capitation basis or a fee-for-service when providing fully private services. Outpatient specialist care is financed by performance points, while in-patient care reimbursement is calculated on a DRG basis (acute care) or *per diem* (long-term care). Specialists are mainly salaried. Despite the dominance of public institutions within specialist care, there is a significant share of private ownership in a few areas (dialysis, hi-tech diagnostics, dentistry). The system is financed through an earmarked payroll tax on employers (11% of gross salary), employees (6% of gross salary) and the self-employed and through contributions from national and local government. Co-payments apply for drugs (total pharmaceutical expenditure was 27.6% of total health expenditure in 2002). Informal payments are common. Complementary private health insurance is negligible. Recognising the low health status of the population, barriers to access and a clear need for better resource allocation, the authorities aim to continue the 2005 "21 steps" programme notably by improving efficiency through substantial restructuring, putting more emphasis on the principle of insurance and transferring capacity.

Accessibility: Despite high coverage, there are some regional inequalities in the distribution of health care services: facilities are concentrated in the major cities, there is a lack of GPs and specialists in some disadvantaged rural areas and there are significant differences in hospital capacity. Shortcomings as well as overlaps in service provision cause barriers to access. The report highlights existing geographical disparities in access to ambulatory care. Out-of–pocket payments are high (25.1% of total health expenditure) and increasing, mainly due to co-payments for pharmaceuticals and informal payments. By law, emergency care is provided free to the entire population. To improve the accessibility of emergency care

ambulance capacity and coverage increased, but further investments are needed. To reduce health inequalities access to preventive and curative care by disadvantaged groups (e.g. Roma, the disabled, poor, unemployed, or homeless) needs to improve. Within the reform a strategic aim is to introduce a basic package of universal health services whilst increasing inpatient charges.

Quality: Minimum quality criteria, standards of care and service and professional guidelines are in place and accreditation programmes for providers have been improved upon. Surveys were conducted to identify the demand for care and to develop a needs-based approach. Improving quality will involve the implementation of a monitoring and evaluation system based on defined indicators and databases. The authorities plan to make a greater use of ICT. Average salary in the health care sector is still lower than in most other sectors of the economy, although it rose by an average of 50% in 2002. Several measures have been/are being undertaken to improve administrative capacity (strengthening community action through the development of the Healthy Cities movement, extending of public health-related research). Patients can freely choose a GP and switch every six month. Satisfaction's surveys are conducted to obtain feedback on services. The report also states that medical equipment and infrastructure are poor and may present a risk in terms of security of supply and the working conditions of health professionals. Authorities are satisfied with the immunisation coverage (vaccination) already achieved.

Long-term sustainability: Health care expenditure (8.4% of GDP and 1334 per capita PPP$ in 2004) is at the EU average in GDP terms[134] and one of the highest among the new Member States and growing slightly (7.3% in 1998, 7.8% in 2002). Its share of public health expenditure (71.8% of total health expenditure) has decreased substantially in the last decade. The most important contribution provided by the central budget is the offset of NHIF budget deficit, which is continually increasing and putting a high financial burden on the sustainability of public finances. To reduce NHIF expenditures, competition between care providers for the NHIF reimbursement will be enhanced and a co-payment scheme will be introduced as of 15 February 2007 for visits to the doctor and for days spent in hospital. Under the new system the NHIF will buy no more services than it actually needs and a health insurance authority will be created. The health problems of the population create a high financial burden, which is amplified by a low income base and high tax evasion. Ageing (2006 EPC/EU shows public health care expenditure is projected to increase by 1 percentage point of GDP by 2050), a low employment rate, the early retirement age and high morbidity are challenges to sustainability in that they limit the inflow of funds. Inpatient specialist care and a drug reimbursement scheme are two areas identified by the government as needing reform in the first phase. Hungary has one of the highest numbers of acute hospital beds in the EU (806.3 per 100.000 inhabitants in 2001) and incentives still lead to inappropriate and excessive use of hospital care. To address this, the authorities intend to replace the overuse of inpatient hospital acute care by day-case hospital care and outpatient specialist care as well as by rehabilitation, chronic care, possibly home nursing and a focus on strengthening the role of PHC and GPs' gate-keeping function. The reform is also expected to create new incentives for prescribing drugs, tight monitoring of the system and more responsible pharmaceutical management. The report highlights the fact that the structure of human resource capacity is incomplete and wasteful. Moreover, international migration of qualified staff is not negligible. The need for an overall human resources strategy is stated in the report. Various actions with regards to promotion and prevention are underway, such as comprehensive screening programmes for target groups, tackling tobacco addiction, public health training for staff, healthy lifestyle campaigns adapted to men and women of all ages.

[134] EU average of 8.87% of GDP and 2376.33 per capita PPP$ in 2004.

5.2. Long-term care

Description of the system: Social care institutions vary in nature and financing. Long-term care services are provided by both the health and social care sectors. Local governments play a vital role in the provision/purchasing of services, mainly through home help. Funding for social services is provided in the form of earmarked central budget support. The institutional framework includes chronic and nursing wards and live-in social institutions maintained mainly by municipalities. In practice, hospitals also provide a proportion of long-term care in the acute care sector. NGOs and religious organisations also provide long-term and transitional tailor-made nursing care to elderly residents. Family carers can apply to local authorities for a nursing fee, which may not be lower than 80% of the minimum old-age pension. Other benefits include an old-age allowance and home maintenance support.

Accessibility: The authorities emphasize that the long-term care system is underdeveloped and hospital-centric. Insufficient capacity, long waiting times for nursing care and geographical disparities in day and residential care lead to an overuse of acute hospital beds by chronic patients. To tackle this, the authorities want to enhance provision by increasing home care and assistance and reorganising excessive acute capacity to convert it into long-term care. Geographical disparities may decrease due to the introduction of a capacity regulation scheme. New geriatric wards are planned and geriatric services will be offered in day hospitals. Rehabilitative care will also be offered in day-hospitals or at home.

Quality: The report states that long-term care is in need of modernisation. Apart from standards and quality protocols, staff training and a patient follow-up system are also needed. A record of social facilities' and a national capacity monitoring system is planned. The aim is to develop a special home-assistance on-request system to allow the elderly to stay in their homes for as long as possible.

Long-term sustainability: Authorities have been looking at ways of financing long-term care which is currently overly reliant on hospitals. Better coordination between health and social sectors and a differentiated financing system are planned. Regional coordination is to be strengthened through the development of care networks involving different stakeholders. The authorities' priority is to define an explicit and sustainable package of long-term care in order to ensure acceptable service provision for the aging population.

6. Challenges ahead:

To promote active inclusion by implementing the reform of the social benefit system, including by further limiting early retirement and reducing the inflow into disability pensions by revising the eligibility criteria, ensuring the conditions for comprehensive rehabilitation and introducing further incentives to remain on the labour market.

In the context of budgetary restraint, to maintain the level of resources dedicated to combating poverty and exclusion, in particular among the Roma minority.

To strengthen the governance of social inclusion policies by improving monitoring and by supporting the involvement of civil society, especially in the implementation of policies.

To address the long-term sustainability of the pension system and ensure adequacy of pensions, in particular by implementing measures to reduce the evasion of contributions and

handling effectively the transition costs arising from the partial shift into private funded schemes.

To implement healthcare reform, to monitor its medical, social and financial effects and to improve the health status of the population through the promotion of healthy life styles and diseases prevention.

To strengthen PHC (enhance the number of GPs and the distribution of PHC, as well as its role in promotion and prevention activities) and enforce GPs' referral and gate-keeping role, to tackle the financial burden of care in particular for disadvantaged groups (reduction of health inequalities) and to improve transparency of patient routes.

To enhance long-term care provision, especially home care.

Hungary: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate*	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	8.1	53.9	**2000**	56.3	63.1	49.7	33.5	22.2	**2000**	6.4	7	5.6	12.4
2002	4.3	59.1	**2002**	56.2	62.9	49.8	28.5	25.6	**2002**	5.8	6.2	5.4	12.7
2004	4.9	61.3	**2004**	56.8	63.1	50.7	23.6	31.1	**2004**	6.1	6.1	6,1	15.5
2006	4.0f	63.6f	**2005**	56.9	63.1	51	21.8	33	**2005**	7.2	7	7.4	19.4

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop.
	Male	Female	Male	Female	Male	Female							
1995	65.3	74.5	12.1	15.8	n/a	n/a	10.7	**1995**	7.5	84			
2000	67.4	75.9	12.7	16.5	n/a	n/a	9.2	**2000**	7.1	70.7	26.3	100	Negligible
2004	68.7sp	77.2sp	13.4sp	17.3sp	53.5p	57.8p	6.6	**2004**	8.4	71.8	25.1		

p: provisional **THE: Total health expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2000	19.3	41.4	27.9	4	13.2	3.8	9.6
2004	20.7	42.5	29.5	2.9	12.1	2.6	10.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	22.8				
2010	24.3	0.3			
2030	35.1	2.8	3.1	0.8	
2050	48.3	7	6.7	1.0	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13pb	20pb	12pb	13pb	6pb	19pb	19pb	18pb	20pb	9pb	**Total**	4.0pb
Male	14pb	-	12pb	13pb	4pb	19pb	-	20pb	21pb	8pb	**Male**	-
Female	13pb	-	12pb	13pb	8pb	18pb	-	18pb	19pb	11pb	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female			Total	Male	Female
1999	15.5	14.2	12.8	15.6	**1999**	3.3	3.7	2.9		**1999**	13	13.3	12.7
2004	13.2	11.9	11.1	12.7	**2004**	2.7	2.8	2.6		**2004**	12.6	13.7	11.4
2006	13.3	11.6	10.6	12.6	**2005**	3.2	3.2	3.2		**2005**	12.3	13.5	11.1

** excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	1.009b	1.071b	0.971b	***Aggregate replacement ratio***	0.611b	0.6b	0.638b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*				
Net	*Gross replacement rate*					Coverage rate (%)		Contribution rates		
			Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**			pensions (or Social Security)	pensions	
Total	Total	Statutory pensions				Statutory pensions	Occupational and voluntary pensions		Current estimate (2002)	Assumption
-4	11	11	DB and DC			100		26.5		

**(DB / NDC/ DC); ** (DB / DC)*

MALTA

1. Situation and key trends:

The Maltese economy has expanded at a steady pace in recent years, after experiencing negative growth in 2003. GDP grew in 2005 by 2.2% and the forecast for 2006 is 2.3%. Activity and employment rates (especially for women) remain low when compared to the EU-25 averages (53.9%), with no considerable change in recent years. The female employment rate increased to 33.7% in 2005 while the older workers' rate decreased to 30.8%; this contrasts with the Lisbon target of 50% in 2010. The unemployment rate remains relatively low compared to the EU average; after rising steadily, the unemployment rate has decreased in the last two years, down to 7.3% in 2005. By contrast, the long-term unemployment rate has remained stable in recent years, staying below the EU average. Youth employment, although declined in recent years (52.8% in 2000), is not an emergency, since the rate in 2005 was 45.3% - well above the EU average.

Life expectancy at birth (75.9 for males and 81 for females in 2002) is equivalent to 2002 EU average (75 and 81.2), having increased by 1 year for men and 2 years for women in less than a decade (compared to 74.9 and 79.5 in 1995) and showing a consistent increase over time (68.4 and 72.56 in 1970). Healthy life expectancy (65.1 and 65.7 in 2002) is slightly above the 2002 EU average (64.3 and 65.8) for men and on the average for women. The social protection system, coupled with an active role played by NGOs and strong family and community ties, explains the low level of poverty in Malta. The percentage of people at-risk-of-poverty is 15%, slightly below the EU average. In any event, social protection expenditure has increased in recent years, reaching 18.5% of GDP in 2004. Single parents, the unemployed, children, persons aged 65 and over and persons in rented housing are those most at-risk-of-poverty. The early school-leavers rate remains by far the highest in the EU (41.2% in 2003), but it is showing a marked downward trend (from 52.7% in 2002); the rate refers to school-leaving age relative to a country's legal provisions.

Malta is expected to experience similar demographic trends to most other Member States, due to a decrease in the fertility rate. The old-age dependency ratio (19% in 2004) is lower than the EU average of 25% and is projected to increase at the same pace as the EU as a whole (41% and 52% respectively) by 2050. Demographic trends indicate a slow gradual ageing of the population with life expectancy at 76.7 for men and 80.7 for women, and a decreasing fertility rate. The demographic ratio is also affected by the immigration increase. According to estimates, social protection expenditure on health care is likely to increase (+1.8%) until 2050; however, public pension expenditure should be offset by a higher employment rate (overall and older workers), thus being contained to 7.0% of GDP from 7.4% in 2004.

2. Overall strategic approach:

Strategic Approach: The Maltese government has confirmed its commitment to ensure adequate social protection and to consolidate social cohesion. Increasing the overall employment rate (with special attention to measures favouring the participation of women) by investing in human capital, strengthening the welfare system through pension reform, improving access to health-care services and guaranteeing quality health services for all are the four pillars of the Maltese strategy. The strategy is sufficiently ambitious and well focused on the key priorities for Malta, with a good comprehensive approach. In addition, the first part of the document highlights employment as a key issue bridging economic and social development. Economic growth and better jobs are the two linchpins of Malta's current

economic and social policy. In this regard, there is a clearly visible link with the Lisbon strategy and the NRP, ensuring the necessary coherence between the two strategies. The overarching objectives for social protection/social inclusion are correctly addressed, with an extensive involvement of other stakeholders in the process. As for gender, the strategy makes an important contribution to the promotion of women's participation in employment with comprehensive measures.

The strategy report also displays some weaknesses. There is little quantification of expected results and indicators are supplied sparingly. Synergies and connections among the three strands (social inclusion, pensions and health care) could be further exploited. References to the previous plan in the main text are very limited, and there is no 'lessons learned' exercise; a detailed update on the previous NAP is contained in a section of its own in the annex.

3. Social inclusion:

3.1 Key trends

The situation in Malta is characterised by slow progress on some of the key issues relative to the Lisbon objectives. This is mainly reflected in low employment and activity rates when compared to the EU25 averages. The trend over recent years has been stable, with a slight decrease in the employment rate from 54.4% in 2002 to 53.9% in 2005. The need to reduce the public deficit and the likely growing demand for increasing social expenditure due to the projected ageing of the population, as well as unemployment, inevitably put conflicting pressures on the social protection system.

Against this background, achieving the Lisbon target on employment is proving to be quite challenging, in particular as concerns the female employment rate, which is by far the lowest in the EU. Although the government has confirmed in different strategy documents (NRP, NSRF) that it considers this issue a priority, the increase in female participation in the workforce has been very modest in the past few years, from 33.1% in 2000 to 33.7% in 2005. Most females seek work when they are young, but many stop working when they have to look after young children, and not all return to work afterwards. The employment of older people is also an issue of concern, being the lowest in the EU: after a gradual increase between 2000 and 2003, it fell back to 30.8% in 2005. The unemployment rate remains relatively low compared to the EU average; after a steady increase during the previous years (from 6.7% in 2000 to 7.6% in 2003), the unemployment rate decreased in the last two years, falling back to 7.3% in 2005. The long-term unemployment rate remained stable in recent years, reaching 3.4% in 2005, which is still below the EU average.

These figures also highlight why the percentage of people living in jobless households is comparatively low: it was 8.2% in 2005, resulting in a slight decrease from 8.6% in 2004, whereas the EU average is 10.2%. The trend is similar when considering children living in jobless households, even though the rate here is closer to the EU average (8.9% compared to 9.6% for EU-25). Although youth employment has fallen in recent years (52.8% in 2000), there is no emergency: the rate in 2005 was 45.3%, well above the EU average. The Maltese government for several years has attached great importance to education and training, in order to combat illiteracy and raise the general level of education. The data on early school leavers, in particular, are worrying; at 42.1%, Malta has by far the highest percentage of early school leavers in the EU. However, the trend in recent years is positive, with the number of early school leavers gradually falling as a direct result of all the special attention directed towards this issue by the Maltese government.

As regards the segments of population at risk of poverty, according to 2000 data the overall rate is 15% - just below the EU average (16%); children and people over 65 are the most vulnerable categories (21% and 20% above the EU average respectively). The wide-ranging social protection system absorbs 18.5% of the GDP; this figure, coupled with the active role played by NGOs and strong family and community ties, explains the low poverty rate. However, the demographic dynamics, coupled with recent poor economic growth and the large fiscal deficits, are putting a strain on the sustainability of the social protection system. The need for reform has been recognized and the process has been initiated.

3.2 Key Challenges and Priorities:

The Maltese National Strategy identifies the following priorities as its main pillars: increasing the overall employment rate (with special attention for measures favouring female participation and making work pay), combating illiteracy, supporting education, training and lifelong learning, strengthening the welfare system through pensions reform, improving access to health services and the quality of services provided. The plan is fully consistent with the NRP and the use of the ESF to support the activities is also referred to in the document.

In general, the strategy explains that Malta is going through a comprehensive reform, marked by a shift from government provision to a growing emphasis on the responsibilities of the individual. Malta's employment strategy addresses in particular the need to increase access to employment through the introduction of more flexible forms of work, and through the provision of services aimed at reconciling family and work. Beside active measures, the Maltese government intends to overhaul the interaction of taxes and benefits, to ensure a positive impact on the labour market.

In order to address these challenges, the plan identifies four major overarching policy priorities, namely: 1) empowering social cohesion, 2) building stronger communities, 3) strengthening the voluntary sector and 4) networking the social welfare sector. The strategy described here is well in tune with the overarching objectives of EU social policy, and in general addresses the seven key EU policies. However, the strategy report is characterised by some weak points. The document is not very clear on the detailed ways of tackling the different challenges. Although there is a very long list of actions described in the annexes, referring to ongoing and future initiatives along with potentially EU funded initiatives, however the document tends to miss a clear link between the strategy report and the different projects. In particular, the document contains no plan identifying specific measures to be implemented in the different sectors, timing, financial resources, expected results and indicators. In particular, the absence of indicators and quantified objectives is a key point, because it risks undermining the future evaluation of the measures. Synergies and connections between the individual strands (social inclusion, pensions, and health care) are not always sufficiently underlined and explained; synergies exist and can be found by reading through the different parts of the document, but the impact of specific activities across the different strands is not adequately explained.

While the strategy document is exhaustive in setting out the range of short and medium term solutions to Malta’s immediate problems, further in-depth analysis would be needed for it to achieve a truly multi-dimensional approach.

3.3 Policy measures

In this chapter, the strategy illustrates the specific measures aimed at fostering social inclusion. The content of the planned activities is consistent with the overall objectives and the approach is comprehensive, addressing overarching issues. As already stated, there are no specific targets or indicators in this chapter and no mention is made of financial resources allocated; this specific point is a major weakness of the document. Very little account has been taken of gender issues in the single projects. The social inclusion strategy mainly focuses on the empowerment of children and young people and on the reinforcement of the local community and particularly through strengthening the voluntary sector and networking, in order to provide the future prospect of a cohesive society achieved through a bottom-up approach.

The strategy identifies a set of measures for each of the key priorities. Under priority 1, "Empowering Social Cohesion", the emphasis is on the education reform undertaken; actions are aimed at tackling early school leaving, reducing illiteracy and enhancing inclusive and quality education. The inclusion dimension of government action is present in the form of measures targeting low-skilled young people, or young people with particular needs. Other measures will address children's rights and child protection. Under priority 2, "Building Stronger Communities", the activities are supposed to build on the specific characteristic of Maltese society, founded on family and local community ties. Particular importance is attached to the need to reinforce the necessary policy and legal framework beyond the existing legislation, to safeguard the rights of the most vulnerable and prevent social exclusion. In this respect, the strategy defines a set of measures to reach these objectives. Priority 3: Strengthening of the voluntary sector. This objective is in some way consistent with priority 2, since the voluntary organisations provide vital support to the development of local communities, adopting a bottom-up approach. Here, too, actions will be oriented towards the development of the necessary legislative structures. Networking the social welfare sector is identified by the Maltese government as the fourth priority, and regarded as an organisational tool to promote a transformation of social welfare.

3.4 Governance:

Care was taken to secure the extensive involvement of all the various actors and stakeholders in the preparation of the document from the earliest stage. This involvement took the form of a national seminar and questionnaires submitted to service providers and users. Public departments, voluntary organisations and the general public have been involved in the consultation process. The document also presents some indication, albeit not exhaustive, of how the implementation of the various actions is monitored.

4. Pensions:

In 2003, older people had a relative living standard close to that of the general population (90%), while the poverty risk among older people (20%) was significantly higher than for the population below the age of 65 (14%). The employment rate of older workers remains at low levels (30.8% in 2005), significantly below the Lisbon target of 50%.

The 2006 Sustainability Report assessed Malta as a medium-risk Member State as regards the sustainability of public finances, in particular because of the current budgetary position. According to the AWG 2005 projections, public spending on pensions was due to fall slightly from 7.4% of GDP in 2005 to 7.0% of GDP in 2050, reflecting the fact that under former

rules indexation of the maximum pension was based solely on the increase in the cost of living. Calculations of the prospective theoretical replacement rates also showed that, in the absence of reform, the gross replacement rates would fall from the current level of 72% to 53% in 2030 and 31% in 2050 (net: 88% current, 61% in 2030 and 34% in 2050).

The 2006 Joint Report underlined that Malta was in the middle of a reform process and stressed the need to strengthen incentives for people to work longer and to ensure adequate replacement income, including through easy access to pension provision. Following a consultation process that began with the launch of a White Paper in November 2004, the Government announced in March 2006 an extensive pension reform which has been enacted by the Maltese Parliament. While the government also announced the introduction at a later stage of a second pension (mandatory occupational scheme) depending on the fiscal position, the current reform proposal should make significant steps towards adequacy by reforming indexation rules and strengthening incentives to work longer.

The national minimum pension will be calculated at a rate of not less than 60% of the national median income, which will be capitalised every year and will translate into a significant reduction of the poverty situation of pensioners. In addition, the proposed new system includes a revision of the calculation of mandatory pensions for both employed and self-employed persons: the contribution period will be gradually increased from 30 to 40 years, while the maximum ceiling on pension payments will be raised significantly between 2010 and 2013 and thereafter indexed on both prices (30%) and wages (70%). Furthermore, the retirement age is to be gradually raised from the present 60 years for women and 61 years for men to 65 years for both men and women from 2015 to 2027, while pension credits are to be introduced for periods of child care. These measures will contribute to an increase in the employment rates of older people and improve gender equality.

While the recent reforms review conditions of early exit through invalidity pension and introduce more flexibility for those who wish to retire before 65, the employment rates of older workers have fallen slightly in recent years; further steps regarding early exit from the labour market may therefore be necessary. Current proposed 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, while it remains to be seen how far the introduction of a second pension would contribute to adequate and sustainable pensions (particularly as regards access).

5. Health and long-term care

5.1. Health Care

Description of the System: A National Health Service (NHS) provides comprehensive public healthcare free at the point of delivery to all residents. Primary healthcare (PHC) is provided through eight health centres offering a full range of preventive, curative and rehabilitative services. General practitioners (GPs) and nurses are supplemented by various specialised services (e.g. antenatal, postnatal, gynaecology, physiotherapy, ophthalmology, psychiatry and diabetes). A referral system is in place, though often bypassed. Specialist and hospital care is provided in public hospitals. A growing private sector (PHC and basic outpatient specialist care) co-exists with public services, and many residents opt for its services. Most public sector doctors also conduct private practice. Public sector doctors are salaried while private sector doctors are paid a fee for their services. The system is funded out of general taxation. Some types of medicines, some dental and optical care, are available on a means-

tested basis. Around 25% of the population purchases voluntary private health insurance for basic care plans. When using the private sector, patients pay directly out of their own pockets. The authorities, together with the country's main stakeholders, have recognised the need to enhance equity in access to care, promote quality and excellence and safeguard sustainability as the main priorities.

Accessibility: Free comprehensive public healthcare (including preventive care such as child immunisation) contributes to ensure access to all. This is coupled with means-tested entitlement (for those on low incomes and the chronically ill) to pharmaceuticals, dental and optical care, i.e. benefits that are excluded from the public healthcare basket. The report states that an elderly population has resulted in a higher demand for certain elective procedures (e.g. cataracts) and thus longer waiting lists and overcrowding of hospital facilities. Authorities anticipate that a new hospital and better management in existing facilities will provide extra care and help bring waiting times down. Extra capacity is to be coupled with an analysis of waiting lists and a new waiting list management system. The government wants to ensure fairer and more transparent prices for medicines, including by increasing the use of generics. A pilot "pharmacy of your choice" scheme is being launched to enhance access to medicines. Several proposed e-health solutions (health portal, electronic patient record) should improve information to patients and patient flows through the system.

Quality: The report states that the new Mater Dei hospital and a new cancer treatment facility will offer modern/latest medical equipment and ICT. It also indicates that a number of quality services charters have been implemented. Authorities stress that the future Bill on Health Services will ensure that uniform standards are applied throughout the system (public and private providers). Providers will be encouraged to set up systematic patient care protocols to enhance patient safety and clinical outcomes. Comparable indicators are seen as relevant to allow informed decision making. According to the authorities there is a large degree of patient choice and the above Bill will further consolidate patient rights, responsibilities and representation within the system. It is hoped that this will lead to a more sensible use of the system. The plan is to use population surveys to monitor satisfaction on the nature and quality of health services, and providers will be required to conduct an in-depth survey of the views of service users. Authorities further expect that ICT and e-health solutions can improve coordination between PHC and secondary care and supply providers with better information. Authorities are satisfied that immunisation rates will help to improve influenza and hepatitis B vaccination coverage.

Long-term Sustainability: Total health care expenditure (9.27% of GDP and 1634.58 per capita PPP$ in 2003) is slightly above the EU average in GDP terms. Public expenditure accounts for 78.19% of the total health care expenditure. Ageing is seen as a challenge (the 2006 EPC/EC age-related projections predict an increase in public expenditure of 1.8 percentage points of GDP by 2050)[135] resulting in an increasing demand for services, together with increased costs of medical devices and pharmaceuticals (also related to stricter quality requirements). The report mentions the setting up of a new earmarked National Insurance Fund for Health that brings together all sources of funding. The Bill on Health Services will introduce a purchaser-provider split, involving a contract system and giving providers more management autonomy, which the authorities expect can bring about efficiency gains and better coordination between public and private services. On staff, to tackle stress and burnout, authorities are introducing psychological and emotional support systems for staff. To maintain/retain staff in the sector a strong focus is put on training, retraining, continuous

[135] Malta has some reservations in relation to the EPC/EC population and labour market projections which impact on expenditure projections that overestimate expenditure projection values.

education and new career pathways. On promotion, given that circulatory diseases and cancer are the main causes of mortality and morbidity, obesity at all ages is the main heath threat and diabetes is highly prevalent, the authorities have introduced a total smoking ban, are planning a national alcohol strategy to curb alcohol consumption especially by those under 16 and will set up a national platform to tackle obesity including through the promotion of a healthy diet and exercise. The education sector is seen by the authorities as a crucial partner in adapting the curricula of health staff and young people to focus on PHC and preventive care and healthy life-styles.

5.2. Long-Term Care

Description of the system: Services are provided by the State, the church and private/voluntary organisations. Complementing PHC and rehabilitation, the Department for the Care of the Elderly runs residential homes for the elderly (who pay a part of their annual income), a geriatric hospital, a home help service (e.g. household activities and shopping, meals-on-wheels, household maintenance) for a nominal charge but free for low income individuals, and the telecare/telephone system. The system is funded through taxation and income-linked co-payments. The church provides free residential care for the disabled. The private sector also provides home care and support. Government policy focuses on keeping people at home and in the community for as long as possible and on ensuring a healthier and more active elderly population.

Accessibility: The report recognises that an increasing demand for services and limited availability of institutional care in the public and church sectors have resulted in long waiting lists, whilst the private sector is only affordable to a segment of the population. Initiatives to enhance provision include increasing the numbers of public sector beds and contracting private beds. Authorities are focusing on enhancing the provision of community services such as day centres and adult learning centres. A legal framework for voluntary organisations will soon be enacted, supporting the role of NGOs in this field. A needs assessment for non-elderly people is planned.

Quality: Legislation on quality standards is deemed rudimentary and is to be updated, and licensing and monitoring will be strengthened. Better coordination between levels of government and the church, the private sector and NGOs is being sought. A step-down facility was created to facilitate transition from acute to long-term care.

Long-term Sustainability: The 2006 EPC/EC age-related projections foresee an increase in public long-term expenditure of 0.2 percentage points of GDP by 2050 (see footnote 1). Authorities expect that a number of initiatives such as privately managed, state funded homes and support to family carers that maintain people at home will help to control costs and ensure an efficient use of resources. Training of human resources ranges from basic care skills to specialised professional training and is considered fundamental by the authorities. Thus, a manpower plan will focus on requirements of staff and their skill mix, as well as training and retraining for staff and carers. Specific promotion and prevention campaigns for the elderly are planned.

6. Challenges ahead

To raise the employment rate, particularly that of women, in order to improve social cohesion and reduce inactivity and the consequent phenomenon of exclusion. Expanding active labour participation and increased labour market integration of the long-term unemployed, women,

the 55+ age group and other groups at high risk of poverty and social exclusion remain the immediate challenge.

To increase efforts to improve education, vocational training and lifelong learning, to fight illiteracy and to reduce the number of early school leavers in order to improve employability, and to prevent marginalisation and social exclusion.

To ensure that the reform of the pension system strengthens incentives to work and to remain in the labour market, provides adequate pensions and strengthens the financial sustainability of the pension scheme;

To enhance equity of access, reduce waiting times and enhance the provision of home and community care.

To safeguard sustainability through improved management and a contract system, through promotion and prevention policies and by keeping staff in the sector.

MALTA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.7	78.0	**2000**	54.2	75.0	33.1	52.8	28.5	**2000**	6.7	6.4	7.4	13.7
2002	1.9	74.9	**2002**	54,4	74.7	33.9	50.5	30.1	**2002**	7.5	6.6	9.3	17.1
2004	0.8	71.3	**2004**	54,0	75.1	32.7	46.2	31.5	**2004**	7.4	6.6	9.0	16.8
2006	2.3f	69.7f	**2005**	53,9	73.8	33.7	45.3	30.8	**2005**	7.3	6.5	9.0	16.4

*:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2002 instead of 2004)		Infant mortality rate	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	Male	Female	Male	Female	male	female							
1995	74.9	79.5	15.3	17.5	na	na	8.9	**1995**			-		
2000	76.2	80.3	15.2	18.5	na	na	6.0	**2000**	8	76.5	21.2		
2003	76.7	80.7	15.8	18.4	65.1	65.7	5.9	**2004**	9.2	78.2	19.7		

*THE: Total Health Expenditures **PHI: Private Health Insurance

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n/a	51.4	24.4	5	11.8	2.5	4.8
2000	16.3	51.8	25.6	6.2	7.9	2.5	5.9
2004	18.8	51.2	27	6.9	5.2	2.9	6.7

* including administrative costs

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio	expenditure (% of GDP) level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-Term care
2005	19	18.2	7.1	4.2	0.9
2010	20.4				
2030	36		1.7	1.3	0.2
2050	40.6		1.8	1.8	0.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	15b	21b	13b	12b	15b	18b	21b	17b	18b	14b	**Total**	4.2b
male	14b	-	12b	11b	15b	19b	-	18b	18b	16b	**male**	-
femal	15b	-	14b	13b	15b	18b	-	17b	18b	13b	**female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers			
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24			
	Total	Total	Male	Female		Total	Male	Female		Total		Male	Female
1999	na	na	na	na	**1999**	na	na	na	**1999**	na		na	na
2004	9.2	8.6	6.8	10.4	**2004**	3.4	3.7	3.0	**2004**	42.0b	44.2b		39.5b
2006	8.2	6.7	5.2	8.2	**2005**	3.4	3.4	3.2	**2005**	41.2	43		39.3

*: excluding students; b: break in series

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.866b	0.886b	0.855b	***Aggregate replacement ratio***	0.546b	0.557b	0.464b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		pensions (or Social Security)	pensions Estimate of current (2002)	Assumption

*:(DB / NDC/ DC); ** (DB / DC)

THE NETHERLANDS

1. Situation and key trends

The recovery of the Dutch economy seems to be more and more in line with the overall economic recovery of the EU. According to the forecast for 2006 it promises to even outperform the latter (3% for NL against 2.8% for EU), bringing the Netherlands more in line with their 2000 level. Unemployment is low compared to the EU average in 2005 (4.7% against an EU-average of 8.7%), but relatively high compared to the (historically low) Dutch level in the period 2000-2002 (average of 2.6%).

Although overall and female employment rates are above Lisbon targets (2005: 73.2% overall and 66.4% for women), the long term unemployment rate has increased from 0.7% in 2002 to 1.9% in 2005 (EU average remained at 3.9% over the period 2002-2004). Also, the unemployment rate gap of 13.9 percentage points between non-EU and EU nationals is above the EU-average of 8.1p.p. This gap is also visible in national data on employment rates (46.9% for ethnic minorities compared to 65.6% for the remaining population, 2005).

The national target on the overall unemployment rate for the age group 15-24 years (8.2%) has been met: it is not more than double the overall unemployment rate (4.7%). Also it is the lowest among the EU-25 and it is expected that, with the economic recovery, youth unemployment will decrease further. The overall employment rate for older workers is gradually increasing, from 42.3% in 2002 to 46.1% in 2005 towards the Lisbon target of 50%. Gross social expenditure on disability, old age and housing has declined by around 1 p.p. since 2000, balancing out the increase in expenditures on health care and unemployment.

The overall poverty risk[136] of 11% in 2004 remains one of the lowest in EU-25 (16%). The at-risk-of-poverty rate for children aged 0-17 years is 15% (19% for EU), but 5% for the population above 65 years (19% for EU). There is a strong ethnic dimension in poverty risk: ethnic minorities account for 23.4% of the total number of minimum-income households, whereas the remaining population make up only 6.2% of such households (national figures). Furthermore, single parents (especially women) are overly represented in the number of minimum-income households and these households also face the highest inactivity trap. The overall unemployment traps also remain high (83% in 2005).

The Netherlands will remain one of the Member States with the lowest old-age dependency ratio (65+ population as a share of 15-64). It currently lies at a relatively low level in comparison to the EU25 average (respectively 20.7 and 25 in 2005), and is projected to remain below the EU25 average (respectively 38.6 and 52 in 2050).

Life expectancy at birth (76.9 for males and 81.4 for females in 2004) is above the EU average[137], showing an increase of two years for men over the last decade (74.6 in 1995). Healthy life expectancy at birth has remained at an average level slightly above 61 years for males since 1995 (64.5 years for EU15 in 2003), but for females it decreased from 62.1 years

[136] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, year to year differences that can be noted (especially for some population sub-groups) are therefore not significant. During the transition to EU SILC (see methodological note) those estimates were based on the national Income Panel Survey that was not fully compatible with the SILC methodology based on detailed income data

[137] EU average of 75.1 and 81.2 for males and females in 2003

in 1995 to 58.8 years in 2003 (66 years for EU15 in 2003). The infant mortality rate (4.1 in 2004) is around the EU[138] average, though it has fallen significantly over recent decades (16.5 in 1960). Perinatal mortality (7.4 in 2003) is high, but has fallen consistently since 1960.

