COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 13.2.2009
SEC(2009) 141

COMMISSION STAFF WORKING DOCUMENT

Joint Report on Social Protection and Social Inclusion

accompanying document to the

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

Proposal for the Joint Report on Social Protection and Social Inclusion 2009

Supporting document

{COM(2009) 58 final}

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1. SCOPE AND OUTLINE OF THE REPORT

This supporting document prepared by the Commission services accompanies the 2009 Joint Report on Social Protection and Social Inclusion [Commission proposal: COM(2009) xx]. It provides an in-depth assessment of the renewed National Strategy Reports (NSRs) presented by EU-27 in autumn 2008[1]. The NSRs outline each Member State's policy priorities up until 2011 in the second cycle of the integrated EU process for Social Protection and Social Inclusion. The assessment draws on the material provided by Member States in their NSR, but also on analysis prepared by independent experts and on studies and research carried out in the framework of the Social Open Method of Coordination (OMC).

Section 2 contains an overview of the social situation in the Member States and of their overall strategic approach. A comprehensive analysis is published on the Commission website[2] showing where each Member State stands in relation to the common objectives[3] of the EU process for social protection and social inclusion based on the data available in 2008: The NSRs were presented at the end September 2008, and were therefore prepared before the fallout of the financial crisis on the real economy took hold. Although these developments could not be anticipated in the NSRs, Member States and the Commission agree on the reports are still relevant, and that the actions envisaged to strengthen delivery on shared social objectives have become all the more urgent. As stated in the Joint Commission/Council Report proper: "Appropriate social policies will simultaneously support the goals of mitigating adverse social impact on the most vulnerable and of containing impact of the crisis on the economy overall."

Section 3 below assesses the chapters in the NSRs dedicated to social inclusion, in other words the National Action Plans for social inclusion (NAP-inclusion). Section 4 analyses national strategies for pensions, while section 5 looks at national strategies in the area of healthcare and long-term care.

The annex contains an overview of the most recent statistical data on the indicators[4] developed to monitor progress towards the overarching common objectives of the Social OMC.

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1 http://ec.europa.eu/employment_social/spsi/strategy_reports_en.htm

2 Monitoring progress towards the objectives of the European Strategy for Social Protection and Social Inclusion : http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm

3 http://ec.europa.eu/employment_social/spsi/common_objectives_en.htm

4 http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm

2. OVERVIEW OF THE SOCIAL SITUATION AND OVERALL STRATEGIC APPROACH

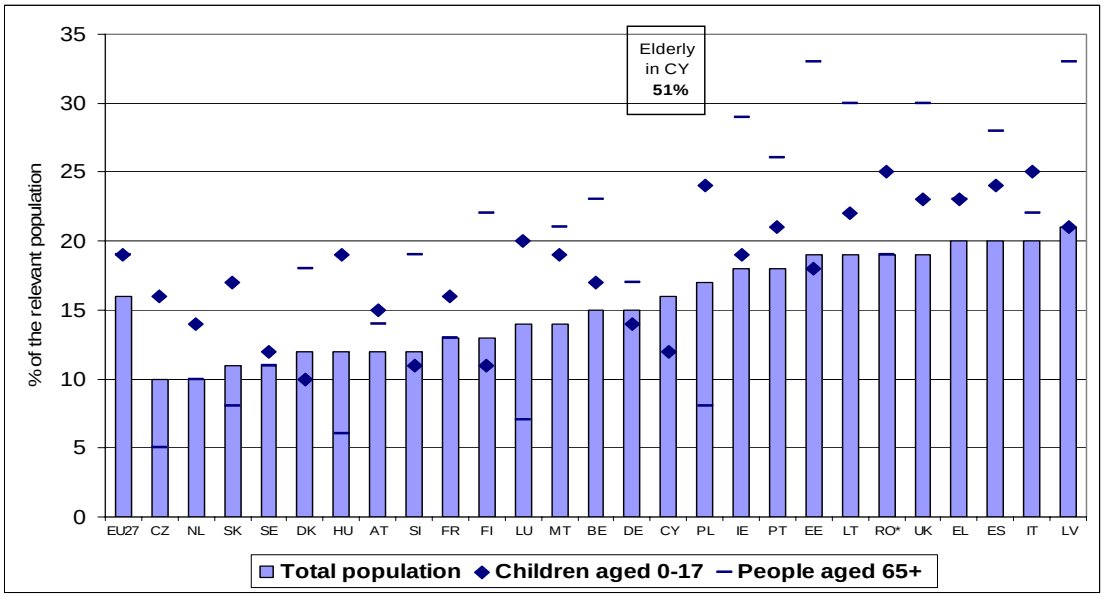
2.1. Overview of key indicators of Social Protection and Social Inclusion in Europe

- 16% of Europeans, or 79 million people, were at risk of poverty in 2007.
- Despite overall progress on the labour markets, 9.3% of working age adults and 9.4% of children live in jobless households and 7% of the employed live below the poverty threshold.
- Social transfers reduce the risk of poverty by 36% on average in the EU, but this impact varies from 17% to more than 60% across the EU.
- The employment rate of older workers reached 45% in 2007 as against 37% in 2001.
- Current pension systems have generally reduced poverty among the elderly, but single elderly women face a much higher risk than single elderly men (28% as against 20%).
- In the future for the generations who have recently entered the labour market, a marked decline in pensions can be expected if the number of years worked and contribution rates remain the same.
- Life expectancy is now 82 years for women and 76 years for men. This follows a gain in longevity of 4 years for women and 5 years for men over the last 20 years.
- The gap in life expectancy between European countries is 8 years for women and 13 years for men.
- Total expenditure on health has increased throughout the EU in the last 20 years. Today it ranges from 10% of GDP or more in some countries to 6% or less in others.

2.1.1. 16% of Europeans are at risk of poverty

In 2007, in EU-27 16% citizens lived below the poverty threshold defined as 60% of their country's median income, a situation likely to hamper their capacity to fully participate in society. National percentages ranged from 10% in the Czech Republic and the Netherlands to 21 in Latvia.

Figure 1: At-risk-of poverty rate in the EU (%), total and children, 2007



Source: EU-SILC (2007); income year 2006; except for UK (income year 2006) and for IE (moving income reference period 2005-06); RO: National Household Budget Survey 2006. BG data missing

Children are often at greater risk-of-poverty than the rest of the population (19% in the EU-27). This is true in most countries except in the Nordic States, Cyprus and Slovenia. Child poverty rates range from 10% in Denmark to 25% in Italy and Romania. The main factors affecting child poverty levels in the EU are the labour market situation of their parents and the effectiveness of government intervention through income support and the provision of enabling services such as childcare. This is particularly evident in the case of lone parents, who face a risk of poverty of 34%.

While on average the elderly also face a higher risk of poverty than the overall population (19% against 16%) substantial differences exist across countries as illustrated in Figure 1 and Table 1. The risk of poverty faced by people aged 65 or more ranges from 5% in the Czech Republic to 30% in Lithuania, and the United Kingdom, 33% in Estonia, and Latvia, 31% in Spain and even reaches 51% in Cyprus. These differences in the relative situation of the elderly depend on a number of factors including the adequacy of the pension systems for current pensioners and the age and gender structure of the elderly population, since elderly women and the very old tend to face much higher risks.

Table 1 gives an overview of the relative situation of the main age groups in the population, in terms of levels and depth of poverty. This situation is assessed both in relation to the EU average and in relation to the overall population. It illustrates the challenges Member States need to address to improve the situation of major population groups.

Table 1: Overview of poverty rates by age groups

Poverty rate/gap is ++: well below; +: below; o: around; -: above; --: well above the EU and national average[5]

	Children (0-17)		Working age (18-64)		Elderly (65+)	
2007	Risk of poverty*	Poverty depth**	Risk of poverty*	Poverty depth**	Risk of poverty*	Poverty depth**
be	o	+	o	o	-	o
bg	o	-	o	++	o	o
cz	-	o	++	+	++	++
dk	++	-	o	--	o	++
de	+	+	--	o	+	o
ee	+	--	o	--	--	+
ie	o	o	o	+	-	++
el	-	--	--	o	o	--
es	-	-	+	-	-	-
fr	o	++	o	++	+	--
it	--	-	-	-	o	-
cy	++	++	++	++	--	--
lv	o	--	-	--	--	o
lt	-	--	o	-	-	+
lu	-	o	-	+	++	++
hu	-	+	-	+	++	+
mt	-	+	o	+	o	-
nl	o	o	+	++	+	+
at	o	o	o	o	+	+
pl	--	-	--	o	++	+
pt	-	-	o	-	-	o
ro	--	-	-	+	+	-
si	++	o	+	++	o	--
sk	-	o	++	+	++	+
fi	++	++	+	+	-	+
se	+	++	o	-	+	++
uk	-	o	+	o	-	-

* Risk of poverty: score based on the at-risk-of poverty (EU-SILC), relative level to EU average and to overall population

** Poverty depth: score based on the at-risk-of poverty gap (EU-SILC), relative level to EU average and to overall population

[5] The scores are calculated on the basis of the at-risk of poverty rates/gaps. They are z-scores and are used to rank countries and to identify 5 relative levels, from ++ to --. Levels are defined so that countries with similar scores are grouped together and that there is a significant step between each group.

The standards of living of "poor" people vary greatly across the EU. In the Baltic States, Hungary, Poland and Slovakia, people at-risk of poverty live on less than €250 per month, whereas in the Nordic countries, as well as in Ireland, Luxembourg, the Netherlands, and the UK the poverty threshold is €900 a month. When taking account of the differences in the cost of living (values expressed in purchasing power standards) the monthly income of the people at risk of poverty vary from €-PPS 280 to € PPS947 (and up to €-PPS1465 in LU). This suggests that the standard of living of the poor is 3.4 times higher in the richest EU countries than in the poorest countries. However, it should be kept in mind that, in each country, the poverty threshold (defined as 60% of the country's median income) represents the level of income that is considered necessary to lead a decent life.

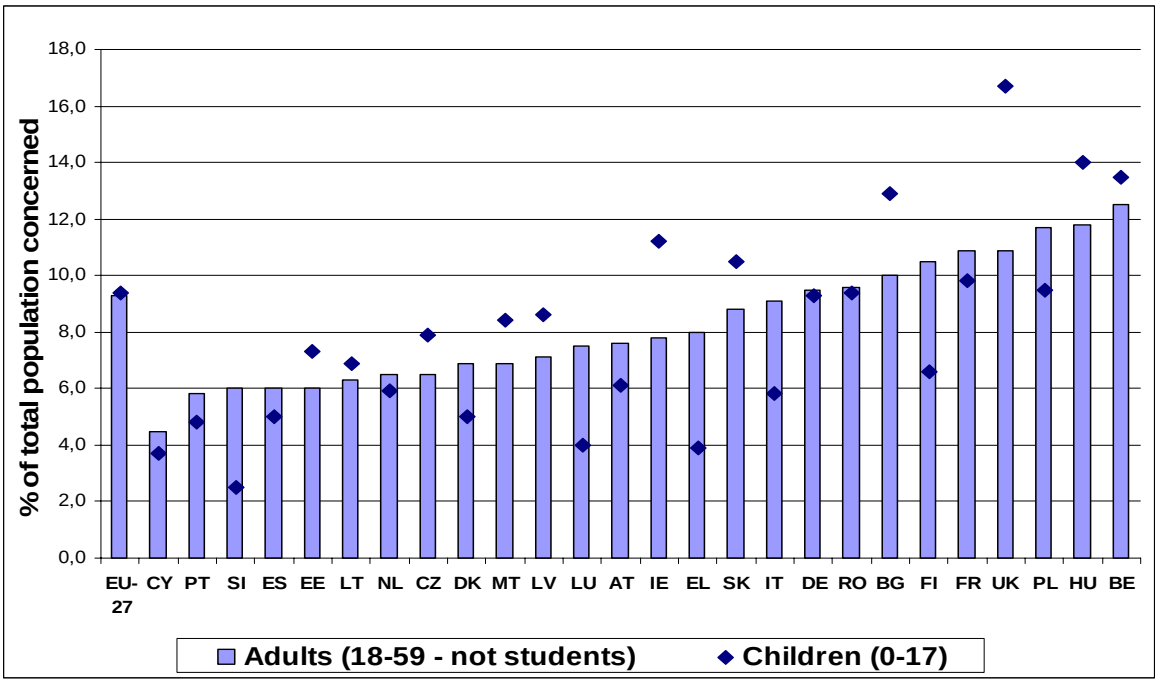
Economic growth has helped to improve overall living standards but the benefits of growth have not reached everyone at the same pace and to the same extent. In a number of countries (CZ, EE, ES, IE, CY, LV, LT, PL, SI, and SK), strong growth rates of 3% or more over several years have not left the poor behind and have helped to improve their living standards while their relative situation either improved or stayed the same. On the contrary, in EL, LU, HU and SE, growth rates over 3.5% have not had the same impact on low income households. The impact of the deepening economic crisis on living standards and inequalities will need to be closely monitored, with a specific focus on the most vulnerable[6].

On average in the EU, the general improvement on the labour market between 2000 and 2008 has had a limited impact on the people that are most excluded. The number of people living in jobless households remains high, despite some recent improvements. In-work poverty is a matter of growing concern in most Member States, as is the integration of migrants into the labour market. The impact of the expected deterioration of labour market conditions on the most vulnerable households will need to be closely monitored.

In 2007, almost 9.3% of EU27 working age adults (aged 18-59, and not students) were living in households where no one was in paid employment. This rate ranged from 4.7% in Cyprus to 11% or more in Belgium, Hungary, and Poland. On average, a similar proportion of children were living in jobless households, 9.4% in the EU-27 in 2007. However, families with children are more affected by joblessness in some countries than in others. The share of children living in jobless households varies greatly across Member States, and ranges from 2.2% in Slovenia to 16.7% in the United Kingdom. Living in a household where no one works affects both children's current living conditions, and their chances to develop their full potential.

[6] The SPC task force on the mutual interaction between growth, jobs and social cohesion policies will address these issues in the first half of 2009.

Figure 2: Adults and children living in jobless households, 2007 (%)

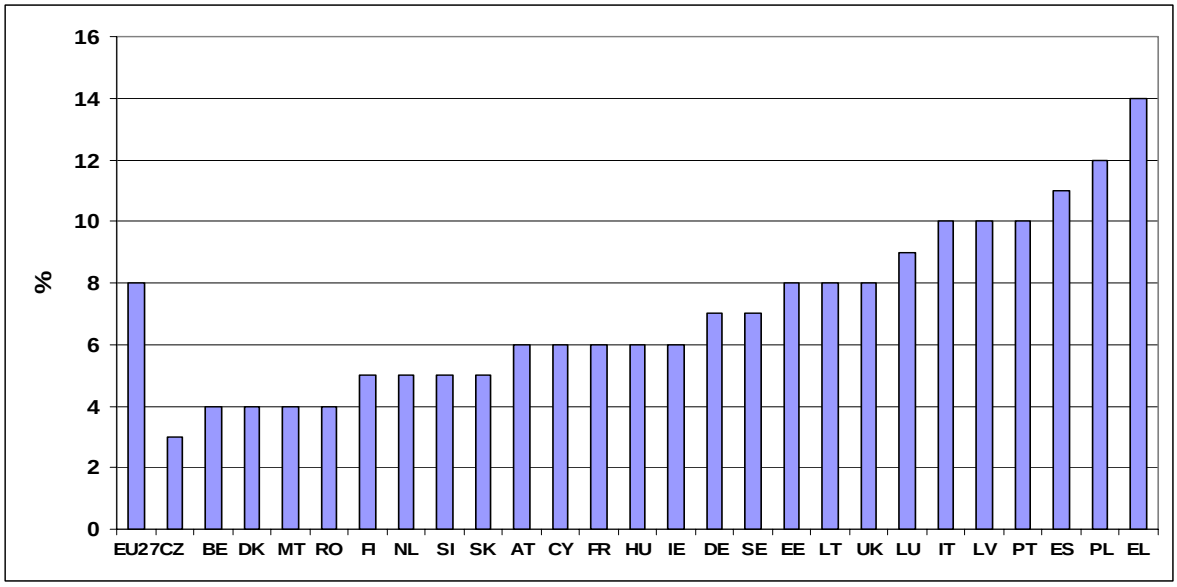


Source: Eurostat Labour Force Survey, spring results, data missing for SE

On average in the EU, general improvements on the labour market only started benefiting people living in jobless households over the past two years (-1 percentage point between 2005 and 2007). These improvements have not had the same impact on families with children, since the reduction in the share of children in jobless households was only 0.3 p.p. between 2005 and 2007. Unfortunately the current recession is likely to put a halt to this recent progress.

As indicated above, having a job does not always protect people from the risk of poverty. In 2007, 8% of EU-27 citizens in employment (aged 18 and over) lived below the poverty threshold, thereby facing difficulties in participating fully in society. This rate ranged from 4% or less in the Czech Republic, Belgium, Denmark, Ireland, Malta, the Netherlands, Slovenia, Slovakia and Finland to 13% in Greece and 10% in Poland. In-work poverty is linked to low pay, low skills, precarious employment and often involuntary part-time working. It is also linked to the type of household in which workers live and to the economic status of other members of the household. In households with children for instance, the single-earner family model is no longer sufficient to ward off the risk of poverty.

Figure 3: In work poverty: at-risk-of-poverty rate of people in employment aged 18 and over, 2007 (%)



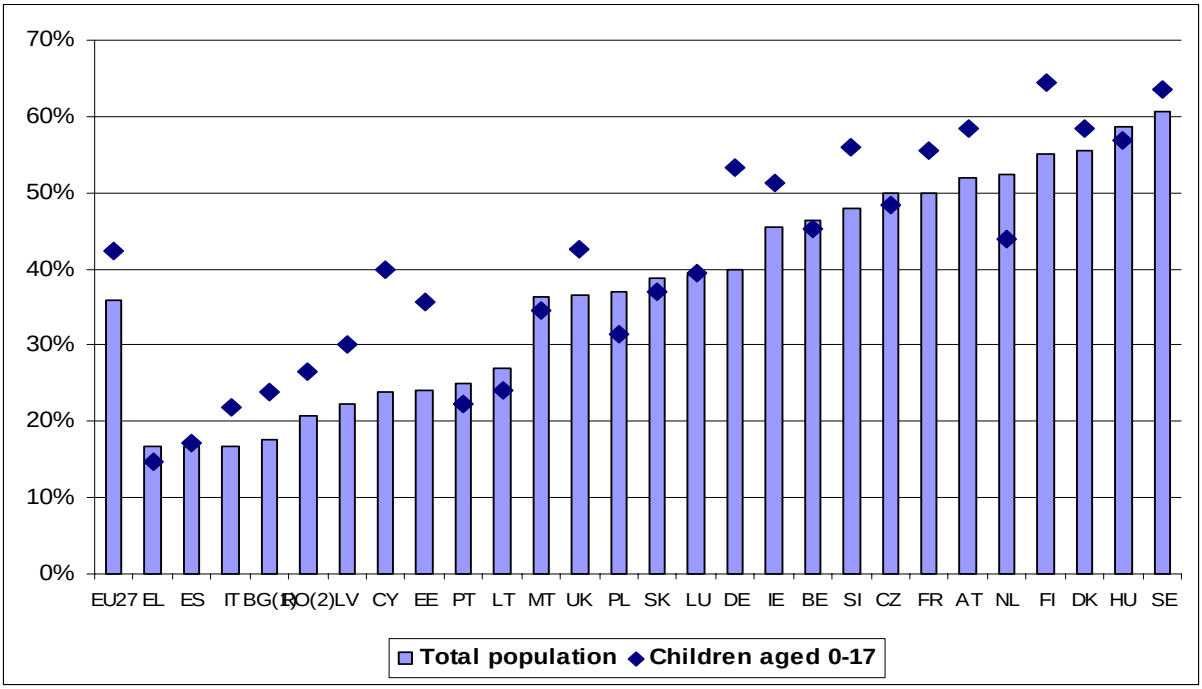
Source: EU-SILC (2007); income year 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-07); RO: National Household Budget Survey 2007; data missing for BG

In 2007, the employment rate of third-country nationals/population born outside the EU was 2.6 percentage points lower than that of the host population, a similar gap to that recorded in 2006 (2.7 p.p.). This masks strong differences across the EU. In Spain, Greece, Italy and Portugal, where migration is a recent phenomenon and mainly economic, migrants have higher employment rates than the native-born population. By contrast, in Belgium, Denmark, Germany, France, Austria, Sweden and the United Kingdom, migrants have much lower employment rates than the host population, with employment gaps ranging from 6% in the United Kingdom to 16% in Denmark.

On average in the EU, social transfers other than pensions (such as unemployment, family and housing benefits) reduce the risk of poverty by 36%. In the absence of all social transfers, the average poverty risk for EU Member States would be 25% (as against 16% after receipt of government support). Social transfers are most effective in the Czech Republic, France, Hungary, the Netherlands, Austria, Slovenia and the Nordic countries, where they reduce poverty by 50% or more. Conversely, in Greece, Spain, and Italy, social transfers only reduce the risk of poverty by 17% or less.

The impact of social transfers in reducing the risk of poverty is higher for children, with the EU average reaching 42% in 2007. This is true in most EU countries, except in BE, CZ, EL, LT, HU, MT, NL, PL, PT and SK, where it is slightly smaller. In the Nordic countries, FR, HU, SI and AT, social transfers (other than pensions) reduce the risk of poverty for children by more than 55%, while in EL and ES the reduction is less than 20% (also for the overall population).

Figure 4: Impact of social transfers (excluding pensions) on the at-risk-of-poverty rate for the total population and for children, 2007 (%)



Source: EU-SILC (2007); income year 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-07); BG: National Household Budget Survey 2006; RO: National Household Budget Survey 2007

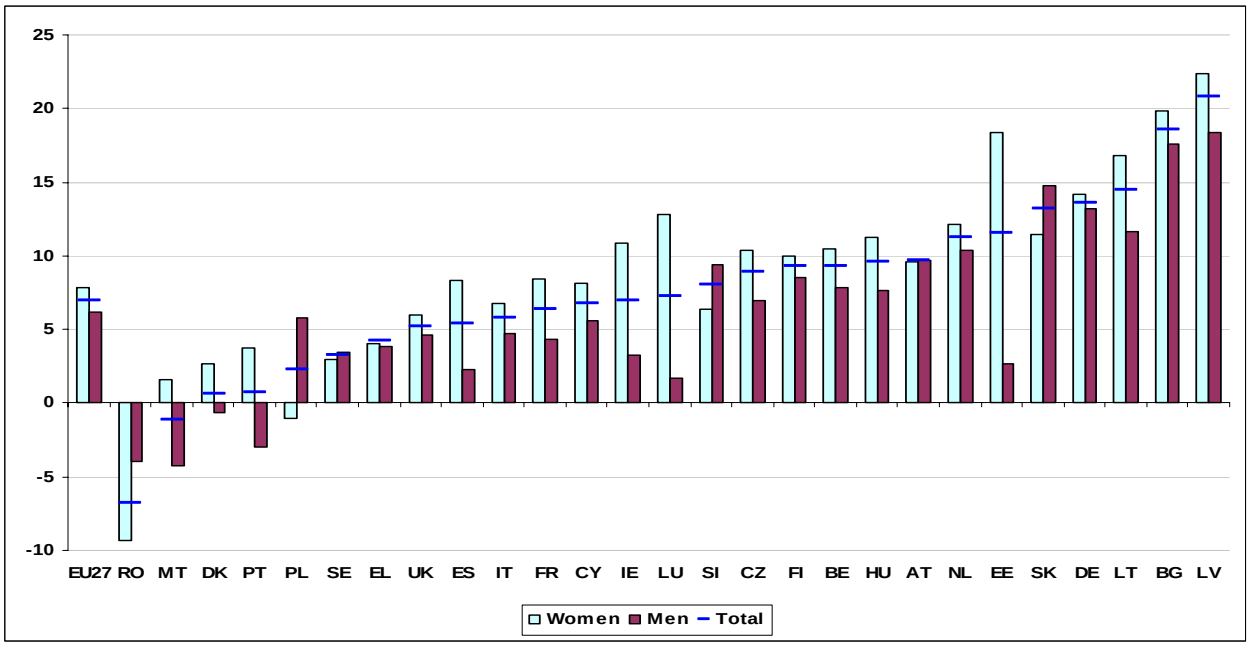
2.1.2. The adequacy and sustainability of pension systems

Ageing of the population is one of the challenges that the EU is facing. Population projections show that the share of people aged 65 years and over in the total population is predicted to increase from 17.1% to 20.1% in 2020. This means that there will be 103.1 million older persons compared to 84.6 million in 2008. The old age dependency ratios will therefore increase from the current 4 persons of working age (15-64) for every person aged 65 years to a ratio of 3 to 1.[7]

The main route to ensure both sustainability of pension systems and an adequate level of income for pensioners is, therefore, to extend working lives. The EU's target under the growth and jobs strategy is to reach a 50% employment rate for older workers by 2010. In 2007, the employment rate for older workers in the EU-27 was 45% compared to 37% in 2001, and 12 countries now exceed the 50% target (Denmark, Germany, Estonia, Ireland, Cyprus, Latvia, Lithuania, the Netherlands, Portugal, Finland, Sweden, and the UK). However, the target is still far away for a group of countries where the employment rate for older workers is still around 30%-35%. The general increase in employment rates of older workers results from two main factors: a demographic effect and the increased participation of women. Due to the ageing of the baby-boom generation, the relative share of people aged 55-59 - who have a higher employment rate - has grown. In addition, most Member States experienced a higher increase in the employment rate for women than for men between 2001 and 2007.

[7] Source: …

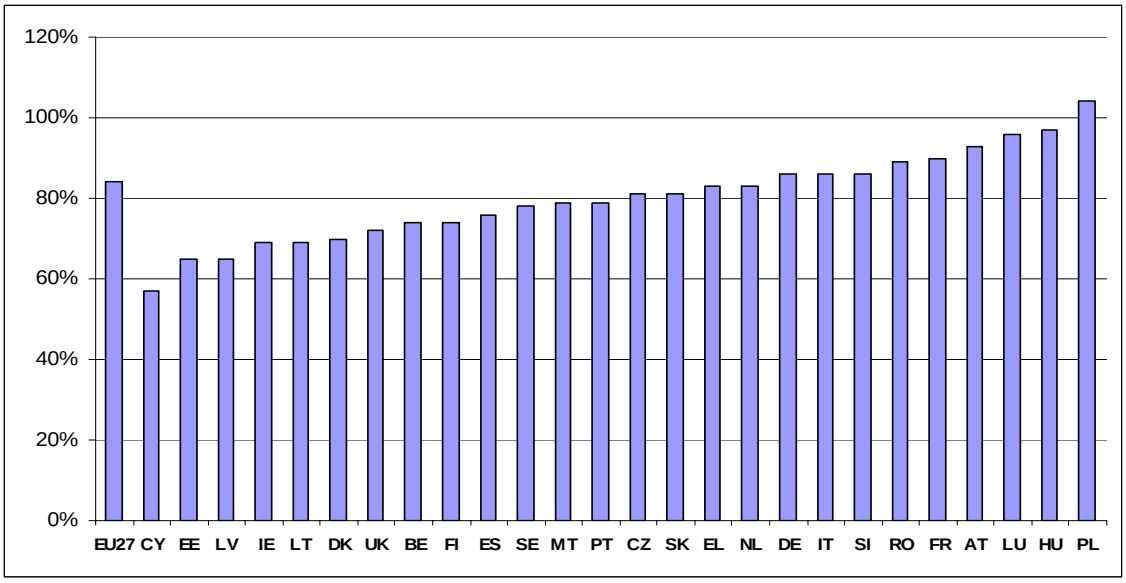
Figure 5: Change in employment rate of older workers, 55-64, 2001-2007



Source: Eurostat, Labour Force Survey, Annual averages

How does the income of the elderly compare to the rest of the population? Pension systems significantly reduce poverty among older people, and people aged 65+ have an income which is around 85% of the income for younger people, ranging from 57% in Cyprus to more than 100% in Poland. However, single elderly women still face a much higher risk of poverty than single men (28% against 20%).

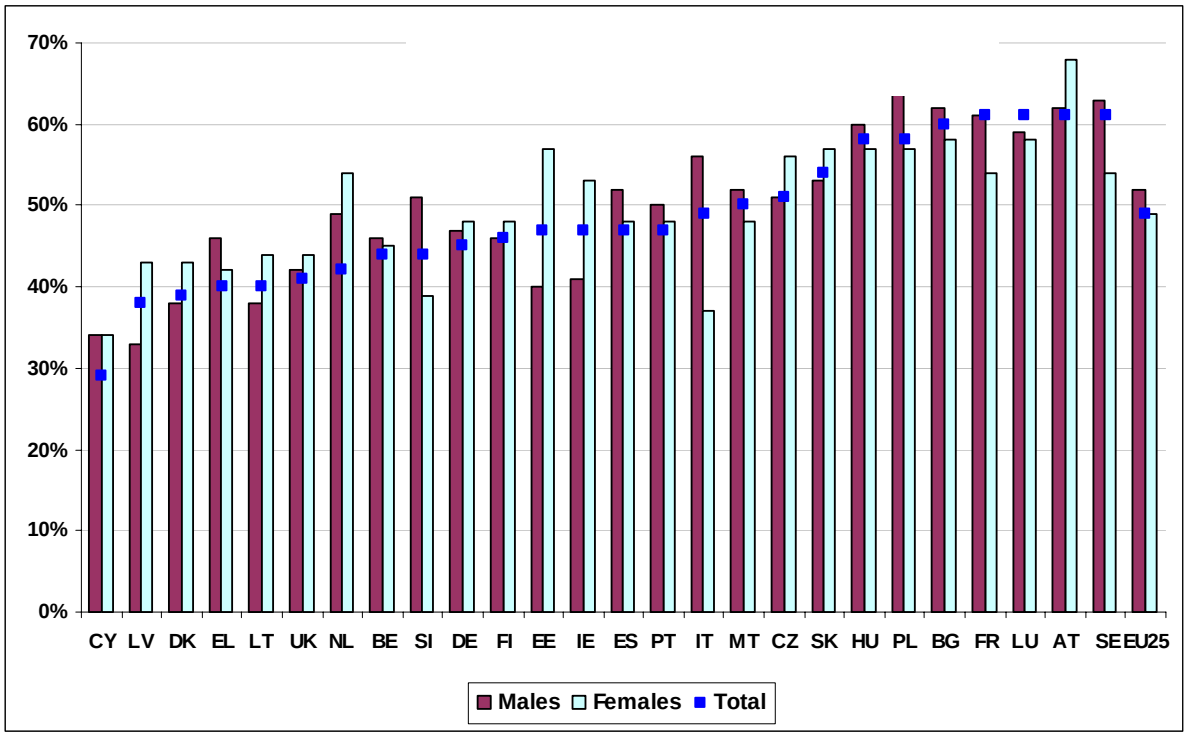
Figure 6: Relative income of the elderly: Median income of people aged 65+ as a ratio of income of people aged 0-64, 2007



Source: SILC (2007) Income reference year 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-2007). RO: National HBS 2007, income data 2007. BG: missing data.

Aggregate replacement ratios - which are based on gross individual income rather than household disposable income - however, generally show that current average pension levels can be rather low compared to current earnings. This can be due to low coverage and/or low income replacement from statutory pension schemes, but can also reflect maturing pension systems and incomplete careers or under-declaration of earnings in the past. In this respect, it should be noted that the aggregate replacement ratio indicator is based on gross income figures, and that several factors besides aggregate replacement rates (such as differences in household composition and size and the overall design of social protection and taxation systems) can have a strong influence on the overall living standards of individuals.

Figure 7: Aggregate replacement ratio for those aged 65+, 2007



Source: SILC (2007) Income data 2006; except for UK (income year 2007) and for IE (moving income reference period 2006-2007); For BG: National HBS (2006) income data 2006. Data for RO not available.
Definition: the aggregate replacement ratio is the ratio of median personal (non-equivalised) income from pensions of persons aged 65-74 relative to median personal (non-equivalised) income from earnings of persons aged 50-59.

The future adequacy and sustainability of pensions can be assessed using theoretical replacement rates. Theoretical replacement rates are case study based calculations that show the level of pension income the first year after retirement as a percentage of individual earnings at the moment of take-up of pensions. Results provided here present the difference in replacement rates under current legislation (enacted by 2006) and replacement rates in 2046 reflecting the effects of legislated pension reforms to be implemented gradually in the future. They show how changes in pension rules can affect pension levels in the future. The results show that most recently enacted pension reforms, while containing future pension expenditure do so through lower benefits giving a decrease in future projected replacement rates given a fixed age of retirement.

Table 2: Change in Theoretical Replacement rates for a worker retiring at 65 after 40 years with average earnings

	Change in Theoretical replacement rates in percentage points (2006-2046)						Assumptions					
	NET	GROSS Replacement Rate					Coverage rate (%)		Contribution rates*			
	Total	Total	Statutory pension	Type of Statutory Scheme (DB, NDC or DC)	Occupational and voluntary pensions	Type of Supplementary Scheme (DB or DC)	Statutory pensions	Occupational and Voluntary pensions	Statutory pensions (or in some cases Social Security)	Occupational and voluntary pensions: Estimate of current	Occupational and voluntary pensions: Assumption	Evolution of statutory pensions expenditures between 2004 and 2050 (source EPC/AWG)**
BE	3	5	-1	DB	5	DC	100	55	16.36	NA	4.25	5,1
BG	15	15	15	DB and DC	/		NA	/	NA	/		NA
CZ	-21	-16	-16	DB	/		100	/	28	/		5,6
DK	7	20	-10	DB	30	DC	100	78	0.9	8.8	12.7	3,0
DE	1	2	-9	DB	11	DC	NA	70	19.5	NA	4	1,7
EE	11	9	9	DB and DC	/		100	/	22	/		-0,1
EL	-7	-12	-12	DB	/		NA	/	20	/		-
ES	-12	-9	-9	DB	/		89	/	28.3	/		7,1
FR	-18	-16	-16	DB	/		100	/	20	/		2,0
IE	-11	-10	-2	DB	-9	DC	100	55	9.5	10-15	10	6,4
IT	3	-3	-17	DB and DC	14	DC	100	11.4	33	5.7	6.91	0,4
CY	16	14	14	DB	/		86	/	16.6	/		12,9
LV	-12	-11	-11	NDC and DC	/		100	/	20	/		1,5
LT	-3	1	1	DB and DC	/		89	/	26	/		3,7
LU	0	-1	-1	DB	/		92	/	24	/		7,4
HU	5	13	13	DB and DC	/		100	/	26.5	/		6,4
MT	-21	-17	-17	DB	/		NA	/	30	/		-0,4
NL	8	5	2	DB	4	DB	100	91	7	9.8	11.5 -12.5	3,5
AT	5	1	1	DB	/		100	/	22.8	/		-1,2
PL	-19	-16	-16	NDC and DC	/		77	/	36.9	/		-4,6
PT	-20	-20	-20	DB	/		81	/	33	/		5,5
RO	52	39	39	DB and DC	/		NA	/	29	/		NA
SI	2	-4	-4	DB	/		100	/	24.35	/		8,3
SK	2	1	1	DB and DC	/		100	/	28.75	/		4,1
FI	-11	-13	-12	DB	/		100	/	21.6	/		3,1
SE	-13	-13	-11	NDC and DC	-2	DB	100	90	17.2	13.7	13.7	0,6
UK	-4	-2	-3	DB	1	DC	100	53 (M)/56(F)	19.85% (17.25%)	9	8	2,0

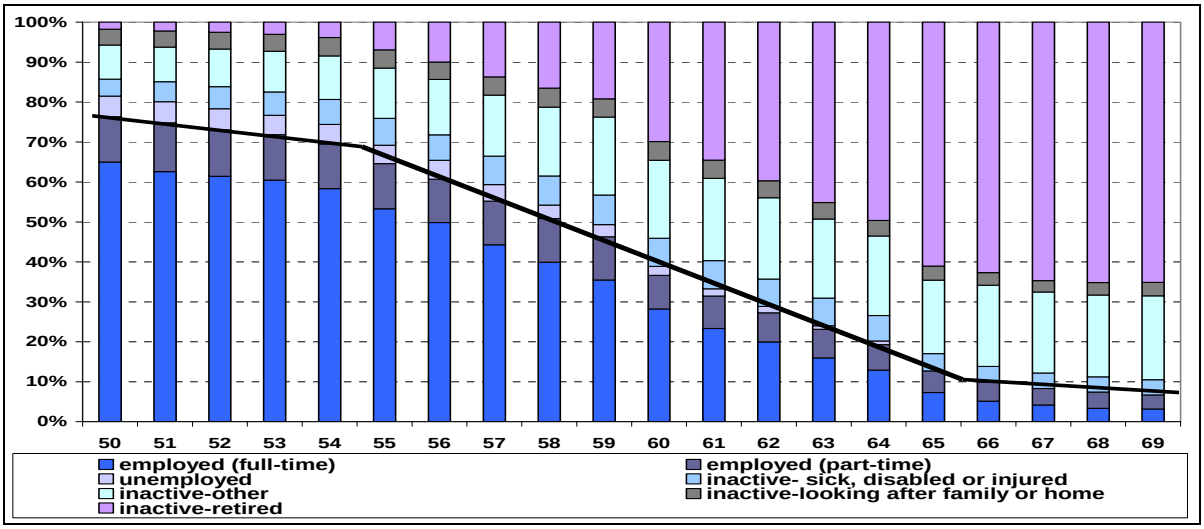
Source: ISG calculations on Theoretical replacement rates carried out in the OECD APEX model or in national models, AWG. Figures for NL are preliminary.

*Note: 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. DK 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. For CY one fourth (4%) comes from the general State budget. For LU one third (8%) also comes from the general State budget. For MT this corresponds to a repartition of 10% from the employee, 10% from the employer and 10% from the State. For PL this corresponds to old-age contributions (19.52% of wage) and disability and survivors contribution (13% of wage). For PT this corresponds to a general estimate (ratio between overall contributions and aggregate wages declared to social security).

** A number of Member States have carried out national projections that better reflect the effects of recent pension reforms on the evolution of pension expenditure.

Meeting the pension challenge is essentially about closing the gap between shorter contributory lives (in terms of delayed first entrance into the labour market as well as low employment rates among older people) and the trend of increased life expectancy at retirement. The main route to solve the dilemma is to increase the labour market exit age. As pension reforms increasingly link benefits to working and contribution years it will be important to monitor how the current economic situation will impact on developments in exit ages.

Figure 8: Economic activity by age in the EU-27 (2006)



Source: LFS, SPC study on flexibility in retirement age and early exit pathways

2.1.3. Health and long-term care

Life expectancy in the EU has generally increased over the past two decades: in 2006 the EU-27 average was 82 years for women and 76 years for men, a gain in longevity of about 4 and 5 years respectively in 20 years. However, different patterns were registered across the EU: while life expectancy has consistently increased in the EU-15 plus MT and CY, it has dropped in Central and Eastern European countries during the economic transition of the early 1990s. Life expectancy in these countries has now recovered but it is still below the level of 1986 in Latvia and Lithuania (for men only). The gap in life expectancy across European countries is as high as 8 years for women and 13 years for men. Some countries are not catching up with the EU average: in BG, LT, RO and SK the difference from to the EU average has actually increased in the last 20 years.

Figure 9a: Life expectancy at birth, men, 1986, 1996 and 2006

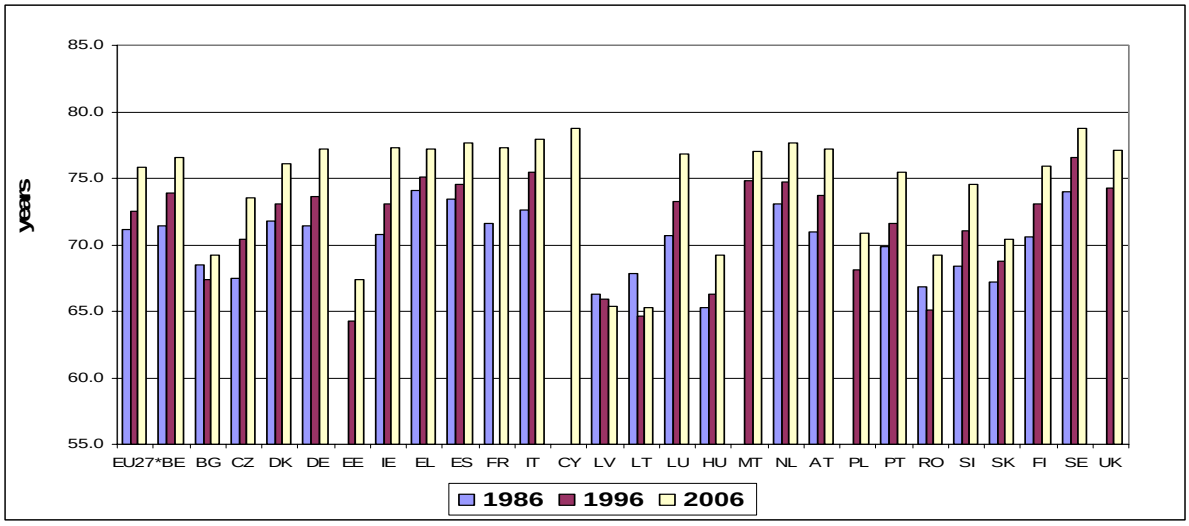
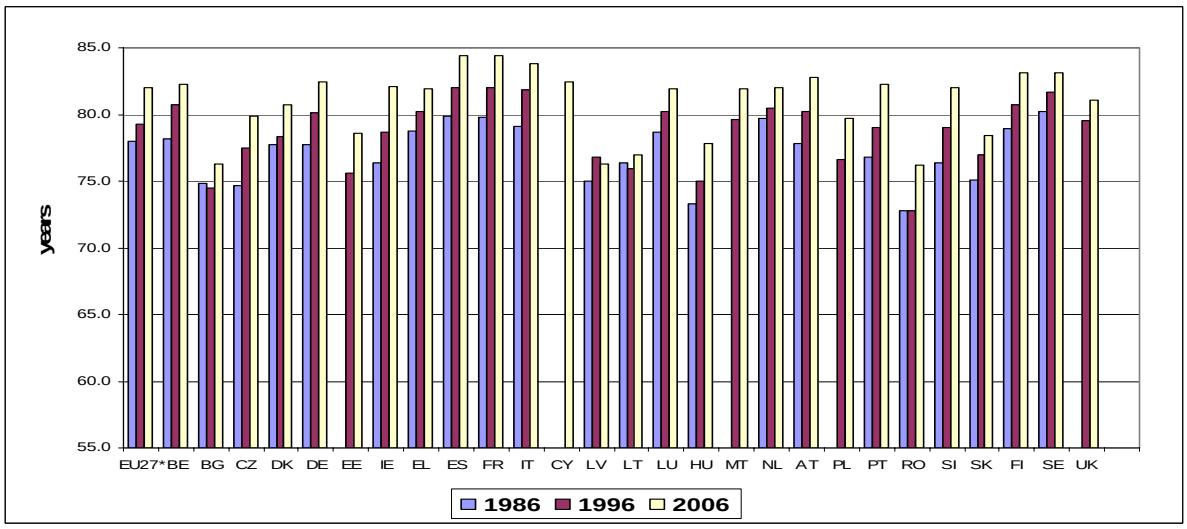


Figure 9b: Life expectancy at birth, women, 1986, 1996 and 2006



Source: Eurostat. LV (1986, 1996): national sources. FR(1986) is for FR Metropolitaine. EU averages are population weighted averages. EU27*(2006) based on 2006 except UK(2005) and IT(2004).

The general increase in life expectancy has been accompanied by a general but small increase in healthy life years. However, there is no clear reduction in the gap between life expectancy and healthy life years. For the EU-15 the number of healthy life years increased from 64.5 in 1999 to 66 years in 2003 for women and from 62.8 in 1999 to 64.5 years in 2003 for men. Even if they live longer lives, women spend a higher proportion of their lives with a disability compared with men. In some countries (UK, FI, PT, NL, EL, IE) the number of healthy life years for women has remained unchanged or even decreased.

Table 3: Life Expectancy and Healthy Life Years[8], 2006

	Healthy Life Years at birth	*Life expectancy at birth*	*Healthy life years as % of life expectancy*	*Healthy Life Years at birth*	*Life expectancy at birth*	*Healthy life years as % of life expectancy*
	females			*males*		
Belgium	62.8	82.3	75.2	62.8	76.6	80.5
Bulgaria						
Czech Republic	59.8	79.9	75.0	57.8	73.5	78.8
Denmark	67.1	80.7	84.5	67.7	76.1	89.9
Germany	58.0	82.4	66.9	58.5	77.2	71.2
Estonia	53.7	78.6	66.4	49.4	67.4	71.2
Ireland	65.0	82.1	78.1	63.3	77.3	81.4
Greece	67.9	81.9	82.1	66.3	77.2	85.1
Spain	63.3	84.4	74.8	63.7	77.7	81.3
France	64.1	84.4	76.2	62.7	77.3	80.2
Italy	67	84	80.2	65.8	78.2	77.4
Cyprus	63.2	82.4	70.3	64.3	78.8	75.5
Latvia	52.1	76.3	69.6	50.5	65.4	77.4
Lithuania	56.1	77.0	70.5	52.4	65.3	78.4
Luxembourg	61.8	81.9	75.8	61.0	76.8	81.0
Hungary	57.0	77.8	69.3	54.2	69.2	75.1
Malta	69.2	81.9	85.6	68.1	77.0	89.0
Netherlands	63.2	82.0	77.0	65.0	77.7	83.7
Austria	60.8	82.8	72.0	58.4	77.2	74.9
Poland	62.5	79.7	83.6	58.2	70.9	86.0
Portugal	57.6	82.3	68.9	59.6	75.5	77.4
Romania						
Slovenia	61.0	82.0	73.0	57.6	74.5	75.6
Slovak Republic	54.4	78.4	71.9	54.3	70.4	78.0
Finland	52.7	83.1	63.1	52.9	75.9	68.1
Sweden	67.0	83.1	75.9	67.1	78.8	81.5
United Kingdom	65	81.1	80	63.2	77.1	82

Source: Eurostat based on EU-SILC data 2006; IT, UK 2005;
IT figures for life expectancy at birth are estimates taken from EHEMU database

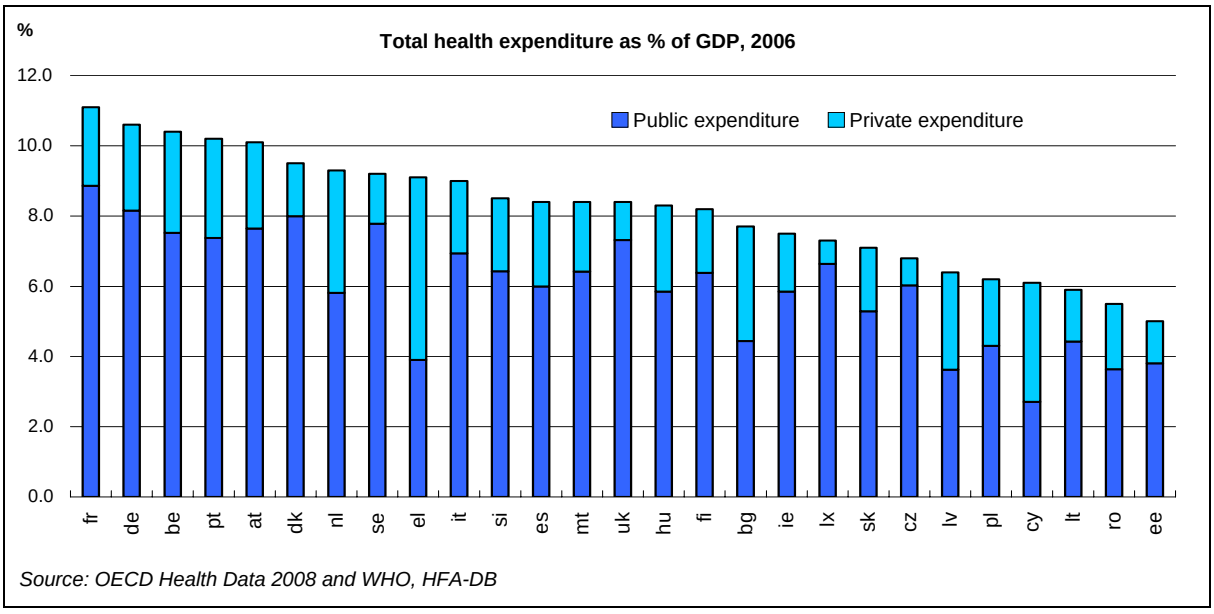
Significant gaps in health status (e.g. self-perceived general health and self-perceived activity limitations due to health problems) across social groups persist in the EU: i.e. those in the lowest (poorest) income quintiles more often report very bad health and more severe limitations than those in the highest (richest) quintiles. Indeed, on average, less advantaged groups not only have shorter lives and suffer more illness but also feel their health to be worse than more advantaged groups. Differences in the availability, quality and use of care services, alongside living and working conditions, life-styles and countries' socio-economic situation can explain such differences in health between and within countries. As an example, Europe is characterised by inequalities (between and within countries) in cancer screening and follow-up.

[8] For the years 2004-2006, the disability prevalence data used in the calculation of the healthy life years indicator were taken from the Statistics on Income and Living Conditions survey (EU-SILC) covering all EU-25. Note moreover that the formulation of the disability/limitations question so far has not necessarily been the same across Member States. Answers may also be prone to cultural differences. Hence, cross-country comparisons may not be meaningful.

Several barriers to accessing care are identified. In the EU there remain significant gaps in health insurance coverage, i.e. non-negligible numbers of individuals are without health insurance coverage of any sort, or with limited insurance coverage (e.g. only emergency care coverage) which deters individuals from seeking necessary health, results in belated care and has significant financial consequences for patients and their families. Even where rights to access healthcare services are universal they have not necessarily translated into equal access for all. Indeed, on average, 3.1% (5%) of those living in the EU, with the exception of DE, BG and RO for which there is no accurate data available, report unmet need for medical care (dental care) because they had to wait, or care was too expensive, or too far away. This percentage also varies greatly across Member States; from 0.2% (0.5%) in SI and DK to 15% (12%) in LV (EE), and across income groups in each country, with the poorest facing the greatest unmet need.

In the last two decades total health expenditure both per capita and as a percentage of GDP rose throughout the EU. There are, however, substantial differences across countries. AT, BE, DE, FR and PT spend 10% or more of their GDP on health, while the Baltic States, CY, PL, and RO spend 6 % of GDP or less. The proportion of public sector expenditure in total expenditure on health is in general substantial (more than 70%). Nevertheless, private healthcare expenditure (mostly out-of-pocket payments) constitutes a very large source of funding in some Member States: in CY and EL private expenditure represents more than 50%, in LV and BG more than 40%, in RO more than 30%. Informal payments are an additional direct cost to patients in SK, RO, BG, EL, HU, PL, LT and LV.

Figure 10: Total health expenditure as a % of GDP (2006 or latest available)



Those countries reporting lower life expectancy (BG, LV, RO, LT, HU, EE, SK, PL and CZ) are also those reporting the highest proportions of unmet need for medical care and those with the lowest expenditure both per capita and as a percentage of GDP.

2.2. Progress towards the overarching[9] objectives

The overarching objectives of the OMC for social protection and social inclusion are to promote:

(a) 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;

(b) Effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social cohesion, and with the EU's Sustainable Development Strategy;

(c) Good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

2.2.1. Overall Strategic Approaches

Many Member States attempt to identify and coordinate the synergies between the three strands of the Social Open Method of Coordination in their policies (notably LU, BE, EE, FI and PT). For many, the overall strategy takes the ageing of the population as the starting point. Population ageing due to low birth rates and increased life expectancy means, if not accompanied by extra years in good health, a larger share of old and very old people with multiple and reinforcing degenerative and chronic conditions. Thiscan threaten the sustainability of social protection because it increases pensions, healthcare and long-term care costs.

The number of active years currently spent on average in the labour market is not enough to sustain the increasing number of years in retirement or inactivity. Hence, on the one hand, Member States are designing their reforms to make pension and social protection systems more sustainable, notably by striving to keep more people in employment longer and increasing the number of healthy life years by encouraging preferred paths of care. On the other hand, Member States are striving to support the inclusion of all in society (by education, active inclusion, etc.), to ensure a minimum safety net for those that cannot otherwise reach acceptable living standards (minimum pensions, minimum income provision and equal access for all to quality care. A more integrated vision is present, for example, when Member States recognise explicitly the various social determinants of health, including alongside access to quality healthcare, also living conditions, unemployment, income inequalities, poverty and material deprivation, education, the environment, migration and more diverse societies. In this context, policies that relate to social inclusion, pensions, healthcare and long-term care have an impact on public health just as improved health of the work-force can have major positive impact on the long term sustainability and adequacy of these systems.

Examples of integrated approaches are found in some countries. In Luxembourg, it is clearly stated that promoting social cohesion has a key role to play for the country's future, on a par with efforts relating to the economy, monetary stability, public finance, taxation, employment and acquiring the necessary infrastructure to meet the challenges of globalisation. Under this approach, social cohesion is the target of political action. The Belgian Federal government

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agreement describes an action framework based on five overall priorities: a global employment strategy, policies to reduce fiscal and parafiscal pressure on labour, encouraging entrepreneurship, reinforcing the social protection system, and reinforcing environmental policy and sustainable development. Estonia sets out to exploit the synergies between the three strands by adopting the overarching message that enhanced social protection and social inclusion require an integrated approach, ensuring coherence between the policy measures taken in various fields. Within this global vision some countries stress the employment dimension (UK, NL) while others stress the social dimension (AT, PT). In this context it is important to mention that in the past decade a number of countries have carried out major pension reform where a key aim has been to encourage longer working lives.

Several Member States (BG, CY, ES, FR, HU, SI, SK, RO, FI, SE, UK, IE, NL, PL) have made efforts to assess progress in relation to the priorities selected in the 2006-2008 NSRs and the challenges identified in the 2007 Joint Report, often in relation to one or more strands. In several cases, however, an evidence-based and systematic approach is hampered by a lack of appropriate monitoring arrangements. Often, quantified targets and objectives in relation to which progress could be assessed are not at hand. Sometimes the stock-taking of progress takes the form of listing the actions taken but without assessment of their concrete impact.

There is a considerable degree of continuity in the social inclusion priorities selected compared with the 2006 round, and this seems in general well justified. As in 2006, active inclusion and child poverty are the challenges most frequently selected as inclusion priorities. Promoting the inclusion of groups at particular risk of exclusion also figures prominently (Roma, migrants, elderly, disabled, young people), although the issues of including migrants and ethnic minorities, in particular, seem not to be given due attention in some Member States where they are major challenges. Other priorities quoted by several Member States include ensuring access to quality services, tackling educational disadvantage and fighting homelessness and housing deprivation. Several Reports would benefit from more clarity with respect to the allocation of resources and of responsibility.

During the last decade Member States have reformed to their pension systems to better provide adequate and sustainable pensions in view of population ageing, new societal norms and changing behavioural patterns. Consequently in their national strategy reports of 2008, countries focus on the implementation of reforms and further incremental progress that has been made. Such progress in many ways involves a delicate balancing of the dual concerns of adequacy and sustainability: how to secure sufficient pensions for all without jeopardizing work incentives and financial sustainability and vice versa. Still a few Member States have legislated more substantial reforms since the last reporting (PT, UK, EL, CY).

This is the second full reporting exercise under the social OMC regarding the healthcare and long-term care strand. As only two years have passed since the previous NSRs, virtually all of the 2008-2010 reports (except perhaps BG, CZ, SK) build on the previous strategies and national health plans with similar priorities and policies and some additions or improvements in relation to the strategies proposed in 2006. For all Member States, universality, fairness and solidarity, accessibility, equity, equality, effectiveness, and efficiency are the guiding principles of reform. Ensuring access to quality healthcare and long-term care services and improving healthcare systems efficiency i.e. obtaining better value for money are still important priorities across all countries. However, there is still scope to strengthen the potential impact of policies by adopting a more multidimensional approach, and gender mainstreaming is evident only in rare cases. Several reports show that more clarity with

respect to the allocation of resources and the responsibility of the different actors involved is needed.

2.2.2. Interaction between economic growth and social inclusion policies

In this round of reporting more Member States underline the importance of positive interaction between economic and employment policies and social inclusion and social protection policies and of the underlying synergies with respect to both goals and measures.

Many reports point out that social protection and social inclusion policies do effectively contribute to growth and jobs. Active inclusion measures aimed at those furthest from the labour market figure prominently in the 2008-2010 NSRs. Increasingly Member States are tailoring social services to promote employment (e.g. DK, FR, EE, AT). Equally, policies to combat child poverty and the inter-generational transmission of poverty, with a specific attention to high quality education, are pursued by several Member States. Other policies include measures to ensure longer working lives, often featured in reforms of pension systems and commonly used early-exit pathways (FR, LV, PL, SE) and policies aiming at debt relief to overcome over-indebtedness as an obstacle to participation in the labour market (FI). Modernisation of social protection systems in order to ensure their long term both financial and social sustainability in view of population ageing is also mentioned as an essential policy intervention by several countries (ES, AT, FR, HU, IE, MT, PT). It is widely indicated that social protection policies leading to an increasingly healthy population enable more people to participate in the labour market at all ages and lead to increases in productivity. Active ageing measures are of growing interest as pension reforms require longer contributory periods to ensure adequate pensions and healthy life years continue to increase. Many Member States suggest that the health and social sector is a large and growing employer that can be used as a tool to improve the economy in disadvantaged regions and increase labour market participation of women.

A wide range of policy priorities are mentioned by Member States to illustrate how growth and jobs can promote social objectives. In many reports reference is made to measures that will contribute to facilitating access to the labour market of people that are far from it, such as training and educational programmes aimed at vulnerable groups (AT, FR, BG, CZ, SE), flexicurity initiatives (AT), specific active labour market programmes (ALMP's) (DK, NL, PL, UK), subsidised employment for various target groups (LV), local employment initiatives (LT) and avoiding inactivity and unemployment traps (EE, SK). Reconciliation of work and family life also features (FI, FR, LV, NL, DE, ES). Some countries refer to policies aimed at the extension of working lives (e.g. AT, DK).

In the area of pensions, the link between better jobs and longer working lives and better pensions is quite clear. In striving for adequate and sustainable pensions and social protection systems there is a clear need to prolong working lives. There is, however, also an observed link between higher paid jobs and longer working lives, which subsequently lead to better pensions. In order to avoid a growing retirement income gap, it is important for economic growth to filter into all segments of the labour market and society. Ample economic growth creates a clear forum for this, creating synergies between the incentives to work longer embedded in pension systems and job creation notably for older workers, who are often amongst the first to suffer job losses in strained economic times.

Economic growth is also seen as an important determinant of health, both directly through the improvement of living conditions, for example, and indirectly as it provides extra resources to the healthcare and long-term care sectors.

Some NSRs point to areas where the mutual positive interaction between economic, labour market and social policy is not at hand. Several countries highlight that economic growth (and in some cases very high rates of growth) has not benefited all groups of society in the same way and indeed social inequalities (income and health for example) persist or have even widened.