2. Overall strategic approach

The choice of priorities for the inclusion part of the NRS is based on the broad political consensus in the Netherlands that work is the best remedy against poverty. The second guiding principle is that people themselves are responsible for their own living conditions. The key emphasis in preventing long term poverty is therefore put on increasing participation through work acceptance and training. This means equipping people with the necessary skills and offering them possibilities to engage in paid work or, if not possible, in volunteer work. This should also increase the chances for disadvantaged groups to benefit from the economic recovery. To increase effectiveness, priority has been given to *preventative* measures in an early stage, for example through the new priority on preventing child poverty.

On the other hand, the NRS includes *curative* measures as well, because the issue of poverty has attracted a lot of political attention in the (past) period of recession. People at minimum income level faced economic setbacks and, combined with poor financial management, the number of minimum income households increased. The government invested in identifying the causes for this increase through consultations with local governments, NGOs and especially those organisations in daily contact with the high-poverty risk group, e.g. municipal credit banks (for people in debt), social housing corporations and providers of energy services. These consultations revealed the need to tackle the non-usage of income benefit schemes and to reduce problem debts.

The number of targets on these priorities is limited: except for the clear targets on measures concerning education and training, no other quantitative targets have been set.

Through the focus on increasing labour market participation there is a clear link between inclusion and employment policy: policy initiatives mentioned in the NRP aimed at increasing the overall education level, reducing early school leaving, and reactivation of partially disabled employees increase both employability and the overall chances for social inclusion.

3. Social Inclusion

3.1 Key trends

Overall employment rates are high and overall youth unemployment is low. On the other hand, key trends in two areas need attention: the low employment rate of ethnic minorities and developments in education.

The causes of the low employment rates for ethnic minorities are the large number of early school leavers and low education levels (only 61.9% of ethnic minorities complete upper secondary education as opposed to 74.0% of the remaining population). Although the youth unemployment rate is relatively low compared to other Member States (2005: 8.2% for NL and 18.5% for EU25), early school leaving is 13.6% (2005) - still far above the national target of 8% set for 2010. The number of people with learning arrears also remains high in the under-18 age group, primarily consisting of ethnic minorities. Although the language gap is

[138] EU average of 4.5 in 2004.

narrowing, the percentage of 15 year-olds who are low-achievers in reading literacy has increased (9.5% in 2000, and 11.5% in 2003). Inactivity traps for single earners with children nearly doubled in 2006 (-2.5% in 2005 and -4% in 2006, national figures showing percentage of income lost when benefit recipient accepts job at minimum income) and rose by 1 p.p. in 2006 for single parents (the level is -7.25%). Low-wage traps for single persons remain high as well (without children 47%, with children 60% - 2004).

3.2 Key Challenges and Priorities

The overall strategic approach in the prevention of poverty is characterised by the focus on reducing the distance to the labour market, especially in the early stages. Possibilities for people to escape poverty through work primarily depend on personal factors determining their future prospects on the labour market. The government considers the level of education, knowledge of the Dutch language, duration of benefit dependence and the person's health as key factors. The strategic focus is on shortening the distance to the labour market, preferably in an early stage, but attention is not focused on target groups as such. By focusing on the factors causing this distance, the government expects to reach disadvantaged groups, like minorities, benefit recipients who are difficult to place and the disabled.

Under the policy of decentralisation local governments are now primarily responsible for the (re-)integration and participation of these groups. While the number of benefit recipients has fallen slightly since 2004, even though this is in a period of recession, municipalities have focused primarily on those who are relatively easy to place (Evaluation of the Social Assistance Act, April 2006). The government expects that in the forthcoming period the people who are more difficult to place are next in line, based on the fact that municipalities have argued that it has taken them longer than expected to translate their new responsibilities on reintegration into policy.. Secondly, municipalities will have an additional reintegration instrument at their disposal in 2007. They can introduce so called "re-entry jobs" for benefit recipients to acquire job experience for a maximum of two years without losing their benefit. This should be an attractive instrument for reintegrating people at a distance from the labour market. However, a recent survey shows that municipalities also assume that around half of their current social benefit recipients will never get a regular job. Therefore it is very important to closely monitor developments in this area. Since the national government is not playing a central role here as part of a decentralising and deregulation operation, monitoring is limited to interactive benchmarking between municipalities and via the on-going evaluation of the 2004 Act on Work and Social Assistance. It is therefore to be welcomed that some municipalities have taken the initiative to monitor and assess their own policy themselves. These reports produce a basis for sharing of best practices. To what extend best practices will be shared by other municipalities remains to be seen but could be of great importance as the report does not mention any other instruments for stimulating progress in this area.

Given the strong emphasis on own responsibility and accepting work, it is disappointing that the NRS 2006 contains no new policies for tackling inactivity and low wage traps, apart from a relatively small increase for in-work benefits. Inactivity traps and low wage traps remain high, especially for single parents. In order to have effective strategies on decreasing the distance to the labour market, it is crucial to point the financial incentives in the right direction. With regard to the social inclusion of ethnic minorities, the NRS 2006 pays special attention to social participation by women from ethnic minorities. This is relevant, given their disadvantaged status. Although it is difficult to forecast the take-up of these measures, concrete targets have been set and the actors responsible are mentioned, making the proposed measures transparent and easy to monitor.

Integration policy and guaranteeing an adequate knowledge of the Dutch language is a responsibility of the national government, whereas active inclusion is a local responsibility. The national integration policy, however, has mostly been developed through dialogue with social partners, NGOs and municipalities, resulting in agreements on reinforcing efforts in the areas of helping women of ethnic minority origin to enter the labour market, fighting discrimination and strengthening social cohesion. Safeguarding coherence between the broad range of national and local policy initiatives remains a challenge, in particular considering the fact that, for some of the objectives in integration policy, budgets are allocated through municipalities. Because of the thin line between active inclusion and integration, target groups may overlap and streamlining of policies is necessary.

The NRS 2006 includes a priority on combating child poverty in line with key policy priority of the European Union. Preventing of inheritance of poverty is mainly targeted through focus on education: combating early school leaving, prompt action on learning arrears risks and fighting youth unemployment. In order to halve the number of early school-leavers over the period 2000-2010, national policy focuses on the 17-23 age group. On the other hand, the number of those with learning arrears in the under-18 age group, consisting primarily of ethnic minorities, also remains high. Development of this group will need close monitoring in the coming period, to safeguard the downward trend in the number of early school leavers in the future.

The remaining two priorities concern the growing number of households at minimum income level. In particular, the number of households that cannot make ends meet has increased. Strategy focuses on the two identified causes of this increase: the non-utilisation of income benefits schemes and the increasing amount of debt. Policy focuses on increasing the consumer's awareness and own financial responsibility consistent with the principle of individual responsibility. However, in consultation rounds, municipalities and other stakeholders also argued the need to relax the criteria on income arrangements and for a generic increase in social assistance payments. Although the government has doubts about the effectiveness of generic income measures, the individual responsibility approach may prove to be too one-sided to bring down the number of minimum income households. Although societal responsibilities are not ignored in the NRS, they are considered as being too difficult to influence. However, the NRS also correctly states that it is likely that the increase in the number of households with difficulties making ends meet is explained not only by individual risks, but by a combination of individual and social risks.

Concerning the new programming period for the ESF, the NRS only refers to the fact that part of the programme will be linked to Lisbon targets through projects concerning vocational training for low-skilled workers.

3.3. Policy measures

The NRS largely focuses on the continuation of existing policy measures. With regard to the objectives on increasing participation, the key policy measure is taken in the area of reintegration with the introduction of the "re-entry jobs" for benefit recipients. In 2007 the Social Support Act will be implemented, making municipalities responsible for social support. At this point, synergies between the latter and the Act on Work and Social Assistance are being explored by municipalities.

In the field of social inclusion of immigrants and ethnic minorities, policy measures focus on acquaintance with the Dutch language and culture and combating discrimination. To better

prepare immigrants the Integration Act (entry into force in March 2006) obliges them to pass a basic exam in the Dutch language and culture as a requirement for immigration. Upon arrival, the integration course is extended. As of 2007 this latter course will also be obligatory for resident immigrants, who have been in the Netherlands longer and are in need of it. On fighting discrimination, both sides of industry will commit themselves to cooperate with the government in a new monitoring tool on labour market discrimination.

The key policy measures on child poverty are in the areas of early school leaving and youth unemployment. The compulsory upper age limit on participation in education has been raised from 17 to 18 years, for which a budget of €130 million per year has been reserved up to 2010. Youth unemployment is tackled through the creation of 40 000 jobs in the period 2003-2007 for the unemployed in the 15-to-22 age group by the Taskforce Youth Unemployment, consisting of schools (Regional Vocational Training Centres, ROCs), the Centre for Work and Income (responsible for vacancies), and local authorities. For young people without upper secondary education, on-the-job training is made available.

With regard to the lack of take-up of income benefit schemes, the government is trying to reach beneficiaries through advertising, merging the databases of different institutions and by simplifying application forms. Merging the databases of the Social Insurance Bank (SVB), responsible for statutory pensions, and of the municipalities, means that elderly people with insufficient pension rights due to a short labour history in the Netherlands could be traced more easily and offered additional income support.

Through a new Financial Law, rules on granting financial loans and responsibilities to check the financial liability of clients have been tightened to reduce the risk of debt accumulation in households. Furthermore, research will be conducted in 2007 on the level of financial liability of consumers.

3.4. Governance

Due to the decentralisation of responsibilities concerning priorities in the NRS, monitoring and evaluation is primarily performed by making policy facts and figures accessible to the public. Best practices are shared between municipalities through websites.

NRS consultation involves not only provinces, municipalities, social partners and NGOs, but also - especially - those organisations in daily contact with the high poverty risk group, e.g. municipal credit bank (for people in debt), social housing corporations and providers of energy services. Civil society dialogue between these parties has resulted in agreements on the scope of NRS-related topics, e.g. in the area of reintegration and education between the Association of Municipalities (VNG) and the Ministry of Social Affairs, in the area of social inclusion with the 31 largest municipalities (G31) and in merging the databases of different institutions.

4. Pensions

In 2004, older people enjoyed a living standard close to that of the general population (88%). The Dutch pension system is extremely efficient at coping with old age poverty, as shown by poverty rates of 5% for the population above 65, significantly lower than that of the 0-64 population. It is noteworthy that the poverty rate for the very old (75 and more) is also low.

The 2006 Sustainability report assessed the Netherlands as a low-risk Member State as regards the sustainability of public finances. According to the AWG 2005 projections, public spending on pensions is expected to increase by 3.5 p.p. to reach 11.2% of GDP in 2050. ISG projections for net replacement rate show replacement rates (including occupational pensions, for which actual coverage is about 90% and assuming a contribution rate of 12 %) remaining fairly constant, from 92% net in 2005 (71% gross) to 90% in 2050 (69% gross).

The 2006 Joint Report recognised that the Dutch system ensures adequacy and highlighted the challenges of ensuring that women are as well provided for within the occupational pension sphere. It also commented on strengthening incentives for older workers to remain in the labour force. To this end the updated report makes reference to the adaptation of tax law and regulations affecting early retirees.

As mentioned, 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 make an 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. Changes have been made in the disability and unemployment benefits to prevent these schemes from being used as an early retirement route and are currently being implemented.

5. Healthcare and long-term care

5.1 Health care

Description of the system: January 2006 saw a major reform of the Dutch health insurance system. The previous dual-funded and partly mandatory system was replaced with a compulsory single universal scheme operated by private health insurance funds. Insurers are obliged to accept every resident in their area and, to accommodate this, a risk adjustment scheme operates. The basic insurance package is fixed by law and health insurers compete with each other on the nominal premium and on services' quality, as well as negotiating with care providers on the price, quality and volume of care to be provided. The new Netherlands Care Authority (NZA) will supervise costs, prices, quality, contractual terms and health market developments from 2007. Provision is decentralized and of a private nature, with public limiting conditions. Service providers are independent and operate on the basis of contracts negotiated with the insurance funds. Primary health care (PHC) is delivered mainly by general practitioners (GPs). These (providing general medicine and promotion and prevention services) perform a gate-keeping role for specialist and hospital care. Specialised care is provided in outpatient and inpatient hospital departments. More than 90% of the hospitals are private while university hospitals are publicly funded owned. GPs are paid both on a capitation basis and a consultation fee. Specialists are paid either a salary or a service fee or a mixture of both. The basic and compulsory health insurance is financed primarily through the nominal and income related premiums. The latter is redistributed according to a risk adjustment scheme for insurers. Each insured individual can obtain a refund of the basic rate premium up to a standard fixed amount in the absence of claims for care. Co-payments apply to certain services but are limited and for supplementary insurance the ban on premium differentiation does not apply. Recognising changes in the demand for care and continuous

technological and medical developments, the authorities aim to create a system that guarantees access while increasing efficiency and maintaining and improving service quality.

Accessibility: The services available within the compulsory basic insurance package are fixed by law and encompass essential curative care. The insurer may not differentiate according to risks between patients in the premiums charged and the government pays the nominal premium for children up to the age of 18. The report highlights the existence of some regional disparities regarding health insurance funds in that not all of them offer the elementary care to the same level in every region. But the authorities expect the recent reform to result in improved access due to new incentives for providers organising care as efficiently as possible without any quality impairment. Although adverse selection is prevented by the legal obligation to take out basic health insurance, people are no longer automatically insured as was the case for participants in the former system. Hence, although authorities expect the new insurance system to provide universal coverage, during an initial transition period there may be a non-negligible number of individuals that are not insured owing to a lack of information or unwillingness to register. Waiting lists, seen as an unsatisfactory feature of the previous system, continue to exist, albeit at significantly reduced levels.

Quality: The government safeguards quality requirements for providers through supervision by the Health Inspectorate. As of 2007, all health care institutions will have to publish an annual public accountability report to ensure transparency and make performance indicators publicly available for insurers and patients. A greater use of ICT and e-health solutions and a nationwide system for the electronic exchange of medical data is expected to reduce medical errors, enhance cost-efficiency and improve access. Patients can choose their health insurer and due to the new incentives they are expected to switch insurer on the basis of price/quality ratio. Patients can also choose and change their GPs at any time. Governmental programmes to improve quality have been launched (e.g. *Better Quicker* programme).

Long-term sustainability: Total health care expenditure (9.8% of GDP and 3056 per capita PPP$ in 2004) was above the EU average and is one of the highest in per capita terms[139]. Since 1990 it has increased by 1.8 percentage points of GDP. The annual growth rate of per capita expenditure is also high compared to the EU average (7.2% in 2002/2003). The report pinpoints several challenges to long-term sustainability. The total costs of care have increased on average by 4.4% a year during the 2001-2006 period and projections predict a 5.5% per annum growth in the period 2008-2011[140] and the 2006 EPC/EC age-related projections show an increase in public health care expenditure of 1.3 percentage points of GDP by 2050. Authorities expect the reforms – notably the liberalisation of the health care purchasing market – to address these challenges by creating new incentives for the efficient use of resources. The aim is 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. Increasing the supply of personnel and improving the attractiveness of working in the care sector is also a government ambition. A new broader strategy of prevention is currently in preparation. It should be noted that the conditions for market competition (leading to greater efficiency) are not always fully satisfied due to large information asymmetries, technical complexity, supply side limitations and the high level of uncertainty about future needs. When conditions are not met, regimes stay less liberalised and stricter regulations will apply.

[139] 8.87% and 2376.33 per capita PPP$ in 2004.
[140] National Strategy Report on Social Protection and Inclusion in the Netherlands 2006-2008

5.2 Long-term care

Description of the system: Long-term care involves primary, home and day care (nursing activities, hygiene, meals-on-wheels, washing, leisure activities, and rehabilitation), assisted housing, residential services (pensioner's homes and boarding houses for pensioners) and sheltered housing. Long-term care medical or high-cost treatments are provided under the Exceptional Medical Expenses Act (AWBZ, financed through an earmarked payroll tax on employees and government grants) while the Social Support Act (Wmo) will enter into force in 2007 and will transfer several responsibilities to municipalities. The authorities' aim is to create stronger local social support. In order to tackle the challenges of ageing and societal changes the authorities aim to increase the provision of home care services and to shift from institutional to primary and individualised, needs-based care in the home environment.

Accessibility: A valid statement of need from the Care Needs Assessment Centre is needed to receive care under AWBZ. The care administration offices direct the process of long-term care at regional level, but their position in implementing the AWBZ is also under discussion. The report underlines that home services still need improvement and expansion, and coordination between regions and municipalities must be enhanced.

Quality: Arrangements have been made with all sectors in long-term care on methods of measuring responsible care. Standards for long-term care have been set. Indeed, the government intends to develop instruments to measure the standard of the care provided by nursing homes and homes for the elderly and how that care is perceived by patients. Additionally care organisations are themselves responsible for carrying out the assessments and reporting the results. Under the new Accreditation of Care Institutions Act care institutions will gradually be given more freedom and greater responsibility. The Making it Better programme supports quality development (e.g. prevention of bedsores and falls) concerning the care provided in seven AWBZ functions, such as residential care, personal care, treatment and counselling.

Long-term sustainability: The national action plan mentions a review of AWBZ in order to control expenditure growth limiting it to the financial ceilings set out in the government agreement. Care providers have committed to helping 1.25% more clients each year up to 2007 on the basis of available funds. Through the AWBZ new financing system function-specific financing will be introduced. It will affect the decisions on the assessed need for care, personal budgets and registration of care. The report also states that long term care providers have few financial incentives to work efficiently under AWBZ.

6. Challenges ahead

To promote active inclusion for the groups furthest from the labour market, in particular by further promoting the labour market integration of ethnic minorities, single parents and older workers, tackling inactivity, addressing low wage traps and increasing take-up of minimum income benefits.

To continue to develop an adequate evaluation and monitoring framework for assessing the participation of, and outcomes for, at risk groups in mainstream employment and social measures, also with an eye to reducing the number of minimum income households.

Increasing the participation of women and part time workers within the occupational pensions sphere, to ensure adequate pensions in retirement for all.

To monitor the medical, social and financial effects of the reform and the competitive changes which must enhance value and efficiency in purchasing health care.

To safeguard the functioning of the newly formed health insurance market – consolidation of the market is expected if insurers are to survive and build up bargaining power in negotiations with providers and tackle potential administrative problems faced by providers (e.g. reimbursement of GPs) and insurers (e.g. huge numbers of patient have changed their insurer);

To monitor the effects of the new AWBZ financing system through a number of pilot projects.

The Netherlands: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.9	124,0	**2000**	72.9	82.1	63.5	68.7	38.2	**2000**	2.8	2.2	3.6	5.7
2002	0.1	125.3	**2002**	74.4	82.4	66.2	70,0	42.3	**2002**	2.8	2.5	3.1	5,0
2004	2,0	124.7	**2004**	73.1	80.2	65.8	65.9	45.2	**2004**	4.6	4.3	4.8	8,0
2006	3.0f	126.1f	**2005**	73.2	79.9	66.4	65.2	46.1	**2005**	4.7	4.4	5.1	8.2

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	74.6	80.4	14.7	19,0	61.1	62.1e	5.5	**1995**	8.4	71	-		
2000	75.5	80.5	15.3	19.2	61.4	60.2	5.1	**2000**	8.3	63.1	9	75.6	92
2004	76.9sp	81.4sp	16.2sp	19.8sp	61.7e	58.8e	4.1	**2004**	9.8	61.2	7.8		

s: Eurostat estimate; p:provisional; e: estimate **THE: Total health expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function. % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	30.6	38	28.5	9.9	4.6	6.5	12.6
2000	26.4	42.4	29.3	5.1	4.6	6.8	11.8
2004	28.5	41.6	30.4	6.3	4.8	6	10.9

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Level in **2004** and changes since 2004: Total social expend.	Public pensions	Health care	Long-term care
2005	20.7				
2010	22.2	-0.3			
2030	36.7	3.8			
2050	38.6	4.9			

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	11b	15b	9b	10b	5b	21b	21b	22b	22b	12b	**Total**	4.0b
Male	11b	-	9b	10b	5b	22b	-	23b	26b	11b	**Male**	-
femal	11b	-	10b	10b	6b	20b	-	20b	20b	12b	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	6.9	7.8	6.3	9.4	**1999**	1.2	0.9	1.5	**1999**	16.2	17.5	14.9
2004	7,0	8,0	6.7	9.3	**2004**	1.6	1.5	1.6	**2004**	14,0	16.1	11.9
2006	6.2	7.4	6.2	8.6	**2005**	1.9	1.9	1.9	**2005**	13.6	15.8	11.2

**: excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.879b	0.882b	0.879b	***Aggregate replacement ratio***	0.426b	0.475b	0.517b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								- pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or Social Security)	Current estimate (2002)	Assumption
	-2	0	DB	-2	DB	100	91	7	9.8	11.5-12.5

**:(DB / NDC/ DC); ** (DB / DC)*

AUSTRIA

1. Situation and key trends

GDP growth increased from 2.4% in 2004 to 3.1% according to the forecast for 2006. The total employment rate stood at 68.6% in 2005 (75.4% for men and 62% for women), well above EU average. In spite of recent increases, the employment rate of older workers at 31.8% in 2005 (41.3% for men and 22.9% for women) remains among the lowest in the EU, far below the Lisbon target of 50%. The unemployment rate, while remaining below EU average, increased for the fourth consecutive year to reach 5.2% in 2005 (4.9% for men and 5.5% for women), affecting young people in particular (10.3%). In 2006, unemployment fell slightly. The long-term unemployment rate stood at 1.3% in 2005, well below the EU average. The at-risk-of-poverty rate was 12% in 2004, with a higher risk for women, elderly people, children, people with disabilities and immigrants. People aged 65+ have a living standard, as measured by average income, close to that of the 0-64 population. In 2004, the social protection systems (including old-age pensions) substantially reduced the overall at-risk-of-poverty (from 43% to 12%). Austria is projected to face similar demographic trends to most EU Member States in coming decades: the old age-dependency ratio will steadily increase from 22% in 2004 to 41% by 2030 (EU25 average of 25% and 40 % respectively). Social protection expenditure, as a percentage of GDP, has increased since 2000 reaching 29.1% in 2004 (old age and survivors' pensions 48.2%, health 25%). Life expectancy at birth (76.4 years for men and 82.2 years for women in 2004) is above the EU average[141]. It increased by 3.1 and 2.3 years in the last decade (from 73.3 and 79.9 in 1995). Healthy life expectancy (66.2 for men and 69.6 for women – Eurostat estimates for 2003) is also above the EU average. Infant mortality (4.5 in 2004) is in line with the 2004 EU average of 4.5. It has seen a substantial decrease since 1960 (37.5) and a continued decrease in the last decade (from 5.4 in 1995). Perinatal mortality is moderate (6.4 in 2002) and has steadily declined since 1960 (34.9).

2. Overall strategic approach

The key challenges identified in the National Strategic Report are the intergenerational transmission of poverty and social exclusion, difficult access to the labour market for disadvantaged groups, social and economic inclusion of people with disabilities, and the adaptation of social protection schemes to demographic changes. Austria's priorities for action address these four challenges. The planned measures should ensure the sustainability of welfare transfers, including pensions, and of social and health services, improve their efficiency and effectiveness and adjust them to demographic, social and economic developments. Promotion of equal opportunities for all, an increase of employment and reforms in the health and long-term care systems have been identified as the main policy instruments.

Some cross references between social inclusion policies and reforms in the pension and health systems are made. In particular, measures to enhance educational attainment and employment opportunities for disadvantaged groups are mentioned, which should contribute both to better social cohesion, a higher employment rate and sustainable financing of social protection schemes. Overall, the aims seem ambitious, although quantified targets and indications on implementation, time frame and budgets are not consistently presented. Quantified targets are defined for the reduction of child poverty and for some aspects related to childcare,

[141] The EU average was 75.8 for men and 81.9 years for women in 2004.

employment and social inclusion of the disabled. Coherence with the Lisbon reform programme should be ensured through close cooperation between the respective ministries. The social protection and social inclusion policies support the Lisbon reform programme insofar as they contribute to enhancing employment of disadvantaged groups, to ensuring the financial sustainability of the social protection systems and to exploiting the employment potential in the care and health sector.

Good governance is promoted by an enhanced involvement of a number of stakeholders including ministries, Länder, local communities, social partners and NGO umbrella organisations in the preparation and monitoring of the strategy.

Gender equality has been given limited attention overall, although gender mainstreaming and gender specific measures are mentioned within some policy areas, in particular with regards to labour market measures, the disabled, reconciliation of family and work. Youth policy is mainstreamed in different policy areas tackling issues like health, indebtedness and the re-socialisation of young delinquents.

3. Social inclusion

3.1 Key trends

Inequality of income and the risk of poverty remained below the EU average in 2004. The at-risk-of-poverty rate stood at 12% in 2004, with a higher risk for women (13%) than for men (11%). Unemployment, in particular long-term unemployment, increases the risk of poverty significantly. Moreover, 7% of people in gainful employment above the age of 18 have incomes below the poverty threshold, i.e. can be considered 'working poor'. For children under 18, the rate stood at 15% and is concentrated mainly on households where parents are not sufficiently integrated into the labour market. With rising unemployment, the number of children (aged 0-17) in jobless households increased from 5.6% in 2004 to 6.4% in 2005. Immigrants from non-EU/EFTA countries face a particular high risk of poverty, at 30% in 2004, as compared with those born in Austria at 11%. People with disabilities are also at above-average risk with a rate of 18% in 2004, which is mainly due to the low employment rate (36% in 2004) and low pensions. The increase in unemployment in recent years (from 3.6% in 2000 to 5.2% in 2005) has gone in hand with a significant increase in the number of people receiving social assistance.

Low educational attainment increases the risk of poverty to 18%. It is particularly high amongst women (24.9% in the age group 25-64 years vs. 14.9% for men in 2005). The percentage of early school leavers stood at 9% in 2005, well below the EU average. Among young immigrants, it is as high as 25% according to national data. While the rate of participation in continuous lifelong learning is above EU average at 14% (Eurostat 2005), that of individuals with no more than compulsory schooling is two thirds below the average (4%).

The increase in unemployment has affected disadvantaged groups in particular. The unemployment rate gap between non-EU and EU nationals has almost doubled since 2001, reaching 9.5% points in 2005. People aged 55+ are also particularly threatened by unemployment.

The situation of women continues to be generally less favourable than that of men. The gender pay gap is above the EU average (18% points in 2004). The risk of poverty is higher among lone parents (25%), of whom 90% are female, and women aged 65+ (20% vs. 13% for

men of the same age group).For single women whose main income is a pension the risk is as high as 24%, due to the fact that the minimum pension is slightly below the poverty threshold. Households with female main bread-winners face a risk of poverty almost double that of households with male bread-winners.

3.2 Key challenges and priorities

Austria's main priorities for social inclusion policies are the prevention of poverty and social exclusion among children and young people, the promotion of more labour market opportunities for at-risk groups, in particular the long-term unemployed, older workers, women, migrants and the low qualified, and enhanced participation of people with disabilities. For all three priorities the approach is centred on access to employment and employability with the primary labour market while measures to facilitate access for all to the resources, rights and services needed for participation in society are covered to a lesser extent. The strategy focuses on continuing current policies rather than introducing new measures. The time horizon is generally limited to 2006/mid-2007. The 2006 Joint Report on Social Protection and Social Inclusion identified the increasing risk of social exclusion for the major at-risk-groups against the background of rising unemployment and the low participation in lifelong learning of the less qualified as main challenges for Austria. While the short-term increase in spending on active labour market measures for at-risk-groups has helped to counteract the negative trend in unemployment, continued efforts will be necessary. The low participation of the less qualified in lifelong learning remains a concern.

In view of the higher poverty risk for women (in particular single parents and elderly people) more determined action seems needed. Gender mainstreaming and gender specific action, although mentioned for some areas of intervention, are not strongly emphasised within the strategy. The disadvantaged position of women on the labour market, in particular with regards to atypical employments with limited security and the gender pay gap, is not directly addressed.

The European Social Fund 2007-13, although reduced by around one third as compared to the present period, will continue to make a contribution to the Austrian social inclusion policy, in particular through supporting active labour market policies.

3.3 Policy measures

Policy measures targeting children and young people aim at reducing child poverty to 10% in the next ten years, from the current 15%. Monetary transfers, such as the childcare and family allowances, and tax reductions, are already in place. As the impact of the childcare allowance scheme on social inclusion has been controversial, it would warrant close monitoring and potential adjustment. It is intended to enhance employment opportunities for parents by helping to reconcile family and work, in particular by improving the availability of childcare facilities. The identified additional need of 18.000 places seems, however, to be an underestimate, and the resulting target not ambitious enough to make a decisive improvement regarding in the prospects of parents, in particular women, on the labour market. Investments in the development potential of children focus on promoting reading skills in elementary schools, and early German language learning for children with another mother tongue. Further stepping up efforts to increase the qualifications of young persons with a migration background, could be warranted given their high drop-out rate from school. The integration of young people into the labour market is supported by active labour market measures with substantial additional expenditures until 2006/07. Since 2004, there has been a legally binding

target of offering a qualification or reinsertion measure to all unemployed young people under 25 within three months. Subsidies for apprenticeship places have helped to reduce, but not to eliminate, the demand/supply gap. A number of important instruments other than active labour market measures are planned, such as health prevention in schools, support measures for young people in crisis, and re-socialisation of juvenile delinquents. However, the respective aims and plans for implementation remain vague.

With regards to the integration of disadvantaged groups into the labour market, the strategy aims at contributing to reaching the EU target of a 70% employment rate before 2010, (68,6% in 2005), and in particular at further increasing the employment rate of older workers. Another aim is to reduce unemployment. One target is that 97% of the unemployed should not become long-term unemployed. The problem of working poor is, however, not addressed. A number of active labour market measures are in place for the long-term unemployed, older persons, women, migrants and the low qualified, which are a main pillar of the employment policies defined also in the National reform programme. These measures have been substantially reinforced for 2006/mid-2007, offering qualifications or employment to an additional 60.000 persons. The effectiveness of some of the qualification measures could be improved by better targeting them to individual needs. While some measures aiming at reducing the gender-specific segregation of the labour market are proposed, the increase of mini-jobs and non-standard employment without full social security for women is not addressed. The foreign nationals law package, which entered into force in 2006, will facilitate migrants' access to the labour market, as will professional orientation and qualification measures.

Policies to enhance participation of disabled people aim at creating conditions that provide opportunities comparable to those of people without disabilities**.** This entails integration in regular schools and in the primary labour market, as far as possible, and barrier-free infrastructure. Measures include extending early learning support for children, expanding integrative schools (common schools for disabled and non-disabled), increasing specific active labour market measures for this target group for 2006/mid-07 and enhancing support for occupational therapies, alternative forms of housing, and personal assistance. Equal opportunities will be promoted by recently adopted legal provisions to fight discrimination. Financial incentives will be offered to medium sized companies to invest in barrier-free access.

The use of the European Social Fund 2007-13 in Austria will focus strongly on the inclusion of disadvantaged groups in society, in particular older persons, the low-skilled, disabled people, and people at the margins of the labour market.

3.4 Governance

The section on inclusion of the Strategic Report was drafted in consultation with the major players at national, regional and local levels, including social partners and umbrella NGOs. The tight timetable, however, did not allow extensive discussion of the underlying strategic decisions. Efforts have been made to enhance the involvement of NGOs by inviting the two main umbrella organisations to carry out a survey of existing reform needs, which will be used for future policy planning. It is envisaged to set up a group of independent experts to continuously monitor and evaluate implementation. The results of this work should serve as a basis for the development of the next strategy report.

4. Pensions

In 2004, older people had a living standard very close to that of the general population (95%), while the poverty risk among older people at 14% (gender differences are high, 10% for men and 17% for women) is slightly higher than for the population below 65. In spite of recent increases, the employment rate of older workers remains low at 31.8% in 2005.

The 2006 Sustainability Report assessed Austria as a low-risk Member States as regards sustainability of public finances. According to the AWG 2005 projections, Austria is expected to face low pressure on its public finances from an ageing population. From a spending level of 13.4% of GDP in 2004, an increase of 0.6 p.p. of GDP is expected between 2004 and 2030, while thereafter a decrease of 1.7 percentage points by 2050 is projected, resulting in a level of public pension spending in 2050 1.2 p.p. lower overall than in 2004. According to projections drafted in the framework of the ISG, before the 2004 pension reform the theoretical pension replacement rate was to decrease smoothly for a worker retiring at 65 after 40 years of contributions at the average wage from a level of 74% to 67% (2050), due in particular to the introduction of a loss limit of 10% for pension entitlements gained from the unreformed system. Following that reform, despite a decreasing accrual rate, Austria expects the theoretical gross replacement rate to decrease to 69% (84% net) by 2050.

The 2006 Joint Report on Social Protection and Social Inclusion underlined that the 2004 reform was a major step towards modernised and more sustainable pensions and stressed that a significant increase in the employment of older workers was needed to ensure both the adequacy and sustainability of future pensions, and that it was important to monitor adequacy of pensions and review policy options if necessary. With that reform, Austria harmonised the pension systems by introducing a uniform pension law for all professions for persons aged less than 50. This pension reform leads to a much stronger link between contributions and benefits, including a "bonus malus" system for deferred and earlier retirement, and a switch in the indexation of pensions to consumer prices as of 2006.

Although minimum pensions were increased slightly in 2006, they remain below the poverty threshold, which strongly influences current poverty among women. 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. However, the risk of poverty for female pensioners could increase in future if the participation of women in the labour market is not further enhanced.

5. Health and long-term care

5.1 Health care

Description of the system: The federal government is responsible for the health care system, except for hospital care, for which the federal government is only responsible for general legislation while the provinces (*Länder*) legislate on implementation of policies. Therefore, the federal and provincial governments conclude agreements to ensure the health care. Some 50% of health care expenditure is financed by compulsory social health insurances, 20% by tax revenue and 30% by private households (including financing by supplementary private health insurance). Self-employed health professionals provide most primary and secondary outpatient care. Outpatient clinics, owned by hospital providers or statutory health insurance funds, deliver secondary outpatient and dental care. General practitioners coordinate care and referrals, serving as formal gatekeepers to inpatient care except in emergency cases. However, patients often access outpatient clinics directly. Public health authorities deliver child health

care and screening services, often financed by statutory health insurance. Acute secondary and tertiary inpatient care is provided by 'fund hospitals', owned by municipalities, *Länder*, religious and other not-for-profit organisations, or by private for-profit hospitals.[142]

Accessibility: The social health insurance system is mandatory for the vast majority of the population. It covers around 98% of the Austrian population, including some social assistance recipients for whom the *Länder* pay contributions. Social health insurance covers all services linked with the treatment of an illness. All individuals covered by social health insurance are entitled to the social health insurance services and benefits laid down by law. Eligibility is not subject to means-testing. When using certain health care services, the insured have to make co-payments or take account of patient deductibles. There are exceptions for low-income earners and for people who provide proof of above average expenses due to illness. Supplementary private health insurance is mainly used to obtain better hospital accommodation and the doctor of one's choice at private hospitals. However, there are still around 2% of the Austrian population who are not covered by health insurance. Social assistance schemes, for which the *Länder* are responsible, pay the treatment costs for some non-insured persons. New legal provisions open access to health care further, in particular granting social insurance coverage to asylum seekers in need of assistance. While Austria has no nationwide data on waiting lists, there seem to be no major issues concerning waiting lists.

Quality: At federal level a large number of laws and regulations have been adopted in recent years that partly contain quality specifications (currently approx. 50 standards). In addition, a variety of standards have been set at *Länder* level. The framework for mandatory quality work has been strengthened by legal standards especially the Federal Act on the Quality of Health Care Services. Future challenges will lie in their implementation. The federal government has supported and financed a large number of quality-related (project) activities, on issues such as interface management, quality reporting, patient guidance, use of antibiotics and prevention of adverse events.

Long-term sustainability: Total health care expenditure (at 7.5% of GDP and 2365 PPP$ per capita in 2004) was recorded to be slightly below the EU average in GDP terms. Public healthcare expenditure as a share of total health expenditure was about 67.6% and mostly constant from 1998 to 2004.[143] According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.6 percentage points of GDP by 2050 due to population ageing, whereas a national projection is 1.2% of GDP. Improving the use and impact of the available financial funds in health care is a continuous challenge to ensure financial sustainability, making it necessary to exploit rationalisation and efficiency improvement potentials. There are continuous policy talks and agreements with doctors' and pharmacists' associations and the pharmaceutical companies to achieve a sustainable dampening of the rising costs of pharmaceuticals. These changes, e.g. a revised reimbursement scheme for pharmaceutical innovations and generics, reduced average cost increases from 7-9% earlier to some 3% in 2005. Demographic developments and patients' increased demands on the services provided are confronting the health and social care sector with major challenges. Nursing and long-term care is becoming increasingly complex and raises both the quantity of staff needed and the quality standards expected of well-trained nursing staff.

[142] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005

[143] Revised expenditure calculations, with the OECD System of Health Accounts, were recently introduced and resulted in increased figures that place Austria in the upper middle bracket among Member States.

5.2 Long-term care

Description of the system: The Austrian system for long-term care has two main components. Firstly, a universal allowance system for long-term care accessible to all those in need of long-term care was introduced in 1993. These benefits are entirely financed from taxes. They are granted to about 4% of the population on the basis of seven categories of need that depend on the hours of nursing care required per month.[144] The allowances provide flat-rate cash benefits that contribute to paying for additional expenses incurred because of a person's need for care, giving the individuals concerned a better chance of managing their own lives, e.g. staying in their own homes. Secondly, the *Länder* are responsible for providing social services for long-term care. In 1993, an agreement between the federal government and the *Länder* was concluded, with a catalogue of services and quality standards. The federal government has undertaken to provide social insurance cover for informal caregivers. 80% of all people in need of long-term care are cared for by family members at home.

Accessibility: The federal and corresponding provincial long-term care allowance programmes cover all persons in need of care, irrespective of age.[145] Persons not entitled to benefits under the federal scheme will receive long-term care benefits from the *Länder* at the same rates and in accordance with the same rules as in the federal scheme. Persons in need of care are legally entitled to this benefit irrespective of their income or wealth, and irrespective of the reason for requiring such care. However, income and assets, as well as care allowance, are taken into account in calculating the beneficiaries' financial contributions to social services. If the household does not have the income or assets to pay for the services, the social assistance service can provide funding in addition to the care allowance. Institutional care is predominantly provided by provinces and municipalities, or by religious and other non-profit organisations. Home care services are provided by non-profit organisations. Informal care traditionally plays a major role in Austrian long-term care. The formal home care sector is still expanding and there are marked regional differences in the availability of services, in particular of services to support informal care giving (such as counselling and respite care).[146]

Quality: There are several efforts made to enhance quality in long-term care. Creating uniform and binding quality standards together with quality assurance procedures for social services is one challenge. A first step in this direction is the agreement concluded between the federal government and the *Länder* on social care occupations, in force from July 2005, which introduced uniform standards for social care training and work. Particular emphasis is placed on standards for ambulatory care, including free choice between available services as well as quality assurance and monitoring by the *Länder*. The agreement concluded in 1993 also defines minimum standards for institutional care, including e.g. priority for small care facilities integrated in the local community and free choice of doctor. All *Länder* have now adopted rules for supervising old-age and nursing homes, including provisions that ensure the legal protection of residents. The policy of "Quality assurance in home care" is increasingly important to both receivers and providers of care. Home visits by certified care workers are a key tool to check, inform and counsel all those involved in a home care situation. Providing support to caring family members is considered a top priority within long-term care, as the work of informal carers is very valuable to society as a whole but frequently associated with great physical and psychological stress.

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[144] Snapshots of health systems, European Observatory on Health Systems and Policies, 2005
[145] Long-term care for older people – ISBN 92-64-00848-9 – © OECD 2005
[146] Long-term care for older people – ISBN 92-64-00848-9 – © OECD 2005

Long-term sustainability: In 2005 the federal government spent € 1566 million on long-term care benefits. The *Länder*'s expenses under provincial long-term care benefit legislation amounted to some €282 million in 2004. Expenses on benefits in kind for social services totalled €1423 million in 2004, mainly financed by the *Länder*'s budgets (social assistance) and partly by municipalities, while the users of such services have to contribute towards these costs with socially graduated co-financing amounts. According to the 2006 EPC/EC projections public long-term care expenditure is projected to increase by 0.9 percentage points of GDP by 2050 due to population ageing (from 0.6% of GDP in 2004), while a national projection is 0.7 percentage points of GDP. (These projections only refer to expenditure under the Federal Long-term Care Allowance Act.) A major challenge for the financial sustainability of long-term care lies in demographic developments that might require more social services and therefore lead to increased financial requirements, which are expected to be balanced by significant employment effects. One immediate challenge, and an important point in the drafting of the new government's agenda, concerns the current availability of professional nursing and care staff, including the recruitment of migrant workers.

6. Challenges ahead

Further reinforce efforts to break the intergenerational transmission of poverty; in this context to develop stronger links between lifelong learning and social inclusion policies, in particular for young immigrants.

Adopt stronger steps to enhance active inclusion of women, especially of single mothers, older female workers and pensioners.

Ensure both the 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, and review policy options if necessary.

To strengthen control of health care expenditure increases through continuous work to counteract various cost-raising factors, such as pharmaceuticals, and to improve the overall efficiency of the health care system.

To continue to improve support functions for informal (family) carers and to recruit, train and keep the professional care workers needed for future long-term care, especially with respect to changing family conditions.

To implement in practice the new legal framework of quality standards and procedures for health care and long-term care services.

AUSTRIA

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3.4	125.5	**2000**	68.5	77.3	59.6	52.4	28.8	**2000**	3.6	3.1	4.3	5.3
2002	0.9	120.0	**2002**	68.7	76.4	61.3	51.7	29.1	**2002**	4.2	4.0	4.4	6.7
2004	2.4	123.4	**2004**	67.8b	74.9b	60.7b	51.9b	28.8b	**2004**	4.8	4.4	5.3	9.4
2006	3.1f	123.3f	**2005**	68.6	75.4	62.0	53.1	31.8	**2005**	5.2	4.9	5.5	10.3

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop.covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	73.3	79.9	14.9	18.6	60.0	na	5.4	**1995**	8.5	69.7	-		0.1
2000	75.1	81.1	16.0	19.4	64.6	68.0	4.8	**2000**	7.5	68.1	20.4	99	
2004	76.4sp	82.2sp	16.9sp	20.3sp	66.2e	69.6e	4.5	**2004**	7.5	67.6	19.2	98	31.8

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	28.7	46.9	25.6	5.8	11.3	1.3	9.1
2000	28.2	48.4	25.4	5	10.7	1.4	9.1
2004	29.1	48.2	25	6	10.7	1.8	8.3

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004: Total social expend.	Public pensions	Health care	Long-term care
2005	23.6	25.4	13.4	5.3	0.6
2010	26.3	-1			
2030	40.8	0.8	0.6	1	0.3
2050	53.2	0.1	-1.2	1.6	0.9

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	15	12	11	14	15	14	15	18	14	**Total**	3.8
male	11	-	11	11	10	15	-	17	19	12	**male**	-
femal	13	-	13	11	17	15	-	15	17	15	**female**	-

	People living in jobless households				Long Term unemployment rate			Early school-leavers		
	Children	% of people aged 18-59*			% of people aged 15-64			% of people aged 18-24		
	Total	Total	Male	Female	Total	Male	Female	Total	Male	Female
1999	4.2	8.2	6.5	9.8	1.2	0.9	1.5	10.7	9.6	11.9
2004	5.6i	8.8i	7.6i	10.0i	1.3 b	1.3b	1.4b	8.7i	9.5i	7.9i
2006	7.2	8.8	7.8	9.8	1.3	1.2	1.4	9.0	9.4	8.5

**: excluding students; i: change in methodology; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.95	1.02	0.91	***Aggregate replacement ratio***	0.67	0.67	0.67

Change in theoretical replacement rates (2005-2050) - source ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
			Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**				pensions (or Social Security)	pensions	
Total	Total	Statutory pensions				Statutory pensions	Occupational and voluntary pensions			Estimate of current (2002)	Assumption
4	5	5	DB	/	/	100	/		22.8	/	/

**:(DB / NDC/ DC); ** (DB / DC)*

POLAND

1. Situation and key trends

In recent years Poland has enjoyed sustained economic growth (3.2% in 2005 and according to forecasts: 5.2% in 2006), but this has not generated many new jobs. Even though the employment rate increased by 1 percentage point to 52.8% in 2005, it is still the lowest in EU, particularly for women (46.8%) and older workers (27.2%). The unemployment rate declined by over 1 percentage point and reached 17.7% in 2005 (16.6% for men and 19.1% for women). The long-term unemployment rate, at 10.2%, is the second highest in the EU. The at-risk-of-poverty rate[147] stood at 21% in 2004, significantly above the EU average. The main group facing poverty was children. Total social expenditure, as a percentage of GDP, reached 20% in 2004, with 60.1% of expenditure related to pensions, 19.5% to healthcare, and 11.5% to disability. Only 0.8% was spent on housing and tackling social exclusion.

Poland is projected to face similar demographic trends to most EU Member States in the coming decades: the elderly dependency ratio will grow from a current level of 19% to 33% by 2025 and to 51% by 2050 (close to the EU-25 average of 52%). Life expectancy (70.6 and 79.2 years for males and females in 2004) is below EU average, but has been consistently increasing over the last decade (67.6 and 76.4 in 1995) following a decrease in 1989-1991. Poland is facing a rapidly decreasing total fertility rate: from 2.0 in 1999 to 1.2 in 2004. Although the infant mortality rate is considerably and steadily decreasing (from 56.1 in 1960 to 13.6 in 1995, 7.0 in 2003 and 6.8 in 2004), it is amongst the highest in the EU.[148] Healthy life expectancy (62.5 years for men and 68.9 years for women) is below the EU-15 average (64.3) for men but quite high and above the EU-15 average (65.8) for women. Perinatal mortality is also high at 7.5 in 2003.

2. Overall strategic approach

The National Strategic Report (NSR) sets as the main policy objective the creation of integrated systems for delivering state policy leading to greater social cohesion, supported by mutually reinforcing social and economic policies, increasing employment, good governance and the involvement of various stakeholders in policy design, implementation and monitoring. To achieve this, the NSR identifies a broad range of priorities and specific measures in the area of social inclusion, social protection, and health care, without, however, systematically assessing their impact on social cohesion and equal opportunities for all. The synergy and the links between the three policy fields should be better developed in a common drive to achieve the strategic policy objective.

The policy approach presented in the NSR is interlinked with the National Reform Programme (NRP) in the area of macroeconomic and employment policies. The NRP is intended to complement the NSR by reforming various social assistance schemes, leading to early withdrawal from the labour market, improving farmers' social insurance system, continuing health care reform, and vocational activation of vulnerable groups, including the disabled.

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[147] Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to EU SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

[148] The EU average was 4.5 in 2004.

A separate priority for governance is envisaged, aimed at improving policy coordination, increased the involvement of all stakeholders and mainstreaming social policy in overall state policy. Although a considerable effort has been made to define indicators in the social inclusion part of the NSR, the absence of quantified targets is regrettable. The gender dimension is included, but with limited visibility. A consistent gender mainstreaming approach, and indications as to how the specific problems of disadvantaged women will be addressed, are outlined in general terms, but need more attention.

3. Social inclusion

3.1 Key trends

Despite sustained economic growth, Poland still has the worst employment and unemployment indicators in the EU. The risk-of-poverty rate was 21% for men and 20% for women. Poverty and exclusion are mainly associated with being out of work. In 2004, the rate of extreme poverty (which, in national statistics, refers to a "market basket" of goods including those needs, whose satisfaction cannot be postponed in time and consumption lower than defined by this level leads to biological deterioration) in households with at least one unemployed person was 26%, whereas in households where no one was unemployed the rate was only 7%. The "working poor" phenomenon affected 14% of people at work, and among them mainly the self-employed. The groups particularly affected by poverty and social exclusion are children (29%), young people, the long-term unemployed, and people living in rural and deprived areas. There is also a high correlation between the risk of poverty and a large number of children in the household.

Social transfers have a significant impact on poverty reduction. Poland has the highest poverty rate prior to social transfers in the EU (51% in 2004). The strongest effect of social transfers on poverty reduction is observed among people over 64 (mainly due to pensions). Although unemployment benefits themselves do not provide a high replacement ratio (65%), when combined with other social transfers, they generate a substantial unemployment trap (83%).

The education level of the Polish population has been improving and educational attainment at 22 years old is one of the highest in the EU (90%). In 2005, early school leavers accounted for only 5.5%. The education system nonetheless contains many inequalities, especially between urban and rural areas. The highest youth unemployment rate in the EU at 36.9% reveals a mismatch between the education system and the needs of the economy.

3.2 Key challenges and priorities

Poland set up three priorities for social inclusion: support for families with children aimed at equalising access to goods and services, ensuring economic security and facilitating reconciliation of work and family life; inclusion by activation, mainly through developing the social economy, reforming tools and instruments for active integration and supporting public-private partnership; and mobilisation and partnership by reinforcing social assistance institutions, strengthening their cooperation with labour market institutions. The above actions will be supplemented by the priority relating to the common objective of better governance, aiming greater policy coordination and at increasing ownership of the social inclusion process.

The strategic approach presented is consistent with the common objectives for fighting poverty and social exclusion. It also responds to the country-specific challenges identified for Poland in the 2006 Joint Report on Social Protection and Social Inclusion. However, the NSR needs a more operational outline of how to achieve these strategic objectives. The strategy combines a continuation of current policies with new initiatives. Some long-term measures, which could have a significant preventive effect on social exclusion (i.e. affordable housing, development of care services), are still being planned. The integration of various education policy measures, and their contribution to policy goals, should be better recognised. There is a certain amount of confusion between objectives and challenges, and some instruments cited under the various priorities seem to overlap. In addition, the links between each measure and the corresponding objective are not always explicit. Lastly, the list of policy measures could be extended to fully ensure their long-term influence on poverty reduction and social exclusion.

3.3 Policy measures

Regarding families with children, the proposed measures focus on developing integrated systems of assistance through supporting incomes, and facilitating reconciliation of work and family life (developing care services and promoting flexible forms of employment). Although the high level of poverty among children fully justifies these measures, the priority does not address the risk of poverty and exclusion faced by single parents. Nor does it refer to prevention and treatment of various addictions, or prevention and treatment of family violence, which often lead to child poverty and exclusion. It is also necessary to level out the quality of the education system at different stages and to provide the necessary financial means, particularly for pupils and students from the poorest families.

Groups threatened by social exclusion will be integrated mainly through improving their access to the labour market, developing the social economy and reinforcing the links between the guaranteed minimum income and activation instruments. Special emphasis was put on people with disabilities. Poland still has to deal fully with reforms in the disability benefit system (i.e. re-evaluate existing disability rights), but the first steps towards improving the low activity rate of the disabled have already been taken. Other groups of instruments will be focused on developing public-social partnerships, by strengthening cooperation between public entities and NGOs operating in the field of social services. The social economy will be supported by developing advisory services, setting up local loan funds and conducting a promotion campaign. The implementation of these measures will depend, however, on local circumstances, such as the organisational and financial strength of the social assistance institutions and their ability to mobilise all partners.

Therefore, in order to strengthen the social assistance system and to involve all relevant stakeholders, a priority for mobilisation and partnership is envisaged. Further development of social services and social assistance institutions will be achieved through increasing the number of social workers, and facilitating cooperation between public employment services and social assistance centres. Complementary actions, planned under the better governance priority, are aimed at improving policy coordination, involving all partners and mainstreaming social integration policy in overall state policy. Although Poland notes some progress in strengthening the administrative capacity of social assistance institutions, the complicated power structure and poor coordination between programmes implemented at various levels remain a concern.

The document contains some statistical data disaggregated by gender, but this is not consistent across the strategy. Reconciling family and working life is recognised as important to increase the fertility rate and to prevent intergenerational transfer of poverty, but promoting gender equality per se is not an explicit goal. A gender breakdown of target populations (provided in tables and annexes) is not discussed in the strategic part. NSR acknowledges the role of the ESF in carrying out the measures planned, but does not give any information on the planned financial allocations.

3.4 Governance

The drafting and consultation process for the NSR involved the representatives of relevant ministries, social partners, NGOs, and higher education entities. Although an effort was made to encourage major actors to engage in active discussion, it seems that the NSR is still not a matter of wide public debate. The situation may improve slightly, especially at local level, once the planned promotion campaign is implemented. Work is under way to establish a monitoring system for social inclusion at national and regional levels. The monitoring indicators devised contain both the main outcome indicators to monitor progress in social inclusion, and input indicators to evaluate implementation of the respective policies. Regrettably, the NSR neither includes any quantified targets, nor contains any analysis of the budgetary implications of the planned activities and policies (although the sources of financing are indicated).

4. Pensions

In 2004, older people had a living standard relatively higher than that of the general population (109%), while the poverty risk among older people (7%) is significantly lower than that of the population below the age of 65. In spite of recent increases, the employment rate of older workers remains very low.

The 2006 Sustainability Report assessed Poland as a low risk Member States as regards sustainability of public finances. The AWG's 2005 projections show a considerable drop in public pension expenditure from 13.9% to 8.0% of GDP over the period 2004-2050 (pension expenditures decrease to 9.3% of GDP in 2050 when the mandatory funded tier is taken into account). Nevertheless, the pay-as-you-go tier is projected to remain in deficit until the mid-2030s due to transition costs. According to ISG projections, the net replacement rate would gradually decline from 2005 to 2050 from 78% (63% gross) to 44% (36% gross) unless the balance between the years in employment and retirement is improved (the decrease is lower for people retiring at 67 after 42 years of contributions).[149]

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, subsidised by moderate tax incentives. 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. The planned reform of early retirement schemes has been delayed by one year and the rules for the miners' pension scheme

149 These calculations are based on wage growth in line with relatively strong productivity growth and with a uniform interest rate for the EU. Any departure from these assumptions may result in a less marked decline in replacement rates.

have been changed back to the old system. Such delays in reform weaken the message that change is necessary. Further initiatives translating into a return to the old system (for instance for people working in so-called special conditions) would erode the pension reform.

Following the projected decline in the replacement rate, the adequacy of pensions may become an issue in the future, notably for those with short careers, predominantly 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 route to early labour market exit. The preparation of legislation for the payout phase of the funded tier of the statutory scheme (annuities) should be concluded soon, as the first pensions will have to be provided in 2009.

5. Health and long-term care

5.1 Health care

Description of the system: The compulsory health insurance scheme administered by the National Health Fund (NHF) and its regional branches (16) provides universal coverage with a defined benefit package to insured persons (with a list of excluded services). Provision is decentralised (there are three tiers: central, regional and communal) and paid out by the decentralised NHF branches. Primary health care (PHC) is provided in outpatient clinics and at home (with doctors obliged to provide home services when required for medical reasons). Family doctors act as gate-keepers for specialist and hospital care. Specialist outpatient care (about 80%) is based on private medical practices or specialised health centres. Doctors (PHC) are paid on a capitation basis. Inpatient hospital care is provided in predominantly public hospitals. The system is financed mostly by insurance contributions with state, regional, county and local budgets financing some population groups (e.g. unemployed people) and capital investment. Private voluntary (supplementary) insurance is negligible. Some companies offer accident and health insurance packages (mostly outpatient care) to their workers. Co-payments apply to food, drugs, medical devices and transport. The national strategy aims at enhancing health promotion and healthy living, increasing the effectiveness of services, achieving better value for money and reducing the health status gap in relation to the EU average.

Accessibility: Though population and service coverage is high there are significant regional discrepancies in care availability (lack of certain specialists) and thus access to health care. Moreover, patients' out-of-pocket payments are high (26.2% in 2004 of total health spending plus informal payments) due to co-payments and the use of private sector hospitals, adversely affecting vulnerable groups. Waiting lists and times for some impatient services are extensive. This results in limited access and forces patients to opt for the private sector, where they have to pay the full cost of care. Waiting data is collected and is to be better monitored, however. The waiting list management system is being improved. The number of GPs is rather low (11.9 per 100 000 inhabitants) by EU standards and can be an obstacle to ensuring access and developing a functioning PHC system. Additional investment in infrastructure is planned, together with a 24-hour info-line and special electronic services (e-health). The authorities are considering reducing patients' financial input by changing the system for reimbursing pharmaceuticals. As well as compiling a list of guaranteed health services, covered by the public health insurance scheme, the authorities are to extend its scope by introducing new schemes of health insurance. This will result in increased coverage and additional resources

for the healthcare system. The authorities are improving the functioning of the national medical emergency system and aim to develop a hospital network, to avoid duplication of provision and strengthen the PHC system so that it becomes the first pillar to the system guaranteeing access. The main concern for the authorities in terms of access is extending the scope of insurance to achieve better and wider coverage of the population. A package of Health Care System Acts will introduce a defined 'basket' of guaranteed health services covered by the public health insurance scheme.

Quality: The Centre for Health Care Quality Monitoring (CHQM) provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are to be developed based on independent expertise. Authorities are developing a health information system and systematic monitoring of quality indicators at different levels. An accreditation system for service providers is being developed on an ongoing basis. The use of technology assessment will increase, leading to evidence-based contracting of services. The authorities aim to publish a Patient's Guide to services, setting out patients' rights. Additionally the planned Health Care System Acts will define the rights and responsibilities of patients.

Long-term sustainability: Total health care expenditure (6.4% of GDP and per capita PPP$810 in 2004) is below the EU average[150]. Per capita expenditure has increased over time and in real terms. Public health expenditure represented 70% of total health expenditure in 2004, with private health expenditure standing at 30% of total health expenditure. According to the 2006 EPC/EC projections public health care expenditure is set to increase by 1.4 percentage points of GDP by 2050 due to population ageing. The cost of drugs in relation to total health expenditure is one of the highest in Europe (30.3% in 2003). Increased demand for care is straining the financial sustainability of the system with a high, albeit declining, degree of indebtedness of care providers. To ensure extra funding, the NHF contribution rate is increasing annually by 0.25% from 7.5% in 2000 to 9% in 2007. Additionally, efforts to improve the effectiveness and efficiency of provided services, such as new rules for the accreditation and establishment of healthcare providers and the increase of public funding towards healthcare entities, are underway. The number of acute hospital beds has decreased and is about the EU average (463.2 acute beds per 100.000 inhabitants in 2003). Average length of stay has also decreased. Further restructuring is necessary: PHC needs to be strengthened and outpatient contacts need to increase vis-à-vis unnecessary and expensive specialist and hospital inpatient care. Agreed drug prices, reference prices and electronic prescription have been introduced to control pharmaceutical expenditure. The system of national health accounts is constantly being improved. Improving care coordination is to bring efficiency gains. With regard to staff, the number of medical professionals is low[151] in EU terms. The structure is imbalanced, with too many specialists. Wages are low and the authorities plan to progressively increase them in order to tackle staff migration. In order to improve health status and productivity, promotion and prevention is emphasised through various programmes (e.g. the National Programme for Cardiovascular Diseases).

5.2 Long-term care

Description of the system: The long-term care (LTC) system operates within both the health and social care sectors. Local bodies are responsible for the provision of long-term care. Under universal insurance coverage, long-term care can be provided in residential or nursing units and care units (hospitals) or as home care (but less so) and is complemented with PHC visits. Care

[150] EU average was 8.87% and 2376.33 PPP$ in 2004
[151] 243.3 practicing physicians and 548.8 nursing staff per 100.000 inhabitants in 2003

services for lower-income groups can also be provided in social welfare centres. While care is funded by the NHF, food and accommodation is funded through the central budget for vulnerable groups, people with severe problems and chronic diseases, on a means-tested basis.

Accessibility: Social assistance is provided in welfare houses which pay additional costs that are not covered by the NHF. Local authorities test the conditionality for receipt of social assistance. They means-test according to household size and income, comparing that level to healthcare costs. New facilities have been set up, grants for service providers have been awarded and special training programmes for nursing staff pursued. Transforming acute care capacity into nursing capacity is a priority for the authorities. In the light of growing demands for LTC, the scope and availability of services are deemed insufficient. There is little state provision of community care services and too few nursing beds. Distribution across the country is uneven and coordination between different stakeholders is unsatisfactory, hampering access in smaller and rural areas.

Quality: The Health Care System Acts will cover the scope of PHC and specialist care (e.g. geriatrics) and the development of the hospital network, defining the competences and responsibilities of LTC entities. They will also enhance coordination between medical branches, competent authorities and social partners. The authorities have identified support for training of staff and nurses as a priority, both to improve quality and retain staff.

Long-term sustainability: According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.1 percentage points of GDP by 2050 due to population ageing. Integrating health and social care services and developing the social infrastructure in rural areas remains a challenge. This will be partly addressed by the compulsory nursing insurance to be introduced, which will provide additional resources for financing the system by increasing the share of NHF funding.

6. Challenges ahead

To promote active inclusion by decreasing inequalities in the education system, further developing active labour market instruments, particularly for young people, women and older workers, implementing policies to make work pay for recipients of various forms of social transfers, and providing the social services needed to support integration in employment, especially for large families.

To pursue action to strengthen the administrative capacity of social assistance and labour market institutions, supported by mechanisms improving coordination of policies at various levels. To ensure that sufficient resources for adequate pensions are available until the funded schemes have matured, while monitoring future adequacy and raising the employment rate of older workers and people with disabilities.

To continue the pension reform process, by reforming the farmers' and disability pension scheme and organising the conversion of funded pension savings into safe annuities.

To ensure equal and better access to healthcare and LTC services by reducing regional discrepancies in supply (notably PHC), patients' direct financial burden of care and long waiting times, by increasing public health expenditure to address under-financing, and improve care purchasing and the administration of purchasing entities.

To improve system efficiency by strengthening PHC, outpatient care and day-case surgery vis-à-vis inpatient care and implementing pharmaceutical reimbursement reform.

Poland: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.2	46.7	**2000**	55,0	61.2	48.9	24.5	28.4	**2000**	16.1	14.4	18.1	35.1
2002	1.4	46.3	**2002**	51.5	56.9	46.2	21.7	26.1	**2002**	19.9	19.1	20.9	42.5
2004	5.3	48.7	**2004**	51.7	57.2	46.2	21.7	26.2	**2004**	19,0	18.2	19.9	39.6
2006	5.2f	51.1f	**2005**	52.8	58.9	46.8	22.5	27.2	**2005**	17.7	16.6	19.1	36.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (data for 1996 and 2002)		Infant mortality rate	WHO	Total health exp. %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	67.6	76.4	12.9	16.6	n.a.	n.a.	13.6	**1995**	5.6	72.9	-	n.a.	n.a.
2000	69.7	77.9	13.6	17.3	59.9	66.8	8.1	**2000**	5.7	70.0	30.0	n.a.	n.a.
2004	70.6sp	79.2sp	14.2sp	18.4sp	62.5	68.9	6.8	**2004**	6.4	70.0	26.2	n.a.	n.a.

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure *(% of GDP)	Old age and survivors	Sickness and health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	19.5	55.8	19.8	4.6	5,0	0.6	14.1
2004	20.0	60.1	19.5	3.5	4.6	0.8	11.5

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2004	18.7	23.7	13.9	4.1	0.1
2010	18.8	20.2	n.a.	n.a.	n.a.
2030	35.7	14.4	9.2	5.1	0.1
2050	51.0	13.7	8.9	5.5	0.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	21b	29b	18b	20b	7b	30b	33b	29b	30b	17b	**Total**	6.6b
male	21b	-	19b	21b	5b	31b	-	30b	31b	19b	**male**	-
femal	20b	-	17b	20b	9b	30b	-	28b	30b	16b	**female**	-

	People living in jobless households					Long-term Unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 16-54				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	n.a.	n.a.	n.a.	n.a.	**1999**	5.8	4.5	7.4	**1999**	n.a.	n.a.	n.a.
2004	n.a.	15.8	14.8	16.8	**2004**	10.3	9.6	11.0	**2004**	5.7b	7.7b	3.7b
2006	11.2	13.5	12.3	14.6	**2005**	10.2	9.3	11.4	**2005**	5.5	6.9	4.0

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	1.089b	1.204b	1.022b	***Aggregate replacement ratio***	0.585b	0.658b	0.573b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
			Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**				Pensions (or social security)	pensions	
Total	Total	Statutory Pensions				Statutory Pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
-33	-27	-27	NDC and DC		n.a.	77	n.a.	n.a.	36.9	n.a.	n.a.

**:(DB / NDC/ DC); ** (DB / DC)*

PORTUGAL

1. Situation and key trends

Underlining the structural weaknesses of the economy, average GDP growth rate in the period 2001-2006 was below 1% per year (0.4% in 2005). The overall employment rate decreased from 68.4% in 2000 to 67.5% in 2005. However, the overall Lisbon target is still within reach and the intermediate targets for women and older workers were achieved in 2005 (61.7% and 50.5% respectively). Unemployment increased from 4% in 2000 to 7.6% in 2005, with a significant impact in youth and long-term unemployment. In 2005, the proportion of early school leavers remained extremely high at 38.6%, and the youth educational attainment level very low (48.4%). These two education indicators are very far below the EU averages. The at-risk-of-poverty rate after social transfers (20% in 2004) and inequality of income distribution (ratio 8.2 in 2004) are among the highest in the EU. Children and the elderly are most at risk of poverty.

Portugal is expected to face faster ageing than most EU Member States in the next decades. The old-age dependency ratio is projected to increase from 25.2% in 2004 to 58.1% in 2050. Public pension expenditure was 11.1% of GDP in 2004, and is projected to increase by 9.7 p.p. until 2050. Life expectancy at birth (74.9 for males and 81.5 for females in 2004) is slightly below the EU average,[152] showing a significant increase since 1995 (71.6 and 78.7) and a consistent increase over time (63.8 and 70.3 in 1971). Healthy life expectancy (59.8 and 61.8 in 2003) is below the 2003 EU average[153] and has remained stable since 1995 for men, with a small reduction for women. Infant mortality (4 in 2004) is around the 2004 EU average of 4.5, a reduction from 77.5 in 1960 and 7.5 in 1995. Perinatal mortality (5.1 in 2003 and 4.4 in 2004) is about EU average, a substantial reduction from 41.1 in 1960.

2. Overall strategic approach

To address structural weaknesses and promote social cohesion, Portugal has identified five key challenges: (i) to pursue economic development, improved competitiveness and budgetary consolidation, while making the necessary changes to structural factors that lead to greater social cohesion; (ii) to significantly reduce poverty levels by focusing on extreme and persistent situations of poverty and social exclusion, while preventing the reproduction of inequalities; (iii) to reform the social protection system to ensure its efficiency, adequacy and financial sustainability; (iv) to improve access to social services, in particular to health and long-term care, and to quality social infrastructure, as a means of promoting healthy working lives and reconciliation of work and family life; (v) to improve the effectiveness of governance in drafting, implementing and assessing policy.

Portugal has significantly improved its strategic approach, and focused on a small set of core priorities that address the key challenges in a fairly comprehensive manner. Although not covering the multitude of existing problems, the strategy has the potential to produce a significant impact on social cohesion, if strongly pursued and sustained by all stakeholders, over the long term. Most of the social inclusion measures have identified the necessary financial resources, set quantified targets, and monitoring indicators. Setting clear overall targets for the main political priorities would give the strategy further credibility.

[152] EU average of 75.8 and 81.9 for males and females in 2004.
[153] EU average of 64.5 and 66 for males and females in 2003.

Social cohesion is one of the key challenges in the Lisbon National Reform Programme (NRP). The 2006 NRP Implementation Report shows substantial progress in incorporating some of the priorities and measures of the Open Method of Coordination (OMC) on Social Inclusion. The "Employment" chapter now identifies shared priorities as raising the qualification levels of the population, reconciling work and family life, and developing activation policies for those excluded from the labour market. The "Macro" chapter includes the reform of the health and social protection systems to ensure their sustainability and adequacy, while the "Micro" chapter sets out action on the structural factors that strongly contribute to reproduce patterns of social exclusion.

Governance of the strategy has been improved by increasing policy coordination mechanisms, and increasing the involvement of the main stakeholders. Through the Non-governmental Forum for Social Inclusion, stakeholders were given a real opportunity to contribute to the process from the conception stage. The potential contribution of Local Social Networks (LSN) has not been fully exploited to profit from their knowledge of local realities and experience. The report could have provided more strategic gender guidelines in close coordination with existing national structures responsible for gender issues. The collection of gender-related data has scope for improvement and the report could be more specific on identifying measures to assess the gender impact of the proposed policies.

3. Social inclusion

3.1 Key trends

The economy remains structurally weak, with a development model based on unskilled and labour intensive activities that offer low wages and poor quality jobs, resulting in low levels of productivity and a high number of working poor (11.4% in 2003). The difficult budgetary situation, with a general government deficit of 6% of GDP in 2005, a large external deficit, and high private sector indebtedness, has strongly conditioned economic recovery.

Youth employment decreased from 42.2% in 2000 to 36.1% in 2005 (40.5% for men and 31.4% for women). However, the employment rate of women continued to increase, from 60.5% in 2000 to 61.7 in 2005.

Unemployment has increased significantly, from 4% in 2000 to 7.6% in 2005, with long-term unemployment now accounting for almost 50% of that total. The youth unemployment rate was 8.8% in 2000, but increased significantly to 16.1 in 2005 (13.6% for men and 19.1% for women). The labour market continues to be highly segmented, with almost 40% of all those employed being either on fixed-term contracts or self-employed. The gender gaps in employment and unemployment favour men, but have decreased slightly since 2000. The gender pay gap in the private sector remained at almost 25% in 2005.

Despite falling since 2000 (when it was 42.6%) the proportion of early school leavers continues to be extremely high and was still 38.6% in 2005 (46.7 for men and 30.1 for women). The educational attainment of young people has improved, from 42.8 in 2000 to 48.4 in 2005 (40.4 for men and 56.6 for women). These two indicators are still very far below the EU averages and the situation is particularly serious for men, with the gender gaps increasing since 2000.

The at-risk-of-poverty rate after social transfers (20% in 2004) and inequality of income distribution (ratio 8.2 in 2004) are among the highest in the EU. Older people (in particular

women) and children are most affected by poverty. In 2004, social protection expenditure was 24.9% of GDP, far below the EU average of 27.3%.