There is a risk that the current economic downturn will exacerbate certain negative tendencies, e.g. an increased segmentation of the labour market or the occurrence that employment growth is not reflected in wage increases. A contracting labour market can ultimately affect pension levels and can lead to a reduction in resources allocated to the healthcare and long-term care sectors, possibly with detrimental affects on access. Much needed quality improvements could be postponed.

Given that the economic context has changed quite dramatically after the preparation of the NSRs Member States were solicited in the framework of the Social Protection Committee to provide information available at this stage on the social impact of the current economic crisis - already demonstrated as well as expected - and on related national policy actions. The outcome of this initial sounding out is summarised below:

- Most Member States expect that the global financial crisis will have a strong impact on the real economy, although not all of them to the same extent. In most countries the social effects of the downturn are already visible.

- Member States underlined that in-built capacities of the social protection systems as well as social inclusion policies in the Member States are there to fully play their role as automatic stabiliser to cushion the impact of the economic downturn.

- A number of Member States indicated that ad-hoc additional measures have already been taken to protect the most vulnerable and to relax supervisory requirements for pension funds.

- Some areas are more frequently indicated as deserving special attention in the present context, notably access to housing, the adequacy of safety nets, and funded pension schemes.

- In general, most countries re-affirmed the commitments made in their NSRs, while not excluding the need for special additional measures, which in some cases are already being defined or introduced.

2.2.3. Governance

On the basis of information provided in the overarching section of the national reports it seems that in most Member States there has not been a fully integrated preparation process covering the three strands and mostly there are separate, different governance arrangements. Exceptions are AT, DK and IT. In AT, for the first time, a joint meeting was held of the various Federal Ministries and umbrella NGOs active in social and environmental affairs to discuss the challenges for the national reform programme as well as interaction between the

OMC, the strategy of sustainable development and measures in these areas. A consultation on the future social model, covering overall social protection and industrial relations, has just closed in Italy.

It seems that in many Member States there has been progress as far as the participation of stakeholders in the policy process is concerned. There is increased attention to the quality of participation. Some Member States ensure stakeholder involvement throughout the reporting and policy cycle. On the whole there is still much room for better participation of stakeholders, e.g. representatives of regional and local governments and people experiencing poverty, but there are some inspiring good practices. In too few cases has the preparation process been used as an opportunity for large-scale media attention and for raising the awareness of the public at large. It appears that only a small minority of the Member States' Parliaments has discussed the plans. For further details see section 3.6.

Mainstreaming and coordinating social inclusion policies remains a challenge in many Member States. Countries are implementing different kinds of structural arrangements at national but also at regional and local level to contribute to this (coordination committees, networks of focal points, etc.). A few Member States report on efforts to establish or further develop ex ante social impact assessment arrangements.

As far as monitoring and evaluation are concerned, progress is uneven and many challenges remain. Data sources, indicators and analytical capacity need to be developed especially also with regard to the groups that are most at risk and that are seldom reached by surveys. However, examples of national target setting have been increasingly observed in the NSRs. Effective monitoring of targets requires regular monitoring. There are major differences between Member States in the extent to which policies are systematically evaluated. Stakeholders and external expertise are often involved in evaluation at the start of the preparation of a new plan. It is good practice to start drawing up a new plan on the basis of a report on the results of the evaluation of the previous plan.

Most Member States have counted on the input of experts from social partners, ministries, institutions involved and scientists for the development of their pension reforms (e.g. DK, ES, IE, FI, DE, AT, PT, GR, CZ, SE, UK). These countries also report that the social partners do the job of informing politicians and the public about latest trends in social systems and stimulate debate to foster a broad social consensus. Some Member States have reported on more direct consultations with the public in order to obtain public consensus (UK, IE, MT). For further details see section 5.4.1.

Safeguarding health and translating it into longer working lives are the result of a set of social and economic factors and also a means to ensure employment and economic development. This holistic approach is reflected in some countries into a broader consultation with various sectors, with NGOs on social welfare and health, and with local and regional authorities. It is, however, not necessarily clear how the consultation has influenced the report. Some of the reports were prepared in joint collaboration by more than one ministry. More multi-sector cooperation is necessary to ensure greater coherence between economic, education, employment, environment and social and health policy.

It should be noted that several European-level civil society organisations active in the social field have provided and made public their assessments of the renewed Strategic Reports, in general drawing on contributions from network members at national level. Some of them examine at the strategic reports as a whole, in most cases focussing in particular on the

National Action Plan for social inclusion (NAPs). This goes notably for the comprehensive assessment carried out by the European Anti-Poverty Network which stresses as the overwhelming concern "the lack of progress on the eradication of poverty in the EU"[10] and proceeds to assessing the NSRs/NAPs overall as well as the policy responses to address specific inclusion concerns. The report presented by Caritas Europe examined in particular the "Process and Quality of Policy Design" of Member States' preparations of the NSRs and Eurodiaconia's report assessed the degree of participation in this process.[11] Depending on their specific mission others concentrate on more limited, well-defined aspects of the NSRs/NAPs within their area of concern and interest. Brief references to the latter contributions are made where appropriate in the following text.

2.3. The European Social Fund – major tool for implementation of strategies

The European Social Fund (ESF) is the main European financial instrument designed to support Member States in the implementation of their strategy as set out in the National Strategy Reports. In the 2007-2013 programming cycle, the European Social Fund will invest approx. €76 billion to support 117 Operational Programmes (OP) across the European Union. Together with the European Regional Development Fund (ERDF) and the European Agricultural Fund for Rural Development (EAFRD), the ESF will make a major contribution to achieving the common objectives in terms of social inclusion and social protection. The 2008 turmoil on financial markets slowed down economic growth and employment in many EU countries, thus posing an extra challenge social inclusion and social protection systems. In this context, the ESF can help to respond to emerging social challenges by supporting those furthest from the labour market and people made redundant in the economic downturn. The current economic outlook underlines the added value of the ESF both as an expression of EU solidarity and as a tool to tailor the labour supply to a changing economic environment. Effective use of ESF funding can cushion the effects of the economic crisis in terms of unemployment and social inclusion. The role of ESF in the various policy priorities is highlighted in most NSRs, in particular with regard to the Social Inclusion strand. The Spanish report includes an annex on the contribution of the 2007-2013 strategy to social inclusion policies, focussing on the ESF-financed OP 'Fight against Discrimination'. The linkage between policy objectives and ESF is clearly visible when ESF funding is more substantial in relation to the total national expenditure on employment and social policies (e.g. BG, SK, PL, RO, HU, PT, CZ). However, the absence of references to ESF is also notable in a number of NSRs (e.g. IE, NL, FI, FR), despite the fact that in some cases the ESF allocation to social inclusion is fairly high (e.g. FR, IE).

There is general evidence of improved coordination between social policies and the use of the Structural Funds. However, the broad linkage established by some of the Reports on the one hand, and some inconsistencies between OP targets and those set out in the NSRs on the other, leave some doubts as to the depth and quality of policy coordination in a number of Member States. A challenge thus remains to ensure that co-ordination between policies and funding goes further than formal cooperation between various departments, and to monitor the extent to which the ESF contributes to achieving the OMC targets.

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[10] The full assessment *Building Security, Giving Hope*: http://www.eapn.eu/content/view/678/29/lang,en/

[11] http://www.caritas-europa.org/code/en/publications.asp?choix=x2x ; http://www.eurodiaconia.org/files/Anti-Poverty%20and%20Social%20Inclusion/Eurodiaconia%20report%20on%20members%20involvement%20in%20social%20omc%202008.pdf]

The Joint Report 2008 provided a detailed overview of Member States priorities in terms of social inclusion and social protection, which will be supported by use of the Structural Funds in the 2007-2013 period. As the implementation of the current cycle of ESF programmes is still in its initial phase, Member States could not report on the progress achieved. Nevertheless, some reports (e.g. EL) point out that many of the measures are the continuation of previous ESF-funded activities, which have already delivered results.

With regard to the overall common objective of governance, a number of country-specific challenges were identified in the 2007 Joint Report (e.g. CY, HU, LT, PL and SK).Here, it is particularly important that Member States make use of the possibilities offered by the ESF to promote the effectiveness of social inclusion and social protection policies. Several Member States have programmed ESF funding to promote the design, the monitoring and evaluation of social policies at national, regional and local levels (e.g. HU, SK, RO), as well as the development of quality standards in social services (PL). Moreover, ESF will support the capacity building of public administration in all EU-12 Member States and convergence regions, which will also contribute to better governance in the social field.

3. FIGHTING POVERTY AND SOCIAL EXCLUSION

3.1. Introduction

The Member States renewed National Action Plans for Social Inclusion (NAPs), presented in September/October 2008 as part of the integrated NSRs focus on a limited number of key priorities deemed particularly important for progress on the Lisbon goal of making a decisive impact on the eradication of poverty by 2010. NAPs increasingly take a more strategic approach while also reflecting multidimensional nature of poverty and exclusion, and the need for integrated policies to address priority issues.

The NAPs aim to translate into action at Member State level the three Common Objectives relating to social inclusion, which were adopted by the European Council in March 2006 and confirmed in March 2008: 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; the active social inclusion of all, both by promoting participation in the labour market and by fighting poverty and exclusion; and ensuring 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.

This report mirrors the particular attention given in NAPs to the issues of child poverty following up on the 2007 thematic year dedicated to this topic, and to active inclusion. Further, it examines Member States' planned policies to improve access to and quality of the various services that are key to enabling social inclusion overall, and to combat the persistent exclusion of certain groups of citizens. It finally reviews measures taken or planned for better governance of social inclusion policies.

3.2. Promoting Child Well-Being and Breaking the Cycle of Deprivation

Out of the 16% of Europeans at risk of poverty, 19 millions are children. In most EU countries children are at greater risk of poverty than adults, a situation which has not improved since 2000. Tackling child poverty and breaking the transmission of disadvantage between generations has been a main concern since the launch of the social inclusion process. In 2006, the March European Council asked Member States to take decisive steps to eradicate poverty among children. Many Member States have taken this invitation to heart.

In the new round of plans, child poverty once again emerges as a key priority for Member States as more than two-thirds of countries have selected it as one of their key priorities for social inclusion. In support of this strong commitment, 20 countries have set quantified targets related to policy goals in the area of child poverty and social exclusion, 16 of them using one or more EU-agreed indicators (at-risk-of-poverty rate of children, children in jobless households, low reading performance of pupils). A few Member States have also set intermediate targets in relation to their specific challenges: jobless households (BE, BG, HU, UK), families most at risk (BG, EE, CY, LT,SK, UK), intensity of poverty (NL), childcare provision (DE, IE, FR, IT, LT, LU, HU, AT, PL, PT, SK, UK, MT).

The 2007 thematic focus on child poverty was the occasion to explore further the policies in place in Member States and deepen the common understanding of the determinants of child poverty in each country[12]. This work helped identify common challenges, but it also shed light on the reasons why considerable differences in the situation of children remain across EU Member States. It also highlighted the fact that among those countries who had not selected child poverty as a key priority some, like France, Slovenia, Finland or Sweden have in fact comprehensive sets of support schemes in place for children and their families. In these countries, child poverty is relatively lower than in the EU as a whole. In other countries such as Spain, where child poverty rates are high, the support to families is part of a broader political commitment to develop the Welfare State.

This assessment of the NAPs builds on the work carried out in 2007. It takes stock of the progress in implementing the policies announced in the 2006-08 plans and aims to assess whether the new measures are in line with the challenges identified in the 2007 and 2008 Joint Reports[13].

The supporting documents to the 2007 and 2008 Joint Report analysed in detail the policies described by Member States in the 2006-08 plans. The measures adopted by Member States in their 2008-10 plans are in continuation of these policies and an increasing number of Member States adopt multidimensional and integrated approaches to tackling child poverty and social exclusion (AT, BE, BG, CY, DE, EE, HU, IE, IT, LU, PL, PT, RO, SK, UK, MT). Such integrated approaches typically include income maintenance, reconciliation of work and family life, services to families including childcare, housing, education, youth protection and

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12 Social Protection Committee (2008): "Child poverty and well-being in the EU. Current status and way forward."
http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/child_poverty_en.pdf

13 Eurochild's assessment to be published in February 2009: www.eurochild.org

support of the most vulnerable children, or as in Finland a specific policy programme for the well-being of children, youth, and families.

3.2.1. Ensuring sufficient resources for children and their families

The 2008 Joint Report stressed the importance of fighting child poverty on all fronts through the implementation of comprehensive strategies. These involve a combination of adequate and well-designed income support, quality job opportunities allowing parents to progress in the labour market, and the provision of necessary services for children and their families (especially childcare). Below we discuss how far the new plans address the challenges identified for the four groups of countries identified in the supporting document SEC(2008)91 to the 2008 Joint Report.

Countries in group A (AT, CY, DK, FI, NL, SE, SI) are characterised by relatively low levels of child poverty and by existing comprehensive support schemes for children and their families. These schemes often rely on universal benefits in cash and in kind (childcare) primarily aimed at compensating the cost of raising a child combined with measures targeting the most vulnerable children. However, some countries report a stagnation or an increase in child poverty (SE) and an increase in benefit dependency rates (SE, NL), especially among families with a migrant background.[14] In these countries, the need to sustain the current comprehensive schemes and to reinforce measures targeting the most vulnerable (increasing take-up rates, enhancing the provision of social services) is highlighted. Austria and the Netherlands are planning to reinforce income support for low-income families and especially lone parents and large families. In the Netherlands special focus is also on families that have been on a low income for more than five years and families on low incomes with school-age children.

The main concern in countries in group B (BE, CZ, DE, FR, EE, IE, BG) is to bring down the high number of children living in jobless households and help parents stay durably on the labour market. In most of these countries, further measures are envisaged to make work pay for parents while adequately supporting their income. Measures that are often part of a wider active inclusion strategy include tax rebates for low-income families (BE, CZ, EE) and activation measures targeted at parents (BE, BG, CZ). Ireland is planning to substantially increase child income support and to structure the payments to remove employment disincentives, especially for lone parents (and other low-income families) who are a specific target group of the Irish active inclusion strategy. The Irish government is also striving to increase the low take-up of in-work supplement for low-income families. In France, the newly introduced RSA (income support scheme designed to support individuals through their transition back to work) will take account of the size and composition of the household. Belgium, Germany, Estonia, Ireland and France plan a significant increase in the availability and affordability of childcare to help parents back into work. In the Czech Republic, however, few measures are planned to increase the low provision of childcare, and the promotion of longer periods of parental leave may have an adverse impact on the relatively low labour market participation of mothers (also in EE). In the Czech Republic and Estonia, the employment rate of mothers is 16 and 14 percentage points respectively below that of women without children. Bulgaria has launched a "long-term strategy for the child" (2008-18) based on mainstreaming and specific actions aimed at families and children.

[14] Please see footnote 12 below

Countries in Group C (HU, MT, RO, SK and the UK) need to address high levels both of in-work poverty and of children living in jobless households, notably by measures aiming at making work pay and at enhancing the labour market participation of parents especially lone parents and second earners (MT, SK). In the UK, despite the substantial progress recorded since the launch of the strategy in 1999, the government recognises that considerable challenges lie ahead before reaching the ambitious target of eradicating child poverty by 2020. Besides reinforcing the existing comprehensive set of measures, the UK is developing a strategy for the next decade in close cooperation with stakeholders. It includes the recent requirement for lone parents with older children and who are able to work to be available for paid work as a condition of receiving benefit. Future policy for lone parents with younger children involves an emphasis on work-related activity and skills development to move lone parents nearer to the labour market and prepare them for employment. However, measures to enhance further childcare provision overall (a Sure Start children's centre in every community, and every school in England to be an extended school by 2010) risk not meeting the challenge: if not fully realised the very high costs and provision mainly on a part time basis can still hamper the labour market participation of low-income parents (especially lone mothers). Hungary plans to reinforce further the set of comprehensive measures implemented between 2006 and 2008, by improving the targeting of universal family allowances (higher for low-income families) and by increasing childcare services provision, the level of which is currently very low. While reinforcing measures aimed at providing equal chances at school for all children, Slovakia will introduce a childcare allowance for working parents of children under three. However, no specific measure is announced to increase the low level of childcare provision. In Malta, the strategy focuses mainly on access to education and contains few specific measures to support families' income and encourage the labour market participation of second earners (the main cause of in-work poverty among families with children). Investments in childcare infrastructure launched in the previous plan need to be enhanced in support of the newly introduced childcare subsidy scheme. Romania puts emphasis on income support and measures supporting access to employment for parents (childcare, enabling social services).

Countries in group D (ES, EL, IT, LT, LV, LU, PL and PT) were those in which comprehensive strategies were most needed to address high levels of in-work poverty and (apart from LU) a relatively low effectiveness of social transfers. Italy, Greece, Lithuania, Latvia, Luxembourg, Poland, and Portugal had already identified child poverty as a key priority in the 2006-08 plans and started implementing a wide range of measures to significantly increase income support to families and facilitate the labour market participation of parents, especially of the second earner. In most of these countries, the measures taken will be further reinforced. Latvia, Lithuania, Poland and Portugal in particular have enhanced income support to families through a wide range of measures including enhancing the level and coverage of family benefits. These countries also put emphasis on developing in-kind benefits (free or subsidised lunches at school, free school books, free childcare for children) and services for families, especially in the area of housing (PT). From 2009, Italy will give priority to the implementation of the newly introduced "social card" system, which allows beneficiaries to buy essential goods such as food and utilities. Some countries enhance universal coverage by for instance extending the coverage of existing benefits further to all children (including those over 18 and still studying and living in the parental home). Latvia, Lithuania, Luxembourg Poland and Portugal also plan to enhance measures to make work pay for parents, and especially for lone parents (in-work benefits, tax credits, higher minimum wage, and childcare subsidies). Significant efforts to develop affordable childcare provision

are notable in Hungary, Italy, Lithuania, Luxembourg, Poland and Portugal in order to encourage the labour market participation of the second earner. Spain does not explicitly report on overall strategies targeted at children and families.

3.2.2. Mainstreaming child poverty

In addition to the emphasis put on child poverty in Member States' key priorities, greater attention is generally paid to children and families in the overall design of social inclusion policies, notably in the context of active inclusion policies (especially in ES, FR, LV).

In addition to the range of income support measures specifically targeted at families (see Joint Report 2008) some countries also highlight the important role played by general minimum wages and minimum income schemes in supporting families' income. Cyprus, Spain, Latvia, Lithuania, Austria, and Portugal in particular are planning to improve the level or design of minimum wages, and Latvia and Portugal have set targets for the planned increase. Latvia, Lithuania, Austria, Portugal and Spain have reinforced their minimum income schemes (ES: harmonisation of MI schemes across regions) and Romania will closely monitor the implementation of the MI scheme introduced in 2007. Austria announces the introduction of minimum income schemes in 2009. A number of countries (LT, ES, PL, UK) also introduced or reinforced tax credits and tax rebates for families with children, another way of supporting families' income without discouraging labour market participation.

Measures to reconcile work and family life are important tools to foster the labour market participation of parents without affecting children's well-being. This concerns both lone parents and second earners, since the one-earner family model is not sufficient any more to ward off the risk of poverty for children (see 2008 Joint Report).

The availability and affordability of quality childcare, especially for children under three, are still the weak points of most EU countries. In its report on progress towards the Barcelona targets[15], the Commission highlights the fact that parents in the EU face a shortage of childcare services[16]. In half of EU countries 20% or fewer children under three are cared for by formal arrangements, well below the Barcelona target of 33%. In several Member States (CZ, EL, HU, LT, MT, AT, PL, SK) this percentage drops below 10%.

Efforts to increase childcare provision are significant in some Member States (AT, DE, HU, IE, IT, LU, PL, PT) where governments have set ambitious targets for the increase (e.g. +100000 childcare places by 2015 in Ireland) and allocated the necessary budget. Other Member States (BE, EE, EL, IT, RO, SI) mention their plan to enhance childcare provision but it is not underpinned by concrete commitments. France and Slovenia have adopted or are planning laws likely to increase the demand for childcare services, and highlight the challenge of developing infrastructure at the local level. IT intends to focus its effort in regions where childcare provisions is especially low. Austria and Portugal also plan to extend opening hours of childcare facilities. Opening hours vary widely across EU countries and in a number of them a particularly high proportion of childcare facilities operate on a part-time basis only

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15 Report from the Commission on the implementation of the Barcelona objectives concerning childcare facilities for pre-school-age children {SEC(2008) 2524}

16 A Eurobarometer survey also says that more than 1.5 million women in the EU declare that they are forced not to work or to work less because of lack of childcare facilities

(e.g. NL, UK). The availability of childcare after school hours is addressed in different ways across countries, either through prolonging the school day or through specific provision at community level.

High fees continue to hamper access to childcare for low-income families in many countries (especially IE and the UK). In this respect several Member States (AT, EE, IE, LV, LU, SK, SI, SE) are planning measures to subsidize further childcare either for all families (e.g. free childcare for the second and all subsequent children of the same family (SI)) or for low-income families in particular.

The quality of childcare is key to ensure that it contributes to the development and well-being of the child and that it is not just seen as a way to facilitate parental employment and sustain families' income. Promoting quality of childcare involves measures to address staff shortages, the qualifications of personnel, quality standards for institutional care and personal services. Giving greater choice to parents by supporting a wide range of care arrangements (in institutions or at home, on demand, at flexible hours) in order to meet their real needs is another way of facilitating family life.

Some €2.4 billion, i.e. 3.2% of the total ESF budget, are aimed at measures designed to increase women's labour market participation and reconciliation of work and private life, such as facilitating access to childcare and care for dependent persons. In addition approximately € 550 million will be invested from the ERDF on childcare infrastructure.

3.2.3. Supporting children's development

All EU Member States have ratified the UN Convention on the Rights of the Child which calls for the best interests of the child to be taken into account in any action affecting children. Member States are therefore committed to provide the maximum extent of their available resources to safeguard the economic, social and cultural rights of children. A number of Member States place their action to support the development of all children in this context. Investing in education, healthcare and creating a favourable and safe environment (housing, parental counselling, etc.) are essential for the child to grow and develop its full potential. The importance of early intervention continues to be very strongly emphasised by the Member States. In particular, there is a clear recognition that pre-schooling can help compensate for socio-economic disadvantage and enhance the future learning capacities of children. It plays a particular role for children with a migrant or ethnic minority background. The prevention of early school leaving is also essential for the well-being of these children and for the full participation in society of the adults they are about to become. Member States efforts to promote early schooling and access to education and measures to prevent early school drop-out are assessed in Section 3.5.5 of this report.

An increasing number of Member States emphasise the need to support families in their parenting role (BG, DK, EE, IE, IT, FR, LV, LU, AT, FI). Counselling for parents is designed as preventive tool and as a means to strengthen parental responsibility. These measures may be addressed to all parents and are provided through the school system or family services infrastructure. They often target families at risk such as families with a migrant background or teen parents (IE), and families in crisis (BG, LU, AT).

Poor housing conditions are likely to hamper children's well-being by affecting their health, their ability to do well at school and to build social ties. According to EU-SILC data, in two-thirds of EU countries child deprivation rates in the housing dimension are higher than for the overall population. Specific housing policy measures for families include priority in accessing social housing for lone parents and large families (most Member States), greater provision of housing accessible to low-income families (IT), increased housing benefits for large families, specific attention to the needs of families in the training of architects, urban planners and other specialists (EE), or mortgage loan guarantees issued for purchase or construction of housing for families with children (LV). See also Section 3.5.2 on housing.

Children born into low-income families are more likely to experience unhealthy lifestyles, and poorer access to health services. A number of Member States have launched innovative initiatives to increase access to health services for young children and their families. They include preventive care such as prenatal and health care for young children, antenatal services for vulnerable pregnant mothers, regular check-ups of children and free maternity and child clinics. Health consultants in schools provide health services (vaccination, dental care, advice on mental health, etc) and information on substance misuse, sexual education and healthy eating habits. Barriers such as the imbalance in professional expertise between regions and additional costs of access need to be overcome to ensure fair access to health services. See also Section 3.5.3 on access to healthcare for the most vulnerable, and Section 5.3. on healthcare in general.

3.2.4. Reaching the most vulnerable children

In the design of their strategies to support children, Member States recognise the need to combine a universal approach for children's well-being with a more targeted approach for children in vulnerable situations.

Despite the increased emphasis on prevention, a number of children in all European countries are still deprived of parental care; being orphaned, victims of violence and abuse, or for economic reasons (e.g. families in financial distress who lose their homes). Most Member States are striving to avoid the institutionalisation of these children and to promote foster care arrangements. Belgium, Bulgaria, the Czech Republic, Estonia, Italy, Hungary, Poland and Portugal set up measures to improve the status of foster families, and to provide them with financial support or specific training and to improve monitoring systems. In most countries, measures are also being taken to raise the standards and quality of institutional care.

NGOs and MEPs from the Baltic States, Poland, Bulgaria and Romania have highlighted the situation of children who are left without parental care after their parents have moved to work abroad. Lithuania reports on specific measures to address this issue.

Cyprus also mentions the specific situation of unaccompanied foreign children who are placed under the protection of the Ministry of Social Affairs.

Measures to support disabled children and their families include supplementary financial support (EE, BG, LV), access to mainstream schools through adapted infrastructure and dedicated staff or additional support staff (LV, AT, BG), and specific social services (transport, housing, etc). The Czech Republic, Estonia, Latvia and Austria have adopted

comprehensive sets of measures and focus on early detection and intervention to improve the situation of disabled children and their families.

3.2.5. Other children at risk

Children and families with a migrant or ethnic minority background receive specific attention in several NAPs (CZ, DK, ES, FR, LU). In Austria and Denmark, efforts are made to better integrate children in schools (including by involving the parents better in school activities) and by providing them with specific training (language). In France, newly arrived families receive specific information on the rights and responsibilities of parents as part of the recently introduced integration contract.[17]

Bulgaria, Cyprus, Hungary, Lithuania report on specific new measures to address the situation of child victims of violence and abuse, including help phone or internet lines, awareness raising campaigns and special training of staff from social services and schools in contact with the children at risk.

A number of NAPs (BG, CZ, EL, ES, IT, HU, LV, PT, RO and SI) refer to measures taken to improve access to education for Roma children. However, due to a lack of reliable data, most NSRs do not present a comprehensive assessment of what would be needed to boost pre-school / primary / secondary education participation of Roma children. Where reasonably reliable data do exist, they show that Roma children continue to face educational disadvantage. In Spain, several studies have been carried out which show that, although much progress has been achieved over the last two decades, 71% of Roma people aged 16 and over have not completed primary education, and only 1.3% have further education. Virtually all Roma children go to school at the compulsory age, and a large part stays through the primary school cycle. However, there are major difficulties in getting the young Roma population to enrol and remain in secondary and further education, particularly Roma girls. Around 80% of Roma students drop out before the end of the last year of secondary school. The illiteracy rate among the Roma can be as high as 13%, compared with 2.3% for the Spanish population as a whole. In Romania, only 2% of young Roma adults (18–30 years old) have completed higher education, compared to 27% of young non-Roma adults. In Slovakia, one-third of Roma aged 25 years or over did not complete primary school, another third stopped after completing the primary school cycle, and only 15% reached secondary school or higher education.

Ireland is expanding the Back to Education Initiative to the Senior Traveller Training Programmes. In Romania and in the Czech Republic, school mediators are attempting to improve the graduation rate of Roma children, as well as increase the rate of school enrolment. Hungary has a long-standing desegregation program under way and, more recently, Bulgaria reports on targets of desegregation of education.

[17] Please see footnote 12 below

3.2.6. Monitoring arrangements

It is too early to assess whether Member States have taken significant steps to act upon the recommendations adopted by the SPC in January 2008 for better monitoring and assessment of child poverty and well-being[18]. However, examples of new initiatives are worth mentioning. Estonia has identified indicators for the monitoring of each priority objectives on the basis of the EU agreed indicators, supplemented by national indicators; and for each objective appropriate arrangements are planned for monitoring the actions and assessing their impact on achieving the objective. As part of a general effort to strengthen the monitoring of the welfare system, Denmark has launched research to evaluate initiatives to help the most vulnerable children (not well covered by standard monitoring tools).

Growing Up in Ireland: The National Longitudinal Study of Children in Ireland (NLSCI) is the most significant study of its kind to be undertaken in the Republic. 10,000 infants aged 9 months and 8,000 children aged nine will be recruited to participate in this study and the initial contract, spanning almost seven years, will facilitate two major data collection sweeps for both cohorts.

3.3. Addressing the needs of other groups at particular risk of exclusion

3.3.1. Inclusion of the Roma in society and the labour market

Roma throughout Europe tend to face multiple disadvantages which often result in extreme social exclusion and severe and persistent poverty, though there is a gaping lack of clear data on the degrees of that poverty. Accordingly, the new NAPs give increased coverage to the situation faced by the Roma. In Portugal, the High Commission for Immigration and Intercultural Dialogue has created an Office to Support Roma Communities' promotion of their social inclusion. Greece has given the issue increased attention. In Hungary beside active labour market policy measures, special assistance was provided in cases of discrimination. In Spain, the Roma Development Programme in place since 1989, which finances projects, and managed by regional and local governments and non-profit organisations working in favour of the Roma population, can be mentioned. But the NAPs of countries with significant recent influx of Roma do not give details of planned action to promote their inclusion.

A number of steps have recently been taken to enhance knowledge. In Spain, numerous regional studies were carried out, aiming at a better understanding of the Roma's social situation, like the "Health and Roma community", promoted by the Ministry of Health and Comsumer Affairs, or the Map on Housing and the Roma Community, sponsored by the Ministry of Housing in 2007. In Romania, data on Roma remain scarce but some qualitative and quantitative analysis was made of Roma communities and questionnaires were sent to local public authorities. The Czech Republic undertook an analysis of socially segregated Roma localities which showed that the number of such neighbourhoods has grown dramatically over the last decade. In Slovakia, the UNDP *Report on the Living Conditions of Roma Households* stresses the need for regular evaluation of the social situation of the Roma. Virtually no data are presented in the NAPs on the involvement of Roma in adult education and lifelong learning or vocational training programmes.

[18] [Link to website]

As to the health situation of Roma people, data provided in the Romanian NSR reported 8 to 10 years lower life expectancy and a higher incidence of contagious-infectious diseases and HIV, deficient infant vaccination and poor diet and nutrition, mainly among children. In Spain, alongside the activities of the Spanish National Strategy on Equal Healthcare aimed at the Roma population (advice, training, a "Guide on assisting the Roma Community in Healthcare Services), the first National Health Survey on the Roma was also conducted to gain knowledge of their health status, lifestyles and inequalities in healthcare access. Moreover, the health of the Roma community is being mainstreamed in relevant policies. Ireland and UK report on the All-Ireland Traveller Health Study which will include a census and an assessment of health status, mortality rates, and impact of health services currently provided.

Segregation remains one main obstacle to Roma inclusion, but no general conclusions can be drawn from the figures on de/segregation presented by several Member States.A comprehensive approach to desegregation is presented in the Hungarian *Strategic Plan for the Decade for Roma Integration* and its related action plan for 2008-2009, specifying tasks, deadlines, resources and comprehensive monitoring. In Hungary, drawing up and implementing an anti-segregation plan is a precondition for obtaining urban rehabilitation development resources. An anti-segregation network was established by the Ministry responsible.

In Spain several programmes, such as the ACCEDER Programme for training and access to employment aimed to Roma population and financed by the European Structural Funds, promote the employability of and jobs for the Roma. In the Czech Republic, the Agency for social inclusion in socially excluded Roma localities will implement a pilot programme in 12 localities. Hungary points to various forms of subsidised temporary employment organised at local level. Romania and Bulgaria report on specialised job fairs helping the Roma enter the labour market. However, policies presented in most NAPs stay within the limit of pilot actions or have a narrow, workfare type perspective. Member States with a significant Roma population should increasingly consider the important untapped potential which this category of citizens constitutes in view of labour force shortages and invest accordingly in education and training, including preparation for (and support of) legitimate forms of self-employment.

The 2008 NAPs are more detailed than previously on the discrimination that Roma are facing and measures taken. In Spain, the Council responsible for non-discrimination on grounds of race or ethnic origin will promote equal treatment in the areas of education, health, benefits, social services, housing, access to goods and services, as well as to employment, self-employment and to professional practice, affiliation and participation in trade union and employers' organisations, working conditions, professional promotion, vocational training and on-going training. Hungary's *Roma Anti-Discrimination Customer Service Network* which provides complainants with legal advice is extending its network. In the Czech Republic, educational seminars were held for 900 police officers in all regions on the right to equal treatment and legal aspects of social exclusion. Italy raises governance aspects, through the improvement of social inclusion and anti-discrimination policies. However, no progress is reported from Romania on the problems in getting ID papers or from Romania and Bulgaria on registering in municipalities.

3.3.2. Inclusion of migrants

In general, important gaps persist between immigrants and the majority population as regards poverty, income, health, employment, unemployment, education and early school-leaving. The new NAPs largely confirm the issue as a major shared priority with ten Member States making it one of their key objectives. Some of them take a comprehensive approach to the various dimensions of social inclusion (participation in the labour market and access to housing but also in social, cultural and political life) and focus on involving both immigrants and the host society[19]. Still, the non-prioritisation of the issue and absence of details in most NAPs comes across as a potentially serious omission.

Implementation of the Regulation on Community Statistics on migration and international protection[20] will help ensure reliable international migration statistics. Nonetheless, the lack of data on the variety of profiles of immigrants, ethnic minorities, asylum seekers and refugees remains a problem. Most often there is not distinction made between first and second generations of migrants and long-established ethnic minorities. Breaking down social indicators by ethnic groups or by country of origin would help to document varying degrees of social inclusion and of vulnerability, target the specific, distinct needs of each group and assess the impact of policies on them. At present the Member States, with very few exceptions (CY, NL), provide no such information in their NAPs, nor on whether and how they distinguish the beneficiaries of their social inclusion policies from this point of view.

Notwithstanding this lack of precise data, social inclusion measures targeted at migrants and ethnic minorities often aim to remove the barriers blocking effective access to social and health services, e.g. by developing the intercultural competences of service providers and through information campaigns; targeted support for children and their parents through the education system; or provision of social services accompanied by language and civic courses, often targeted at women.

Here are some examples from the NAPs of holistic policy measures to achieve the social inclusion of migrants:[21] Ireland focuses on three interlinked policy priorities: integration, educational supports and follow-up action arising from the 2005-2008 National Action plan against racism. In Spain, the 2007-2010 Strategic Plan for citizenship and integration provides the framework for promoting, inter alia, the social inclusion of migrants into Spanish society, while the regionally-managed Fund for the reception and integration of migrants and educational support is the main financial instrument used for this purpose. The strategy developed in Denmark provides that both refugees and citizens of migrant background must have access to the necessary resources and welfare services while making active efforts to

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19 he Third Commission Annual Report on Migration and Integration, (COM(2007) 512 final) elaborated a summary report on integration policies and an annex describing the developments in the EU-27 in this field. The Commission Staff Working Document 'Strengthening actions and tools to meet integration challenges' reports on what has been done on participation and citizenship, as far as measures targeting the host society are concerned and how integration policies have helped prevent social alienation

20 Regulation (EC) No 862/2007, adopted by the Council and the European Parliament on 11 July 2007

21 For a complete account of relevant activities in Member States beyond those that Member States choose to highlight in their NAPs-inclusion, see the Third Annual Report on Migration and Integration . The European Integration Fund supports a range of measures relevant in this regard). .Best practices are described in the Handbook on Integration for policy makers and practitioners the next edition of which will be published in 2009. when the European Integration Web Site will also be in operation, as the one stop shop on integration, collecting relevant information and best practices from all stakeholders

enter the labour market and become included in the Danish society. Austria for its part adopts a mainstreaming approach for the social inclusion of migrants in its policy priorities, together with more specific measures for refugees and asylum seekers. In the Netherlands the two main points of the policy are social emancipation and social integration especially for newcomers with a strong emphasis on participation which may take various forms such as voluntary work without neglecting other aspects. Germany highlights the relevance of its National Integration Plan also from a holistic social inclusion perspective.

Increasing efforts are discernible to create synergies between social inclusion policies and anti-discrimination measures. France, for example, relates its actions in favour of migrants or people with a migrant background to its policies on non-discrimination particularly as regards access to employment for women, social and professional integration of youth and access to decent housing for the Gens de voyage. The UK uses the framework of the Equality Public Service Agreement for developing its policies in respect of race, ethnic minority employment and 'Gypsies, Roma and Travellers'. Malta is developing its policy for ensuring the social inclusion of non-EU nationals as part of its priority to promote equal opportunities, with a specific focus on asylum seekers, refugees and irregular immigrants. Luxemburg adopts a similar approach, mainly through a suite on legislation on immigration policy.

Within the ESF, specific action to increase migrants' labour market participation will account for some € 1.17 billion (1.5% of total ESF budget).

3.3.3. Inclusion of disabled people in society and the labour market

With an estimated 50 million European citizens or more having some form of disability[22], the inclusion of disabled people is frequently mentioned in the 2008-2010 NSRs. For Estonia and Austria, it is among their key priorities. Measures in favour of labour market integration are strongly emphasised in the 2008-2010 NSRs, but less emphasis is placed on structural accessibility measures. Economic inactivity is commonly seen as underlying disabled people's poverty, yet quantitative evidence is scarce.

For a number of Member States, an effective policy to promote inclusion of disabled people implies a mix of *mainstreaming policy* **(**e.g. SE, SI, LV, LT, EE, MT, BG and IE), combined with *targeted measures* where needed (e.g. DE, FI, SE, IR, AT, BE, EE, ES, IE, CY, LT, LV, HU, SI, SK, SE, BG and UK), as well as enhanced access to needed *resources,* (e.g. BE AT, EE, IS, LV, HU and UK) *and,* for the bulk of Member States, *quality services*.

The reports contain evidence of alignment and compliance with Directive 2000/78, the Disability Action Plan and to some extent with the UN Convention, but only a few Member States make systematic reference to these policy documents. More attention could be paid to mainstreaming disability in policies.

The aim to tackle the use of disability benefits as an early exit route out of the labour market is addressed by virtually all countries, some of which address it as a major policy priority (e.g. LU, RO, UK, MT, HU, NL and SI)[23]. Inadequate accessibility in society limits the opportunities and choices of people with consequently lower education levels and lower labour market participation among disabled people. Nevertheless, some Member States (AT, SI, UK, DE, LT and CZ) report slight improvements in labour market participation among

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22 LFS ad hoc module on disability 2002 combined with the Eurostat population estimate for 2008.

23 On this issue, see also section 4.2.3.6, Restricting access to disability schemes

disabled people**.** and the Netherlands even reports a sharp decline in the number of benefit recipients. Several reports make a link between increased labour market participation through active labour market policy and targeted measures and the need to expand and strengthen the workforce. Ireland emphasises that the main objective is to promote equal opportunities for people with disabilities in the open labour market, by means of enhanced vocational training, employment programmes and further development of support.

Several NAPs treat the removal of barriers to education and lifelong learning as key to increase labour market participation among disabled people, as well as to enhance active participation in society and overall quality of life (e.g. DE, SK, UK, HU, SI, AT, CZ, LU, EE, ES, IE, CY, LT, and LV). However, disabled people's labour market skills are addressed by Member States more often in terms of special vocational rehabilitation programmes than by tackling access to lifelong learning in mainstream programmes.

Social enterprises are highlighted by Lithuania, Latvia, UK, Romania, Bulgaria and Slovakia, wage subsidies by Austria, Estonia, Lithuania, Sweden and the Netherlands**,** flexible work schemes by Spain, Cyprus and Denmark**,** job coaching services by Austria and Malta and mentor schemes for mentally ill people by Denmark. In Sweden wage subsidies will be extended by more than 2,000 places in 2008. In the UK**,** workability assessment measures are enforced and combined with tailored empowerment and skill support to promote labour market participation. In France**,** an action plan facilitating labour market access for disabled people was launched in June 2008. Only rare references are made to barriers to employment, wider structural investment and legal protection.

Synergies between different strands of social inclusion could be shown more clearly, particularly with regard to employment activation policies and policies for accessible education, transport, housing, information technologies and personal assistance. Accessibility to goods, services and infrastructure is a key feature of the EU Disability Action Plan, but is not frequently mentioned in NSRs. However, accessibility to buildings and transport is frequently cited (EE, MT, LT, CY, IE, LU, SI, SK, SE, UK, BG and AT). Lithuania acknowledges the general link between inclusion and mobility, and Slovakia and Austria propose specific responses. Estonia highlights Universal design and Hungary wants to eliminate discrimination and obstacles to employment by making public institutions physically accessible**.**

As to independent living, Germany and the UK have introduced personal budgets, Cyprus and Hungary focus on improvement of services, Ireland and Estonia highlight case management, and Austria and Slovenia a personal assistant supplement. Some Member States are looking at benefits to compensate costs related to disabilities in general, and for disabled children and their families in particular (e.g. EE, LV, SI, HU, BG and SK). The UK, Romania and Ireland seem to have construed income schemes as a matter of human rights.

There is a trend from centralisation to de-institutionalisation and service provision closer to the citizen. Many Member States (CZ, BG and RO) are making efforts towards de-institutionalisation of care for people with disabilities and to develop more community-based services. However, progress tends to be slow, and it seems important to strengthen the financial resources allocated to support this process. Structural Funds are sometimes used to help revamp the crumbling system of residential institutions, and it should be looked at how this can be prioritised and strengthened in coming years. Re-organisation and development of rehabilitation services seem to be at the forefront in several Member States. In Sweden**,** a rehabilitation guarantee has been introduced, aimed at facilitating participation in the labour

market, and in the UK**,** a "One-touch service" has been introduced to simplify access to services.

Several Member States focus on measures to promote mental health and well-being (e.g. MT, SI, SE, AT, BE, DK, FR, CY, IE, LT and LV). Some Member States recognise mental health problems as one of the main reasons for exclusion from the labour market and society, closely linked to and re-enforcing substance abuse and homelessness. Accordingly, measures to combat mental health problems are included on the agenda, aiming to enable people to live active and dignified lives, and recognised as underpinning well-being, social cohesion and economic growth in society. In Finland**,** mental health problems and prevention are targeted in both the entire population and groups at risk, including in the work place. In Slovenia**,** day care places are increased for mentally and physically disabled people.

Sweden is implementing major initiatives to promote mental health. Psychiatric care is a priority for the Government, with SEK500 million allocated in 2007 and 2008. The aim is to raise skills levels for personnel in psychiatric care and social services dealing with people with mental disabilities, and to improve access to psychiatric care for children and adolescents. A development centre for children's mental health has been set up with the aim of increasing knowledge of preventive measures, early detection and early support.

Several Member States highlight a need to *develop more knowledge-based policy* (e.g. DK, EE, LV, MT, HU, RO, SI, SE, UK, IE and AT), using indicators, targets, monitoring and evaluation. Good examples of target setting are available from Ireland. Looking at *governance,* some Member States (SE, EE, MT, FR, HU, SK, UK, AT, BE, IE, CY and LV) are improving the participation of people with disability in policy-making processes.

3.3.4. Inclusion of young people in society and the labour market

Many NAPs focus on strategies aimed at young people, given that some sub-groups, such as early school leavers and lone parents, are particularly at risk of poverty. Young people are a priority in Finland, where a cross-administrative programme on children, young people and families was launched for 2007-2011. The social inclusion of young people is also a priority for the UK, with substantial funding.

In France, measures are taken in the areas of non-formal education, social inclusion, counselling, housing, health and policy governance. Germany is developing strategies to overcome child poverty, early school leaving and youth unemployment. Measures in Spain and Estonia focus on entrepreneurship, validation of non-formal learning and identification of new job opportunities, even if a global strategic approach is not always detectable. Cyprus is planning measures to enhance youth entrepreneurship and prevent juvenile delinquency. In Romania**,** several plans target young people - the National Programme for the employment of socially excluded people, programmes for homeless children and young people, measures to increase the quality of life for young families, as well as health prevention programmes. Sweden is set to better include young people in the national fund programme for competitiveness and employment. Measures in Luxembourg include the "voluntary vocational orientation" and protective and preventative measures in the field of youth health care. Malta put forward a number of measures aimed at consolidating the personal development of children and young people (through education, training and employment initiatives), enhancing their well-being (through improved housing and quality of services), and safeguarding their rights and responsibilities (through more awareness and a more effective juvenile justice system).

3.3.5. Inclusion of older people in society and the labour market

Older people, especially elderly women and the very old, on average face a greater risk of poverty than the overall population in EU-27 (19% as against 16% in 2006; in BE, EE, EL, PT, IE, UK, LV, ES, MT, FI, CY older people still face a poverty rate of 25% or more). The NAPs pay increasing attention to older people. Some Member States even make the issue as one of their priority objectives (EE, EL, LU, PT, ES and SE) or as a cross-cutting issue (e.g. AT, LT). Most NSRs focus on active ageing policies with the aim to increase the length of working lives, raise the employment rate of older people, and maintain and promote their capacity for work. Alongside this, the increasing need of accessible quality services was also emphasised to promote better coping by the elderly and longer independent living. Moreover, the NAPs highlight the need to ensure sufficient income for elderly people and improve pension adequacy. See also Chapter 4 on pensions, and more specifically Section 4.2.3.7.

3.3.6. Rural poverty and deprived urban areas

Rural poverty tends to receive less attention than poverty in urban areas. E.g. in Romania, with at-risk-of-poverty in rural areas three times higher than in urban areas, the NAP is not very specific on how to foster social inclusion in rural areas. Addressing rural disadvantages figures are comparatively prominent only in the reports from Hungary. On the one hand the programme ‘For a more liveable village’ will provide opportunities for the 600 most disadvantaged settlements to catch up through programmes of employment creation, community development, environment protection and culture, while on the other hand the programme ‘No one left behind’ aims at catching-up by the 33 most disadvantages micro-regions of the country through the coordinated application of EU resources. Each micro-region will draw up their development plan and will then implement infrastructure, employment, social and community development programmes in a coordinated way (About 10% of the population live in these 33 micro-regions with a significant proportion of Roma people). Ireland reports on measures for improved access to services in disadvantaged areas (transport, rural enterprise, rural tourism, recreation, sustainable housing and broadband access), and Lithuania on coordination between measures related to labour market, social policy, education, rural development, business support and infrastructure development to stimulate the development of rural areas. The UK is improving access to employment and skills services (Jobcentre Plus) through innovative outreach strategies including the installation of 'jobpoints' in libraries, partnering in local authority outlets and mobile services.

Some NAPs address the problem of disadvantaged urban areas and refer to specific regeneration programmes that tackle housing, social and economic problems in an integrated, bottom-up and participative way. The Czech Republic stresses its regional and local NAPs and a community approach for the integrated planning and provision of social services. Germany highlights the Soziale Stadt programme supporting 500 urban micro-regions complemented by ESF support to employment and training measures. In Denmark's “Our Collective Responsibility II” programme satellite offices are established in deprived areas for easy access to support from public authorities. In France urban renovation is a key priority that must reach the most disadvantaged residents and 'Mixité sociale' insists on facilitating equal access to housing for people facing multiple economic and social problems. The UK City Strategy tests an area-based partnership approach to tackling worklessness in the most disadvantaged communities. In Poland a pilot social revitalisation programme will be implemented in rural and urban local communities in the period of 2008-2010. Nonetheless,

the specific urban problems or the more complex deprivation issues that are present in cities could be more adequately reflected in the NAPs[24].

Among those countries with the highest regional dispersion of the regional employment rates (IT, HU, SK, ES and FR), only HU expresses concerns about its regional cohesion. But other NAPs (CZ, DE, FR, IE, LT, LV, PT, UK) refer to territorial challenges and report efforts to improve social services in rural areas and/or to promote access to employment and targeted services in a disadvantaged urban environment[25].

3.3.7. Use of ESF to support inclusion of excluded groups

Member States apply different approaches and focus on various target groups in their Operational Programmes, in line with those identified in the NSRs. Nonetheless, actions to promote social inclusion are an essential part of ESF interventions in all Member States and are generally programmed as a separate priority within the programmes. For the 2007-2013 period, Member States have allocated more than €10 billion, representing some 13.1% of the total ESF funding available to promote social inclusion of disadvantaged groups.

3.4. Active inclusion – bringing the most excluded back into society and the labour market

Despite developments since the 2006-08 NAPs, persistent rates of poverty, long-term unemployment and inactivity show that much still needs to be done. Access to quality employment is a sustainable way out of poverty and social exclusion. There is a need to design and implement integrated and comprehensive active inclusion strategies, and ensure social protection systems able to mobilise people capable of working, while providing resources that can make it possible to live in dignity, together with support for social participation, for those who cannot.

Although most Member States refer to "active inclusion" in their NAP, they tend to treat the issue mainly as a means to integrate people into the labour market. A few Member States construe "active inclusion" as a holistic strategy that combines adequate income support, inclusive labour markets, and access to quality services.

Bulgaria and Malta made active inclusion a priority objective for 2008-2010, while a few other Member States reported priority objectives that simultaneously include reference to all three elements of the comprehensive active inclusion policy (LV, SI, ES, FR). Other Member States selecting active inclusion refer to all three pillars with varying degrees of coordination (AT, BE, BG, LV, NL, SI, ES, PL, PT, DK, FI, IE and MT).

3.4.1. Adequate income support

Adequate income support is an important element of active inclusion policies given that for those excluded from the labour market minimum income schemes can be the only way to escape extreme poverty; yet, the NAPs give limited attention to the issue. A balanced active inclusion policy provides minimum resources at a sufficient level, with appropriate work incentives to encourage job search and labour market (re)integration.

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[24] See "EUROCITIES analysis of National Action Plans on social inclusion 2008-2010" (http://www.eurocities.eu)

[25] See also Chapter 5 on healthcare, and more specifically section 5.2.6

Some Member States did in fact outline policies to better link social assistance benefits to labour market (re)integration and social support. In France, the "Revenu de solidarité active" (RSA), already mentioned in 3.2.1., is designed to create a bridge between out-of-work benefit and in-work financial support, to improve incentives to (re-)enter the labour market and fight in-work poverty. This is combined with personalised employment and social support programmes. In Spain, the "Active Income for Insertion" (RAI) aims to make it easier for unemployed workers with special economic needs and difficulty in finding work to return to the labour market, by combining income support with active labour market policies. In Portugal, the Social Integration Income (MTSS) has been combined with programmes aimed at the social and professional integration of beneficiaries. Austria reported on the introduction of the means-tested guaranteed minimum income. In Germany the previous separate approaches to assistance for the integration were brought together by combining social assistance for employable people with unemployment assistance as basic social security benefits for jobseekers (ALG II). Following the "rights and duties" approach, benefit recipients are required to actively participate in schemes designed to integrate them into working life and to do all in their power to reduce or end their reliance on benefits.

Cyprus reported on amendments to the revised Public Assistance and Services Law that financially support public assistance recipients, especially for persons with disabilities and lone parents, and encourage their integration into the labour market. Bulgaria emphasised adequate guaranteed minimum income for people in need while maintaining incentives for labour market participation.

Other Member States also reported on further plans to modernise or reform the current system. The Czech Republic pointed out that a new conception of the living minimum, a subsistence minimum and fundamental change in terms of benefits (assistance in material need) was introduced in 2007. Luxembourg is planning to complement its guaranteed minimum income scheme, an important moderating factor in poverty risk since 1986, through adoption of a law on the modernisation of social assistance at local level. Romania emphasised that the major challenge lies in the permanent endeavours to redistribute resources to specific categories of beneficiaries, and develop an assessment and monitoring system to measure the efficiency of granting assistance. Finland reports that the minimum and last-resort benefits will be retained at a level that safeguards a reasonable quality of life. Latvia is about increasing the guaranteed minimum income for needy families and persons, while Slovenia will review minimum income schemes to assess their adequacy. Belgium plans to maintain a certain level of purchasing power by raising minimum benefits and awarding decent minimum incomes.

The Netherlands encourages the use of income support and aims to reduce non-take-up of support schemes. It aims to achieve this by informing people about their opportunities, by the active poverty policy of municipalities and by simplifying the application procedure.

3.4.2. Inclusive labour markets

Member States reported on a wide range of measures aimed at promoting inclusive labour markets in the areas of a) education, training and lifelong learning, b) active labour market policies, c) financial incentives, d) non-financial incentives and e) demand side initiatives.

Expanding and Improving Investment in Human Capital

As highlighted above, Member States are giving increased attention to inclusive education possibilities for children and young people in a bid to improve their future opportunities and reduce the number of early-school leavers and drop-outs (e.g. AT, BE, BG, DE, DK, HU, LU). Most Member States are introducing more possibilities for young people with regard to training and apprenticeship programmes in the transition from school to work (e.g. AT, BG, CZ, DE, DK, EL, IE, ES). Alongside the previous measures, some Member States put emphasis on the need to improve cooperation between employers and educational and training institutions (DE, NL, RO).

Almost all Member States underline the need to ensure access to lifelong learning in order to secure sustainable employment and longer working lives, and also the need for a system of occupational certification and of skills accreditation and recognition (e.g. EL, ES, PL).

Member States' education and training policies often address the specific needs of disadvantaged groups, including older workers (AT, CZ, DE, EE, IE, PL, SE), disabled workers (AT, CY, DE, FI, EE, IE, UK), migrants, ethnic minorities and refugees (AT, BE, BG, CY, CZ, DE, EL, IE, LU, MT, NL, PT, SK, SL, SE, many of them offering language courses), persons with low educational levels (AT, BG, DK, HU, MT, SK) and inactive people (EE, MT, NL). However, only a few Member States reported the adoption of measures to strengthen in-work and on-the-job training possibilities or IT skills (e.g. DK, MT).

Active and Preventive Labour Market Measures

In most Member States, reforms of the Public Employment Services centre on functional restructuring, decentralisation and strengthened cooperation between local authorities, private actors, non-governmental organisations and employers. They also aim to develop personalised approaches to support job search, notably including services for specific target groups (AT: "occupational diagnostics"; CY: individualised counselling guidance, DK: "mentor schemes", "marginalised-people team" in local authorities, "satellite offices" to offer personalised help to disadvantaged people, EL: customised intervention, EE: individual action plans, case management, IE: new active case management; UK: Jobcentre Plus to help disabled people to get into paid work and to get on at work, partnership approach FI; MT: Social Inclusion Partnership Programme; SK, ES).

As part of the reforms, Member States are improving and adopting more efficient counselling services (e.g. AT: early intervention; IE: early engagement ; FI and MT: online employment services; FR: reinforced mentoring, including for job retention), and more comprehensive ones (DK: Job Plan, EL, EE, SK: Local social inclusion partnership, ES, UK: Jobcentre Plus, Flexible New Deal), but also more targeted job counselling activities (HU: Start Programmes; SE: New start jobs, Job guarantee for young people, UK: Work Related Activity Group). However, just a few report on measures to extend the programmes beyond the unemployed to include inactive people (e.g. EE, BG, HU, MT) and on schemes to raise awareness of career choices, programmes and other services (EE).

Financial Incentives to Work

Active inclusion policies need to ensure a balanced interaction between tax and benefits, both providing adequate work incentives and making work pay. In many Member States entitlement to benefits has been made conditional on active job search, availability for work

or participation in training (CZ, BE, BG, DE, EE, ES). Hungary mentioned that, as from 2009, those who are capable of working and receive regular social allowance will increasingly be required to participate in public employment and to cooperate with employment centres.

All NAPs indicate that Member States are implementing or planning reforms of their tax and social benefit systems. (AT: reduction of unemployment insurance contribution, and in some cases non-payment of this contribution by low income earners, increase of unemployment insurance benefits for the long-term unemployed, coverage of more people by unemployment insurance and occupational retirement schemes; BE: increase tax-exempt income, tax-exempt quota, limit tax scales; CZ: decreasing the overall tax burden; FI: revision of the dual income tax system; FR: the RSA – see 3.4.1; LU: transforming employees', pensioners' and single parents' tax allowances into tax credits, 9% adjustment to income tax scales in 2009; SI: gradual abolition of payroll tax; UK: greater support through tax credits system, such as the "Better off in Work Credit" programme to ensure that work pays, and for lone parents the national roll out of In-Work Credit, In-Work Advisory Support and In-Work Emergency Discretion Fund).

In the same spirit some Member States introduced measures to make it possible to work and receive benefits at the same time. The Netherlands introduced a statutory scheme for working while retaining benefits; Latvia implemented a new regulation in 2007 entitling employed persons who take care of a child aged up to one year to work and receive the full childcare benefit. Member States also report initiatives to introduce and *increase the minimum wage* (AT, BE, CY, LV, ES, UK) as a tool, for instance, to supporting women in seeking employment and working, and narrowing the gender pay gap.

Non Financial Incentives to Work

In order to get people into *quality and sustainable work* and avoid poverty and social exclusion, effective active inclusion policies should address *other social factors that can also represent obstacles to labour market participation*, e.g. offering solutions for those who cannot become economically active or increase work intensity due to inadequate care facilities for children, for older persons and persons with disabilities or due to health-related issues. Helping people to obtain or retain quality jobs, also entails promoting *supportive, healthy and non-discriminative working environments.* Despite this, just a few Member States mention measures that would offer job retention and progression and the reduction of in-work poverty (EE, UK, IE).

One of the main issues addressed by Member State is support for *reconciling work and family life*, offering family-friendly measures and workplaces (e.g. with flexible working hours and flexible forms of work) better and more comprehensive *childcare facilities* with a special emphasis on expanding women's opportunities to enter the labour market (AT: increasing capacity of childcare, enhancing day-school services; BE, BG; CY: services for the care of children, elderly, disabled, other dependents; DE: extension of care availability, modular parental leave; DK: public day-care facilities; EL: parental and other leaves, combining work with motherhood; EE: right to use paid leaves (maternity leave, parental leave) and additional childcare leave without pay, development of flexible and accessible childcare; HU: Sure Start programmes; IE: additional childcare places and provision for care of older family members and those with disabilities; LU: more childcare centres, quality care and affordable prices with flexible opening hours, increase in number of parental assistants, LT, MT, PL, PT: increase parental leave and childcare facilities; RO, SK, ES, UK: New Deal for Lone Parents, Sure Start Children’s Centres).

A few Member States also put emphasis on the importance of the *health and well-being* of the workforce (AT, DK, EE, FI: also paying attention to age management and mental health at work, SE), and on measures to *reduce sick leave and increase return to work* (AT, DK, SE).

Supporting the Demand Side

An integrated and comprehensive approach should also focus on the *demand side of the labour market*, including financial incentives for employers to recruit, developing new sources of jobs and providing support for the social economy and sheltered employment (see subsection below).

One issue mentioned below by the National Strategic Reports concerned *financial incentives for employers to hire disadvantaged people through subsidised employment*. (AT: subsidised employment for different vulnerable groups, increased financial aid to enterprises by granting pay subsidies and subsidies for safeguarding jobs, "Action 500" and "Disability Flexicurity"; BE: employment bonus; CY; DE: employment subsidy for recruiting long-term and older long-term unemployed and younger workers, 50 plus Initiative; EE and IT: subsidised employment for disabled people; HU: employment policy programmes based on reduced contributions for employers employing disadvantaged employees (START programmes), LT: subsidy-based employment for people aged over 50, pregnant women, mothers, fathers, foster parents; NL: temporary wage cost subsidy to employers when they employ people in a step-up job, micro-credits for entrepreneurs starting up; PT; PL: suspending contributions to the Labour Fund and Guaranteed Employee Benefit Fund pertaining to employers employing persons returning from maternity or childcare leave; RO: employers' subsidies for lone parents and people aged 45 or more, and those who are 3 years away from reaching the legal retirement age; SI: for long-term unemployed beneficiaries; SE: subsidised employment through step-in jobs for newly arrived immigrants, new-start jobs for elderly people, job guarantee for unemployed young people).