3.2 Key challenges and priorities

The report identifies six multidimensional and systemic risks that strongly affect social inclusion in Portugal: (i) child and elderly poverty; (ii) school failure and early school leaving; (iii) low qualification levels; (iv) low participation in life-long learning; (v) info-exclusion; (vi) inequality and discrimination in the access to rights of people with disabilities and immigrants. These risks have been substantiated with statistics and detailed analysis.

To address these risks, three key priorities have been established: (i) fight child and elderly poverty, through measures ensuring basic rights of citizenship; (ii) correct the disadvantages in qualification levels, as a means of preventing exclusion and interrupting poverty cycles; (iii) overcome discrimination by including the disabled and the immigrants.

The overall strategic approach seems adequate and focused on a clear set of non-exhaustive priorities, while paying increasing attention to operational aspects. However, the complementarities between existing and proposed actions are unclear (e.g. links between the Critical Neighbourhoods Programme and Social Development Contracts, and the existing work done by the LSN). The synergies between the three strands of the OMC could have been further developed. The specific needs of the most vulnerable (e.g. immigrants and the homeless), for example that of health care access, are not adequately addressed. Moreover, social transfers are known to have little impact on reducing poverty in Portugal. The report could have further elaborated on how the social security reform will address this serious weakness.

Portugal has responded positively to the challenges identified in the 2006 Joint Report, by setting up mechanisms to mainstream social inclusion in relevant policy initiatives and establishing closer links with the reforms being conducted under the Lisbon Process. Furthermore, there has been a strong effort to streamline the extensive list of sometimes overlapping and redundant measures, while increasing their clarity, attributing responsibilities, establishing schedules for implementation and allocating financial resources. These efforts need to be further pursued and improved, for example by setting precise deadlines and clear measurable monitoring and impact indicators for the various priorities. Measures to tackle inequality in income distribution are not sufficiently detailed. The report does not elaborate on how the Structural Funds are going to support the proposed measures.

3.3 Policy measures

Reducing child and elderly poverty is a major policy priority with cross-cutting measures such as the activation instruments in the Social Integration Income scheme and the Social Development Contracts, as well as specific measures designed for each of these target groups. Targets for reducing child poverty include 200 000 family allowances to support single parents, and the achievement of the Barcelona commitments for child care. For the elderly, the measures include a "solidarity supplement" to increase income to a minimum of EUR 4200 a year. Although the measures and targets are very positive developments that clearly contribute to the objectives, they are not sufficient to reduce poverty significantly.

To correct disadvantages with regard to educational attainment**,** strong links have been established with the measures provided for in the National Reform Programme and in

particular with the *Novas Oportunidades* initiative. Targets include reducing the proportion of early school leavers to 25% by 2009, reducing school failure by 50% by 2009, and training one million working-age adults by 2010. The measures and the very ambitious targets seem adequate to address the structurally low educational attainment of the population, but they do not focus on those most subject to exclusion. Furthermore, they do not include operational information such as the quality control and evaluation mechanisms proposed to ensure that the stated social integration and employability objectives are achieved.

People with disabilities and immigrants have been identified as particular target groups for tackling discrimination. For the disabled, measures focus on increasing access to goods and services and fostering integration in the labour market to increase their social and professional participation and economic independence. Targets include assigning 4 000 special education teachers to support 26 000 young people, and education/training courses for 46 000 people with disabilities. For immigrants, the legalisation process has been simplified and the network of centres providing integrated support is to be further improved. Targets include giving schools the autonomy to cater for the 80 000 foreign students and provide active employment measures for 38 500 unemployed immigrants by 2008. Although specific measures for both these target groups are necessary and justified, the report does not explain the criteria for selecting them rather than others (e.g. the homeless, people in debt, ex-offenders, Roma, etc.). It is not clear how the proposed measures are expected to produce a lasting impact on these target groups.

A significant improvement on previous National Action Plans (NAPs) is the fact that for most measures the necessary financial resources have been identified, and that quantified targets are linked to concrete objectives. However, some targets lack any preceding diagnosis or contextual framework, which makes it difficult to understand the reasoning for the quantification being proposed. Most indicators allow only quantitative achievements to be monitored, which makes it difficult to assess whether the measures achieve their expected impacts. For some measures, there is also a clear need for operational objectives which would explain how they will be put into practice.

In spite of the effort made to collect gender-related data and the explicit concern for gender mainstreaming, the measures and targets do not translate this concern into operational action.

3.4 Governance

The Ministry of Labour and Social Solidarity is ultimately responsible for coordinating and drafting the Social Inclusion Strategy. A National Coordinator supported by a Technical Team has been appointed to coordinate, draft, monitor and evaluate the strategy. An Inter-Ministerial Commission, established by the Council of Ministers, includes representatives from the various national ministries, from the Autonomous Regions of Azores and Madeira, and from the Non-Governmental Forum for Social Inclusion. This Commission is also responsible for monitoring the whole process. The LSN are expected to have a major operational role in implementing the Social Inclusion Strategy.

For the first time since the launch of the OMC on Social Inclusion, civil society (namely the NGOs), had a real chance to actively participate in the first stage of the preparation of the NAP. The Inter-Ministerial Commission, which was rather ineffective in the past, has created the conditions to enhance its role in the process. The quality of stakeholder involvement could be further improved by developing adequate and effective coordination mechanisms with the LSN. During the planning phase, the meetings conducted with the LSN had essentially an

informative role, which meant losing out on all their operational experience and field knowledge.

The setting up of Focal Points within each Ministry clearly adds value to the strategy, and reinforces the organisational and institutional mechanisms. While important, these Focal Points will need strong support, because mainstreaming social inclusion demands an active approach in different governmental departments. With the growing number of participatory mechanisms and contributions from different sectors and different levels of governance, there is an increased risk of conflict, competition and unnecessary overlapping. Therefore, it is vital that the strategic coordinating role of the NAP be reinforced.

The monitoring and evaluation mechanisms provide for a new model of coordination based on national and local information systems. This is a challenging task due to the huge variety within the different LSNs, and in their capacity to contribute effectively. It will be a long process, which needs a clear strategic and participatory approach in close cooperation with the local structures to build on existing work, while adapting it to new challenges.

4. Pensions

In 2004, older people had a relative living standard relatively close to that of the general population (77%). The poverty risk among older people (28%) is estimated to be higher than that of the population below the age of 65.

The 2006 Sustainability Report assessed Portugal as a high-risk Member State as regards sustainability of public finances, notably due to the high projected increase in age-related expenditure. Portugal is expected to face significant pressure on its public finance system resulting from ageing populations. According to the AWG's 2005 projections, public spending on pensions is set to rise from 11.1% of GDP to 20.8% between 2004 and 2050. This increase in pension spending is one of the highest in the EU, resulting in a serious risk to the long-term sustainability of public finances. According to ISG projections, theoretical replacement rates are set to remain stable overall. In the case of a worker retiring at 65 after 40 years of a career at the average wage, the net replacement rate would be stable at 91% in 2005 to 92% in 2050 (gross replacement rate declines from 75% to 70%).
The 2006 Joint Report stressed progress as regards adequacy of pensions and highlighted the importance of further reforms, in particular regarding measures to strengthen the incentives for active ageing and defining a framework to support supplementary individual savings.

The Government and social partners signed an agreement on the reform of social security in the second half of 2006. Detailed proposals will now have to be approved by Parliament. The changes introduced by the current reform (the Framework Law on Social Security is already enacted, the specific legal framework on pensions benefit formula, currently under public discussion, is expected to be passed into law on the short term) are expected to enter into effect as from early 2007, and be gradually phased in until 2016. The proposal introduces significant changes in the calculation of pension benefits (e.g. introducing a mechanism that adjusts benefits to changes in life expectancy) and introduces a new indexation mechanism for calculating adjustments to pension benefits (replacing the national minimum wage as a reference). It is essential that reform leads to a strengthening of incentives to work longer and contributes to more equitable treatment of members of different schemes. The progressive convergence of the various public social security sub-systems (private and public sectors) will not only contribute to greater equity among beneficiaries but also to future sustainability. Future generations with complete insurance careers in better-paid employment will receive

higher pensions than most current pensioners who had on average shorter contribution records. In this respect it remains to be seen whether the modernisation of occupational pension schemes will enable an appropriate contribution to be made to future adequacy, notably as regards gender differences. To help alleviate current poverty risks, a major priority has been the establishment of a minimum level of income for old-age pensioners, which could particularly benefit women. The new tax-financed social benefit Solidarity Supplement for the Elderly, launched in 2006, will progressively be extended to all those above 65 years.

5. Health and long-term care

5.1. Health care

Description of the system: A National Health Service (NHS) provides coverage to all. NHS primary health care – PHC (general and family medicine, promotion and prevention) – is provided through a network of health centres and outreach services and private profit and non-profit entities that provide care for NHS users. In the NHS general practitioners (GPs) refer patients for specialist care, operating as gate-keepers. Specialist care is provided in hospital outpatient departments and by private entities with established Ministry of Health contracts. The NHS provides most hospital inpatient care (74% of all inpatient beds). Private provision consists of: a) diagnostic, dental and therapeutic care, often contracted by the NHS and b) specialists' private practice, in private facilities for private users. NHS doctors are salaried while private doctors are paid a fee for service. The NHS is mainly funded by general taxation. Co-payments apply to pharmaceuticals, consultations, hospital care and home visits. A number of social health insurance schemes based on employer and employees' contributions fund health care for 25% of the population (e.g. civil servants and the banking sector), who directly access any specialist or hospital allowed by their scheme. 14.8% of the population has voluntary health insurance (duplicate, supplementary or complementary). Despite the large health improvement since the 1970s, the authorities point to the need to improve health status further through promotion and prevention activities. Moreover, recognising the need to improve access and quality, they propose to reform PHC, to reinforce it as the central pillar of the system and to ensure (preventive and curative) care for all including to those who are more vulnerable or at greater risk. Reinforcing resource planning and management and attaining better value for money are other goals of current policy.

Accessibility: High private expenditure (out-of-pocket payments were 29% of total health expenditure in 2004), high reliance on indirect taxes and the various social insurance systems lead to regressive financing and a pro-rich use of care. The lack of GPs and certain specialists in rural areas and certain regions, the concentration of resources in hospitals, big cities and the coast and NHS lack of coverage of certain services (e.g. dental care) are highlighted as obstacles to access. This also interferes with the running of a PHC-led NHS and leads to unnecessary use of expensive hospital and emergency care. Increased social inequality and access inequities have lead to a greater prevalence of less healthy lifestyles, ill-health conditions (e.g. tuberculosis) and health inequalities. The authorities are setting up a contact centre that provides information and help on how to access and find one's way around the NHS. They are restructuring PHC to create small family units (multidisciplinary and autonomous, providing a common basket of services under an NHS contract) that are closer to the home or workplace and are better matched with hospitals and long-term care units. A range of ehealth mechanisms (health portal, electronic health records, tele-appointments, electronic prescription, information networks between health care entities) and direct phone lines (e.g. a paediatric line, an influenza line) are to improve access to care. To better manage

waiting times and lists an integrated waiting list management system is to be extended to the whole country. Over-the-counter medicines can now be sold in a variety of places.

Quality: The state ensures quality standards in public and private institutions. An independent quality authority has been established. Quality measures include: audits, inspections, national accreditation and qualification for facilities, a national safety programme to prevent hospital infections, national clinical guidelines and national staff safety guidelines. Investment has been made in developing information systems to improve the monitoring and evaluation of processes and outcomes. Legislation has established patient rights and choice (seen as informed choice, compatible with referral networks and respecting rational resource use). The government plans for the participation of beneficiaries in services management as a means to identify problems and search for solutions and patient satisfaction is to be closely monitored. Ethic commissions and an ethics charter are to promote professionalism, good practice and respect for users. The authorities also wish to improve coordination between services (notably via ehealth solutions), ensuring that primary, hospital and long-term care act as a network. The report refers to several screening schemes.

Long-term sustainability: Total health care expenditure (9.8% of GDP and 1903 per capita PPP$ in 2004) is above the EU average[154] in GDP terms. Public expenditure as a share of total expenditure (69.7% in 2004) is below the EU average but increasing. The 2006 EPC/EC age-related projections suggest an increase in public expenditure of 0.5 percentage points of GDP by 2050. In this context, slightly more public funding could be used to improve access and ensure effective prevention and promotion policies. The authorities identify the ineffective referral system and care coordination, high patient expectations and specialists' perverse behaviour as notable challenges. These have resulted in a doubling of diagnostic procedures and overuse of (expensive and unnecessary) specialist, hospital and emergency care. The authorities stress that the pharmaceutical industry's influence and the fact that pharmacies act monopolistically has resulted in overprescribing and excessive cost. They propose to use generics, reference prices, a rational use of medication, electronic prescription and protocols with the industry to lower pharmaceutical expenditure. The authorities are introducing a purchaser-provider split and establishing contracts (partly based on DRGs) with all hospitals (more autonomous but regularly evaluated) for the provision of care. They want to promote complementarities between hospitals and avoid duplication in each region. Joint procurement of goods is to be introduced. With regards to staff, medical training has increased and the number of doctors and nurses is close to the EU average. However, the number of GPs is still imbalanced with respect to specialists: GPs are 29.5% of the total number of doctors. Furthermore, there was a reduction in numbers of GPs from 70.1 per 100 000 inhabitants in 1990 to 55 in 2002. The authorities are strongly focusing on human resource planning and continuous training. They expect that promotion in different sectors and settings can help reduce premature mortality.

5.2. Long-term care

Description of the system: The "Misericordias" and other non-profit organisations operate facilities for rehabilitation, long-term care and residential care. Day care centres provide activities, meals, laundry services, bathing, assistance with medication and attendance at health centres. There are a number of private nursing and residential homes. A joint venture between the Ministry of Health and Ministry of Labour & Social Solidarity has been established to define a long-term care plan for dependent individuals and patients with progressive chronic pathologies. It is a partnership of health authorities, municipalities and

[154] EU average of 8.87% of GDP and 2376.33 per capita PPP$ in 2004.

public and private/ third sector providers. The system will include convalescence units integrated in acute hospitals and other institutions, medical medium-stay units, rehabilitation units, long-term care institutions, palliative care units, day care, hospital teams preparing patient discharge to other settings, mixed teams providing PHC and social support in health centres, social security centres and at home and mixed teams in hospitals and in the community providing support and counselling for palliative care. Simultaneously, the authorities are promoting responses adjusted to the needs of the elderly with dependency in different moments of the evolution of the illness and possible social complications.

Accessibility: The government recognises the weaknesses of long-term care. There is little state provision of community and home services and care is concentrated in large cities. Private nursing homes are very expensive and most have no means to pay for them. The new plan aims to improve access (with full implementation at national level by 2016), launch information campaigns and strengthen the use of ICT (e.g. telemedicine and call centres).

Quality: The authorities see public sector residential care as being of poor quality and lacking resources. The National Network of Integrated Continuous Care is to monitor, both health care and organisational quality. The Network units and teams are subject to regular (self and external) evaluation by the regional coordination team. The use of contracts will clarify the responsibility of providers.

Long-term sustainability: There is a political guarantee of: specific funding; centralised control of management and financial allocation; payment models to providers, adapted to the nature of the services; and permanent economic and financial evaluation.

6. Challenges ahead

To closely monitor and evaluate the impact of measures relating to the minimum income scheme, ensuring effective social integration of groups at risk.

To ensure that the groups furthest from the labour market benefit from mainstream measures to raise the qualification levels of the population, with a particular focus on the large numbers of unskilled working poor and early school leavers.

To implement the pension reform, with the aim of improving financial sustainability and ensuring that sufficient resources for adequate pensions are available, notably through the promotion of longer working lives and establishment of a comprehensive active ageing strategy that promotes longer healthy working lives in quality jobs.

To tackle regressive financing in healthcare, reduce the financial costs of care for disadvantaged groups, reduce geographical disparities of supply and enhance the provision of long-term care.

To improve efficiency (notably through reinforcing primary care, adjusting hospital capacity and controlling pharmaceutical expenditure) and implement comprehensive all-ages promotion policies to improve health status and reduce health inequalities.

PORTUGAL: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,9	80,3	**2000**	68,4	76,5	60,5	42,2	50,7	**2000**	4,0	3,2	4,9	8,8
2002	0,8	79,5	**2002**	68,8	76,5	61,4	42,2	51,4	**2002**	5,0	4,1	6,0	11,6
2004	1,2	71,8	**2004**	67,8	74,2	61,7	37,1	50,3	**2004**	6,7	5,8	7,6	15,3
2006	1.2f	69.8f	**2005**	67,5	73,4	61,7	36,1	50,5	**2005**	7,6	6,7	8,7	16,1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp.% of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	71,6	78,7	14,6	17,8	59,6	63,1	7,5	**1995**	8,2	62,6	-		
2000	73,2	80,0	15,3	18,7	60,2	62,2	5,5	**2000**	9,2	69,5	29,2	100,0	14,8
2004	74,9sp	81,5sp	16,2sp	19,7sp	59.8e	61.8e	4,0	**2004**	9,8	69,7	29,0		

s: Eurostat estimate; p: provisional **THE: Total health exp.enditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and Health care	Unemploy ment	Family and children	Housing and social exclusion	Disability
1995	21,0	41,1	36,2	5,3	5,2	0,4	11,8
2000	21,7	44,7	32,0	3,7	5,4	1,4	12,7
2004	24,9	47,2	30,4	5,7	5,3	1,0	10,4

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes sinc: Total social expend.	Public pensions	Health care	Long-term care
B 2004	25,2	23,8	11,1	6,7	
2010	26,5	0,4			
2030	39,0	4,2	4,9	-0,1	
2050	58,1	9,8	9,7	0,5	

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	20	24	19	18	28	27	28	26	29	17	**Total**	8,2
Male	20	-	19	17	28	27	-	26	30	16	**Male**	-
femal	21	-	20	18	28	27	-	26	29	19	**Female**	-

	People living in jobless households					***Long-term Unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 16-54				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	4,5	4,7	4,1	5,3	**1999**	1,8	1,5	2,1	**1999**	44,9	50,8	38,9
2004	4,3	5,3	5,0	5,7	**2004**	3,0	2,6	3,4	**2004**	39.4b	47.9b	30.6b
2006	4,7	5,8	5,3	6,4	**2005**	3,7	3,2	4,2	**2005**	38,6	46,7	30,1

** excluding students; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0,775	0,785	0,763	***Aggregate replacement ratio***	0,628	0,612	0,678

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*					
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates		
									pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		(or Social Security)	Current estimate (2002)	Assumption
1	-5	-5	DB			82			32.6 g		

**:(DB / NDC/ DC); ** (DB / DC)*

ROMANIA

1. Situation and key trends

Since 2000, Romania has seen its GDP grow by around 5% per annum in real terms. GDP growth in real terms in 2005 was 4.1%, and the forecast for 2006 is for 7.2.1% [sic]. However, per capita GDP in PPS[155] is only around one third of the average for the EU25. Although the GDP growth figures are encouraging, the employment rate has been fairly constant since 2002 — in 2005, it was 57.6%, with employment in subsistence agriculture still quite high, despite the fall recorded recently (from 41.4% in 2000 to 31.7% in 2004)[156]. In general, this type of employment yields very little monetary income and is a major source of poverty. Its important role, as well as emigration of working-age persons, may explain how the number of employees has fallen without a corresponding increase in the unemployment rate. According to the NSI[157], the activity rate in 2005 was 62.4% (69.5% for men and 55.3% for women). The female employment rate (51.5%) is still below the European average. The employment rate for young people has been falling steadily since 2000[158] (from 33.1% in 2000 to 24.9% in 2005), and the same trend can be seen among older workers, with a recovery in 2004, when the employment rate rose from 36.9% (2004) to 39.4% (2005). The unemployment rate is 7.2%, lower than the European average, although the rate for young people is still a cause for concern (20.2%, 2005).

The at-risk-of-poverty rate[159] was 18% in 2004, with higher rates for rural areas, Roma people, children and elderly women. The total population has fallen recently, from 22.8 to 21.7 million, because of a low fertility rate (1.3), one of the highest stillbirth rates in Europe (16.8 in 2004), a life expectancy at birth also one of the lowest in the EU (68.3 years for men and 75.6 years for women in 2004), and high emigration between 1990 and 2002. Social expenditure rose during this transition period, but it is still one of the lowest in Europe (a national source quoted a figure of 19.4% of GDP in 2005[160]).

2. Overall strategic approach

The challenges to be met in the area of social protection and social inclusion include: population shrinkage and ageing, the extent of the informal economy and high rates of employment in subsistence agriculture, the quality of human resources, the insufficient development of social services in terms of their territorial coverage, quality and diversification, the continuing low level of social benefits, obstacles for vulnerable groups trying to gain access to the labour market, services and resources.

For the period 2006/2008, the strategic objective chosen by Romania is "creating an inclusive society" able to provide the resources and means to ensure that all citizens have a decent life. The strategic approach presented is ambitious and poses significant challenges for Romanian society. However, subsequent progress evaluations could benefit from a choice of quantified

[155] Purchasing Power Standards (PPS)
[156] Data from the National Statistical Institute (NSI), processed by Catalin Ghinararu
[157] National Statistical Institute (NSI)
[158] In 2002, the definitions were revised, which means that the indicators are not always compatible with the series of data from previous years.
[159] Data for all income-based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc.) are based on the national household budget survey that is adjusted ex-post to the EU harmonised SILC methodology but is not fully compatible with the SILC detailed definition of income.
[160] NSI data processed by Zamfir, 2005

indicators appropriate for the country's situation. Developing a coherent framework for the sectoral strategies and a shared vision and understanding of social inclusion would be appropriate at this stage. The strategy identifies and encourages an integrated approach based on partnership, with roles for all those with responsibilities in this area. The gender dimension is another priority, and clearer references would be desirable as far as women's work/home life balance, the lack of services in this sector and the serious problems affecting some women (e.g. the trafficking of women, domestic violence, insufficient and ineffective family planning services, etc.) are concerned.

3. Social inclusion

3.1 Key trends

The groups most at risk of poverty include the rural population (70% of poor people live in rural areas), the Roma (three times poorer than the average), elderly women, single-parent familes, households with three children or more and the long-term unemployed. Certain children and young people can also be identified as the next generation of poor people. The level of poverty quoted in the strategy is 18.2% in 2005, slightly down on the previous year. The available Eurostat data indicate a falling risk-of-poverty rate both before social transfers (from 23% in 2002 to 22% in 2003) and after them (17% in 2003, compared to 18% in 2002). The number of children living in households where no one has a job has fallen (from 11.1% in 2004 to 10% in 2006). The same trend can be seen for persons aged 18-59 years. The long-term unemployment rate has stayed relatively constant at 4.4% in 2005 (4.7% for men and 3.9% for women). However, this indicator does not reflect the true situation, because many inactive persons claiming social benefits are capable of working but are considered "inactive" because of a lack of alternatives to work. Out of all inactive persons in Romania, 27% are young people and 51.8% are pensioners and persons on social benefits. One worrying phenomenon is youth unemployment (20.2% in 2005). As far as school drop-out is concerned, a fall has been recorded from 23.6% in 2004 to 20.8% in 2005, but it still remains high. The situation is worrying for Roma children, 17.3% of whom aged between 7 and 16 years have no formal education. More than a third (38.6%) of the Roma population is functionally illiterate.

3.2 Main challenges and priorities

Romania's concerns in the field of social inclusion for the coming period are in line with the main challenges identified in part 2 above. They focus on facilitating access and return to employment for persons furthest from the labour market, increasing the level of benefits and implementing a national social services strategy and sectoral strategies.

3.3 Political measures

In order to create an inclusive society for all, the three priorities are: i) to increase the population's standard of living by increasing income from work, stimulating employment and promoting inclusive policies; ii) to facilitate access to resources, rights and services**;** iii) to improve living conditions for the Roma population.

As regards the first objective, the Romanian Government has proposed continuing with existing measures to stimulate employment in general (e.g. new employment promotion programmes, increasing the budget for active measures, improving the legislative framework in order to encourage employers to recruit persons at risk of social marginalisation,

stimulating job creation in rural areas, raising the gross minimum wage, etc.). Increasing employment will certainly have a positive impact on reducing poverty and social exclusion, but specific measures and policies for the active integration of vulnerable groups and those living in disadvantaged areas (rural areas in particular) should also be stepped up.

The second objective, "to facilitate access to resources, rights and services", is very ambitious and corresponds to the priorities identified in the Joint Inclusion Memorandum (JIM). The introduction of quantified objectives would be useful in order to give a precise idea of what is expected. Improving access to health services is one of the priorities identified in the JIM and should be one of the priorities listed under this objective. Measures to prevent discrimination against vulnerable groups should also be considered a priority.

The measures planned for the priority concerning the improvement of living conditions for the Roma population are designed to improve the social and educational integration of Roma people (improved access to education, to the labour market and to housing, solving the problem of persons without identity papers, etc.) and to improve interinstitutional dialogue and cooperation. A large proportion of the Roma population work in the informal economy. Measures to combat this phenomenon, with a serious impact on the social protection system, should be stepped up over the coming period. Particular attention should be paid to measures targeting Roma women.

These three objectives are ambitious, in line with the priorities in the Joint Inclusion Memorandum (JIM). In order to achieve them, there must be a clear and sufficient budget, a description of the content and phases of the planned programmes and quantifiable indicators for each objective.

3.4 Governance

The strategy was drawn up by the Ministry of Labour, Social Solidarity and the Family, with contributions from the other ministries and agencies directly involved. The drafting of the strategy would have benefited from the greater participation of all those with responsibilities in this area (local authorities, NGOs, providers of social services, etc.), as the mobilisation of all those involved is both an instrument and a goal, in order to achieve social inclusion and protection objectives.

The strategy identifies, for each priority objective, the institutions responsible for implementing them. Particular attention should be paid to stepping up the capacity of local authorities. Evaluation and monitoring will be performed using a management information system to allow the collection and analysis of data at central, regional and local levels. A national mechanism to promote social inclusion, with the aim of broadening the institutional consultation at territorial level, is being drawn up. The social monitoring centre, a new institution currently being established (Act 47/2006), will monitor the impact of social policies.

4. Pensions

Like all EU Member States, Romania faces significant demographic challenges, with projections for Romania's future old-age dependency ratio being close to the EU average: 21.1% in 2005, rising to 51.1% in 2050.

Eurostat's figures for Romania's pensioner poverty for 2003 show a poverty rate of 17% for those over the age of 65 (with a significant gender gap: 24% for women and 14% for men). This is higher than the EU average, although slightly lower than that of the 0-64 population in Romania, which was 18.4%. Poverty levels have remained stable in recent years, decreasing by a couple of percentage points in the last year. Attention should be paid to the large gender discrepancies at risk of poverty.

According to national sources, public expenditure on pensions remained stable at 6.5% of GDP between 1995 and 2005. In 1995, the pension system registered deficits that were covered by transfers from the State budget, while for 2006 forecasts suggest that there will be a surplus (mainly due to the cut in spending as a result of the externalisation of short-term benefits and the removal of liabilities relating to the pensions of independent farmers). The average pension in Romania is 38.8% of the average wage (national sources, including those with incomplete contributory histories, early retirement pensions and invalidity pensions).

Romania's pension system has undergone substantial reform in the last decade, resulting in a system that aims to offer more equity and sustainability in the long term. The system itself, with the reforms of the pay-as-you-go component and the development of new funded provisions (both mandatory and voluntary), mirrors similar reform packages undertaken across Europe, especially in the new Member States. A notable difference in the development of funded provision is the lack of involvement of employers (through collective agreements) in the new system. This may have a considerable impact on the success of including significant proportions of the employed workforce in voluntary saving for retirement.

The recent reforms to the pay-as-you-go system, and measures designed to increase the levels of pensions for those outside the p-a-y-g system (most notably independent farmers), have resulted in increases to all pensions and subsequently in poverty levels for the current generation of older people being lower than that of the general population.

However, Romania faces a real risk of high levels of old-age poverty for future cohorts due to a significant proportion of current workers not contributing to the pay-as-you-go system, as in the case of current independent farmers with insufficient contributory records to qualify for specific assistance. With only a third of current workers contributing to the State pension system, both long-term sustainability and adequacy could be a serious challenge. Romania must step up its efforts to increase employment while ensuring a corresponding increase in contributions to the pension system (notably as regards the collection of contributions). Consideration should also be given to the position of women and carers, to ensure that the pension system does not penalise them for their caring roles. Failure to do so may result in the development of a two-tier system, where those who have contributed in their working lives have adequate retirement pensions, but a large proportion of elderly individuals will be reliant on means-tested assistance, leading to the need for large and unpredictable transfers of revenue to the elderly in the future.

5. Health and long-term care

5.1 Health care

Description of the system: Major reforms in health care have transformed the centralised, tax-based system into a decentralised and pluralistic social health insurance system with contractual relationships between health insurance funds as purchasers and healthcare providers. The system covers the whole population through public and private facilities. It is

insurance-based with mandatory, employment-linked, membership and contributions are a percentage of income paid in equal proportions by the employer and the insured. Primary health care (PHC) has been reformed and GPs are independent practitioners, contracted by the insurance funds, operating in private practices. They act as gatekeepers, with outpatient treatment requiring a referral. Ambulatory services are provided by outpatient hospital departments and specialised centres. Private practice is allowed, although hospitals are mainly publicly owned. The District Health Insurance Funds (DHIF) collect insurance contributions, contract healthcare providers and ensure payment and reimbursement. The National Health Insurance Fund (NHIF) can reallocate up to 25% of the collected funds to under-financed districts. 5% of the funds collected must be set aside for reserves. The NHIF negotiates contracts with the College of Physicians. The State budget (taxes) has retained responsibility for public health services funding, capital investment and preventive policies. Formal co-payments are required for drugs expenditure, out-of-pocket payments are considerable and there are significant under-the-table payments to public providers. Hospitals are financed according to hospital activities and their ownership is to be transferred to the local councils. All physicians' income is provided by the DHIFs on a contractual basis. In PHC, their payment is a mix of weighted capitation (70%) and fees for services (30% for preventive services). Ambulatory secondary care physicians are paid on a fee-for-service basis. Hospital staff are salaried. The national strategy prioritises increased access for disadvantaged groups and improving the quality of the services provided.

Accessibility: Children, dependants, war veterans and the disabled have free access to health insurance. The high proportion of private out-of-pocket payments (33.5% of total health expenditure in 2003) and the non-affordability of health services effectively hinder access. Despite the reforms and integration of PHC, a large proportion of the population are not registered on a family doctor's list. Recent increases in the numbers of medical staff have not resolved accessibility issues in rural areas that are isolated, lacking specialised services and far away from health units or hospitals. This is of particular importance for the Roma population. Although pilot programmes and the legal framework for developing a network of community nurses have been initiated (starting in 2002), the process of implementation needs to be further intensified and extended to reach the most vulnerable and isolated communities. In 2002, a national system of Roma mediators was developed. Their role is to improve the health status of the Roma communities and their number has been increasing. Differentiated access is also due to heterogeneous territorial distribution of hospitals, hospital beds and medical staff. Another important problem is that care is provided, after referral, to persons covered by health insurance, thereby disqualifying the non-covered. This is a dual problem of lack of GPs and non-registering on GP lists. Ambulatory services are materially limited and need to be improved. In addressing accessibility issues, medical assistance has to be provided, whether on a GP list or not, on the basis of a minimum medical package which has been introduced (emergency) and is legally enacted.

Quality: For PHC, there is a free patient choice of GP and hospital. Legal regulations are often misinterpreted by the DHIFs, creating confusion about patients' rights. Insured persons are often misinformed about their rights and obligations within a wider setting, there being a lack of evaluative and controlling mechanisms. One option for quality improvement through increased funding is expanding private provision. With the exception of capital investment, redistributive mechanisms are in place without, however, showing any immediate quality improvements. The main difficulty for quality improvement is the misdistribution and low pay of specialised medical staff, requiring renewed training investment and retraining. Efforts have been made to concentrate resources on the best-performing health institutions and eliminate poor-quality hospitals and specialised centres. The resulting decrease in hospital

beds has not been matched by the corresponding development and quality improvement of ambulatory services. Equipment acquisition is problematic with important regional disparities. **Long-term sustainability:** In 2004, total health care expenditure was estimated to be 5.7% of GDP. In 2004, the share of public health expenditure was 59.6% of total health expenditure, whereas out-of-pocket payments were on the increase and accounted for 36.3% of total health expenditure. In ambulatory care, the payment of physicians based on a fee for service with a points system can cause low reimbursement and payment values due to the single closed budget for those services. The authorities aim to develop a unique information system (ICT), which would increase the system's efficiency and performance through informed access to a patient's health files and tackling of informal and unregulated pharmaceutical provision. Although total health care expenditure appears to be on the decline, the measures announced to integrate PHC can be beneficial for the long-term sustainability of the system, and make for more rational and efficient use of resources and medical staff. This is important, as the referral system is often bypassed. In an effort to tackle high private expenditure, co-payments for specialised care will be introduced, addressing hospital overuse and informal payments.

5.2. Long-term care

Description of the system: There is no comprehensive community-based social care network. External assistance and support is still very important to the future development of the LTC sector. One problem is that it is impossible to discharge persons in need of LTC from acute hospital beds due to the lack of suitable alternatives. The reforms in LTC have shifted responsibilities from the central budget to local authorities and districts. Old people's and nursing homes are under the responsibility of the DHIFs. LTC recipients are asked to pay a fee, which is deducted from their pension or income and then passed on to the central budget. People with no income come under the responsibility of the district budget. Although some free LTC services are available to vulnerable groups, the financing of the system is mixed, with a combination from the State and local (district) budgets. The system remains poorly developed and NGOs play an important organisational and financial role. Specific efforts have been made with additional allocated funds for mental health patients and drug users. Pilot programmes and new psychiatric centres have been created, coupled with legal developments to ensure that mental health patients' needs are met. A new law aims to set up a dependency benefit for financing LTC in a residential and home setting. The benefit will be entirely means-tested (depending on degree of dependency and place of service). The same law proposes a compulsory insurance contribution for LTC, with the funds collected being used to finance the dependency benefit. The implementation target is 2007.

Accessibility: The number of institutions providing LTC needs to be increased in order to improve access to LTC services, particularly in isolated and rural areas. The aim is to switch from residential care to the promotion of home care. However, addressing acute bed use and their shortages for LTC recipients appears to be a prerequisite.

Quality: Improving the quality of LTC and living standards in residential homes of LTC recipients is a priority for the authorities. Similarly, developing a social workers' network and enhancing facilities with appropriate training of LTC medical staff is another priority for the authorities.

Long-term sustainability: The new law sets out to address the long-term sustainability of the LTC system, with the introduction of a financing method based on means-testing and targeting LTC recipients and compulsory LTC insurance participation. Although the new

Agency for Child Protection has been created, local authorities are still underfunded and LTC is still underdeveloped.

6. Challenges

To step up measures needed to break the cycle of poverty, by targeting income in particular and access to services by groups at high risk, be they rural populations, Roma people, elderly women, single-parent families or families with many children.

To promote an approach based on active inclusion, in particular the creation of high-quality jobs that make work pay. In this context, to target vulnerable groups (in particular, young people) and people living in disadvantaged areas (especially rural areas) by way of reinforced measures and specific policies.

To pay particular attention to empowering local authorities, so that they can better identify and implement priorities and ensure that the implementation of measures, actions and projects uses the funding allocated in a consistent and effective way and effectively meets the objectives set.

To conclude the implementation of the government strategy to improve the situation of the Roma population (issue identity papers for all Roma people, combat any form of discrimination, increase access to education, to the labour market, to housing, etc.).

To strengthen the functioning of the pension system by greatly increasing the proportion of those in work to declare all paid work and ensuring that appropriate contributions to the social security system are made and also to improve general employment rates and in particular to increase numbers of older workers.

To continue with the ongoing reforms to ensure both increased adequacy for today's and more importantly future older people and future sustainability.

To continue efforts to achieve a fully-fledged, decentralised, social health insurance-based system that can address the limited coverage of the system and its long-term financial sustainability.

To extend resource allocation to health care and LTC systems in order to tackle accessibility issues (geographical discrepancies and lack of specialised services), improve the quality of the services provided and coordinate the central and local funding authorities better to make for a well-functioning PHC, referral and gatekeeping systems and to tackle high private expenditure in health care and pharmaceutical use.

Romania: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	2.1	24.9	**2000**	63.0	68.6	57.5	33.1	49.5	**2000**	7.2	7.8	6.4	20.0
2002	5.1	28.1	**2002**	57.6b	63.6b	51.8b	28.7b	37.3b	**2002**	8.4	9.1	7.7	23.2
2004	8.4	32.6	**2004**	57.7	63.4	52.1	27.9	36.9	**2004**	8.1	9.1	6.9	21.9
2006	7.2f	35.8f	**2005**	57.6	63.7	51.5	24.9	39.4	**2005**	7.2	7.8	6.4	20.2

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	65.3	73.1	12.6	15.1	n.a	n.a	21.2	**1995**	n.a	n.a	n.a		
2000	67.7	74.6	13.4	15.7	n.a	n.a	18.6	**2000**	5.4	65.5	31.7		
2004	68.3sp	75.6sp	13.3sp	16.2sp	n.a	n.a	16.8	**2004**	5.7	59.6	36.3		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a	n.a	n.a	n.a	n.a	n.a	n.a
2000	n.a	n.a	n.a	n.a	n.a	n.a	n.a
2004	n.a	n.a	n.a	n.a	n.a	n.a	n.a

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	21.1	n.a	n.a	n.a	n.a
2010	21.2	n.a	n.a	n.a	n.a
2030	29.6	n.a	n.a	n.a	n.a
2050	51.1	n.a	n.a	n.a	n.a

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					***Poverty risk gap***					***Income inequalities***	
HBS income 2004	Total	Children 0-15	16+	16-64	65+	Total	Children 0-15	16+	16-64	65+		S80/S20
Total	18	25	16	16	17	23	24	22	23	19	**Total**	4,8
Male	18	-	16	17	11	23	-	23	23	18	**Male**	-
Female	18	-	17	16	21	23	-	22	23	19	**Female**	-

	People living in jobless households					***Long-term unemployment rate***				***Early school-leavers***		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	7.3	7.8	7.0	8.6	**1999**	2.8	2.8	2.7	**1999**	21.5	23.0	20.0
2004	11.1	11.1	10.4	11.7	**2004**	4.5	5.2	3.6	**2004**	23.6b	24.9b	22.4b
2006	10.0	9.7	8.8	10.6	**2005**	4.4	4.7	3.9	**2005**	20.8	21.4	20.1

**: excluding students; b: break in series*

HBS income 2004	Total	Male	Female	HBS income 2004	Total	Male	Female
Relative income of 65+	0.91	0.99	0.86	***Aggregate replacement ratio***	n.a	n.a	n.a

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						*Assumptions*						
Net	*Gross replacement rate*					Coverage rate (%)			Contribution rates			
									Pensions (or social security)	pensions		
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)		Assumption
n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a

**:(DB / NDC/ DC); ** (DB / DC)*

SLOVENIA

1. Situation and key trends

The Slovene economy has experienced robust GDP growth, averaging almost 4.0% p.a. over the last decade. GDP per capita reached 83.6% of the EU average in 2006. While the employment rate is slightly above the EU average (66.0% in 2005), and the unemployment rate is one of the lowest (6.5%), the labour market is characterised by low employment of older workers (30.7%), especially older women (18.5%). Youth unemployment stands at 15.9% in 2005 and is higher for young women (17.8%). Regional disparities are considerable, with Eastern Slovenia significantly lagging behind. A fairly high level of total expenditure on social protection (24.3% of GDP in 2004) helps achieve a relatively low at-risk-of-poverty rate[161] (12% in 2004; below the EU average). Within social protection expenditure (expressed as percentage of total benefits), the highest share was spent on old-age and survivors (44.7 %), followed by sickness and health care (32.7 %), while 2.8% was spent on housing and social exclusion. Due to the projected rapid ageing of the population in the coming decades – life expectancy is increasing and the fertility rate is low (1.26 in 2005) –age-related public social expenditure is expected to rise by 9.6 percentage points by 2050 and the old-age dependency ratio (21.7% in 2005) to more than double (55.6% in 2050). Life expectancy (73.7 and 80.6 years for males and females in 2004) is below the EU average, but one of the highest among the new Member States. Infant mortality (3.7 in 2004) is below the EU of 4.5 average and has fallen considerably from 35.1 in 1960. Perinatal mortality is 7.7, down from 29.6 in 1960.

2. Overall strategic approach

The National Strategic Report recognises that globalisation and the ageing of Slovenian society require changes in social protection systems in order to promote a just and sustainable social state, which will at the same time motivate people to be more active. Consequently, the overall Slovenian strategy for social protection and social inclusion focuses on improving flexibility in the labour market, modernising the system of social transfers, promoting longer working lives through sustainable pension systems, and maintaining the standard of public health care achieved.

The strategy for promoting social inclusion focuses on activation of those furthest away from the labour market, providing housing for the most vulnerable groups, fighting discrimination and promoting integration of immigrants into society as well as ensuring care for elderly. These priorities address the main challenges Slovenia is facing in the field of social inclusion. However, the measures on activation and fighting discrimination might prove to be insufficient, and the targets not ambitious enough, to tackle the existing challenges, in terms of strengthening labour market flexibility and competitiveness and prolonging working lives. Gender mainstreaming is not systematically applied in policies and measures; however, some positive measures for women are reported.

[161] SILC(2005) income year 2004: Provisional data. Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the estimates presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were based on the national household budget survey that was not fully compatible with the SILC methodology based on detailed income data.

The National Strategic Report is strongly interrelated with the Lisbon National Reform Programme, especially in the fields of active inclusion and modernisation of social protection systems. However, ensuring a proper level of security within the planned reforms is a challenge, which should be addressed.

Good governance is promoted by the involvement of relevant stakeholders in drafting the national report, and in monitoring and evaluating its implementation. Transparency was ensured through discussions on the report on different occasions (public debates, consultation of social partners, etc.).

3. Social inclusion

3.1 Key trends

The key trends in the field of social inclusion are generally favourable. The at-risk-of- poverty rate[162] (12% in 2004) and income inequalities (3.4 in 2004) are among the lowest in the EU. However, the at-risk-of-poverty rate is high among certain population groups, such as older people living in one-person households (45%), the unemployed (25%), one-person households with at least one child (22.4%) and women over the age of 65 (26%). The at-risk-of-poverty rate of these groups and the population in general would be even higher (42%) without social transfers and pensions.

According to the National Strategic Report, the number of welfare recipients is growing. 41% of recipients are younger than 27, 15% are long-term unemployed. Although the indicators for education and skills are good (the educational attainment of 22-year-olds is 90.6% and the proportion of early school-leavers is low at 4.3%), 41% of welfare recipients have a low educational attainment level (national data).

According to the 2002 population census, 83.5% of the population own their homes. Nevertheless, access to housing is a challenge for certain groups of population due to the scarcity of housing in highly urban areas and the high prices of housing.

3.2 Key challenges and priorities

In line with the key challenges recognised by the National Strategic Report, the social inclusion strand of the report concentrates on four priorities: increasing the activity of social assistance beneficiaries by raising their level of education and offering more employment possibilities; providing accommodation to vulnerable groups; combating discrimination and integrating immigrants in society; and ensuring care for elderly people. These reflect the challenges identified for Slovenia in the Joint Social Protection and Social Inclusion Report 2006. The first priority of the Slovene report concentrates on active social inclusion for all; the others focus on access for all to the resources, rights and services needed for participation in society.

According to the report, progress has already been achieved in recent years in addressing some of the Slovenian priorities. New measures for bringing people, who depend on benefits, back to the labour market were introduced and existing measures were further developed. The new active inclusion measures focused on introducing conditions for social benefits and subsidies for employers employing long-term unemployed people. The recent tax reforms

[162] SILC(2005) income year 2004: Provisional data

should provide additional incentives for work. It is important to monitor the impact of these reforms on the income security and effective inclusion of the people concerned. Progress has also been achieved in increasing access to accommodation, especially for the most vulnerable groups. Nevertheless, several challenges have not been sufficiently tackled so far. There is a lack of systematic focus on gender-related issues. The report recognises that discrimination exists, but is vague in terms of types and scope of discrimination. Within the priorities defined, the strategy does not take into account regional differences.

The social inclusion policies are coordinated and mainstreamed into relevant public policies to a certain extent, through several strategic documents prepared recent years. The role of the Structural Funds, particularly the ESF, is very important in supporting the National Strategic Report objectives, since it is planned that the ESF will co-finance the majority of the labour-market-related measures.

3.3 Policy measures

The National Strategic Report identifies different measures such as legislative amendments, active labour market policy/inclusion activities and concrete projects, to address each of the priorities. Under each priority, targets and indicators are set and corresponding financial resources indicated.

The first priority, increasing the activity of social assistance beneficiaries by raising their level of education and offering more employment opportunities, focuses on increasing employment among older people, activation of the recipients of social assistance and reforming social transfers. Higher employment among older people will be achieved by a combination of activation policies (e.g. subsidies to employers and innovative measures supported by the ESF) and amendments to legislation (broadening the scope of part-time employment for older people and incentives for later exit from the labour market). The main measures taken to increase activity of social assistance beneficiaries are increasing conditionality in access to benefits and subsidies to employers hiring long-term unemployed people. These measures could be more ambitious, especially in light of plans for increasing labour market flexibility and prolonging working lives. Especially the most vulnerable groups, such as older women and people living in one-person households with at least one child, should receive further attention. In addition, this priority should concentrate more on young unemployed people as they are over-represented among long-term unemployed people on social benefits, especially given the European Council's call to ensure that each unemployed young person gets a job or training offer within six months. Mechanisms need to be introduced to evaluate the impact of the measures.

The second priority, providing accommodation to vulnerable groups, focuses on the one hand on temporary housing for the most vulnerable groups, and on the other hand on problems related to the general lack of housing and its high costs. Accommodation for the most vulnerable groups, such as single mothers, people with mental or physical disabilities, drug users and homeless people, is guaranteed by the National Programme for Social Protection 2006-2010, which sets clear targets for providing additional housing up to 2008. The issues of housing supply, and its financing, will be tackled by the National Housing Strategy, which is under preparation. These measures will be complemented by reducing administrative and other barriers in spatial planning and tax legislation, and by ensuring financial incentives to municipalities to support additional supply of housing. The priority covers key aspects of to housing issues; nevertheless, it is not clear whether these measures are sufficient to help

vulnerable groups to leave temporary housing and move into permanent housing arrangements.

The third priority, fighting against discrimination and integrating immigrants in society, is the least focused and clear. Stronger evidence to underpin this priority is needed, together with an overall strategy taking into consideration the needs of all disadvantaged groups. The work of the Council for the Implementation of the Principle of Equal Treatment and the implementation of the National Programme for Equal Opportunities for women and men 2005-2013 are mentioned, but clear objectives and targets are not provided The National Strategic Report does not pay enough attention to other problems related to discrimination, such as including ethnic minorities and ethnic groups (Roma) in all spheres of life. Additional emphasis should also be given to support for single mothers, who face a high risk of poverty, especially in relation to reconciling work and private life. The measures on integration of immigrants (drafting and implementation of an integration plan for each immigrant, housing, special attention to vulnerable groups of immigrants, consulting and psychosocial assistance) concentrate on refugees and asylum seekers, while other groups of immigrants are not mentioned. Targets and financial allocation (partly funded by the ESF) are set in relation to some aspects of the integration of immigrants.

The fourth priority, ensuring care for elderly, combines the objectives of all three strands of the streamlined open method of coordination in the fields of social protection and social inclusion. The measures will be achieved as part of the implementation of the Strategy for Protection of Elderly up to 2010, which is being drafted. It will cover activation of older workers, ensuring socially adequate and sustainable pensions, and a variety of measures in the field of health and long-term-care for the elderly. In addition, the National Programme for Social Protection 2006-2010 covers maintaining and developing the existing services for social protection of the elderly (institutional care, network of daily care, domestic help services, sheltered housing, etc.).

3.4 Governance

The social inclusion strand of the National Strategic Report was drafted by the Ministry of Labour, Family and Social Affairs and sent for consultation to a working group involving representatives of governmental services, research institutions, local communities, NGOs and social partners. The report was also presented and discussed at a seminar organised for the general public, although the report as such had not yet been made available at that time. The final document will be distributed among all stakeholders, which is important for raising awareness. An effort has been made in the report to identify, as far as possible, quantified targets to improve monitoring of outputs and impacts. In addition, a special evaluation group, involving all relevant stakeholders, will be established and at least one evaluation report will be drafted. However, more could be done to involve those who actually implement the proposed policies and measures (centres for social work, NGOs, etc.) in the process of drafting, implementing and evaluating the report. According to some actors involved in implementing of policies and measures, they are aware neither of the existence of the report not of its added value.

4. Pensions

In 2004, older people had a relative living standard close to that of the general population (87%)[163], while the poverty risk among older people at 20% (gender differences are high, 11% for men and 26% for women) is estimated to be significantly higher than of the population below the age of 65 (11%). The employment rate of older workers remains low in spite of recent increases and, at 30.7% in 2005, contrasts with the Lisbon target of 50%.

The 2006 Sustainability Report assessed Slovenia as a high-risk Member State as regards sustainability of public finances, notably due to the high projected increase in age-related expenditure. Slovenia is facing significantly stronger budgetary pressures due to ageing populations than most other Member States. According to 2005 AWG projections, public pension expenditure is set to increase to 18.3% GDP in 2050, a rise of 7.3 p.p. of GDP from 2004. According to ISG projections of theoretical replacement rates for a worker retiring at 65 after 40 years of employment at the average wage, the net replacement rate in the statutory scheme is expected to decrease significantly from 82% in 2004 to 60% in 2050 (declining from 64% to 39% in gross terms).

The 2006 Joint Report stated that the 2000 reform constitutes an important step towards ensuring adequate and sustainable pensions, but stressed that pressures on the pension system are strong in Slovenia and that further measures are needed to strengthen incentives to work longer.

While the gradual increase in pension age will be effective in 2008 for men (63) and in 2023 for women (61), both after 20 years of contributions, this transition period appears long and faster reduction of the gender gap in retirement age would also contribute to ensuring future adequacy. Furthermore, improving financial incentives to work longer is urgently needed as the employment rate among older workers is very low. Furthermore, reducing early exit from the labour market (before the standard retirement age) is a major challenge and would contribute to ensuring future adequacy (through further accrual of pension rights which are otherwise planned to decrease) and sustainability.

Following the introduction of strong incentives to participate in voluntary provision, the share of actively insured persons covered by voluntary supplementary pension schemes is increasing (51% in 2004, 56% in 2005), highlighting the importance of adequate portability as well as risk-sharing rules.

5. Health and long-term care

5.1 Health Care

Description of the system: A compulsory health insurance system, operated through the Health Insurance Institute of Slovenia (HIIS) and its branches, provides comprehensive coverage to all residents. The citizens of Croatia and Macedonia are provided care on the basis of bilateral treaties. Provision is mostly public although there are a growing number of private practitioners. Local governments finance primary healthcare (PHC) facilities. PHC is provided via general practitioners (GPs) and their teams in public healthcare centres or private practices with an HIIS contract. These operate as “gatekeepers”. Specialist and hospital care is

[163] SILC(2005) income year 2004: Provisional data

performed in hospitals (75%), spas or private health facilities. Hospitals are mostly state owned. PHC centres are paid a combination of capitation and fee for service by the HIIS. Public sector doctors are salaried and there are bonus payments in place. Private non-HIIS contracted doctors are paid a fee-for-service. Financing is mainly employment-based (with equal contribution rates by employees and employers). Pensioners, the self-employed, farmers and craft workers also pay contributions. The state pays for the unemployed and non-insured and capital investment. Co-payments are paid for a range of services. Voluntary supplementary health insurance (to cover co-payments) covers 1.4 million people (70% of the population). Recognising important access challenges, the authorities wish to improve countrywide availability of care, tackle the financial burden of care, reduce waiting times and improve the equity of financing. Recognising the potential efficiency gains, authorities are focusing further on PHC, referral systems, outpatient care and day surgery. Highlighting the benefits of a healthy population for sustainability and economic growth promotion and prevention activities are strongly emphasised.

Accessibility: About 20 000 people, mostly from the other former republics of Yugoslavia, do not have health insurance because they have no settled residence or citizenship, although they can receive free emergency care. According to the authorities, though insurance covers all costs of certain groups (children, students, persons with disabilities) and of many services (preventive, emergency, cancer, diabetes and reproductive/family care), out-of-pocket payments (9.8% of total expenditure in 2004) and insurance premiums paid for voluntary insurance (13% of total expenditure) may pose a financial burden to low-income groups. Hence, they want to define a basic care package for which there are no co-payments. Some services are directed at the population groups most at-risk (e.g. new-borns, children). It is reported that a general shortage of PHC doctors (16.3 per 100 000 inhabitants) may pose difficulties to a PHC-led system, whilst regional differences exist in relation to specialist outpatient care, as trained personnel and facilities are concentrated in major urban centres. The authorities have thus established regional targets for staff and plan additional incentives for staff to work in deficit areas. They also express the concern that albeit decreasing, waiting times for certain non-urgent procedures can be very long causing public dissatisfaction. The report claims that waiting times are due to: a) restricted resources not allocated on the basis of needs and b) population ageing, which results in needs greater than capacity. Additional funding and co-payments to staff in specialties where waiting times are long thus aim at increasing activity and reducing the wait.

Quality: To improve quality, the authorities are introducing standards, clinical guidelines and clinical paths. EU law has been implemented in relation to quality control, the registration and the sale of pharmaceuticals. As the report indicates, alongside a free choice of PHC doctor (although registration is to last for one year), there is a free choice of hospital or specialist clinic after referral. A law on patient rights is to be adopted. Service users are represented in the Assembly of the HIIS and participate in the management of health institutes. The authorities expect that users' involvement will raise awareness of financial issues and contributes to the sustainability of the system. Slovenia is developing an extensive ICT and health infrastructure (electronic data exchange, health insurance card system with patient information, electronic insurance applications, advice, and communication between actors in the field) which will provide information for policy and bring services closer to users and providers. The authorities are focusing strongly on reinforcing free preventive services (five-yearly check-ups and counselling for cardiovascular diseases, screening for cervix and breast cancer, vaccination, and preventive examinations of newborns, children and women).

Long-term sustainability: Total expenditure on health (8.7% of GDP and 1760 per capita $PPP in 2004) is at the EU average in GDP terms[164]. It has consistently increased over time. Public health expenditure comprises 77.2% of total health expenditure and though relatively high in EU terms has showed a significant decrease from 100% in 1990. This decrease has been compensated by voluntary private insurance and service co-payments (to add funds and control unnecessary demand). The authorities identify ageing and growing pharmaceutical expenditure as financial pressures. The 2006 EPC/EC age-related projections foresee an increase in public expenditure of 1.6 percentage points of GDP by 2050. Moreover, the report underlines that current contribution evasion can be detrimental to the sector's funding, with some groups (e.g. the self-employed) not paying a high enough proportion of their income (16% less than they ought to). To eliminate these deficiencies and enhance the system's solidarity, the authorities plan changes in the law regulating health insurance. According to the report measures to improve efficiency include: reinforcing the referral system and redirecting resources and responsibilities to PHC and outpatient specialist care, further decreasing the number of acute inpatient beds and increasing occupancy rates, further increasing the use of day case surgery vis-à-vis inpatient care, and reducing hospital length of stay. Moreover, the introduction of new health interventions is to be based on evidence-based medicine. With regard to staff, a shortage of PHC doctors and nurses is identified, so more professional training is planned. Strong emphasis is placed on promotion programmes including awareness campaigns on world days (exercise, tobacco, suicide, breastfeeding, aids, and mental health) and in coordination with different levels of government and NGOs.

5.2 Long-term care

Description of the system: Long-term care includes PHC and PHC home visits (GPs and nurses), institutional medical care provide in hospital in nursing departments and non-acute wards, home domestic help, home assistance, sheltered housing, homes for elderly people and disabled people and a widespread network of health resort treatment, which provides physiotherapy and rehabilitation services. Those needing care can also receive cash benefits which can be used to buy non-formal care. Services are financed partly from taxes, partly from social security contributions and partly from co-payments but a new compulsory long-term care insurance is to be implemented.

Accessibility: The state pays for those who are unable to pay for services. The authorities are expanding network capacity (increasing the number of providers), with a focus on home and community services. Options include domestic help and mobile help services, day care centres, care in another family, sheltered housing and non-acute hospitalisation in all hospitals to transfer patients from acute care to the community and home. Better coordination (through co-ordination offices) between local and regionally provided services is expected to allow better and faster access to services as well as quality. Access to palliative care is low as this is only provided by voluntary organisations.

Quality: The report suggests that national quality policy applies to this field.

Long-term sustainability: The 2006 EPC/EC age-related projections forecast an increase in public expenditure of 1.2 percentage points of GDP by 2050. As pinpointed in the report additional funding will be sought through new compulsory long-term care insurance. The authorities highlight the need for sufficient trained staff in the areas of geriatric care,

[164] 8.87% of GDP and 2376.33 per capita PPP$ in 2004

gerontology, psychiatry, palliative care, communication and coordination. Several promotion programmes are planned (diet, exercise, social contacts).

6. Challenges ahead

To strengthen the active inclusion of people depending on social assistance, especially young long-term unemployed persons, by ensuring proper accompanying measures and adequate incomes to ensure that those furthest from the labour market are not marginalised further. Gender and regional difference should be systematically taken into account in this context.

To undertake with all relevant stakeholders, a thorough analysis of the extent and nature of discriminations and adapt the strategy as appropriate.

To address the financial sustainability and ensure the adequacy of pensions, notably by considering strengthening pension reform and by taking complementary measures to increase the employment rate of older workers.

To extend coverage, increase PHC staff numbers and enhance long-term care provision.

To improve efficiency (notably through a stronger focus on PHC, outpatient and day-case surgery) and improving health by focusing on promotion and reinforcing free preventive services.

Slovenia: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.1	72.7	**2000**	62.8	67.2	58.4	32.8	22.7	**2000**	6.7	6.5	7.0	16.3
2002	3.5	74.5	**2002**	63.4	68.2	58.6	30.6	24.5	**2002**	6.3	5.9	6.8	16.5
2004	4.4	79.9	**2004**	65.3	70.0	60.5	33.8	29.0	**2004**	6.3	5.8	6.8	16.1
2006	4.8f	83.6f	**2005**	66.0	70.4	61.3	34.1	30.7	**2005**	6.5	6.1	7.0	15.9

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	70.3	77.8	13.5	17.1	n.a.	n.a.	5.5	**1995**	7.8	89.7	:	:	:
2000	72.3	79.7	14.2	18.5	n.a.	n.a.	4.9	**2000**	8.6	77.7	8.6	:	:
2004	73.7sp	80.6sp	14.9sp	19sp	n.a.	n.a.	3.7	**2004**	8.7	77.2	9.8	:	:

s: Eurostat estimate; p: provisional **THE: Total health expenditure* ***PHI: Private health insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old-age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2000	24.9	45.2	30.7	4.3	9.2	1.6	9
2004	24.3	44.7	32.7	3.1	8.6	2.8	8.1

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since 2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	21.7	24.2	11	6.4	0.9
2010	23.6	-0.2	:	:	:
2030	40.4	4.4	3.4	1.2	0.5
2050	55.6	9.6	7.3	1.6	1.2

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk-of-poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12bp	12bp	12bp	10bp	20bp	19bp	17bp	20bp	19bp	20bp	**Total**	3.4bp
Male	11bp	-	10bp	10bp	11bp	20bp	-	21bp	22bp	17bp	**Male**	-
Female	14bp	-	14bp	10bp	26bp	19bp	-	19bp	17bp	20bp	**Female**	-

	People living in jobless households					Long-term unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	4.1	9.6	8.7	10.5	**1999**	3.3	3.5	3.1	**1999**	na	na	na
2004	3.8	7.5	7.0	8.0	**2004**	3.2	3.1	3.4	**2004**	4.2u	5.8u	2.6u
2006	3.6	7.2	6.6	7.8	**2005**	3.1	2.9	3.3	**2005**	4.3u	5.7u	2.8u

** excluding students; b: break in series; p: provisional* *u: unreliable*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.865bp	0.943bp	0.804bp	***Aggregate replacement ratio***	0.424bp	0.515bp	0.376bp

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)		Contribution rates		
								pensions (or social security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions		Current estimate (2002)	Assumption
-22	-25	-25	DB	/	/	100	/	24.35	/	/

** (DB / NDC/ DC); ** (DB / DC)*

SLOVAKIA

1. Situation and key trends

Slovakia continued in its positive trend of high GDP growth rate; the fourth highest in the EU at 6.1 % in 2005 (6.7 % forecast for 2006). GDP per capita, however, stood at 55 % of the EU average, with a forecast at 59.4% in 2006. Strong growth was only partially reflected in better labour market performance in 2005, with total employment increasing by 0.7 percentage points to 57.7%. Employment rates for both young people (15-24 years), at 25.6%, and older people (55-64 years) at 30.3% in 2005 are among the lowest in the EU. However, while youth employment has fallen continuously since 2000 (29 %), that of older workers has steadily risen from 21.3 % in 2000. The unemployment rate decreased by 2.5 percentage points to 16.3 % since 2000, but remained the second highest in the EU, particularly hitting young people at 30.1%. The activity rate of the population aged 15-64 was almost stable throughout the years 1998 – 2005, standing at 68.9 % for the whole population (76.5 for males and 61.5 for females) in 2005 (EU-25: 70.2%). Significant regional employment disparities persist (9% total registered unemployment and over 28 % in the weakest region).

The at-risk of a poverty rate[165] after social transfers was 13 %[166] in 2004, with a higher risk for children at 19%. By contrast, people over 65 faced a significantly lower risk at 7%. Life expectancy in 2004 has increased by almost 2 years since 1995 to 70.3 years for males and 78.0 years for females however it is bellow the EU average[167]. The trend in the fertility rate has been marginally positive since 2002 when it hit an all-time-low of 1.18 (in 2004: 1.25). Infant mortality (6.8 in 2004) is the third highest in the EU[168] though it has improved considerably over the years (28.6 in 1960 and 11.0 in 1995). Perinatal mortality is high (7.6 in 2003) but has constantly fallen since 1960 (21). The current and projected old-age dependency ratio 65+ is well below the EU average: it is set to increase quickly from the present 16.3% to 28% in 2025 and 50.6% in 2050 (just below the EU25 52%). Total gross social protection expenditure in 2004 slightly decreased compared with 2000 (by 2.1 percentage points) and represented 17.2 % of GDP (EU average: 27.3%). Health and pensions represented the majority of expenditure in 2004 (30.1% and 40.1% respectively) with social inclusion somewhat behind (29.8%).

2. Overall strategic approach

Main strategic messages identified by Slovakia and addressed in the submitted National Strategic Report for years 2006-2008 are described as 1) ensuring financial sustainability, adequacy and accessibility of social protection systems and social inclusion policies with strengthened principle of solidarity, 2) ensuring integrated multidimensional approach to tackling poverty and social exclusion based on prevention, active inclusion, and creating conditions for decent life, and 3) improving management, implementation and monitoring of political measures at national, regional, and local levels and strengthening human resources development.

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[165] Following the implementation of EU-SILC in 2005, the values of all indicators related to income and living condition (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years, the large year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) those estimates were extrapolations based on the national micro-census survey that was not fully compatible with the SILC methodology based on detailed income data.

[166] EU average of 16 % in 2005.

[167] EU average of 75.8 and 81.9 years for males and females in 2004.

[168] EU average of 4.5 in 2004.

Social cohesion will apply the principles of activation and protection, emphasising prevention and effective social assistance in order to achieve its objectives. In the area of health-care the principle of solidarity[169] will be preserved. Introducing the voluntary option and ensuring a financial stability will be priorities for the pension system. The National strategy report is broadly in line with the Lisbon strategy and National Reform programme. Systems of social protection and social inclusion started to be interconnected with measures for increasing employment in recent years. The governance objective will be pursued in particular through the creation of partnerships at a horizontal and vertical level, human resources development, and social inclusion mainstreaming.

Activities to tackle children poverty and the inter-generational transmission of poverty are good examples of synergies between social and employment policy. Children from low-earning families are motivated to school attendance through school grants and social scholarships from pre-school education to University, by granting child allowances, school expenses, fiscal bonuses, etc.

The Slovak government is promoting gender equality as a significant aspect of the approach to addressing social exclusion. In the last years, gender equality legislation started to be adopted; however mechanisms for its implementation still need to be regulated, including a regular monitoring and the introduction of institutional structures.

3. Social inclusion

3.1 Key trends

At-risk-of-poverty rate in 2004 was almost identical for males and females in all age groups except for adults over 65, where 10 % of women compared to 3 % of men were at risk.

The percentage of adults living in jobless households has slightly decreased during the last years, reaching 9.6 % in 2006 (EU average 9.8%). However, larger proportion of children live in jobless households (11.8 % in 2006 compared with 9.5 % in the EU).

The youth unemployment rate (15-24) which rose considerably in 2000 (to 36.9 % compared with 25.3 % in 1998), has decreased to reach 30.1% in 2005 (EU-25: 18 %). Young males tend to have higher unemployment rates than females.

With respect to early school-leavers (18-24 years) SK is among the most successful MS. The rate was further reduced to 5.8% in 2005 (EU: 15.2%). In the last three years, life-long learning in Slovakia represented approximately half of the EU average (SK: 4.8 %, 4.6%, and 5.0% respectively).

The gender pay gap is a specific issue in Slovakia (24% in 2004, compared to the EU average of 15 %), which found itself among 3 countries with the biggest gap in 2004.

3.2 Key challenges and priorities

The National action plan on social inclusion develops the principles and measures set out in the National Reform Programme 2006-2008, in particular those connected with an inclusive labour

[169] Ensuring efficient performance, accessibility, and quality of health care for all inhabitants, with preservation of their economically and socially sustainable financial participation for selected types of health care.

market and an inclusive society. The ambition of the plan is to be a strategic umbrella document in the area of inclusion which defines the priority objectives and reflects a long-term vision. In its National report, Slovakia established as its four priority political objectives (1) reduction of child poverty and inter-generational reproduction of poverty, (2) increasing inclusion and fighting against discrimination of vulnerable groups through the public services, local solutions, and increased participation of excluded groups, (3) improved access to the labour market and increasing employment and employability of vulnerable groups, (4) and finally strengthening management, implementation, and monitoring of policy measures.

As highlighted in the 2006 Joint Report on social protection and social inclusion, the main social inclusion challenges Slovakia is facing are increasing the overall employment rate and the one of elderly in particular, monitoring and assessing an impact and an implementation of the reforms with regard to vulnerable groups including Roma, and tackling housing shortage. Slovakia partially succeeded in addressing all three challenges: (1) the overall employment rate has slightly increased from 57 % in '04 to 57.7 % in '05, while the one of older workers noted a more impressive increase from 26.8% in '04 to 30.3% in '05; (2) new flexible tailored services and measures in regions are going to be introduced based on the monitoring and assessing (social services, social-legal protection, and social curators), though the lack of detailed statistics still continues to be a problem; and (3) the NAP establishes the goal to increase the availability of housing for vulnerable groups of population through the State Fund of the Housing Development and other measures, however there has been no comprehensive approach yet.

The NAP also refers to the NSRF and programming documents prepared for the new programming period 2007-2013 and their compatibility with the intentions, objectives and priorities defined in the National strategy; however indicative reference to the amounts and contributions of Structural Funds or ESF was described only later in the draft NSRF.

3.3 Policy measures

All priorities except for the last one are intended in particular for vulnerable groups of population. In relation to the pursued policy priorities, the measures and partially also targets employed seem in general feasible and appropriate. Slovakia considers gender equality a significant aspect of tackling social exclusion, however new more effective mechanisms for implementation of gender legislation needs to be introduced. The objectives of capacity building and enhancement of local and community development are considered to be a core of the Slovak strategy.

3.3.1. To reduce poverty of children and to resolve the inter-generation reproduction of poverty by preventive measures and by support of families with children

Government considers educational policy and the provision of equal opportunities in access to quality education including support measures starting with pre-school education to be one of the key tools to fight intergenerational poverty. The new School Act on upbringing and education should be prepared by 2007. Changes in the system and increase of the level and structure of the support in the framework of state social benefits should be introduced in 2006 and 2007 in order to enhance solidarity for families with children. The composition of minimum subsistence will be revaluated, in order to better correspond to the actual fundamental living needs. Slovakia plans to concentrate on improving the implementation of the new legal regulation on social-legal protection of children and social curatorship with emphasis on the prevention and package

of measures. The need for intensive social work in the natural biological family environment and more and better public services for families is recognised.

3.3.2. To increase inclusion and to fight against discrimination of vulnerable population groups by supporting the availability of public services, developing local solutions and increasing the participation of excluded groups in the life of society

Slovakia will increase the availability, quality, modernize and ensure higher variability of social services provision (social-legal protection and social curatorship, social work on the spot, community work, and other integration activities) and measures of social and legal protection of children and social curatorship as a key tool for addressing this priority. The NAP intends to invest more massively in this area, also by adopting appropriate compatible operational programmes of Structural Funds in the new programming period. The new Act on Social Services should be prepared in 2007, with a view to creating conditions for the development of community work and improving the provision of social services. Some of the measures for increasing the accessibility of housing and apartments' construction for low-earning vulnerable groups of population have been adopted already. The system of cost-less legal aid and support of access to health care will be maintained. The integration process will be strengthened by culture mechanisms, information society measures and e-inclusion, and finally by systematic activities to prevent all forms of discrimination, racism, xenophobia, anti-Semitism, and other intolerances.

3.3.3. To improve access to the labour market and to increase employment and employability of the population groups threatened with exclusion

Key measures applied will be the support for the integration of disadvantaged groups and creation of equal opportunities in the access to the labour market, in particular of marginalised Roma communities. Despite measures used so far proved to be effective as concerns short-term unemployed, in the future mainly vulnerable groups will be tackled, which creates the need to provide higher intensity assistance in regions lagging behind, in order to decrease regional disparities and increase job creation, with the use of the Structural Funds, in particular ESF. Existing tools for support of employment would be further developed and sharply targeted. Key objectives include decreasing of long-term unemployment, youth unemployment, and increasing the share of persons with disabilities in the total number of employed.