Another issue relating to the demand side of the labour market is *support for labour market flexibility* to increase job creation and thus – as mentioned above – address the needs of disadvantaged groups for which full-time or regular work is not always suitable (CY, CZ, DE, EE, FI, HU, LT, LV, PT, SK, ES, UK).

Some Member States encourage *special forms of employment* addressing primarily the most vulnerable groups (e.g. HU and RO), while considering the higher level of in-work poverty of self-employed workers; others provide *support for entrepreneurship and self-employment*, especially among disadvantaged people (CY, DE, EL, LT, LV, NL, ES: approval of the Charter for the Self-Employed, PT: micro-credits for self-employment). The UK plans another type of project for bringing the economically inactive into work: the *"Homeshoring"* project enables call centre staff to work from home by using the Voice over Internet Protocol and broadband.

As an important element related to the demand aspects, all Member States' strategies also focus on *anti-discrimination*. Since discrimination is one of the main determinants of social exclusion, Member States have either enhanced their anti-discrimination legislation or reinforced their instruments to deal with it, mainly focusing on the field of mainstreaming gender equality and reducing the wage gap, thus *targeting women as one of the most vulnerable group* (e.g. AT, CY, DE, EL, IE, LU, MT, SK, ES, UK). Some Member States also focused on the issue of *age equality* (e.g. AT, CZ, PL, SE, UK). On the issue in relation to Roma, migrants and ethnic minorities, see 3.3.1 and 3.3.2.

The Role of the Social Economy

Almost all NSRs emphasise the *increasing role of the "social economy"*, as it continues to provide employment and a path for re-entry into the mainstream labour market for the disabled and other groups with difficulties in finding jobs. In addition to strengthening governance and social capital, social enterprises' close ties to and knowledge of local areas also contribute to regional development objectives. For these reasons, several Member States have set the promotion and support of social enterprises as a policy priority (BG, CZ, FR, LT, NL, SK, SE, UK).

Examples of such initiatives include: increased support for placement in social enterprises of people with health-related placement handicaps (AT); establishment of an inter-departmental commission to steer investment in socially-oriented entrepreneurial initiatives (CZ); state support targeted at creating enterprises providing jobs for the disabled; (LT, see box below); pluriannual plan for reforming the governance of social enterprises; creation of a committee to investigate how labour market participation of people with an occupational disability can be encouraged (NL); increased budget assistance and easing of rules for setting up social enterprises (PL); the "Establishment and Networking and Social Enterprises" project, intended to create favourable conditions for the development of social enterprises (SK); establishment of centres that employ a group of at least four benefit claimants who have problems other than unemployment and integrate the work in the enterprise's normal operation (DK); and the national roll-out of the Pathways to Work service utilising mainly private and voluntary providers (UK).

In Lithuania, the Ministry of Social Security and Labour and the Labour Exchange have taken national measures to provide support for the creation of social enterprises. With the disabled as beneficiaries, 15 new enterprises were established in 2007, eleven of which were granted the status of a social enterprise for the disabled; 87 new workplaces were created and 20 workplaces renovated for the disabled. The initiative is intended to counter a 23% increase in 2007 in the number of registered disabled unemployed people in Lithuania.

Examples of measures providing social services and assistance include: creation of an association for the priority development of community-based social services (BG); the Money Matters Financial Learning Project providing vulnerable groups with counselling on financial capability and management of their finances (UK); projects under the EQUAL framework with an emphasis on non-governmental organisations providing community public services (SK); municipal cooperation with organisations of the 'National Empowered Neighbourhoods Alliance' on sports programmes aimed at disadvantaged children (NL) and a formal agreement between government authorities and various NGOs to support the emergence of a substantially greater diversity of providers and suppliers in healthcare and social care (SE).

3.4.3. Access to quality services for active inclusion

As disadvantaged people tend to suffer from several, interconnected problems, such as unemployment, inadequate skills, poverty, health problems, poor housing, family breakdowns and social isolation, current policies and programmes may lack the necessary holistic approach. The multiple problems disadvantaged people face outside the labour market require coordinated action from different public services in order to ensure their social participation and (re)entry into the labour market. Access to social services of high quality has an essential role to play in enhancing the employability of inactive individuals who are also at risk of social exclusion.

While few NAPs describe policies for service provision which fully take into account how they may complement and be reinforced by the other two active inclusion pillars, Member States nevertheless identify a variety of dimensions in the provision of social services which are part of active inclusion strategies. One of the chief priorities touched upon is the need to coordinate provision, not only between public authorities and private providers, but also between central, regional and local levels of government. Other priorities include the delivery of personalised social services, not least employment services, and the involvement of users in both the design and provision of these services. Assuring quality in services is also highlighted in the NAPs, which also frequently identify equity of access as a prerequisite for quality. Finally, services in specific areas receive attention, especially housing, healthcare and, to a lesser extent, financial services. The objective of active inclusion strategies is to (re)integrate people in society and, where possible, into the labour market: social inclusion is not only the key objective of social policies, but also a pre-requisite for a sustainable integration in the labour market. This section focuses on services designed to enhance the employability of individuals while Section 3.5 covers access to services more broadly and those essential to support active inclusion strategies.

Examples of efforts to improve *coordination of social services* related to labour market participation: In Finland the city of Turku is promoting an intersectoral welfare policy programme on children and young people to help reconcile work and private life, which includes enhanced service coordination and provision; in Spain the governance process in the 2nd Regional Plan for Social Integration (2nd PRIS) of the Community Board of Castilla La Mancha emphasises cooperation between regional and local authorities and NGOs and other partners in achieving better access to employment for vulnerable groups.

Examples of *personalised employment and social services* include: In Austria a project of the City of Vienna, 'Basic vocational guidance in the mother tongue' which is addressing the labour market integration of migrants and persons entitled to asylum with counselling, provided on an individual basis, offering basic vocational guidance in the mother tongue, attempting to identify previous qualifications and work experience and offering information about official recognition of qualifications in Austria. In Denmark the action programme 'Our Collective Responsibility II' aims at improving the inclusion of socially disadvantaged groups, partly through training and educational initiatives.

There are some national examples of measures aimed at assuring *quality in service delivery* with regard to labour market participation: in France the quality of services offered by the PES will be improved, notably by simplifying access and improving reception of vulnerable groups; in Slovakia “Modernisation of Employment Services by means of Education for Staff of Offices of Labour, Social Affairs and the Family”, funded outside Bratislava county by the ESF, is aimed at providing innovative education for civil servants and employees in the employment services sections of labour offices.

Examples of initiatives aimed at improving access to social services related to labour market access: in Cyprus the programme 'Expansion and Improvement of Care Services for Children, the Elderly, Disabled persons and other Dependants' to improve and expand social care services at the local level, and promoting programmes of open social care in order to facilitate the activation and access of inactive and unemployed women to the labour market; in the Czech Republic the government is reenergizing the vocational rehabilitation system. This initiative will facilitate effective communication between all partners involved, and attempt to broaden the system of vocational rehabilitation; in Ireland an additional 100,000 childcare places (of all types), by 2016 is a key target under the social partnership agreement Towards

2016; in Lithuania: the 'Integration of Hearing Impaired Persons into the Open Labour Market' initiative funded under EQUAL is opening up access to employment placement services for this group of people which has traditionally been reluctant to make use of PES facilities due to their handicap.

Housing, as related to improving employability, is the focus of the following measures: in France an inter-ministerial committee (CIDOL) aims to increase the number of homes available to young people with a special focus on those requiring housing in order to follow their chosen occupation. In Hungary independent housing outside institutions is being provided to homeless people by two public foundations under a government decree; in Malta the HEADSTART initiative funded under Equal is aimed at smoothing the transition from residential care to society and gainful employment of young people by helping them find affordable housing.

Specific labour market measures related to *health* include: in Sweden the government intends to introduce measures for the insured that strengthen sick-leave reform including a rehabilitation guarantee.

Finally these initiatives focus on *financial services* in connection with gaining a foothold on the labour market: Austria is setting up bank accounts for poor people / persons without cash, including the unemployed. The programme is aimed at countering a lack of access to banking services for the disadvantaged; in the United Kingdom the 'Money Matters Financial Learning Project' is providing vulnerable groups with counselling on financial capability and management of their finances on a range of topics including 'Employment and Money'.

3.4.4. The ESF contribution to active inclusion

Most NSRs acknowledge that the ESF plays a key role in promoting active inclusion. While income support schemes fall outside the scope of ESF, it can contribute significantly to the other two pillars of active inclusion by enhancing inclusive labour markets and access to quality services. In this context, the main focus of ESF interventions is on developing pathways to integration and re-entry into the labour market for disadvantaged people. Actions in this field include providing access to vocational training, the development of the social economy, improving access to social and other services, and fighting discrimination.

In addition to the € 10 billion directly targeted at social inclusion mentioned above, it is estimated that around € 21.6 billion (28. 4% of total ESF budget) will be spent on improving access to employment and sustainability.

3.5. Access to services to enable social inclusion

3.5.1. Access to services overall

Services play an essential role in preventing exclusion and helping people at risk of poverty to come out of it and regain autonomy. This is why access to services is a priority on a par with access to resources and rights in the common objectives of the social inclusion strand of the open method of coordination. Yet, issues such as availability, adequacy, accessibility and quality are much less frequently mentioned in the NAPs than in relation to long-term care or healthcare, whether they apply to social or non-social services.

The availability of services may depend on their geographical location, but also on their ability to respond to users' needs. A proper share of services is a key component of regional

equality, but when services are handled by decentralised bodies, they rely on local resources, likely to be scarcer in areas with greater needs. Planning strategies and proper allocation of funds, help to address this challenge. Reports contain less information on the responsiveness of services, although this clearly influences their impact and can be monitored (e.g. time needed to make an appointment). Greater complementarity between different types of answers may be achieved through a variety of means (e.g. by using ICT for providing remote assistance or by sharing premises between different public services).

The European Social Network in its contribution to the assessment of the NSRs and preparation of the 2009 Joint Report stresses the need to fully recognise the role of local public social services.[26]

The ability to check that services match users' needs is very much dependent on acknowledging that users have a say in the matter, and a right to assess what is delivered. In this respect, all categories of vulnerable people do not seem to be treated equally. While older or disabled people are very often seen as customers, the unemployed or the poor are more likely to be considered as more passive recipients.

The non-take-up of benefits is very much linked with accessibility of services, and several Member States have reported on initiatives aimed at targeting better those who do not spontaneously claim for help (through targeted information campaigns or merging of databases).

Proper funding is a pre-requisite, but service quality also relies on personnel and processes. A shortage of qualified staff is an issue for a few Member States, while others give details of training strategies (e.g. intercultural competences to deal with migrants). Standards for quality are obviously less developed than in the area of long-term care and healthcare. Integrated services addressing multi-dimensional problems which vulnerable people may face contribute to a higher quality of delivery. They require adequate coordination. Some €17 billion will be invested from the ERDF on social infrastructure (including some €7 billion on education, €555 million on child-care, €809 million on housing and some €3 billion on other social infrastructure), which will enhance access to high quality social services.

Services of general interest are also relevant, notably in the context of the high fuel price increasse in 2008: measures are being taken to help at-risk-of-poverty households access fuel and energy are detailed (e.g. specific allowances, social tariffs). Social tariffs in public transportation are also widespread. Nevertheless a lack of availability of public transport services in some areas may prevent people not only taking up a job, but also o participating in society.

3.5.2. Access to housing and fighting homelessness

Homelessness is one of the most severe forms of social exclusion. It was highlighted as a key priority in the previous reporting round and most countries continue to develop or consolidate actions to tackle it. In the current economic context, access to affordable housing and preventing evictions are particularly crucial in fighting poverty and social exclusion.

The first NAPs showed that homelessness was often under-researched, with a focus mainly on the most visible and severe forms of homelessness, i.e. sleeping rough. Social policies now

[26] http://www.esn-eu.org/

increasingly approach homelessness in an integrated manner by looking at people who are experiencing various forms of homelessness[27], and policy priorities increasingly include access to decent and affordable housing. Housing inclusion policies are also linked to urban regeneration schemes, or other locally-based measures aimed at promoting sustainable communities.

Homeless people often face multiple disadvantages. To promote full reintegration into society, a set of coordinated policies are needed in the areas of housing, social assistance services, employment and health. While in most Member States, programmes are being implemented within separate policy frameworks, some Member States are promoting more integrated strategies (IE, UK) e.g. in housing where independent accommodation comes hand-in-hand with offering adequate social support (AT, FI, DK, PT).

Member States put forward different strategies to promote access to affordable and quality housing. These include increasing the housing supply, with specific attention to social housing (UK, AT, FI, FR, IE, IT, BE, LU, MT, PL); financial support, such as housing benefits and allowances, rent guarantees and tax rebates (UK, FI, SE, SK, EE, IE, LU, MT, BE); and appropriate regulatory instruments, such as rent controls (AT, BE, MT). Several Member States have also put in place policies to promote decent housing and energy efficiency (HU, FI, DK, FR, IE). The issue of preventing eviction has received renewed attention in relation to the current financial crisis (AT, DK, FR, SE, BE).

Housing is also one of the main components of area-based policies, and the fight against regional disadvantages often goes hand-in-hand with the fight against housing disadvantage. These policies are targeted at urban development and sustainable communities, in order to fight ghettoisation and promote a social mix (FI, DK, HU, FR)[28].

Reporting on housing policies for Roma refers to some measures for Roma neighbourhoods or travellers groups. In Slovenia, municipalities received €2.7m in 2007–2009 (€1.5m for 2008–2010) to co-finance basic public utility infrastructure in Roma settlements. The UK is also making funding available for 2006-2008 through the Gypsy and Traveller Sites Grant for new sites and the refurbishment of existing sites. France reported about improvements made to the '*aires d'accueil*' for *travellers.*

As to governance issues relating to homeless policies, local stakeholders play a key role in promoting innovative and more effective solutions. Moreover, there is now more reinforced cooperation between government social and housing departments (FI, SE, PL, DK, PT, SI) and between different levels of government that take into account the central role of local authorities in housing inclusion policies (e.g. "Municipal Compass" plans in NL).

In France, the right to housing is becoming legally enforceable. Some Member States have set specific targets for reducing the number of homeless people (FI: halve the number of long-

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[27] For example people sleeping rough, people in emergency accommodation, people living in accommodation for homeless people, people living in institutions (due to lack of shelter), people living in non-conventional dwellings, or people living with family/friends. See ETHOS classification http://www.feantsa.org/files/indicators_wg/ETHOS2007/general/EN_2007EthosLeaflet.pdf. For a more complete assessment of homelessness strategies in the NAPs 2008-2010, see also FEANTSA position paper "Paving the way for a European consensual framework on homelessness" (http://www.feantsa.org)

[28] On place-based policies and the role of cities, see also the EUROCITIES position paper on the analysis of the NAPs inclusion 2008-2010 (http://www.eurocities.eu)

term homeless by 2011; UK: reduce the number of rough sleepers; IE: eliminate long-term occupancy of emergency homeless accommodation by 2010; DK: reduce and ultimately eradicate homelessness), while other targets relate to increasing the supply of services and housing support (e.g. FR: developing 12,000 places in "maisons relais"; SI: increase the capacity of admission centres and shelters for the homeless). Here, there is a need for more reliable data on the extent of homelessness, and on the social characteristics of homeless people, and the causes and geographical spread of homelessness.

3.5.3. Access to healthcare

Although overall life expectancy in the EU has increased over the past two decades, substantial disparities still remain.[29] The reduction of inequalities between socio-economic groups and regional differences in health is mentioned as the most important health policy challenge for Finland and the UK, and as a major goal for some other countries (LT, IE, AT, EE, SI, SK), and as part of the Belgian, Hungarian and Spanish strategy. Some, such as the UK, have allocated extra funding for direct action to reduce health inequalities. As part of their strategies to address health status inequalities, countries are endeavouring to improve the take-up rate for healthcare insurance, eliminate barriers of access to healthcare and break the cycle of transfer of ill-health from one generation to the next, by focusing on vulnerable groups. Amongst the vulnerable groups identified by Member States are, for example, children and families, immigrants, Roma[30], disabled people, people with mental health problems[31], homeless people, vulnerable elderly people, and substance abusers. Countries are also targeting specific deprived areas and regions in removing barriers to access.

Ensuring equal access to healthcare, notably by enhancing primary and preventive care provision, and implementing policies to promote healthy behaviour, are key policy areas. Health promotion and disease prevention activities include: programmes focusing on breast-feeding, vaccination and screening system (HU); subsidised school-meals (SI); promoting healthy eating and access to healthy food and physical activity among adults in disadvantaged areas (IE). To reduce financial barriers, France provides free care to people with chronic conditions. To increase insurance coverage, Germany established mandatory health insurance that has given public or private health insurance to an additional 120,000 people. Cyprus gives attention to the high co-morbidity and health risks of people with mental disorders, thus addressing stigma as a major access barrier affecting this group of people.

The reports show that there are many sources of social inequality in health in the EU, such as income disparities, differences in living conditions, lifestyles and risky behaviour. Evidence suggests that low levels of income and education are strongly correlated with ill-health. A multifaceted strategy covering health promotion and disease prevention actions in a number of policy fields are deemed necessary by several Member States. Accordingly, reports mention the development of cross-sectoral policies. Some Member States (FI, IE, AT, SI, EE, SK and UK) use specific action plans to tackle health inequalities by encouraging health protection in other policy sectors (e.g. education, employment, working conditions, housing conditions, social work, rural development, environment). Finland has adopted an action plan against health inequalities for 2008-2011, whose objectives are 1) to impact on poverty,

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29 See also the healthcare chapter of this report for further information

30 For further details see the part on Roma

31 Mental Health Europe assessed the treatment of this issue in the 2008-10 NSRs: http://www.mhe-sme.org/assets/files/MHE%20members%20Analysis%20of%20National%20Strategic%20Reports%202008-2010.pdf

education, employment, working conditions and housing conditions through socio-political measures, 2) to promote a healthy lifestyle in general, and among those in a weaker social position in particular, and 3) to improve the availability and use of social and health services.

3.5.4. Access to financial services / fighting financial exclusion and over-indebtedness

The study *Financial Services Provision and Prevention of Financial Exclusion*[32] published by the European Commission in May 2008 highlighted the close interaction between financial and social exclusion. On the one hand, groups facing poverty and/or exclusion encounter specific difficulties in accessing financial services, with negative consequences for their personal finance or ability to find a job. Denial of access to financial services on the mainstream market may lead people to turn to more costly and risky alternative financial products. On the other hand, for the general population, an improper use of financial services may, when combined with a critical life event, lead to over-indebtedness.

7% of the population in the EU-15 and 34% in the EU-10 can be considered as financially excluded. This is why financial inclusion, defined as everyone's capacity to access and properly use the financial services required to participate fully in economic and social life, is to be recognised as a dimension of the broader social inclusion objectives. In this perspective, financial inclusion covers several areas, in which those latter goals are to be mainstreamed: 1) effective, adequate and affordable access to basic banking services; 2) prevention and rehabilitation of over-indebtedness; 3) promotion of professional and personal microcredit and 4) development of financial information and education for vulnerable consumers.

Several Member States did not mention this issue in their report (BG, CY, DK, EE, EL, IE, LT, LU, RO, SK, SI), illustrating a discrepancy between social needs and the current crisis, and the national policies as reflected in the NAPs. Very few countries claim to have a comprehensive policy as regards financial inclusion (AT, BE, FR, NL, UK). In the UK an action plan for financial inclusion 2008-2011 was published, with an associated fund. More Member States acknowledge that the situation is worrying. In FR and BE, indicators relating to the level of access to banking as well as over-indebtedness are used in the monitoring of the NAPs. But the Netherlands is the only Member State where addressing over-indebtedness is one of the specific NAP objectives (as already in 2003 and 2006) consistently encompassing regulatory measures and initiatives agreed with stakeholders.

A consistent over-indebtedness policy requires both prevention (encompassing responsible borrowing and money management; responsible lending; and responsible arrears management and debt recovery) and measures to alleviate over-indebtedness and rehabilitate debtors (debt advice and counselling services; judicial processes, including bankruptcy; and non-judicial procedures for debt settlement)[33]. Debt advice is the dimension of over-indebtedness which is most commonly mentioned (FI, PT, UK). In the Netherlands, where it lies within the remit of municipalities, it will be further developed, with a special target for early detection. Several groups of the population require specific attention, namely young people (AT, NL), migrants (AT, NL), and Roma (HU).

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32 http://ec.europa.eu/employment_social/spsi/financial_exclusion_en.htm

33 Study on *Common operational European definition of overindebtedness*, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/leaflet_overindebtedness_en.pdf

In Austria, in order to ensure actual access to a bank account, a specific account has been developed by Sparkassen, already with 2,000 recipients out of a potential target of 50,000 customers. In the UK, the Government agreed in 2004 a shared goal with the banking sector to halve the number of adults living in households without access to a bank account. 800,000 people have already been brought into banking, but 1.3 million households are still unbanked.

Social credit in Belgium, and personal microcredit in France (3000 beneficiaries) help people without access to the mainstream credit market to restore a borrowing capacity that can be used for investing in mobility, home equipment, training or health. Spain and Portugal mention measures to develop microcredit as a support to active inclusion of people excluded from the labour market thanks to self-employment.

Financial exclusion is often linked with housing problems: unsustainable mortgage credit may put families at risk; unpaid utility bills rise among at-risk-of-poverty people; evictions are very often caused by situations of over-indebtedness, and over-indebtedness seems more widespread among homeless people. Sweden implements municipal rent guarantees. Denmark has been experimenting since 2004 with a remission of public-sector debt for socially disadvantaged groups who have received social assistance for four years or longer.

3.5.5. Access to Education/training

Most NAPs recognise the importance of education, but only a few integrate it in a coherent long-term strategy to tackle social exclusion. However, there is a general lack of assessments of progress and clear evaluation mechanisms, based on targets and indicators.

Pre-school education is seen as fundamental in most strategies, both to provide a firm basis for competence from the start, and to help families reconcile work and private life, especially beneficial for the most disadvantaged. As mentioned under 3.2.2., some NAPs (AT, EE, ES) address childcare facilities for 0-3 year-olds, as well as (LT) disparities in provisions between regions and rural and urban areas. Germany has decided to considerably increase the places in crèches for children under 3 (750,000 by 2013). In Belgium, enrolment in pre-school education will be possible from the age of 2.5. Ireland launched a National Childcare Strategy for early childhood development and care. Hungary prioritises pre-school attendance for children with multiple disadvantages, also by providing attendance allowances. Other countries (SI, SK) are issuing allowances and subsidies to support enrolment of children from disadvantaged backgrounds. In Poland, ESF intervention will support pre-school education in rural areas. Some countries (e.g. NL) are giving priority to reducing backlog in language learning by expanding and strengthening pre-school education. Sweden has targeted support to children who do not have Swedish as their mother tongue.

Targeted resources for improving access to education and training for specific groups at risk of exclusion: Germany focuses on young people with a migrant background. The Netherlands and Belgium focus on the acquisition of basic skills and job coaching for young migrants. The French community of Belgium also intends to facilitate enrolment in schools for irregular migrants, to improve social heterogeneity in schools and re-establish teaching of language and culture of origin. Austria promotes early language support in kindergarten and provides remedial lessons in German. Denmark strengthens advisory units for bilingual pupils in vocational training programmes, through mentors, optional classes and support for parental involvement. In Ireland, English language training is offered to migrant workers. The Swedish plan includes a number of strategic initiatives for the education of migrants. In Poland the extensive measures are undertaken to support students from rural areas and help them to reach

higher levels of education. In Slovakia, a new law on education prohibits all forms of discrimination and segregation in education, and is supported by financial mechanisms. Spain focuses on developing key competences and taking better account of the needs of students with an immigrant background and improving the quality and attractiveness of vocational education and training, and on grants and study allowances. Estonia, Germany, Slovakia, Lithuania and Slovenia are reviewing or extending grants and/or loans for students from financially disadvantaged families. Portugal facilitated access to higher education for older learners by making enrolment more flexible. For a complete account, please refer to the Third Annual Report on Migration and Integration (COM(2007) 512 final). The Annex provides a full description for all 27 Member States of the implementation of Common Basic Principle number *5 'Efforts in education are critical to preparing immigrants, and particularly their descendants, to be more successful and more active participants in society*".

Combating early school leaving: While Member States' ESL rates differ considerably, the link with disadvantage is clear. According to the EU benchmark, by 2010 no more than 10% of young people on average should leave school early – but in 2007 the average EU rate for 18-24 year-olds was still 14.8%. Many Member States are implementing preventive measures. For instance, Estonia is developing career counselling and guidance; in 2006 the Netherlands established an "Offensive on drop-outs" strategy, aiming to halve the number of new school drop-outs by 2012, also focusing on smoothing transitions between school types. France is developing mentoring for pupils with difficulties and disseminating knowledge about jobs in various sectors of industry and services among young people. Austria is introducing a right to education up to the age of 18 and endeavours to offer more places in vocational schools, while new educational pathways are under discussion. Denmark established an overall goal of 95% of a youth cohort to complete qualifying education by 2015, and addresses drop-outs from VET through mentor schemes and practical training programmes. In Finland, measures to combat ESL include the increase of apprenticeships and possibilities for a flexible completion of compulsory education ('JoPo'). Ireland is investing additional resources in education support programmes. Portugal is creating alternative curricular paths and increasing the range of courses for young people. Slovakia introduced grants to access education and training from pre-primary to tertiary level. England has legislated to raise the participation age so by 2015 all young people will be in education or training until at least 18. Spain promotes measures to ensure success at school for all students, such as PROA Plan to reduce school failure in primary and secondary education centres in social deprived areas, the Initial Vocational Qualification programmes to offer a new educational alternative for young people who have not obtained the qualification of graduate in obligatory secondary or to establish a programme of pay-grants to encourage those at risk of leaving school for financial reasons.

Several EU-8+2 Member States are concentrating their efforts on improving educational opportunities and access to the labour market for Roma (see further in section 3.3).

Most plans address the need to improve access at all levels for learners with disabilities and special needs. A trend can be observed toward inclusive education as opposed to special education in separate settings. Estonia will develop counselling networks to achieve early identification and treatment of special education needs, and will foster e-education programmes and flexible education opportunities. The Portuguese "Novas oportunidades" plan provides for a review of the national Special Education system, including new units specialised in multiple disabilities and autism, and an increase in the number of special education teachers in mainstream schools. Austria is planning to adopt measures to improve special pedagogical support in mainstream primary and lower secondary schools. Bulgaria hopes to induce a change in public attitude, even though issues persist in relation to

institutional care for mentally disabled people. In Latvia, concrete targets have been fixed to accommodate special education needs in mainstream education. In Hungary, the number of disabled students enrolled in higher education increases year-on-year, and the state provides supplementary state subsidy for these students, though numbers still seem low. Germany refers to an ESF-funded initiative to train people with disabilities and sensitise employers.

In the area of vocational training, France plans to modernise VET and to increase its labour market relevance. The Netherlands put in place obligatory work/schooling for young people without basic qualifications, and aims to make education more relevant to the labour market. Germany is improving access to VET for people at risk, as is Portugal through the Novas Oportunidades initiative. Poland is adapting VET programmes to labour market requirements, and focusing on training and qualification standards for trainers. Both Latvia and Lithuania are modernising VET, and set ambitious national targets on participation. Ireland aims to improve the quality of training for low-skilled workers. Hungary continues to establish regional integrated training centres.

Some NAPs address the validation of prior learning as a means of facilitating inclusion through better access to employment or further learning. (Accreditation of Prior Learning processes (NL), a network of specialised centres on recognition and certification of competences (BE, PT), and initiatives for recognition of prior learning of migrants (LU, SE))

The digital divide is mentioned in only a few reports. Measures to ensure access to ICT for disadvantaged groups (PT, SK), supported access to ICT for young people (BE, Wallonia), improved school infrastructure with over 98% of schools having high-speed Internet access (BG), a network of public Internet access points, and promotion of software development for learners with special needs (SI).

As to adult participation in lifelong learning (LLL) the Czech Republic has established plans, including networking of adult education providers, using structural funds. Finland plans an overall reform of adult training. Portugal promotes adult participation in LLL through the Novas Oportunidades initiative. The Flemish Community of Belgium launched a strategic plan to tackle illiteracy, also in companies. In Luxembourg, training leave has been introduced for workers. In Lithuania, at least one LLL centre has been established in each municipality. As mentioned above, some NAPs describe measures to facilitate access to education and training for parents.

The ESF will provide substantial support to reducing inequalities in access to high quality education and training. A significant part of the above measures will also be co-financed by the ESF. In the 2007-13 period, Member States will spend some €20 billion on the introduction of reforms in education and training systems, including measures aimed at improving the labour market relevance of initial and vocational education, increasing participation in education and training throughout the life-cycle, combating early school-leaving, and reducing gender-based segregation of subjects. In addition, €7 billion will be invested from the ERDF on education infrastructure.

3.6. Enhancing governance of social inclusion policies

3.6.1. Mobilising actors/raising awareness

Preparation process

Increased involvement of stakeholders in the preparation of the national reports of many Member States should contribute to better social inclusion policies.

In some cases, participation of stakeholders was organised for the preparation of the National Strategy Report as a whole (all three strands) (e.g. AT, DK), but more often as a separate process for the NAPs, reflecting the differences between the three strands, as regards the characteristics of the policy area and the stakeholders traditionally involved.

Depending on whether the NAP is the result of a strategic decision-making process or a reporting exercise, participation of stakeholders can mean different things. In the first case, participation can lead to direct impact on decision-making. In the latter, it can be an occasion to exchange information, discuss social inclusion policy in an integrated framework, review implementation and put subjects on the agenda for later decision-making. Assessing whether participation has made a difference is key.

In most Member States, a working group consisting of several ministries, led by a coordinating ministry (often a ministry of social affairs and labour) drew up a draft NAP that was discussed by a NAP or social inclusion committee including stakeholder representatives and/or was discussed at ad hoc events (hearings, conferences, seminars). Sometimes it was presented to existing permanent consultation forums (e.g. social partners forum). Often, NGOs, social partners and service providers were involved in preparing the plans. Their participation is easier to arrange if umbrella organisations exist. Since policies are often implemented at the regional and local level a strong involvement of regional and local authorities in the preparation of the plan is needed. In this respect there is considerable room for improvement but some countries have tried to better involve municipalities and regions (municipalities (e.g. BE, BG, NL, PL); provinces (e.g. AT)). Although there are some good practice examples (BE, LU, UK (e.g. meeting organised to ensure participation of children living in deprived areas)) in many countries there is room for increasing involvement of people experiencing poverty and social exclusion. People who are suffering from poverty and social exclusion should be listened to when policies are developed to address their situation.

Quality of participation

As to quality of participation there have been some positive developments. Some Member States started early with the preparation of the plan informing and involving stakeholders at an early stage (e.g. AT, FR, NL). Several Member States opened up the preparation process and invited the public at large to send in comments and proposals. Sometimes a draft of the plan was put on a website (BG, PL) and a broad and open consultation took place (DK, FI, HU, MT). Some countries organised a survey (ES, LT) or used consultation techniques such as focus groups (NL, MT).

Some Member States ensured that high level decision-makers, e.g. ministers, participated in the seminars and conferences, thereby, highlighting the importance of these events (e.g. AT, LU). Several Member States are providing or intend to start providing capacity-building support to stakeholders so that their participation is facilitated and supported (BE subsidises

organisations where people experiencing poverty can speak out, PT, LT). Participation is often more fruitful when adequate consultation documents are produced, e.g. an early draft of the plan and a report on the results of policies in the previous planning period (e.g. BG, ES, PT, HU). An important aspect of quality is the provision of feedback on the results of participation. Some of the plans refer to participation results. The Dutch plan includes an annex describing the results of consultation and the plan itself indicates how consultation has impacted on it. The Spanish plan also contains an annex that reports on the results of the consultation. For each of the main objectives of the NAP and for all target groups / policy areas, effective measures in the previous plan are highlighted, new problems and needs are identified, proposals for the new NAP are put forward, and actions developed by the stakeholders consulted are described. Luxembourg's plan indicates how the results of the consultation have been taken into account. The UK NAP includes quotations from a stakeholders' participation event.

In several Member States codes on minimum quality standards for participation or consultation have been adopted (e.g. UK: Code of Practice on Consultation; AT: Standards of Public Involvement (also inspired by the UK code); EE: Good engagement practices; Wales: National Children and Young People's Participation Standards). The European Commission has its own minimum standards on consultation. These examples can be a good basis for mutual learning.

Insufficient attention to the quality of participation ultimately risks leading to 'consultation' or 'participation fatigue'.

Stakeholder involvement over the reporting and policy cycle

Because major decisions on social inclusion policy are taken in between OMC reporting deadlines and because stakeholder involvement in the implementation, monitoring and evaluation stages of the policy process can help make the policies more effective, it is important that participation in the preparation of the NAPs be embedded in a continuous process of stakeholder participation throughout the reporting and policy cycle. Although many of the plans contain a general commitment to uphold stakeholder involvement, on this subject they are often not very specific. In several Member States more or less permanent social inclusion or NAPs committees will ensure continued involvement of stakeholders throughout the policy process. The Belgian report indicates that the actions working group met ten times during 2006-2008 to follow up implementation of the report. In the UK a stakeholder working group meets regularly and a social policy task force grouping NGO's participating in the OMC process meets frequently with a social inclusion unit (ministry)). The Swedish report indicates that there may be room for improving stakeholder participation in the preparation of the NAP, but it is considered more important that stakeholders are continuously involved in the work of state agencies and bodies like the Service Users Commission. Hungary mentions several permanent consultation councils (on Roma inclusion, elderly people, disabled, gender equality). Germany set up a "Permanent Council of Advisors on Social Integration" and organised a series of seminars ("FORTEIL"). In some Member States conferences or seminars marking the start of the implementation of the NAPIncl have been planned (e.g. UK, SK, EE).

Awareness raising

In general, it seems that only a few Member States have used the preparation of the reports as an opportunity for broader awareness-raising activities in the media and society at large. Only on rare occasions has there been a real broad public debate. Parliament seems to have debated the NAP in only some countries (NL, DE, MT). The Spanish plan announces that the intention is to promote a debate in the Parliament. In Luxembourg some members of Parliament participated in a preparatory meeting with people experiencing poverty. In Portugal Parliament has decided that an annual social inclusion implementation report should be presented to it. Several Member States announce that dissemination measures will be taken in the future (publish plan on paper, organise seminar, e.g. EE, PT). An increasing number of Member States put the NSR/NAP documents on the internet on dedicated web pages and announce that follow up information (e.g. monitoring data) will be added. Regular updating of such web pages is an important challenge.

3.6.2. Mainstreaming social inclusion / horizontal coordination

In the national reports many Member States acknowledge the need for mainstreaming social inclusion concerns across different policy areas but often only limited or partial information on mainstreaming arrangements is provided. Several countries quite openly admit that this still remains a challenge. Inadequate mainstreaming will result in less effective and efficient social inclusion policies. The extent of mainstreaming is directly linked to the level of political priority that is given to the issue in the Member States. Mainstreaming is a 'characteristic' of policy that should be analysed for specific policy areas and policies. An analysis of the extent of mainstreaming of social inclusion objectives in the Growth and Jobs Strategy (National Reform Programmes), the Sustainable Development Strategy and the structural funds, in particular the European Social Fund is included elsewhere in this report. Mainstreaming of specific thematic issues like child poverty has also been touched upon in the thematic sections of this report**.** In the good governance part of the NAPIncl's Member States report on structural measures in place to facilitate mainstreaming and horizontal policy coordination. Such measures have been implemented at the national, but also at the regional and local level of government.

One important way of ensuring mainstreaming is by coordinating policies through coordination committees within the government (at the political level) or at the level of public administration (see also above: the preparation process) e.g. Belgium, Lithuania and Cyprus. Some Member States attach a long detailed list of ministries involved in these committees in an annex to the report (e.g. BG). In many cases such committees are coordinated by social ministries. Potentially the effective mainstreaming impact may be bigger when they are composed of high-level representatives, when they are coordinated by the prime minister's office (e.g. IE) or when they are 'horizontal', overarching entities within the administration.

The active involvement of stakeholders working on the issue of social inclusion from different perspectives in the policymaking process for different policy areas (see above) can also contribute significantly to social inclusion mainstreaming.

Mainstreaming at the regional and local level is encouraged by the development of regional and local action plans. Some Member States mention a Progress-funded project to develop a methodology for developing these plans (CZ, ES). The challenge will be to implement the results on a permanent basis. Regional plans have been developed in Belgium. The Netherlands gives an example of social inclusion policy coordination at local level: the

Groningen poverty pact. Bulgaria intends to provide methodological support to regional and local authorities for developing regional and municipal social inclusion plans (The goal is that at least half of all municipalities should have a social inclusion plan by 2010). In Portugal local social networks and supra district (regional) territorial platforms aim to take an integrated approach to social policy. In Poland a more flexible framework for cooperation between public administration and civil society, including new institutions such as public-social partnership and local initiatives, is to be implemented in 2009.

Another way of ensuring that social inclusion concerns are taken on board across different policy areas is by developing a network of focal points. In Bulgaria a network of social inclusion focal points in all relevant departments has been established at national level and networks at regional and local level are also being put in place. The importance of capacity building is highlighted. Belgium announces that the pilot project on mediators in the field (federal level) will be rolled out and given a structural framework. Also in Portugal there is a network of focal points, antennas for monitoring and evaluating different ministries' contribution to social inclusion policy. Also, a platform has been created for national sectoral plans (16 such plans are mentioned) to ensure integrated policy. In Ireland social inclusion units have been established in many government departments. At the local level the social exclusion unit programme is being extended.

Another interesting way of integrating social inclusion concerns in different policy areas is by putting in place ex ante social impact assessment arrangements. This means the potential social inclusion impacts of proposed measures can be assessed before the measure is adopted. The process provides an opportunity to increase the transparency of decision-making and to involve stakeholders early in the policy process. In Ireland Poverty Proofing / Impact Assessment has been around for a long time. It has been mentioned in several previous editions of this joint report. Revised guidelines have been adopted. There is increased attention to supporting departments in implementing them. In a number of other countries social impact assessment is mentioned as part of a more integrated impact assessment system that also looks at other impacts (on the economy, the environment etc.) In Belgium the federal government announces that it intends to strengthen the poverty aspect of sustainability development impact assessment (put in place at the start of 2007). In Slovakia an integrated impact assessment system (with a social impact component) is currently being tested (a pilot is ongoing and the system is to be rolled out in 2009). The LT plan announces ex ante assessment of the impact of all proposed laws on social exclusion and poverty.

3.6.3. Involvement of regional and local authorities / vertical coordination

Despite some progress, there is still a big discrepancy between the actual role that regional and local authorities play on social inclusion and their uneven involvement in the NAPs. Indeed, the reports mention a large number of concrete achievements in which these authorities have a key role, when delivering social services on the basis of national regulations or within their own schemes, contributing to social innovations or embedding social inclusion needs into broader local development requirements. But in general, the governance arrangements needed to ensure that they contribute and pay attention to the NAPs have yet to be developed. Many reports (e.g. CY, ES, NL, UK) emphasise that these authorities were consulted when preparing the national strategies but do not show whether it was done systematically and in a strategic manner. The various specificities of particular stakeholders are seldom emphasised. Consistency between national policy and local planning seems to remain a challenge. That is why, when national strategies come to be implemented, local

action plans (PT) can help to make the objectives effective and adapt them to local specificities.

The Council of European Municipalities and Regions (CEMR) provided its assessment of the involvement of its members in the preparations of the NAPs-inclusion[34] (EUROCITIES' contribution was referred to above).

3.6.4. Gender mainstreaming

Efforts made by Member States to mainstream gender issues in policy priorities show a mixed picture. Some make explicit commitments to improve equality between genders across the plan (e.g. BG, ES, FR, IE, LT and PT) or refer to the government's gender equality programme (e.g. CY, DK, EL, FI, SK and the UK), but how specific measures will take this into account is not always reflected throughout the plans. While a number of measures tackle gender-specific problems (such as labour market integration, child poverty, lone parenthood, and flexible forms of work) which are likely to benefit women, a general tendency is that these are not always analysed from a gender perspective or said to aim at increasing gender equality.

Assessing the gender impact of policies

Spain: The Spanish Government prepared a report on the gender impact of policies contained in its National Report on Strategies for Social Protection and Inclusion,. As set out in the report, "learning about gender impact in the use of Strategies for Social Protection and Inclusion is also becoming a way to make a balanced inclusion of both men's and women's different interests, wishes and needs, thus ensuring greater efficiency of public services, better governance and a fairer and equal treatment for both sexes."

UK: The UK Government prepared a gender impact assessment of pension reform. This concluded that the state pension reforms will narrow the gender pension gap and remove discrimination for carers in the pension system. The private pension reforms will ensure equality of access to a workplace scheme of a minimum standard, giving 3.5 to 4 million of women access for the first time.

Labour market integration of disadvantaged groups is a priority objective in most plans. Almost half of the Member States acknowledged the specific problems faced by women, and proposed measures aimed at directly helping them (e.g. AT, CY, EL, ES, FR, HU, IT, IE, LT, MT, NL, RO, SI, UK). Measures to improve reconciliation of work and family life are often seen as the way to help women (re-)integrate into employment. More than one third of Member States expressed their commitment to increasing the availability of childcare (e.g. AT, BE, DE, DK, EE, EL, FR, HU, IT, IE, LU, MT, PT, RO, UK), which should be considered a positive development. However, it is less frequently for measures to pay attention to the role of men: Bulgaria will introduce leave of absence for fathers and child-raising; Estonia noted that fathers can take leave in the case of childbirth; Sweden created a gender equality bonus as an incentive for parents to share parental leave as evenly as possible, and the UK is proposing to give a new right to fathers to take up to 26 weeks Additional Paternity Leave before their child's first birthday to allow mothers to return to work earlier if they wish.

[34] http://www.ccre.org xxx

Only a handful of MS have taken on board the need to combat the gender pay gap (e.g. BG, CY, DE, FI, LT, SK and the UK) and even fewer expressed a commitment to eliminate gender-related stereotypes (e.g. BG and LT). However, a number of Member States have expressed a commitment to promote gender equality in training and education (e.g. AT, EL, ES, FR, IE, LT, PT, SE and SK). Individual measures directed specifically at women also include the promotion of female entrepreneurship (e.g. CY, EL, FR, LT and PT) and commitment to improve women's representation in decision-making positions (e.g. BG, DK, EL, FI and LT).

Some MS have designed specific measures to help immigrant women (e.g. AT, DE, DK, ES and FR), but only one proposes to improve the specific situation of Roma women (BG).

Social inclusion measures targeted at immigrant women*

Austria: The Report highlights as an important element in promoting inclusion of migrants the emphasis placed in integration programmes on women-specific measures, with language and health being prioritised. Child-minding services are provided while migrant women attend vocational guidance and qualification programmes,. In 2007, the inter-ministerial working group “Migrant Women" was set up aiming to develop demand-oriented measures for women with a migrant background, with cooperation by all ministries. About 30 counselling centres for migrants and women’s service centres, predominantly active in counselling migrants, were funded in 2008. **Denmark** - Special actions for women with immigrant backgrounds and their families: A *Women’s Programme* has been launched, with the general purpose of helping more women with migrant backgrounds to become active citizens in Danish society. It comprises 11 specific initiatives to strengthen women’s chances of finding work, getting an education and participating in sports and association life. They also aim to enhance women’s ability to support their children’s integration and development in the wider sense.

*A range of relevant activities are carried out in the framework of the European Integration Fund; targeting specific groups, including women and children, is a specific priority and many national programmes foresee activities in this respect. For further information: http://ec.europa.eu/justice_home/funding/integration/funding_integration_en.htm

Improved measures to combat violence are cited in many NAPs (AT, CZ, DK, EL, ES, HU, FR, LT, LV, PL, RO, SE, SI, SK, UK), but proposals to combat trafficking are less frequently mentioned (e.g. DK, EL and LT).

A few plans (e.g. AT, BE, DK and IE) pay specific attention to the need for a gender sensitive approach into measures to improve the situation of homeless people but actions designed for disabled people seldom take specific account of disabled women (e.g. AT and EL).

There is very little evidence that gender equality actors are involved in the consultation process, with some exceptions (CY, ES, HU, PT, UK), but a number of countries intend to allocate funding for capacity building of bodies responsible for promotiing equality between genders.

3.6.5. Monitoring and evaluation

There are substantial differences in the amount of detail Member States have provided in the national reports on monitoring and evaluation arrangements. Often, the information given is not sufficient to allow an adequate assessment. Some Member States have developed specific

OMC monitoring systems. Others rely on regular national reporting tools (reports from ministries and statistical institutes) (e.g. FI, DE), or produce reports in line with other, sometimes longer-term national strategies (e.g. IE NAPs 2007-2016**)**.

Where specific monitoring systems have been developed in the context of the OMC, it appears that in most Member States there are separate arrangements for the social inclusion strand (NAPs). Only some Member States have planned fully integrated monitoring and evaluation arrangements covering all strands of the OMC (e.g. SI).

Two kinds of monitoring systems can be distinguished: indicator sets that can provide quantitative information on input, output and outcome of policies, and monitoring systems that provide information on the implementation of measures. Typically, the latter type of system gives a description of measures, who is responsible, to what extent measures have been implemented, what resources have been committed etc. (annex to ES, PL, PT, HU report).

Only few Member States continuously update their monitoring systems (some are available on-line). In most cases, annual reports are produced or reports are updated in line with the OMC or national strategy reporting cycle.

From the reports, it is not always clear how monitoring reports are to be used or who will be examining them. In the case of PT**,** the Parliament has decided that a NAPIncl implementation report will have to be presented to it on an annual basis. Also in LV**,** each year, ministries have to report on the implementation of the plan. The report is to be presented to the Cabinet.

Concerning the use of indicators overall, the NSRs 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 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 agreed in the framework of the Social OMC. The EU-based indicators are often supplemented by national outcome indicators, mainly to cover populations such as specific vulnerable groups (immigrants, ethnic minorities, the disabled, people living in deprived areas, the homeless), or to reflect dimensions that are not yet covered by EU indicators (housing, persistent poverty, socio-economic gaps in life expectancy, etc).

Member States use EU indicators to a lesser degree to monitor progress towards the policy objectives they have set. A number of countries have nevertheless adopted targets based on EU outcome indicators, especially in the area of child poverty (see Section 3.1). Some (AT, BE, BG, DE, EE, ES, FR, HU, IE, SK) have also enhanced their use of indicators for monitoring purposes. To this end, Member States more often use national input or output indicators that are timelier and directly related to specific policy measures, such as the number of childcare 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.

Most but not all Member States have developed monitoring arrangements for each policy priority as suggested in the guidance note for the national reports. Many of them frankly acknowledge that in this respect much work still needs to be done. Although specific issues have been singled out as policy priorities, sometimes data sources and indicators still need to

be developed to allow monitoring of progress. Especially when targets have been set, effective monitoring will only be possible if regular measurement and time series are available.

Some countries have set up indicator working groups that are tasked with systematically developing data sources and monitoring indicators. See e.g. Ireland good practice on 'technical advisory group and data matrix', Spain, Belgium. Sometimes the priority issues the groups will be working on in the near future are indicated.

If the idea is to move to more evidence-based policies, investment in basic data and analytical capacity are a sine qua non. A so-called evaluation culture needs to be fostered. In Romania a social observatory will be established. In Greece**,** a new social protection national council is to be created that should support a network consisting of observatories, study centres and the National Statistical Institute. It is often mentioned that there is a specific need for developing data sources and indicators on the most vulnerable groups that are not covered by standard surveys (BE is developing surveys to reach population groups that are not covered under EU-SILC). One example of an area that is particularly challenging is the issue of the social inclusion of migrants and ethnic minorities. Another example of a priority issue that is mentioned in the reports is the development of an absolute poverty measure (SK).

An additional challenge, which became clear again with the sudden economic downturn, is the need to develop short-term indicators of poverty and social exclusion. Several of the most important commonly agreed, survey-based indicators only become available with considerable delay. In fact, sometimes data in the plans refer to 2006, i.e. the start of the previous planning period. There seems to be no obvious solution to this problem, but in some cases one could consider developing proxy indicators that are available much faster.

A common problem is that monitoring is often organised at the national, aggregate level, even though important social inclusion competences are situated at the regional or local level and important territorial disparities exist. Some Member States have developed monitoring instruments that allow the government to keep an overview of what is happening and that at the same time allow municipalities or regions to compare or benchmark their performance. Examples of such systems are: the Work and Benefits Core Card in the Netherlands and the social map website in Lithuania. The choice and development of appropriate indicators and context variables is especially challenging in these monitoring systems. Portugal mentions a database social network programme (local level).

Various institutional monitoring arrangements have been put in place. In some Member States, a specific NAPs Committee is involved in the preparation of the plan, its monitoring and evaluation (often also coordination). Some of these committees consist mainly of representatives from the different ministries involved in social inclusion policy. A broad composition will ensure more effective monitoring. In Portugal and Ireland**,** monitoring involves focal points in different ministries relevant for social inclusion policy. Some committees are open to stakeholders and non-governmental experts: NGOs, service providers, academics, representatives of regional and local government, etc. For instance, Italy is planning to create a body of this kind on a permanent basis. Monitoring will be more effective if there is high-quality involvement of non-governmental experts and also people experiencing poverty and social exclusion.

Several Member States have started the preparation of the new NAPs with a review or evaluation of the previous plan. E.g. in ES**,** an evaluation seminar was organised. For this, a

detailed implementation report and a report on the diagnosis of poverty and social exclusion in Spain were prepared (annexed to the plan). In the guidance note for this report Member States were asked to include a progress report and to indicate how lessons have been drawn from the evaluation of the previous action plan. Member States have done this to a different extent. Some Member States report briefly on the way in which the plan will be evaluated but generally little detail is provided. In many Member States it seems to be assumed that permanent social inclusion or NAP Committees will be involved in monitoring and that evaluation will take place when preparing the next action plan. More detailed information is provided in the Slovenian plan. Here it is announced that a special evaluation group is to be set up the end of 2008. The composition of the group is described in detail. It will meet twice a year to discuss implementation and an annual evaluation report will be produced.

3.7. Annexes to Chapter 3

GOOD PRACTICE EXAMPLES OF SOCIAL INCLUSION POLICIES

IN THE 2008 NAPs-INCLUSION

To support evidence-based policy development, the examples selected below aim to cover key policy areas evenly and to highlight projects that take a comprehensive approach, to tackling the multiple facets of social exclusion and accumulated disadvantages. The examples covered are: tackling child poverty, access to services, addressing social inequalities in health, housing/homelessness, migrants and minorities, addressing financial exclusion and over-indebtedness, active inclusion/labour market integration and fighting poverty/ minimum income support, Roma, governance, and mainstreaming. The aim has been to select examples of projects that have received a positive evaluation and seem to have a lasting impact. In some cases, however, projects are promising but a full evaluation still remains to be carried out. 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.

Tackling child poverty

UK: Family Nurse Partnership programme.

Target group: Single-parent families.

Objective: Improving outcomes in pregnancy and birth, enhancing child health and development, improving parent's life course and economic self-sufficiency.

Actions / what they do: Family Nurses visit parents from early pregnancy until the child is two years old, building a therapeutic relationship with the mother-to-be and guiding parents to change their health behaviours, improve care given to the infant and become economically self-sufficient.

Monitoring and evaluation: External evaluation by Birkbeck College, London. The evaluation will focus on implementation, deliverability, take-up and costs, while looking at the short-term impact on mothers' and children's health. The evaluation is expected to report in 2009.

Outcome / result: Early signs are promising. Early learning suggests that the FNP has high take up, that it is welcomed by practitioners, and that it can lead to positive changes in behaviour, relationships and well-being.

CZ: Introducing multidisciplinary teams into Youth Court practice.

Target group: Children, their families and other relevant stakeholders.

Objective: Map out a system of care for children at risk or in danger in the locality, optimising the coordination of solutions to cases and carrying out strategic work with children at risk or in danger and with their parents; regular evaluation and proposals for new measures.

Actions / what they do: Creation of multidisciplinary teams including representatives from PMS, the courts, the public prosecution office, the Police of the Czech Republic, institutions providing social legal protection for children, city councils, criminality prevention coordinators, service providers (social, healthcare, educational) and other stakeholders.

Monitoring and evaluation: Monitored and evaluated by the Czech PMS Headquarters, Department of Methodology, Conception and Analysis, on a regular basis.

Outcome / result: Multi-disciplinary Youth Teams have been introduced in almost all judicial districts and have been integrated into the practice of the Early Intervention Centre, greatly increasing the number of cases resolved in preparatory proceedings.

Active inclusion: Minimum income support

ES: The minimum income system of the autonomous communities.

Target group: The socially disadvantaged including single-parent families, the unemployed, the elderly, young people, the disabled, immigrants/refugees, Roma, the homeless and drug abusers.

Objective: To guarantee minimum resources and social and labour market integration.

Actions / what they do: Creation through legislation of last-resort and basic minimum income guarantee system in the Autonomous Communities.

Monitoring and evaluation: Control and follow-up by each community and an annual report by central government detailing regulations, access requirements, benefit composition and an analysis of the results.

Outcome / result: Introduction of schemes in all Autonomous Communities except the City of Ceuta (currently being implemented) resulting in total expenditure in 2007 exceeding €415 mio.

Active inclusion: Inclusive labour markets

UK: National roll-out of the Provider-led Pathways to Work service.

Target group: Disabled people and others of working age receiving incapacity benefit.

Objective: Reducing the number of people receiving incapacity benefits by 1 million over the ten years ending 2015/2016 by moving people into sustained employment.

Actions / what they do: Building on the service provided by 18 Jobcentre Plus districts by contracting providers nationwide to conduct work-focused interviews and provide tailored, job-focused support for IB and voluntary customers.

Monitoring and evaluation: Quality review process for all products, user assurance groups, quantitative assessment on exits from benefits and process evaluation.

Outcome / result: Roll-out accomplished in all 31 Jobcentre Plus districts on time with quality and performance objectives being met.

LT: Integration of hearing-impaired persons into the open labor market.

Target group: Individuals with a hearing impairment.

Objective: The implementation of an innovative and effective job-seeking programme for the hearing-impaired.

Actions / what they do: Arranging motivation seminars, aiding active work search utilising individual audiovisual presentations, on-site supervision of employed participants, and utilisation of employment agents active in all phases of the process.

Monitoring and evaluation: Quarterly reports, external expert evaluation, semi-annual assessment meetings.

Outcome / result: 126 out of 159 participants have obtained jobs, contacts have been made with 84 firms.

Active inclusion: Access to services

BG: Social Services for New Employment – social support to vulnerable groups, persons and families (SANE).

Target group: The elderly, people with disabilities, unemployed acting as 'social assistants'.

Objective: Deinstitutionalsze and decentralize the provision of social services.

Actions / what they do: Development and testing of new funding management and provision models and development of new standards for the 'social assistants' programme.

Monitoring and evaluation: Central project management unit (PMU SANE) monitors procedures, carries out audits and evaluations.

Outcome / result: Social services were provided to 2037 users by 700 trained social assistants in 12 pilot municipalities, capacity was strengthened in 264 municipalities to offer the service, 250 social workers were trained in programme quality standards.

Addressing social inequalities in health

AT: 'To your heart's content' – women from Favoriten live a healthy life.

Target group: Socially disadvantaged women living in the Favoriten district of Vienna.

Objective: Health promotion and prevention of cardio-vascular disease.

Actions / what they do: An extensive sensitization and information campaign, creation of a women's exercise group, invitation to join a nutrition, exercise and counselling programme, networking and cooperation with health authorities and local institutions.

Monitoring and evaluation: Ongoing evaluation documenting satisfaction with the programme and achievement of goals among users.

Outcome / result: Almost 1000 contacts with the target group; 250 women from a multicultural background participated in the programme.

Housing/homelessness

CZ: Strategy for the social inclusion of the homeless.

Target group: The homeless.

*Objective: More s*ystematic and effective efforts to improve the situation of the homeless.

Actions / what they do: Creation of a definition and typology of the homeless, establishment of a monitoring system, research into the provision of healthcare to the homeless, evaluation of increased number of social workers working with the homeless, creation of a dedicated website.

Monitoring and evaluation: Permanent evaluation (e.g. the typology working groups consulted with experts at intervals) and evaluation of monitoring reports in context of ESF grant procedure.

Outcome / result: All initiatives were carried out, research was disseminated and is still being carried out after the completion of the project, documentation showing the effectiveness of increased numbers of social workers was passed on to the authorities.

PL: Social work for the benefit of social housing development.

Target group: The homeless, the unemployed, the elderly and young people.

Objective: Possibilities of using programmes of social and vocational activation of social assistance recipients in order to improve their own housing situation.

Actions / what they do: Local partnerships between social assistance institutions, labour offices and local employers were formed during the project period 2007-2008.

Monitoring and evaluation: Monitoring was ensured through the principles of ministerial project "Active Forms of Counteracting Social Exclusion".

Outcome / result: Increased initiative of municipal self-governments in 2008 within the scope of initiating local programs of social work and public works in the area of social housing facilities and in the field of care services. Greater interest in system solutions in the field of state co-financing of initiatives in the area of the construction of social housing flats, night shelters and facilities for the homeless. All in all, 84 social housing flats were constructed, a house for the homeless was renovated and 145 persons were engaged in social work, whereas 40 persons threatened by social exclusion participated in the programme in one of the cities participating in the programme.

Migrants and minorities

EL: Training for Muslim children.

Target group: The minority student population, including those of Roma origin.

Objective: Harmonious integration of minority children in the system, acceptance of these children by the educational staff and all citizens of Thrace, provision of knowledge and suitable educational material to teachers including Turkish language courses, support for families to encourage their children's good school performance, awareness of the education administration mechanism and representatives of local administration, awareness of all parents and the public opinion in general.

Actions / what they do: Included establishment of Muslim Children Education Programme Support Centres offering language classes, creative activities for pre-school children, creative workshops for young persons, creation of mobile support centres to reach rural areas, creation of educational materials including electronic versions, training for teachers and psychologists including Turkish language training, counselling.

Monitoring and evaluation: Continuing evaluation by a scientific board.

Outcome / result: Five-fold increase in attendance by the target group.

AT: Basic vocational guidance in the mother tongue.

Target group: Immigrants/refugees.

Objective: Labour market integration.

Actions / what they do: Basic vocational guidance in the mother tongue is provided at three group sessions covering the labour market in Vienna, the legal framework and information on job-seeking.

Monitoring and evaluation: The programme is reviewed annually in the WAFF report.

Outcome / result: The counselling has made it possible for participants to formulate individual goals and plans of action leading to employment.

Addressing financial exclusion and over-indebtedness

IT: Microcredit to families at zero rate for unforeseen economic difficulties (Veneto region)

Policy area: Addressing financial exclusion and over-indebtedness – Tackling child poverty

Target group: Families or lone parents facing unexpected financial difficulties

Objectives: Prevention of over-indebtedness with the aim to ensure in particular sufficient resources for children

Actions / what they do: Provide microcredits free of charge in order to cover extraordinary costs related to healthcare, education, housing, debt recovery and all unforeseen costs related to children

Monitoring and evaluation: Computerized management of the project, regular evaluation of the activities and possible critical issues

Outcome / result: High number of applications received and full use of allocated funds. Payments are in line with project forecast

NL: Measures intended to strengthen debt counselling and reduce over-indebtedness.