3.3.4. To strengthen management, implementation and monitoring of political measures accepted at national, regional and local levels

The efforts for a comprehensive and effective approach to the policy and social inclusion measures' creation will continue to be strengthened by the coordination of policy creation in the framework of individual institutions, inter-service and vertical co-operation, and mainstreaming activities. Non-governmental sector would play an important role in this area including the awareness rising of the issue of poverty and social inclusion. Different types of partnerships for the needs of inclusive policies including local partnerships of social inclusion with action plans of social inclusion under the Social Development Fund would be pursued. Operational priority would cover the capacity building and enhancing the quality of public services and non-profit organisations in the area of management and creation of inclusive policies, building partnerships and networks. Obtaining good quality, reliable social statistics has been a distinctive weak spot for the creation, implementation and evaluation of policies

and measures until recently. The data collection and creation of indicators at regional and local levels are still problematic.

3.4 Governance

A working group has been established in order to draft the National report on the strategies of social protection and social inclusion 2006-2008. A seminar organised by the Ministry of Labour took place as part of the consultation process, with the intention to initiate the discussion and obtain new concrete proposals and recommendations from stakeholders from public and state institutions and non-governmental area.

Committee of Ministers for Children and Youth, Council of Government for Seniors, and institutional structures and monitoring systems for applying a gender-based approach will be established, in order to co-ordinate and build a more efficient system of protection of the mentioned subjects' rights.

However, arrangements for implementation, monitoring and evaluation of the inclusion part of the Report are not described into detail. Quantified objectives, indicators, financial sources, and institutions responsible for monitoring and management of priorities have been set, however amounts of financial resources assigned for priorities or key targets are missing.

4. Pensions

In 2004 the relative living standard of older people was around 85% of that of the population under 65. The risk of poverty of the 65+ age group is low, at 7% in 2004 (3% for men and 10% for women) and is significantly lower than that of the under-65 age group.

The projected increase in age-related spending in Slovakia is lower than the average in the EU, rising by 2.9 percentage points of GDP between 2004 and 2050. The increase in expenditure on pensions is projected to be relatively limited, rising by 1.8 percentage points of GDP as a result of a pension reform. According to calculations, replacement rates from the statutory scheme for a worker retiring at 65 after 40 years of average earnings will remain stable over the coming decades, with the net rate increasing slightly from its present level of 63% to 64% by 2050 and the total gross rate from 49% to 50% by 2050.

The 2006 report highlighted the extensive reform that the Slovak pension system has undergone and outlined the key challenges facing the reformed system, the main one being the improvement of overall employment levels, in particular that of older workers.

The 2005 reforms 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 Slovak Government has amended legislation recently to stop individuals continually changing pension fund providers within this system. The voluntary supplementary pension saving system consists of a variety of saving plans, privately managed by specialised pension managers and sponsored by employers. Individuals are also encouraged to use other pension-related and tax deductible products from other financial institutions.

A key challenge for the Slovak Republic is to raise its employment rates in general and those 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, which could lead to adequacy issues in the future for the lower income earners and people who have taken career breaks, notably women.

5. Health and long-term care

5.1. Health care

Description of the system: A compulsory social health insurance scheme, with multiple (currently not-for profit but in the future, for-profit) health insurance companies acting as purchasers of care, provides universal comprehensive coverage to all residents. The provision of healthcare is decentralised and based on a public-private mix. Service providers operate on the basis of contracts concluded with health insurance companies. Primary healthcare (PHC) is provided via general practitioners (GPs), gynaecologists-obstetricians and dentists, practising mainly independently with health insurance contracts. Specialist and hospital care is performed in polyclinics, medical centres and hospitals. Some specialist outpatient care facilities are also private. Most hospitals and polyclinics have been decentralised to municipalities. The 2004 reform led to the privatisation of state-owned hospitals and other facilities into for-profit, joint stock companies. GPs are paid a capitation income plus a fee for service for preventive services. Specialists and inpatient doctors are mostly salaried employees, although they receive a fee for services in the private sphere. GPs now have a gate-keeping role, though patients have direct access to some specialist care. The social insurance system is financed mainly by insurance contributions and by state contributions on behalf of certain groups. Co-payments exist for virtually all services. Voluntary health insurance has a limited but growing role and informal payments are common. The insurance system and care provision is regulated by the Health Care Surveillance Authority (HCSA). The complex reform package of six major laws launched in 2004 focus on ensuring universal coverage, solidarity and equity of access (notably through social insurance and the definition of minimum provision and a basic healthcare package), whilst enhancing efficiency in the delivery of services through the privatisation and decentralisation of provision. It also emphasises the control and supervision role of the state and ensuring financial sustainability (notably through explicit rationing and treatment prioritisation). The report highlights that the maintenance of quality and accessibility within limited financial resources requires the restructuring of the network of healthcare providers.

Accessibility: The minimum public network of providers is defined by law. Nevertheless inequity in access for some vulnerable groups (low-income households, Roma communities) is an important issue. Patients can freely select healthcare providers, but the selected providers can refuse patients in some cases. Increasing out-of-pocket payments (12% of total health expenditure in 2004) are also a cause for concern though the share of private expenditure is one of the lowest in the EU. Informal payments are also high but the data is ambiguous. The authorities have defined a set of fully reimbursed medical services related to priority diseases (a "solidarity package" with an increasing share of screening benefits) and specified the scope of co-payments. Those in material need, children under six, blood donors, the mentally ill and long-term care patients are exempt from co-payments. The authorities expect voluntary supplementary insurance to develop substantially and thereby decrease the burden of direct payments. Access to care in rural areas is more limited than in the cities due to regional disparities. Hence, to improve regional accessibility the government plans to modernise the

local infrastructure of health-related services and transport networks. The authorities also plan to organise an ambulance network that reaches the patient in 15 minutes.

Quality: All outpatient and inpatient service providers have a legal requirement to set up, maintain and improve quality assurance systems, which expressly gives them responsibility for the quality and efficiency of the services provided. The legislator has required all health insurance companies to evaluate the quality of healthcare providers according to specific quality indicators drafted annually by the Ministry of Public Health. Since 2004 providers and health insurance companies have been accredited and supervised by the HCSA. This authority is also responsible for the scope and quality of medical services purchased within the framework of the "solidarity package". Private health insurance companies must be accredited and supervised by the Financial Market Authority and patients can freely choose health insurers and change once a year. The modernisation of healthcare facilities, the development of advanced technologies, the informatisation of hospitals and eHealth are priorities identified by the authorities for the next decade to be co-financed by the European Social Fund. The report emphasises the importance of some existing preventive programmes (the oncology programme, the cardio-vascular programme, the mother and child programme and the care for seniors programme) along with other screening programmes.

Long-term sustainability: Total health expenditure (5.8% of GDP and 829 per capita PPP$ in 2004) is among the lowest in the EU and has been relatively constant in GDP terms. The share of public expenditure spent on health (88% of total expenditures in 2004) is one of the highest in the EU and has remained stable (91.6% in 1998). The 2006 EPC/EC age-related projections show an increase in public expenditure of 1.9 percentage points of GDP by 2050 due to population ageing. Expenditure on pharmaceuticals is particularly high by international standards (38.5% of total health expenditure in 2003). The report notes that the government strongly focuses on financial and organisational restructuring of the health system to stabilise its finances and stop debt rising. The government expects that co-payments (for all services and notably pharmaceuticals) and spending caps for drugs will limit excessive consumption. Prospective budgeting and DRGs were also introduced to render costs and finance more transparent. The authorities plan to increase the self-responsibility of service providers, to improve efficiency incentives through privatisation and competition, to free the state from settling the debts of providers, and to ensure better monitoring of providers by insurers. Restructuring the system of healthcare facilities, shifting activities into the outpatient sphere is also a government priority. Regarding staff, the low income of practising doctors and the decrease in the number of nurses due to migration is an area of concern. Regarding promotion and prevention, authorities are prioritising initiatives to combat major national diseases through enhanced screening benefits for targeted groups and disease-specific programmes.

5.2. Long-term care

Description of the system: The government declared its intention, in its programme declaration 2006-2010, to introduce legislative provision for the development of social services/long-term care. The integration of healthcare services and social services is an additional objective of the government. Residential and non-residential care is provided mostly by municipalities and self-governing regions in pensioners' homes, lodging houses, nursing service facilities, day or rehabilitation centres, at home (notably through nurses), in regional integration centres and in state-owned care facilities. The system is financed by a mix of public (state budget, public health insurance funds) and private funds (with co-payments based on income). The report points out that the main objective of the Slovak authorities is to

balance home and institutional provision, depending on patients' needs and preferences, and to provide adequate support for dependent individuals and their carers.

Accessibility: The provision of adequate long-term care is a priority of the Slovak authorities. The report highlights that at present the municipalities are insufficiently equipped in terms of personnel, expertise and technical outfitting. The network of social service facilities is insufficient with regional disparities. Waiting times for placement in public facilities (e.g. pensioners' homes) vary from several months to several years and regional inequalities in access to long-term care services (availability, waiting times, and financial costs) are high.

Quality: At present, there are no legal requirements or standards for the provision of social services, though the government aims to draft them in the form of an amendment to the Social Services Act. In 2005-2006 23 projects were supported by the European Development Bank under the heading of "Transformation of the existing social service facilities".

Long-term sustainability: According to the 2006 EPC/EC projections, public long-term care expenditure is set to increase by 0.6 percentage points of GDP by 2050 as a result of population ageing, from 0.7% of GDP in 2004. The authorities stress the need to support both the disabled and elderly people, and their families, and activities that enable them to return to their home environment.

6. Challenges ahead

- To increase the overall employment rate and in particular for young and older workers, to improve access to the labour market and to increase the employability of vulnerable groups of population.

- To promote the social inclusion of vulnerable groups of population in particular Marginalised Roma Communities through support of public services and addressing housing shortages, and to increase public awareness and fight against discrimination.

- To strengthen the management, implementation, and monitoring of policy measures at national, regional, and local level with the participation of all stakeholders.

To ensure that sufficient resources for adequate pensions are available in the long run, and ensure that the transition costs of the partial shift into private funded schemes can be met and the long-term sustainability of public finances maintained.

To monitor the medical, social and financial effects of the reforms in order to ensure universal access to high-quality health and long-term care services.

To restructure the network of healthcare facilities and to address the issue of human capital management.

To develop an adequate and financially sustainable long-term care system based on the integration of health and social care sectors into one comprehensive system.

SLOVAKIA: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	0.7	47.4	**2000**	56.8	62.2	51.5	29,0	21.3	**2000**	18.8	18.9	18.6	36.9
2002	4.1	51,0	**2002**	56.8	62.4	51.4	27,0	22.8	**2002**	18.7	18.6	18.7	37.7
2004	5.4	54.4	**2004**	57,0	63.2	50.9	26.3	26.8	**2004**	18.2	17.4	19.2	33.1
2006	6.7f	59.4f	**2005**	57.7	64.6	50.9	25.6	30.3	**2005**	16.3	15.5	17.2	30.1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth		Infant mortality	WHO	Total Health exp %GDP	Public Health Exp % of THE*	Out-of-pocket payments % of THE	Public System coverage % of pop	Pop Covered by PHI** % of pop
	male	female	male	female	male	female							
1995	68.4	76.3	12.7	16.1	n.a	n.a	11,0	**1995**	N	N	-		
2000	69.1	77.4	12.9	16.5	n.a	n.a	8.6	**2000**	5.5	89.4	10.6	100	Negligible
2004	70.3sp	78sp	13.4sp	17.1sp	n.a	n.a	6.8	**2004**	5.8	88	12		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	18.4	38.1	33	3.5	14	4.6	6.8
2000	19.3	37.2	34.9	4.8	9	6.5	7.6
2004	17.2	40.1	30.1	6.2	10.7	3.3	9.6

** including administrative costs*

Age related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	expenditure (% of GDP) level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health Care	Long Term care
2005	16.3	16.2	7.2	4.4	0.7
2010	16.9	0.8			
2030	31.7	0.3	0.5	1.3	0.2
2050	50.6	2.9	1.8	1.9	0.6

4. Social inclusion and pensions adequacy (Eurostat)

	At-risk of poverty rate					Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	13b	19b	12b	13b	7b	23b	24b	23b	25b	16b	**Total**	3.9b
male	13b	-	11b	13b	3b	25b	-	25b	26b	23b	**male**	-
femal	13b	-	12b	13b	10b	23b	-	23b	24b	16b	**female**	-

	People living in jobless households					Long Term Unemployment rate				Early school leavers		
	Children	% of people aged 18-59*				% of people aged 15-64				% of people aged 18-24		
	Total	Total	male	female		Total	male	female		Total	male	female
1999	10.6	9.8	8.8	10.9	**1999**	7.8	7.4	8.3	**1999**	na	na	na
2004	12.8	10.8	10.0	11.6	**2004**	11.8	11.3	12.4	**2004**	7.1	7.8	6.4
2006	11.8	9.6	9.0	10.2	**2005**	11.7	11.2	12.3	**2005**	5.8	6,0	5.7

**: excluding students; b: break in series*

SILC income 2004	Total	male	female	SILC income 2004	Total	male	female
Relative income of 65+	0.849b	0.904b	0.818b	***Aggregate replacement ratio***	0.549b	0.53b	0.557b

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions (or Social Security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Estimate of current (2002)	Assumption
1	1	1	DB and DC	/	/	Nd	/		Nd	/	/

**:(DB / NDC/ DC); ** (DB / DC)*

FINLAND

1. Situation and key trends

Finland's GDP grew by 3.5% in 2004 (EU-15 2.2%), 2.9% in 2005 (EU-15 1.6%), and 4.5% in 2006. A slowdown to 3.0% is predicted for 2007. Employment continues to grow. In the short term, the unemployment rate will decrease due to the decline in labour supply as bigger cohorts retire and smaller ones enter the labour market. Long-term unemployment has decreased but remains a major cause for exclusion and is often connected with other risk factors. The youth unemployment ratio has slightly decreased since 1998, but was still relatively high (20.1%). The unemployment rate of foreigners is as high as 28%, but the trend is decreasing.

In 2004, 12% of Finns lived on an income of less than 60% of the median income (in 2003 11%) and the inequality ratio of 3,6 in 2004 is still low (EU-25 4,9).

At risk of poverty figures before social transfers are very high - 29% for the whole population (EU 26%) - but national data on relative poverty are more favourable - 12.0%. This indicator, however, is on the increase. Certain households have a higher than average risk of poverty: youth under 25 years of age (22.0%), many of them students and unemployed (40.1%).

Finland faces atypical demographic ageing: the increase in the dependency ratio will be faster than that for EU-25 until 2025 and then become slower. Indeed, it is expected to rise from current levels of 23% (25% for EU-25) in 2004 to 45% in 2030 (40% for EU-25), and then increase slowly to 47% by 2050 (while the EU average would be 52%). Life expectancy at birth (75.3 and 82.3 for males and females in 2004) is at the 2004 EU average, showing a consistent increase over time. Healthy life expectancy (57.3 and 56.5) is however below the EU average, especially for women (who spend 10 years more in disability). The infant mortality rate (3.3 in 2004) is one of the lowest in the EU, down from 21 in 1960. Perinatal mortality (4.9) is average, having decreased from 27.5 in 1960.

Finnish gross social protection expenditures were put at 26.7% of GDP (EU 27.3 %). The biggest items are pensions 35.8% (EU 43.9%), health care 24.3% (EU 27.2%) and disability 12.8% (EU 7.6%).

2. Overall strategic approach

Finland has a strong tradition in promoting social cohesion and social progress based on comprehensive social protection systems, and mutually reinforcing and complementary economic, employment, social and educational policies. As regards the financing of social policy programmes, the greatest threats are from the international rather than the national operating environment. Long-term unemployment is still a major challenge among certain young unemployed groups and those nearer old age.

The Finnish NRS recognises that gender equality and anti-discrimination policies are important requirements for social inclusion and economic growth. Finland has a century-long tradition of equal and universal suffrage and the right to stand for election, which has furthered women's participation in political decision-making. In terms of social exclusion, the report shows that most individual recipients of social assistance are men, while most of the single parents receiving this form of support are women. Furthermore, the majority of people receiving the basic unemployment allowance, labour market subsidy and earnings-related

allowance are men. The Strategy concludes that gender equality will have increased without any operational targets. The government is implementing the Action Plan for Gender Equality in 2004–2007. The revised equality law entered into force in summer 2005.

The Ministry of Social Affairs and Health revised its strategy up to 2015 in spring 2006. The four strategic lines of policy for social protection are: *The promotion of health and working capacity*; *Increasing the attraction of employment; Care about and prevention of social exclusion;* and *Well-functioning social and health services and adequate income protection.*

The overarching objectives of the OMC for social protection and social inclusion are addressed in the Finnish NRS. Reducing health and welfare differences will improve social cohesion. NGOs will be mobilised to support this objective. The social inclusion of migrants and ethnic minorities has received special attention in the NRS.

The plans for a national reform are in accordance with the integrated guidelines forming the key part of the Lisbon strategy. These two reports have been coordinated. The role of structural funds in pursuit of the Lisbon strategy will be specified and developed. A detailed description of the use of the structural funds was not included in the NRS.

3. Social inclusion

3.1 Key trends

Despite the overall positive developments, a number of negative ones are also evident, in particular high structural unemployment and the increasing difficulty of breaking the cycle of social exclusion. The gap between the demands of working life and the skills and functional capacity of the socially excluded is perceived to have widened.

The groups under high risk of exclusion are the long-term unemployed, poor families with children, the homeless, the over-indebted, people with chronic illnesses, the disabled, substance abusers, prisoners and certain groups of immigrants.

At present, the price and distribution of alcoholic beverages is a target of critical public discussion. The NRS highlights the importance of the prevention of alcohol and drug experimentation and drug use, especially among children and young people. The unemployment rate decreased from 9.8% in 2000 to 8.4% in 2005, but this positive development does not mitigate the negative influence of the misuse of alcohol and drugs. There is a vicious circle: misuse prevents employment and unemployment supports misuse.

The level of relative poverty in Finland is 12% in 2004, and is among the lowest in the EU. This is the result of economic growth and improved employment rates, but also active measures aimed at improving the quality of coverage of social services; and active labour market policy measures have seen the number of the homeless and long-term unemployed fall and the need for social assistance reduced. High structural unemployment remains a problem, however, and makes it difficult to break the cycle of social exclusion because unemployment and income problems have become a long-term issue. Evidence based on national data show that the rate of relative poverty has increased since the mid 90's.

The risks of social exclusion among children and young people, as well as among substance abusers, have increased recently. The number of children and young people subject to child protection measures has risen alarmingly. For example, the number of children placed outside

the home (59 100 in 2005) increased by 19.8% from 2000 to 2005. However, this is partly the result of more effective and systematic policies, and does not necessarily reflect only changes or increases in social exclusion.

The number of people with a persistently low income continues to rise, increasing the risk of social exclusion. Normally, prolonged poverty is connected to remaining permanently outside the labour market. The number of insolvent people has remained steady at around 300 000.

Overall, favourable labour market developments have not eased the problem of structural unemployment. Most of the structurally unemployable people, approximately 100 000 in number, are under 55 years of age and could still be employed, but the insufficient number of jobs suitable for the structurally unemployable and the geographical mismatch between jobs and unemployed will continue to hamper their prospects of employment even in the future.

3.2 Key challenges and priorities

In the 2006 joint report, Finland identified four main challenges: increase in employment, decrease in unemployment, safeguarding of the pension reform and improved health. These challenges are covered in the NSR.

Finland's goal for 2015 is to be a socially and economically sustainable, efficient and dynamic society. Well-being is rooted in the maintenance of working capacity and general functional capacity, adequate income protection, and independent initiative.

In terms of social inclusion, this means, among other things, that the general functional capacity and social welfare of the population will be improved. People will stay at work for, on average, two to three years longer than they do at present. Poverty and marginalisation will be reduced and the promotion of health and welfare will become established as a normal aspect of operations in social policy. The availability, quality and impact of services will be improved. Income transfers will provide a reasonable income while still offering an incentive to work and social protection will have a sustainable financing base rooted in collective responsibility supplemented by individual responsibility.

The goals are set high. Two major problems may hamper the attainment of the goals: the ageing of the population and the financial cost of the programme. However, the social expenditure forecasts that are available up to 2030 indicate that increases in social expenditure can be funded, assuming positive growth and employment rates.

The Finnish strategy addresses the social inclusion objectives and supports the Commission's key policy priorities. The Finnish strategy does not, however, make any exact references to the Structural Funds. The funds are mentioned as a source of support for local and national projects.

3.3 Policy measures

In Finland, action to curb poverty and social exclusion is based on the development of extensive social security benefits and services. The measures launched by the government to combat poverty and social exclusion are based on the 2003 government programme. The strategic targets of the programme were presented in the national action plan against poverty and social exclusion for 2003–2005. The strategic outlines of the government programme are supplemented and specified by different administrative sectors' own strategies and sector-specific targets.

The implementation of measures launched during the current term of government and the monitoring of results continue in the main part in 2006 and 2007. The outlines of measures against poverty and social exclusion will be re-examined when the new government takes office after the parliamentary elections of 2007. Therefore, the targets and concrete measures of the Finnish policies against poverty and social exclusion will not be specified until preparations are made for the programme of the next government in 2007.

The NRS lists four objectives (priorities): guaranteeing work opportunities for as many as possible; prevention of social problems and social risks; safeguarding the continuity of measures to prevent and correct social exclusion and poverty; and ensuring the supply of skilled labour in services safeguarding the welfare of residents.

In terms of social inclusion, the main objectives are the prevention of social problems and the safeguarding of preventive and corrective measures. A preventive approach will be the primary operating model. Early intervention is needed in the problems of children, young people and families with children. A major problem can, however, be the ability to maintain the universal service model under the economic constraints.

As for young people, the new youth act which took effect in March 2006 includes a target on social empowerment of young people with measures to improve young people's skills and prevent social exclusion. A social guarantee for young people was also put into place to prevent prolonged unemployment of young people and the linked exclusion threat.

As regards the gender perspective, the NRS identifies equality as an important requirement for social inclusion and economic growth. The majority of the structurally and long-term unemployed are men. Most individual recipients of social assistance are men, while most of the single parents receiving this form of support are women. The majority of those receiving the basic unemployment allowance, labour market subsidy and earnings-related allowance are men. Gender differences of this kind should be further considered in social policy planning and in the implementation of social inclusion programmes.

3.4 Governance

The NRS was drawn up following the Finnish administrative procedure in cooperation with various ministries. In this context, organisations representing the poor and socially excluded, labour market organisations, research institutes, local government representatives, and social work representatives of the Evangelical Lutheran Church of Finland have been consulted.

As regards the arrangements for monitoring and evaluation, the results of actions will be assessed separately once updated statistics on changes in poverty and social exclusion are completed. Efforts will also be made to use the available qualitative descriptions on the development of Finnish welfare. The development of poverty and social exclusion is assessed in connection with the follow-up to the government programme and in the annual reviews of various administrative sectors.

4. Pensions

In 2004, older people acknowledge a living standard relatively close to that of the general population (75%), while the poverty risk among older people at 18% (gender differences are high, 11% for men and 23% for women) is estimated to be significantly higher than for the population below the age of 65.

The 2006 Sustainability report assessed Finland as a low-risk Member States as regards the sustainability of public finances. Finland is expected to face relatively strong pressure on its public finances due to an ageing population. According to projections made by the AWG in 2005, public spending on pensions is expected to increase by a further 3.0 percentage points of GDP by 2050. According to ISG projections, net replacement rate levels are projected to remain roughly stable for a worker retiring at 65 after 40 years on the average wage, at a level of 63% in 2005 (gross 57%) to 62% in 2050 (gross 52%).
The 2006 Joint Report highlighted the key steps embedded in the 2005 reform, while stressing the need to ensure an effective further increase in the employment rate of older workers. 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 a mechanism to adjust pensions to increases in life expectancy. In the long run, the latest reform is expected to 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 the public sector (in total, the assets of social security pension schemes accounted for 59% 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. The government also plans to reform funding and insolvency rules as well as stepping up supervision with the aim of increasing returns and the security of earnings-related pensions and possibly softening the projected increase in contribution rates. The occupational pension schemes reform of 2005 made family-related leave a period of accumulating credits towards occupational pensions. This policy is likely to increase gender equality.

5. Health and long-term care

5.1. Health care

Description of the system: Municipalities provide/ purchase care for all their residents regardless of social and financial position. Primary health care – PHC (a wide variety of services, including preventive care) is provided in public health centres. Patients need a referral from their PHC doctor to visit a specialist. Specialised care is provided in outpatient and inpatient hospital departments. Federations of municipalities form hospital districts and own public hospitals. Private provision is mostly outpatient specialist care in large cities. Private physicians can refer patients to public hospitals. Public sector doctors receive salaries whilst private doctors are paid a fee for service. It is a taxation-based system: municipalities' flat-rate taxes and state subsidies cover most of the costs. It is coupled with co-payments for various services (e.g. hospital care, drugs). A compulsory sickness insurance scheme covers all residents and is financed through employers, the state and the insured. It refunds approximately a third of the costs of doctors' fees, examinations and treatment in the private sector, two thirds of the costs of medicines (2005) and 90% of transportation costs. Employers (and the self-employed), through employers' contributions, provide/ buy occupational health care for 1.8 million employees (2004). Voluntary private insurance covers approximately 11% of the population, mostly children (2005). Authorities recognise as policy goals the need to ensure nationwide availability of accessible and quality services, prolong healthy and active life and reduce health inequalities. Recognising that a healthy population improves

sustainability, a public health policy has been formulated with actions in all sectors (e.g. impact assessment of all policies, environmental policy, education and occupational health).

Accessibility: The report notes that local decision-making and different geographical conditions, treatment practices and shortages of staff have in the past resulted in geographical disparities in provision (e.g. different types of care provided/covered, differences in waiting times). With nationwide harmonised legislation and guidelines, the geographic differences in supply and access criteria have been diminishing. The authorities plan a municipal and service structure reform that extends the population base and the co-operation of municipalities, thus ensuring better countrywide availability of services. To reduce disparities in and shorten waiting times, legislation establishes the right to immediate access to health centres by phone during working hours or visit within 3 working days. Treatment should be provided within 3 months and maximum 6 months. A referral must be assessed within 3 weeks and hospital treatment provided within 6 months. Otherwise patients can be treated in another hospital district or in the private sector at the municipality's expense. The government stresses that centralised phone and internet services have been improving access. Inequity in access exists in that free of charge occupational health care is available only to a part of the population. The state is allocating extra funding to health care to face an increased demand for services. Private financing especially co-payments (19% of total expenditure in 2004) are still rather high but have decreased in recent years (20.4% in 2000). Payment ceilings are in place to reduce patients' cost burden. Data show that health inequalities exist.

Quality: The report describes the use of quality recommendations (e.g. staff numbers) and national safety guidelines as a means of improving general quality and patient safety (e.g. reducing hospital infections). It stresses that Finland has an extensive information management and statistics system that can be used for informed policy. Evidence-based medicine guidelines based on scientific expertise are being developed and published (on-line, on CD ROM) to make for better evaluation of the introduction of health interventions. Patient rights are legislated, as is the non-fault patient injury compensation system. All providers contribute to the injury fund out of which compensation is paid. Cases are analysed free of charge. Whilst recognising that in most municipalities there is little choice of public hospital and PHC doctor, authorities highlight that patients can choose between public and private providers when available. The choice of place of treatment is planned to increase. Authorities expect that the use of patients' assessment of services enhances responsiveness and that a national electronic patient record can ensure a better care path. On prevention, municipalities are responsible for child, maternal and school health care. Occupational health (adjusting working conditions, assessing and monitoring health hazards and employees' health through medical check-ups and arranging health care) is seen by authorities as a way to ensure lasting health and working capabilities as well as the system's long-term sustainability.

Long-term sustainability: Total health care expenditure (7.5% of GDP and 2275 per capita PPP$ in 2004) is at the EU average. The share of public health care expenditure (76.8% of total expenditure in 2004) is at the EU average and has been constant throughout the decade. The 2006 EPC/EC age-related projections show an increase in public expenditure of 2.3 percentage points of GDP by 2050. The insufficient coordination between specialist care, PHC and social welfare and the division of duties between them are identified by the authorities as challenges to sustainability. Concentrating certain services at regional level, increasing municipal joint provision of care, creating health districts and work division at health district level, implementing joint procurement of medicines and material and national electronic patient records are some of the ongoing/ proposed measures to improve efficiency. Generic use – pharmacies must offer the cheapest medicine available for each active

substance – is also seen as helping to control the increase in pharmaceutical expenditure together with the promotion of a more rational prescription and use of medicines and growing use of technology assessment for reimbursement. A reform of the pharmacies system is also planned to control retail prices. Regarding staff, the number of medical students has increased, which the government hopes will help overcome staff shortages especially in certain medical (PHC, dentists) and regional areas. Finland wants to ensure that staff adapt to a changing technological and multicultural environment. Authorities expect that the implementation of various health promotion programmes will reduce the prevalence of non-communicable diseases and reduce health inequalities. Municipalities have seen their role in health promotion increase. A health in all policies approach is to ensure that healthy options are widely promoted.

5.2. Long-term care

Description of the system: Long-term care is part of the health and social care systems and the responsibility of municipalities. All are eligible. Municipalities provide long-term medical care in health centres and non-medical long-term care in institutions and they provide service vouchers to social welfare clients to buy for example home help services. These are coupled with home help and support services, home health care, day hospitals and day-care centres and comprehensive rehabilitation services. Cash benefits (e.g. care allowances) are provided to pensioners. Informal carers receive municipal financial support (minimum €300/month) and a combination of health and social services (e.g. respite care) in agreement with the municipality and based on a care plan. Services are funded through municipal and state taxation plus client fees (e.g. in the public sector long-term inpatient fees are means-tested, and can be up to 80 % of clients' net income but no more than the actual costs of production). The policy focus is to improve/ maintain the autonomy and health of older persons while increasing access to care when needed by supporting independent living at one's home for as long as possible. Healthy ageing, enhancing home care, reinforcing rights and autonomy, and ensuring sufficient funding for services and individual reasonable incomes are priorities.

Accessibility: According to the report, provision and access vary substantially across regions and only 11.4% of all 75+ received regular home help (social) services, whereas the target is 25%. Thus, the government expects that a guidance project and additional state subsidies to municipalities will help to establish home help services, home nursing, day hospitals, day-care centres and part-time nursing. This is to be coupled with service housing (i.e. people live in rented apartments tailored to their needs, and are provided with meals, nursing and other help) and intermittent care in residential homes (whereby clients have at least eight periods of care a year). Joint municipal provision and access legislation (equal treatment, non-discrimination) are being implemented as a means of improving supply and access to care. Authorities also see the routine needs assessment of each 80+ as a way to define a care plan for those in need.

Quality: National quality guidelines (e.g. number of staff), better monitoring and a good practice guide are in place to enhance quality in the area. Indicators are increasingly used to measure patients' needs and services quality. Authorities seek more flexible and client-oriented provision (e.g. vouchers, an individual care plan established by a multidisciplinary team, mother tongue) to increase choice and provision. Legislation has strengthened the rights of clients. As local authorities provide both health and social services, the report highlights that there are opportunities for coordinated/ integrated care. Authorities are encouraging close cooperation between municipalities, and between municipalities and national authorities and with third sector organisations, voluntary workers and enterprises. Prevention and rehabilitation in old age are receiving particular attention.

Long-term sustainability: In view of ageing (the 2006 EPC/EC age-related projections foresee an increase in public long-term care expenditure of 1.8 percentage points of GDP by 2050) and with the aim of decreasing and postponing inpatient and institutional treatment authorities are implementing various healthy ageing programmes (e.g. the health fitness programme for older people) and promoting volunteer work in old age. Staff qualifications have been revised and further education and training have been mandatory since August 2005. A special focus is put on geriatric and multi-professionalism training. A challenge identified in the report is work-related fatigue among staff.

6. Challenges ahead:

To promote the active inclusion of the long-term unemployed and inactive, especially young and older people and immigrants, in order to break the cycle of deprivation and avoid the development of new exclusions.

To address exclusion and other social problems associated with the misuse of alcohol and drugs.

With an ageing population, to increase the employment rate at both ends at the age spectrum, and in particular to ensure that the recent pension reforms effectively translate into further increases in the employment rate of older workers, thus contributing to adequacy and sustainability.

To reduce regional differences in access, tackle waiting times and enhance the provision of home care.

To improve system efficiency through greater emphasis on primary and outpatient care and regional concentration of services and promote health through a health in all policies approach.

Finland: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	5.0	114.0	**2000**	67.2	70.1	64.2	41.1	41.6	**2000**	9.8	9.1	10.6	21.4
2002	1.6	114.7	**2002**	68.1	70,0	66.2	40.7	47.8	**2002**	9.1	9.1	9.1	21,0
2004	3.5	110.8	**2004**	67.6	69.7	65.6	39.4	50.9	**2004**	8.8	8.7	8.9	20.7
2006	4.9f	113.1f	**2005**	68.4	70.3	66.5	40.5	52.7	**2005**	8.4	8.2	8.6	20.1

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality rate	WHO	Total health exp %GDP	Public health Exp % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. Covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	72.8	80.2	14.5	18.6	na	na	3.9	**1995**	7.5	75.6	-		
2000	74.2	81,0	15.5	19.3	56.3	56.8e	3.8	**2000**	6.6	75.1	20.4		
2004	75.3sp	82.3sp	16.5sp	20.5sp	57.3e	56.5e	3.3	**2004**	7.5	76.8	19		

s:Eurostat etsimate; p: provisional **THE: Total health exp.* ** Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits								Age-related projection of expenditure (AWG)					
Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability	EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since			
										Total social expend.	Public pensions	Health care	Long - term care
1995	31.4	32.8	20.9	14.4	13.4	3.6	15	**2005**	23.7	25.4	10.7	5.6	1.7
2000	25.1	35.8	23.8	10.5	12.5	3.5	13.9	**2010**	25.4	0.2			
2004	26.7	36.9	25.5	9.8	11.5	3.1	13.2	**2030**	45	4.7	3.3	1.1	1.2
								2050	46.7	5.2	3.1	1.4	1.8

** including administrative costs*

4. Social inclusion and pensions adequacy (Eurostat)

At-risk- of- poverty rate						Poverty risk gap					Income inequalities	
SILC income 2004	Total	Children 0-17	18+	18-64	65+	Total	Children 0-17	18+	18-64	65+		S80/S20
Total	12	10	24	11	18	14	11	14	17	10	**Total**	3.6
Male	11	-	22	11	11	15	-	16	18	9	**Male**	-
femal	13	-	26	10	23	13	-	13	17	11	**Female**	-

	People living in jobless households					Long-term Unemployment rate				Early school-leavers		
	Children	% of people aged 18-59*				people				% of people aged 18-24		
	Total	Total	Male	Female		Total	Male	Female		Total	Male	Female
1999	na	na	na	na	**1999**	3,0	3.2	2.8	**1999**	9.9	12,0	7.9
2004	5.7	11,0	11.2	10.9	**2004**	2.1	2.3	2.0	**2004**	8.7	10.6	6.9
2006	6.6p	10.5p	11.0p	10.0p	**2005**	2.2	2.4	1.9	**2005**	9.3	11.3	7.3

**: excluding students; p: provisional*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.748	0.811	0.712	***Aggregate replacement ratio***	0.46	0.455	0.459

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)		Contribution rates			
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	pensions (or social security)	pensions Current estimate (2002)		Assumption
	-4	-4	DB			100		21.6			

**(DB / NDC/ DC); ** (DB / DC)*

SWEDEN

The Swedish government reports that, following the general election on 17 September 2006, it intends to present an update of its National Report on Strategies for SPSI. This country paper is based on the Report presented on 15 of September 2006. As with other countries, this paper should be read in conjunction with the analysis presented with the Annual Progress Report under the Lisbon process.