Target group: The over-indebted including homeless people.

Objective: To reduce the number of homes with over-indebtedness and to improve the effectiveness of debt counselling.

Actions / what they do: Letter of intent and bilateral arrangements with housing corporations, power companies, debt-counselling organisations and municipalities, amendment to the Debt Rescheduling Act to create two new instruments: moratoriums and insolvency.

Monitoring and evaluation: Amendments to legislation on debt rescheduling will be evaluated in a report to Parliament in three years time.

Outcome / result: Letter of intent and bilateral arrangements have improved cooperation between institutions/organisations, but still room for improvement.

Governance

IE: Technical Advisory Group and Data Matrix.

Target group: Government bodies, social partners, NGOs.

Objective: Advice on and support for the development of relevant indicators on poverty and social exclusion and the added scope for research into poverty and exclusion.

Actions / what they do: Advise the Office of Social Inclusion (OSI) on indicator development, creation of a data matrix containing indicators for each goal, target and action contained in the Irish NAPincl.

Monitoring and evaluation: The OSI regularly consults stakeholders in order to ensure the timeliness of the data matrix.

Outcome / result: The data matrix is being designed to serve as a reference point for a streamlined reporting mechanism of social inclusion activity across the various Government strategies.

Mobilising stakeholders

LT: Webpage "Social map"

Target group: Politicians, representatives of local communities, civil organisations, local and central authorities, society at large.

Objective: Improved governance in the field of social support to combat social exclusion and poverty.

Actions / what they do: Webpage with information on EU and LT initiatives like e.g. legal acts, programmes, projects, reports, data and indicators, good examples, a discussion forum and list of stakeholders in the field of social inclusion.

Monitoring and evaluation: Permanent monitoring of usage.

Outcome / result: Total number of webpage visitors from October 2007 to July 2008; 170433. Sharing of good examples between actors in the municipalities; opportunity for dialogue between local and national level.

Mainstreaming

ES: Programme for the development of local Plans for Social Inclusion in Cataluña.

Target group: The socially excluded in 103 municipalities.

Objective: Stimulate and generate resources for drawing up Plans for Social Inclusion in the local sphere.

Actions / what they do: The government of Cataluña provides financial resources, technical cooperation and advice, training and the transfer of knowledge aimed at supporting the drawing up of local Plans.

Monitoring and evaluation: A working group consisting of regional government technical personnel and representatives of the participating municipalities is developing indicators to monitor progress while another group has been established to identify criteria for good practices; the projects of 6-8 councils will be assessed.

Outcome / result: The number of local councils with Plans in place has grown from 12 in 2006 to 22 as at 1 July 2008.

LIST OF EXAMPLES OF GOOD PRACTICE IN THE FIELD OF SOCIAL INCLUSION BY MEMBER STATE

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
Austria	Credit account for people affected by poverty / persons without cash
	KomenskýFond (Komensky Fund): an initiative of the ERSTE Foundation and Caritas
	"Mummy learns German" at nurseries and schools in Vienna
	Three City of Vienna projects: 1. “Prospects“: vocational and educational counselling for persons entitled to asylum and financial support for further education; 2. “Competence Centre“: counselling to assess prior learning and further education needs ofnew migrants; 3. “Basic vocational guidance in the mother tongue” targeting newcomers
	“To your heart’s content” - -women from Favoriten live a healthy life
	“… but healthy despite everything!”
Belgium	Les experts du vécu/médiateurs de terrain
	Les fonctionnaires d’attention
	Inclusion de personnes sans-abri
	Validation des compétences
Bulgaria	Social Services Against New Employment – social support for vulnerable groups, persons and families (SANE)
	Increasing the employability of the unemployed by vocational training (German-Bulgarian Vocational Training Centres)
	Programme for targeted social protection for heating to the population with low income
Cyprus	Development of local services in social welfare services
	Project “Expansion and Improvement of Care Services for Children, the Elderly, Disabled persons and other Dependants”
Czech	Three-stage permeable housing system

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
Republic	Rehabilitation – Activation – Work
	Support for inclusion – Career counselling
	Introducing multidisciplinary teams into Youth Court practice
	Strategy for the social inclusion of the homeless
Denmark	Evaluation of the project Focus on the Family
	Forward - To ensure work and education for drug and alcohol misusers
	Integration of mothers and their children through the project Neighbourhood Mothers
	SPIDO (Socio-pedagogic Practice in Dementia Care)
	National Indicator Project (NIP)
Estonia	The ESF programme 'Welfare measures to support employment 2007-2009'
	Introduction of the case management principle
Finland	Intersectoral welfare policy programme on children and youth
	Kaiku Programme to promote occupational wellbeing
	Promoting health and functional capacity
France	Instaurer la fluidité du parc hébergement/logement /Improving availability of housing
	Favoriser le retour à l'emploi des bénéficiaires de minima sociaux et augmenter le temps de travail des travailleurs pauvres / Return to employment of minimum benefit recipients and increased working hours for low-paid workers
	La mesure de l'atteinte de l'objectif de baisse d'un tiers de la pauvreté en 5 ans /Monitorinig target to reduce poverty by one-third in five years
	L'insertion des jeunes par la deuxième chance / Inclusion of young people by giving a second chance
Germany	The Federal Government's "Job – Jobs without Barriers" initiative
	Hesse's "Experience has a Future" programme
	The Free State of Saxony's programme "Training unemployed people without

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
	vocational qualifications to obtain recognised vocational qualifications”
	Rhineland-Palatinate “InPact” programme
Greece	Training addressed to Muslim children 2005-2008
Hungary	Micro-regional social closing-up programmes
	Subsidised housing programme for homeless people
	Senior-friendly municipality award and grant programme
Ireland	Creation of the Office of the Minister for Integration
	National Intercultural Health Strategy 2007 – 2012
	Technical Advisory Group and Data Matrix
Italy	A certificate for the Italian language: the way to know and to get known
	Prestito sull'Onore: microcredit at zero rate for unforeseen economic difficulties
	Education and training of foster families of foreign minors deprived of parental care (undocumented children)
	Fondo Autonomia Possible: Fund allowing Autonomy
Latvia	The "Complex inclusion programme"
	Creation of ‘one-stop shop’ for employment counselling through merging of two state agencies
Lithuania	Webpage “Social map”
	State support for the social enterprises
	EQUAL project “Integration of hearing impaired persons into the open labor market”
	Development of public internet access points network (alliance “Window to the future”)
Luxemburg	Foyer scolaire “Parc Hosingen” by SISPOLO (Syndicat intercommunal pour l’éducation , l’enseignement, le sport et les loisirs) - Regional initiative of 4 neighbour communes to offer after-school quality childcare for school children aged 3-13 years, in close collaboration with pre-school and primary school professionals

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
	RESONORD Regional Sozialétude Norden : Projet d'étude sociale de la région LEADER+ Clervaux-Vianden en vue d'une démarche intercommunale de développement social / Project for social study of the region aimed at multi/commune action on social development
Malta	Integration of Asylum Seekers into Maltese Society
	Equal Project - HEADSTART
	National Standards of Care for Residential Childcare
	Gender Mainstreaming - The Way Forward
Netherlands	Prevention Information Team (PIT) Eindhoven
	Measures intended to strengthen debt counselling and reduce over-indebtedness
Poland	The Social Integration Program (the Post-Accession Support Program for Rural Areas – PSPRA)
	Construction of multi-function sports fields generally accessible to children and young people
	Social work for the benefit of social housing development
Portugal	Transnational Project LAPs & RAPs (financed by the EU)
	Entrepreneurs for Social Inclusion (EPIS)
Romania	Training modules for the technical secretariats of the County Commission for Social Inclusion
	Job Fairs and Employment Caravan aimed at individuals with Roma background
Slovakia	Improving the quality of social assistance provision for citizens in the Bratislava Self-governing Region (BSK), extending and modernising social services provided and developing new types of social services relevant to the needs and the demand
	Building a system for prevention and job placement for the long-term unemployed, persons with low qualification and other disadvantaged groups
	Twinning project to improve resocialisation and rehabilitation of drug addicts
Slovenia	'Project Man' programme for self-help therapy and social rehabilitation of

MEMBER STATE	EXAMPLE OF GOOD PRACTICE
	people with various forms of addiction
	Network of maternity homes and shelters for women and children who are victims of violence
	'Involvement of the elderly in providing home assistance to the elderly'
Spain	Programme for development of local plans for social inclusion in Cataluña
	The minimum incomes system of the autonomous communities
	Governance process in the 2nd regional plan for social integration (2nd PRIS) of the Regional Board of Castilla-La Mancha
Sweden	National guidelines on misuse and dependency care issued by the National Board of Health and Welfare
	Action plan against male violence against women
United Kingdom	Family Nurse Partnership programme
	Provider-led Pathways to Work
	Money Matters Financial Learning Project, Inverclyde
	Social Firms
	Off the Streets and into Work & St Mungos: improving access to training and employment for homeless people

4. ADEQUATE AND SUSTAINABLE PENSIONS

4.1. Overall strategy for Adequacy and Sustainability of Pensions

4.1.1. Introduction

Common objectives for Pensions

Member States are committed to providing 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.

The 2006 Synthesis Report on Adequate and Sustainable Pensions outlined the main challenges to be met in the area of pension provision. Over the past decade reforms have improved sustainability by braking and counteracting the effects of declining ratios of working years to retirement years and of workers to pensioners. The 2006 report reiterated that financially sustainable systems must be balanced with adequate benefits. Member States have increasingly employed a mix of different types of pension designs: public and private, pay-as-you-go and funded, mandatory and voluntary in order to reach these goals. At the same time they have sought to underpin changes to pension systems by improvements in labour markets, notably by raising employment rates of women and older workers.

The 2007 and 2008 joint reports have included in-depth analyses of specific issues, policy findings and indicators to measure progress towards the common objectives. The SPC has also adopted reports on current and prospective theoretical replacement rates, minimum income provision for older people, promoting longer working lives through pension reforms and privately managed pension provision. Other issues such as pension information and financial literacy have been covered through peer reviews [35]. Countries have contributed to these studies by responding to questionnaires and participating in peer review processes.

National Strategy Reports delivered in the early autumn of 2008 where Member States report on their responses to the challenges identified in the 2006 and 2007 Joint Reports form the

[35] For information from the peer review on Public information on pension systems and pension system changes please refer to: http://www.peer-review-social-inclusion.net/peer-reviews/2008/public-information-on-pension-systems-and-pension-system-changes

foundation for the policy analysis in this document, which is issued in support of the Joint Report 2009.

4.1.2. Reforming pension systems to meet the demographic challenge

Over the last decade Member States have reformed their pension systems to better provide adequate and sustainable pensions in view of population ageing, new societal norms and changing behavioural patterns. Consequently in their 2008 national strategy reports, countries focus on the implementation of reforms and further incremental progress that has been made. Such progress in many ways involves a delicate balancing of the dual concerns of adequacy and sustainability: how to secure sufficient pensions for all without jeopardizing work incentives and the financial sustainability, and vice versa.

Still a few Member States have legislated more substantial reforms since the last reporting.

The Portuguese pension reform, following an agreement with the social partners, entered into force in May 2007. The reform entails increasing the pensionable age and the eligibility periods until 2015, as well as changes to the benefit formula, that will lower replacement rates. The reform covers both government and private sector schemes. Changes in the latter include larger benefit reductions in case of early retirement and creation of incentives to postpone retirement, the introduction of a 'sustainability factor' that automatically adjusts benefits to changes in residual life expectancy and indexation rules for pension benefits as a function of real GDP growth and consumer inflation.

The Czech Republic has started a pension reform in three phases. The first phase adopted in July 2008 included new legislation that increases the pensionable age to 65, prolongs the eligibility criterion for contributory years and introduces new incentives for prolonging working lives by strengthening the bonus-malus system for earlier or delayed retirement. The second and third phases of the reform which are to be carried out by 2010 concentrate more on strengthening the role of funded, privately managed pension provision.

Greece has adopted legislation reducing the number of pension funds, harmonising pension eligibility ages, limiting access to early retirement, crediting child caring years and introducing a social security number for beneficiaries. While still rather complex the system has been simplified to improve its financial efficiency.

Cyprus has introduced a reform that will entail gradual increases in the contribution rate and in the minimum eligibility requirements. The pensionable age for civil servants has been increased to 63 years. In Cyprus, the introductions of a Special Allowance and some ad hoc increases in the minimum pension have been legislated in order to address the high risk-of-poverty in old age. Given these improvements, there is still a need to monitor the incomes of those claiming solely a social pension and those living in single-person households.

The UK is continuing its programme of pension reforms affecting public and private pillars. Reforms adopted or proposed since the 2007 Joint Report include a major easing of entitlement criteria for basic pension, earnings related indexation from 2012 and much wider coverage of supplementary pensions encouraged through means of auto-enrolment and further financial incentives for people to contribute to these schemes.

A number of Member States have introduced quantitative national targets or monitoring of national indicators as methods of motivating progress in the area of pensions. Bulgaria and

Romania have targets to decrease contributions in order to encourage participation in the labour force. Slovenia has set a target to achieve a coverage rate of 70% by 2030 in the voluntary funded scheme. Ten Member States have succeeded in reaching the Lisbon target of a 50% employment rate for older workers agreed by all Member States. In Poland a programme has been introduced to increase the employment rate of older workers to 40% in 2013 and 50% in 2020. Germany has set national targets on the employment rate of older workers beyond the Lisbon target. The United Kingdom is assessing progress using indicators on the employment rates of those ages 50-69 as compared with the overall employment rate.

Some countries have defined targets on the adequacy of pension benefits or adopted an indicator-based approach to monitor and improve the welfare of the elderly. Cyprus has introduced a target to reduce the at-risk-of-poverty from 52% to 40% by 2011 with the intent to pursue a risk-of-poverty ratio for the elderly that is lower than 20% by 2013. Other countries have pegged the adequacy of pensions by quantifying targets in terms of replacement rates, although the definitions of replacement rates may vary in the targets set. Ireland has endorsed a target of a 50% replacement rate from all sources of pension income in the Programme for Government. In Belgium, the current government wants to increase the old-age pension replacement rate for workers who are currently active. In Lithuania, targets correspond to a long-term adequacy goal of mandatory pension levels equivalent to 50% of average net wages. In the United Kingdom, the percentage of pensioners with low income will be monitored as part of a public service agreement to 'tackle poverty and promote greater independence and wellbeing in later life'.

4.1.3. Prolonging working lives to address the pension challenge

Meeting the pension challenge is essentially about closing the gap between shorter contributory lives and longer retirement periods – with the first resulting from later labour market entrance and decreased employment rates of older workers and the second triggered by premature exit and rising life expectancy. Maintaining the adequacy and sustainability of pension provision in an ageing society depends crucially on more people working more and longer.

Pension systems can support labour market objectives by including all active groups, by signalling appropriate ages of retirement and by establishing economic incentives (bonus/malus) in support of desired behaviour. Activity and employment rates are influenced by a whole range of factors unrelated to pensions. Yet, norms for pensioning and retirement practices are influenced by the institutional framework created by the state. Rules of pension accruals, the pensionable age and designs of early retirement benefits represent signals for workers and employers that impact on age management.

As Members States are seeking to re-establish a sustainable balance between contributory working years and years spent in retirement they are faced with a combined need for: (a) lowering the entry age, (b) lowering the incidence and length of careers breaks and (c) increasing the effective exit age. So far most efforts have been directed at influencing the effective exit age.

Table 4.1: Average labour market exit age and life expectancy at 60 in selected EU Member States in 2006

Member State	Statutory pensionable age		Effective exit age from the labour market		Life expectancy at 60	
	Males	Females	Males	Females	Males	Females
Belgium	65	64	61.2*	61.9*	80.8	84.9
Bulgaria	63*	59*	64.1	64.1	76.2	80.3
Czech Republic	61y 6m	59y 8m	61.8	59	78.2	82.4
Denmark	65	65	62.5	61.3	80	83.3
Germany	65	65	62.1	61.6	81.1	84.8
Estonia	63	59y 6m	62.6+	62.6+	75.9	82.2
Ireland	65	65	63.5	64.7	80.8	84.5
Greece	65	60	61.8	60.4	81.4	83.9
Spain	65	65	61.8	62.3	81.7	86.5
France	60	60	58.7	59.1	82	87
Italy	65	60	60.5	60	81.4***	85.9***
Cyprus	65	65	:	:	81.8	84.2
Latvia	62	61y 6m — 62	:	:	75.2	81.1
Lithuania	62y 6m	60	:	:	75.5	81.5
Luxembourg	65	65	:	:	80.7	84.4
Hungary	62	60	61.2**	58.7**	76.5	81.6
Malta	61	60	:	:	80.1	83.8
Netherlands	65	65	62.1	62.1	80.8	84.5
Austria	65	60	61.3	60.6	81.1	85.1
Poland	65	60	61.4*	57.5*	77.7	82.9
Portugal	65	65	62.9*	62.3*	80.4	84.6
Romania	63*	58*	65.5	63.2	76.7	80.5
Slovenia	63	61	:	:	79.4	84.3
Slovakia	62	62	59.7*	57.8*	76.5	81.4
Finland	65	65	62.3	62.5	80.6	85.5
Sweden	61-67	61-67	64.2	63.7	81.8	85.2
United Kingdom	65	60	63.8	62.6	80.9**	83.7**

Source: Eurostat Note: * — 2007 data, ** — 2005 data, *** — 2004 data, $^{+}$ — common data for both sexes

The 2007 Joint Report identified the challenge of increasing the employment rate of older workers (or promoting longer working lives) for 16 out of 25 Member States (CZ, DK, GR, ES, FR, IT, CY, LT, LU, MT, NL, AT, PT, SI, FI, and SE). Some of these have sought to respond through new initiatives in pension and labour market policies. Yet, despite significant progress in recent years in many Member States (for instance LV, BG, LT, DE, SK, EE and NL), there is still a need to extend working lives across the Union, as illustrated by Table 4.1 which shows that the difference between remaining life expectancy at age 60 and the average labour market exit age is over 20 years for women in most Member States (see 4.2).

4.1.4. The increasing role of privately managed pensions

Most Member States have reported on increasing contributions to privately managed pensions as a means of improving the adequacy and sustainability of overall national pension provisions. In recent reforms, some Member States promote or mandate extra contributions for occupational and private pension provision (e.g. BE, DK, DE, IE, UK).

A number of Member States that have introduced mandatory funded schemes recently have done so by allowing for a transfer of contributions from old pay-as-you-go systems to the funded schemes, instead of increasing the overall contribution rates (e.g. HU, LT, LV, SK). Romania has introduced a voluntary funded scheme that implies moderate extra contributions for privately managed pension savings. In Bulgaria participation in the new funded scheme of supplementary pensions is mandatory. The interest in these schemes has often been higher than expected possibly because they were introduced in years of relatively high economic growth. The large number of people shifting part of their contribution has caused deficits in the pay-as-you-go systems. Slovakia has responded by allowing contributors who earlier chose to opt out of the pay-as-you-go system to review their choice. This has resulted in an increase of revenue in the pay-as-you-go systems and a delay in the full establishment of the mandatory funded scheme. Changing the rules within such a short timeframe though temporarily expedient may erode the legitimacy and stability of the reforms enacted and the long-term sustainability of the different tiers of the pension system.

The Joint Report of 2008 showed that the broader use of private pensions is equivalent to a transfer of the risk of maintaining the value of pension accruals from governments to pension funds and in some cases ultimately to individuals. Member State experiences indicate a need to monitor the effects of this trend on the adequacy of pensions, and underpin private funded provision by an appropriate and careful design of public regulation clarifying the definition of pay-out conditions, government supervisory roles, and the definition of new instruments. Current reporting shows that Bulgaria has chosen to curb risks by introducing guarantees and putting restrictions on the risk levels of investment portfolios. Slovakia is introducing a life-cycle approach to fund investments on behalf of individuals (see 4.3).

4.1.5. Maintaining pension adequacy while ensuring sustainability: indexing and automatic adjustments

The adequacy of retirement income systems vary widely between Member States. In recent years some countries have improved the share of income from earnings-related pensions considerably, while in others reliance on basic pensions is just beginning to decline as a result of the maturing of earnings-related pensions and higher employment rates. In this context, the 2007 Joint Report identified that Member States need to monitor whether the income of pensioners, including those with the weakest prior links to the labour market, maintain their value relative to prices and do not fall too far behind wage developments.

Adequacy is not just about replacement levels at the time of retirement and pension take-up but also about how the value of benefits relative to prices and wages is maintained over time. Indexation allows pensions to keep a certain value over time ensuring adequacy not only at the time of retirement and pension take-up but also in the following years.

Not all Member States have systems of regular indexing. But a few of those without introduced it in this reporting period (e.g. LT). A number of Member States have chosen to boost the adequacy of pensions by reforming of the indexation rules or by ad hoc increases in pensions – sometimes in combination.

Some countries report a shift towards a higher degree of earnings-linked indexing of statutory old age pensions (e.g. CZ, HU, PL, UK). To what extent this shift entails higher up-rating depends on the economic situation. In many Member States 2006-2008 has been a period with higher growth and increasing inflation. Pensions have typically been indexed to prices in order to ensure a constant purchasing power over time. Wage or GDP growth oriented

indexation of pensions has been advocated as it allows the incomes of retirees to track those of the working population more closely. It is also positive from a financial sustainability point of view as the up-rating of pensions become more closely connected to economic development. The coming period 2008-2010 is likely to see very moderate economic growth and lower inflation.

Member State experience, as reported in the National Strategy Reports, indicates that it is also important to weigh the adequacy effects of different types of indexation carefully against the sustainability impacts.

The use of automatic annual indexation rather than ad hoc increases is an important development for ensuring the transparency and legitimacy of a pension system. Some Member States have also introduced automatic or semi-automatic adjustments to the level of outgoing pensions through periodic assessments of pressures on pensions. These are designed to stabilise the financial sustainability of pension systems through automatic adjustments of benefit levels (e.g. SE, FI, PL, LV or DE) or periodically required reviews and fine-tuning (e.g. AT, IT or FR).

Automatic adjustment and indexing rules only boost the transparency and credibility of a system if the triggers are allowed to function. Most automatic mechanisms have not yet been applied in practice and experience from 2006-2008 highlight that it is critical to monitor the functioning of these mechanisms. A few countries have already postponed automatic adjustments by political means (e.g. the delay in the automatic updating of life-expectancy projections for annuity calculations in IT or increases to benefit levels above those guaranteed by stability enhancing factors in adjustment rules in DE). This may undermine the credibility of such reforms.

4.1.6. The role and quality of minimum income provision for older people

Amid the increasing importance of pension schemes where benefit levels are linked to work-, earnings- and contribution records many pensioners - including some of those currently taking up a retirement income - have to rely on the systems of minimum income provision for older people (MIPs) found in all Member States. The role, design and benefit levels of these vary widely across the Union. But everywhere they are meant to cater to the needs of people with insufficient or no rights in the employment related pension schemes and gender role legacies entail that women constitute the bulk of recipients. As these benefits represent a particularly fragile part of the overall adequacy of retirement income the 2007 Joint Report called for greater attention to the role, levels and indexing of minimum income provisions for older people. MIP-recipients spend a relatively high share of their income on basic needs price developments in certain commodities are therefore of particular concern. Phenomena such as the sudden hike in energy and food prices in the spring of 2008 have presented a particular challenge to adequacy. Only a few Member States have reformed their MIPs and those countries with particular challenges with regard to MIP adequacy have primarily adjusted their systems in smaller ways. But ad hoc up-ratings and improvements to indexing mechanisms have been both frequent and widespread. Indeed, in many Member States such measures have meant that the relative value of MIPs has been reasonably maintained despite rapid growth and rising inflation (see 4.4).

4.1.7. Ensuring information and transparency

Pension reforms have resulted in a move towards multi-pillar systems with defined-benefit elements and made eventual retirement income considerably more dependent on individual behaviour and decisions in the active years. Pension systems have become more difficult to understand and pension benefits less easy to predict. In order to be able to respond well to the new incentives in pension systems and make the decisions most befitting their set of circumstances and preferences workers need far more information than before. Providing this in an effective way has become another part of the pension challenge which Member States increasingly have to take up to ensure that pension reforms are well understood, gain popular support and achieve their intended results (see 4.5).

4.2. More people in work and working longer: The response of pension policy

Getting more people to work more and for longer has been identified as one key solution to the pension challenge that allows for both financially robust pension systems and adequate benefits. While raising the likelihood that adequate pension rights are earned, the extra years of contributions also improve the financial situation of the system.

4.2.1. Increasing the contributory base to meet the challenges of sustainability and adequacy

In a number of Member States improving the financial base of a pension system through increases in the contribution rates has been identified as a solution to the complex problem of providing adequate pensions without compromising the financial standing of the pension system.

A few countries report on reforms to increase their contribution revenue through higher contribution rates to existing schemes, thus securing the adequacy and sustainability of pensions (e.g. CY, DE, HU, IT). Low contribution rates can lead to inadequate benefits or insufficient financing of benefits. From a solidarity point of view it is, however, important to ensure that mandatory contributions are at a reasonable level so as to not over-burden the income of the working population.

Too big a contributory burden on work income can create strong incentives to contribution avoidance and may endanger the financial and political legitimacy of the pension system. Romania report on reductions in contribution rates to the pension system from extraordinarily high levels. The idea is to improve sustainability by encouraging more workers to participate in the formal sector, thus widening the contributory base and the volume of contributions. In countries with a large informal sector, broadening the tax or contributory base also increases adequacy as more people are covered by the retirement insurance. At the same time it contributes to the long-term sustainability of the system because the financing base increases as more people become active in the formal economy. Most Member States with problems in their contribution base are looking at ways to include groups at the margins of labour market and social security systems, such as the self-employed, immigrants and the disabled.

In many Member States young people are increasingly employed on temporary contracts. But membership of pension schemes is usually linked to permanent employment status, so young workers are very often exempted from mandatory pension contributions. For example Italy has made improvements allowing more people with atypical contracts to be better covered by

social security and pension schemes. Member States have also made it easier to transfer entitlements between pension funds and thereby improved labour mobility.

If younger workers join the labour market later it can reduce the cumulative yield of accrued pension rights in notional defined-contribution or funded schemes, because the yield depends on the length of time that returns are accumulated. But even in PAYG schemes late entry will increase the risk of being unable to accrue enough contributory years to earn a full pension.

4.2.2. Protecting those with non-standard careers in reforms

Typically pension reforms have extended the number of contributory years needed for a full pension and have based calculations of earnings-related benefits on income from a greater number of working years. Thus, length of career and income earned over the career have become much more important for the pension benefits accruing to individuals. In view of this development, the 2007 report advocated more in-depth analysis of the impact of these reforms on people u able to meet these conditions due to atypical career patterns. Future risk groups would include the low skilled, low waged women and men, individuals affected by long-term unemployment or illness, people with caring duties and people excluded from pension coverage due to short term, temporary contracts or self-employed status. The 2008 national strategy reports show that the lowest pensions currently are received by those that have had the weakest link to the labour market in the past. De facto inactivity and longer spells of unemployment will impact on the future pension benefit of individuals. Past levels of long-term unemployment in many new Member States are already likely to result in lower retirement incomes in conjunction with recent reforms. Widespread future unemployment in generations where the old-age dependency ratios are already high will impact on the long-term financial sustainability of pension systems, but also affect the adequacy of pension accruals for some.

While maintaining scheme incentives to return to work as quickly as possible many Member States have two mechanisms for addressing the issue of adequacy for those with career breaks, minimum pensions and the accrual of pension rights in non-contributory periods. Earnings-related systems usually offer a minimum pension calculated on more favourable terms for those with lower incomes or shorter working lives (e.g. BE, BG, CZ, ES, FR, LV, LT, LU HU, PL, PT, SE, SI). In their main statutory schemes all Member States offer some form of protection of the accrual of pension entitlements in typical contingencies of involuntary interruption of employment. Usually periods of unemployment, long-term illness and maternity are credited by pension contributions being paid on behalf of the affected individuals by the relevant social insurances dealing with the contingency. Yet, contributions are mostly only continued at a general low level of income equivalent to the minimum wage. Pension accruals will therefore be much smaller in such periods. Similar protections may exist in many occupational schemes, but would not be present in voluntary funded schemes.

All Member States provide some kind of recognition of caring duties in pension entitlements. Many Member States have recently improved the crediting of caring years (e.g. EL, ES, LT, MT, PT, UK). The most common approach is to credit caring years at the same level for everybody irrespective of the level of income lost or foregone. Malta has introduced and Luxembourg plans to introduce credits for childcare years. In Spain new rules allow a person restricted to part-time work due to child or family care to be credited for a full day's work in the eligibility calculations. Other Member States provide a protection of pension entitlements during childcare which is linked to the employment situation and income of the individual

(e.g. EE, HU, IE, PL, PT, RO, SE). Some countries, however, still deal with the issue of care years by lowering the pension eligibility age for women with children (e.g. CZ, SI).

In recent years, a number of member States have also introduced care credits for other types of care than for children. These are usually linked to a general reference value rather than earnings (e.g. BE, DE, AT) or simply include care periods as a part of eligible qualifying periods (e.g. EL, IE, LT, PL, UK).

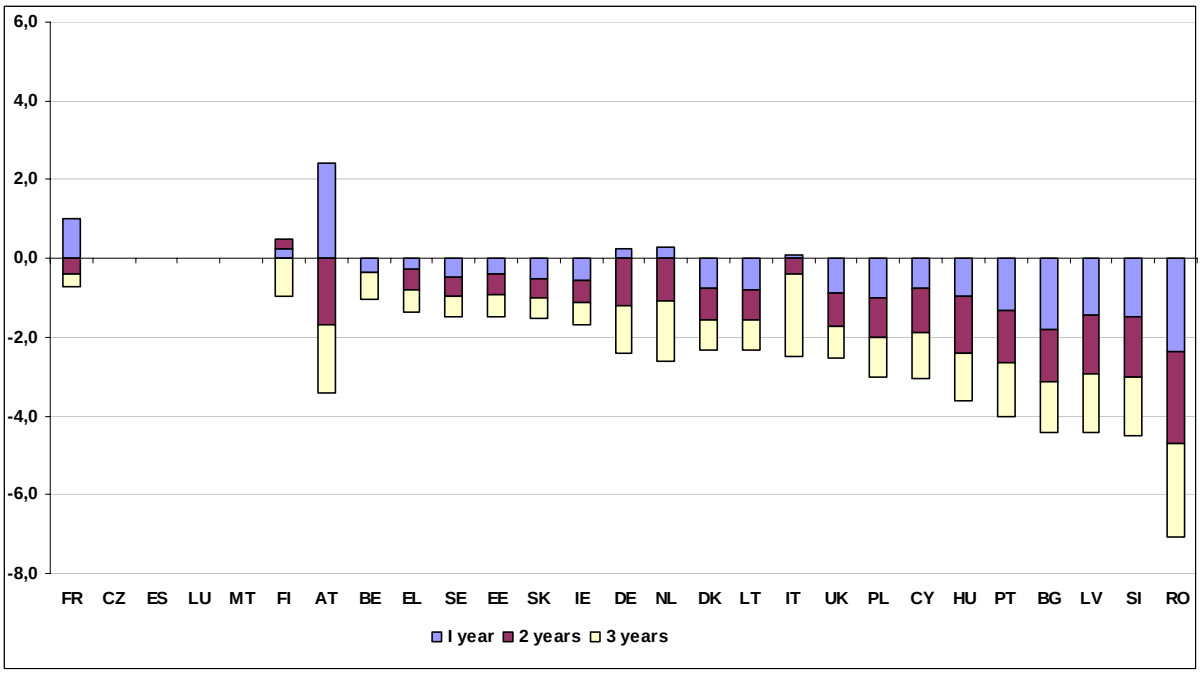
Box 1: Illustrations of the result of absences from the labour market on pensions

Calculations show that in most Member States absences from the labour market due to unemployment or childcare, though partially protected, generally lead to decreases in theoretical replacement ratios.

In many Member states, absences from the labour market for childcare are typically protected to a certain extent for the first few years of absence and usually the protection is equally spread over these years. In a few Member States pension rights for up to three years of absence are so well protected that calculations show no drop in replacement rates (e.g. CZ, ES, LU, MT). Whereas this improves the adequacy of benefits accruals during childcare absences, the work incentives in the system can be questioned. In the Czech Republic, the retirement age for women is decreased depending on the number of children they bear and the years of retirement before the age of 65 are accredited giving no change in the replacement rates. In Malta, where the minimum statutory retirement age is 61 and only 30 contributory years are needed for a full pension, the replacement rates do not change with a prolonged or shortened retirement age in this exercise which is based on a 36 year contributory period. However, recent legislation credits social security contributions for interrupted careers of up to 2 years.

In some countries childcare credits are connected to the birth of the child rather than an absence from the labour market (e.g. DE, FR, IT) resulting in an increase in pension entitlements when a child is born. In Romania, childcare breaks are less well protected than in most other Member States. In the UK the decline on the state pension side is marginal, and results depend more on whether private pension schemes award care credits or not.

Figure 11: Difference in net theoretical replacement rates for an average earner entering the labour market at 25 and retiring at the statutory retirement age with a 1, 2 and 3 year career break for childcare compared with no break*



Source: ISG calculations on Theoretical replacement rates carried out in the OECD APEX model or in national models. The figures for NL are preliminary.

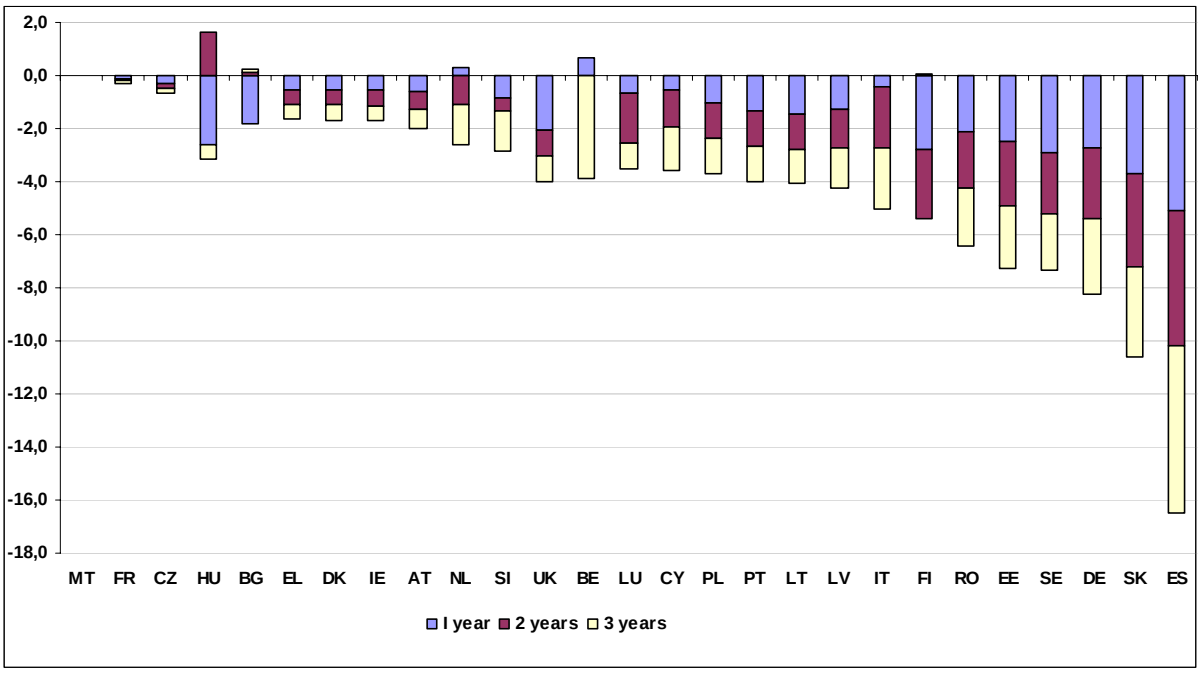
* The calculations assume two children are born and that the timing of the childcare years is such that full childcare benefits are received for each child. Retirement at the legislated statutory retirement age for women is calculated here

In some Member States (e.g. CZ, DE, EE, EL, ES, FR, IT, CY, LT, LU, AT, PL, SK, FI, SE, UK) the protection for childcare is better than for unemployment over a three year period. Yet, in many Member States absence for childcare translates into lower replacement rates than unemployment absence.

Whiles important to protect certain types of absences from the labour market it is important to consider the work incentives within the retirement and unemployment systems.

On the other hand, the drop in replacement rates are much higher in some Member States during the three years of unemployment (e.g. SK, ES), bringing the adequacy of protection of pension entitlements during unemployment into question. In most Member States the drop in theoretical replacement rates is equal throughout the three years of unemployment. In a few cases the drop is lower (e.g. BG, DE, FI, HU, SE, UK) or bigger (e.g. DE, ES, FR, IT, CY, PL, LU, SK, SI) after the first or second year of unemployment.

Figure 12: Difference in net theoretical replacement rates for an average earner entering the labour market at 25 and retiring at the statutory retirement age with a 1, 2 and 3 year career break for unemployment compared with no break*



Source: ISG calculations on Theoretical replacement rates carried out in the OECD APEX model or in national models. The figures for NL are preliminary.

* The unemployment break is assumed to take place in the years just prior to old age retirement which is assumed to take place at the legislated statutory old retirement age for men.

4.2.3. Improving gender equality in pension policy

Many Member States report on significant wage gaps between employed men and women, ranging from under 5% (MT) to 25% (EE). Women also tend to work part-time and so their earnings often develop more slowly than men's. Though substantially reduced the resulting gender gaps in retirement income are set to persist. Equalising the pension eligibility ages for men and women is part of the solution legislated by Member States to ensure that women have a decent retirement income. Some Member States plan to equalise pensionable ages in the near future (e.g. BE, LV, HU) whiles others have longer transitional rules (e.g. EL, EE, LT, MT, AT, CZ). Some Member States will narrow the gap between the pensionable ages for men and women without making them identical (e.g. BG, RO, SI). Others have so far made no steps in this direction (e.g. PL).

Constant observation and efforts are needed to achieve gender equality on the labour market and in the distribution of care burdens, which today are still mainly borne by women. It is also important to monitor the effects of policies whereby replacement incomes and pension entitlements are given for care-related absences from the labour market in order to avoid that such protections become new dependency traps. As caring years have a significant negative effect on women's long-term participation to the labour market in many Member States, a careful balance must be struck between care crediting and incentives to get women back into paid work. Tailoring pension scheme mechanisms to the new gender roles would promote the

reconciliation of work and family life, enabling women (and men) to resume their careers quickly and combine parenting with work.

4.2.4. Increasing the employment of older workers

Member States have sought to encourage more employment of older workers by raising the pensionable age, closing early exit routes and allowing for flexible combinations of work and pensioning. Employment rates of older workers (aged 55-64) have improved in recent years, reversing a long-lasting downward trend (see section 2.1.2).

4.2.4.1. Increasing the pensionable age in statutory schemes

Politically pension reforms are difficult to initiate and implement. Raising the pensionable age in the statutory scheme is notoriously difficult as this age is intimately connected to the social institution of retirement and signals the recognised age at which it should take place. A number of Member States have legislated an increase in the pensionable age for both genders in recent reforms. In most of these Member States the higher eligibility ages for a statutory pension will be phased in over a long period and have more effect on younger cohorts (e.g. CZ, DK, DE, LT, MT, UK). It is therefore important to monitor the actual implementation of these reforms and study the political climate that allows for increases in the pensionable age to be carried forward. Despite the general trend towards increases in the pensionable age, there are Member States where the pension eligibility age is still relatively low (e.g. BG, EE, FR, LV, HU, SK).

4.2.4.2. Increasing the contribution period

Usually the length of contributory periods corresponds to pensionable ages. However, some Member States (e.g. France) have kept the formal pensionable age at the same level while increasing the contribution period needed for a full pension. This solution might be more acceptable from a political point of view than increasing the pension eligibility age in statutory schemes. If the right to receive a full pension depends on the contribution period, people who start working at a late age are not unduly rewarded.

Contribution periods required for a full pension have been increased in some member States (e.g. CZ, FR, AT), so the link between contributions paid into the system and benefits paid out has been tightened. Nevertheless, conditions for drawing a full pension are very diverse and sometimes they are not sufficient to make people work longer, as there are Member States which still require only 30 years of contribution (e.g. LT, RO).

The qualifying period for a minimum pension has recently been extended in CZ, CY, ES, and RO. If a minimum pension scheme guarantees the major part of pensioners' income, and the contribution period is too short, it can act as a disincentive to stay in the labour market.

With the aim of ensuring that more women and men with caring duties and shorter careers gain entitlement to a basic pension, the United Kingdom has gone against the general trend by reducing and equalising the number of qualifying years. This example highlights the need to study the effects of longer qualifying periods on those with shorter careers.

4.2.4.3. Promoting flexible retirement options

Under specific circumstances more flexible paths out of employment into retirement can help to promote longer working lives. For instance, the increase in the employment of older workers over the past decade is partly due to a rise in part-time work, notably by men. About 25% of employment among older workers in the EU-15 is now part-time (22.5% in the EU-25 and 22% in the EU-27).

Another issue for the design of flexibility in pensionable age is the conditions for partial pensions, and where individuals can take a share of their pension whilst continuing to work (given particular conditions). This type of provision is reported in a number of Member States (CZ, ES, FR, IT, NL, FI, and SE). Individuals' motives for choosing these options include reducing the number of hours worked and accruing further pension rights in order to ensure a higher pension in the future. Member States are fine-tuning both arrangements, and sometimes restricting flexibility in the name of preventing abuse is required. It has recently been seen in the case of Spain, where the age when partial pension is accessible has been raised, and in Hungary where the rules on cumulating the early retirement benefits and income from work have been tightened.

Providing flexibility in combinations of work and partial pension may enable people to work longer. Work time reduction can be essential for facilitating and encouraging people to remain in work after 60. Nevertheless, introducing more flexible retirement provision requires a careful design of the structure of incentives and a focus on a proper target group of workers (for instance in terms of age).

One solution is to link the pensionable age to the length of the contribution period and a bonus/malus system for earlier or later take-up of the pension. This is for instance the case in Sweden, where the pensionable age is optional within the 61-67 age brackets.

A common way to promote longer working lives pursued in recent reforms is to strengthen the bonus-malus system in schemes with delayed and early retirement possibilities. A number of Member States (BE, BG, CZ, ES, GR, HU, NL, PT and UK) have recently introduced or increased bonuses (higher accrual factors) as reward for later retirement, and/or maluses as penalty for early retirement. Workers who decide to work longer are usually rewarded for every additional month or year in work. One of the dilemmas concern deadweight problems connected to the risk of subsidising those who would in any case have postponed retirement. The impact of these specific measures can be rather limited. For instance the pension bonus introduced in France by the 2003 reform attracted only 7.6% in 2007. Furthermore, it seems that incentives to defer retirement have less impact than opportunities to retire early.

Box 2: Illustration of the effects of longer and shorter working lives on pension adequacy

Calculations of theoretical replacement rates point to a decline in future pension levels and the subsequent replacement rates at a given pension age (please refer to Table 2, Chapter 2). This reflects the fact that reforms of statutory pensions will be lowering pensions to meet the challenges caused by increased life expectancy. Member States are planning to compensate for this decline by extending working lives and increasing supplementary pension savings.

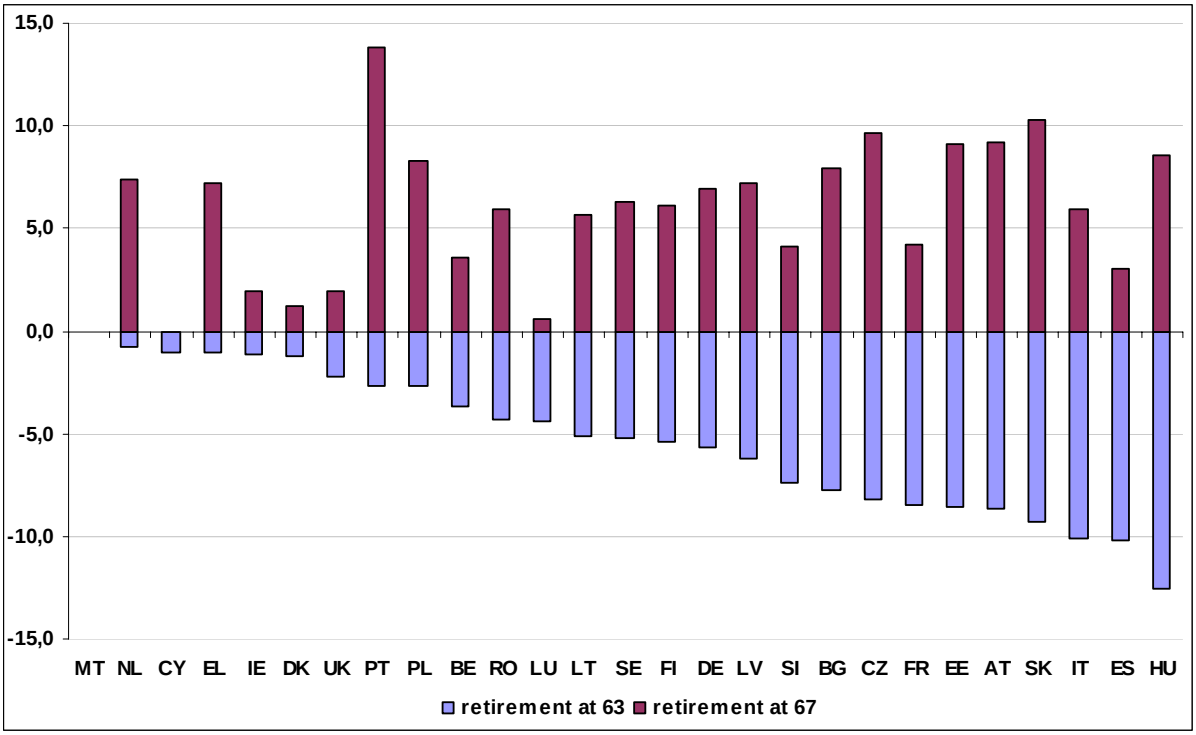
Most countries have incorporated incentives to prolong working life into their pension systems. Many of these incentives take the form of reductions for early retirement or bonuses for later retirement. These may be carried out in an actuarial manner often based on remaining life expectancy or through bonuses and penalties fixed by legislation. Other incentives to work more and longer are generated by increasing the contributory period in pension systems and strengthening the link between pensions and contributions.

Calculations show that in most Member States delaying retirement results in higher theoretical replacement rates, while earlier retirement usually results in lower theoretical replacement rates. In all but a few Member States (e.g. DK, ES, FR, HU, IT, LU, SI, UK) the increments in pensions for prolonged working lives are higher than the fall in replacement rates with earlier retirement. In most cases the difference is small, but there is a clear trend towards rewarding late retirement more than early exit is penalised.

In Member States where the retirement age is lower than 65 the calculations show how the bonus-malus system would work if the retirement age was set at 65 (e.g. BG, CZ, EE, LV, LT, HU, MT, SI, SK). In Malta, for example, where the minimum statutory retirement age is 61 and only 30 contributory years are needed for a full pension the replacement rates do not change with a prolonged or shortened retirement age in this exercise which is based on a 40 year contributory period. In Member States where the pensionable age is planned to be higher than 65 in 2046 (e.g. DE, UK), the effects of deferring retirement beyond the legislated retirement age are not captured by the exercise.

In the Netherlands it is interesting to note that the replacement rates from statutory scheme does not change with shorter or longer working lives as the pension is resident based. There are, however, clear changes in the occupational schemes that play an important role in Dutch pension income. In Italy, it is observed that the annuity coefficients used in the public notional defined contribution system currently do not increase above 65 years of age.

Figure 13: Difference in net theoretical replacement rates for an average earner working until the age of 63 and 67 with 38 and 42 contributory years respectively as compared with working until the age of 65



Source: ISG calculations on Theoretical replacement rates carried out in the OECD APEX model or in national models. The figures for NL are preliminary.

4.2.4.4. Restricting access to early retirement

Most transitions from work into retirement are not direct. The average age of exit from the labour market is often lower than the average age at which an old-age pension is drawn. Only 35% of older workers leave their last job or business to take up a pension. 20% take up an early retirement benefit, 13% leave due to unemployment and 12% for reasons of long-term sickness or disability.

The proportion of early or indirect exits varies considerably from one Member State to another. Nevertheless, a positive trend is visible, as a number of Member States adopt reforms to discourage the take-up of, or even to close access to, early retirement paths from the labour market. Member States increase the age of entitlement to early retirement (e.g. BE, CZ, SK, UK), equalise the rules of access for both genders (e.g. DE, HU), plan to limit the number of professions entitled to benefits (e.g. PL), tighten the rules of access to recently introduced schemes that turned out to be unexpectedly popular (e.g. FR), or simply phase out the schemes (e.g. IE). Other Member States strengthen the financial disincentives to retire early, by increasing the value of penalty factors (e.g. CZ, GR, PT, UK). Another solution adopted is suspension of early pension benefits for those who earn more than a minimum wage (e.g. HU). Since January 2006 the Netherlands has tightened fiscal treatment of early retirement and pre-pension schemes, and a reform of unemployment benefits is aimed at preventing the use of the scheme as an early retirement path. Yet some Member States have delayed planned reforms. Italy, Austria and Poland decided to slow down the process of tightening the minimum requirements for early retirement.

Some early retirement schemes automatically create exceptions from general rules for certain occupations which are thought to be ‘arduous’ or dangerous for health. The National Strategy Reports do not report the details of such rules, so the differences and similarities between Member States would be an issue for further study.

Attempts to restrict or close early retirement options often lead to a run on schemes in the period before the changes take effect. This was the case in Poland and Slovakia, for example, where announcements of restrictions on early retirement from 2008 caused a massive increase in applications in the final months of 2007. The French National Strategic Report mentions that a similar situation occurred in France between 2003 and 2006 with the early retirement option for those with long working records. Latvia experienced a drop in the effective retirement age in 2007 due to early exit paths for certain categories of workers, and despite the fact that the pension eligibility age had been raised.

In general Member States are closing access to early exit paths from the labour market. However, developments in the labour market will also have a strong influence on future take-up of benefits, and expectations of a decline in the take-up might be questioned in the light of the global economic downturn.

4.2.4.5. Restricting access to disability schemes

In line with the challenge highlighted in the 2008 Joint Report some Member States have sought to extend working lives by curbing exits through sickness and disability schemes (e.g. CZ, DK, ES, HU, MT, NL, PL, AT, SE). Measures generally involve rehabilitation efforts in connection with stricter eligibility rules and greater cooperation between institutions involved to allow for a quicker transition back into the labour market. Restricting the use of sickness

and disability schemes as pathways for early exit should however not preclude the use of such schemes for the contingencies they were meant for.

Some Member States have recently introduced a distinction between relative and absolute invalidity (CZ, PT, UK). These reforms aim at reducing early exits from the labour market by differentiating between those claimants potentially fit to be employed on a full or part-time basis and those more severely impaired. Member States are looking for ways to activate everyone according to their capabilities and the dichotomy of "employable" versus "unemployable" persons with disabilities is being challenged.

4.2.4.6. Improving employment opportunities for older workers

To sustain pension promises it is essential to have both a well-functioning labour market and a high activity rate among the population of working age. Lack of progress in the employment rate of older workers is often caused by poor employment opportunities.

The National Reports present two major kinds of instrument to boost activity. First, Member States are adapting lifelong learning, offering more training designed to make older workers' skills more adaptive and to help them keep their jobs (e.g. AT, BG, and CZ). Second, by subsidising employment and giving employers financial incentives, they are making it more attractive to employ elderly people (e.g. AT, DK, ES, LT, HU, and SE). There are also approaches that involve shifting part of the financial burden of early retirement schemes on to employers and committing them to employ a certain share of older workers in their work force (e.g. FR).

As a number of National Strategy Reports point out, the European Social Fund (ESF) contributes to the financial sustainability and adequacy of pension systems (€ 1 billion, 1.3% of total ESF budget) by encouraging active ageing and prolonging working lives (e.g. AT, HU, SK), as well as by developing life long learning systems in enterprises and improving the adaptability of workers (€ 9.4 billion, 12.4% of total ESF budget).

Member States are also using European anti-discrimination law in their promotion of better age management (e.g. DK, NL, UK). European legislation on age-based discrimination (Council Directive 2000/78/EC) states that less favourable treatment of employees on the grounds of age needs to be objectively justified. Judgments from the European Court of Justice have recently confirmed that the provisions of the Directive also apply to the mandatory pensionable age. So the fact that a worker has reached pensionable age cannot be a sufficient reason to terminate the employment. Moreover, some Member States encourage employers, particularly in small and medium enterprises, to change ageist practices and to provide more opportunity and choice for their older workers (UK).

4.3. Supplementary funded pensions: impact on adequacy and sustainability

4.3.1. The growing importance of funded schemes

Member States are attaching increasing importance to privately funded supplementary pensions as a way of helping to maintain adequate and sustainable pensions in the face of the demographic challenge[36]. So whilst public Pay-as-you-go (PAYG) pensions are and will remain the most important element in European pension provision, private funded pensions will have a growing role within the overall pension income of EU citizens.

This and the impacts on the financial markets from the credit crunch and ensuing economic problems make it more important than ever for systems to be carefully designed. In particular systems need to strike the right overall balance between public PAYG and private funded provision and ensure that funded schemes take an appropriate approach to investment risk.

Member States employ three types of funded pension provision: statutory funded pensions (pillar I); occupational pensions (pillar II); and voluntary pensions (pillar III).

Statutory funded pensions are generally a recent phenomenon with little relevance for present pensioners. Only Denmark has a mature scheme of this sort and its role in overall pension provision is very limited. However, such pensions will gradually become more important with Latvia, Lithuania, Hungary, Poland, Romania, Slovakia and Sweden all relying on statutory funded provision to some degree as an element in overall future pension income. Romania is the most recent Member State to introduce statutory funded provision, with a system of compulsory individual accounts starting in 2008. This pre-funded pension will sit alongside the traditional PAYG first pillar pension and be funded by compulsory contributions of 2% of salaries rising in 0.5% increments over 8 years until they reach 6%. Like all the other statutory funded schemes this is defined contribution (DC) in character, where the risks are with the individual.

Occupational funded pensions are the most significant form of funded provision for people retiring today particularly in the Netherlands, Ireland the UK and Sweden. Belgium, Cyprus, Denmark and Germany also have pertinent occupational provision for those retiring today. Traditionally these schemes were normally defined benefit (DB) in nature. However, there is a longstanding trend away from DB occupational pensions to DC occupational pensions, particularly in Ireland and the UK, and in Denmark major schemes were DC from the beginning. For the future occupational pension schemes are expected to grow in importance in a number of Member States, but these schemes will increasingly be DC in nature.

Voluntary pension provision is typically not a very significant element in today's pension incomes except in Germany and to a lesser extent the UK, Ireland and the Czech Republic. Germany is one of the few Member States anticipating significant strengthening of this type of provision on the back of the generous incentive structure in place for *Riester* pensions.

The role these different pensions schemes are expected to play in the wider system varies considerably. Some, in particular statutory funded pensions, are meant to support or replace

[36] such as the 2005 SPC study on privately managed funded pensions, the 2006 Synthesis Report on Adequate and Sustainable pensions, the 2007 Joint Report and the 2008 SPC report on privately managed funded pension and their contribution to adequate and sustainable pensions

pension income from the main public PAYG scheme. Others, notably voluntary saving, may except for the self-employed simply have the role of providing a top-up to other substantial pension income, perhaps to allow high earners to match the replacement rates of those with lower pre-retirement income. Occupational pension schemes tend to sit between these two, offering significant support to statutory PAYG pension provision. The important thing is that factors like the coverage and adequacy of any particular funded pension appropriately match its intended role in the wider pension system.

4.3.2. The double payment problem

Funded pension provision that is intended to replace some elements of PAYG pensions effectively brings forward the costs. This can help with smoothing the expected future increases in pension expenditure that demographic change will bring and so help with sustainability. But it means that the present active generations will have to pay for both the PAYG schemes and the new funded schemes at the same time. Often Member States divert part of the contribution for the PAYG scheme into the funded scheme while covering the shortfall from the state budget though general taxation (e.g. SK, LV, LT, EE, HU). Irrespective of the way it is done, bringing forward costs by increasing pre-funding can place strains on Members States' fiscal positions and the current economic situation provides a serious stress test of the viability of such arrangements.

For instance, the 2007 report flagged up Slovakian transition costs on the one hand and long-term sustainability on the other. Even before the financial crisis, SK had taken various actions to reduce the amounts of costs brought forward by earlier reforms enacted a few years earlier. Thus on 1st January 2008, SK re-opened the statutory funded pension scheme for a 6 month period giving savers a chance to join or leave. 104,000 people left and 20,000 joined. From the same date new entrants to the labour market will have six months to decide whether they want to take part in funded pension savings or not. All of this means more Government revenue now at the expense of greater pension costs later. An unwelcome side effect of rapid changes of direction can be the uncertainty it creates about the long-term stability of pension reforms.

4.3.3. Privately managed funded pension and their contribution to adequate and sustainable pensions

The 2008 SPC study *Privately managed funded pension and their contribution to adequate and sustainable pensions*[37] highlighted a number of issues which also emerge from the National Strategy Reports. These included:-

There is a need to improve the data on this growing segment of pension provision.

The role and development of private pensions is very diverse across the EU, reflecting cultural and historical issues as well as the wider pensions systems in place in the different Member States. Thus private schemes must be assessed in the context of the role envisioned for them in the wider pension systems of particular Member States. Low coverage and breaks in contributions can be a cause for concern about future adequacy, in particular for women, the young, the less educated and the low paid.

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[37] Published 20/10/08 and available at http://ec.europa.eu/employment_social/spsi/adequacy_sustainability_en.htm

As investment and longevity risk increasingly are shifted onto individuals they will need better financial education and information. Lifestyling/lifecycling approaches to investment and flexibility around when a pension must be taken represent important ways of mitigating financial risk for individuals. The payout phase of funded schemes must be carefully designed if adequacy is to be properly ensured. Given the significant impact of administration charges on the pension ultimately accrued they must be kept as low as possible and this cannot be left to market forces alone.

4.3.4. Coverage

For statutory funded schemes we could expect coverage to be near universal given the role they are intended to play. However, such coverage does not happen instantly - schemes are phased in and have varying transitional arrangements. At the time of the 2008 SPC report it ranged from 25% (in IT) to 90% (DK) or 100% (SE). In most Member States, where such schemes have been introduced, coverage ranges around between 50% and 70%: BG (50%), EE (50%), LT (54%), LV (80%), HU (70%), PL (70%), SK (65%).[38] Coverage should approach 100% as schemes mature (since mostly only younger workers are required to join), but it may take a generation.