1. Situation and key trends

The Swedish economy is performing well, with growth in GDP of 4.1% in 2004 and expected growth of 4.0% in 2006. After some years of jobless growth, it now seems that employment will start to rise. With an overall employment rate of 72.5% and a high employment rate among women (70.4%) and older workers (69.4), Sweden still has one of the highest employment rates in the EU. The unemployment rate is almost the EU average and is especially high among young people and immigrants. The long-term unemployment rate is still low (1.2%) and the high youth unemployment rate gives cause for concern (22.6%[170]). The early school leavers' rate is still lower in Sweden (11.7%) than the EU average (15.1%) but exceeds the target to be reached by 2010. Sweden has an overall low at risk of poverty rate (9% in 2004) and low income inequalities (3.3). Differences can however be found between groups. Young people aged 18-24 and women over 65 live at significantly higher risk of poverty (25% and 14% respectively). Sweden still has the highest gross expenditure on social protection in relation to GDP (32.9% in 2004). Life expectancy at birth (78.4 and 82.7 years for males and females in 2004) is relatively high.[171] It has increased by about 1.5 years in the last decade (76.2 and 81.4 in 1995). Life expectancy at 65 was 17.4 years for men and 20.6 years for women in 2004. Sweden is projected to face less challenging demographic trends in comparison to most EU Member States: the old age-dependency ratio will increase from 26% in 2004 to 41% by 2050 (while the EU25 average will increase from 25% to 52%). Perinatal mortality is also low (5.2 in 2003) and has constantly declined since 1960 (25.4). Although the general statistics are favourable, the Swedish National Strategy Report 2006 points to certain signs of deteriorations in the public health status, e.g. increasing obesity rates in all ages, increased alcohol-related deaths in some regions and less favourable self-perceptions of the psychological situation.

2. Overall strategic approach

To pursue social cohesion the Swedish welfare system continues to be built on the principle of general income maintenance, to ensure a decent standard of living during periods of illness, unemployment, parenthood or old age. The Swedish National Strategic Report identifies a range of social conditions where improvements are needed and a quite extensive list of policy measures for the coming two years. The priorities chosen in the report are in line with the challenges Sweden is facing, with a broad list of measures chosen from the spring budget bill 2006 and earlier bills, but without any prioritising among them. Therefore, it is difficult to know what the main priority is. The key challenges identified in the report, as in former reports are on combating poverty and social exclusion, and increasing labour supply and the number of hours worked. The overarching aim is to boost the employment rate to 80% (for people in the 20-64 age bracket) and to reduce the unemployment rate to 4%. The employment goal was initially meant to be reached by 2004, but now it is as soon as possible.

[170] Provisional data.
[171] EU average was 75.1 and 81.2 years for males and females in 2003.

Furthermore, the Government has set itself the target of halving the number of sick leave days between 2002 and 2008 and decreasing the number of new entrants into sickness- and activity schemes (former disability pensions). Progress has been made but the stock of people already on disability schemes is still increasing although expected to reach its peak this year.

The relationship with the Lisbon strategy is visible and complementary. Disadvantaged groups on the labour market mentioned in the NRP for Sweden last year are also given priority in the report for social protection and social inclusion. It is mentioned that the relationship between the revised Lisbon strategy and how the open method of co-ordination is applied in the social area must be mutual. The Swedish government, as usual, invited a large number of stakeholders to participate in the work on the strategic report. The Swedish Social Insurance Agency (Försäkringskassan) plays an important role in reducing sickness leave while the National Labour Market Board (AMS) is responsible for active labour market policy. Gender mainstreaming, gender equality and the adequacy of the policy approach for advancing gender equality are good. Gender mainstreaming is applied to women and men in general and to immigrant women and men, but less so to young persons and handicapped persons, which could be further expanded on.

3. Social inclusion

3.1 Key trends

Sweden has an overall low at risk of poverty rate (9% in 2004 against 16% in the EU). Looking at the poverty rate in more detail, it can be seen that single-adult households, as expected, have a higher poverty rate than two-adult households (19% and 5% respectively).

One of the main policies in recent years has been to increase the number of people that proceeds to university studies. However, the labour market situation for young people with an academic degree has worsened in recent years and the unemployment rate among this group is on the increase. Even more striking is the growing problem of poor students (21.4% in 2000 and 32.3% in 2004).[172] Unemployed people with academic degrees face a difficult situation because of the very strict repayment schedules for student loans. One consequence of this is a drop in the number of applications for tertiary education, implying that the objective of 50% of every cohort gaining a university qualification seems further away now than it was a year ago.

In general, people out of the labour market, such as unemployed people, retired and other inactive people, have a much higher risk of poverty (26%, 14% and 24% respectively) compared with the average at risk of poverty rate (9%). Single persons, especially women, and single parents also have a higher risk of poverty (19%, 20% and 18% respectively). For immigrants, especially recent, the poverty rate is much higher than for native born (18.9% and 6.9% respectively).[173]

The employment rate for immigrants and foreign-born citizens remains much lower than for native Swedes. According to national data the employment rate for foreign born citizens was 61.6% in 2005 compared with 76.1% for native Swedes.

[172] National data, source. Income distribution Survey 2004. N.B. The students concerned are not necessarily university students.

[173] National data: Income Distribution Survey 2004, National equivalence scale.

3.2 Key challenges and priorities

The Swedish social model is characterised by a general welfare policy and an active labour market policy. The overall objectives during the period 2006-2008 are to create more jobs, reduce ill-health in working life, improve care of the elderly, make society accessible for disabled people, combat homelessness, enhance integration, create the conditions for staying longer in working life and increase gender equality. The Swedish government has put forward four main priorities for action; firs, to encourage work and education for all; second, to enhance integration; third, to guarantee good housing and to combat homelessness; and fourth, to support groups in especially vulnerable situations.

There is a high degree of congruence between the 2006 Joint Report and the Swedish Strategic Report: the four priorities chosen match the challenges identified in the 2006 Joint Report. The contribution of the European Social Fund (ESF) is mentioned as one possible source of funding to combat social exclusion during the next programming period, especially when it comes to integrating disadvantaged people and reducing the number of people on long-term sick leave. However, the ESF budget is relatively low in comparison with overall spending in this field.

3.3 Policy measures

To promote work and education for everybody is the first priority chosen by the Swedish government to combat social exclusion and poverty. All children are offered pre-school education for at least 15 hours per week as from the autumn when they turn four years old and there is a maximum ceiling on what you pay for childcare. The government has made commitments to increase the number of staff in schools and also to improve the quality. More attention is also given to students who are not completing the year in primary and secondary school. The government has recently adopted a comprehensive employment package that will give 55 000 more people, corresponding to 1% of the labour force, an active labour market measure in the form of a job or work-place experience during 2006 and 2007. In line with the challenges for Sweden, those targeted are disadvantaged people such as certain groups of immigrants, disabled people, long-term unemployed and people on long-term sick leave. Measures to give disabled people the possibility to work have also been improved. Furthermore, the government's work on reducing the number of people on sick leave and bringing them back to work continues. The proposed measures seem extensive but a better balance between supply-side measures and demand-side measures is wanted.

The responsibility for implementing the policy measures within this first priority is mainly shared between the municipalities, the National Labour Market Board and the Swedish Social Insurance Agency. Under the proposed Swedish NSRF for the Structural Funds, the ESF will play an active role within this field during 2003-2007.

Increasing integration is the second priority in the Swedish NSR, the aim being to help people to participate in society, to have their own income, to protect democratic rights, to act for equal opportunities for men and women and to prevent racism and ethnic discrimination. Measures to improve integration during the years to come include giving more financial resources to the municipalities, enabling them to hire teachers with specific language knowledge to work in highly segregated areas in order to decrease the percentage of children and youths with uncompleted years in primary school. In view of the increase in early school leaving and the high youth unemployment rate this is welcome. Furthermore, additional resources will be given to the National Labour Market Board (AMS) to improve integration

into the labour market. Also measures to fight discrimination will be given priority within this field. In the years to come specific measures in urban areas to increase integration (with support from the ESF) will also be introduced. Given the relatively high at risk of poverty rates for immigrants, together with the low employment rate, it is crucial to improve the integration of immigrants in order to meet the target of increasing labour supply.

To secure decent accommodation and to combat homelessness is the third priority in the Swedish NSR. The Government has appointed a national co-ordinator with responsibility for proposing measures by the end of 2007 on how the situation for young people could be improved as regards accommodation. To combat homelessness the National Board of Health and Welfare has been given the assignment of developing methods to map out homelessness. A large proportion of homeless people have substance abuse problems or mental health disabilities, and, for the latter personal representatives play an important role in representing them in, for example, contacts with authorities. In order to combat homelessness the government has set aside approximately €3.5 million yearly for 2007 and 2008. Beyond this almost €11 million is spent on personal representatives for people with mental health disabilities. The Swedish government's view is that the effort made by society to prevent families becoming homeless must be improved and it should be done by enhancing co-operation among the relevant stakeholders involved. Even though very important this priority is less expanded upon than others, especially as regards the housing situation for young people. It remains to be seen what conclusions the national co-ordinator will draw.

The fourth and final priority in the Swedish report is to support groups in particularly vulnerable situations. For young people a three-year trial will be conducted to develop and test a consilidated care chain in juvenile care. The aim is to give young people who put their health or development in serious danger through criminality or substance abuse the specific care offered by special approved homes. The young persons are to have a care co-ordinator. Approximately €250 million will be spent on this project. The government will also continue their commitment on enhanced care to people with problems of abuse. Women and their children who are facing violence will be given additional resources, approximately €11 million yearly as from 2006. More support for people faced by both problems of abuse and mental problems will be made available during 2005 and 2006. The main responsibility for implementing policies that secure the support and help needed for people lies with the municipality where the people in need of assistance live. This priority could be further expanded upon, for example, on the situation of people who have recently received their residence permits and the recent increase in number of poor students.

3.5 Governance

Most of the relevant stakeholders seem to have been involved in preparing the Swedish NSR. However, the parliament has not been consulted, which has been criticised by the NGO network. The NGO network consists of a large number of voluntary organisations in which labour market organisations also participate. Beyond regular talks with the government, NGOs have also offset out their priorities in one of the three annexes to the NSR, albeit without concrete suggestions as to what kind of practices NGOs could provide. Central authorities and the Swedish Association of Local Authorities and Regions have also been invited to information meetings on the preparation of the NSR. The social partners have been informed via the regular meetings held between them and the Ministry of Social Affairs. It is not clear, however, what their impact on the NSR has been. Most of the measures that are presented in the NSR are implemented by central authorities. The government monitors the implementation of measures with ordinary instruments already in place.

4. Pensions

In 2004, older people acknowledge a living standard relative of fairly close to that of the general population (80%), while the poverty risk among older people at 11% (gender differences are high, 6% for men and 14% for women) is estimated to be slightly higher than for the population below the age of 65.

The 2006 Sustainability report assessed Sweden as a low-risk Member State as regards the sustainability of public finances. Sweden's public pension system is expected to face only low pressure due to the ageing population: according to the 2005 AWG projections, public spending on pensions is projected to increase very slowly until 2050 (of only 0.6 percentage points). Replacement rates at a given age are projected to decrease in the coming decades, following the increase in life expectancy. According to ISG projections, a worker retiring at 65 after 40 years of work would see the net replacement rate markedly decrease from 71% in 2005 to 57% in 2050 (from 68% in 2005 to 56% in 2050 for the gross rate; this includes occupational pensions that cover about 90% of the workforce). Accordingly, cohorts who retire in 2050 would need to work for about 4 more years in order to achieve the same replacement rate as those who retire in 2005.

The 2006 Joint Report underlined that 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 in replacement rates by leaving the labour market later. Sweden ensures the financial sustainability of the pension system by automatic adjustments embedded in the pension system and through a reserve fund created at the beginning of the 1960s. Occupational pensions also make a notable contribution as they cover around 90% of employees and usually provide extra income amounting to approximately 10-15% of a person's final wage/salary.

While the Swedish pension system provides very comprehensive information to individuals (for instance, by sending out annual statements of pension capital accumulated so far and a projection of future pension entitlements), the 2006 report notes potential deficits in the level of knowledge that require long-term efforts. Although actuarial neutrality in the statutory scheme and possibilities for flexible retirement would keep people from retiring early, some channels of early exit from the labour market are starting to develop, in particular through sick leave and disability benefit, while the design of occupational pensions could be more supportive of longer working lives, in particular for white-collar workers.

5. Health and long-term care

5.1. Health care

Description of the System: Health care in Sweden is coordinated within a three-tier structure. The national level sets out policy goals and financial transfer mechanisms. The regional county councils are responsible for the organisation and provision of health care, and municipalities have a duty to provide health services for the disabled and elderly in certain circumstances. The county councils and municipalities impose taxes to finance health services and their autonomy means that services can be organised and prioritised differently in various parts of the country. Health care is mainly tax-financed and health care services are mainly provided by public providers: public health care centres, hospitals and pharmacies. The physicians, mainly employed in public health care centres, act as gatekeepers guiding patients to specialists, usually resident within public hospitals. Some private care providers are

affiliated to the county councils' reimbursement systems for providers. Outpatient care, hospital care and prescribed medicines are usually provided with only patient co-payment fees to be paid. The co-payment method differs depending on the type of benefit that is provided. For some age groups medical and dental care is free of charge. Maximum, total co-payments per year per patient apply in most areas and county councils can apply different co-payment rules and amounts.

Accessibility: Several initiatives to improve accessibility and to reduce waiting times (such as a national action plan for the development of health care services) have been taken recently. Patients now have increased options to access health care in another county than the one they reside in, with databases being developed to enable waiting time comparisons. Since 1997, a care guarantee has been in use to ensure that counties provide health care within a set timeframe. Currently, county councils have agreed to provide planned treatment within 90 days of a doctor's diagnosis. Co-payment fees can deter individuals from using healthcare as needed, which has been noticeable for dental care in recent years. To counteract access limitations by co-payments, medical and/or dental care is completely free for certain age groups and maximum total co-payment limits are set for others. Out-of-pocket payments by private households' (as a percentage of total health expenditure) amounted to around 13.4% in 2004. (The EU value in 2004 was 16.7%.) A reduction in the availability of psychiatric care in recent years is a growing issue in Swedish public debate leading to the appointment of a national co-ordinator in 2003.

Quality: The National Board of Health and Welfare and the counties' administrative boards are responsible for supervision, follow-up and evaluation of county council and municipal healthcare services, through the establishment of norms and guidance, supervision and the furthering of knowledge. The Board is also an important referee for proposed new policy measures. The 21 county administrative boards are responsible for supervision, follow-up and evaluation at regional level. The National Board has the task of developing a set of national quality indicators. Health professionals have established national quality registers to follow up specific treatments for major illnesses, with patient data on diagnosis, treatments and results. Currently 57 registers exist.

Long-term sustainability: Total healthcare expenditure (9.5% of GDP and 2875 PPP$ per capita in 2004) was above the EU average (8.87% and 2376.33 in 2004) and the sixth highest in EU as a percentage of GDP. The share of GDP was 9.2% in 1980-1983, declining to 8.2% in 1990-1997, but has since risen again. Public healthcare expenditure as a percentage of total health care expenditure decreased continuously from 92% in 1980 to 85.4% in 2004. Public health care expenditure has grown from 7.1% of GDP in 1998 to 8.1% in 2004. According to the 2006 EPC/EC projections public health care expenditure is projected to increase by 1.0 percentage points of GDP by 2050 due to population ageing, whereas a national projection state 1.3% of GDP. The Swedish report notes that it is necessary to continue restructuring healthcare to improve quality, productivity and efficiency, e.g. by further increased use of day-care surgery, with quicker use of truly innovative medical developments, and also efficient rejection of non-useful treatments after a fair evaluation. More cost-efficient use of pharmaceuticals should be further promoted. The generic substitution procedure in pharmacies since 2002 is reported to have resulted in considerable cost savings with similar treatment quality. The Swedish report in 2005 noted the challenge of quickly counteracting new deteriorations in the public health status so as to avoid future expenditure risks. It made reference to prevention and health promotion being further incorporated within the healthcare system, with normal patient consultations being used to support the individual's own efforts to prevent illness by life style changes, etc.

5.2. Long-term care

Description of the system: Sweden's 290 municipalities have a statutory duty to meet the social service and housing needs of persons with disabilities and the elderly. Their autonomy allows services to be organised and prioritised differently in different parts of Sweden. The individual's need for support is assessed (though not means tested) in relation to income. The national policy for the elderly and the national disability policy stipulates that both groups should be able to live independent lives and should be enabled to live in their own home as long as possible.

Accessibility: Care services for the elderly and persons with disabilities have been significantly restructured over the last 15 years, with a reduction in institutional living and care and an increase in those living at home (sometimes with special adaptations) and receiving services provided at home. Home health care services still require improvement and expansion, and coordination between the county councils and the municipalities must be improved. The quality of care for persons with dementia also needs to be improved, through better service integration and more education. The restructuring and downsizing of institutional care has, in some communities, led to a noticeable lack of places in institutions / special housing, resulting in long waiting times. More detailed statistics and evaluation are required to help monitor whether social home care services actually reach those requiring care at home.

Quality: Legislation related to care for the elderly has been refined to improve legal security for individuals requiring care services, especially as regards institutional care provided by the communities. Knowledgeable and engaged personnel are key prerequisites for achieving and maintaining high quality in care services. Two earlier initiatives, the "Competence ladder" and "Education leave", supported the development of local education and training in basic know-how for care occupations. A study is planned to present proposals for a national system concerning professional qualifications, education and training for care occupations, and to propose actions to enhance future personnel recruitment.

Long-term sustainability: The long-term sustainability of care for the elderly is dependent on sound public finances and high labour force participation to finance projected care needs. The National action plan for elderly care, from 2005, includes actions that focus on support for development efforts in the communities and county councils to improve service quality and increase efficiency. The ministry of health and social affairs is preparing a study on long-term needs and expenditure for welfare services, including care for the elderly. Between 2000 and 2004 total expenditure on care for people 65 years and older increased 1.5 times more than the numbers in this group increased. Only county councils' expenditures increased whereas the community sector's expenditure fell. According to the 2006 EPC/EC projections, public long-term care expenditure is projected to increase by 1.8 percentage points of GDP by 2050 due to population ageing (from 3.8% of GDP in 2004), whereas a national projection put this figure at 2.9 percentage points.

6. Challenges ahead

To continue with measures targeting the active inclusion of more people into the labour market by addressing the persistently high employment gap between immigrants and the native-born population as well as the worrying problem of high unemployment among young people.

To put further emphasis on transitions from sickness-related schemes, including the high stock of people already in sickness- and activity schemes, 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 and efficient organisation of care services and more cooperation between different care providers, but it may also require significant reorganisation of the political and administrative levels responsible for care services.

To quickly counteract recent deteriorations in the public health status as to avoid future expenditure risks.

Sweden: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	4.3	118.8	**2000**	73,0	75.1	70.9	42.2	64.9	**2000**	5.6	5.9	5.3	10.5
2002	2.0	113.7	**2002**	73.6	74.9	72.2	42.8	68,0	**2002**	4.9	5.3	4.6	11.9
2004	4.1	115.4	**2004**	72.1	73.6	70.5	39.2	69.1	**2004**	6.3	6.5	6.1	16.3
2006	4.0f	116.1f	**2005**	72.5b	74.4b	70.4b	38.7b	69.4b	**2005**	7.8p	7.9p	7.7p	22.6p

**:Growth rate of GDP at constant prices (2000) - year to year % change; **: GDP per capita in PPS (EU25 = 100); f: forecast; b: break in series; p: provisional*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp. %GDP	Public health Exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop.	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	76.2	81.4	16.0	19.6	n.a	n.a	4.1	**1995**	8.1	86.6	-		
2000	77.4	82.0	16.7	20.0	63.1	61.9	3.4	**2000**	8.4	84.9	13.8	100	n.a.
2004	78.4sp	82.7sp	17.4sp	20.6sp	62.5e	62.2e	3.1	**2004**	9.5	85.4	13.4		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Health Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	34.3	37.4	22	10.8	11.4	6.2	12.2
2000	30.7	39.4	27	7.1	9.3	4.5	12.8
2004	32.9	40.1	25.4	6.2	9.6	3.9	14.8

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since2004			
		Total social expend.	Public pensions	Health care	Long-term care
2005	26.4	29.6	10.6	6.7	3.8
2010	28.0	-1.4			
2030	38.5	1.3	0.4	0.7	1.1
2050	40.9	2.2	0.6	1.0	1.7

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64*	65+
Total	9	9	9	9	11
Male	9	-	9	9	6
femal	10	-	10	8	14

* break in series

Poverty risk gap

	Total	Children 0-17	18+	18-64	65+
Total	19	17	19	23	10
Male	20	-	23	26	9
Female	17	-	17	20	11

Income inequalities

	S80/S20
Total	3.3
Male	-
Female	-

People living in jobless households

	Children	% of people aged 18-59*		
	Total	Total	Male	Female
1999	n.a.	n.a.	n.a.	n.a.
2004	n.a.	n.a.	n.a.	n.a.
2006	n.a.	n.a.	n.a.	n.a.

Long-term unemployment rate

	% of people aged 15-64		
	Total	Male	Female
1999	1.9	2.2	1.4
2004	1.2	1.4	1.0
2005	1.2p	1.4p	1.0p

Early school-leavers

	% of people aged 18-24		
	Total	Male	Female
1999	7.7	9.2	6.2
2004	8.6	9.3	7.9
2005	11.7b	12.4b	10.9b

**: excluding students; p: provisional; b: break in series*

SILC income 2004	Total	Male	Female	SILC income 2004	Total	Male	Female
Relative income of 65+	0.797	0.865	0.754	***Aggregate replacement ratio***	0.581	0.605	0.543

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions					
Net	Gross replacement rate					Coverage rate (%)			Contribution rates		
									pensions (or social security)	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions			Current estimate (2002)	Assumption
-15	-12	-13	NDC/DC	1	DB	100	90		17.2	13.7	13.7

** (DB / NDC/ DC); ** (DB / DC)*

UNITED KINGDOM

1. Situation and key trends

In 2005 UK GDP growth slowed to 1.9%, although forecasts for 2006 estimate an increase in GDP growth to 2.7%. Employment rates continue to grow, albeit modestly, and the UK exceeds all quantitative Lisbon targets on employment. Total employment in 2005 stood at 71.7% (male employment of 77.6% and female employment 65.9%). Employment amongst those aged 15-24 (54%) and employment amongst those aged 55-64 (56.9%) are both above EU averages. Unemployment remains stable at 4.8% (2005), yet the number of people living in jobless households continues to give cause for concern: 10.7% of 18-59 year-olds excluding students (EU25=10.2%) and 16.2% of children (EU25=9.6%); in this context it should be noted, however, that the UK has a high number of one-person, or one-adult households. Furthermore, whilst overall activity rates compare favourably with EU averages (75.3% as against 70.2% for the EU-25 in 2005), the number of people inactive because of poor health continues to be a key concern for the UK government. However, it is starting to fall and is now the focus of major labour market reform. In 2004, at 19%, the at-risk-of-relative-poverty rate[174] remains 2% points higher than the EU average. According to SILC provisional data, at-risk-of-poverty rates are particularly high amongst those under 18 (22%) and over 65 (27% in total, rising to 29% for women), but according to national data the rates for both groups have improved considerably in recent years.

The UK faces similar demographic trends to most EU Member States: the old-age dependency ratio (24% in 2005) is broadly in line with the EU average; and projections estimate that increases in the UK dependency ratio (to 45% in 2050) will be at a slower rate than the EU average. Life expectancy (76.3 for males and 81.1 for females in 2004) is above the EU average for males and below the EU average for females, showing a increase of two years since 1995 (74.0 and 79.2). Healthy life expectancy (61.5 and 60.9 in 2004) is well below the EU average, by about 3 years for males and 5 years for females. Infant mortality, at 5.1 deaths per 1,000 live births (2004), remains above the EU average of 4.5, but much reduced from 18.5 in 1970. Gross social protection expenditure was equal to 26.3% of GDP in 2004; there has been a steady net downward trend in expenditure as a proportion of national income, but that masks significant variation in the component parts of spending, e.g. as the number of people unemployed has fallen, consequent total expenditure on unemployment benefit has fallen. Total age-related social protection expenditure is projected to grow from its current level (19.6% GDP) by an extra 4 percentage points by 2050.

2. Overall strategic approach

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 are rooted in activation measures, facilitating access to the labour market, and providing financial incentives to work. Measures are often tested in small areas before being rolled out to a wider population. In its National Report the UK identifies its key challenges as: maintaining a positive economic situation; ensuring access to employment; tackling child poverty; ensuring access to services; and tackling discrimination. Priorities for action stem directly from these challenges, chief amongst which is the commitment to eradicate child poverty. To this end the UK plans to

174 Following the implementation of EU-SILC in 2005, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc for income year 2004) cannot be compared to the data presented in previous years, the year to year differences that can be noted are therefore not significant. During the transition to the new EU harmonised and comparable source SILC (see methodological note) the data used was based on the national family resources survey that was not fully compatible with the SILC methodology based on detailed income data. The EU-SILC data for the UK is provisional.

intervene in favour of disadvantaged children and young people in order to break the transfer of poverty from one generation to the next. There is a strong correlation between the approaches set out in the UK's Lisbon National Reform Programme and the National Report on Strategies for Social Protection and Social Inclusion and a clear commitment to involving stakeholders in the development of policies that will affect them. Perhaps less clear is how inequalities in British society are being addressed and social cohesion achieved.

3. Social inclusion

3.1 Key trends

In 2004, according to SILC provisional data, the overall poverty rate of 19% of the total population remained above the EU average (16%). However, according to national data, it has improved slightly over recent years. Progress in reducing the proportions at risk of poverty can be noted, particularly with regard to pensioners and children. It is clear that additional resources targeting these groups are now beginning to take effect. Whilst the government's own targets on child poverty reduction were narrowly missed in 2004/5 significant progress has been made, with 700 000 fewer children at risk of poverty than in 1998/99 (national data). Nonetheless, ambitious targets for future years are unlikely to be realised without sustained extra effort and resources. NEET (young people not in education, employment or training) are likely to stay a particular focus of government efforts in the UK. Other groups such as disabled people, jobless lone parents, certain ethnic minorities and people living in areas of high deprivation continue to exhibit high at-risk-of-poverty rates.

The net income of jobless social assistance recipients is roughly equivalent to the poverty threshold, with lone parents better off as a result of transfers than single people or couples with children. The long-term trend shows a reduction in the proportion of jobless households, although this remains above the EU average and has slowed in recent years (for households with children the proportion continues to decline at a steady pace). Reductions in the employment gaps for some at-risk groups have been evident in recent years, most notably lone parents where the employment rate has increased by 11.3 percentage points since 1997. Income inequality remains significantly above the EU average; only Poland, Portugal and the Baltic States exhibit wider income disparities.

3.2 Key challenges and priorities

The key priorities identified by the UK in the NRS are: eliminating child poverty via a combination of measures to ensure financial stability and break cycles of deprivation, including via early years provision and improved education; increasing labour market participation where key policies focus on activation of lone parents, people out of work for health reasons and those over 50 years of age; improving access to quality services through more competition in their provision, measures to build the capability and capacity of civil and public service and the setting of public service agreement targets; and tackling discrimination – notably towards disabled people and people in and ethnic minority groups. The priorities selected would seem appropriate, and are consistent with the challenges for the UK identified by the 2006 Joint Report.

Much attention is paid to getting people into work. The importance of addressing the challenge of poor basic and transferable skills (particularly literacy and numeracy) as a driver to enhance individuals' chances for inclusion, employment and advancement is referenced in both the NRS and NRP. A fuller discussion of the quality and sustainability of work would benefit, however,

and will be informed by research undertaken through the on-going Employment and Retention and Advancement Demonstrator.

There is recognition of the risks of over-indebtedness with the development of a strategy in 2004 to minimise the number of people falling into problem debt and improve support processes for those already in debt. The impact of action stemming from this strategy is as yet not demonstrated as personal debt has reached record high levels and the number of people signalling problems keeping up with debt repayment, including the number of personal insolvencies, continues to rise.

3.3 Policy measures

UK government strategy continues to move away from a more passive welfare system to one which encourages the development of individuals' potential, including via a preventative approach. The UK has a wide and sophisticated array of initiatives and benefits aimed at increasing activation, alleviating poverty particularly child poverty, and making work pay. Worth highlighting are the National Minimum Wage and the new system of ‘tax credits’ which seek to increase the financial incentives to work. Many of the benefits available are means-tested or designed for specific target groups to focus on those most in need. Such schemes have been criticised for being overly complex and the initial impact of the tax credits programme was hampered by administrative problems. Simplification could help to ensure that people are aware of the support available to them and not discouraged from availing themselves of this.

The Welfare Reform Bill of 2006 seeks to introduce reforms to benefit systems, notably for incapacity and housing benefits. The successful 'Pathways to Work' activation pilot initiative will be extended nationally by 2008 to support the replacement of the existing system of incapacity benefits with a new simplified benefit with a clearer balance of rights and responsibilities. A Cities Strategy has also been launched for some of the most deprived areas of the country. Proposals include key targets of: reducing the number of people claiming incapacity benefits by a million in a decade; helping 300 000 more lone parents into work; and increasing the number of older workers by a million.

In addition, the UK government has announced its intention to ‘improve opportunity and strengthen society’ by increasing equality between races and deepening people’s sense of ‘togetherness’ amidst increasing concerns over divisions in society. An Action Plan has been launched to focus on the most vulnerable in society (children in care, families with complex problems, teenage pregnancies and people with mental health problems). Such groups undoubtedly face a greater risk of poverty and social exclusion and their targeting should be welcomed. However, it is not yet clear what mix of activation and support will be proposed. Some commentators have raised concerns that the approach taken by the UK government may risk stigmatising the very groups they are trying to assist. Furthermore, as the focus shifts yet further to the most excluded, success will increasingly depend upon ensuring the continued capacity of the relevant services and agencies to intervene flexibly according to the needs of individuals, in the context of substantial administrative efficiency savings.

Some reference to gender issues and the impact of inequalities is made in the NRS and in the Lisbon NRP. The UK average hourly gender pay gap is the highest in the EU. In addition, high UK rates of part-time employment amongst women impact upon earnings over working lives and pension prospects. Following the report of the Women and Work Commission report, the UK government has stated its intent to "take action to address all causes of the gender pay gap" but it is not yet clear that current measures will bring substantial results in narrowing the gender pay gap.

Because of the complex and inter-related nature of the measures cited, which will contribute to the achievement of the UK priorities, as set out above, the resource implications are not easily disaggregated. In addition to domestic resources, European Structural Funds, and particularly the European Social Fund, contribute to the reduction of poverty and social exclusion via a range of measures, often highly innovative and closely tailored to providing solutions to individualised and diverse needs. In the main this is achieved through a focus on the activation of disadvantaged groups via a pathway approach of 'soft' interventions to more mainstream active labour market policies. The strong partnership ethos in the allocation and delivery of ESF, through models such as Global Grants, has been particularly valuable in enabling small grass roots NGOs to work with the most disconnected in society who are often too hard to reach for more mainstream activities.

3.4 Governance

There is a clear commitment to delivery on goals set out in the National Report on Strategies at all levels and an increased impetus to do so. This is evidenced by the appointment of a Minister for Social Exclusion and by an increased engagement with stakeholders in the policy process. The UK has a complex system of government and an active voluntary and community sector.The National Action Plan on social inclusion, as part of the NRS, is highlighted as "providing an important means of linking action at central government level with the wide range of actors across the UK who are concerned with social inclusion". The 'Get Heard!' toolkit and 146 workshops held around the UK have informed the production of the NRS and serve as a valuable two-way communication with many and varied stakeholders. The substantial and qualitative involvement of these stakeholders in the design, implementation, and to some degree, monitoring of social inclusion policy and the framing of the NRS has undoubtedly had positive effects on the policy process and in many respects can be viewed as a model of best practice.

4. Pensions

In 2003 older people had an average income 72% of that for people aged 0-64. The at-risk-of-poverty rate among elderly people in the UK has declined significantly in recent years, but remains above the EU average and higher than for the general population.[175]

The 2006 Sustainability Report assessed the UK as a medium-risk Member State as regards the sustainability of public finances. According to the AWG projections of 2005 (which do not include the effects of the proposed 2006 pensions reform) spending on public pensions, including pensions of public employees, will increase by 2 percentage points of GDP from 6.6% of GDP in 2004 to reach 8.6% in 2050. According to ISG projections (which do not reflect the 2006 proposed reforms), replacement rates are set to decline slightly in the coming decades for people with supplementary pension provision, from 82% to 73% in net terms (under the assumption of a contribution rate of 23.7% - 18.7% employer and 5% employee - which is significantly higher than the current average contribution rates to occupational schemes).[176] For people with no supplementary pension provision (nearly half the workforce) the decline in replacement rates would be sharper (from 38% in 2005 to 23% in 2050, 53% to 38% in net terms), essentially reflecting current indexation rules and the clear incentives for supplementary saving.
The key challenges, identified in the last report, were for the UK to continue making progress in addressing the adequacy of pensions. The momentum in reducing pensioner poverty is expected to continue with the implementation, and improving take-up, of Pension Credit. As set out in the

[175] According to latest national figures, in 2004/05, when incomes are measured after housing costs, a pensioner in the UK is nowadays less likely to be in poverty than the rest of the population.

[176] It should be noted that UK pension funds appear to have achieved higher rates of return in the past and lower administration costs than those assumed for the purpose of the ISG exercise

White Paper on pension reform – *Security in Retirement* – it had long been recognised that 'further steps would be needed to ensure that people could get the retirement income that they expect in the future'. The UK pensions system has historically been characterised by a reliance on occupational and personal pension schemes to ensure adequacy and sustainability, but participation and contributions to such schemes has declined since the early eighties. In response to this the UK government appointed a Pensions Commission in 2002 to make recommendations on the future adequacy of private pension saving and set out proposals for reform.

In 2006 the UK Government, after looking at the recommendations of the Pensions Commission, proposed to introduce (in particular in view of the decline in supplementary saving) low-cost personal accounts to give those without access to occupational pension schemes the opportunity to save. Individuals will be automatically enrolled into either their employer's scheme or a new, low cost, personal retirement account, with the freedom to opt out, and employers will also contribute to these accounts. In order to provide a solid foundation to private saving, the state pension system will be reformed by indexing both the guarantee element of Pension Credit and the basic state pension in line with earnings growth, rather than prices. Both elements of the state pension will be made more equitable and more widely available (which will especially benefit women and carers) and the State Pension age will gradually rise in line with increasing longevity, reaching 68 by 2046. Legislation on these proposals was submitted to Parliament in November 2006 (and is expected to receive royal assent by mid-2007), and a white paper on personal accounts was published in December 2006. The development of the reformed system will be watched with interest, in particular the development of automatic enrolment and personal accounts.