For coverage of occupational pension schemes, we can divide Member States can into three broad groups:

– High coverage (over 75%): DK (around 75%), NL and SE (over 90%);

– Medium coverage (between 40 and 70%): IE (around 40%), CY (around 45%, including both occupational schemes and provident funds), UK (around 47%), BE (around 55%) and DE (around 60-65%, which includes a significant share of Entgeltumwandlung);

– Low coverage (under 20%): IT (17%), AT (13% at the time of the SPC report, now 15%), FR (around 15%), ES and FI (8%), LU (5%), PT (4%), or very low (around 2.2% in PL).[39]

Coverage levels may change as schemes evolve. The closure of existing schemes to new members as employers seek to control costs will cause it to fall. Initiatives such as the UK's auto-enrolment legislation are likely to expand coverage and reverse this trend. From 2012, employees, who are not already in a good quality workplace pension scheme, will be automatically enrolled into either their employer's sponsored scheme (if it meets quality requirements) or into a new savings vehicle, known as personal accounts. The personal accounts scheme is expected to have between four and seven million members, with up to £200 billion of assets under management by 2040. The UK's Pensions Act 2008 ensures that for the first time in the UK all employees will have access to an occupational pension scheme supported by employer contributions and tax relief.

Another innovative approach is in Italy. The 2004 reform modified the TFR (*Trattamento di Fine Rapporto*) workers' severance pay (a portion of the worker's pay set aside by the employer formerly paid as a lump sum at the end of employment period) so that it is automatically transferred to defined contribution occupational pension schemes unless the

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[38] All figures from 2008 SPC report *Privately managed funded pension and their contribution to adequate and sustainable pensions* available at:
http://ec.europa.eu/employment_social/spsi/adequacy_sustainability_en.htm

[39] ibid

employee actively chooses another option. With this so called 'silent-assent' mechanism if workers do not express their desire not to be members within a six month deadline, the TFR is transferred to the pension schemes set up by collective agreements between employers and trade unions at sector or local level. Employees remain free, however, to make an active choice to decide to keep the TFR with their employer, a decision that can be subsequently revoked. There has been a 43.4% increase in take up in 2007 compared to the previous year. Larger employers with good worker communication and union presence were key factors.

For voluntary pensions, coverage is generally negligible at a few percent or less, for example the French PERP has coverage of around 2.8%. The Czech Republic introduced the Supplementary Pension Insurance in 1994 which covers 49% of those aged 18 (minimum age to take part) to 64, though contributions tend to be low and funds are often taken as lump sums. The German *Riester* pensions have expanded rapidly, doubling in coverage to 28% between 2005 and the end of 2007[40] and as at March 2008 there were 11 million Riester-Rente contracts[41]. The UK at 19% and Ireland at 15% are the other exceptions with relatively high coverage levels[42]. In Portugal a Public Funded Regime (RPC) was introduced in 2008, based on individual accounts to which individuals can pay supplementary contributions (from 2% to 6%) on a voluntary basis. The fund assets are invested and managed in the Portuguese Reserve fund, with a prudential profile and with very low administrative charges. Every year, individuals have the option to suspend, increase or decrease contributions. When retirement conditions are met, the balance of the individual account can either be transformed into an annuity or taken as a lump sum payment.

As such saving is voluntary it is hard to predict how coverage might develop as it can be influenced by a range of factors. These include tax and other incentives, other long-term saving options, information provision, perceptions of likely investment growth and the levels of other retirement income and the availability of the necessary spare income to be able to contribute. Current economic conditions are likely to negatively impact on such saving at least in the short term. For most Member States we could perhaps expect little change or some continued modest growth in this area. The exception is Germany where, on the back of strong incentives, the coverage and significance of the Riester pensions are expected to grow considerably. The reason for the increasing popularity of the Riester pension is the attractive design of State assistance owing to the supplement system, which is particularly true for low-income earners subject to pension insurance and for large families. At the beginning of 2008, the Riester pension reached its highest level of support. The basic supplement is now € 154 and the child supplement € 185 per year for each child for whom the beneficiary receives child benefit. For children born from 2008 onwards, the child supplement is as much as € 300. Retirement pension contributions (taking into account the supplement) up to € 2,100 can be offset as additional special expenditure against tax.

4.3.5. Contributions

Contributions vary considerably between Member States and scheme type and also between occupational and voluntary pension schemes. But very broadly, DB occupational pensions tend to have the highest contributions. For instance in the UK, contributions to DB funds

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40 ibid

41 NSR for DE 2008

42 Figures from 2008 SPC report *Privately managed funded pension and their contribution to adequate and sustainable pensions* available at http://ec.europa.eu/employment_social/spsi/adequacy_sustainability_en.htm

amount to just over 20% of the gross wage whilst they are just over 16% in the Netherlands. DC occupational schemes tend to have lower contributions, around 9% in the UK with about 10% in Ireland and 11% in Cyprus, though in Denmark they are at 12-17%. But contributions can also be quite low for occupational schemes in general for instance between 1 and 5% in Belgium.

For statutory funded schemes contribution levels are typically below the levels of DC occupational schemes and well below DB occupational scheme levels. Some levels are very low such as 1% on ATP and 1% on SP in Denmark, or the severance pay in Austria with 1.53%, or the Premium Pensions in Sweden with contributions of 2.5% of gross wages. But more typical, particularly for the new Member States, are contributions between 5% and 10% for instance Lithuania at 5.5% and Slovakia at 9% with Italy around the mid-point at 6.9%. Also within this range are some Member States that have chosen to gradually increase contribution levels. For instance in Latvia they were 4% in 2007 and will rise to 10% in 2011, whilst in Romania they were 2% in 2008 and will rise to 6% by 2016.

There is little data on voluntary schemes and clearly by definition contributions will vary considerably. For the Czech Republic, which has the highest coverage of this type of scheme, levels are low at 2.1%. Better data are needed, particularly in DE where the Riester schemes are expected to grow significantly in importance, as coverage alone does not tell the full story. What we can say for now is that overall it is likely that contributions will typically be the lowest in voluntary schemes.

Very broadly DB occupational schemes tend to rely more on employer contributions than DC schemes. Other than that there are no real patterns with statutory schemes varying from 100% of contributions from the employer and 0% from the employee to the opposite.

One important element on contributions for DC schemes is administrative charges. Clearly schemes have to cover their various costs, but even quite modest charges can eat significantly into investment returns over the many years of pension saving. So costs need to be kept low, but their complexity and the typical information and skills disparity between individuals and providers means the market does not necessarily do this efficiently[43].

4.3.6. Vulnerable groups

One aspect of increasing the proportion of funded provision is that, despite variable investment returns, this typically brings with it a more direct relationship between actual contributions paid and actual pension received than is the case with PAYG schemes. This can help to foster personal responsibility and increase choice and transparency. On the other hand the reduction in cross-subsidy can mean that groups vulnerable to low or missing contributions more exposed to poor retirement outcomes in Member States where funded pensions are expected to play a significant overall role in pension provision. Because of current labour market characteristics, women are more at risk than men of having poor outcomes from funded provision. Where these labour market inequalities are expected to persist the pension system will also give unequal outcomes unless it is designed to mitigate them.

[43] ibid

Some countries have introduced solidarity elements into their statutory funded schemes, while some others have also done so in occupational schemes, for example, by compensating for certain periods outside active employment, e.g. with the state paying contributions during periods of childcare or unemployment. In LV, HU, PL and SE, the same periods are credited in both tiers of statutory schemes (in SE all non contributory periods are provided with crediting, whatever the tier of the statutory scheme). In BG, EE, LT, SK and the UK only some risks covered under the unfunded tier are also covered by the funded tier (in BG, LT and UK none, in EE parental leave, in SK child care).

Furthermore, when the same risks are covered under the two tiers, there can be differences in the treatments, for instance for child-raising and unemployment periods. In LV, PL, SK and SE, these periods are treated in the same way in both tiers, both in terms of the duration of payment of contributions and the applicable contribution base. On the other hand, BG, EE, HU and LT treat individuals differently in both tiers, either by not covering them or with a less extensive coverage.

4.3.7. Risk sharing

No pension system is risk-free, including PAYG systems. But the move towards greater private pension provision means the addition of investment risk and a different sharing of risks. For DB occupational pensions the risks like longevity, inflation and investment performance are shared in different ways depending on the nature of the scheme. Some DB schemes have explicit mechanisms for sharing the risks with pensioners and/or contributors via indexation and/or contribution adjustments (as in the Netherlands). Others rely on employer sponsors (as in the UK) to take on the risks, though even here ad hoc employer negotiations with social partners may result in a sharing of the burden of cost increases, for instance by agreeing to reduce the generosity of the pension scheme or increase employee contributions. DB schemes also smooth out the risks from shorter term investment volatility by spreading it between large numbers of people retiring at different times.

DC schemes expose individuals most directly to risk. So-called 'lifestyling' or 'lifecycling' investment strategies[44] can help to manage risk over the saving cycle and give a reasonable rate of return at appropriate levels of risk. Strong consideration should be given to such investment approaches, particularly for statutory funded pension provision that is meant to be a crucial element of overall pension income. The right framework, including good information and appropriate use of default[45] options, needs to be in place to ensure people make the right choices. In SE the premium pension system had a choice of 785 different funds in 2007. When the system started in 2000 33% of people made no active choice and were defaulted into the Premium Savings Fund. By the end of 2007 41% had made no active choice and were in Premium Savings Fund. The Premium Savings Fund is described as medium-risk and has 85% of the capital invested in equities. Currently many Member States with DC funded provision, including the vast majority of those with statutory funded pensions, do not have lifestyling as the mainstream option. This needs to be critically re-examined as these schemes grow in importance and particularly in the light of recent market events.

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[44] With "lifestyling" or "lifecycling" approaches, investment risk is concentrated in the earlier part of a person's working life with investments gradually shifted over time into lower yielding but less volatile assets. By the time someone is approaching retirement, where there may not be sufficient time for falls in investments to recover, their investments would be mostly protected from significant investment risk.

[45] For instance ensuring that those who don't make an active choice of investment are automatically placed in funds with the best chance of meeting their needs.

4.3.8. Decumulation – taking a pension

With PAYG or DB occupational pensions people acquire rights to a certain level of regular payments in the payout phase from retirement age until their death. With DC pensions instead of rights to a stream of payments, a pension fund builds up. This sum of money is then used for financial support in retirement.

Where DC pension provision is only a small part of overall pension income, the exact design of the payout phase may be less critical. But where DC pensions are significant, or will become so, the payout phase rules can have important implications for adequacy and risk in retirement. At the extreme, poorly designed payout rules can threaten the viability of pension policies that are based on a significant element of DC funded pension provision, as money intended for pensions is instead used for other purposes.

As individuals don't know how long they will live, they face longevity risk. They could run out of money by using up their DC pension fund too quickly or they could have pension fund money left over on death that they could have used to have a more comforTable retirement. PAYG and DB schemes do not present this problem and share the risks, with those who die early cross-subsidising those who live longer.

Annuities provide a regular and secure income for life and offer DC pensions with the closest match to the way PAYG and other DB schemes work in the payout phase. As an insurance product, annuities pool risks and just as with PAYG and DB pensions there are cross-subsidies from those who die early to those who live longer. Where annuities are used in the payout phase there are also further design choices. These include how to mitigate the spot risk of annuity purchase (for instance by allowing annuities to be purchased within a period of time rather than at a fixed point) whether to include inflation protection (by having indexed annuities) and how much cross-subsidy should be maintained (for instance mandating unisex annuities implies a cross-subsidy from men to women, allowing impaired life annuities implies a reduction in cross-subsidy from the short lived to the long lived).

However, with a few exceptions (notably the UK which has the biggest annuity market in the world on the back of compulsory DC pension fund annuitisation) annuity markets are often small and underdeveloped. Often DC payouts can be via phased withdrawal leaving longevity risk and continued investment risk with the individual. Most risky are lump sum payments as these do not provide a retirement income, threatening adequacy.

But whilst building up a DC pension fund may engender a sense of personal responsibility in pension savers, one difficulty this sense of ownership brings is that people do not wish to be restricted in how this money is ultimately used. This is in contrast to PAYG and DB pensions where it is accepted that contributions (or taxes) will lead to regular pension payments ending on death, with the inherent cross subsidies these arrangements bring. So for significant DC pensions it is important to be clear that the money is to provide a pension and how this will be done in practical terms.

Some Member States which have established statutory DC pensions have yet to fully set out the payout phase rules. For example in the 2007 Report it was noted that PL needed to put in place payout phase arrangements. These arrangements are still not complete, although the issue is currently being addressed. The PL Government has introduced a bill to Parliament on the pay-out phase of the mandatory funded scheme proposing two kinds of payments, life annuities and temporary funded pension benefits (for women aged 60 – 64). EE has stipulated

the basic features of the funded pension payout phase, which includes compulsory annuities as the main mode of payout, but the regulatory framework needs completing. In others such as SK where annuities are mandated, there remain questions about how viable this might be for small pension funds, although it will be some years before payouts begin.

4.3.9. Pension security and financial crisis impacts

Pension funds are not immune to the financial crisis, though their inherent nature and the way overall pension systems are organised in Europe means that *for those retiring today* we can expect the impacts to be limited for most people. The impacts are dependent on the mix and proportions of various types of pensions in Member States' overall systems, the detailed design of these various elements and the severity and length of the ongoing financial crisis and wider economic impacts.

The overall pension income of people retiring today in Europe is still made up in the main of statutory public pensions funded on a PAYG basis, rather than from funded pensions which are invested. So the overall pension income of European people is typically less vulnerable to impacts on investments. In the majority of Member States PAYG provides almost all of the pensions for those retiring today. There are only five Member States where funded provision is above 10% (these are DK on 16%, SE and UK both on 22%, IE on 54% and NL on 60%) with a further three at or slightly below the 10% level (DE, CY, BE).[46]

Funded provision that is DB helps mutualise the risks of investment volatility reducing the impacts on individuals who can expect to get a pension based on their contributions and service. The DB pension funds themselves have long-term liabilities and assets and so can cope in the short term with falls in the value of investments. They will, though, need to take action to continue to preserve their long-term health and this will impact on pension scheme members to the extent that risks are shared via formal or informal mechanisms.

Within the broad European framework, different Member States have different funding regimes and protection systems in place to ensure the security of DB pension funds. Some, such as the Netherlands, have long established methods for risk sharing via lower indexation and higher contributions and these will need to be allowed to operate for the long-term good. From January 2007 a new supervisory framework for pension funds, the Financial Assessment Framework (FTK) was introduced. Others such as the UK, where employers have a legal obligation to support the pension schemes they sponsor, have strengthened their funding regimes. In addition the UK brought in a compulsory insurance-style protection fund to pay most of the benefits of pension scheme members should the worst happen. DE also has extensive arrangements to protect pension benefits including were necessary insurance type protection for pension scheme members benefits. However, there could be concerns that some other Member States regimes are not sufficiently strong to withstand serious economic stress and they will need to critically examine their systems to ensure they are robust for the long-term. Indeed some, such as IE, were already looking at options for reform.

For DC schemes, temporary falls in the value of investments of those some way from retirement should be seen as part of natural investment volatility and nothing to particularly worry about. Financial information and education needs to stress the nature of investment risk

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[46] According to Table 7 "Contributions of various schemes to theoretical replacement rates (base case)" page 19 of the SPC report "Privately managed pension provision and their contribution to adequate and sustainable pensions" http://ec.europa.eu/employment_social/spsi/adequacy_sustainability_en.htm

in order to encourage informed decisions and to help maintain confidence in these schemes. For those close to retirement who are taking significant investment risk with insufficient time for investments to recover, falls in DC pension investments will mean delayed or poorer retirements. Lifestyling investment approaches can mitigate this, but may not even be an option currently in some Member States with funded DC provision. Given the typically low importance of funded DC provision for those retiring today, this may not be critical. But in Member States where these funds are, or will be, an important element of overall pension provision, the mainstream investment strategy choice needs to match this role providing reasonable returns but also not being subject to unaccepTable volatility close to retirement. In HU, an optional portfolio system has been introduced in the statutory funded pension as from 2007. This creates the opportunity for long-term optimisation of investments adjusted to age and individual risk-taking ability and this system will become compulsory from 2009.

4.3.10. Pension policy responses to financial crisis

It is too early to see how the crisis will develop and if it will affect pension schemes, but some Member States and their pensions regulatory bodies have taken initial policy steps. For instance in DK pension rules on the composition and size of assets would have forced pension funds to sell real estate bonds due to their fall in value. Apart from the knock-on effects to the market for such bonds, this would have forced pension funds to realise the value of these assets at a low point in the market. The Danish FSA therefore changed the method of calculating solvency requirements to allow pension funds to continue to hold these bonds.

Similarly in FI the government put a Bill to Parliament on 17 October 2008 to strengthen the employment pension funds of the earnings-related pension scheme in view of the decline in the equity market. The proposal aims at ensuring the solvency requirements of the pension funds can be met without leading to forced selling of equities in a disadvantageous market situation.

Another action taken in several Member States (notably IE and NL) has been to give DB pension funds more time to report their funding position and recovery plan in the hope markets become less volatile making valuations, planning and negotiations with social partners and others easier.

A number of national regulators have also signalled that they will use their existing flexibility as regards recovery periods and plans for DB schemes (for instance the UK, NL, IE) to allow more time for pension schemes to recover their funding positions.

PL is considering introducing lifestyling investment for its statutory funded pension; the option had been considered previously, but the financial crisis has now given it sharper focus.

In SK, a law approved in October 2008 will make it possible, between 15 November 2008 until 30 June 2009, for people to switch back from the funded second pillar as well as allowing people to move into the second pillar who are not yet in it. The Slovak Government decided to open the second pillar because of the negative impact of the financial crisis on assets, especially for those who are relatively close to retirement.

As things develop further, shorter-term policy responses may be necessary following the essentially pragmatic approaches taken so far. In addition there may be longer-term lessons requiring policy action on issues like the balance of funded and unfunded provision and the approach to investment risk.

4.4. Minimum income provision for older people (MIP)

Building on the SPC study on minimum income provision the 2007 Joint Report - while noting that several Member States have improved their minimum income provisions significantly - called for greater attention to what minimum incomes are likely to deliver for whom and to the way improved minimum guarantees may impact on incentives for accrual of proper pension rights. Consideration should be given to levels of minimum incomes and mechanisms of indexing. In the 2006 & 2007 Joint Report improving the adequacy of minimum pensions/income provision formed part of the challenges to be addressed for eight Member States (BG, EE, IE, CY, LV, LT, RO & UK).

Member States are using different types of provision and delivery mechanisms: (1) Minimum pensions within contributory earnings-related pension schemes for people with low income or short contribution records (e.g. in BE, BG, CZ, ES, FR, LV, LT, LU HU, PL, PT, SE, SI). (2) Basic flat-rate pensions that may be non-contributory or contributory and include years of residency in their qualifying criteria (e.g. in NL, DK, FI, IE). (3) Separate social assistance-like, means tested benefits for older people with few or no other pension rights – often referred to as 'Social Pensions' (e.g. in SI, PT, IT, LV, CY) or as 'guaranteed minimum' for the elderly (e.g. AT, DE, BE, FR, UK). Many Member States operate parallel or combined systems of minimum pensions and means-tested guaranteed minimum income.

In addition all Member States to varying extents use a transversal category of old-age related benefits in cash and kind that contribute to the living standards of pensioners and are of particular importance to those who rely on minimum income provision. Beyond these, there is considerable variation between Member States in the reference points for MIP levels and their coverage, means-testing, taxation and indexing. While poverty avoidance classically has been a goal of pension systems, minimum provision for older people tends to be aimed more at reducing the poverty risks to accepTable levels.

Currently minimum pensions and minimum income provisions cater primarily to the needs of women, who are poorly covered by the employment-related entitlement mechanisms of most pension systems owing to historical gender roles and subsequent gendered patterns of activity, employment and income. Though gender differences in longevity make women the great majority of recipients in any provision for old age, they have typically had to rely on benefits at the margin or outside of pension systems: Widows/survivors and minimum pensions or MIPs — possibly in combination. Thus minimum pensions and MIPs are very much about ensuring a minimum of adequacy for women.

4.4.1. Developments and progress 2006-2008

In some Member States poverty rates grew substantially as the relative value of benefits fell behind rapidly growing wages (e.g. EE, LT, LV). High inflation added to problems of people on MIP in these Member States. In others efforts directed at improving MIP apparently lost most of their impact on relative poverty rates because of wage growth (e.g. ES, CY, FI, UK). Still, in these countries as in most Member States, the negative effects of growth not captured by indexing mechanisms on the income position of minimum pensioners and recipients of MIP, and the sudden price hikes in food and energy in the second quarter of 2008, have to a large degree been corrected through ad hoc up-ratings and structural improvements.

A couple of Member States reformed their MIP in major ways (e.g. PT, LT). Parametric changes did also occur. Changes to up-rating and indexing mechanisms or ad-hoc increases

were particularly frequent (e.g. BE, CZ, ES, FR, IE, MT, PL). Several Member States efforts were more directed at implementing earlier adopted reorganisations (e.g. UK, SK, DE, AT).

Member States where adequacy was seen as a particular challenge addressed the problems primarily through incremental upratings and smaller parametric adjustments; a couple of countries prepared major future advances

A number of Member States are reviewing the results of reforms to minimum income provision and highlighting progress over a longer period (e.g. BG, DK, IE, SE, UK). For some important advances until 2005 seem to have been reversed in the heat of hectic growth (e.g. LT, LV).

Though many highlight their importance very few Member States report in detail on improvements to the MIP elements that take the form of exemptions, rebates and subsidised services. Attention goes first to minimum pensions and secondly to the main cash element in MIP.

Recently the role of MIPs has been solidified through various improvements to benefit levels and access (e.g. DE, AT, UK, PT, BE, BG). In the medium to longer term there are both trends that will reduce (i.e. increasing employment rates of women and OW) and trends that would seem to increase their role (i.e. reduction of replacement rates in statutory systems).

Generally the period 2006-2008 saw *fewer reforms* than the former period 2003-2006. Member States tended to be more preoccupied with implementing adopted reforms than with introducing new ones. Still changes to minimum pensions and minimum income provision were adopted in a few Member States. In the prior period a number of countries 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. Major improvements of the inclusiveness and the benefit levels of basic pensions were enacted in the UK and were being planned in Ireland. Structural upgrading of minimum pension benefits came on track in some Member States (e.g. ES, PT, SL). In Spain minimum pensions where raised by 26% between 2004 and 2008. MIP reforms in this period resulted in the Solidarity Supplement in Portugal (2006-08) and social assistance pensions in Lithuania (2006). Supplements to existing benefits were introduced in Latvia (Monthly supplement) and Cyprus (Special allowance). Denmark, Hungary and others increased the supplements introduced in the last period. Slovakia's top-up scheme for retirees with pension lower than the subsistence level will be significantly improved as this is raised. Parametric adjustments that made access to benefits easier or allowed for better combination with other income happened in several Member States (e.g. BE, CZ, DE, ES, MT). Various improvements to transversal benefits in cash and kind included a health allowance in PT. While MIPs typically are targeted on the older and poorer elderly they may only be delivered after application wherefore some Member States also step up efforts to raise the take up rate (e.g. BE, PT, UK). In some Member States, minimum guarantee pensions maintain an accepTable living standard to a reasonable degree (e.g. BE, CZ, DK, FR, LT, LU, PL, SE, SK). In many cases, however, the risk of poverty for those living solely on minimum pension is still very high, despite the improvements made in the last few years (e.g. EL, ES, HU, MT, NL, PT, SI, FI, UK, BG).

Improving the adequacy of minimum pensions and/or minimum income provision was highlighted as a key challenge for seven Member States in the 2007 Joint Report (BG, EE, IE,

LT, LV, IE, UK). Assuring adequate minimum income for older people was a problem for lower GDP-per-capita Member States such as BG, RO, LV, LT, and to a lesser extent EE, but it also created problems in higher-income fast-growing Member States like CY, IE and the UK. It may be because the results of policy efforts are not captured by the common indicator data available, but it seems that most Member States facing serious challenges with minimum adequacy have made only moderate advances from 2006 to 2008. Yet in a couple of countries major new approaches which would significantly reduce at-risk-of-poverty-rates are planned or about to be presented (e.g. CY, IE). In the context of rapid wage growth and rising inflation and pressure of other priorities some may have limited themselves to alleviating poverty for the worst-off (e.g. LV, EE, RO). Others have worked at the inclusiveness of the pension system particularly in relation to women while at the same time improving their MIP systems (e.g. LT, UK, IE). The UK has reformed its basic pension so that by 2010 around 75% of women (over 90% by 2025) will receive the full amount, up from 35% at present, while lifting a large number of pensioners out of taxation and providing home visits to vulnerable pensioners. In a few Member States moderate progress reflects the amount of efforts invested. Yet, some have experienced a jump in poverty rates 65+ despite considerable efforts (e.g. UK, LV, LT). Ireland managed to lower the at-risk-of-poverty-rate for people 65+ despite rapid growth. Generally the adequacy of minimum pensions has received the bulk of attention whereas MIPs were less in focus. But Lithuania reformed widows/survivors pensions as well as its MIP scheme and introduced regular indexing.

4.4.2. Maintaining a minimum of adequacy: the issue of up-rating

As minimum incomes are utilised to alleviate poverty the indexation of benefits in payment is an important aspect of the efficacy of the provision. In a context of rapid growth and sudden price increases on food and energy many Member States have introduced extra ad hoc increases of minimum income provision and minimum pensions, (e.g. AT, CY, ES, LT, LV, SI, SK, IE, IT) or have opted to offer or increase an extra annual payment of pensions (e.g. BG, CY, UK). While the intensity has varied 2005-2008 has been a period of higher economic growth in almost all Member States. Which effects have existing indexing mechanisms had in this period and to what extent have indexing been corrected or changed? While common indicator data only cover the beginning of the period National Strategy Reports recount part of the story since and allow for generalisations. In as much as many MIP 65+ schemes tend to be price-indexed (if automatically adjusted) one should expect the relative incomes to have fallen behind. This is also the case in the many Member States where minimum pensions and minimum income provision primarily have been price indexed (or only ad hoc up-rated) and the at-risk-of-poverty-rate of 65+ therefore has increased (e.g. RO, LT, LV, EE, ES) and older people's share of median equalized income for 0-64 year olds has declined. Yet, it would seem that the relative erosion is mostly substantially smaller than could be expected. In many Member States the extra wealth and tax revenues generated have been used to introduce ad hoc up-rating or structural improvements to pension benefit levels and/or their indexing. This may have benefitted recipients of minimum income in particular or have been granted to benefit levels of 65+ in general. The insufficiency of ad hoc mechanisms in the period caused some Member States to introduce or plan regular indexing (e.g. RO, LT, or LV). Others changed the indexing towards wages (e.g. PL). In 2007, the UK introduced a statutory commitment to uprate the minimum guarantee by earnings on a regular basis. Some countries are planning further corrections to the erosion of relative incomes (e.g. FR).

Various patterns emerge. In EE, LT and LV at-risk-of-poverty-rates 65+ were being reduced until 2005. While high growth and increasing inflation rates since made it difficult to maintain minimum adequacy ad hoc up-ratings together with structural improvements have allowed

recipients of minimum pensions and MIP to retain purchasing power and not to fall too far behind. In Lithuania, for example, the at-risk-of-poverty-rate from 2005 to 2006 jumped from 17% to 22% as rapid wage development caused ad hoc up-rated benefits to fall behind. Likewise the median equalized income of 65+ as percentage of the one for 0-64 dropped about 6 pp. These measurements however fail to capture further up-ratings and improvements which from 2006-2007 caused the average social insurance pension to increase from 31.9% to 32.9% of the average wage. In LV and EE minimum pensions fell radically behind wages but their purchasing power was maintained. In LV a referendum on minimum pensions provoked extra up ratings even though it failed. Through regular and extra up-ratings ES has largely been able to maintain the relative income position of the elderly despite rapid growth. On the other hand the latter has prevented substantial upward adjustments from registering in the at-risk-of-poverty-rate 65+. In PT where growth has been lower the targeted implementation of the Solidarity Supplement and improvements to minimum pensions has helped reduce poverty rates. In the context of rapid growth the Special Allowance introduced in CY has had no discernable impact on poverty rates. Despite considerable growth in the period CZ, SK and PL relying on mixed price/wage indexation have managed to keep relative poverty rates at almost the same level. By contrast HU with some economic difficulties has seen an increase from 6% to 9% despite a balanced index and some extra up-rating. In Malta the national minimum pension has been pegged to poverty thresholds. Some Member States have improved the indexation of minimum income provision (e.g. BG, IT, AT). Turning to Member States with flat-rate pensions (UK, IE, DK, NL, FI) recipients of basic pensions in the NL have retained their absolute and relative income position. In Denmark older people relying solely on the people's pension have seen moderate improvements in their situation. From a less comforTable income position pensioners dependent on flat-rate pension in Ireland have seen marked improvements. The same goes for the UK. Fast growth in FI has generated a sudden increase in the 65+ poverty rate. By contrast SE where the minimum pension also is price indexed has maintained a moderate at-risk-of-poverty-rate.

While inflation rates generally remained rather low in most Member States the large rapid increases in energy and food prices in the spring and summer of 2008 presented a particular challenge to mechanisms for safe-guarding the purchasing power of older people on minimum pensions or minimum income provision across the Union. Many countries have sought to counteract the effects of these and other price hikes by special up rating of minimum pensions and/or MIPs (e.g. AT, BG, CY, CZ, DE, LT, LV, MT, SI, SK, IE, IT, UK). In AT, where lower pensions are indexed at a higher rate, it was decided to move pension indexation scheduled for January 2009 two months forward to compensate for the price rises in energy, food and basic goods. In the 2008 budget MT introduced a cost of living increase (COLA) for pensioners comparable to that of employed persons. FR, reacting to erosion of benefits, paid MIP pensioners a one-off lump sum in March and added supplementary indexation in September 2008 and plans to do so until 2012. As supplement to the normal annual indexing CZ introduced extra up rating whenever price inflation exceeds five percent. Reacting to a number of factors Germany has achieved a similar effect by suspending the lowering impact of the so-called Riester Treppe in the pension formula to allow for a higher increase of benefits in 2008 and 2009, which will be matched by smaller increases in 2012 and 2013.

On average older people spend a higher share of their incomes paying for basic needs (food, housing, energy and health) than the working age population. As indicated by Table 4.2 the Member States where food costs have risen the most, are also the Member States where food costs dominate the spending of the elderly (i.e. BG, CZ, EE, LT, LV, HU, MT, RO, SI) Generally speaking, the actual increase in pensions, including ad hoc increases, have been

higher than price inflation but lower than real wage increases. This has meant that pensioners have fared better than what could be expected given the indexing mechanisms in the economic situation.

Table 4.2: Structure of consumption expenditure by age in 2005,

and inflation in October 2008

		Structure of consumption expenditure by age				
		Less than 30 years	Between 30 and 44 years	Between 45 and 59 years	60 years and over	Average inflation Oct. 07 - Oct. 08
EU-27	**All items**					**3,8**
	Food	13,1	14,3	15	16,5	6,6
	Housing, excl. imputed rents	16,3	11,5	10,6	13,2	5,7
	of which, energy	*4,3*	*4,6*	*5,1*	*6,4*	*10,1*
	Health	1,8	2,3	3	4,6	2,3
Bulgaria	**All items**					**12,6**
	Food	30,3	29,7	30,2	35	19,2
	Housing, excl. imputed rents	11,7	12,7	12,6	13,1	9,5
	of which, energy	*8,2*	*8,9*	*8,9*	*10,1*	*8,9*
	Health	2,5	2,6	3,6	7	6,3
Czech Republic	**All items**					**6,5**
	Food	16,5	19,4	19,8	25,3	9,9
	Housing, excl. imputed rents	19,6	17,6	19,4	25,6	11,4
	of which, energy	*8,8*	*9,7*	*10,8*	*14,9*	*12,2*
	Health	1,5	1,5	1,9	3	26,1
Estonia	**All items**					**10,9**
	Food	18,6	21,6	23,5	24,4	15,9
	Housing, excl. imputed rents	14,4	11	12,5	15,1	15,9
	of which, energy	*5,2*	*5,4*	*6,2*	*8,6*	*23,3*
	Health	1,2	1,7	2,6	4,7	8,4
Greece	**All items**					**4,4**
	Food	13,9	14,5	14,4	18,6	5,3
	Housing, excl. imputed rents	15,5	10	8,7	9,7	11,6
	of which, energy	*2,8*	*2,7*	*2,8*	*4*	*23,6*
	Health	4,3	5,7	5,1	7,5	3,6
Latvia	**All items**					**15,8**
	Food	24	27	29,7	36,9	19,9
	Housing, excl. imputed rents	10,2	10	11	15,6	27,3
	of which, energy	*5,6*	*5,8*	*6,6*	*9,9*	*31,1*
	Health	2,4	2,4	3,5	7,8	12,8
Lithuania	**All items**					**11,0**
	Food	26,8	32,6	34,6	39,6	16,5
	Housing, excl. imputed rents	10,9	9,9	10,9	13,5	17,5
	of which, energy	*6,2*	*7*	*7,9*	*10,4*	*17,0*
	Health	2,4	3	4,2	10	10,6
Hungary	**All items**					**6,7**
	Food	21,1	21,3	21,6	26,5	12,0
	Housing, excl. imputed rents	19,2	17,8	18,1	22,4	11,2
	of which, energy	*10,2*	*10,4*	*10,8*	*14,9*	*12,4*
	Health	2,5	2,5	3,4	8,1	3,6
Romania	**All items**					**7,9**
	Food	42,9	42,5	50	51,4	10,0
	Housing, excl. imputed rents	14,7	15,5	17,9	19,1	9,2
	of which, energy	*10,5*	*11,6*	*14,6*	*15,5*	*7,7*
	Health	2,3	3,6	7,5	10,3	-1,5
Slovenia	**All items**					**6,1**
	Food	16,1	15,4	16,2	20	10,9
	Housing, excl. imputed rents	9,8	9,7	10,1	13,1	11,3
	of which, energy	*6*	*6*	*6,4*	*8,6*	*15,4*
	Health	1,3	1,1	1,5	2,2	2,6
Note: in HU, MT and RO, imputed rents are unknown and supposed to be 0.						

The period 2008-2010 is likely to be marked by an economic downturn in all Member States. The question is how minimum pensions and minimum income provision will fare in this period. Obviously much will hinge on price developments in the period and the mechanisms of indexing. Much also depends on political intention. A few Member States have already indicated that up-rating of pensions planned for 2009 will be maintained (e.g. ES, IE). Others have announced major retrenchments across the board (e.g. LT and LV).

4.4.3. Shifting relations between pensions proper and MIPs

The boundaries between minimum income provision and minimum pension may shift as a result of pension reforms and developments in labour markets. Some Member States are making major efforts to include hitherto excluded groups in the pension system (e.g. UK, ES, FR, RO). Others are making efforts not to lose groups as pension systems diversify (e.g. DE). The UK has fundamentally widened the access of women to full entitlement to the Basic State Pension. In the Netherlands, occupational pension coverage is now extended to young people from the age of 21. In Germany extraordinary efforts are being made to include low-waged groups in the voluntary 'Riester' pension schemes that are meant to supplement pension entitlements in the main statutory scheme. A combination of direct subsidies and tax deductions for these groups mean that their premiums are substantially lowered. In many Member States crediting of childcare has been improved (e.g. AT, DE, PT, EL, LT) while in DE subsidies for private pension insurance are also tied to the number of children one is raising.

The structural increase in female labour force participation is affecting the relative income position of the retired. The growing share of women with pension entitlements of their own among present retirees is already lowering the number of women who have to rely on minimum income instruments in a number of Member States (e.g. SE, DE, AT, FR, UK). The long standing trend towards higher activity and employment rates of women will increasingly tend to reduce the role of MIP in all Member States. So will the more recent growth in employment rates of older workers and the maturing of supplementary pension schemes. The same goes for reforms that extends the reach and inclusiveness of pensions prober through wider entitlements and easier access – for example for women with careers interrupted by caring duties (e.g. EL, PT, AT, DE, UK,) or for young people such as in occupational schemes in NL. Long-term reductions in replacement rates of statutory schemes will pull in the other direction. In the short to medium term recent improvements of MIPs including easier access will also tend to solidify and expand their role. Cohorts that experienced high rates of long-term unemployment during the transition/unification period in Central European Member States are rapidly approaching retirement (e.g. in CZ, PL, SK, HU [DE]). This will lead to lower pensions and increase the need for MIP.

But present pension scheme designs are not just challenged to adapt better to historical gaps in coverage and set to benefit from or make up for labour market developments. Member States with scheme designs that used to relegate MIP features to a minute role are seeing evolving phenomena that cause the role of MIPs to grow. Thus even all-inclusive pension designs such as the residence-based pensions in DK, NL, (SE) and FI may increasingly find that a growing share of new pensioners is unable to meet entitlement criteria. The bulk of these are immigrants - including older parents brought in through family unification. But there is also a growing number who have worked abroad in their careers. In the Netherlands a possibility to buy in missing years of entitlement has been introduced.

The change in women's role in the labour market is gradually leading to a change in the dependency on the traditional breadwinner's income. In some Member States, survivors pensions are being phased out completely and being replaced by minimum pensions (e.g. DK, SE). But in many Member States the quality of survivor pensions still play an important role in the risk of poverty for those women who survive to the death of their husbands and have not earned full entitlements to a pension in their own right. To what extent these benefits provide a sufficient income in old age is an area for further study.

A special dynamic in the relation between pensions proper and guaranteed minimum provision for older people has to do with the disincentive effects of MIPs. Where the National Strategy Reports discuss this, they tend to see the potential negative effects of MIPs on propensity to build up pension rights and to save as rather small (e.g. DE, SE). In systems where membership of state, occupational or savings schemes are mandatory or de facto very difficult to avoid, eventual access to minimum income guarantees do not discourage take-up of work. In practice workers cannot deselect pension insurance when working. Moreover, since MIP guarantees are rarely if ever available before pensionable age, their existence would not in themselves erode incentives to continue working until that age arrives. But in combination with early exit routes they may. For some low-wage groups with incomplete contribution records it may then be of little importance that no or only small pension entitlements can be earned from spending the last years before retirement on unemployment, sickness or disability benefit. Through MIP they would anyway obtain a standard of living equivalent to that which could be achieved through pension contributions on a working wage. MIP may also make pension contributions/savings less legitimate for low-waged workers as these would not buy them a standard of living above what anyway is guaranteed for all. I.e. the income testing of MIP appears to function as a tax on the entitlements and savings of those who (continue to) contribute. This is a standard problem of targeted benefits which crops up in public debate in Member States from time to time (e.g. UK, DK, SE) in connection with incentives for low-income groups to save for pensions. The discussion centres on whether it is the low income or the MIP that constitutes the main barrier.

4.5. Ensuring information and transparency

Pension reform all over Europe has lead to a trend away from simpler singular systems, usually of a defined-benefit nature, towards multi-pillar pension provision with elements of defined-contribution design. Multi-pillar systems, while offering different risk profiles, also make pensions systems more complicated to understand and retirement income more difficult to predict.

Pension reforms have, furthermore, implied a transfer of risk from pension scheme sponsors to the beneficiaries. Increasing links between contributions and benefits, and a transition to more individually funded pension provisions, require more decisions by the individual beneficiary concerning time of retirement and investments in order to secure an adequate income in old age. Reforms have already been implemented in most EU Member States. But evidence shows, both from this round of reporting and a peer review on Information on pension systems held in Warsaw, that in order for these to work and gain full acceptance, pension scheme members will have to be better furnished with reliable, intelligible information.

4.5.1. Public consensus building and information during pension reform

Member States report that gaining a wide consensus for reform is vital to its success. Where pension reforms have been carried out there has often been a political consensus and a consensus between politicians and social partners. Most Member States have counted on the input of experts from social partners, ministries, institutions involved and scientists for the development of their pension reforms (e.g. DK, IE, FI, DE, AT, PT, GR, CZ, SE). These countries also report that the social partners fulfil the task of informing politicians and the public about the latest trends in social systems and stimulate debate in order to foster a broad social consensus. One example is the Toledo Pact Commission that stretches over all the main political parties in Spain and debates reform proposals with the objectives recommended by consensus among all political parties.

However, some Member States have reported on more direct consultations with the public in order to receive public consensus. To study options for pension reform, the United Kingdom government set up an independent Pension Commission. In more recent reform efforts in Ireland, a pensions green paper was published followed by an extensive consultation which will influence long-term pensions policy. A national awareness campaign was launched at the same time inviting citizens to make submissions on the Green Paper either in writing or via a website. In Malta the White Paper entitled 'Pensions: Adequate & Sustainable' was distributed for public consultation and subsequently the Pensions Working Group developed various models of reform scenarios to reflect public concerns. In Portugal, building social and political consensus in favour of reform was considered of great importance. The involvement of social partners and advisory councils for social security bodies was an important part of the Agreement on Social Security Reforms, signed after thorough consultation and broad debates in Parliament and other forums.

A few Member States have reported on the information provided to citizens at the time of reform and the effects it had on the choices made by individuals. This is particularly interesting where an active choice was required by beneficiaries, for example where there was an opt-in/ opt-out choice (e.g. SK, PL, BG, LT, LV, RO, EE). Judging from presentations and comments at the peer review it appears that in some cases citizens opted to join the newly developed funded pillars in their systems due to ambitious information campaigns, although this may not have been the best choice for them financially (e.g. BG, SK).

In order for people to make economically rational pension decisions appropriate to their individual circumstances they will need to have access either to unbiased information or to equally balanced information from different partisan sources. In the absence of this they may be persuaded to make erroneous choices. If this happens on a large scale it can obviously undermine popular confidence in pension reform. How to better involve social partners and other stakeholders in the provision of unbiased or equally balanced information is a field for future study.

4.5.2. Pension projections and their effects on incentives to work longer

In many pension reforms, work incentives have been built into the structure of the pension systems, by a closer link between contributions and benefits, increasing the number of contributory years necessary to be eligible for a full pension or introducing a bonus/malus system with deferred or early retirement.

The strengthening of work incentives in pensions means that individuals should keep the effects on their retirement income in mind as they make work-related decisions throughout their working life. Prolonging working lives not only entails decisions for the individual regarding the age at which they retire or take up a pension but also regarding full or part-time work, career breaks and the age of entry into the labour market.

Most Member States have information regulations requiring pension schemes of all types to provide information on the accumulation of pension rights, but the amount and character of information provided differs. Some may provide information on accumulated pension rights only if requested by individuals, while in others it is sent out automatically. This can affect how the information is absorbed and spread. Having to actively seek pension information probably limits it to certain groups, excluding the people who may need the information most.

A growing number of Member States are now also providing or developing calculations of how these pensions rights may translate into a pension income, based on projections given certain economic assumptions (e.g. BE, DE, DK, IE, ES, FR, LT, FI, SE, UK). Finland and Portugal have recently introduced pension projections. In Finland these are available only for those closest to retirement, as projections for younger cohorts are considered too hypothetical. Yet with a move towards longer contributory periods it would seem important that individuals understand the effects of shorter careers early on. As the pros and cons of different approaches are weighed, even younger cohorts might appreciate forecasting tools which provide different scenarios depending on economic assumptions, contributory years and point of retrieving the pension.

Projections are mostly provided for each scheme in isolation even though individuals ideally would need to know how their different entitlements combine into a full package of potential retirement income. But in a few of the Member States with widespread occupational and private pension provision, steps are being taken to develop web-based pension portals where people can check how their pension accruals from different schemes would come together in an overall amount of pension income (e.g. DK). This will help citizens to avoid making retirement decisions based on incomplete or fragmented information.

4.5.3. Financial education and adequate private pension provision

Providing information on accumulated pension entitlements and pension projections can involve many uncertainties even in the simplest of schemes. There is a greater element of choice, and therefore complication, in funded schemes with individual accounts than in pay-as-you-go schemes. As funded pensions overwhelmingly tend to be or become defined contribution schemes most of the risks are furthermore placed with the insured individuals. Improving information and levels of financial literacy of people covered by individual funded schemes is therefore integral to the success of private pensions especially given times of financial volatility. While this may have presented less of a problem earlier, as the new funded schemes were generally introduced during times of economic growth, developments in 2008 have shown that sufficient levels of information and financial literacy are a prerequisite for individual choices on investment risk. It is vital for the continued success of schemes already launched that individuals have a basic understanding of the risks involved.

The SPC report on Privately Managed Pension Provision published in October 2008 shows that while the increased need for financial information has been widely recognised, the type and standard of financial information varies greatly between Member States. Information is regulated in a number of Member States (e.g. AT, BE, IE, IT, HU, MT, NL, UK, BG) by the

supervisory authority or through self-regulation by partnership bodies. Presenting complicated financial information to people who may not have the ability or interest to take it in is difficult. Improving accessibility and absorption of information through simplification of information presented is a key concern (e.g. ES, IE, UK). Yet simplification of the information has to be strategic in order not to leave out any important information that might affect any savings decision. The number of investment choices in funded schemes varies vastly from just three or four (e.g. HU, BG, PL) to several hundred (e.g. SE, UK, IE, NL). Obviously the amount of choice will determine the depth of financial knowledge required by beneficiaries. Member States are trying various approaches. The 'Altersvorsorge macht Schule' (pension provision goes to school) project in DE is a government initiative together with social partners, consumer organisations and adult educational institutions, and courses focus on all relevant issues of old-age provision.

In most Member States, information is provided on current and past returns of pension funds, but there is limited information on fees and administration costs and the compounded effects of these on effective investment returns. Some countries oblige pension funds to list their administration costs (e.g. DK, S) but these may not include the effect of all investment fees. This is a vital element when comparing funds and also when considering guaranteed returns. The SPC report on privately managed pension provision shows, for example, that minimum returns may help to support adequacy. Yet they may also entail higher direct insurance costs and indirect costs due to changes in the portfolio structure. Circumstances are not always clearly presented and this may disfavour the least knowledgeable, often including people with risk-averse investment behaviour who might have benefited from less choice.

The peer review in May 2008 concluded that there is a need for independent parties who could provide information on effective yield performance in the light of administration costs. Companies that rate pension providers and assist consumer choice with information on market concentration, corporate reputation and informative advertising appear to be very successful in some countries.

Whilst risks associated with pension saving are often highlighted, particularly given recent turbulence in investment markets, less attention is given to risks associated with the payout phase of pensions. The options for payout phases vary, with little standardisation and often limited restrictions. In some Member States where funded schemes are still maturing, the payout phase is yet to be fully legislated (e.g. PL).

Proper information on the payout phase can help mitigate some of the risks otherwise borne by individuals such as longevity, investment and inflation risks, depending on the payout options available. For example where lump-sum payments are given at retirement, the investment, inflation and longevity risks lie with the retired person. Where the possibility exists of purchasing an index-linked annuity, an individual could transfer the longevity, investment risk and inflation risk to the insurance company offering the annuity, but often at a cost that needs to be made clear to the individual. The advantages of annuities are not always well understood even in countries, such as the UK, where they are prevalent. It seems safe to assume that little is known in countries where the payout phase has typically not yet begun for the first cohort affected. This is an issue that needs to be further addressed to avoid future policy problems and perhaps problems with income adequacy of older retirees due to an underestimation of the longevity risk in particular.

4.5.4. The effectiveness of information channels

Beneficiaries generally receive pension information through the pension providers, and government agencies are the main source of pension provision (the main source of pension income is statutory schemes, except in NL). These are complimented by non-governmental pension providers and information sources such as agents, employers and advertisements. A growing number of Member States have reported the development of websites gathering pension information from different schemes. There is, however, clear room for improvement regarding the content of the information provided and the information channels used.

Information and information channels are often standardised for the entire population, yet surveys have found that certain groups have disadvantages in absorbing information. There is a need for targeted information, but experiences differ when it comes to reaching target groups. People are unlikely to make much effort to obtain information, so campaigns and information should focus on the communication methods people tend to trust and use anyway. Local culture must be taken into account. For example, call centres may be a success in one country but remain basically unused in another. The internet has growing importance, especially with regard to forecasting and comparing different providers. However, internet access differs greatly in different countries, and tends to be more suited to younger better-educated groups. The young and low-educated groups are the hardest to reach.

Most Member States reported that young people are not usually interested in pension-related issues. This could cause problems in the future, as reformed pension systems tend to require an early interest in pensions. But it may not be realistic to expect young people to show an interest in issues relating to their financial situation in old age.

The information campaigns have typically been held in conjunction with reform (e.g. DE, PL, EE, SE). Few countries have, however, reported on how the campaigns went, which can be vital when parametric changes to a pension system are made, for example increasing the pensionable age or extending eligibility rules. In Sweden, an information campaign has been carried out annually since the pension reform in 1999 in conjunction with the annual pension rights information sent to all insured persons.

Few countries monitor the results of their campaigns. Even fewer Member States report on efforts to evaluate annual pension information to the public and try to assess developments in public knowledge on pensions. In Sweden, a survey is carried out annually to gauge the level of knowledge of the pension system, which despite extensive information, is improving only slowly. Surveys and evaluations tend, to be restricted to the main source of pension provision. Yet as other forms of pension provision grow in importance, it is also essential to measure public knowledge of all sources of pensions, as these collectively constitute incentives or disincentives to work longer or to save more for retirement.

4.6. Conclusions

The employment rate of older people has increased markedly over the past decade, and improvements are particularly visible in a number of Member States. Nevertheless, much still needs to be done to reach the EU target of 50% employment among older workers by 2010 which, given current demographic trends, is in itself insufficient in the long run. So it is encouraging that some Member States ratchet up their targets as soon as they pass the 50% mark. Throughout Europe there is a growing willingness to act on the realisation that the age when people stop working has to increase. Member States are starting to increase the pension

eligibility age in statutory schemes. Through bonus/malus rules they are also strengthening the economic incentives in pension systems to avoid premature exit and motivate people to work to higher ages. These are important signals for employers to adjust their age management practices and for employees to plan for later retirement. Member States are also trying to close early exit routes and remove unintended incentives to early retirement. Building a broad consensus for this, including the social partners, is often very difficult and in many countries there are still certain occupations for which exemptions or special regimes apply.

Properly designed pension systems can provide important flanking support for developments in labour markets by signalling to workers, managers and employers which age management practices are acceptable and rewarded. Pension systems need to be complemented by Active Labour Market Policies, Life Long Learning and active ageing measures, as the lack of progress in activity and employment rates often can be explained by poor employment opportunities for older workers, thus undermining the incentives created in pension systems.

Unfortunately, further progress is now threatened by the worsening of the economic outlook. The economic downturn will be a real test for the durability of the achievements of the last decade. There is a risk that if labour shedding is again concentrated on older workers the problem may be off-loaded to retirement systems through various early exit paths, thus reversing recent gains in activity rates and effective retirement ages.

More people working more and longer while being covered by and contributing to pensions schemes has been identified as the single solution to providing both adequate and sustainable pensions in an ageing society. This entails increasing the participation not only of older workers but also of all other groups of working age, thus widening the contributory base and the coverage of the pension systems. More stringent eligibility requirements, such as increasing the length of required contributory periods for pensions and a tighter link between the levels of benefits paid out and contributions paid in are also becoming a commonly used practice in pension reform to ensure longer working lives. While providing beneficial work incentives, this makes it increasingly important to protect justified career breaks in order to avoid a reduction in pension adequacy for those who are not able to meet these conditions during their working lives, notably women who often take on a carer role. In view of the current economic situation, it is also important to consider the position of the long-term unemployed.

Since pension schemes are being made more inclusive, with more and longer employment of women and older workers, the role of minimum income provision will decline. Yet the long-term trend towards longer contribution periods and falling replacement rates will tend to make more people dependent on schemes that top up or replace their pension incomes, especially groups with lower lifetime incomes and shorter contribution records.

For Member States with special challenges in minimum income provision adequacy, there have been only moderate advances. The best solution would be fundamental reform, but in the absence of that, determined strategies are needed for adequate indexing and gradual structural improvements over a longer period. In general the absolute and relative incomes of older people have weathered this period of rapid wage growth and higher inflation better than expected, thanks to ad hoc measures in many Member States. But the Member States that have fared best are those that have adopted regular indexing mechanisms that help to maintain both the absolute and the relative income position of MIP recipients by a combination of links to prices and wages.

In Member States that recently introduced substantial funded schemes to boost overall pension provision, private-funded pensions have shown themselves to be less appropriate for groups of workers with low income and short careers. As workers are asked to opt in or out of alternative arrangements, it is crucial to tell them which options are better suited to their profile.

In order to optimise reasonable returns whilst reducing the impact of investment volatility close to retirement, it is advisable that Member States with significant funded provision of the defined-contribution type adopt a 'lifestyle/lifecycle' approach to investment: a gradual move from riskier profiles in younger years to low risk, stable yield investment later in the career.

Given the difficult investment climate, Member States are also learning that unresolved issues, such as the pension payout phase rules in funded schemes, need to be clarified. Where these pensions are a significant part of overall pension provision the rules need to ensure that pension savings are ultimately used to provide pensions and not lump sums in order to properly address adequacy. Annuities provide the payout solution most closely resembling payout structures for pay-as-you-go and defined-benefit pensions. Some countries are also considering supporting continued provision of defined-benefit occupational pensions by establishing greater risk-sharing elements and learning from the negative and positive experiences of the Member States that pioneered these. Risk-sharing is also raised in the context of collective defined-contribution schemes.

In some Member States where funded provision was recently introduced, it has been difficult to get unbiased information. Introducing individual choice of risk profiles creates the need for targeted financial education of the public and in particular of vulnerable groups. But information and the channels for providing it are often to the same for the entire population, and surveys show that certain groups have difficulty absorbing this information. The need for information is a broad issue. In pay-as-you-go schemes too, workers need to make well-informed decisions on employment choices and the need for supplementary savings. Partial information may mislead individuals into economically irrational choices and may even undermine the legitimacy of pension policy. One solution would be to involve the social partners and other stakeholders in providing equally balanced information from different sources.

5. NATIONAL STRATEGIES ON HEALTHCARE AND LONG-TERM CARE

5.1. Introduction

Common objectives for healthcare and long-term care

Member States are committed to accessible, high-quality and sustainable healthcare 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.

5.1.1. Health as a goal and as a determinant of wealth

Throughout the 2008-2010 National Strategy Reports (NSRs) good health is seen as an important goal, as it contributes to each individual's general well-being. There is also wide recognition that good health enables people to participate in the labour market, as well as in social and political activities, reduces sick leave and absenteeism, increases productivity and postpones retirement, allowing for longer working lives. Ensuring good population health reduces dependency on government transfers such as disability benefits and pension expenditure through reducing early retirement (due to ill-health).[47] Health (and good healthcare services through promotion, prevention and curative care) contributes to the improvement of welfare levels of a country and its sTable economic and social development and social and territorial cohesion. Moreover, many suggest that the health and social sector is a large and growing employer that can be used as a tool to improve the economy in disadvantaged regions. It can also contribute to achieve the Lisbon objective of increasing women's participation in the labour market in view of the fact that a vast majority of this sector's employees are women. It is, therefore, not surprising that for all countries the objective of health policy and healthcare services is more than just saving lives but that of ensuring healthy and active lives at all ages.

Regarding health, countries identify a number of health risks and ill-health conditions that remain important and require attention. Risks include increasing alcohol and drugs consumption by younger people, and smoking, poor diet and lack of physical exercise in general. The main ill-health conditions in the EU are obesity, cancer, cardiovascular and respiratory diseases, mental ill-health and injuries and accidents, alongside some infectious diseases such as HIV and tuberculosis. Mental health diseases are seen to be gaining ground and appear to be related to working conditions and exclusion. These risks and ill-health conditions are deemed avoidable to a large extent, especially by those countries that report

[47] For example the UK suggests that the UK economy loses over £100 billion a year due to ill health.

poor health status performance (HU, EE, LV, LT). This pattern of risks and diseases is determining the policy choices in the health sector (public health and healthcare services) to a large degree.

5.1.2. Health as the result of complex social, economic and environment factors

Together with accessibility and quality of healthcare services and healthy lifestyles, living and working conditions, employment and income can play a vital role in determining health status. In this context, Member States identify the high rates of long-term (structural) unemployment, income inequalities (which have risen in recent times) and poverty, and an economic development that has not necessarily preserve a healthy environment, as further determinants of health, contributing to social and regional health inequalities and creating an extra burden to the health sector. Evidence indicates for example that poorer households tend to experience a poorer quality environment and less access to environmental 'goods' such as parks and green areas.[48] Things as varied as climate change, migration, more diverse societies and ageing are listed as additional challenges to policy in this field. Moreover, even economic growth is said not have been enjoyed by all in the same way and regional and social inequality (including health inequality) has increased in many countries in recent years.

According to the NSRs, ageing (related to longer life expectancy, lower birth rates and, in some countries, strong emigration of the working age population) not only means a larger share of old and very old people with multiple and reinforcing degenerative and chronic conditions, and thus stronger demand for healthcare and long-term care services,[49] but also more workers needed and fewer workers available (including fewer informal/family carers), and thus high labour costs. As it is not age per se but the health status of the elderly population that results in greater needs for care, preventing ill-health at all ages (delaying the onset of disability/ dependency) is deemed crucial to ensure higher quality of life in old age, control healthcare and long-term care costs and ensure longer working lives.

Patient expectations (translating into having more informed patients wanting top technology, more choice and faster treatment) and the changing epidemiological situation imply a need to adapt the healthcare system to new patient needs and wishes, while ensuring long-term sustainability of systems.

5.1.3. Main priorities for 2008-2010

This is the second full reporting exercise under the social OMC regarding the healthcare and long-term care strand. As only two years have passed since the previous NSRs, virtually all of the 2008-2010 reports (except perhaps BG, CZ, SK) build on the previous strategies and national health plans with similar priorities and policies and some additions or improvements in relation to the strategies proposed in 2006. For all Member States, universality, fairness and solidarity, accessibility, equity, equality, effectiveness, and efficiency are the guiding principles of reform. Between 2006 and 2008 a number of countries (e.g. RO, SE, UK, IE, NL) have produced inquiries/assessments of population needs and/ or health sector policies

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[48] See for example "The linkages between environmental and social sustainability in Europe" at http://ec.europa.eu/social/BlobServlet?docId=1574&langId=en

[49] See for example the report Europe's Demographic Future: Facts And Figures, European Commission, May 2007, which states: "An ageing population will place a strong upward pressure on public spending for long-term care as frailty and disability rise sharply at older ages, especially amongst the very old (aged 80+)".

and, on that basis, have introduced/ plan to introduce additional policies (e.g. specific policy programme for health promotion in FI). Most countries have limited their reporting to a small number of policy areas, potentially those where they see more is happening or they see as priorities. Thus, the 2008-2010 NSRs are not always as detailed in relation to all the objectives as the 2006-2008 reports were.

In general the 2008-2010 NSRs in comparison to the previous 2006-2008 NSRs have seen more emphasis placed on health promotion and disease prevention to improve population health status at all ages and counteract the rise in expenditure expected as a result of ageing. There is substantial information on the implementation of national vaccination schemes and national screening programmes for cancer, diabetes and cardiovascular diseases. There is also considerable information regarding national or group-targeted campaigns to encourage healthy life styles and develop environments that promote healthy choices, involving a variety of settings (from nurseries and schools to businesses). In 2008, more and growing interest (although still restricted to a number of countries) is placed on disease management programmes in the context of chronic disease (e.g. obesity, diabetes, heart disease, renal failure) as well as some infectious diseases such as tuberculosis and HIV.