5. Health and long-term care

5.1. Health care

Description of the system. Health care is delivered through the mainly tax-funded National Health Service (NHS), which provides health care services free of charge at the point of delivery, with universal coverage based on residency in the UK. There are a limited number of patient co-payments for non-medical services, e.g. pharmaceuticals. Children, elderly people and benefit recipients, do not pay these charges. The responsibility for health care in Scotland, Northern Ireland and Wales is devolved to the respective administrations. The health strategy and challenges include: continuing to improve the quality and capacity of health care service (reduce waiting times); building a service that is responsive to patients and their needs; improving value for money; preventing ill-health; and addressing health inequalities (especially in access to HC services). England exhibits a clear purchaser-provider split in its NHS organisation, which is not present in the rest of the UK. In **England,** the Strategic Health Authorities (SHAs) are responsible for strategic leadership, for ensuring local systems operate effectively and deliver improved performance. Primary Care Trusts (PCT's) are responsible for improving the health status of their populations, contributing to well-being and protecting health. This includes the commissioning of health services to meet population needs. Hospital services are managed and run by NHS Trusts, which are self-governing organisations, managed by the SHAs. The Trusts receive most of their income from service level agreements with PCTs. The best performing NHS Trusts are awarded 'foundation status' as independent public benefit corporations, accountable to Monitor, an independent regulator. This status brings increased flexibility in managing their own budgets and the possibility of borrowing money privately. In **Scotland,** the power to provide comprehensive health care services is delegated to 15 NHS Boards, which establish Community Health Partnerships in order to further integrate primary care, specialist services and social care. In **Wales** the National Assembly has put in place a structure where 13 NHS Trusts are the main providers of hospital care. 22 Local Health Boards, created in 2003, are responsible for determining the health

needs of the local population and commissioning appropriate services. In **Northern Ireland,** the four Health and Social Services Boards are responsible for commissioning integrated health and personal social services from a range of providers, with 19 Health and Social Services Trusts being the main providers.

Accessibility. Waiting times have been a major concern in UK health service provision. Substantial increases in public health care investment and expenditure throughout the UK in recent years have begun to improve waiting times in most areas, although these continue to give cause for concern for some types of treatments and in some geographic areas. NHS patients in **England** have the right to choose between different health care providers, since 2005. A target of 'free choice of provision' by 2008 has been set (providing that providers meet NHS standards and treat patients within the national maximum NHS price).Care is shifting from hospitals to primary care and the community. Steps to increase accessibility have been taken (walk-in centres, NHS Direct). National procurement is underway to provide more GPs in geographic areas where there are shortages. In **Scotland,** the overarching focus is placed on tackling health inequalities. Several initiatives are in place to help the NHS Boards optimise the use of acute hospital beds. In **Northern Ireland,** reducing the length of waiting times is a key priority and waiting times have been reduced significantly in recent years. There is a systemic shift of focus towards measuring total waiting times from referral to treatment. In **Wales**, there is high demand on acute hospitals, with high levels of emergency admissions resulting in long waiting times. In order to tackle the causes of poor health, a resource allocation model, which channels resources to Local Health Boards on the basis of residents' direct health needs, is being implemented. Despite improvements in access to health services, the 2009 target remains the reduction of maximum waiting times to six months.

Quality. In **England**, the development and delivery of National Service Frameworks has resulted in improvements in the quality of care, with progress made in tackling the country's bigger killer diseases. Patient-choice has been facilitated with an emphasis on helping patients decide on the time and place of their care, as well as the development of a new system of tariffs to ensure that money follows the patient. Maximum waiting times for inpatient treatment has been reduced from 18 months to less than 6, and by the end of 2008 will be a maximum of 18 weeks from GP referral to treatment. **Scotland** has a poor record on healthy life expectancy and there are large gaps between the health status of rich and poor. A key objective is to improve health generally through persuading and supporting people to make healthy lifestyle choices. In **Wales,** a new resource allocation model aims to reduce acute hospital treatment by improving illness prevention, developing more comprehensive primary care and improving social care provision. Patients and the public are being given a greater role in local decisions about the NHS. The standards set have been broadened to include an evaluation system based on a 'balanced scoreboard' approach. In **Northern Ireland,** a statutory duty of quality has been in place since 2003. A number of new standards will be introduced in the coming years to assist service providers in assessing risks and in reporting on the quality of service provision. A range of initiatives are underway concerning wider determinants of health and encouraging people to make healthy choices.

Long-term sustainability. In recent years the UK government has implemented historic levels of increased investment in health care whilst recognising the importance of promoting healthy lifestyles to ensure the financial sustainability of its health care system. Health care investment is expected to increase and reach around 9% of GDP by 2007-8, combining both public and private sources as well as reflecting the overall GDP growth. According to the 2006 EPC/EC projections, public health care expenditure is set to increase by 1.9 percentage points of GDP by 2050 due to population ageing. In **Scotland,** the 2006-7 budget for health and community care services is £9.5bn. Scottish authorities have identified significant cash savings over the three-year period to

2007-8 and a Scottish National Tariff is being implemented to create a set of standard prices for most procedures. Several initiatives in health improvement policy are in place, helping people make healthy lifestyle choices. In **Wales,** commissioning arrangements are being strengthened in order to make these as effective as possible. *Health Challenge Wales* has raised the profile of health improvement and the Health Inequalities Fund has contributed significantly in reducing health inequalities across the Welsh nation. The expected increase in demand for health and social services in **Northern Ireland** is to be addressed through encouraging individual responsibility for their own care, the promotion of their own health and their communities.

5.2. Long-term care

Description of the system. In **England,** Local Authorities (LA's) have a statutory duty to provide social care. Most LA's commission social care from private and voluntary organisations, although some local authorities also provide services. In the majority of local authority areas access to social care services is means-tested and determined through eligibility criteria. Service users can choose to receive a direct payment rather than a pre-determined care package. In **Scotland,** 32 local authorities are responsible for service delivery. They have a duty to assess and provide appropriate services to people in need and to decide upon the most appropriate service for individuals, taking into consideration their wishes. Social services in **Wales** are delivered by around 1 800 statutory, private and voluntary organisations. Most social services are commissioned by Local Authorities (22), which have a legal duty to provide support in ways that meet individuals' needs, and are provided by the independent sector. In **Northern Ireland,** residents who are assessed by their local Health & Social Services Trust as requiring social services are entitled to have those needs met, subject to available resources. Social services are required to carry out regular reassessment of an individual's needs. Where care is delivered in a residential setting, Trusts assess the client's ability to pay for those services with possibilities for charges recovery.

Accessibility. In **England,** local councils are responsible for determining eligibility for adult social care in accordance with a national eligibility framework. Guidance requires regular reassessment to ensure that the care provided is still appropriate and necessary. Social services are means-tested and out-of-pocket payments are the norm, even though many people receive support via welfare benefits; the use of direct payments is increasing. The government has taken several steps to support informal carers: increased financial support through enhanced social security provision and statutory changes to increase flexibility for carers. **Scotland** introduced free personal and nursing care in 2002. People who live in care homes and pay their own fees will receive payments if they require nursing care. Persons aged 65 and over are also eligible for payments towards the cost of their personal care. People at home, aged 65 and over, in receipt of personal care services from the local councils are not charged for them. The **Welsh** Assembly Government has emphasised its commitment to supporting carers and has announced a significant package of investment to support older and disabled people through a range of initiatives. These will reduce the burden of paying for home care while at the same time offering people and their carers additional services and support. In **Northern Ireland** free personal care in residential care and nursing homes has not been introduced, despite recommendations. Direct payments are increasingly used and a plan for delivering a range of practical support services for carers has been introduced (e.g. respite services for carers).

Quality. In **England,** service users generally prefer support to stay at home if possible; the Government has prioritised this and expects to meet its PSA target. A ten-year strategy to ensure fair, high quality integrated health and social care services for older people has been set up. The government has committed itself to creating a single, integrated regulator of both health and social

care. In **Scotland,** community care policy has tended to enable people to live as normal a life as possible in their own homes. The Social Work Inspection Agency replaced the former inspection arrangements with a national Performance Inspection Model (2005). In **Wales,** the establishment of a Commissioner for Older People is being considered. In **Northern Ireland**, recognising that older people prefer to remain in their own homes wherever possible, there is a target for 2007 stating that 42% of people in care management should have their needs met at home. The DHSSPS has commissioned the development of a single comprehensive assessment process for care needs.

Long-term sustainability. Throughout the UK there have been substantial increases in the level of funding or resource allocation for long term care to the relevant authorities and bodies. According to the 2006 EPC/EC projections public long-term care expenditure is set to increase by 0.8 percentage points of GDP by 2050 due to population ageing. In **Wales,** the Revenue Support Grant in 2006-7 included an extra £45m to help LA's to address pressures in the health and social care system, avoiding admissions to hospital, improving commissioning and addressing the needs of an ageing population. In **Northern Ireland,** the 1993 changes have moved service provision away from institutional settings to community and domiciliary care services.

6. 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 improved engagement with vulnerable groups whilst adequately supporting the transition to quality and sustainable work.

To pursue the reform process and continue to address the pensions adequacy gap, in particular for those with more modest incomes; to ensure continued and increasing access to quality supplementary pension provision and that the pension system offers adequate incentives to save and work longer.

To address health inequalities (regional and socio-professional groups), particularly with regard to access in both health care and long-term care, since some parts of the UK have made some care services free (Scotland, Northern Ireland) and the remaining counterparts have maintained means-testing and discretion in the provision of long-term care.

To look at ways of integrating health and social care services to achieve a uniform setting for the continuation of adequate and high quality care, throughout the UK.

UK: data summary sheet

1. Employment and growth

Eurostat	GDP growth rate *	GDP per capita**	Eurostat	Employment rate (% of 15-64 population)					Eurostat	Unemployment rate (% of labour force)			
				15-64			15-24	55-64		15+			15-24
				Total	Male	Female				Total	Male	Female	
2000	3,8	111,8	**2000**	71.2b	77.8b	64.7b	56.6b	50.7b	**2000**	5,5	6,0	4,9	12,6
2002	2,1	116,1	**2002**	71,3	77,6	65,2	56,1	53,4	**2002**	5,1	5,6	4,5	12,0
2004	3,3	118,0	**2004**	71,6	77,8	65,6	55,4	56,2	**2004**	4,7	5,0	4,2	12,1
2006	2.7f	117.2f	**2005**	71,7	77,6	65,9	54,0	56,9	**2005**	4,8	5,1	4,3	12,9

** Growth rate of GDP at constant prices (2000) - year to year % change; ** GDP per capita in PPS (EU25 = 100); f: forecast*

2. Demography and health

Eurostat	Life expectancy at birth		Life expectancy at 65		Healthy life expectancy at birth (2003 instead of 2004)		Infant mortality	WHO	Total health exp %GDP	Public health exp. % of THE*	Out-of-pocket payments % of THE	Public system coverage % of pop	Pop. covered by PHI** % of pop
	Male	Female	Male	Female	Male	Female							
1995	74,0	79,2	14,6	18,2	60,6	61.2e	6,2	**1995**	8,19		:		
2000	75,4	80,2	15,7	18,9	61.3e	61.2e	5,6	**2000**	7,3	80,9	10,5	100	10
2004	76.3sp	81.1sp	16.6sp	19.6sp	61.5e	60.9e	5,1	**2004**	8,1	85,9	10,8		

s: Eurostat estimate; p: provisional **THE: Total Health Expenditures* ***PHI: Private Helath Insurance*

3. Expenditure and sustainability

Social protection expenditure (Esspros) - by function, % of total benefits

Eurostat	Total expenditure * (% of GDP)	Old age and survivors	Sickness and health care	Unemployment	Family and children	Housing and social exclusion	Disability
1995	28,2	43,1	24	5,6	8,9	7,5	10,9
2000	27,1	48,8	25,5	3	6,9	6,4	9,4
2004	26,3	44,6	30,4	2,6	6,7	6,4	9,2

** including administrative costs*

Age-related projection of expenditure (AWG)

EPC-AWG	Old-age dependency ratio eurostat	Expenditure (% of GDP) Level in **2004** and changes since: Total social expend.	Public pensions	Health care	Long-term care
2005	24,4	19.6 (20	6.6 (2005)	7 (2005)	1 (2005)
2010	25,1	-0.2			
2030	30,3	+2.2	+1.3	+1.1	+0.3
2050	45,3	+4	+2	+1.9	+0.8

4. Social inclusion and pensions adequacy (Eurostat)

At-risk-of-poverty rate

SILC income 2004	Total	Children 0-17	18+	18-64	65+
Total	19pb	22pb	18pb	15pb	27pb
Male	18pb	-	16pb	14pb	24pb
Female	19pb	-	19pb	16pb	29pb

Poverty risk gap

Total	Children 0-17	18+	18-64	65+
21pb	19pb	22pb	24pb	19pb
23pb	-	24pb	26pb	19pb
20pb	-	21	22pb	20pb

Income inequalities

	S80/S20
Total	5.6pb
Male	-
Female	-

b: break in series; p: provisional

People living in jobless households

	Children	% of people aged 18-59*		
	Total	Total	Male	Female
1999	18,4	11,8	9,6	13,9
2004	16,8	11,0	9,0	13,0
2006	16,2	10,7	8,8	12,5

Long-term unemployment rate

	% of people aged 15-64		
	Total	Male	Female
1999	1,7	2,2	1,0
2004	1,0	1,2	0,6
2005	1,0	1,3	0,7

Early school-leavers

	% of people aged 18-24		
	Total	Male	Female
1999	18,4	19	17,9
2004	14.9i	15.7i	14.2i
2005	14	14,7	13,2

** excluding students* *i: change in methodology*

SILC income 2005	Total	Male	Female	SILC income 2005	Total	Male	Female
Relative income of 65+	0.720pb	0.738pb	0.713pb	***Aggregate replacement ratio***	:	:	:

Change in theoretical replacement rates (2005-2050) - source: ISG

Change in TRR in percentage points (2005-2050)						Assumptions				
Net	Gross replacement rate					Coverage rate (%)			Contribution rates	
								pensions	pensions	
Total	Total	Statutory pensions	Type of statutory scheme*	Occup. & voluntary pensions	Type of suppl. scheme**	Statutory pensions	Occupational and voluntary pensions	(or social security)	Current estimate (2002)	Assumption
3	3	2	DB	0	DB	100	56	17.75-10.9	16,6	23,7

**:(DB / NDC/ DC); ** (DB / DC)*

ANNEXES

ANNEX IA - OVERARCHING INDICATORS

BACKGROUND

In December 2001, the Laeken European Council endorsed a set of 18 indicators of social exclusion and poverty, organised in a two-level structure of primary indicators – consisting of 10 leading indicators covering the broad fields considered to be the most important elements leading to social exclusion – and 8 secondary indicators – intended to support the leading indicators and describe other dimensions of the problem.

After the Laeken European Council, the Indicators Sub-Group has continued working with a view to refining and consolidating the original list of indicators. It has also worked at developing indicators to support the OMC on adequate and sustainable Pensions and more recently the OMC on health care and long-term care.

In June 2006, the Social Protection Committee adopted the report on indicators to be used in the context of the streamlined OMC on social protection and social inclusion177. The adopted set of indicators consists of a portfolio of 14 overarching indicators (+11 context indicators) meant to reflect the newly adopted overarching objectives (a) "social cohesion" and (b) "interaction with the Lisbon strategy growth and jobs objectives"; and of three strand portfolios for social inclusion, pensions, and health and long-term care.

In this context, the ISG confirmed the Laeken criteria for the selection of indicators and agreed on a new typology of indicators:

– Commonly agreed EU indicators contributing to a comparative assessment of MS's progress towards the common objectives. These indicators might refer to social outcomes, intermediate social outcomes or outputs.

– Commonly agreed national indicators based on commonly agreed definitions and assumptions that provide key information to assess the progress of MS in relation to certain objectives, while not allowing for a direct cross-country comparison, or not necessarily having a clear normative interpretation. These indicators should be interpreted jointly with the relevant background information (exact definition, assumptions, representativeness).

– Context information: Each portfolio will have to be assessed in the light of key context information, and by referring to past, and where relevant, future trends. The list of context information proposed is indicative and leaves room to other background information that would be most relevant to better frame and understand the national context.

The report also contains a streamlined list for each of the individual processes of social inclusion and pensions and a preliminary list for health and long-term care.

[177] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/indicators_en.pdf

DEFINITION OF THE OVERARCHING INDICATORS

Title	Definition
OVERARCHING INDICATORS	
At-risk-of-poverty rate + Illustrative threshold value	Share of persons aged 0+ with an equivalised disposable income below 60% of the national median equivalised disposable income Equivalised disposable income is defined as the household's total disposable income divided by its "equivalent size" to take account of its size and composition.. Value of the at-risk-of-poverty threshold (60% median national equivalised income) in PPS for an illustrative household type (e.g., single person household) Source: EU-SILC
Relative median poverty risk gap	Difference between the median equivalised disposable income of persons aged 0+ below the at-risk-of poverty threshold and the threshold itself, expressed as a percentage of the at-risk-of poverty threshold. Source: EU-SILC
S80/S20	Ratio of total income received by the 20% of the country's population with the highest income (top quintile) to that received by the 20% of the country's population with the lowest income (lowest quintile). Income must be understood as equivalised disposable income. Source: EU-SILC
Healthy life expectancy	Number of years that a person at birth, at 45, at 65 is still expected to live in a healthy condition (also called disability- free life expectancy). To be interpreted jointly with life expectancy Source: Eurostat
Early school leavers	Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training attained is 0, 1 or 2 according to the 1997 International Standard Classification of Education – ISCED 97) and have not received education or training in the four weeks preceding the survey. Source: LFS
People living in jobless households	Proportion of adults (aged 18-59 and not students) and children living in jobless households, expressed as a share of all people in the same age group . This indicator should be analysed in the light of context indicator: jobless households by main household types Source: LFS
Projected Total Public Social expenditures	Age-related projections of total public social expenditures (e.g. pensions, health care, long-term care, education and unemployment transfers), current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-20-30-40-50) Specific assumptions agreed in the AWG/EPC. See "The 2005 EPC projections of age-related expenditures (2004-2050) for EU-25: underlying assumptions and projection methodologies" http://ec.europa.eu/economy_finance/epc/documents/2006/ageingreport_en.pdf Source: EPC/AWG
Median relative income of elderly people	Median individual pension income of retirees aged 65-74 in relation to median earnings of employed persons aged 50-59 excluding social benefits other than pensions, based on gross income Source: EU-SILC
Aggregate replacement ratio	Median **individual** pensions of 65-74 relative to median individual earnings of 50-59, excluding other social benefits Source: EU-SILC
Employment rate of older workers	Persons in employment in age groups 55 - 59 and 60 – 64 as a proportion of total population in the same age group Source: LFS

Title	Definition
In-work poverty risk	Individuals who are classified as employed (distinguishing between "wage and salary employment plus self-employment" and "wage and salary employment" only) and who are at risk of poverty. This indicator needs to be analysed according to personal, job and household characteristics. It should also be analysed in comparison with the poverty risk faced by the unemployed and the inactive. Source: EU-SILC
Activity rate	Share of employed and unemployed people in total population of working age 15-64 Source: LFS
Regional disparities – coefficient of variation of employment rates	Standard deviation of regional employment rates divided by the weighted national average (age group 15-64 years). (NUTS II) Source: LFS
SELECTED HEALTH INDICATORS	
Total expenditure on health	Sum of general government health expenditure and private health expenditure in a given year, calculated in national currency units in current prices. It comprises the outlays earmarked for health maintenance, restoration or enhancement of the health status of the population, paid for in cash or in kind. It is expressed in $PPP. International dollars are derived by dividing local currency units by an estimate of their Purchasing Power Parity (PPP) compared to US dollar, i.e. the measure which minimizes the consequences of differences in price levels between countries. Source: NHA (WHO)
General government expenditure on health as a % of Total health expenditure	Comprises the direct outlays earmarked for the enhancement of the health status of the population and/or the distribution of medical care goods and services among population by the following financing agents: central/federal, state/provincial/regional, and local/municipal authorities; extrabudgetary agencies, social security schemes; parastatals and public firms. Expenditures on health include final consumption, subsidies to producers, and transfers to households (chiefly reimbursements for medical and pharmaceutical bills). It includes both recurrent and investment expenditures (including capital transfers) made during the year. Besides domestic funds it also includes external resources (mainly as grants passing through the government or loans channelled through the national budget). Source: NHA (WHO)
Private health expenditure as a % of total health expenditure	Sum of expenditures on health by the following entities: - Prepaid plans and risk-pooling arrangements: the outlays of private insurance schemes and private social insurance schemes (with no government control over payment rates and participating providers but with broad guidelines from government) - Firms' expenditure on health: the outlays by private enterprises for medical care and health enhancing benefits other than payment to social security or other pre-paid schemes. - Non-profit institutions serving mainly households: outlays of those entities whose status do not permit them to be a source of financial gain for the units that establish, control or finance them. This includes funding from internal and external sources. - Household out -of-pocket spending: the direct outlays of households, including gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services. This includes household direct payments to public and private providers of health care services, non-profit institutions, and non-reimbursable cost sharing, such as deductibles, co-payments and fee for services. Source: NHA (WHO)
CONTEXT INDICATORS	
GDP growth	Growth rate of GDP volume - percentage change on previous year Source: Eurostat STRIND

Title	Definition
Employment rate, by sex	The employment rate is calculated by dividing the number of persons aged 15 to 64 in employment by the total population of the same age group. Source: LFS
Unemployment rate, by sex, and key age groups	Unemployment rates represent unemployed persons as a percentage of the labour force. The labour force is the total number of people employed and unemployed. Unemployed persons comprise persons aged 15+ who were: a. without work during the reference week, b. currently available for work, i.e. were available for paid employment or self-employment before the end of the two weeks following the reference week, c. actively seeking work, i.e. had taken specific steps in the four weeks period ending with the reference week to seek paid employment or self-employment or who found a job to start later, i.e. within a period of, at most, three months. Source: LFS
Long term unemployment rate, by sex and key age groups	Long-term unemployed (12 months and more) persons are those aged at least 15 years who are without work within the next two weeks, are available to start work within the next two weeks and who are seeking work (have actively sought employment at some time during the previous four weeks or are not seeking a job because they have already found a job to start later). The total active population (labour force) is the total number of the employed and unemployed population. The duration of unemployment is defined as the duration of a search for a job or as the length of the period since the last job was held (if this period is shorter than the duration of the search for a job). Source: LFS
Life expectancy at birth and at 65	LE at birth: The mean number of years that a newborn child can expect to live if subjected throughout his life to the current mortality conditions (age specific probabilities of dying). LE at 65: The mean number of years still to be lived by a person who have reached 65, if subjected throughout the rest of his life to the current mortality conditions (age specific probabilities of dying). Source Eurostat – Demography
Old age dependency ratio, current and projected	Ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64). Source Eurostat – Demography
Distribution of population by household types, incl. collective households	Number and % of people living in private resp. collective households. Source Eurostat - Census 2001 data collection
Public debt, current and projected, % of GDP	Government debt is the consolidated gross debt of the whole general government sector outstanding at the end of the year (in nominal value). These data are reported to the European Commission in the framework of the Excessive Deficit Procedure (EDP). Projections are produced by the Commission Services in the context of the assessment of the long-term sustainability of the public finances based on the 2005/06 updates of Stability and Convergence Programmes (SCPs). http://ec.europa.eu/economy_finance/publications/european_economy/2006/ee306_en.pdf
Social protection expenditure, current, by function, gross and net (ESPROSS)	Total social protection expenditures broken down in social benefits, administration cost and other expenditure. In addition, social benefits are classified by functions of social protection. Net expenditures are not presented here since they are not available in ESSPROS yet. Source: Eurostat – ESSPROS
Jobless households by main household types	Breakdown of jobless households by main household types Source: EU-SILC

Title	Definition
Making work pay indicators (unemployment trap, inactivity trap (esp. second earner case), low-wage trap.	Unemployment trap: Marginal effective tax rate (METR) on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from unemployment to a job with a wage level of 67% of APW. Inactivity trap: METR on labour income taking account of the combined effect of increased taxes and benefits withdrawal as one takes up a job while previously inactive. Calculated as the ratio of change in gross income minus (net in work income minus net out of work income) divided by change in gross income for a single person moving from inactivity to a job with a wage level of 67% of APW. Low wage trap: METR on labour income taking account of the combined effect of increased taxes on labour and in-work benefits withdrawal as one increases the work effort (increased working hours or moving to a better job). Calculated as the ratio of change in personal income tax and employee contributions plus change (reductions) in benefits, divided by increases in gross earnings, using the "discrete" income changes from 34-66% of APW. Breakdown by family types: one-earner couple with two children and single parent with two children. Source: Joint Commission -OECD project using tax-benefit Models
Net income of social assistance recipients as a % of the at-risk of poverty threshold for 3 jobless household types	This indicator refers to the income of people living in households that only rely on "last resort" social assistance benefits (including related housing benefits) and for which no other income stream is available (from other social protection benefits – e.g. unemployment or disability schemes – or from work). The aim of such an indicator is to evaluate if the safety nets provided to those households most excluded from the labour market are sufficient to lift people out of poverty. This indicator is calculated on the basis of the tax-benefit models developed jointly by the OECD and the European Commission. It is only calculated for Countries where non-categorical social benefits are in place and for 3 jobless household types: single, lone parent, 2 children and couple with 2 children. This indicator is especially relevant when analysing MWP indicators. Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat (see Chapter I and Annex I)
Change in projected theoretical replacement ratio for base case 2004-2050 accompanied with information on type of pension scheme (DB, DC or NDC), and change in projected public pension expenditure 2004-2050. (results should systematically be presented collectively in one table).	Change in the theoretical level of income from pensions at the moment of take-up related to the income from work in the last year before retirement for a hypothetical worker (base case), percentage points, 2004-2050, with information on the type of pension scheme (DB, DC or NDC) and changes in the public pension expenditure as a share of GDP, 2004-2050. This information can only collectively form the indicator called Projected theoretical replacement ratio. Results relate to current and projected, gross (public and private) and total net replacement rates, and should be accompanied by information on representativeness and assumptions (contribution rates and coverage rate, public and private), and calculations of changes in replacement rates for 1 or 2 other cases, if suitable (e.g. OECD) Specific assumptions agreed in the ISG. For further details, see 2006 report on Replacement Rates. http://ec.europa.eu/employment_social/social_protection/docs/isg_repl_rates_en.pdf Source: ISG and AWG

ANNEX IB - DATA SOURCES – specific notes

INDICATORS OF INCOME AND LIVING CONDITIONS: *EU-SILC*

For the first time this year, EU-SILC data is available for 25 EU Countries. The newly implemented reference source of statistics on income and social exclusion is the European Survey on Income and Living Conditions (EU-SILC) framework regulation (No.1177/2003). Technical aspects of this instrument are developed through Commission implementing regulations, which are published in the Official Journal. The data for Bulgaria and Romania are still based on the national household budget surveys following the transitional arrangements agreed by the European Statistical System[178].

The EU-SILC definition of total household gross and disposable income and the different income components keep as close as possible to the international recommendations of the UN 'Canberra Manual'. A key objective of EU-SILC is to deliver timely, robust and comparable data on total disposable household income, total disposable household income before transfers, total gross income and gross income at component level (in the ECHP, the income components were recorded net). This objective will be reached in two steps, in that Member States have been allowed to postpone the delivery of gross income at component level and of total household gross income data until after the first year of their operations.

Although certain countries (eg. Denmark) are already able to supply income including imputed rent - i.e. the money that one saves on full (market) rent by living in one's own accommodation or in accommodation rented at a price that is lower than the market rent -, for reasons of comparability, **the income definition underlying the calculation of indicators currently excludes imputed rent**. This could have a distorting effect in comparisons between countries, or between population sub-groups, when accommodation tenure status varies. This impact may be particularly apparent for the elderly who may have been able to accumulate wealth in the form of housing assets. In the statistical annex, data for Denmark are therefore shown both with and without imputed rent, as an illustration of the impact of this income component on the results. Once imputed rent is taken into account, the at-risk-of-poverty rate is reduced for people aged 65 and over, the inactive other than pensioners and those living in owner-occupied accommodation.

It should also be noted that the definition of income currently used excludes non monetary income components, which include the value of goods produced for own consumption[179] and non-cash employee income. This component will be available for all countries from the SILC(2007) exercise onwards, and therefore included in the indicators that will be published in January 2009.

The reference year for the data is the year to which information on income refers (i.e., the "income year"), which in most cases differs from the survey year in which the data have been collected. Namely, 2004 data refer to the income situation of the population in 2004, even if the information has been collected in 2005. EU aggregates are computed as population-weighted averages of available national values.

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[178] National data sources are adjusted ex-post and as far as possible with the EU-SILC methodology. Whilst the maximum effort is made to maximise consistency of definitions and concepts, the resulting indicators cannot be considered to be fully comparable to the EU-SILC based indicators.

[179] Before the introduction of EU-SILC in the New Member States, the value of goods produced for own consumption was included in the calculation of the EU indicators estimated on the basis of national sources. This transitory agreement was made to take account of the potentially significant impact of this component on the income distribution in these countries.

Note on trends

During the transition to EU-SILC income based indicators were calculated on the basis of available national sources (household budget survey, micro-censuses, etc.[180]) that were not fully compatible with the SILC methodology based on detailed income. Following the implementation of EU-SILC in a given country, the values of all income based indicators (at-risk-of poverty rates, S80/S20, aggregate replacement ratio, etc) cannot be compared to the estimates presented in previous years. This is why no trends in income based indicators are presented in this year's report.

Limitations

The limited sample size of certain data sources used for the collection of income data and the specific difficulties of collecting accurate information on disposable income directly from households or through administrative registers raise certain concerns as regards data quality. This is particularly the case for information on income at the two ends of the income distribution.

Furthermore, household surveys do not cover persons living in collective households, homeless persons or other difficult-to-reach groups.

It must also be acknowledged that self-employment income is difficult to collect, whatever the data source. It must also be kept in mind that the difficulty in recording income from the informal economy can introduce a bias in the income distribution as measured by surveys.

Finally, whilst it is considered to be the best basis for such analyses, current income is acknowledged to be an imperfect measure of consumption capabilities and welfare, as, among other things, it does not reflect access to credit, access to accumulated savings or ability to liquidate accumulated assets, informal community support arrangements, aspects of non monetary deprivation, differential pricing, etc. These factors may be of particular relevance for persons at the lower end of the income distribution. The bottom 10 per cent of the income distribution should not, therefore, necessarily be interpreted as having the bottom 10 per cent of living standards. This is why reference is made to the "at-risk-of-poverty" rate rather than simply the poverty rate.

Confidence intervals

Indicators are estimated values based on a sample drawn from the target population and thus are affected by sampling error. Statistical theory provides us with tools for calculating confidence intervals in which the population value lies with a high probability. The confidence intervals are centred around the estimated values reported and their length is a measure of the precision of these estimates. The precision depends on the design of the survey and can thus vary between the countries. However, the EU-SILC regulation provides for national samples to be designed so as to achieve a confidence interval of +/- 1% around the estimated value of the total at-risk- of-poverty rate. Eurostat is computing these intervals for a number of indicators and exact values will be reported in EU quality reports. First computations show that the confidence intervals around total at risk of poverty rate are of the order of +/- 0.8%. For S80/S20 income quintile share ratio, the confidence intervals are of the order of +/- 0.2. For the relative median at risk of poverty gap, they are of the order of +/- 1.7. For the Gini-coefficient, they are of the order of +/- 0.9. These indications of precision must be taken into account when interpreting the data.

[180] See specific footnotes in each country profile

AGE-RELATED EXPENDITURE PROJECTIONS

Long-term budgetary projections were prepared in 2006 by the Economic Policy Committee and the European Commission (DG ECFIN) - see European Policy Committee and European Commission (2006), "The impact of ageing on public expenditure: projections for the EU25 Member States on pensions, health care, long-term care, education and unemployment transfers (2004-2050)", European Economy, Special Report No.1/2006.

The projections are made on the basis of a common population projection and agreed common underlying economic assumptions that have been endorsed by the EPC. The projections are made on the basis of "no policy change", i.e. only reflecting enacted legislation but not possible future policy changes (although account is taken of provisions in enacted legislation that enter into force over time). The pension projections are made on the basis of legislation enacted by mid-2005. They are also made on the basis of the current behaviour of economic agents, without assuming any future changes in behaviour over time: for example, this is reflected in the assumptions on participation rates, which are based on the most recently observed trends by age and gender. While the underlying assumptions have been made by applying a common methodology uniformly to all Member States, for several countries adjustments have been made to avoid an overly mechanical approach that leads to economically unsound outcomes and to take due account of significant country-specific circumstances. The pension projections were made using the models of national authorities, and thus reflect the current institutional features of national pension systems. In contrast, the projections for health care, long-term care, education and unemployment transfers were made using common models developed by the European Commission in close cooperation with the EPC and its Working Group on Ageing Populations. The projection results show the combined impact of expected changes in size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in health status of the population in each Member State of the European Union.

PENSION EXPENDITURE

The "pension expenditure" aggregate according to the ESSPROS definition, goes beyond that of public expenditure and also includes expenditure by private social protection schemes. "Pension expenditure" is the sum of seven different categories of benefits, as defined in the 1996 ESSPROS Manual: disability pension, early retirement benefit due to reduced capacity to work, old-age pension, anticipated old-age pension, partial pension, survivors' pension and early retirement benefit for labour market reasons. Some of these benefits (for example, disability pensions) may be paid to people who have not reached the standard retirement age.

REPLACEMENT RATES

The figures for current and prospective pension replacement rates are based on the methodology developed by the Indicators Sub-Group of the Social Protection Committee. The results are based on the baseline assumption of a hypothetical person (male if gender matters), retiring at the age of 65 after a 40 years full-time work career with a flat earnings profile at average earnings with contributions to the most general public pension scheme as well as to occupational and private pension schemes for some Member States.

The replacement rate represents the individual pension income during the first year of retirement relative to the individual income received during the year preceding retirement. Calculations were conducted by the Member States.

HEALTHCARE EXPENDITURE – WHO-health for all database (www.who.int\nha)

This information is based on national health accounts (NHA) collected within an internationally recognised framework. NHA are a synthesis of the financing and spending flows recorded in the operation of a health system. In the future the System of health accounts (SHA) will contain uniform data for Eurostat, the OECD and the WHO. In the meantime, the WHO database is the only one to cover all Member States.

About 100 countries either have produced full national health accounts or report expenditure on health to the OECD. Standard accounting estimation and extrapolation techniques have been used to provide time series (1998-2004). Ministries of Health have responded to the draft updates sent for their inputs and comments. The principal international references used are the International Monetary Fund (IMF), Government Finance Statistics and International Financial Statistics; OECD health data; and the United Nations National Accounts Statistics. National sources include: national health accounts reports, public expenditure reports, statistical yearbooks and other periodicals, budgetary documents, national accounts reports, central bank reports, non-governmental organisation reports, academic studies, reports and data provided by central statistical offices and ministries and statistical data on official websites.

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