Also high in the 2008-2010 agenda is the need to address geographic disparities in the availability and quality of care and, relatedly, the development of primary care as a means to address those disparities and improve access, as a vehicle for promotion and prevention, as a tool to ensure better care coordination between types of medical care and between medical and social care, and as a means to ensure a rational use of resources in the sector and obtain greater value for money.

Considerable attention is paid to technology[50] in a variety of ways: to improve information and access, as a dimension of quality, to allow for a better use of resources, notably in the context of shortage of staff and high labour costs, as a means to ensure good data collection and monitoring in the sector, to allow for better coordination of care, and as one of the drivers of expenditure, as technology allows for new treatments previously unavailable.

Also there is considerably more consideration of staff issues and human resources policies in 2008 than ever before, including policies directed at informal/family carers, in view of an ageing population and ageing staff (and thus future staff shortages) and current staff shortages due to emigration. Policies are articulated around increasing training of staff and carers, improving work organisation, increasing staff motivation through remuneration and better working conditions, and developing support structures for informal/family carers.

Significant importance is attributed to the coordination of care, between levels of government, between sources of funding and budget lines, between types of medical care, between health and social care, between public and private provision, between the public and the third sector[51] which is strongly involved in the care for vulnerable groups and the elderly.

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50 Technology should be seen in a broader way including not only information and communication technology (ICT), devices and equipment, but also pharmaceuticals, procedures and services.

51 The third sector is typically made up of all those organisations that are not-for-profit and non-government, those that are involved in community services or charity, those that relate to volunteering, and associations, co-operatives, foundations, church, charities, unions, clubs, societies, etc. While they differ between themselves as a group they also differ from profit businesses and from government departments and authorities.

The contribution of the Structural Funds to the improvement of accessibility and quality of healthcare and long-term care is underlined in several NSRs. ESF interventions target human resources development and training of health personnel (e.g. CZ, EL, LT, LV, PT, PL, HU, SK), as well as health campaigns (e.g. HU, EL) while the ERDF will invest some € 5.2 billion in health infrastructure in Convergence regions (EU 12, PT, ES, EL, IT, DE). An effective use of Structural Funds support can contribute to reducing health inequalities across and within Member States. Therefore it is important to strengthen coordination between health strategies and investments from the Structural Funds, and improving monitoring mechanisms.

5.1.4. Progress in relation to 2007 Joint Report

Overall, Member States have been implementing reforms in relation to the challenges identified in the 2007 Joint report on social inclusion and social protection. Most have continued with the implementation of the reforms proposed in 2006, with the exception perhaps of: SK, that has retracted on some of the previous reforms, CZ and BG which propose new reforms, SI who has approved a health plan in 2008 and CY where the reform to implement a national health scheme is still pending. In PL some steps have been taken but delays have been registered. For LU the focus should now be on implementing the proposed measures rather than focusing on new ones. For most Member States the 2007 challenges remain valid.

Based on the 2008-2010 NSRs, since 2007 the Baltic States (EE, LV, LT) plus BG and RO have allocated more (public) resources to the sector to improve access and quality of care and have placed more emphasis on health promotion and disease prevention and in accordance to what had been suggested in the 2007 Joint Report. However, there are concerns that the economic crisis will have a retracting effect in relation to this trend. A state of crisis has been declared in LV and a number of proposals has been put on hold, while in EE the budget rules suggests that a smaller amount of resources will be available to for healthcare. In LV, there are concerns that cost-sharing and out-of-pockets will increase as a result of the crisis, thus potentially undermine the progress so far in improving access to care.

Since 2007 several countries, such as EE, BE and DE, have been successful in improving population coverage, although some gaps still remain. Other countries send more mixed messages. For example, in AT, gaps in insurance coverage have not improved despite concerted efforts with the third sector and local authorities to provide access to basic care to non-insured individuals. In CY the National Health Scheme that would ensure universal coverage has been postponed for some years. In addition, PL, LT, SK, and SI do not refer to specific policies that can lead to universal coverage. In NL, though health insurance is mandatory and universal, it is not clear what happens to those individuals who do not register with an insurance company and how many these are. It is estimated that approximately 1.5% of the Dutch population is not insured. Interestingly, RO has conducted a population needs assessment exercise which showed a high proportion of the population lacking insurance coverage. This can be seen as a first step towards improving access to care, by identifying the extent of the problem.

Reducing the financial barriers to access was an identified challenged in 2007. While all countries appear to have exemptions or reductions in relation to cost-sharing, some have actually increased the number of cost-sharing schemes (CZ, FR, NL with a deductible, and LV in the future and in view of the financial crisis). The reduction in care utilisation in CZ, for example, has been significant. It remains to be seen what the impacts of these schemes on more vulnerable groups are. In LV, where direct financing costs of care are more than 40% of

expenditure, extra payments may translate into an extra financial burden on patients especially those more vulnerable. The financial costs of care remain high in CY and EL and no specific policies have been mentioned to address this. In IE, while the income threshold for free medical care has increased, the entitlement to free care based on age has been removed causing quite an internal uproar. Interestingly, HU and SK have withdrawn cost-sharing schemes that had been recently implemented. Following the 2007 Joint Report, BE has made substantial efforts in reducing the risk of impoverishment due to healthcare use. Some countries (e.g. PT)have since 2007 been improving system coverage for dental care for certain groups of the population (such as children, youth, and low income individuals). Just as in 2007, dental, ophthalmic and aural care remain, for the most part, outside the public basket and more countries need to make an effort to ensure their coverage for more vulnerable groups. Moreover, informal payments still persist in several countries (SK, RO, BG, EL, HU, PL, LT, LV, IT) and it is not clear if any policies were put in place to address them and if indeed they have decreased.

Some policies appear to have been extended to many countries (FI, LT, HU, IE, AT, SI, EE, PT, MT, DK, SE, ES, UK, CZ) such as those regarding the more centralised management of waiting lists for treatment often accompanied by the establishment of time frames/ limits/ guarantees and more public information on waiting times by health facility. These policies are in some cases accompanied by the possibility to use other regional hospitals or private providers when the wait goes beyond the specified limit. Note though that a number of patients prefer not to exercise the right to go elsewhere for treatment. In general these policies appear to have reduced waiting times for certain treatments.

In relation to the 2007 challenges, some countries (e.g. FR, FI, SE, ES) continued working on reducing geographic disparities in access and quality of care through the implementation of harmonised minimum criteria for access and quality or through incentives to staff (FR, BE, BG, RO, LV) or better data on regional age and health status profiles and inequalities in the use of healthcare (HU). Others (e.g. EL, IT) do not appear to have gone so far in addressing such disparities.

The implementation of screening programmes (e.g. cancer) and disease management programmes (diabetes) is becoming more common across the whole EU. Some countries, as compared to 2007, are encouraging more promotion and prevention at the primary care level through increased competences of general practitioners / family doctors (IE, LT, HU, EE, SI, RO, CY, SK, PT, BE, LV) and through extra remuneration based on prevention activities (LT, HU, EE, SI). In relation to cancer, DK and IE are gradually establishing nationwide cancer pathways to improve access to and quality of associated care, which has nevertheless required some rearrangement of services. The establishment of patient rights and more formal means of patient involvement in decision making are also taking a growing space in the EU. Most countries show progress in the establishment of quality standards and accreditation of facilities and staff, as well as in the use of clinical guidelines. Some (e.g. BE, ES) have also shown more use of health technology assessment. Most EU countries, however, are at an early stage in terms of using health technology assessment in health policy decision making. Quality differences are still significant across the EU countries.

As the biggest spenders in the EU, BE, FR, AT, DE and PT face the important challenge of ensuring long-term sustainability and obtaining greater value for money. While an array of policies have been proposed and some implemented, which translates in the fact that in recent years expenditure levels have been more sTable (as a % of GDP), more needs to be done. Amongst other measures, AT still needs to work towards more integrated funding as

announced in 2007, DE still need to reap the fruits of selective contracting, FR is focusing mainly on the demand side (e.g. cost-sharing, with a possible burden on more vulnerable patients) and need to look at the supply side incentives (e.g. contracting, health technology assessment), PT needs to continue the implementation of primary care units and centres of excellence. Strict budgeting and cost-containment are measures that have allowed BE to control expenditure growth in recent times. BE is still to implement a "future fund" to build up reserves for future use. Greater use of primary care and more cost-effective use of pharmaceuticals may be of relevance to all these countries.

Still in relation to sustainability reforms, note that while NL expected to reap efficiency gains from competition in the insurance sector, 4 companies currently hold 90% of the market, fact that requires further monitoring and may question the ability for this type of competition to ensure efficiency gains. Furthermore, selective contracting is not fully implemented and the authorities' strong focus on increasing patient choice may go against selective contracting and efficiency. SK, that appeared to be following the Dutch example, does appear to have somewhat retracted from their focus on private insurers and providers. Since 2007 CZ and DE appear to have improved risk-adjustment/equalisation across insurance funds. Nonetheless, there are concerns that, in CZ, the possible privatisation of insurance funds may not consider risk-equalisation, thus questioning the solidarity and equity elements of healthcare financing and the sustainability of funds. It is also important to consider whether the required institutional capacity is available in CZ to proceed with such a reform. In relation to 2007 challenges, HU appears to have improved on expenditure control notably through a more strict controlled of patient care paths, the restructuring of the inpatient system, and greater use of generics.

In line with the 2007 challenges all countries want to increase the provision of home and community care and enhance the quality of existing facilities. Some countries are redesigning their financing and provision system. NL, for example, is limiting the scope of the benefits provided by their long-term care insurance scheme and making provision a responsibility of local authorities, which may have access, quality and sustainability implications. Many countries are, however, still at an early stage of these developments.

5.1.5. The financial crisis and economic slowdown

High growth, low inflation, low interest rates and monetary stability witnessed in a large number of Member States in recent years have allowed a positive environment to address social challenges and improve social cohesion. In contrast, the current economic uncertainty and slow down, due to unfavourable global tendencies including the early 2008 high inflation (increase in energy and food prices), adverse exchange rate movements, and more recently the severe financial market crisis ("biggest global financial shock since the great depression" - IMF), can have a negative impact on welfare and well-being, including the health status of the population notably those in more vulnerable groups. The Commission Communication on the financial crisis (COM (2008)706) forecasts that shocks hitting the European economy will reduce the potential growth rate in the medium term and cut actual growth significantly in 2009 and 2010. The economic downturn will affect families, households and the most vulnerable people in our societies. Those with low income, low education, living in poorer neighbourhoods, single parents, and children are likely to be worst affected.

Some of the consequences of a severe economic crisis include significant risks for health[52] in two ways: on the supply side and on the demand side. On the demand side, depending on the severity of the crisis, the demand for healthcare increases as a result of poor health due to a combination of factors: increased job insecurity, unemployment and lower disposable income typically relate to increased levels of psycho-social stress and more frequent health damaging behaviours such as increased consumption of alcohol, tobacco, and drugs, together with poorer nutrition. Severe past economic crisis have led to sharp rises in many causes of death particularly cardiovascular disease but also to alcohol related accidents and death and increased cancer incidence. Rises in chronic illness and mental health problems have also been observed. Furthermore, negative health impacts may persist long after the economic circumstances have changed.

On the supply side, the bases for spending on health are typically taxation and employment-based contributions. With slow economic growth and recession such revenues decrease, as a result of higher unemployment, and thus constrain the level of resources that can be spent on healthcare and long-term care services. How much is then spent on care services depends on the budgetary reserves Member States have made in good times and can use in worse times, as well as budgetary rules (e.g. Can the health insurance funds run a deficit or not?) which are stricter in some countries than in others. In this context, governments may be under pressure to cut expenditure and services or, in other words, to focus on the short-term rather than on long-term agendas.

Thus, it is likely that the ambitious plans exposed in the NSRs may be delayed or made more gradual or even frozen. Indeed, recent country experiences related to macroeconomic stability (BG), high budget deficits leading to macroeconomic convergence plans and structural reforms (HU, EE, PT, DE and FR), have shown that additional economic constraints are placed on social policy budgets in economically difficult times. Additionally, lack of societal support for reform has delayed or brought reform to a standstill (e.g. HU). Hence, it is realistic to expect that the current crisis will place economic constraints in all Member States. In general, more than healthcare, long-term care stands to lose as it is more often based on local authorities' budget and this is often and quickly adjusted in view of the macroeconomic situation. As long-term care represents a smaller share of the budget, focus on only a part of population, and in most countries it is at an initial stage of development it may be perceived as an easier target for financial cuts. This is the more worrying when so many countries have seen a recent impetus in the provision of services.

In this context some crucial questions come to one's mind: "how well prepared is each of the 27 Member States to face this economic crisis/slow growth and the social and health challenges that come with it?" and also, "in view of the ambitions expressed in the NSRs how will Member States reconcile the pressure on expenditure with the need to reinforce the safety net in a difficult economic context?".

These are important especially when Member States recognise that social protection including social security and social and health services have significantly contributed to improving health and reducing the risk of poverty and exclusion including that associated with ill-health, old age or accident. Indeed, the values of universality, solidarity and equity including the protection of the most vulnerable in our societies become even more pertinent and should be

[52] For example the Finnish recession in the late 1980s and early 1990s and the economic crisis following economic transition in Central and Eastern European Countries had significant health consequences.

emphasised as the basis for policy responses. The most relevant policies in such economic circumstances are those which protect health such as access to food and housing and those that ensure universal access to good quality care especially primary care and in particularly for children and vulnerable groups. Public health policies aimed at creating a culture of solidarity and resilience, promoting mental health and dealing with stress and at reducing risk taking behaviour such as smoking and harmful alcohol use are also very important.

The remaining of the chapter goes as follows. Section 2 looks at access to healthcare in greater detail, while section 3 identifies the main issues in relation to quality. Section 4 describes the main challenges and associated policy measures regarding long-term sustainability of healthcare. Section 5 then addresses the specific field of long-term care. Some issues such as primary care or care coordination cut across several sections. Section 6 concludes and identifies key issues for further work and best practice exchange under the OMC.

5.2. Addressing health inequalities and inequities in access to care

Member States argue that good health and longer working lives require, amongst other things, effective health-in-the-workplace policies (notably those emphasising age management and mental health) and, importantly, that healthcare services (including health promotion, disease prevention, curative care and rehabilitation) are accessible for all. Inequalities in health status between social groups and between different parts of Member States are seen as an important problem by about half of all Member States. Across the EU the gap in life expectancy between Member States has widened to 13 years for men and 8 years for women For the EU as a whole there is significantly more (reported) long-term illness and disability in lower income groups. Strategies to tackle health inequalities range from those which focus mainly on tackling inequities in access to healthcare to those which aim to also tackle the underlying social and economic determinants and involve policies across all areas of government. This area represents major challenges to health and social policy and is of increasing importance.

5.2.1. Health inequalities

On average, general health (measured by e.g. life expectancy) has increased in the EU over the past two decades as a result of health policy, more widely available medical care and improvements in living and working conditions. However, improvements have followed different patterns across countries. Economic transition, for example, had a negative impact on life expectancy in the early 1990s in Central and Eastern European Countries, followed by strong recovery in many but not all countries (e.g. life expectancy in LV and LT (for men) is still below the 1986 level). Across the EU the gap in life expectancy between Member States has widened to 13 years for men and 8 years for women, with individuals in the new Member States of Central and Eastern Europe typically living shorter lives than their Western counterparts.

In addition, within country socio-economic differences in health have remained or even increased in a large number of countries for which there is data available. For example, FI, LT, EE, AT, IE, UK, and DK all report in the 2008 NSRs that life expectancy, healthy life years, long-term illness, functional capacity, self-reported working ability, and severe mental problems are more common in the lower socio-economic groups (measured using income or education) than in the higher ones. More specifically, in AT those with higher education a) are less often smokers, b) are less frequently overweight and obese, c) have preventive health checks more often, and d) more often perceived their health to be good or very good. In EE

women with higher education live on average 13 years longer than men with basic education (against the average 11-year gender gap). The UK states that parts of Wales (notably the former mining and industrial areas of south Wales) and parts of Scotland have some of the worst health indicators of Europe and certainly Western Europe. DK indicates that the most disadvantaged groups generally have poorer health and fewer healthy years to live than the rest of the population. In BE life expectancy at birth of those with low qualifications compared to those with higher education is 5.5 years less for men and 3.5 years less for women. At 45 a 5-year difference for men and women is observed. Recent EU-SILC data also indicates[53] that lower income groups feel their health to be worse than more advantaged groups and that in some countries the gap has increased.

Inequalities in health status between social groups and between different parts of Member States are seen as an important problem by about half of all Member States. Reducing socio-economic and regional health inequalities has become the most important health policy challenge for FI and UK, a major goal for LT, IE, AT, EE, SI and SK and part of BE, HU and ES strategy. In the UK extra funding has been allocated to implement direct action to reduce health inequalities, and in FI a national programme has been launched. DK reports the reduction of socio-economic health inequalities as a high point of discussion during the national forum on social protection and social inclusion and MT recognises the need to look further into this issue. Interestingly, a number of countries recognise that action to reduce health inequalities (i.e. improving the health of specific groups) can actually increase general population health at faster rate.

Socio-economic differences in health status suggest that not all population groups have benefited in the same way, either from the economic progress that delivers better health through better living and monetary conditions, or, and importantly, from the availability of and improvements in medical care. Differences in care access and care utilisation explain part of the observed inequalities (e.g. EE reports that poorer households make a different use of care vis-à-vis richer households). Several countries argue that access care is not understood by those to whom it was designed and in greater need. EU-SILC data shows a clear socio-economic gradient in self-reported unmet need, which may proxy differences in care use across socio-economic groups.[53] A crucial aspect in tackling health inequalities is therefore that of addressing socio-economic and regional differences in the availability and use of care and creating health-supportive environments (see next section). As the UK puts it, we need better, local and faster access to care in some more deprived areas and for some groups.

The set of measures put forward include routine monitoring of health status of different population groups (DK, UK, IE, MT) and geographical areas (UK), which indeed can be an important step in drafting informed policy. Monitoring should also done in relation to care utilisation by the different population groups (e.g. IE proposes looking at cancer screening by different socio-economic groups). In the UK, monitoring is to be accompanied by targets (for life expectancy and infant mortality by 2010 for the so-called most deprived areas). In DK, an ill-health survey ("SUSY UDSAT") provides comprehensive health-information on alcohol and drug users, homeless, mentally ill and poor people, and shows significant differences between their health and that of the overall population (61 % suffer from long-term illness compared to 39% of the general population).

[53] See http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/omc_monitoring_en.pdf

Some countries have designed health programmes targeting specific groups in society: the national intercultural health strategy in IE, including for Travellers; Roma and disability programmes in SI; health checks and health promotion for the Roma in LT; health mediators for Roma in RO and BG; the health strategy for disadvantaged communities (for Roma, homeless) in SK; Travellers programme in the UK; the strategic citizenship and integration plan in ES which looks at the health of immigrants; a plan for health of migrants in MT; mobile units directed at minorities and migrants in PT; improve services delivery to homeless, illegal migrants and drug addicts in BE; prevention programmes for disadvantaged groups in DK; the phone counselling line available in Estonian and Russian in EE.

More general policies relate to training care staff to make them aware of possible inequities of access (UK) and of obstacles faced by those with disabilities (CZ). In addition, Member States suggest that there is a need to reinforce the existing national structures of health promotion to ensure community education on health promotion. Hence, health promotion (based on national messages) is becoming a local responsibility as a means to reduce disparities. Municipal public health offices in LT, local authorities in DK and regional offices in AT, SI and SK are now responsible to adapt national health promotion policy to their local features and monitor health status and access to care. Countries also propose that health promotion is adapted to those at higher risk (e.g. IE proposes action to promote healthy eating, access to healthy food and physical activity among adults in disadvantaged areas). Nurseries and schools are seen as important vehicles for health promotion for all, notably through appropriate curricula in schools and as healthy environments. Children and youth health is a priority in several countries (IE, SK, SI and BE, and LV).

Given the various social determinants of health above, some countries (FI, IE, AT, SI, EE, SK, UK) have encouraged health protection and the reduction of health inequalities in other sectors' policies (e.g. education, employment, housing, social work, rural development, environment). This is in line, for example, with a study looking at the links between environment and health[54] that recommends that the policy development process be strengthened by making distributional aspects a more important part of the policy impact assessment process, and by providing guidance on methods and approaches. This would both avoid/mitigate negative distributional impacts and identify (and enhance) positive synergies between environmental and social objectives.

Overall, however, only half of the countries refer to health inequalities across population groups and some do it quite lightly. Even those who put forward the reduction of health inequalities as a major goal, are not too detailed in relation to what policies are pursued, let alone effective, in reducing unnecessary inequalities in health. This suggests that more awareness and exchange is needed in this area.

[54] See for example "The linkages between environmental and social sustainability in Europe" at http://ec.europa.eu/social/BlobServlet?docId=1574&langId=en

5.2.2. Access

All Member States are committed to the objective of ensuring access for all to adequate healthcare and long-term care[55]. Some of the goals expressed in the NSRs are "to develop a network of quality services accessible to all"; "create equal conditions for all citizens to get access to the care they need"; "safeguard services for all, independently of their financial or social status background, gender, age, residence, race or religious background"; and "that access does not cause financial dependence and poverty". Universal or almost universal rights to access to healthcare can be found in all EU Member States and, by design, countries want to ensure that, while financing is based on ability to pay (taxation, social insurance contributions), access to services is not dependent on income or wealth.

Nevertheless, EU-SILC data (with the exception of DE, BG and RO) indicates that, on average, 3.1% and 5% of those living in the EU report unmet need for medical care and dental care respectively. Percentages vary from 0.2% in DK and SI to 15% in LV when looking at medical care, and from 0.5% in SI to 12.2% in EE in relation to dental care.[53] In 8 Member States, 40% or more of the population says that access to home services and nursing homes is difficult.[56] As in the 2006 NSRs, the 2008-2010 NSRs identify disparities in access on a socio-economic and regional basis (e.g. available income, unemployment, ethnical and racial basis, geographical areas). Barriers to access include lack of health insurance coverage, direct financial costs of care, including direct payments for care and transport, geographical disparities in the availability of services and their quality, waiting times for receiving care, lack of information regarding access to the healthcare and long-term care packages, lack of registration with health insurance or family doctor, complex and very lengthy administrative procedures in relation to eligibility and enrolment for long-term care services, and discrimination, language barriers and socio-cultural expectations in relation to life and care services. As the current supply of long-term care services is deemed insufficient to meet current and future needs, these obstacles are often more acute in the context of long-term care. Differences in provision and quality across EU countries are more marked here than in the context of medical care.[57]

To improve manners, more public investment is being allocated to the healthcare sector in a number of countries (FI, LT, HU, IE, RO, UK, DK) notably to improve infrastructure (facilities and beds), staff availability and technology. Additional public funding has been/ is to be allocated to expand community and home care (LV, CZ, HU, LT, MT) and improve residential care (BE, FR, LV, HU). Many Member States wish to promote rehabilitative care (PT, BE, CZ, EL, FI, FR, DE, LT) with a view to restoring patients' skills to regain maximum self-sufficiency. Significant emphasis is being put on improving coordination between primary and secondary care and between healthcare and long-term care. However, the reading of the reports suggests that we are still at an early stage in this process.

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55 Although different definitions exist, long-term care is often defined as a combined range of health (nursing) and social services provided for an extended period to individuals who are dependent and need assistance on a continuing basis due to their physical or mental disability/limitations. Services relate to the basic activities of daily living (bathing, dressing, eating, getting in and out of bed or chair and moving around, using the toilet and incontinence) but also include help with instrumental activities of daily living (meals, shopping, housework).

56 See for example Special Eurobarometer 283 at http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

57 See for example Special Eurobarometer 283 at http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf

5.2.3. Lack of insurance coverage

All Member States express the wish to have full universal coverage of their population. While this is implicit in national health systems (NHS), the state usually pays for non-contributory groups where the right to care is related to contributions to social insurance. While emergency care is available for all (though sometimes involving a fee), there remain a number of individuals not covered for other and more common care services. The proportion of the population not covered is 4% in EE, 1.5% in AT, 1% in LT, 0.84% in SI, 0.4% in BE, 0.2% in DE and (as OECD health data suggests) 2.7% in PL, 2.4% in SK, and 0.1% in FR. In RO, 5.7% of those who visited the doctor during a national health assessment were not insured, suggesting a significant proportion of uninsured in RO.

The reports, though, are not always clear about who the individuals that lack insurance coverage are. In EE the figure includes those on long-term unemployment, while in SI it relates to refugees, asylum seekers, former prisoners and foreigners with temporary residency. In general, in addition to those who fall out of social security (long-term unemployed, homeless), they appear to include those who lack residency, citizenship or official papers (illegal immigrants, asylum seekers, refugees) or lack information regarding registration with the system (minorities). Informal unemployment and the grey economy under which individuals do not pay contributions also imply a lack of health insurance coverage.

Moreover, for example in PT, certain groups (e.g. civil servants) have double coverage through the NHS and own social insurance scheme, while CY highlights that the current system favours civil servants who get a wide range of free public healthcare.

The numbers above show a reduction vis-à-vis 2006 and thus a positive outcome of the policy efforts put in place by Member States (e.g. in BE coverage was extended to all those self-employed; in EE coverage was extended to those on unemployment benefits; in DE mandatory health insurance led to 134000 persons formerly without coverage entering public health insurance and 5000 persons entering private health insurance). Further steps have been taken since or are proposed. In DE, legislation introduced in 2007 enables people to re-enter social or private health insurance and ensures individuals are not ‘kicked out’ of insurance. DE expects to reach full coverage by 2009. AT wants to improve cooperation with private social welfare organisations to improve access to health and long-term care of those more vulnerable and not currently covered. EE and RO are encouraging local governments to provide primary care to those who lack insurance and EE wants to ensure that all unemployed persons participate in active labour market measures to which insurance coverage is associated. CY is planning to introduce universal residence-based coverage under the National Health Scheme (though it has been a very lengthy process). Some countries (IE, HU, RO, ES, CZ, PL) are working on clarifying the statutory provisions on eligibility for health and social services (i.e. defining the who, what, when and where), in relation to a minimum/ common basket under social health insurance or NHS. While clarity is a first step in ensuring coverage, notably by reducing discrimination and regional/ local discretion, and thus disparities in service provision, more needs to be done to ensure access to care for all.

5.2.4. Lack of coverage of certain types of care and high direct financial costs of care

While most EU countries rely heavily on public finance, private healthcare expenditure is significant (about 20-30% on average) and consists primarily of out-of-pocket payments (direct payments made at the point of access to care) for services excluded from the public basket and increasing cost-sharing[58] for public services. In some countries the share of private expenditure, mostly made up of out-of-pocket payments, is rather high: CY (57%), LV and BG (39%), and EL (38%). The 2008 NSRs mention (though perhaps less strongly than in 2006) that dental, ophthalmic and aural care services continue to be some of the common services not covered by social health insurance or the NHS. Additionally, the lack of public provision or funding for home, community and residential care places a large direct financial burden on patients and their families/relatives and large out-of-pocket payments are common for these services.[59] Additionally, differences in the evaluation of 'dependency' and its scope may determine whether individuals are entitled to publicly funded services or not. Moreover, cost-sharing, in place in all Member States (to a greater or lesser extent), applies to pharmaceuticals, specialist and hospital care, home visits and, in some countries, to primary and emergency care. In some countries informal payments are an additional cost to patients (SK, RO, BG, EL, HU, PL, LT, LV).

As highlighted in the 2007 Joint Report, while cost-sharing can have a role in the health sector in raising cost-awareness, reducing unnecessary consumption, and encouraging a preferred path of care, it is a component of healthcare that must be carefully designed so that it does not deter or delay access to necessary care by those more vulnerable (lower income, chronically ill) who may face the greatest need.[60] This is the more important in the context of high expenditure and growing demand where cost-sharing may be seen as unavoidable. Hence, it is crucial to design it so that it minimises any negative impacts and maximises efficiency gains.

All countries have reductions or exemptions of cost-sharing for certain population groups based on income, age and severity of disease (e.g. children, students, elderly, chronically ill, benefit recipients, low income, pregnant women, disabled, victims of violence). In many countries a minimum basket of care is available free of charge for all residents. For example, in BE and LV a set of preventive care (vaccination and screening) is free for all. In NL, primary, obstetric and maternity care, and dental care for those up to 22 are not included in the compulsory excess (deductible). Some (RO) plan to extend the basic care basket covered by social insurance. Several countries (BE, FR, IE) want to decrease the financial burden of care in general and for those in more vulnerable groups in particular (low income and/or chronically ill patients). In FR free care is now available for those with chronic conditions. In IE medical and GP cards entitle those in lower incomes to access free care or free primary care. IE is increasing and indexing the income threshold that qualifies for free care (though decreasing age eligibility). In BE a medical card allows full reimbursement for some

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58 Cost-sharing includes: a) co-payments or fixed amounts paid by patients for a service (common for visits and hospital stays); b) co-insurance or a percentage of total cost of service (common for pharmaceuticals); and c) deductibles or a fixed amount paid (e.g. first €100) by the insured person before any reimbursement occurs.

59 According to the Special Eurobarometer 283 in 9 Member States, 40% or more of the population says that home services are unaffordable while in 19 Member States residential services are unaffordable (please tell me if for you personally, or for your close ones, each of the following are very affordable, fairly affordable, not very affordable or not at all affordable.).

60 Evidence indicates that charging can reduce utilisation and has negative consequences on the health status of those poor and with poor health.

individuals and for some conditions. Some countries operate expenditure ceilings to alleviate the burden of those using services (including medication) frequently (FI, BE, LV). In AT, prescription charges for those with chronic illnesses are capped at 2% of individuals' income.

Plans are put forward to increase the reimbursement of drugs (RO, PT, LV, MT for cost-effective drugs) or decrease/control the price of drugs (PT, BE, MT, BG) especially for those with special difficulties and the elderly (ES, UK), or chronic disease (MT) or children (UK). Some see a greater use of generics (PT, MT) as a way to increase the affordability of drugs and ensure extra reimbursement.

FR sustains that the Couverture Maladie Universelle complémentaire funded by the State for those with low incomes plus financial aid to acquire complementary insurance to those around the CMUc income threshold have reduced financial barriers (although there are reports of doctors refusing CMUc patients). NL has increased the allowance to low income groups and those chronically ill to help paying for health insurance premiums and direct costs of care. Vouchers for dental care and home help services and home healthcare are now available in PT (for children, pregnant women and elderly with lower income) and in FI respectively. Extra financial aid/ welfare benefits are granted to the elderly dependent, disabled and chronically ill (FR), while State coverage of long-term care for low-income households is provided within social assistance (FR, NL, BE, HU, DE, SK, LV) and State subsidies are given to use private services (FR).

5.2.5. Waiting times

Waiting times for a number of treatments are seen as another obstacle to access, although often seen as a dimension of care quality. They appear to receive greater attention in this reporting exercise than in the previous one. Waiting times vary by ill-health condition and between regions (FI, SI). For some countries they are important in the context of elective (non-urgent) surgery, while for others improvement is needed also in relation to primary, specialist or emergency care, chronic disease and malignant disorders. In several countries, waiting times are also long in the context of long-term care services, particularly residential care, due to the current inadequate public provision/funding and limited availability of nursing staff.

Several policies are proposed on the line of more centralised and transparent waiting list management (FI, LT, HU, IE, AT, SI, EE, PT, MT), especially for non-urgent surgery. A first policy is that of implementing a national monitoring system on waiting lists and times for different healthcare facilities, whose information could be made publicly available to staff and patients, thus helping these choose the facilities with the shorter wait (FI, SI, DK, EE, ES). This is typically, though not necessary, related to the implementation of time frames/ time limits/ time guarantees that are applied to either all or some of the following: primary care, urgent treatment, non-urgent surgery, chronic and malignant disorders (FI, SI, SE, DK, UK, ES, CZ, PT, MT). The aim is not only to ensure that no one waits too long, and thus bears negative repercussions on his/her health status, but also that there are harmonised principles for all regions in an attempt to decrease geographic disparities in waiting times. When time limits are reached, other public facilities in other regions or in the private sector (FI, UK, DK, LT, SE, IE, PT) can be used, following agreements with private institutions. For example, in IE, the National Treatment Purchase Fund that manages those on the waiting list (i.e. checks if patients still require treatment), arranges treatment for those who have been waiting the longest. Interestingly, not all patients accept being treated elsewhere from originally planned (IE, PT, DK, SE) and prefer to wait longer but be treated closer to home. Further to these

measures, in DK the patient ombudsman is to deal with waiting time complaints. In addition, extra funding has been put into increasing the number of public beds (IE, UK, MT) or directed at those conditions with very long waits (SI). It is expected that an increase in long-term care services also increases capacity and reduces the wait by reducing bed-blockers (MT). Moving certain healthcare services from the tertiary/secondary to the primary sector is also expected to reduce waiting times for surgery (MT). The implementation of electronic referral systems may contribute to faster evaluation of referrals to hospitals (UK). Longer hours for surgical and outpatient wards are to decrease the waiting (MT). In general, better coordination between primary and secondary care is crucial to achieve faster referrals and treatment. Policies centralising the management of waiting lists together with time frames are becoming common around the EU and appear to have reduced waiting times for several conditions.

5.2.6. Geographic differences in services availability and quality

Virtually all countries report geographic differences in the availability and quality of healthcare and long-term care services, and recognise the need to ensure territorial cohesion in these fields. Typically, the 2008 NSRs report a concentration of health and social care professionals, facilities and equipment in cities and major urban centres vis-à-vis rural and remote areas. Member States report uneven use of care together with regional and social economic differences in lifestyles and even in the compliance to therapies (LT). In many cases the differences are regional and coincide with the socio-economic structure of the population (e.g. high income versus low income regions, high unemployment versus high employment regions). Some countries refer to deprived areas that are part of urban centres. Disparities are more acute in the case of long-term care, which is more often a responsibility of local authorities or regions than healthcare. Differences in assessing dependency and thus eligibility are common across regions.

In some countries differences are related to the decentralisation in the provision and financing of services, which provides an opportunity to adapt service to local circumstances, but makes services dependent on the region's income and discretion in decision making (FI, ES). Some argued that ageing and urbanisation have led to thinly populated rural areas and highly populated cities, making it difficult to plan and distribute services. Some state that geographic differences are the result of previous "no-policy" situation. A lack of coordination between public and private provision/funding leads to the concentration of private provision in big centres (CY, EL). Shortages of primary care doctors, which is not always seen as an attractive discipline, result in an uneven distribution of care (e.g. there are unoccupied facilities in disadvantaged areas in BG and PT as a result).

Measures proposed relate to improving infrastructure, resource allocation and staff support structures in needed areas. A large number of countries are focusing on building new infrastructure and modernising facilities focusing on primary, common outpatient and emergency care. The attraction of health personnel (i.e. primary care doctors) in isolated or economically disadvantaged areas is also a priority, and some (FR, RO, BE, BG) provide a related package of incentives (also for emergency staff in LV). In some countries the municipal and regional reform to broaden the population base continues (FI) and cooperation and partnerships between local authorities (FI, SI) or groups of health centres (PT) is encouraged to enhance provision. Another important aspect is to develop an adequate financial framework that guarantees a uniform supply of basic health services of standard quality by adjusting regional funding to population characteristics with annual updates (IE, AT, HU, RO, UK) or where health indicators deviate most from the average (SI). A maximum

distance to hospital (BE) and mobile services in remote areas (RO, BG) are also foreseen, together with the setting up of pharmacies or outlets in disadvantaged areas (RO). SE is working with local authorities to provide more psychiatric care while DK is implementing cancer pathways throughout the country. FR is setting up regional health agencies comprising medical and social care professionals to improve the organisation of healthcare services across regions. Interestingly, in ES the ministry of health is working with the ministry of environment and rural affairs to ensure quality primary and emergency care in rural areas.

The structural funds can provide extra funding for regional development including in healthcare. Although some Member States mentioned their use, (HU, SK, EE, LT) there is, room for improvement in terms of more and better use of funds in this field.

5.2.7. Primary care

An important conclusion is that primary care is an important tool in ensuring greater accessibility for all and is at the heart of addressing disparities in care supply. All countries indicate that efforts must be made to have a country wide and effective primary care network as well as a minimum emergency care structure (FI, RO, SK, UK, LT, HU, PT, LV, BG, PL). Primary care should be available near to the place of residence, i.e. all individuals should have a family/ personal doctor close to where they live and when they need. To this aim RO is establishing more agreements between county health insurers and primary care practices for those in rural areas; IE wants to increase the number of primary care teams; BG, FI and LT want to establish greater cooperation between municipalities, and SK is defining primary care districts where GPs have to serve all patients, including Roma communities. Better coordination between private and public provision of primary care (CY), allowing all those who meet certain requirements to establish themselves as primary care providers (SE), increasing out of hours GP services (IE, BG) and increasing service hours of health centres (PT) are other policies designed at strengthening primary care.

And important element is that the attractiveness of primary care must be improved. To this end, FR established a forum with health professionals and policymakers and patients, while FI is developing a national development centre for primary healthcare and a network of health centres, together with institutes of general practice in universities and units of general practice in hospital districts. To increase motivation, countries (LT, HU, EE, SI) propose changes in payment for primary care doctors including a mixed system of age-adjusted capitation (money follows the patient) plus a fee for preventive services. Motivation is also provided through greater competences attributed to primary care doctors and nurses (promotion and prevention - screening and immunisation in IE, LT, HU, EE, SI, RO, CY, SK, PT, BE, LV and disease management of e.g. diabetes, obesity and heart disease in IE and BE). Primary care (primary care teams) is also to be the basis of multidisciplinary networks involving GPs, nurses, healthcare assistants, physiotherapists, occupational therapists, obstetricians, social workers, among other (BE, FR, IE, LT, MT, PT and UK,) to ensure better access through better coordination of care (i.e. referrals to secondary and social care).

Indicators to monitor progress in national primary care strategy are also proposed (ES). This is quite pertinent given that a country wide primary care network requires sufficient numbers of staff which may prove difficult in the context of increasing staff shortages and when primary care physicians are fewer than specialists in many countries. Strengthening primary care is strongly related to the availability of human resources and only few countries currently acknowledge that.

5.2.8. ICT as a means to improve access to as well as quality of care

A vast number of countries places high hopes on ICT to improve access and quality. ICT, through health websites/portals, can allow for more complete and always available information regarding rights to access (how one can use what services when) and health promotion, disease prevention, treatment or rehabilitation. Aside internet guidance, booking of services (HU, RO, EE, FI, PT, ES), choosing providers (SE, DK), a centralised free medical counselling phone (SE, FI, EE, DK, PT, MT) and remote electronic diagnosis (HU, LV, ES) or ICT alternatives to staff in remote areas (EE) can help improving access and diminishing regional differences. Tele-monitoring, telemedicine and independent living systems can contribute to ensuring independent living and more user-oriented services. It can enable better self-management of chronic conditions and can support informal carers in their role. All countries are investing in the computerisation of services which allows for personal identification systems and patient electronic records (ES, SE, EE, FI, IE, AT, LV, BG, RO also for chronic disease, UK for health and social care). Electronic referrals (SE) and e-prescriptions (PT, LV, ES, FI) can ensure faster patient flows in the system. Finally, ICT allows for data collection, monitoring and planning (EE).

In this optimistic scenario two issues need reflexion. Indeed, if better care coordination and thus faster and better quality care is to be achieved, it is fundamental that technology is compatible across all care facilities to ensure that information flows across different medical facilities and from these to social care facilities. Moreover, and some countries recognise that ICT use is still limited, there is the problem that ICT can create a further gap between those richer and those poorer (as a computer and internet access is needed, for example) but perhaps in greater need of care. Hence, it remains to be seen how the benefits of ICT can spread across the whole population.

5.3. Quality of healthcare

5.3.1. Introduction

Quality of care is an emerging policy issue across the EU. European healthcare and long-term care systems are currently facing a number of challenges, including population ageing, migration, mobility of patients and health professionals, and rising expectation of citizens. While rapid progress of medical and ICT technologies is seen as a source of demand and expenditure growth because it allows for the treatment of conditions that would previously go untreated, they can also contribute to innovative solutions and changes in organisation of care, for example, shifting from hospital care to preventive and primary care. In these changing systems it is crucial to ensure the provision of high quality healthcare and long-term care for the European citizens, i.e. care that is effective, safe and responds to the needs and preferences of patients and society.

The European Observatory on Health Systems and Policies[61] uses the definition of the American Institute of Medicine (1990) that defines quality as "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The Council of Europe (1998) adds to this "increases (…) and diminishes the chances of undesirable results (…)". More recently the WHO (2000) defined quality of care as "the level of attainment of health systems' intrinsic goals for health improvement and responsiveness to legitimate expectations of the

[61] http://www.euro.who.int/observatory/Glossary/TopPage

population". Several Member States also propose a definition of quality: for example, the UK Department of Health (1997) states that quality is "doing the right thing, at the right time, in the right way, for the right person". Such definitions cover the dimensions of effectiveness, safety, timeliness and patient centeredness. Under the social OMC we focus on all these aspects which relate directly to the common objectives and indicators that have been agreed.

The previous NSRs provided a number of tools that had been developed in Member States to increase high quality of care. They were categorised into three groups: effectiveness, evidence-based medicine, and integrated care. They covered issues such as quality assurance systems, prevention schemes, evidence-based medicine and clinical guidelines, patient safety, care coordination, and patient choice, rights, and involvement in decision making. Current reports continue along these lines but give further details about preventive care and primary care as a vehicle for prevention; they point out the management of chronic diseases as an issue of growing concern; they present work on quality standards; finally, they give an overview of how the Member States introduce patients-centred care.

5.3.2. Quality assurance systems

As in 2006, most Member States report on their progress in relation to the implementation of quality standards. The 2008 NSRs provide further details about elaboration and implementation of quality standards for hospital care (DE, DK, IE, CZ, EE, NL, UK, SI, FR, PL and AT) but also for other healthcare providers (e.g. FR, AT). The standards are elaborated internally but often are inspired by international organisations' work (e.g. the Joint Commission – CZ). Many Member States created devoted bodies at national level (national quality agencies) aiming at quality improvement (ES, DE, IE, CZ, EE, NL, SI, MT and AT) and in some cases with the new mission of studying the medico-economic aspects of healthcare (FR). While in some countries quality standards are not binding, in most cases national agencies are in charge of accreditation or certification of hospitals and other health providers based on the specified quality standards (e.g. BE, FR). Some Member States also issue national clinical guidelines (FI, BE, UK and DK), which are sometimes based on evidence-based medicine or health technology assessment.

The work on standards is in line with the Commission's proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare which refers to Member States defining clear quality and safety standards for healthcare provided on their territory and ensuring their implementation.

The level to which the defined standards have been met by healthcare providers is seen as necessary source of information about the quality of services provided, to help decision makers in planning actions aimed at reducing unaccepTable variation and to help patients choosing care facilities (i.e. more informed choices by patients).

5.3.3. Effectiveness: disease prevention and chronic disease management programmes

According to the European Observatory on Health Systems and Policies effectiveness means "The extent to which a specific intervention, procedure, regimen of service … does what it is intended to do for a defined population" (WHO). The OECD also defines effectiveness as "the degree of achieving desirable outcomes given the correct provision of evidence-based healthcare services to all who could benefit"[62]; "the extent to which attainable improvements in health are, in fact, attained".

[62] http://www.oecd.org/dataoecd/1/36/36262363.pdf

Rendering healthcare systems more effective is an issue for the vast majority of Member States and is the driver of several reforms currently undergoing or being prepared in Europe. In this context, improving disease prevention is reported as a way of improving health system effectiveness and efficiency (as disease prevention interventions such as vaccination and screening can prevent disease or provide early diagnosis that result in lower healthcare costs). Many preventive interventions are deemed effective and cost-effective to reduce disease. They may also offer opportunities to increase social welfare or enhance health equity[63].

In many Member States, preventive care has a history, especially with regard to newborn, young mothers, and children, with a free of charge follow-up in schools for example (AT, BE, SI, LV, CY, LT and PL), and notably vaccination and oral health. More punctual preventive programmes also exist and are gaining more ground concerning specific diseases (tuberculosis, AIDS, cardiovascular diseases, diabetes). Cancer prevention, notably routine screening and follow-up, have however received greater attention in the 2008 NSRs and are well documented in the majority of the reports, although the statistical data about the percentage of population screened are not always provided. Breast cancer screening is implemented in the majority of Member States, followed by cervical cancer screening. European Guidelines on Breast Cancer Screening are/ planned to be implemented shortly in almost all Member States. Other measures include introducing (LU) or considering the introduction (IE) of vaccination programme against HPV. This is potentially related with the implementation of the Council Regulation on cancer screening, in relation to which the first report was launched. This report identifies differences in cancer diagnosis and follow-up across Member States and that the EU is only about half-way to the goal of 125 million examinations per year.[64]

Chronic diseases are the subject of growing awareness in Europe. Characterized by long duration and generally slow progression, they represent a considerable burden from societal and economical perspective. Europe today has a high prevalence of non-communicable diseases such as diabetes, obesity, and osteoporosis[65]. They can lead to death or long-term disability. Chronic diseases can be attributable to the interaction of various genetic, environmental and especially lifestyle factors, including smoking, alcohol abuse, unhealthy diets and physical inactivity and therefore can be to certain point preventable. Good quality and evidence-based care of patients presenting chronic conditions may bring better quality of life to the patients and savings to the healthcare systems.

Different aspects of chronic diseases management (often diabetes, kidney failure and heart disease) are addressed at the Member States level. Clinical protocols and guidelines for use in primary and specialist care were introduced in Ireland. The French national plan for chronic diseases considers as a priority the introduction of educational programme for chronic patients on one side, and foresees a new system of payment (other than fee for service) for physicians following patients with chronic conditions. This new financial mechanism, rewarding preventive actions and better care coordination in ambulatory sector, hopes to contribute to provision of better quality care.

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63 Franco Sassi and Jeremy Hurst The Prevention of Lifestyle-Related Chronic Diseases: an Economic Framework, OECD Health Working Paper No. 32, 2008.

64 http://ec.europa.eu/health/ph_information/dissemination/diseases/cancer_en.htm#4

65 Health-EU. The Public Health Portal of the European Union. http://ec.europa.eu/health-eu/health_problems/other_non-communicable_diseases/index_en.htm

Investing in primary care as a vehicle for disease prevention and care coordination is also proposed by a number of Member States.

5.3.4. Patient safety

The WHO defines patient safety as "freedom for a patient from unnecessary harm or potential harm associated with healthcare" and the OECD defines it as "the degree to which healthcare processes avoid, prevent and ameliorate adverse outcomes or injuries that stem from the processes of healthcare itself"[66], The American Institute of Medicine's definition of patient safety is "avoiding injuries to patients from the care that is intended to help them". It is estimated that, in the EU, between 8% and 12% of patients admitted to hospital suffer from adverse effects while receiving healthcare, although harm to patients can occur in all healthcare settings. The 2005 Eurobarometer survey on the perception of medical errors in the EU[67] showed that over half of Europeans believed they cannot avoid serious medical errors in hospitals.

Although patient safety is narrower in its definition than healthcare quality more generally, it is a key foundation of any high quality health system. Implementing effective quality and patient safety improvements is of interest to many international organisations (e.g. WHO, OECD). The European Commission has also taken specific steps in many areas to address the issue of patient safety. However, these have focused mostly on specific sources of risk such as the safety of medicines, medical devices and resistance to antimicrobials. Building on those achievements, the Commission is currently preparing an initiative on patient safety which aims to outline an integrated approach, placing patient safety at the core of high quality healthcare systems by bringing together all factors that have an impact on the safety of patients, including a specific focus on healthcare-associated infections.

However, in the 2008 NSRs patient safety is reported as a priority by only a few Member States. The efforts towards improving patient safety focus on reducing healthcare associated infections (which are among the most frequent and potentially harmful causes of unintended harm) and other avoidable incidents in curative care. Member States which invested in patient safety strategies set up very ambitious objectives (reducing by 50% the health related infections over 2-year period in SE or reducing the number of avoidable incidents in curative care by 50% within 5 years in NL). Some of the measures proposed to achieve those goals are as follows. The introduction of a reporting system that obliges the health providers to report harm connected to healthcare, albeit within a blame-free culture of reporting that makes healthcare providers feeling confident that they can report without fear of negative consequences (SE, UK, IE). Collecting and sharing examples of good practice between the health providers is another way of addressing patient safety and it was introduced in several Member States (NL, FR, UK, IE) to facilitate mutual learning. The introduction of statutory complaints and redress systems and information ensures a possibility for patients and their families to get compensation for harm. Protected disclosures or "whistleblowing" on issues of patient safety proposed, for example, by Irish health authorities, helps to capture the extent, type and causes of adverse events. This information also enables efficient use of resources, through developing solutions addressing the problems as evidenced by the reporting.

Examples provided by the National Reports, although not abundant, are very constructive and show the political awareness of patient safety issues, and the willingness to place patient safety as a public health priority.

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66 http://www.oecd.org/dataoecd/1/36/36262363.pdf

67 http://ec.europa.eu/health/ph_publication/eurobarometers_en.htm

5.3.5. Patient centeredness

Although there is an overall awareness of the need to make the patient the central point of healthcare and especially long-term care systems, the level of effort and the measures undertaken by Member States to assure the patient's central role vary across Europe. This is partly due to different departing points and partly due to different systems of delivering care.

The most common way to address patient centeredness is defining the patient rights. A Charter of Patient Rights, either already in existence or under preparation, is reported as a measure being used by most EU countries. For example, CY issued, in 2008, the Charter of Citizens' Rights regarding healthcare in public medical institutions and in the NL there is ongoing work on establishing seven rights for patients, giving them a central role in the Dutch healthcare system.

In some systems patient centeredness is addressed by providing more choice of physician or hospital (e.g. DK, EE, UK).

The National Reports stress also the importance of providing information for patients (SE, DK, EE, BE, CZ) about quality in care settings, level of patient safety, waiting lists, etc. in a form easily accessible for everyone (e.g. webpages) and that may help patients choose between care facilities. An interesting example of information to a specific target group of the population is reported by BE where the right to information for foreigners is assured by the presence of a mediator and translator.

Active participation of patients in the decision-making process is becoming a reality across Europe. Recently reported efforts in this area come from EE (where patients' associations actively participate in policy-making) and DK (which encourages participation of patients in advisory boards of the legal health insurance).

Patient's satisfaction with healthcare services is rarely mentioned in the NSRs. Indeed, only a few Member States report about the satisfaction of patients with healthcare services. Data exist in BE and a study is planned for the last quarter of 2008 for hospitalised patients in LU.

Strengthening self-responsibility and self-determination of patients is a priority for certain Member States (AT, FI).

Only a few Member States (IE, FR) underline the role of patients' relatives and carers as being part of the policy-making process.

5.4. Sustainability

5.4.1. Introduction

The sustainability of the healthcare system is a complex issue depending on many factors, but especially two: financial sustainability and a continuous and sustainable flow of workers. Regarding the first aspect, as demand for healthcare increases, it is difficult to impose restrictions on financing without jeopardising quality and access at the same time. As healthcare systems can be financed publicly or privately, it is essential to find the best combination of financial sources in order to solve existing trade-offs in the design of incentive mechanisms i.e. maximise efficiency gains and minimise the negative impact on the access of those more vulnerable (e.g. lower income and severely or chronically ill). Regarding staff, societal changes, mainly the ageing of the population and staff migration trends, will have an enormous impact on the inflow of workers to the healthcare sector, putting at risk access, quality, and long-term sustainability at the same time. Additionally, the health status of the

population, which determines the need for care, can have a significant impact on expenditure and long-term sustainability as shown in the EC/EPC forecasts.

Most EU Member States prioritise highly the health of their population, as the high level of expenditure in healthcare shows. Nevertheless, there are big differences in the amounts spent, as it can be seen in Figure 10 above (section 2.1).

Data from the OECD and the WHO show that health expenditure varies from 11.1% of GDP in FR to 5.0% of GDP in EE. DE, BE, PT and AT also spend more than 10% of GDP in the health sector, while PL, CY, LT and RO spend only around or less than 6% of GDP. A previous European Commission document[68] states that in order to ensure more equiTable access to care, improve the health status of the general population and reduce health inequalities in these last countries, it may be necessary to increased funding – notably public funding to the sector, given the structure of expenditure in most of these countries (high private expenditure). As regards the composition of expenditure, public health expenditure as a percentage of total health expenditure ranges from 90.9% in LU to 42.8% in EL. It is more than 80% of total expenditure in the CZ, the UK, DK and SE and less than 70% in PL, RO, NL, BG, LV and CY.

Nevertheless, both public and private expenditure have increased during the last decades throughout the EU, especially in those countries that had a very low departure level and are now catching up in improving the general availability of healthcare services to their citizens such as CY, LT, LV or RO. In addition to this catching-up trend, the main drivers of expenditure have been the demographic composition of the population, where the weight of the elderly drives costs up, changes in the health status of the population and morbidity patterns, the income level of the population, which increases demand for more and better services, the rising expectations of people to receive quality care at an affordable price and the surge of new medical and pharmaceutical technologies that most people are willing to take advantage of.

The projections of public expenditure on healthcare as % of GDP show a rise from 6.4% of GDP in 2004 to 7.9% of GDP in 2050 in the EU-25 (EU-15: from 6.4% of GDP to 8.1% of GDP and EU-10: from 4.9% of GDP to 6.2% of GDP). The Commission services have carried out an analysis to assess the impact of medical technology on healthcare expenditure[69]. In the model, aggregate healthcare spending is determined both by demographic factors, such as the size and the structure of a population, and by non-demographic factors, such as aggregate income (GDP), technological factors growth and relative-price movements in the supply of health services. As it is not possible to make reliable forecasts of the future developments in the medical technology the document concentrates on an econometric analysis of the past trends, which suggests that between 2% and 3% of yearly growth in the health care spending can be associated with non-demographic and non-income factors. However, given high level of uncertainty and strong assumptions underlying the calculations, the results of this exercise should be interpreted with caution in the future policy debate.

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68 Monitoring progress towards the objectives of the European Strategy for Social Protection and Social Inclusion. Commission Staff Working Document - October 2008.

69 European Commission, DG ECFIN (2008), Alternative scenarios for assessing the impact of technology on health care expenditure projections. Note for the attention of the Ageing Working Group attached to the EPC, REP. 56451.

5.4.2. Progress on reforming healthcare financing and provision

Due to the above mentioned expenditure trends, the 2008-2010 NSRs show that most countries are adjusting the structure of health financing and delivery in order to rationalise resources, make their systems more efficient and cost-effective, avoid duplication and improve the link between the provision of health services and their financing.

However, Member States face a big dilemma between access, quality, and financial sustainability. In some Member States, financial sustainability seems assured but either at the cost of lower quality of the services or by not guaranteeing access to everybody. Once the intended measures to improve both quality and access are implemented, sustainability is not longer certain. In other Member States, measures intended to improve financial sustainability, as for instance, making the system more dependent on social contributions or improving the incentive mechanisms in order to contain costs, could jeopardise the access to healthcare services of the poorest people. Finally, in another group of countries, financial sustainability does not appear to be the binding constraint but the scarcity of human resources. This is a real problem, especially in those countries that are currently loosing qualified healthcare personnel to countries that may offer better working and salary conditions. The measures presented in the reports can be articulated around the following core lines: reinforcing funding, rationalising care provision, containing costs, improving incentive mechanisms, rationalising administration and strengthening health promotion policies.

Reinforcing and improving financing

In the EU, sustainability problems regarding funding have mainly two different origins; one is insufficient financing, the other is the design of the funding structure. In the first case, the problem relates to a) non-mature/still developing health insurance systems which witness constant reforms, and/or b) to the existence of relatively high unemployment and extensive informal labour markets, which imply that contributions are not always paid and revenues are limited. In the second case, the coexistence of compulsory social health insurance and voluntary private health insurance combined with a lack of risk adjustment mechanisms may have the undesirable outcome of a segmented market due to adverse selection effects. This can in turn imply an underfinanced social health fund for the poor together with rich private health funds for the well-off part of the population.

The required solutions are therefore different. Measures to increase funding are taking effect in many countries that are improving the collection mechanisms of health insurance contributions (BG), imposing more control against the avoidance of contributions (HU), increasing the health insurance tax base (EE) or earmarking the revenues from some so-called “sin” taxes as tobacco and/or alcohol excise duties (RO, AT). Regarding the lack of risk-adjustment, DE has carried out an extensive reform that will centralise contributions in a new National Health Fund. On the basis of a unified contribution rate, the National Health Fund will allocate resources to each of the other funds based on a risk-adjusted capitation formula, which will be adjusted to take account of morbidity in addition to gender and age. The Social Health Insurance and the Private Health Insurance systems will be modified so that the first will become more competitive, while more social elements are introduced in the second. The German authorities will evaluate the effects of the new risk adjustment system in due time. In AT, there are some measures intended to improve financing, such as increasing health insurance contributions and increasing patient' co-payments. In HU, health insurance coverage was linked to employment and this resulted in an increase in the number of

contribution payers and in the revenue of the health insurance fund and in a surplus of the Health Insurance Fund in 2007.

Making healthcare provision more rational

A group of countries are restructuring the provision of healthcare services in order to make a more rational use of public resources by avoiding waste, duplication or expensive treatments in expensive facilities when it is possible to offer effective, high quality care using less money. The main idea is to develop and reinforce primary healthcare and the role of the general practitioner (GP)/ family doctor as a gatekeeper, channelling resources from inpatient to outpatient care, concentrating some hospital care in a smaller number of hospitals and modulating rehabilitation and nursing care in case of chronic illness.

Therefore, EE, IE, GR, FR, LV, HU, AT, PT, RO, SE, UK are reinforcing primary care by developing the GP or family physician system, by reorganising existing professional resources and by introducing financial incentives to increase and strengthen the use of a GP as a gatekeeper and avoid the excessive use of specialists. As a novelty, in IE there is active community involvement in the planning and the delivery of primary care services.

Cost-effectiveness is thus achieved by reinforcing the patient routing (i.e. ensuring preferred and cost-effective paths of care) and restructuring outpatient and inpatient healthcare services in order to increase the share of outpatient care and channelling services from inpatient care to ambulatory, outpatient and home care. This makes possible a concentration of the specialised care and the optimisation of the work of inpatient care institutions, strengthening the efficiency of inpatient treatment and containing costs.

Finally, the management of chronic diseases will be improved through a reorientation of care towards primary and prevention care and self-care and coordinating these efforts with those of the specialists.

Containing costs

In some countries health expenditure has risen in GDP terms more than the average in the EU, so they are taking measures in order to contain costs. Several Member States argue (EL, ES, LV, LU, AT, FI) that one of the reasons behind the growth in expenditure is the extended use of pharmaceuticals or their increasing price. To contain pharmaceutical expenditure growth they are implementing a wide array of solutions to curb overuse and control prices including more rational methods of prescription, better purchasing policies in hospitals (such as better negotiations i.e. licensing deals with the pharmaceutical companies), a better administration and more efficient use of medicines in hospitals and extending the use of generics (see Box on pharmaceutical expenditure in the EU).

Some measures improve the mechanisms of payments as in BG, EE or LT. In EE, for instance, the control and optimisation of health insurance costs will be done via cost-based prices and diagnostics-related group prices Other measures are: more rational criteria for purchasing management (ES, LU, LV and MT), making costs more transparent (NL) or stronger incentives (e.g. performance based contracts) for providers to deliver high quality care whilst controlling costs (MT and UK). Cost control at macro level by the use of expenditure ceilings has been implemented in some countries, more or less successfully. In

BE financial resources not used in the corresponding budget will be allocated to a "Fund for the future of healthcare", whose purpose is to constitute reserves that can be used when the ageing of the population will require greater growth of the budget of mandatory healthcare insurance.

Pharmaceutical expenditures in the EU

Spending on pharmaceuticals has risen rapidly across most OECD countries, consuming an increasing share of overall health expenditure. Since 1995, growth in pharmaceutical spending has averaged around 4.6% per year, compared with the 4.0% annual rise in total health spending, to account for around 17% of health spending or 1.5% of GDP by 2006. [70]

In 2007, the total size of the pharmaceutical market in the EU was € 214 billion at retail price level.[71] On ex-factory price level this corresponded to € 138 billion, of which 88% was for medicines that required a prescription from a medical doctor. The remaining part of the market was non-prescription medicines, which usually can be bought freely over the counter by the consumers. For the medicines sold via pharmacies in the EU, public funding (tax-financed or by compulsory health insurance) cover on average 82% of the prices, and patients have to pay some 18% themselves.[72] This ratio varies between 60% / 40% and 99% / 1% in the EU Member States. On the demand side, the pharmaceutical sector is unusual in that for prescription medicines the ultimate consumer (the patient) is not the decision maker, but generally it is the prescribing doctor and in certain Member States the pharmacist. Nor does the ultimate consumer usually directly bear the costs, as these are generally paid for by a public health scheme. Because of this unique structure, there is usually limited price sensitivity on the part of decision makers and patients.[73]

Given the limited public financial resources available for healthcare and the constantly increasing expenditures, it is highly important for the Member States to continuously optimise the use of different pharmaceuticals and achieve the best value possible for the money spent. In doing so Member States can apply a range of various strategies, for instance: regulation of prices, reimbursement conditions for prescription medicines, optimise the use of generic products that replace more expensive original medicines. These issues were addressed by Member States, EFTA, members of the European Parliament, various stakeholders and the European Commission in the Pharmaceutical Forum[74].

The actual market conditions for, and effects of, the entry of generic medicine products into EU markets are currently being studied by the European Commission with a sector inquiry. In markets where generic medicines become available, average savings to the health system (as measured by the development of a weighted price index of originator and generic products) are almost 20% one year after the first generic entry, and about 25% after two years (EU average). Generic companies began selling generic medicines, on average, 25% lower than the price of the originator medicines. Two years after entry, generic medicine prices were on

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70 Introductory Presentation: Some key features of growth and cross-country differences in health-care spending, at the conference Improving Health-system efficiency - achieving better value for money, jointly organised by the European Commission and the OECD 17 Sept. 2008 http://ec.europa.eu/social/main.jsp?catId=88&langId=en&eventsId=106&furtherEvents=yes

71 Pharmaceutical Sector Inquiry, Preliminary report (28 Nov. 2008), European Commission, DG Competition http://ec.europa.eu/competition/sectors/pharmaceuticals/inquiry/index.html

72 The pharmaceutical industry in figures 2008, European Federation of Pharmaceutical Industries and Associations http://www.efpia.org/content/default.asp?PageID=322

73 Pharmaceutical Sector Inquiry, Preliminary report, European Commission, DG Competition.

74 The Pharmaceutical Forum: http://ec.europa.eu/pharmaforum/

average 40% below the former originator price. The inquiry points to considerable differences, however, in the entry of generics in various EU Member States and in the effects.

However, a generic alternative product can usually only enter the market 20-25 years after the first introduction of a new, patenTable original medicine. Thus, Member States apply a range of policy measures to optimise the use of and expenditures for prescription medicines. Pharmaceutical policies are expected to attain multiple goals that reflect different perspectives. So, market interventions, such as regulating prices and reimbursement conditions for pharmaceuticals, aim to limit dynamic expenditure increases while ensuring affordable access to medicines, and maintaining the incentive for pharmaceutical companies to continue with research and development on new, useful medicines.

In the National Strategy Reports 2008-2010 several member States report on actions that have been carried out to either increase citizens access to pharmaceuticals (e.g. BG), make prescription medicines more affordable to the patients (BE, DE) and/or limit the increases in public expenditures for pharmaceuticals (AT). Some Member States also report on planned actions (e.g. FI). The improved affordability for patients is often achieved by ensuring that the co-payment amounts do not grow too fast. For instance, BE states that various policies enacted to reduce the cost of medicines have reduced the average cost (all medicines prescribed for ambulatory care) for the patient by 8% from 2003 to 2007. To achieve this BE apply a whole range of measures with both detailed expenditure budgeting, use of generic alternatives and regular decreases in the price of medicines older than 12 years. However, there are also Member States that introduce (or increase) the patients' co-payment share trying to reduce the consumption of pharmaceuticals (e.g. CZ). Such measures typically also include maximum co-payment limits to ensure that more vulnerable groups can still access the medicines needed (e.g. SI).

A peer review to exchange practical experiences and ideas about pricing and reimbursement of pharmaceuticals was held in Berlin mid 2008.[75] The peer review concluded that it is essential to promote the transparency of the pharmaceutical markets in the EU, especially on the efficacy and safety of the products, the prices actually paid by consumers and insurers, as well an on the price-setting, reimbursing and other regulatory mechanisms for pharmaceuticals. Future work within the OMC could aim to contribute significantly to the needed transparency.

Improving incentive mechanisms for patients

Some countries can contain costs by reducing the overuse of resources caused by a wrong mechanism design. This is done by implementing policies to motivate people to use healthcare services in a more responsibly manner as in CZ, where the introduction of regulatory fees is giving good financial results – after the introduction of the fees, the number of specialist outpatients visits, the length of hospitalisation and the use of pharmaceuticals were reduced – or in FR where the financial participation of patients in the form of co-payments was augmented in order to moderate demand. More innovative is the coordination of care, in order to avoid duplication, and the introduction of a financial incentive to increase the use of a GP as a gatekeeper. In case the patient does not use the GP and goes directly to the specialist, the patient will face reductions in the amount paid by the social insurance and the specialist would be allowed to surpass the established tariffs. ES will establish mechanisms to promote responsible demand.

[75] See http://www.peer-review-social-inclusion.eu/peer-reviews/2008/cost-containment-in-the-pharmaceutical-sector-innovative-approaches-to-contracting-while-ensuring-fair-access-to-drugs

Rationalising bureaucracy

To render the system more cost-effective, another type of measures aims at rationalising and simplifying bureaucracy. Thus in BE, DK, SE and FI there are administrative simplification policies, which intend to identify and eliminate needless bureaucracy in order to get more time to core activities. Many countries like BE, EL, ES, FR, LV, LT, MT and AT, are developing e-Health systems to integrate information files about patients, organize medicine prescriptions, ensure a quicker examination of patients and assessment of the results, optimise therapeutic processes and increase quality, and avoid duplication.

Health promotion policies

Many countries have recognised in their policies that better promotion will help to trim costs down in the future by reducing the need for healthcare services. Health promotion in early ages can result in a better health status later in life, requiring thus fewer resources from the healthcare system. Therefore, CZ, DK, DE, ES, LV, LU, MT, NL, AT, SE, and the UK will intensify the promotion of healthy lifestyles regarding better eating and exercise habits to improve the general health of the population. With the same objective, DE, EE, LV, LU, HU and the UK will pay particular attention to health promotion of children and young people and to the promotion of better food at schools and childcare institutions.

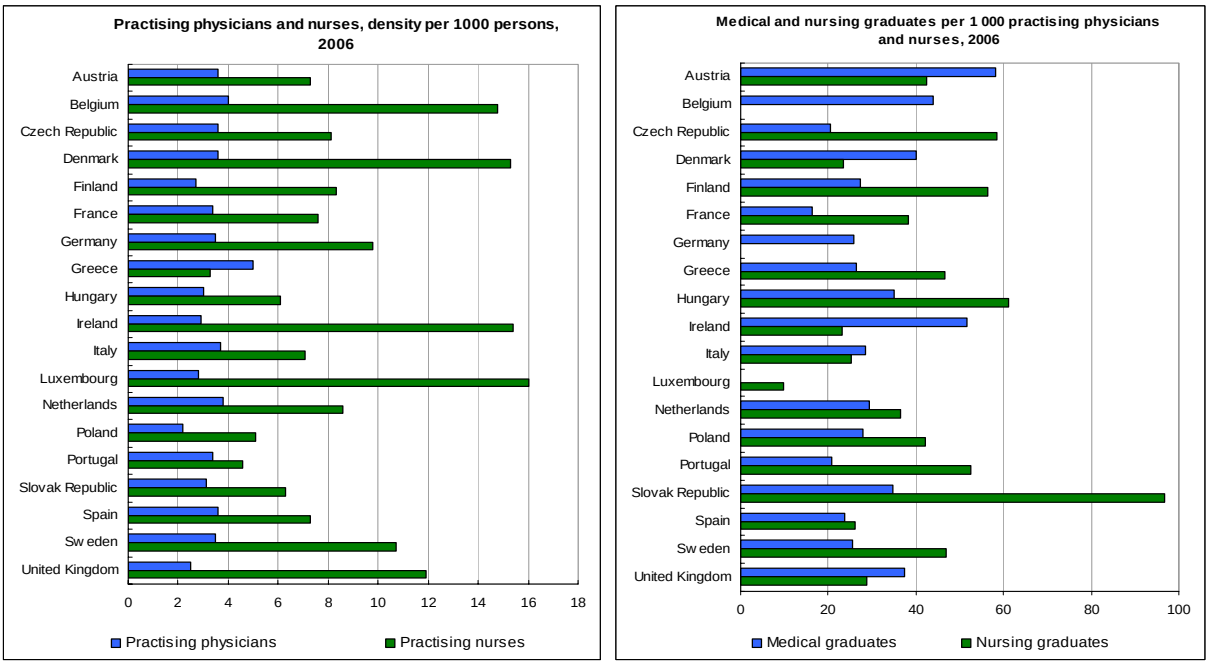
Furthermore, EE, NL, AT, RO, SE, and the UK will implement policies aimed at reducing the consumption of addictive substances, tobacco and alcohol, accompanied in some cases (AT and RO) by financial disincentives in the form of excise duties that will be assigned to health expenditure or (NL) by encouraging health insurance funds to promote healthy behaviour and reward it. Even if it may sometimes seem an exaggerated intervention of public policies in individual decisions, in general it is considered that prevention policies regarding smoking, alcohol and obesity are needed, as these lifestyle risks are increasing the number of the chronically ill. In the last years, many countries, as BE, DK, ES and the UK, have banned smoking from public spaces. Moreover, policies intended to raise awareness concerning the prevention of some specific diseases such as diabetes, obesity, cardiovascular diseases and several types of cancer are being implemented in CZ, DK, EE, IE, HU, NL and SE. DK has decidedly set up a Prevention Commission, which will study the possibilities of reducing the need for healthcare services in the future. There are also some country-specific policies: LU's Action Plan will promote health in the area of sexual education, EE will improve the physical and psychosocial environment and the UK will implement a health improvement policy aimed to support people to make healthier lifestyle choices, particularly children and young people, adults of working age and those who are socially excluded or are "hard to reach".

Long-term sustainability of human resources

Over the next 20 years, the EU will face a serious challenge in the availability of human resources in the healthcare sector. This also casts doubts on its long-term sustainability. One reason for this development is to be found in the ageing of the population. This implies not only an increase in the needs for care in general, but also an increase in the age profile of the health workforce. A second reason is the underinvestment in education and training of professionals, which was seen in the late 80s and early 90s in some countries. The insufficient training of professionals was due to restrictions in the access to training in healthcare professions (numerus clausus). This trend is now reversed, but will not have any immediate effect. It shows both the difficulty of long-term planning the availability of human resources

and the existence of trade-offs between financing more training and lacking doctors and healthcare workers. In other countries, even if training and education has been sufficient, the emigration of trained personnel has led to a serious drain of human resources. The healthcare sector in some countries also faces the dilemma that it needs people with high qualifications, but neither wages nor working conditions are especially attractive compared to other sectors. Keeping the wages of health workers low is also used to contain expenditure growth, so in some countries working conditions in the health professions do not motivate health workers to stay in the sector, but rather provoke an exodus to other sectors.

Figure 14: Medical and nursing graduates, practising physicians and nurses, 2006



Source: OECD, Health data 2008.

Hence, policies regarding human resources are articulated around a) granting more financial resources to the training of qualified doctors and nurses, b) organising work more efficiently, c) restructuring care between primary, outpatient, inpatient and long-term care, d) improving the structure of incentive mechanisms in order to motivate the health work force to stay in or to return to the profession and e) smoothing regional differences in the allocation of human resources.

CZ, IE, HU, MT, NL, FI, and the UK are granting more financial resources to the training of qualified doctors and nurses, improving the systems of training and re-training (including on-the-job training) and increasing the influx of new personnel focusing on young people, non-natives and people with low qualifications. The European Social Fund interventions in this field are targeted at developing human resources for the health sector (CZ, EL, LT, LV, PT, PL, HU, SK).

In DK, NL, SE and FI the main long-term challenge is to attract sufficient and qualified labour, so efforts aim at ensuring efficient work organisation and avoid needless bureaucracy to devote staff time mostly to core activities. They are making efforts to raise productivity introducing modern techniques, using IT more effectively and developing new care concepts,

dropping inefficient and outdated administrative routines and thus reducing waiting times and costs. Also in order to attain a more effective utilisation of healthcare personnel, EE and SE are restructuring their systems by reinforcing primary care, making hospital care more efficient, e.g. by concentrating highly specialised care at national level, and modulating rehabilitation and nursing care in case of chronic illness.

Regarding incentive mechanisms, IE, ES, LT, HU, MT, NL and FI are all trying to improve the working and professional development conditions of health workers through a broad range of measures in order to restore the prestige of the professions and to get them to remain in or return to the profession. These measures involve the development of new systems for attaining and recognising qualifications in medical care (CZ and MT), better career prospects and on-the-job training that offer opportunities for learning and personal improvement, more competitive payroll systems and new salary conditions for young doctors, more decision capacity in developing the content of work, management systems and the assignment of duties and last but not least offering the personnel more flexibility in general and, in particular, more flexible working hours.

Finally, some countries (BE, BG, FR, RO) show strong regional differences in the allocation of human resources and are trying to implement plans that will motivate young professionals to go to less attractive regions. Others, like LV and LT, face the challenge of emigration through a better planning of human resources.

5.5. Long-term care services

5.5.1. Introduction

Long-term care is often defined as a variety of health and social services provided for an ongoing or extended period to individuals who need assistance on a continuing basis due to physical or mental disability[76]. The definition of long-term care, the services and benefits provided and the population coverage vary between Member States.

Member States have continued in their quest for modernising social protection systems, particularly in light of ageing and the concerns over expanding expenditure. The growing demand for long-term care continues representing a major policy challenge for many countries as current supply is considered to be insufficient and inadequate to meet current and future long-term care needs. Recognition that there is no comprehensive system for the provision of long-term services in the EU is coupled with a firm commitment on the part of EU countries to ensure universal access to high quality and affordable long-term care.

2008 saw an impetus in the attempts to address the expanding long-term care needs of the population. The majority of Member States acknowledged that policy actions were necessary in order to secure adequate and sustainable funding structures for current and future long-term care (LTC) provision, particularly in light of demographic ageing and its consequences. The work carried out in cooperation with the Social Protection Committee within the framework of the social OMC resulted in the publication of a European Report on LTC in April 2008[77]. Following the submission of the 2006 national reports, the 2007 and 2008 Joint Reports on Social Protection and Social Inclusion identified several challenges that were assessed in the

[76] OECD Observer 2007, Long-term care: a complex challenge.

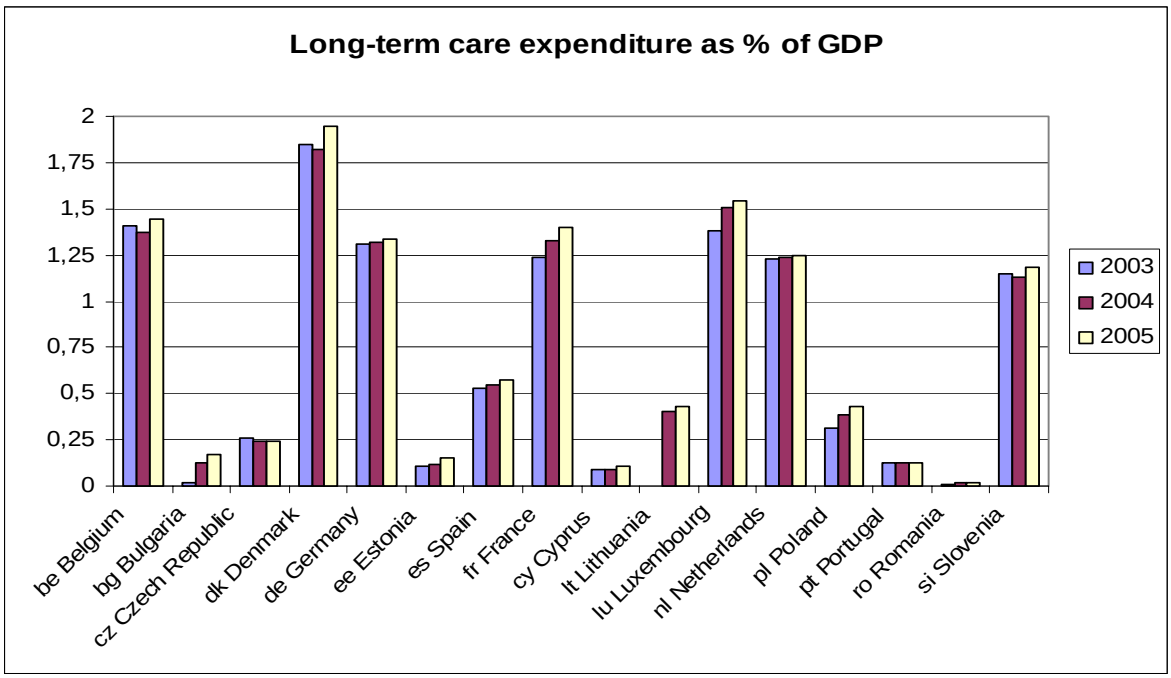
[77] See http://ec.europa.eu/employment_social/spsi/docs/social_protection/ltc_final_2504_en.pdf

European Report. The 2008-2010 national reports are examined in relation to those challenges, focusing on four specific themes and stressing the progress since the last reporting round: the search for financial sustainability, care coordination practices, high level of quality in LTC services and the LTC workforce.

5.5.2. The search for financial sustainability

Long-term care funding and expenditure varies across the EU as shown in Figure 15, with an upward resource-allocation trend over time.

Figure 15: Long-term care expenditure as percentage of GDP, 2003-2005



Source: Eurostat Health expenditure data

Several Member States are concerned by the need to create a solid financing basis for long-term care and ensure the availability of devoted resources. Some established or are in the process of establishing dedicated universal social insurance schemes (DE, LU, NL, SI). Due to the important increase in expenditure spent through the LTC insurance and concerned by the future funding of the system, the NL are planning a reform that would reduce/ redefine the entitlements of the LTC insurance scheme and thus address the observed increase in spending and duplication with other policy fields such as social support and domestic care. Though improving financial sustainability, there are reports that local authorities may initially struggle with the role of buyers of services. Others address LTC via general taxation (AT, SE) or within a more restrictive social assistance framework, defining access and allocating resources through means or dependency testing (UK, CY, HU). Other countries intend to or have implemented a combination of healthcare insurance elements with tax funded social assistance mechanisms such as social care (FR).

Most Member States are concerned by the expected increases in demand for LTC services. Some intend to foster, via an increase in provision, the services provided (AT, FR, LT, BE, HU, DE) reinforcing the capacity of their systems to address the resulting multiplicity of health and social care needs. Others, wish to expand the range of provision through the

establishment of new and amelioration/adaptation of existing services, responding to patients needs and reflecting their preferences in terms of locus of care (SK, LV, BG, MT, PT, LT, DE).

Independent of a country's public financial arrangements, private direct payments play an important role, with a differentiated impact on the devised systems' accessibility. Some countries envisage including the assets of dependent and elderly people in the calculation and aggregation of financial benefits with a targeting for vulnerable groups (FR, LT, SK). The 2008 National Reports point to a potential mix of public, private and third-sector provision (CY, EL). Private sources of finance refer to private health insurance coverage of LTC (often supplementary or for high income groups) and to private household payments (either co-payments for publicly provided care, and/or out-of-pocket payments for which very little or no reimbursement is offered).

High private costs impose a major financial burden on users and their relatives and act as a barrier to access, particularly for low-income groups, with private payments having a significantly regressive effect. Some countries have recourse to private health insurance in order to address the regressive incidence, with the introduction of supplementary insurance (FR). Policies to reduce the individual direct costs of care include amongst others: co-payment exemptions, means-tested co-payments capping (FR); extra financial aid/welfare benefits granted to the elderly dependent, disabled and chronically ill (FR); state coverage of LTC for low-income groups in a social assistance framework (FR, NL, CY, BE, HU, DE, SK, LV, RO); nationwide standardisation of copayments; state subsidies to use private services and coordination between the different benefits provided through the social welfare budget and the healthcare budget (FR, FI, DE).

Since demographic developments point to increasing longevity of the population, a serious challenge, or opportunity, in terms of public health is the prevention of ill-health in old age, i.e. delaying the onset of disability or dependence. Successful health promotion and disease prevention programmes can delay the onset of dependency/disability and could result in financial savings, which is a major concern for countries that aim to limit or curb long-term care expenditures (DK). Equally important is the degree of care coordination between different contingency-based social benefits, which can help in avoiding the duplication of support and care services provision, leading to a more rational use and allocation of resources.

5.5.3. Care Coordination and integrated long-term care provision

Several Member States emphasise their strategies to address often new and (re)emerging health threats such as chronic conditions (LT) and mental illnesses, with national action plans aimed at holistically addressing the needs of mentally affected patients (AT, BE, LV, LT, HU, BG, PT, MT). Equally related to the ageing of the population is the emerging health threat and necessity to address a growing number of patients affected by Alzheimer's disease, with countries proposing national plans (FR, AT, SK). Some countries focused on the provision of integrated geriatric and palliative care (LT, LU). Many Member States wish to promote rehabilitative care (PT, BE, CZ, EL, FI, FR, DE, LT) with a view to restoring patients' skills so that they regain maximum self-sufficiency in order to function in a normal or as near a normal manner as possible, also aimed at allowing, where possible, the patients' reintegration within the labour market (BE, DE).

Several countries have made significant steps towards increasing the public spending dedicated to home and/or community care (LV, CZ, HU, MT, DE) and develop homecare

provision for particular target groups such as the elderly (LT, BG), patients affected by Alzheimer's disease (DE) and/or disabled persons (BG). Countries are firmly focused on enhancing tailored home and community care services (LT, HU) and moving away from institutional care, whilst allowing and/or securing institutional care access if alternatives are unsuiTable or unavailable (BE, FR, LV, HU, BG, DE, RO). Information and communication technology can enable better self-management of chronic conditions and can support carers in their role (DK). The provision of home care services in conjunction with enhanced information and communication technology depends on resource availability (SK, LV) and the degree to which long-term care is provided in an integrated framework.

The uniform and tailored provision of long-term care services depends on the organisational features of each system and on the degree of coordination between the different services operating within these systems. Care coordination is mainly aimed at enabling a high level of quality and efficient use of resources in the provision of LTC services in an institutional or community setting (FR, DE); ensuring an adequate continuum of care irrespective of the different levels of long-term care provision and organisation (BE); and promoting a sustainable funding base streamlining the various related social benefits such as health insurance and social assistance benefits (FR, FI). Care coordination policies, particularly between different associated budgets, can help addressing differentiated provision modes and result in a more integrated financing structure clarifying entitlement rules for dependent persons and addressing the sustainability and adequacy of the provided social benefits. Equally important is the demarcated address of different contingencies that can become mutually reinforcing (disability, dependency and old-age).

Coordination problems in the interface between medical care, social services and informal care can result in negative outcomes for users and inefficient use of resources, with duplication of care provision or of financial and in-kind benefit provision. In some instances, care professionals, or dedicated teams are responsible for ensuring that patients can follow a coherent path of care with the appropriate treatment provided in the appropriate setting, with an integration of the various social benefits or insurance coverage (BE, DE, FR, FI). Long-term care is often associated with the notion of a 'care continuum' and an integrated care provision including elements of other public health policies such as preventive measures, active ageing, autonomy promotion and empowerment, social assistance, healthcare and palliative care. The care continuum approach is aimed towards the coordinated provision of a range of services (particularly homecare) on one hand and the bettered management of the transitions between services and settings. Several Member States encourage care coordination practices and integrated long-term care provision (FR, DE, MT, NL, and FI).

The uniform allocation of resources across administrative levels and loci of care can be sought on dependency profiles for example (BE, HU, NL). Since long-term care is usually provided in a devolved context and run by sub-national levels of government, national standards can ensure uniform provision and financing for all the regions of the country (ES, SE, UK, BG). Another mechanism relies on framework contracts and binding recommendations between long-term care insurers and providers (DE). The alignment of long-term care funding between health and social care components (HU, FR, BE) are also aimed at a care continuum provision. When resources are lacking, in addition to the integration between health and social care budgets, several countries are engaging with the private and voluntary sectors of the economy (HU, LV, LT, EL, CY). The integration of long-term care delivery involves creating single entry points or local assessment teams (NL, PT, UK, DK, DE) on one hand and the devolution of long-term care services at sub-national level (ES, PT, SE, UK), for a bettered management, on the other. Several countries are

encountering financial complications as the sought decentralisation in the provision of services is not backed by a solid funding basis for the local, devolved or decentralised responsible level (LT, SK, BG, RO).

5.5.4. High level of quality in long-term care services

The quality of long-term care services for dependent persons varies widely both between and within countries. Many Member States have introduced or improved regulation and legislation for assessing and enhancing the quality of long-term care services. The increasingly pervasive and all-encompassing nature of long-term care services renders quality definition and measurement a complex task. Indicators of the quality of care are used in some countries to assess and evaluate the quality of the services provided in both institutional and community settings (BE). Quality regulations for long-term care are evolving from basic or minimum requirements for the structure and process of care into more comprehensive and complex quality assurance mechanisms combining procedural, structural and outcome oriented indicators such as continuous staff training requirements (BE, LT) coupled with patient rights mechanisms allowing greater patient participation and consultation (DK, HU, and MT). Inevitably, they refer to formal long-term care services rather than informal provision, which is much more difficult to measure and evaluate.

For some countries with devolved responsibility for LTC provision at municipal or local level, quality in LTC services is mainly assessed through formal regulatory and licensing mechanisms, determining the scope and accreditation processes of the services provided (SK, LT, DE, RO). Others focus on the establishment of national quality standards (CZ, ES, HU, LT, MT, RO) throughout the concerned territories. The use of outcome indicators for quality monitoring still remains in its infancy and different modes of quality assurance coexist such as internal (DE) or external quality assurance mechanisms and national inspectorates (FR, UK) with varying sanctioning capacities. Accessibility of internal and external auditing results to service users and the general public also has been taken up as an important measure of quality control (DE). Quality of care and its evaluation are increasingly viewed as encompassing other important factors such as the support given to family caregivers (DE), increasing consumer choice through the promotion of consumer-directed care (BE), ensuring the capacity of the long-term care workforce and assistive technologies. Examples of poor or inadequate care quality in both institutional and community settings include: inadequate housing (nursing homes), lack of privacy, poor social relationships and use of restraints, amongst others. One basic requirement for quality assurance, of particular relevance to long-term care, is also the active deterrence of patient maltreatment or abuse (SK, LT, RO), particularly in the institutional setting.

5.5.5. Workforce shortages

Most countries have expressed concerns with regard to expected staff shortages in the LTC sector (LT, SK, LV, NL, DK). The availability of carers and their competence and skill specialisation are inseparable concerns (SI). LTC needs have traditionally been met within the private sphere or the extended network of families. In a home or community care setting, the problem of insufficient and inadequately trained caregivers is more difficult to tackle than in institutional settings, even if formal home or community care tends to be cheaper than acute institutional care. The support of relatives (as care providers) and volunteers is and will remain an indispensable part of LTC provision. It is important to ensure that family or informal caregivers receive adequate training, guidance and support (DE, LV, RO). Supply

shortages in the homecare sector cannot be viewed in isolation, but are related to the labour situation in other care settings.

Recognition that the bulk of long-term care is provided within informal settings has prompted national concerns regarding the availability and role of informal carers. While informal home care is not included in cost calculations, the lack of support of informal carers does not entail that it is a budget-neutral option for society. Informal carers are often relied upon heavily without necessarily receiving compensation, whilst foregoing employment. The expected increase in the demand for LTC services translates into an expected increase in demand for formal LTC services since the number of working age women able to provide informal care will decrease at a time when the number of elderly dependent people is increasing; the increased labour market participation of women means less time at their disposal to devote to providing care and the changing family structures such as smaller families and an increase in the prevalence of single-parent families, mean that family members are further apart and less able to care for dependent family members in an informal, unsupported setting.

In both the institutional and home care settings, the main concern is recruiting and retaining an adequately qualified and skilled workforce. In an institutional setting, developments in medical and assistive technologies necessitate an upgrading of workforce skills and qualifications as well as measures to ensure their retention in the LTC sector, with reports of difficult working conditions and low pay levels (EL, DK). The earmarking of specific funds to upgrade working conditions and training (DK) is all the more difficult in light of existing budgetary constraints and several countries intend complementing the devoted resources with Structural Fund support (BG). The increased recourse to cost-sharing mechanisms coupled with limited financial resources dedicated to LTC and coordination problems between competing budgets, inevitably limit the possibilities for upgrading working conditions and raising pay for the staff formally employed in the sector.

Several measures are proposed in order to support informal carers. These measures depend in turn, on the organisational, administrative and funding mechanisms prevalent in each country. A overview of measures can be found in the following list: in-kind benefits (DE); financial benefits such as care allowances dedicated to paying the informal carers (HU, BG, AT, DE, RO) and to provide some additional financial support to the person in need (FR), amongst others; respite care services to allow time-off and maintenance of employment activities for informal carers (UK, MT, AT, DE); counselling and training services (MT, DE) and informal carers' needs-assessment and social security inclusion and formalisation measures for the informal carers (BG, DE).

5.6. Conclusions

As mentioned, the 2008-2010 NSRs build on the previous 2006 NSRs and national health, inclusion and/or social protection plans. They tend to focus on some more specific topics that are seen as priorities or on the most recent policies. The fact that reforms often require the approval and implementation of legislation, which are often lengthy processes, may partly explain the similarities between the 2006 and the 2008 NSRs. As in the 2007 Joint Report, the 2008 NSRs show the strong interlinks between improving access, enhancing quality and ensuring sustainability in a number of policies. Moreover, all Member States recognise that social protection including healthcare can have a significant impact in improving health and reducing poverty.

In assessing the 2008-2010 NSRs a number of issues can be raised.

While important efforts have been made to ensure universal care coverage, some gaps can still be identified in a number of Member States. In some countries private expenditure (direct payments for care) is large and in all countries some types of care (dental, aural, ophthalmic, residential care) are not covered by the public basket of health or social care. In addition, large differences in the availability and quality of healthcare and long-term care services can be observed. This suggests that barriers to access still remain that need addressing.

As said, for all countries primary care is seen as the way forward to address geographic disparities and improve access, as a vehicle for promotion and prevention, as the basis for better care coordination, and as a means to ensure a rational use of resources in the sector and obtain greater value for money. However, in many countries the shortages in GPs/ primary care doctors are structural i.e. they have been going on for a long time and appear to continue. Ageing may render them even more acute. Therefore, it is difficult to see how the ambition expressed in the reports of having primary care close to residence of all individuals and reducing regional disparities may be met without a proper primary care policy that encompasses more training and motivation of GPs (competences and remuneration related to additional competences on health promotion, disease prevention and care coordination and if are to go to deprived areas). Additionally, there is a widespread consensus of the need to address the expected workforce shortages in the long-term care sector (formal care) as well as devising ways to support family or informal carers. Adequately recruiting, (re)training, and retaining long-term care workers remains a challenge. Again, measures proposed relate to training and motivation (higher wages and better working conditions), and the formalisation, where possible, of informal carers into social security schemes. The looming/ current staff shortages may remain a challenge for years to come as even training (which is proposed by some countries in their attempt to address the ageing consequences on healthcare staff) requires time to bear fruit. Finally, several countries are currently advertising for doctors and nursing staff in nearby countries while some are experiencing massive brain-drain of care staff. This suggests that more responsibility is needed in recruiting staff and that there may be place for improved exchange of information and coordination between Member States regarding staff policies.

Another issue is technology and more specifically e-health. Virtually all countries propose a package of e-health measures to improve access, quality and sustainability. While this may be the case, they require important sums of investment (informatisation of the system, e-prescription, e-booking) and, importantly, they require that technology is compatible across all facilities in the sector, if technology is to bring about better care coordination. Moreover, despite claims that technology may improve access, some of the measures (internet-based measures) may actually create a gap, as those more vulnerable are also likely to be those more computer illiterate or have fewer means to access computers and internet.

The 2008-2010 NSRs show a growing awareness of the need to ensure healthcare and long-term care quality and present different initiatives aimed at providing their citizens with good quality and safe preventive and curative healthcare as well as long-term care services. However, quality is being addressed to varying degrees from one country to another. The 2008 NSRs reflect the lack of consensus across Europe about the definition and perimeter of quality of care. While investing in health promotion, disease prevention and primary care does not appeared to be controversial and Member States continue developing related strategies – though some more successfully than others given their available resources, existing care delivery structures and primary care attractiveness in each country –, huge disparities are observed regarding patient centeredness and patient safety.

While patient centeredness is often declared as an important issue, only a few concrete examples of action are provided. Some Member States are advanced in their efforts to ensure that the patient act as an actor in their healthcare systems, in others awareness of the issue is growing, and others are still at the beginning of their reflection process in this area. Patient safety is addressed in a very advanced way in several reports, but not even mentioned in others. Some of these disparities may be explained by the limited resources allocated to healthcare in some Member States and the need to address other more urgent issues. Patient safety strategies, for example, require a considerable initial investment, with long-term expected results. Member States may therefore choose allocating their limited resources to other areas of healthcare which are supposed to bring immediate improvement of health indicators of the population (for example the emergency care system). Hence, enhancing quality of care and notably patient safety remains a significant challenge for healthcare, while quality of facilities, care coordination and the need for qualified carers are important issues in the context of long-term care. Growing interest is placed on prevention and management of chronic diseases, which are addressed through targeted health promotion actions, clinical guidelines and financial encouragement of doctors to provide better quality care for patients presenting chronic conditions. Finally, a number of indicators exist and are used with regard to quality of care, but available data do not, however, enable solid international comparisons about care quality in European countries. Further effort is needed to develop common terminology and gather comparable data on different aspects of quality at European level.

The NSRs also show that several Member States have been going down the avenue of privatisation and decentralisation as a way to improve access, quality and especially efficiency of the health system. However, it is important to note that these should be treated as means to an end and not a goal in itself or a decision taken on the basis of political whims. It is important to assess whether it is possible to achieve efficiency gains by privatisation and decentralisation in each national context. In general, it is necessary to consider if there is the institutional capacity to monitor and regulate private practice, to ensure risk equalisation and quality standards, to identify what the private and what the public can do better, or to induce the geographic location of private entities in order to tackle geographic disparities. Whether private entities promote quality and efficiency depends on the number of entities and the incentives they face notably the nature of contracts established in the market. The experience with decentralisation in some Member States is a mixed one, resulting in variations in supply and quality of care which have lead these countries to rethink their resource allocation mechanisms and establish nationwide norms and guidelines. Some countries that have a large private provision report duplication of care and waste of resources and thus the need to coordinate private and public provision. Hence, a number of issues must be taken into account when going down the avenue of more private insurance, private provision and decentralisation of provision.

All countries have cost-sharing schemes in place, complemented with exemptions. In some countries these have increased and have led to a reduction in care utilisation while in others they do not appear to have much effect on patient behaviour as they are covered by insurance. It is also not always clear whether there is a coherent logic behind their design i.e. are they inducing preferred pathways of care? Are they based on what is cost-effective? More monitoring is needed to ensure they achieve maximum efficiency gains while minimising the impact on necessary care utilisation by vulnerable groups.

Another interesting trade-off relates to increased patient choice. While a large number of countries see increased patient choice as a dimension of patient centeredness, it is not acknowledged how greater choice impacts on the goal of increasing system efficiency.

Several countries claim they will increase patient choice but at the same time refer to the establishment of selective contracting between insurers and providers as a means to encourage efficiency. This would mean that what countries refer to as choice is additional choice within a preferred care framework. From the point of view of efficiency this is logical as evidence suggests that free choice is related to increased costs of care.

Member States are looking at various mechanisms to address the expected increase in demand for long-term care services in light of the demographic ageing and the prevalence of disability and dependency, particularly in old age. In their quest for a sound financial footing for the long-term care sector, Member States are fostering and upgrading existing services and establishing new ones, on one hand, whilst developing sound financial mechanisms to cover the multiple contingencies, on the other. Secure long-term care financing is still to be achieved in many countries and changes to financing mechanisms are required, with several countries engaging in reforms. Care coordination is seen as crucial in enabling a high level of quality and efficient use of resources in the provision of long-term care services and thus ensuring an adequate continuum of care. It also encompasses the search for coordination of budgets and thus sustainability of long-term care systems.

Ageing is seen as an important challenge as it leads to multi-morbidity and increased disability and dependence if increased life expectancy is not accompanied by healthier lives. Hence, the intensification of health promotion and disease prevention in all Member States, seen as crucial means to improve health at all ages, thus increasing quality of life while reducing the demand and costs of healthcare and long-term care. Several countries expect successful health promotion and disease prevention programmes to delay the onset of dependency/disability and eventually result in financial savings. In this context, there may be room for more effective and targeted health promotion actions. Interestingly, though, while all countries put a stronger emphasis on promotion and prevention, curative care, notably hospital care, engulfs the largest part of the expenditure and a large number of countries are still directing extra funds towards the hospital sector. Hence, the expenditure share allocated to promotion and prevention may be too small in relation to the goals they are to achieve.

Ageing is also seen as a window of opportunity to use in relation to older employees, immigrants, people with disabilities and socially disadvantaged and the young and contribute to attaining the Lisbon objectives, if these groups are provided with relevant training. On the other hand, it may mean that countries need to be more innovative and improve the use of technology and methods of work as well as working with third sector to try and reach those in more remote and disadvantaged areas or at risk groups when in the presence of staff shortages.

A final number of issues are worth mentioning. Firstly, as mentioned in the introduction, health is seen as goal in itself but also as a means to ensure employment and economic development, while the result of a set of social and economic factors. This holistic approach is translated in some countries by a broader consultation with various sectors, with NGOs on social welfare and health, and with local and regional authorities. It is, however, not necessarily clear how the consultation was taken into consideration in the report. Some of the reports were prepared in joint collaboration by more than one ministry. More multi-sector cooperation is necessary to ensure greater coherence between economic, education, employment, environment and social policy including health and housing policies if we are to ensure a high level of health protection in all policies.

Secondly, only a handful of countries report using the European Structural Funds in the field of health, even if health is a priority for the 2007-2010 funding programme. This may reflect general lack of awareness of the possibility to use structural funds for developing health promotion, address geographical gaps in infrastructure, or increased staff training. At the same time, some argue that more technical support and monitoring of the investment is needed.

Finally, some countries show a departure from previous reforms. While this may be expected in the field of healthcare due to a continuous change of treatment practices and staff qualifications, in some cases new reform choices are political in nature and their design is not necessarily thought through. Ensuring a rationale for reforms and avoid leaving health systems in a limbo is also an important responsibility of policy makers.

6. ANNEX: INDICATORS

6.1. Definition of the 14 overarching indicators

1a. At-risk-of-poverty rate: Share of persons aged 0+ with an equivalised disposable income below 60% of the national equivalised median income[78]. Source: SILC.

+ Illustrative threshold value: 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: SILC.

1b. Relative median poverty risk gap: Difference between the median equivalised 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: SILC.

2. 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: SILC.

3. Healthy life expectancy Number of years that a person at birth, at 45, and at 65 is still expected to live a healthy life (also called disability-free life expectancy). To be interpreted jointly with life expectancy. Source: EUROSTAT.

4. Early school-leavers: Share of persons aged 18 to 24 who have only lower secondary education (their highest level of education or training 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.

5. People living in jobless households: Proportion of people living in jobless households, expressed as a share of all people in the same age group[79]. This indicator should be analysed in the light of context indicator No 8: jobless households by main household types. Source: LFS.

6. Projected total public social expenditure: Age-related projections of total public social expenditure (e.g. pensions, healthcare, 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' Source: EPC/AWG.

7a. Median relative income of elderly people: Median equivalised income of people aged 65+ as a ratio of income of people aged 0-64. Source: EU-SILC.

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[78] **Equivalised median income** is defined as the household's total disposable income divided by its 'equivalent size', to take account of the size and composition of the household, and is attributed to each household member (including children). Equivalisation is on the basis of the OECD modified scale.

[79] Students aged 18-24 who live in households composed solely of students are not counted in either the numerator or denominator.

7b. Aggregate replacement ratio: Median individual pensions of 65-74 year-olds relative to median individual earnings of 50-59 year-olds, excluding other social benefits. Source: EU-SILC.

8. Self-reported unmet need for medical care: Total self-reported unmet need for medical care for the following three reasons: financial barriers + waiting times + too far to travel.

+ Care utilisation: To be analysed together with care utilisation defined as the number of visits to a doctor (GP or specialist) during the last 12 months. Source: EU-SILC.

9. At-risk-of-poverty rate anchored at a fixed moment in time (2005): Share of persons aged 0+ with an equivalised disposable income below the at-risk-of-poverty threshold calculated in the year 2005 (1st EU-SILC income reference year for all 25 EU countries), adjusted for inflation over the years. Source: SILC.

10. Employment rate of older workers: Persons in employment in the 55–59 and 60–64 age groups as a proportion of the total population in the same age group. Source: LFS.

11. In-work poverty risk: Individuals who are classified as employed[80] (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: SILC.

12. Activity rate: Share of employed and unemployed people in the total population of working age, 15-64. Source: LFS.

13. Regional disparities — coefficient of variation of employment rates: Standard deviation[81] of regional employment rates divided by the weighted national average (15-64 age group). (NUTS II). Source: LFS.

14. Total health expenditure per capita: Total health expenditure per capita in PPP. Source: EUROSTAT based on system of health accounts (SHA) data.

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80 Individuals classified as employed according to most frequent activity status. The most frequent activity status is defined as the status that individuals declare having for more than half the number of months in the calendar year.

81 Standard deviation measures how, on average, the situation in regions differs from the national average. As a complement to the indicator, a graph showing max/min/average per country is presented.
Possible alternative measures:
Regional disparities — underperforming regions. *Source LFS*
1. Share of underperforming regions in terms of employment and unemployment (in relation to all regions and to the working age population/labour force) (NUTS II).
2. Differential between average employment/unemployment in underperforming regions and the national average for employment/unemployment (NUTS II). Thresholds to be applied: 90% and 150% of the national average rates for employment and unemployment, respectively. (An extra column with the national employment and unemployment rates would be included).

6.2. Data sources

Indicators of income and living conditions: EU-SILC

For the first time this year, EU-SILC data are available for 25 EU countries. The newly implemented reference source of statistics on income and social exclusion is the Framework Regulation (No 1177/2003) for the European Survey on Income and Living Conditions (EU-SILC). The technical aspects of this instrument are developed by 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 under the transitional arrangements agreed for the European Statistical System[82].

The EU-SILC definitions 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 total household gross income data until after the first year of operation.

Although certain countries (e.g. 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 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 effect 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 falls 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 currently used for income excludes non-monetary income components, which include the value of goods produced for own consumption[83] and non-cash employee income. This component will be available for all countries from the SILC (2007) exercise onwards, and will therefore be included in the indicators to be published in January 2009.

The reference year for the data is the year to which the income information refers (i.e. the 'income year'), which in most cases differs from the survey year in which the data were collected. Accordingly, 2006 data refer to the income situation of the population in 2005, even

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

83 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 transitional arrangement was intended to take account of the potentially significant impact of this component on income distribution in these countries.

if the information was collected in 2006. EU aggregates are computed as population-weighted averages of available national values.

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) 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 for income-based indicators are presented in this year's report.

Limitations

The limited sample size for 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 records 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 income distribution as measured by surveys.

Finally, while 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% of the income distribution should not, therefore, necessarily be interpreted as being the bottom 10% in terms 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 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 the total at-risk-of-poverty rate are of the order of +/-0.8%. For the 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.

LFS: the European Union Labour Force Survey

The European Union Labour Force Survey (LFS) is the EU's harmonised survey on labour market developments. The survey has been carried out since 1983 in the EU Members States, with some states providing quarterly results from a continuous labour force survey, and others conducting a single annual survey in the spring. From 2005, all EU Member States have conducted a quarterly survey. If not mentioned otherwise, the results based on the LFS refer to surveys conducted in the spring ('second quarter' in all countries except for France and Austria, which is 'first quarter') of each year. It also provides data for Bulgaria, Croatia and Romania.

The Annual Averages of Labour Force Data series is a harmonised, consistent series of annual averages of quarterly results on employment statistics based on the LFS, completed through estimates when quarterly data are not available. It covers all the EU-15 (for the period from 1991 to present) and all new Member States and Candidate Countries (since 1996 or later, depending on data availability) except the Former Yugoslav Republic of Macedonia. The Annual Averages of Labour Force Data consist of two series: 1) population, employment and unemployment, and 2) employment by economic activity and employment status. The first series is based mainly on the EU LFS. Data covers the population living in private households only (collective households are excluded) and refers to the place of residence (household residence concept). They are broken down by gender and aggregate age group (15–24, 25–54, 55–64 and 15–64). Unemployment data is also broken down by job search duration (less than 6 months, 6–11, 12–23, 24 months or more). The second series is based on the ESA 1995 national accounts employment data. Data covers all people employed in resident producer units (domestic concept), including people living in collective households. They are broken down by sex, working-time status (full-time/part-time) and contract status (permanent/temporary) using LFS distributions. All key employment indicators presented in this document are based on the Annual Averages of Labour Force Data series. They represent yearly averages unless stated otherwise. Where the Annual Averages of Labour Force Data series does not provide the relevant breakdowns, the original LFS data has been used for this report.

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, healthcare, 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 for 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 healthcare, 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 the size and demographic structure of the population, projected macroeconomic developments and assumed neutral evolution in the 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 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 where gender matters) retiring at the age of 65 after a 40-year full-time working 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 are by the Member States.

Healthcare expenditure — WHO Health for All database (www.who.int\nha)

This information is based on national health accounts (NHAs) collected within an internationally recognised framework. NHAs depict the financing and spending flows recorded in the operation of a health system. In 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 have either 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.

6.3. Statistical tables

1a. At-risk-of-poverty rate by age and gender, 2007

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Total population	Total	16ps	16p	15	14i	10	12	13p	15p	19	18	20	20	13	20	16	21	19	14	12	14	10	12	17	18	19p	12	11	13	11	19
	Men	15ps	15p	14	12i	9	11	13p	14p	17	16	20	19	12	18	14	19	17	13	12	14	10	11	18	17	18p	10	10	12	11	18
	Women	17ps	17p	16	16i	10	12	13p	16p	22	19	21	21	14	21	17	23	21	14	12	15	11	13	17	19	19p	13	11	14	11	20
Children aged 0-17	Total	19ps	19p	17	16i	16	10	12p	14p	18	19	23	24	16	25	12	21	22	20	19	19	14	15	24	21	25p	11	17	11	12	23
People aged 18-64	Total	15ps	15p	13	12i	8	11	13p	15p	16	15	19	16	12	18	10	18	16	13	12	12	9	11	17	15	17p	10	9	11	10	15
	Men	14ps	14p	12	12i	8	11	13p	14p	15	14	18	15	11	16	8	18	15	12	11	10	8	9	18	14	17p	10	9	12	11	14
	Women	15ps	15p	13	12i	9	11	13p	16p	17	16	19	17	13	19	12	19	16	13	12	14	10	12	17	16	16p	10	10	11	10	16
People aged 65+	Total	19ps	19p	23	18i	5	18	14p	17p	33	29	23	28	13	22	51	33	30	7	6	21	10	14	8	26	19p	19	8	22	11	30
	Men	16ps	17p	21	9i	2	16	12p	14p	21	24	21	26	12	18	47	21	15	7	3	24	9	10	6	24	13p	11	3	18	7	27
	Women	22ps	21p	25	24i	8	19	16p	20p	39	33	25	30	14	25	54	39	37	8	8	18	11	18	9	27	22p	25	11	24	14	32

1a. At-risk-of-poverty threshold (illustrative values), EUR and PPS, 2007

	EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
EUR '- One-person household	:	8368s	10538	:i	3251	14004	15002,73	10624p	2668	13291	6120	7203	9938	9003	9590	2010	1966	17929	2361	5475b	10924	10945	2101	4544	90p	5944b	2382	11222	11132	12572
'- Two adults with two dep. ch	:	17573s	22129	:i	6828	29409	31505,91	22310p	5603	27911	12852	15127	20870	18907	20140	4222	4128	37650	4959	11498b	22941	22985	4413	9542	140p	12482b	5003	23565	23378	26402
PPS '- One-person household	:	:	10035	:i	5348	10175	10819p	10403p	4059	10706	6946	7807	9363	8748	6298	3356	3512	17575	3979	7543b	10631	10933	3422	5360	189p	7979b	4133	9321	9581	11366
'- Two adults with two dep. ch	:	:	21075	:i	11231	21367	22720p	21846p	8524	22483	14588	16394	19661	18371	13226	7049	7376	36908	8355	15841b	22325	22960	7187	11255	295p	16756b	8678	19573	20120	23868

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); [1] BG HBS 2006, income data 2006and RO National HBS 2007, income data 2007; [2] with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

1b. Relative median at-risk-of-poverty gap by age and gender, 2007

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

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); [1] BG HBS 2007, income data 2007 and RO National HBS 2006, income data 2006; [2] with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

2. Inequality of income distribution: S80/S20 income quintile share ratio

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
S80/S20	Total	4.8ps	4.8p	3.9	3.5i	3.5	3.7	3.6p	5p	5.5p	4.8p	6p	5.3	3.8p	5.5	4.5	6.3	5.9	4	3.7	3.8	4p	3.8	5.3	6.5p	5.3p	3.3	3.5	3.7	3.4	5.5

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); [1] BG and RO National HBS 2006, income data 2006; [2] with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

3. Healthy life years : Disability free life expectancy (+ life expectancy at 0, 45, 65) 1995-2005

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
life expectancy at birth - males	**eu27**	:	:	:	:	:	:	:	74,5	74,6	75,2	:
life expectancy at 45 - males	**eu27**	**:**	**:**	**:**	**:**	:	:	:	31,9	31,9	32,5	:
life expectancy at 65 - males	**eu27**	:	:	:	:	:	:	:	15,9	15,9	16,4	:
life expectancy at birth - females	**eu27**	:	:	:	:	:	:	:	80,9	80,8	81,5	:
life expectancy at 45 - females	**eu27**	:	:	:	:	:	:	:	37,2	37,2	37,7	:
life expectancy at 65 - females	**eu27**	:	:	:	:	:	:	:	19,5	19,4	19,9	:
life expectancy at birth - males	**eu25**	72,8	73,2	73,5	73,5	73,8	74,4	74,7	75	75,1	75,7	75,8
life expectancy at 45 - males	**eu25**	**:**	**:**	**:**	**:**	:	31,8	32,1	32,3	32,3	32,8	:
life expectancy at 65 - males	**eu25**	:	:	:	:	:	15,7	15,9	16,1	16,1	16,6	:
life expectancy at birth - females	**eu25**	79,7	79,9	80,2	80,2	80,4	80,8	81,1	81,3	81,2	81,9	81,9
life expectancy at 45 - females	**eu25**	:	:	:	:	:	37,2	37,4	37,6	37,5	38,1	:
life expectancy at 65 - females	**eu25**	:	:	:	:	:	19,4	19,6	19,7	19,6	20,2	:
life expectancy at birth - males	**eu15**	73,9	74,2	74,6	74,6	74,9	75,4	75,7	75,9	76	76,8	:
life expectancy at 45 - males	**eu15**	31,5	31,7	32	:	:	32,6	32,9	33	33,1	33,7	:
life expectancy at 65 - males	**eu15**	15,3	15,4	15,6	:	:	16,1	16,3	16,4	16,4	17,1	:
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	82,8	:
life expectancy at 45 - females	**eu15**	36,9	37,1	37,3	:	:	37,7	37,9	38	38	38,9	:
life expectancy at 65 - females	**eu15**	19,1	19,2	19,4	:	:	19,7	20	20	20	20,8	:
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

Disability free Life expectancy (+ Life expectancy at 0, 45, 65) 1995-2006

Source: Eurostat - Demography

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**BE**	73,5	73,9	74,2	74,4	74,4	74,6	75	75,1	75,3	76	76,2	76,6
Life expectancy at 45 - males	**BE**	31,1	31,4	31,6	31,7	31,8	32	32,3	32,3	32,5	33	33,1	33,6
Life expectancy at 65 - males	**BE**	14,8	15	15,2	15,3	15,5	15,6	15,9	15,8	15,9	16,4	16,6	17
Healthy Life Years at birth - males	**BE**	63,3	64,1	66,5	63,3	66	65,7	66,6	66.9 (e)	67.4 (e)	58.4 (b)	61,7	62,8
Life expectancy at birth - females	**BE**	80,4	80,7	80,7	80,7	81	81	81,2	81,2	81,1	81,8	81,9	82,3
Life expectancy at 45 - females	**BE**	37	37,2	37,2	37,2	37,4	37,5	37,7	37,5	37,3	38	38	38,5
Life expectancy at 65 - females	**BE**	19,3	19,4	19,5	19,6	19,6	19,7	19,9	19,7	19,6	20,2	20,2	20,6
Healthy Life Years 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)	58.1 (b)	61,9	62,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**BG**	67,4	67,4	67	67,4	68,2	68,4	68,6	68,8	68,9	68,9	69	69,2
Life expectancy at 45 - males	**BG**	26,6	26,6	26,3	26,4	27,2	27	27,2	27,3	27,3	27,3	27,2	27,3
Life expectancy at 65 - males	**BG**	12,7	12,5	12,3	12,5	12,9	12,7	13	13	13	13	13,1	13,2
Healthy Life Years at birth - males	**BG**	:	:	:	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**BG**	74,9	74,5	73,8	74,6	75	75	75,4	75,5	75,9	75,8	76,2	76,3
Life expectancy at 45 - females	**BG**	32,4	32,2	31,7	32,2	32,5	32,4	32,8	32,9	33,1	33	33,3	33,5
Life expectancy at 65 - females	**BG**	15,3	15	14,7	15	15,4	15,3	15,6	15,7	15,8	15,8	16,1	16,3
Healthy Life Years at birth - females	**BG**	:	:	:	:	:	:	:	:	:	:	:	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**CZ**	69,7	70,4	70,5	71,2	71,5	71,7	72,1	72,1	72	72,6	72,9	73,5
Life expectancy at 45 - males	**CZ**	27,6	27,9	28,1	28,6	28,8	29	29,3	29,3	29,2	29,7	29,9	30,4
Life expectancy at 65 - males	**CZ**	12,7	13,1	13,2	13,5	13,7	13,8	14	13,9	13,8	14,2	14,4	14,8
Healthy Life Years at birth - males	**CZ**	:	:	:	:	:	:	:	62.8 (p)	:	:	57.9 (b)	57,8
Life expectancy at birth - females	**CZ**	76,8	77,5	77,6	78,2	78,3	78,5	78,6	78,7	78,6	79,2	79,2	79,9
Life expectancy at 45 - females	**CZ**	33,4	33,9	34,1	34,5	34,5	34,8	34,8	34,9	34,7	35,3	35,3	36
Life expectancy at 65 - females	**CZ**	16,2	16,6	16,7	17	17	17,3	17,3	17,3	17,2	17,6	17,7	18,3
Healthy Life Years at birth - females	**CZ**	:	:	:	:	:	:	:	63.3 (p)	:	:	59.9 (b)	59,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**DK**	72,7	73,1	73,6	74	74,2	74,5	74,7	74,8	75	75,4	76	76,1
Life expectancy at 45 - males	**DK**	30,2	30,5	30,9	31,1	31,3	31,6	31,7	31,8	32	32,4	32,8	32,8
Life expectancy at 65 - males	**DK**	14,1	14,4	14,6	14,9	15	15,2	15,2	15,4	15,6	15,9	16,1	16,2
Healthy Life Years at birth - males	**DK**	61,6	61,7	61,6	62,4	62,5	62,9	62,2	62.8 (e)	63 (e)	68.3 (b)	68,4	67,7
Life expectancy at birth - females	**DK**	77,9	78,3	78,6	79	79	79,2	79,3	79,4	79,8	80,2	80,5	80,7
Life expectancy at 45 - females	**DK**	34,4	34,9	35	35,4	35,2	35,5	35,6	35,6	35,9	36,4	36,6	36,8
Life expectancy at 65 - females	**DK**	17,6	17,9	18	18,3	18,1	18,3	18,3	18,2	18,5	19	19,1	19,2
Healthy Life Years 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)	68.8 (b)	68,2	67,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**DE**	73,3	73,6	74,1	74,5	74,8	75,1	75,6	75,7	75,8	76,5	76,7	77,2
Life expectancy at 45 - males	**DE**	30,7	31	31,4	31,7	32	32,2	32,5	32,6	32,7	33,3	33,4	33,8
Life expectancy at 65 - males	**DE**	14,8	14,9	15,2	15,4	15,6	15,8	16,1	16,2	16,2	16,7	16,9	17,2
Healthy Life Years 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 (e)	:	55 (b)	58,5
Life expectancy at birth - females	**DE**	79,9	80,1	80,5	80,8	81	81,2	81,4	81,3	81,3	81,9	82	82,4
Life expectancy at 45 - females	**DE**	36,4	36,5	36,9	37,1	37,3	37,5	37,6	37,5	37,5	38	38,1	38,5
Life expectancy at 65 - females	**DE**	18,7	18,8	19,1	19,3	19,4	19,6	19,8	19,6	19,5	20,1	20,1	20,5
Healthy Life Years 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)	:	55.1 (b)	58

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**EE**	61,5	64,3	64,3	64,1	64,9	65,5	64,9	65,3	66,1	66,4	67,3	67,4
Life expectancy at 45 - males	**EE**	23,4	24,5	24,9	24,3	25,2	25,3	24,9	25,3	25,6	25,8	26,2	26,3
Life expectancy at 65 - males	**EE**	12	12,2	12,5	12,2	12,6	12,8	12,7	12,8	12,7	13	13,1	13,2
Healthy Life Years at birth - males	**EE**	:	:	:	:	:	:	:	:	:	49.8 (b)	48	49,4
Life expectancy at birth - females	**EE**	74,3	75,6	75,9	75,4	76	76,2	76,4	77	77,1	77,8	78,2	78,6
Life expectancy at 45 - females	**EE**	32,4	33	33,3	32,9	33,5	33,6	33,7	34	34,1	34,6	35	35,1
Life expectancy at 65 - females	**EE**	16,1	16,4	16,8	16,5	17	17	17,3	17,3	17,4	17,8	18	18,3
Healthy Life Years at birth - females	**EE**	:	:	:	:	:	:	:	:	:	53.3 (b)	52,2	53,7

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**IE**	72,8	73,1	73,4	73,4	73,4	74	74,5	75,2	75,9	76,4	77,3	77,3
Life expectancy at 45 - males	**IE**	30,1	30,5	30,7	30,9	30,8	31,5	31,9	32,4	33	33,4	34,1	34,1
Life expectancy at 65 - males	**IE**	13,5	13,9	14	14,2	14,1	14,6	15	15,4	15,9	16,2	16,8	16,8
Healthy Life Years at birth - males	**IE**	63,2	64	63,2	64	63,9	63,3	63,3	63.5 (e)	63.4 (e)	62.5 (b)	62,9	63,3
Life expectancy at birth - females	**IE**	78,3	78,7	78,7	79,1	78,9	79,2	79,9	80,5	80,8	81,4	81,7	82,1
Life expectancy at 45 - females	**IE**	34,8	35,1	35,2	35,5	35,3	35,7	36,4	36,9	37	37,6	37,9	38,2
Life expectancy at 65 - females	**IE**	17,2	17,4	17,6	17,8	17,6	18	18,5	18,9	19,2	19,7	20	20,2
Healthy Life Years at birth - females	**IE**	:	:	:	:	67,6	66,9	66,5	65.9 (e)	65.4 (e)	64.3 (b)	64,1	65

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**EL**	75	75,1	75,4	75,4	75,5	75,5	75,9	76,2	76,5	76,6	76,8	77,2
Life expectancy at 45 - males	**EL**	32,6	32,6	32,9	32,8	32,9	32,8	33,2	33,4	33,5	33,7	33,9	34,3
Life expectancy at 65 - males	**EL**	15,9	16	16,2	16,1	16,2	16,1	16,5	16,6	16,7	16,9	17,1	17,5
Healthy Life Years at birth - males	**EL**	65,8	66,9	66,4	66,5	66,7	66,3	66,7	66.7 (e)	66.7 (e)	63.7 (b)	65.7	66,3
Life expectancy at birth - females	**EL**	80,1	80,2	80,4	80,3	80,5	80,6	81	81,1	81,2	81,3	81,6	81,9
Life expectancy at 45 - females	**EL**	36,5	36,6	36,8	36,7	36,8	36,8	37,2	37,2	37,2	37,5	37,8	37,9
Life expectancy at 65 - females	**EL**	18,2	18,3	18,4	18,3	18,4	18,4	18,7	18,7	18,7	18,9	19,2	19,4
Healthy Life Years at birth - females	**EL**	69.2 (e)	69,6	68,7	68,3	69,4	68,2	68,8	68.5 (e)	68.4 (e)	65.2 (b)	67,2	67,9

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**ES**	74,4	74,5	75,2	75,3	75,3	75,8	76,2	76,3	76,3	76,9	77	77,7
Life expectancy at 45 - males	**ES**	32,5	32,6	32,8	32,8	32,7	33,2	33,4	33,5	33,5	34	33,9	34,6
Life expectancy at 65 - males	**ES**	16,2	16,2	16,3	16,2	16,2	16,7	16,9	16,9	16,8	17,3	17,3	17,9
Healthy Life Years at birth - males	**ES**	64,2	65,1	65,5	65,2	65,6	66,5	66	66.6 (e)	66.8 (e)	62.5 (b)	63,2	63,7
Life expectancy at birth - females	**ES**	81,8	82	82,3	82,4	82,4	82,9	83,2	83,2	83	83,7	83,7	84,4
Life expectancy at 45 - females	**ES**	38,4	38,5	38,8	38,7	38,7	39,2	39,4	39,4	39,2	39,9	39,7	40,4
Life expectancy at 65 - females	**ES**	20,2	20,3	20,5	20,4	20,3	20,8	21	21	20,8	21,5	21,3	22
Healthy Life Years 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)	62.5 (b)	63,1	63,3

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**FR**	:	:	:	74,8	75	75,3	75,5	75,7	75,8	76,7	76,7	77,3
Life expectancy at 45 - males	**FR**	:	:	:	32,4	32,6	32,9	33	33,1	33,1	33,9	33,9	34,4
Life expectancy at 65 - males	**FR**	:	:	:	16,5	16,6	16,8	17	17	17	17,7	17,7	18,2
Healthy Life Years at birth - males	**FR**	60	59,6	60,2	59,2	60,1	60,1	60,5	60.4 (e)	60.6 (e)	61.2 (b)	62	62,7
Life expectancy at birth - females	**FR**	:	:	:	82,6	82,7	83	83	83	82,7	83,8	83,7	84,4
Life expectancy at 45 - females	**FR**	:	:	:	39,1	39,2	39,4	39,4	39,3	39	40,1	40	40,6
Life expectancy at 65 - females	**FR**	:	:	:	21,2	21,2	21,4	21,5	21,3	21	22,1	22	22,6
Healthy Life Years 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)	64.1 (b)	64,3	64,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**IT**	75,1	75,5	75,9	76,1	76,6	77	77,2	77,4	77,1	77,9	:	:
Life expectancy at 45 - males	**IT**	32,6	32,9	33,1	33,1	33,5	33,8	34,1	34,2	34	34,7	:	:
Life expectancy at 65 - males	**IT**	15,8	16	16,1	16,1	16,4	16,7	16,9	17	16,8	17,5	:	:
Healthy Life Years at birth - males	**IT**	66,7	67,4	68	67,9	68,7	69,7	69,8	70.4 (e)	70.9 (e)	67.9 (b)	65,8	:
Life expectancy at birth - females	**IT**	81,6	81,8	82,1	82,2	82,7	82,9	83,2	83,2	82,8	83,8	:	:
Life expectancy at 45 - females	**IT**	38	38,3	38,4	38,5	38,8	39	39,3	39,3	38,8	39,8	:	:
Life expectancy at 65 - females	**IT**	19,9	20,1	20,2	20,3	20,5	20,7	21	21	20,6	21,5	:	:
Healthy Life Years 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)	70.2 (b)	67	:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**CY**	:	:	:	:	:	:	:	76,4	77,4	76,8	76,8	78,8
Life expectancy at 45 - males	**CY**	:	:	:	:	:	:	:	33,7	34,2	33,9	34,2	35,4
Life expectancy at 65 - males	**CY**	:	:	:	:	:	:	:	16,3	16,8	16,7	16,8	17,7
Healthy Life Years at birth - males	**CY**	:	:	:	:	:	:	:	:	68,4	:	59.5 (b)	64,3
Life expectancy at birth - females	**CY**	:	:	:	:	:	:	:	81	81,6	82,1	81,1	82,4
Life expectancy at 45 - females	**CY**	:	:	:	:	:	:	:	37,4	37,7	38	37,6	38,3
Life expectancy at 65 - females	**CY**	:	:	:	:	:	:	:	19	19,3	19,5	19,1	19,7
Healthy Life Years at birth - females	**CY**	:	:	:	:	:	:	:	:	69,6	:	57.9 (b)	63,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LV**	:	:	:	:	:	:	:	64,7	65,6	65,9	65,4	65,4
Life expectancy at 45 - males	**LV**	:	:	:	:	:	:	:	24,9	25,3	25,4	25	24,9
Life expectancy at 65 - males	**LV**	:	:	:	:	:	:	:	12,5	12,6	12,6	12,5	12,7
Healthy Life Years at birth - males	**LV**	:	:	:	:	:	:	:	:	:	:	50.6 (b)	50,5
Life expectancy at birth - females	**LV**	:	:	:	:	:	:	:	76	75,9	76,2	76,5	76,3
Life expectancy at 45 - females	**LV**	:	:	:	:	:	:	:	33,5	33,2	33,7	33,8	33,5
Life expectancy at 65 - females	**LV**	:	:	:	:	:	:	:	17	16,8	17,1	17,2	17,3
Healthy Life Years at birth - females	**LV**	:	:	:	:	:	:	:	:	:	:	53.1 (b)	52,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LT**	63,3	64,6	65,5	66	66,3	66,8	65,9	66,2	66,4	66,3	65,3	65,3
Life expectancy at 45 - males	**LT**	24,5	25,2	26	26,2	26,4	26,7	26,2	26,1	26,1	26,1	25,3	25,1
Life expectancy at 65 - males	**LT**	12,9	13	13,2	13,3	13,4	13,7	13,5	13,3	13,3	13,4	13	13
Healthy Life Years at birth - males	**LT**	:	:	:	:	:	:	:	:	:	:	51.2 (b)	52,4
Life expectancy at birth - females	**LT**	75,1	75,9	76,6	76,6	77	77,5	77,6	77,5	77,8	77,7	77,3	77
Life expectancy at 45 - females	**LT**	33	33,6	34,1	34,1	34,5	34,8	34,7	34,6	34,8	34,7	34,3	34,2
Life expectancy at 65 - females	**LT**	16,9	17,2	17,3	17,4	17,6	17,9	17,9	17,8	18,1	17,9	17,6	17,6
Healthy Life Years at birth - females	**LT**	:	:	:	:	:	:	:	:	:	:	54.3 (b)	56,1

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**LU**	73	73,3	74	73,7	74,4	74,6	75,1	74,6	74,8	75,9	76,7	76,8
Life expectancy at 45 - males	**LU**	30,5	30,7	31,2	31,2	31,8	32	32,5	32,3	31,9	33,1	33,3	33,5
Life expectancy at 65 - males	**LU**	14,7	14,8	14,8	15,2	15,3	15,5	16	15,9	15,3	16,5	16,7	17
Healthy Life Years at birth - males	**LU**	:	:	:	:	:	:	:	:	:	59.1 (b)	62,2	61
Life expectancy at birth - females	**LU**	80,6	80,2	80	80,8	81,4	81,3	80,7	81,5	80,8	82,3	82,3	81,9
Life expectancy at 45 - females	**LU**	37,3	37,1	36,7	37,3	37,5	37,7	37,4	37,7	37	38,5	38,4	38
Life expectancy at 65 - females	**LU**	19,7	19,5	19,2	19,5	19,8	20,1	19,7	20	18,9	20,5	20,4	20,3
Healthy Life Years at birth - females	**LU**	:	:	:	:	:	:	:	:	:	60.2 (b)	62,1	61,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**HU**	65,4	66,3	66,7	66,5	66,7	67,6	68,2	68,3	68,4	68,7	68,7	69,2
Life expectancy at 45 - males	**HU**	24,7	25,1	25,4	25,3	25,3	26	26,4	26,4	26,3	26,6	26,4	26,8
Life expectancy at 65 - males	**HU**	12,2	12,3	12,5	12,5	12,5	13	13,2	13,2	13	13,4	13,3	13,6
Healthy Life Years at birth - males	**HU**	:	:	:	:	:	:	:	:	53.5 (p)	:	52 (b)	54,2
Life expectancy at birth - females	**HU**	74,8	75	75,5	75,6	75,6	76,2	76,7	76,7	76,7	77,2	77,2	77,8
Life expectancy at 45 - females	**HU**	32,2	32,4	32,7	32,8	32,6	33,2	33,5	33,6	33,5	33,8	33,8	34,3
Life expectancy at 65 - females	**HU**	16	15,9	16,3	16,4	16,2	16,7	17	17	16,9	17,3	17,2	17,7
Healthy Life Years at birth - females	**HU**	:	:	:	:	:	:	:	:	57.8 (p)	:	53.9 (b)	57

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**MT**	74,8	74,8	75,2	74,9	75,3	76,2	76,6	76,3	76,4	77,4	77,3	77
Life expectancy at 45 - males	**MT**	32,5	32,3	32,1	32	32,1	32,7	33,4	33	33,2	34,1	33,8	33,6
Life expectancy at 65 - males	**MT**	15,5	14,8	14,6	14,6	15	15,1	15,7	15,3	15,6	16,3	16,2	16,1
Healthy Life Years at birth - males	**MT**	:	:	:	:	:	:	:	65.1 (p)	:	:	68.5 (b)	68,1
Life expectancy at birth - females	**MT**	79,6	79,6	80,1	80	79,4	80,3	81,2	81,3	80,8	81,2	81,4	81,9
Life expectancy at 45 - females	**MT**	35,7	36,5	36,6	36,3	35,9	36,5	36,9	37,3	36,9	37,4	37,5	37,7
Life expectancy at 65 - females	**MT**	17,6	18,3	18,4	18,1	17,8	18,5	18,7	19,1	18,6	19,1	19,4	19,5
Healthy Life Years at birth - females	**MT**	:	:	:	:	:	:	:	65.7 (p)	:	:	70.1 (b)	69,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**NL**	74,6	74,7	75,2	75,2	75,3	:	75,8	76	76,3	76,9	77,2	77,7
Life expectancy at 45 - males	**NL**	31,6	31,6	32	32	32,1	:	32,6	32,7	32,9	33,5	33,8	34,2
Life expectancy at 65 - males	**NL**	14,7	14,8	15,1	15,1	15,2	:	15,6	15,6	15,8	16,3	16,4	16,8
Healthy Life Years at birth - males	**NL**	61,1	62,1	62,5	61,9	61,6	61,4	61,9	61.7 (e)	61.7 (e)	:	65 (b)	65
Life expectancy at birth - females	**NL**	80,5	80,5	80,7	80,8	80,5	:	80,8	80,7	81	81,5	81,7	82
Life expectancy at 45 - females	**NL**	36,9	36,9	37	37,1	36,9	:	37,1	37	37,2	37,7	37,9	38,1
Life expectancy at 65 - females	**NL**	19,2	19,2	19,3	19,4	19,2	:	19,4	19,3	19,5	19,9	20,1	20,3
Healthy Life Years 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)	:	63.1 (b)	63,2

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**AT**	73,4	73,7	74,1	74,5	74,9	75,2	75,7	75,8	75,9	76,4	76,7	77,2
Life expectancy at 45 - males	**AT**	31	31,2	31,4	31,7	32	32,4	32,8	32,9	32,9	33,4	33,6	34
Life expectancy at 65 - males	**AT**	15	15,1	15,2	15,4	15,7	16	16,3	16,3	16,4	16,9	17	17,3
Healthy Life Years at birth - males	**AT**	60	62,3	62,2	63,4	63,6	64,6	64,2	65.6 (e)	66.2 (e)	58.1 (b)	57,8	58,4
Life expectancy at birth - females	**AT**	80,1	80,2	80,7	81	81	81,2	81,7	81,7	81,5	82,1	82,3	82,8
Life expectancy at 45 - females	**AT**	36,5	36,6	37	37,3	37,3	37,5	37,9	37,8	37,7	38,3	38,4	38,9
Life expectancy at 65 - females	**AT**	18,8	18,9	19,1	19,4	19,4	19,6	20	19,8	19,8	20,2	20,4	20,7
Healthy Life Years at birth - females	**AT**	:	:	:	:	:	68	68,5	69.0 (e)	69.6 (e)	60.2 (b)	59,6	60,8

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**PL**	67,7	68,1	68,5	68,9	68,8	69,6	70	70,3	70,5	70,6	70,8	70,9
Life expectancy at 45 - males	**PL**	26,7	26,9	27,1	27,4	27,3	27,9	28,1	28,3	28,4	28,5	28,6	28,8
Life expectancy at 65 - males	**PL**	12,9	12,9	13,1	13,4	13,3	13,6	13,7	13,9	13,9	14,2	14,3	14,5
Healthy Life Years at birth - males	**PL**	:	59,9	:	:	:	:	:	62,5	:	:	61	58,2
Life expectancy at birth - females	**PL**	76,4	76,6	77	77,4	77,5	78	78,4	78,8	78,8	79,2	79,3	79,7
Life expectancy at 45 - females	**PL**	33,6	33,7	33,9	34,2	34,3	34,7	35	35,3	35,3	35,6	35,8	36,1
Life expectancy at 65 - females	**PL**	16,5	16,5	16,8	17,1	17,1	17,5	17,7	18	18	18,3	18,5	18,8
Healthy Life Years at birth - females	**PL**	:	66,8	:	:	:	:	:	68,9	:	:	66.6 (b)	62,5

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**PT**	71,7	71,6	72,2	72,4	72,6	73,2	73,5	73,8	74,2	75	74,9	75,5
Life expectancy at 45 - males	**PT**	30,7	30,6	31	31,1	31,3	31,6	31,9	31,9	32	32,6	32,4	32,9
Life expectancy at 65 - males	**PT**	14,7	14,6	14,9	14,9	15	15,4	15,7	15,7	15,7	16,3	16,1	16,6
Healthy Life Years at birth - males	**PT**	59,6	58,2	59,3	59,1	58,8	60,2	59,5	59.7 (e)	59.8 (e)	55.1 (b)	58,4	59,6
Life expectancy at birth - females	**PT**	79	79	79,3	79,5	79,7	80,2	80,5	80,6	80,6	81,5	81,3	82,3
Life expectancy at 45 - females	**PT**	35,9	35,9	36,3	36,4	36,4	36,9	37,1	37,2	37	37,9	37,6	38,5
Life expectancy at 65 - females	**PT**	18,1	18,1	18,4	18,5	18,5	18,9	19,1	19,2	19	19,7	19,4	20,2
Healthy Life Years at birth - females	**PT**	63,1	60,5	60,4	61,1	60,7	62,2	62,7	61.8 (e)	61.8 (e)	52 (b)	56,7	57,6

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**RO**	65,5	65,1	65,2	66,3	67,1	67,7	67,5	67,3	67,7	68,2	68,7	69,2
Life expectancy at 45 - males	**RO**	26	25,6	25,8	26,4	26,9	27,3	27	26,7	26,8	27,3	27,4	27,7
Life expectancy at 65 - males	**RO**	12,8	12,4	12,7	13	13	13,4	13,3	12,9	13	13,3	13,4	13,6
Healthy Life Years at birth - males	**RO**												:
Life expectancy at birth - females	**RO**	73,5	72,8	73,3	73,8	74,2	74,8	74,9	74,7	75	75,5	75,7	76,2
Life expectancy at 45 - females	**RO**	31,8	31,4	31,8	32,1	32,3	32,7	32,7	32,4	32,7	33,1	33,1	33,5
Life expectancy at 65 - females	**RO**	15,3	14,9	15,3	15,5	15,5	15,9	16	15,7	15,8	16,2	16,1	16,5
Healthy Life Years at birth - females	**RO**												:

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SI**	70,8	71,1	71,1	71,3	71,8	72,2	72,3	72,6	72,5	73,5	73,9	74,5
Life expectancy at 45 - males	**SI**	28,6	29	29	29,1	29,3	29,7	29,8	30	29,8	30,7	31,1	31,6
Life expectancy at 65 - males	**SI**	13,6	13,8	14	13,9	14,1	14,2	14,5	14,5	14,3	15	15,2	15,8
Healthy Life Years at birth - males	**SI**	:	:	:	:	:	:	:	:	:	:	56.3 (b)	57,6
Life expectancy at birth - females	**SI**	78,5	79	79,1	79,2	79,5	79,9	80,4	80,5	80,3	80,8	80,9	82
Life expectancy at 45 - females	**SI**	35	35,4	35,5	35,6	35,8	36,2	36,5	36,6	36,5	37	37,1	37,9
Life expectancy at 65 - females	**SI**	17,6	18,1	18	18,1	18,3	18,7	19	19	18,7	19,4	19,3	20
Healthy Life Years at birth - females	**SI**	:	:	:	:	:	:	:	:	:	:	59.9 (b)	61

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SK**	68,4	68,8	68,9	68,6	69	69,2	69,5	69,8	69,8	70,3	70,2	70,4
Life expectancy at 45 - males	**SK**	26,7	27	27	26,9	27,1	27,2	27,3	27,5	27,6	28	27,8	28
Life expectancy at 65 - males	**SK**	12,7	12,8	12,9	12,8	13	12,9	13	13,2	13,2	13,3	13,3	13,3
Healthy Life Years at birth - males	**SK**	:	:	:	:	:	:	:	:	:	:	54.9 (b)	54,3
Life expectancy at birth - females	**SK**	76,5	77	76,9	77	77,4	77,5	77,7	77,7	77,7	78	78,1	78,4
Life expectancy at 45 - females	**SK**	33,3	33,8	33,7	33,8	34	34,1	34,1	34,3	34,3	34,5	34,5	34,8
Life expectancy at 65 - females	**SK**	16,2	16,6	16,5	16,6	16,8	16,7	16,8	16,9	16,9	17,1	17,1	17,3
Healthy Life Years at birth - females	**SK**	:	:	:	:	:	:	:	:	:	:	56.4 (b)	54,4

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**FI**	72,8	73,1	73,5	73,6	73,8	74,2	74,6	74,9	75,1	75,4	75,6	75,9
Life expectancy at 45 - males	**FI**	30,4	30,7	31	31	31,2	31,6	32	32,1	32,3	32,6	32,8	33,1
Life expectancy at 65 - males	**FI**	14,6	14,7	15	15	15,2	15,5	15,7	15,8	16,2	16,5	16,8	16,9
Healthy Life Years at birth - males	**FI**	:	54,6	55,5	55,9	55,8	56,3	56,7	57.0 (e)	57.3 (e)	53.1 (b)	51,7	52,9
Life expectancy at birth - females	**FI**	80,4	80,7	80,7	81	81,2	81,2	81,7	81,6	81,9	82,5	82,5	83,1
Life expectancy at 45 - females	**FI**	36,7	37	37	37,3	37,5	37,5	37,8	37,8	38	38,6	38,8	39,2
Life expectancy at 65 - females	**FI**	18,7	18,9	19,1	19,3	19,5	19,5	19,8	19,8	20	20,7	21	21,2
Healthy Life Years at birth - females	**FI**	:	57,7	57,6	58,3	57,4	56.8 (e)	56,9	56.8 (e)	56.5 (e)	52.9 (b)	52,4	52,7

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**SE**	76,2	76,6	76,8	76,9	77,1	77,4	77,6	77,7	78	78,4	78,5	78,8
Life expectancy at 45 - males	**SE**	33	33,2	33,4	33,6	33,8	34,1	34,2	34,3	34,5	34,9	34,9	35,2
Life expectancy at 65 - males	**SE**	16	16,1	16,3	16,4	16,5	16,7	16,9	16,9	17,1	17,5	17,4	17,7
Healthy Life Years at birth - males	**SE**	:	:	62,1	61,7	62	63,1	61,9	62.4 (e)	62.5 (e)	62 (b)	64,2	67,1
Life expectancy at birth - females	**SE**	81,7	81,7	82	82,1	82	82	82,2	82,1	82,5	82,8	82,9	83,1
Life expectancy at 45 - females	**SE**	37,8	37,8	38,1	38,2	38	38	38,1	38,1	38,5	38,8	38,8	39
Life expectancy at 65 - females	**SE**	19,9	19,9	20,1	20,2	20	20,2	20,2	20,1	20,4	20,7	20,7	20,9
Healthy Life Years at birth - females	**SE**	:	:	60	61.3 (e)	61,8	61,9	61	61.9 (e)	62.2 (e)	60.9 (b)	63,1	67

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth - males	**UK**	74	74,3	74,6	74,8	75	75,5	75,8	76	76,2	76,8	77,1	:
Life expectancy at 45 - males	**UK**	31,2	31,5	31,8	32	32,1	32,6	32,9	33,1	33,2	33,8	34	:
Life expectancy at 65 - males	**UK**	14,6	14,9	15,1	15,3	15,4	15,8	16,1	16,2	16,3	16,8	17	:
Healthy Life Years 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)	:	63.2 (b)	:
Life expectancy at birth - females	**UK**	79,3	79,5	79,7	79,8	79,9	80,3	80,5	80,6	80,5	81	81,1	:
Life expectancy at 45 - females	**UK**	35,7	35,9	36,1	36,2	36,2	36,7	36,9	36,9	36,8	37,2	37,4	:
Life expectancy at 65 - females	**UK**	18,2	18,4	18,5	18,6	18,6	19	19,2	19,2	19,1	19,4	19,5	:
Healthy Life Years 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)	:	65 (b)	:

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	:	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	15,3	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	17,4	12,4	41,7	12,9	9,6	5,6	39,2p	19	5,2u	6,4	8,3p	12	13
female	13,2	12,8	10,2	17,9	5,4	9,1	13,6	:	9	11	23,8	11,2	17,3	9,2	16.1p	7u	14	10,7	38,8	10,7	9,8	3,8	31,8p	18,9	3,3u	5,5	6,4p	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	20,9	14	44,6	15,1	9,3	7,2	46,4p	19,1	6,9u	7,3	10,4p	13,3	14,6
2007 total	14,8	14,5	12,3	16,6	:	12.4b	12,7	14,3	11,5	14,7	31	12,7	19,3	12,6	16p	8,7	15,1	10,9	37,3	12	10,9	5	36.3p	19,2	4.3u	7,2	7,9	8,6b	17,0b
female	12,7	12,3	10,7	16,9	:	8.9b	11,9	:	8,7	10,7	25,6	10,9	15,9	6,8	12.3p	5.9u	11.1u	9,3	32,9	9,6	10,2	3,6	30.4p	19,1	2.7u	6,3	6,3	7,0b	15,8b
male	16,9	16,7	13,9	16,3	:	15.7b	13,4	21,0	14,2	18,6	36,1	14,6	22,6	19,5	19.7p	11,4	19,2	12,5	41,1	14,4	11,6	6,4	42.0p	19,2	5.7u	8,1	9,7	10,2b	18,2b

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	SI	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	9.6e	12,9	14,5	8,1	5,7	10.7p	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	2.7u	13,8	6,6	:	16,5
	Adults (18-59)																													
	Total	10,3e	10.2e	13,5	13	7,4	7,7	11p	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	9.2e	11,6	12,6	5,8	7,7	10.9p	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	11.2e	15,4	13,5	9	7,8	11.2p	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	9,7e	9.6e	13,5	14,5	8,2	5	10.3p	8,2	11,3	3,6	5,1	9.5p	5,4	3,9	7,1	5,3	3,7	13,3	8,2	6,2	7,2	12,8	4,7	10	3,6	11,8	4,9	:	16,2
	Adults (18-59)																													
	Total	9,9e	9.9e	14,3	11,6	7,3	6,9	10.5p	6	7,9	8,1	6,3	10.9p	9,2	4,9	6,8	7	7,1	11,6	6,7	7,4	8,8	14,4	5,8	9,7	7,2	9,6	9,5	:	10,7
	Men	8,9e	8.9e	12,3	11,1	5,8	6,4	10.3p	6,1	6,5	6,1	5,8	9.9p	7,8	3,7	7,5	7,2	5,4	10,6	5,2	6,2	7,8	13,2	5,3	8,8	6,6	9	10,1	:	8,8
	Women	10,9e	10.9e	16,4	12	8,8	7,3	10.7p	5,8	9,3	10,1	6,8	12p	10,6	5,9	6,2	6,9	8,9	12,6	8,2	8,6	9,8	15,6	6,4	10,6	7,8	10,2	9	:	12,5
2007	Children	9.4e	9.3e	12	12,8	8	:	9,6	7,2	11,5	3,9	5,3	8,7	5,8	3,9	8,3	8,3	3,4	13,9	9,2	5,9	5,3	9,5	5,1	10	2,2	10,6	4,4	:	16,7
	Adults (18-59)																													
	Total	9.3e	9.2e	12,3	10,2	6,5	:	9,5	6	7,9	8	6,2	10	9,2	4,7	6,6	7	7	11,9	7,7	6,5	7,1	11,6	5,7	10,4	6,5	8,9	9,1	:	10,7
	Men	8,2e	8.2e	10,6	10,1	4,9	:	9,1	6,1	6,7	6	5,8	9	7,9	4,2	6,7	7,3	6	10,8	6,2	5,3	5,9	10,4	5,3	9,3	5,5	8,1	9,6	:	8,8
	Women	10.3e	10.2e	13,9	10,3	8,1	:	9,9	5,9	9,3	10	6,7	11,1	10,6	5,2	6,6	6,8	7,9	12,9	9,3	7,6	8,4	12,7	6,1	11,5	7,5	9,6	8,6	:	12,7

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

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 median income ratio of people aged 65+ (relative to the complementary age group 0-64) (%), 2007

	EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
Relative median income ratio (65+/0-64) Total	0.84ps	0.84p	0,74	0.83i	0,81	0,7	0.62p	0.86p	0.65p	0.69p	0.83p	0,76	0.9p	0,86	0,57	0,65	0,69	0,96	0,97	0,79	0.83p	0,93	1,04	0.79p	0.89p	0,86	0,81	0,74	0,78	0,72

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); (1) BG National HBS 2006, income data 2006; (2) with imputed rent data 2006 (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

7b. Aggregate replacement ratio (%), 2007

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
Aggregate replacement ratio (Pensions 65-74 /Earnings 50-59)	Total	:	0,49	0,44	0.6i	0,51	0,39	0.37p	0,45	0,47	0,47	0,4	0,47	0,61	0,49	0,29	0,38	0,4	0,61	0,58	0,5	0,42	0,61	0,58	0,47	:	0,44	0,54	0,46	0,61	0,41
	Men	:	0,52	0,46	0.62i	0,51	0,38	:	0,47	0,4	0,41	0,46	0,52	0,61	0,56	0,34	0,33	0,38	0,59	0,6	0,52	0,49	0,62	0,64	0,5	:	0,51	0,53	0,46	0,63	0,42
	Women	:	0,49	0,45	0.58i	0,56	0,43	:	0,48	0,57	0,53	0,42	0,48	0,54	0,37	0,34	0,43	0,44	0,58	0,57	0,48	0,54	0,68	0,57	0,48	:	0,39	0,57	0,48	0,54	0,44

Source: SILC 2007, Income data 2006; except for UK, income year 2006 and for IE moving income reference period (2005-2006); (1) BG National HBS 2006, income data 2006; (2) with imputed rent data 2006 (see methodological note).

Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

8a. Inequalities in access to health care (unmet need for care by income quintile for 3 reasons: too expensive, too long waiting time, too far to travel), SILC 2006

	EU-27	EU-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
1st quintile	:	:	1,8	1,4	0,2	:	14,4	2,7	7,9	0,9	4,3	9,2	6,6	28,9	13,6	0,8	3,9	3,4	0,9	1	13,3	9,6	0,3	6,4	4,7	4,1	2,6
2nd quintile	:	:	0,4	0,7	0,3	:	7	2,1	7,8	0,9	1,4	5,1	4,7	20,5	10,5	0,1	3,2	1,9	0,3	0,5	11	6,8	0,2	3,4	3,3	3,9	1,7
3rd quintile	:	:	0,2	0,5	0,2	:	5,9	2,4	7,3	0,5	1,2	4	2,6	10,2	7,9	0,2	2,4	1,6	0,3	0,2	8,9	4,9	0,1	2,2	2,1	3,3	1,5
4th quintile	:	:	:	0,5	0,2	:	6,3	1,9	4,1	0,4	0,3	3,1	1,5	9,8	5,2	0,2	1,7	1,2	0,3	0,3	7,2	2,7	0,1	1,5	1,7	2	2,4
5th quintile	:	:	0,1	0,2	0,2	:	3,1	0,7	2	0,2	0,6	2,1	0,5	5,9	3,9	0,4	0,8	0,8	0,3	0,3	6,4	1,1	0,2	0,8	0,9	1,1	1,5

Source: SILC(2006)

* This data should be interpreted with care when comparing levels of across countries due to a problem in the translation of the questionnaire.

8b. Doctor's consultations

EU-27	EU-25	BE	CZ	DK	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
:	:	7,5	12,9	7,5	6,9	:	:	8,1	6,4	7,0	2,0	5,2	6,8	6,0	12,9	1,9	5,6	6,7	6,6	3,9	7,2	10,4	4,3	2,8	5,1

Notes: (:) = data not available

Source: OECD Health Data. Calculated as the number of contacts with an ambulatory care physician divided by the population. Includes contacts in out-patient wards.

9. At-risk of poverty rate anchored at a fixed moment in time (poverty threshold of 2005), 2007

		EU27	EU25	BE	BG[(1)]	CZ	DK	DK[(2)]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[(1)]	SI	SK	FI	SE	UK
Total population	Total	:	14p	14	:	7	11		14p	8	12	20	17	13	20	10	10	8	14	10	11	9	13	13	18	:	10	5	11	9	16
	Men	:	14p	14	:	7	10		13p	8	11	19	16	12	18	9	10	7	13	10	10	9	12	13	17	:	8	5	10	9	15
	Women	:	15p	15	:	8	11		15p	8	12	20	18	14	21	12	10	8	15	10	11	10	15	12	19	:	11	5	11	9	17
Children aged 0-17	Total	:	17p	16	:	13	9		13p	9	14	23	20	16	25	7	11	11	21	16	14	13	17	18	21	:	9	9	9	10	19
People aged 18-64	Total		13p	12		7	10		14p	8	11	18	14	12	17	6	10	7	13	10	9	8	11	12	15	:	8	5	10	9	13
	Men	:	12p	11	:	6	11		13p	9	10	18	13	11	16	5	10	7	13	10	8	7	10	13	14	:	8	5	10	10	12
	Women	:	14p	13	:	7	10		15p	8	11	19	15	13	19	8	10	7	14	10	10	9	13	12	16	:	8	5	9	8	13
People aged 65+	Total	:	17p	22	:	3	16		15p	6	13	22	23	13	22	39	9	5	8	4	13	8	16	4	26	:	17	3	18	8	24
	Men	:	14p	19	:	1	13		12p	4	11	20	22	12	18	35	5	1	7	2	16	7	11	3	24	:	9	2	14	5	21
	Women	:	18p	24	:	4	17		17p	7	15	24	25	14	25	42	10	6	8	6	11	9	19	5	27	:	22	4	20	11	27

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); [(1)] BG, RO (:) data not available; [(2)] with imputed rent (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available n.a.=forthcomimg
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

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	42.3p	42.5p	31,8	34,7	44,5	59,5	45.4p	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	51.5p	51.8p	41,7	45,5	59,3	65,6	53.5p	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	33.5p	33.7p	22,1	25,5	30,9	53,5	37.5p	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
2006	total	43.5p	43.6p	32	39,6	45,2	60,7	48.4p	58,5	53,1	42,3	44,1	37.6p	32,5	53,6	53,3	49,6	33,2	33,6	30	47,7	35,5	28,1	50,1	41,7	32,6	33,1	54,5	69,6	57,4
	male	52.6p	52.8p	40,9	49,5	59,5	67,1	56.4p	57,5	67	59,2	60,4	40.1p	43,7	71,6	59,5	55,7	38,7	41,4	50,4	58	45,3	38,4	58,2	50	44,5	49,8	54,8	72,3	66
	female	34.8p	34.9p	23,2	31,1	32,1	54,3	40.6p	59,2	39,1	26,6	28,7	35.2p	21,9	36,6	48,7	45,1	27,8	27,1	11,2	37,2	26,3	19	42,8	34,5	21	18,9	54,3	66,9	49,1
2007	total	44,7	44,9	34,4	42,6	46	58,6	51,5	60	53,8	42,4	44,6	38,3	33,8	55,9	57,7	53,4	32	33,1	28,5	50,9	38,6	29,7	50,9	41,4	33,5	35,6	55	70	57,4
	male	53,9	54,1	42,9	51,8	59,6	64,9	59,7	59,4	67,9	59,1	60	40,5	45,1	72,5	64,6	60,8	35,6	41,7	45,9	61,5	49,8	41,4	58,6	50,3	45,3	52,5	55,1	72,9	66,3
	female	36	36,1	26	34,5	33,5	52,4	43,6	60,5	39,6	26,9	30	36,2	23	40,3	52,4	47,9	28,6	26,2	11,6	40,1	28	19,4	44	33,6	22,2	21,2	55	67	48,9

b= break in data series u= unreliable or uncertain data
Source : Eurostat - Labour Force Survey, Annual averages.

11. In work at-risk-of-poverty rate after social transfers by gender (Age 18+), 2007

		EU27	EU25	BE	BG[1]	CZ	DK	DK[2]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
In work	Total	8ps	8p	4	:	3	4	:	7p	8	6	14	11	6	10	6	10	8	9	6	4	5	6	12	10	4p	5	5	5	7	8
	Men	8ps	9p	4	:	3	5	:	7p	6	6	15	12	7	12	6	9	8	9	7	5	5	6	13	10	5p	5	5	5	7	8
	Women	7ps	7p	4	:	3	3	:	8p	9	6	12	9	6	7	7	10	8	9	5	2	5	6	10	9	3p	4	5	6	6	8

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); [1] BG National HBS 2007, income data 2007; [2] with imputed rent data 2006 (see methodological
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

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	:	68,0	63,5	:	72,0	79,7	70,8	72,2	65,6	63,2	63,0	68,4	59,0	:	69,8	72,1	62,1	58,7	:	73,0	71,0	65,7	70.6b	68,9	68,2	69,3	72,3	76,2	75,4
	Male	:	77,4	72,8	:	80,0	83,8	79,2	79,0	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	79,0	83,2
	Female	:	58,7	54,0	:	64,0	75,6	62,2	66,4	52,9	49,0	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	80,0	71,1	70,2	68,2	63,8	65,4	68,7	60,1	69,1	67,2	70,8	64,1	60,1	58,0	75,2	71,0	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	75,0	71,9	76,8	77,2	79,8	82.8b
	Female	60,1	60,0	56,4	55,6	63,6	75,6	63,3	65,3	56,3	50,5	52,0	62,4	46,3	57,7	62,1	67,3	51,6	52,7	35,2	66,0	62,0	59,9	63,9	61,9	62,9	63,2	71,9	74,8	68.2b
2002	Total	68,6	69,0	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	80,0	70.4b	72,5	76,7	77,0	79,4	82,3
	Female	60,5	60,7	56,3	57,5	62,7	75,5	64,4	64,4	57,8	51,0	53,1	63,0	47,9	61,8	63,9	65,8	53,6	52,7	36,7	68,3	63,7	58,7	65,6	56.6b	63,0	63,2	72,8	75,8	68,3
2004	Total	69,3	69,7	65,9	61,8	70,0	80,1	72,6	70,0	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	64,0	73,0	63,0	69,8	69,7	74,2	77,2	75,2
	Male	77,0	77,5	73,4	66,4	77,9	84,0	79,2	74,4	79,9	79,0	80,4	75,3	74.9b	83,0	74,3	72,8	75,6	67,2	80,2	83,9	78.5b	70,1	79,1	70,0	74,5	76,5	76,4	79,1	82,0
	Female	61,6	62,0	58,2	57,2	62,2	76,2	65,8	66,0	59,0	54,1	56,8	63,9	50.6b	62,8	65,3	65,6	55,8	54,0	36,0	69,2	64.2b	57,9	67,0	56,2	65,0	63,0	72,0	75,2	68,6
2005	Total	69.8p	70.3p	66,7	62,1	70,4	79,8	74.3p	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	77.3p	77.8p	73,9	67,0	78,4	83,6	80.6p	73,6	80,6	79,2	80.9b	75,1	74,6	82,9	74,4	72,1	76,0	67,9	79,1	83,7	79,3	70,8	79,0	69,4	75,1	76,5	76,6	80.9b	81,9
	Female	62.3p	62.7p	59,5	57,3	62,4	75,9	68p	66,9	60,8	54,5	58.3b	64,1	50,4	62,5	65,1	64,9	57,0	55,1	36,9	70,0	65,6	58,1	67,9	55,3	66,1	61,5	72,8	76.3b	68,8
2006	Total	70.2p	70.6p	66,5	64,5	70,3	80,6	75.3p	72,4	71,8	67,0	70,8	69.4p	62,7	73,0	71,3	67,4	66,7	62,0	59,2	77,4	73,7	63,4	73,9	63,6	70,9	68,6	75,2	78,8	75,5
	Male	77.5p	78p	73,4	68,8	78,3	84,1	81.3p	75,8	81,5	79,1	81,3	74.8p	74,6	82,7	76,2	70,5	75,3	68,7	79,7	83,9	80,5	70,1	79,5	70,7	74,9	76,4	77,1	81,2	82,1
	Female	62.9p	63.2p	59,5	60,2	62,3	77,0	69.2p	69,3	61,9	55,0	60,2	64.1p	50,8	63,8	66,7	64,6	58,2	55,5	38,3	70,7	67,0	56,8	68,4	56,6	66,7	60,9	73,3	76,3	69,2
2007	Total	70,5	70,9	67,1	66,3	69,9	80,2	76,0	72,9	72,4	67,0	71,6	70,2	62,5	73,9	72,8	67,9	66,9	61,9	58,4	78,5	74,7	63,2	74,1	63,0	71,3	68,3	75,6	79,1	75,5
	Male	77,7	78,2	73,6	70,6	78,1	83,9	81,8	77,5	81,4	79,1	81,4	74,9	74,4	82,9	77,6	71,0	75,0	69,0	77,6	84,6	81,7	70,0	79,4	70,1	75,8	75,9	77,2	81,4	82,2
	Female	63,4	63,7	60,4	62,1	61,5	76,4	70,1	68,7	63,3	54,9	61,4	65,6	50,7	65,4	68,3	65,0	58,9	55,1	38,6	72,2	67,8	56,5	68,8	56,0	66,6	60,8	73,8	76,8	69,0

Source: Eurostat - Labour Force Survey, Annual averages.
(b) break in series

13. Dispersion of regional employment rates*, selected years (%)

	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		13.4	7.9	10.3	5.8	-	5.7	-	-	5.1	10.7	6.9	17.5	-	-	-	-	9.0	-	2.2	2.5	6.9	4.3	4.6	-	9.1	6.8	4.5	7.1
2004		12.2	8.7	7.0	5.6	-	6.2	-	-	4.1	8.7	7.1	15.6	-	-	-	-	9.4	-	2.3	3.5	6.4	3.5	4.9	-	9.0	5.5	4.4	5.8
2005		11.9	8.4	7.1	5.5	-	5.6	-	-	4.3	8.3	7.3	16.0	-	-	-	-	9.9	-	2.0	4.1	5.6	3.3	4.5	-	9.8	5.5	3.0	5.7
2006	11,4	:	8,7	7,3	5,2	:	5,2	-	:	3,7	7,8	7,5	16,3	-	-	-	-	9,1	-	2,2	3,4	5,1	3,1	3,6	:	8,6	5,4	2,9	5,5
2007	11,1	:	8,6	7,1	4,6	:	4,8	-	:	3,5	7,5	6,6	16,3	-	-	-	-	9,7	-	2,2	3,8	4,5	3,3	4,6	:	8,3	5,6	2,4	5,4

* Coefficient of variation of employment rates across regions at NUTS2 level
e = estimate; p = provisional figure
Source: Eurostat - Labour Force Survey, Annual averages

14. Total health expenditure per capita

	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
1990		1358	244	560	1544	1769	...	792	853	873	1449	1359	...	161	162	1532	...	...	1416	1631	290	636	81	311	...	1367	1592	965
1991		1488		541	1591			887	874	952	1553	1471				1630	578		1518	1728	346	754				1503	1576	1052
1992		1576		568	1666	1977		1009	974	1030	1649	1522				1757	615		1604	1870	366	805				1507	1617	1153
1993		1616		768	1772	1993		1040	1086	1086	1752	1534				1870	629		1673	2014	372	842				1393	1660	1209
1994		1654		817	1857	2129		1120	1227	1114	1813	1540				1904	709		1719	2183	375	872				1373	1665	1299
1995		1854		899	1871	2275		1204	1264	1193	1997	1538				1911	660		1799	2259	411	1036				1440	1746	1350
1996		1923		917	1979	2399		1280	1301	1249	2050	1613				1990	659		1862	2351	478	1117				1509	1861	1436
1997		1969		922	2060	2413		1395	1354	1298	2107	1728				1972	679		1916	2439	498	1186			564	1562	1886	1499
1998	1637	2042	289	926	2176	2483	474	1499	1382	1383	2190	1829	947	439	489	2083	763	1058	2054	2598	559	1210	246	1226	584	1622	1982	1569
1999	1717	2176	343	938	2281	2592	522	1626	1468	1450	2279	1879	984	473	498	2384	810	1103	2178	2726	573	1329	253	1303	599	1700	2129	1690
2000	1823	2377	386	980	2379	2671	513	1801	1429	1536	2421	2053	1074	482	559	2554	852	1247	2337	2859	583	1509	275	1447	603	1794	2284	1847
2001	1960	2484	484	1082	2521	2809	519	2128	1669	1636	2590	2215	1140	541	598	2738	971	1294	2556	2890	642	1569	312	1581	665	1913	2511	2021
2002	2087	2685	552	1195	2696	2937	561	2360	1792	1745	2780	2223	1228	611	681	3081	1114	1492	2833	3068	733	1657	368	1693	730	2089	2707	2165
2003	2226	3153	609	1340	2824	3090	646	2515	1928	2019	2988	2272	1335	653	793	3582	1302	1586	2988	3206	749	1824	415	1767	792	2210	2841	2259
2004	2347	3311	655	1388	3030	3162	740	2724	1991	2128	3117	2401	1335	796	756	4083	1327	1608	3156	3397	808	1913	427	1863	1058	2412	2964	2509
2005	2454	3421	734	1447	3169	3251	846	3126	2283	2260	3306	2496	1550	860	862	4153	1440	1733	3192	3507	843	2029	507	1959	1130	2523	3012	2580
2006		3488		1490	3349	3371		3082	2483	2458	3449	2614				4303	1504		3391	3606	910	2120				2668	3202	2760

Source: OECD health data 2008 for OECD Member States and WHO health for all database for the others

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
2000	3,9	3,9	3,7	5,4	3,6	3,5	3,2	9,6	9,2	4,5	5,0	3,9	3,7	5,0	6,9	4,2	8,4	5,2	:	3,9	3,7	4,3	3,9	2,1	4,4	1,4	5,0	4,4	3,9
2005	2,0	2,0	1,8	6,2	6,3	2,4	0,8	9,2	6,4	2,9	3,6	1,9	0,6	3,9	10,6	7,8	5,2	4,0	3,5	2,0	2,9	3,6	0,9	4,2	4,3	6,5	2,8	3,3	2,1
2006	3,1	3,1	3,0	6,3	6,8	3,3	3,0	10,4	5,7	4,5	3,9	2,2	1,8	4,1	11,9	7,8	6,4	4,1	3,2	3,4	3,4	6,2	1,4	7,9	5,9	8,5	4,9	4,2	2,8
2007	2,9	2,9	2,8	6,2	6,0	1,6	2,5	6,3	6,0	4,0	3,7	2,2	1,5	4,4	10,2	8,9	5,2	1,1	3,9	3,5	3,1	6,6	1,9	6,2	6,8	10,4	4,5	2,5	3,0
2008f	1,0	1,0	1,3	6,4	4,2	-0,6	1,3	-2,4	-2,0	2,9	1,2	0,7	-0,6	3,6	-2,3	3,4	1,0	0,9	2,1	1,9	1,7	5,0	0,2	7,8	4,0	7,1	1,5	0,5	0,7

Source : Eurostat, Structural indicators database

f = forecast

Context 1: GDP per capita in Purchasing Power Standards (PPS), (EU-27 = 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
2000	100,0	105,0	125,9	27,8	68,5	131,6	118,5	44,6	131,0	84,1	97,3	115,3	116,9	88,8	36,7	39,3	243,7	56,1	83,6	134,3	131,4	48,2	78,0	25,9	79,8	1,7	117,3	126,7	119,0
2005	100,0	104,1	119,4	34,5	75,9	123,6	116,9	61,1	144,1	92,8	102,0	110,8	104,7	90,9	48,6	52,9	254,1	63,2	78,2	130,8	124,8	51,3	76,9	35,0	87,4	2,0	114,3	120,3	121,8
2006	100,0	103,9	118,5	36,5	77,4	122,9	115,8	65,3	147,4	94,1	104,1	109,5	103,5	90,3	52,6	55,5	267,1	63,6	76,9	130,9	124,3	52,3	76,4	38,4	87,7	2,1	114,9	121,5	120,4
2007	100,0	103,7	118,2	37,3	80,2	120,1	114,8	68,0	150,4	94,9	105,5	109,2	101,5	90,7	54,7	59,5	266,5	62,6	77,8	131,0	124,0	53,4	76,2	42,2	89,3	2,2	115,9	122,2	119,2
2008f	100	103,6	114,7	38,5	80,6	116,3	112,4	64,8	140,1	94,1	101,7	105,7	97,6	89,3	52,6	59,9	261,1	61,5	76,4	129	121,5	54,3	73,7	44,3	89,3	69,1	114,1	118,1	115,5

f = forecast

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	56,0	51,3	60,2	51,9	:	59,9	62,3	60,5	53,7	:	70,2	67,9	59,0	66.8b	64,2	62,9	60,6	64,6	70,3	70,5
	male	:	70,6	67,1	:	76,0	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	77,0	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	49,0	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	65,0	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	55,0	68,4	63,0	62,8	56,8	67,2	73,0	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	68,0	78,7	61,5	60,5	75,0	63,1	75,0	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	62,0	65,5	57,5	58,5	63,0	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	71,0	68,3	53,7	73,9	80,0	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	70,0	74,9	77,6
	female	54,4	54,7	51,4	47,5	57,0	71,7	58,9	57,9	55,4	42,9	44,4	56,7	42,0	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	65,0	63,0	66,3	59,4	61,1	63,1	57.6b	68,9	62,3	61,2	62,5	56,8	54,0	73,1	67.8b	51,7	67,8	57,7	65,3	57,0	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	69,0	70.1b	79,8	66,4	64,7	72,8	63,1	75,1	80,2	74.9b	57,2	74,2	63,4	70,0	63,2	69,7	73,6	77,8
	female	55,4	55,7	52,6	50,6	56,0	71,6	59,2	60,0	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	63.4p	63.9p	61,1	55,8	64,8	75,9	66p	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	66,0	57,7	68,4	72.5b	71,7
	male	70.8p	71.3p	68,3	60,0	73,3	79,8	71.3p	67,0	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	56.2p	56.5p	53,8	51,7	56,3	71,9	60.6p	62,1	58,3	46,1	51.2b	57,6	45,3	58,4	59,3	59,4	53,7	51,0	33,7	66,4	62,0	46,8	61,7	51,5	61,3	50,9	66,5	70.4b	65,9
2006	total	64.4p	64.7p	61,0	58,6	65,3	77,4	67.5p	68,1	68,6	61,0	64,8	63p	58,4	69,6	66,3	63,6	63,6	57,3	54,8	74,3	70,2	54,5	67,9	58,8	66,6	59,4	69,3	73,1	71,5
	male	71.6p	72p	67,9	62,8	73,7	81,2	72.8p	71,0	77,7	74,6	76,1	68.5p	70,5	79,4	70,4	66,3	72,6	63,8	74,5	80,9	76,9	60,9	73,9	64,6	71,1	67,0	71,4	75,5	77,3
	female	57.2p	57.4p	54,0	54,6	56,8	73,4	62.2p	65,3	59,3	47,4	53,2	57.7p	46,3	60,3	62,4	61,0	54,6	51,1	34,9	67,7	63,5	48,2	62,0	53,0	61,8	51,9	67,3	70,7	65,8
2007	total	65,4	65,8	62,0	61,7	66,1	77,1	69,4	69,4	69,1	61,4	65,6	64,6	58,7	71,0	68,3	64,9	64,2	57,3	54,6	76,0	71,4	57,0	67,8	58,8	67,8	60,7	70,3	74,2	71,5
	male	72,5	73,0	68,7	66,0	74,8	81,0	74,7	73,2	77,4	74,9	76,2	69,3	70,7	80,0	72,5	67,9	72,3	64,0	72,9	82,2	78,4	63,6	73,8	64,8	72,7	68,4	72,1	76,5	77,5
	female	58,3	58,6	55,3	57,6	57,3	73,2	64,0	65,9	60,6	47,9	54,7	60,0	46,6	62,4	64,4	62,2	56,1	50,9	35,7	69,6	64,4	50,6	61,9	52,8	62,6	53,0	68,5	71,8	65,5

Source : Eurostat - Labour Force Survey, Annual averages.

b= break in data 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	15,0	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	:	8,0	7,7	:	5,0	3,9	7,1	9,9	7,7	7,0	11,2	9,5	8,8	:	15,1	14,6	1,9	9,0	:	3,0	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	6,0	11,1	8,3	7,3	16,7	21,1	12,9	15,4	:	13,6	11,7	4,0	7,8	:	5,0	5,4	12,2	6,3	5,3	7,5	13,1	12,0	8,0	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	4,0	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	6,0	13,8	4,3	7,4	7,9	7,6	7,8	3,2	14,4	18,6	1,8	7,0	6,4	2,2	3,1	14,4	3,2	7,8	6,5	18,9	9,1	5,9	6,0
	Females	10,1	10,2	8,5	16,2	10,3	4,8	8,7	11,8	4,2	17,1	16,0	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	7,0	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	5,0	8,4	6,3	18,7	9,1	4,9	5,1
	Males	8,0	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	2,0	6,2	6,6	2,5	4,0	19,1	4,1	9,1	5,9	18,6	9,1	5,3	5,6
	Females	10,0	10,0	8,6	17,3	9,0	5,0	9,4	9,7	4,1	15,6	15,7	9,8	11,5	4,5	11,0	12,8	3,7	5,4	9,3	3,1	4,4	20,9	6,0	7,7	6,8	18,7	9,1	4,6	4,5
2004	Total	9,1	9,1	8,4	12,0	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	19,0	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	8,0	8,7	6.4b	3,6	10,6	11,0	3,7	6,1	6,6	4,3	4.4b	18,2	5,8	9,1	5,8	17,4	8,7	6,5	5,0
	Females	10,1	10,2	9,5	11,5	9,9	6,0	10,5	8,9	4,1	16,2	14,3	10,6	10.5b	6,0	10,2	11,8	7,1	6,1	9,0	4,8	5.3b	19,9	7,6	6,9	6,8	19,2	8,9	6,1	4,2
2005	Total	8,7	8,7	8,4	10,1	7,9	4,8	9.4p	7,9	4,3	9,8	9,2	9.7p	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	7.4b	4,8
	Males	7,9	7,9	7,6	10,3	6,5	4,4	8.7p	8,8	4,6	6,1	7,0	8.8p	6,2	4,3	9,1	8,2	3,5	7,0	6,5	4,4	4,9	16,6	6,7	7,8	6,1	15,5	8,2	7.5b	5,1
	Females	9,7	9,8	9,5	9,8	9,8	5,3	10.3p	7,1	4,0	15,3	12,2	10.7p	10,1	6,5	8,7	8,3	5,8	7,4	9,0	5,1	5,5	19,1	8,7	6,4	7,0	17,2	8,6	7.3b	4,3
2006	Total	7,9	7,9	8,2	9,0	7,1	3,9	8.4p	5,9	4,4	8,9	8,5	9.5p	6,8	4,6	6,8	5,6	4,7	7,5	7,3	3,9	4,7	13,8	7,7	7,3	6,0	13,4	7,7	7,1	5,3
	Males	7,2	7,1	7,4	8,6	5,8	3,3	7.7p	6,2	4,6	5,6	6,3	8.8p	5,4	4,0	7,4	5,8	3,5	7,2	6,5	3,5	4,4	13,0	6,5	8,2	4,9	12,3	7,4	6,9	5,7
	Females	8,9	9,0	9,3	9,3	8,8	4,5	9.2p	5,6	4,1	13,6	11,6	10.4p	8,8	5,4	6,2	5,4	6,2	7,8	8,9	4,4	5,2	14,9	9,0	6,1	7,2	14,7	8,1	7,2	4,9
2007	Total	7,1	7,1	7,5	6,9	5,3	3,8	8,6	4,7	4,6	8,3	8,3	7,9	6,1	3,9	6,0	4,3	4,1	7,4	6,5	3,2	4,4	9,6	8,0	6,4	4,8	6,9	6,2	5,3	5,3
	Males	6,5	6,5	6,7	6,5	4,2	3,5	8,5	5,4	4,9	5,2	6,4	7,4	4,9	3,4	6,4	4,3	3,6	7,1	6,0	2,8	3,9	9,0	6,6	7,2	4,0	6,5	5,9	5,6	5,6
	Females	7,8	7,9	8,4	7,3	6,7	4,2	8,7	3.9u	4,2	12,8	10,9	8,5	7,9	4,6	5,6	4,3	4,7	7,7	7,6	3,6	5,0	10,3	9,6	5,4	5,8	7,2	6,5	4,9	5,0

Source: Eurostat - Harmonised unemployment series, Annual average
p = provisional value u = unreliable or uncertain data b= break in data series

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	18,4	18,3	21,5	22,3	19,2	8,6	14,1p	15,9	8,6	26	19,7	22,7p	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	21,1b	12,9
	Males	18,1	17,9	21	23,4	19,3	8,6	14,4p	16,6	9,1	18,7	16,7	21,3p	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	21,1b	14,5
	Females	18,7	18,7	22,1	21	19,1	8,6	13,8p	14,9	8	34,8	23,4	24,4p	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	21,1b	11,1
2006	Total	17,3	17,1	20,5	19,5	17,5	7,7	13,7	12u	8,6	25,2	17,9	21,3	21,6	10	12,2	9,8	16,2	19,1	15,9	6,6	9,1	29,8	16,3	21,4	13,9	26,6	18,7	21,5	14
	Males	16,9	16,7	18,8	18,9	16,6	7,9	14,8	10	9,1	17,7	15	20,1	19,1	8,9	10,5	10u	17u	18,6	17,2u	6,1	8,9	28,3	14,5	22,3	11,6u	26,4	19	21	15,7
	Females	17,7	17,5	22,6	20,3	18,7	7,5	12,5	14,7	8	34,7	21,6	22,9	25,3	11,1	14,7	9,6	15,2	19,8	14,3u	7,1	9,3	31,6	18,4	20,2	16,8u	27	18,4	22	12
2007	Total	15,4	15,3	18,8	15,1	10,7	7,9	11,9	10u	9,1	22,9	18,2	18,7	20,3	10,2	10,7	8.2u	15.2u	18	13,9	5,9	8,7	21,7	16,6	20,1	10,1	20,3	16,5	19,3	14,4
	Males	15,1	14,9	17,1	14,5	10,6	8,2	12,6	:	10	15,7	15,2	18	18,2	11	11,2	7u	13.5u	17,6	15,8u	5,6	8,3	20	13,5	21,1	9.4u	20,4	16,4	18,8	15,8
	Females	15,8	15,7	20,9	15,9	11	7,5	11,1	:	8,1	32,1	21,9	19,6	23,3	9,4	10u	10u	17.5u	18,6	11,6u	6,2	9,1	23,8	20,3	18,7	11.2u	20,2	16,6	19,8	12,5

Source: Eurostat - Harmonised unemployment series, Annual average
p = provisional value u = unreliable or uncertain data b= break in data series

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	4,2	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	3,7	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	4,7	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	4p	3,9p	4,4	6	4,2	1,1	5p	4,2	1,5	5,1	2,2b	4	3,9	1,2	4,1	4,3	1,2p	3,2	3,4	1,9	1,3	10,2	3,7	4	3,1	11,7	2,2	1,2p	1
	Males	3,6p	3,5p	3,8	6,1	3,4	1,1	4,7p	4,2	1,9	2,6	1,4b	3,5	2,9	0,8	4,4	4,2	1,2p	3,3	3,4	1,9	1,2	9,3	3,2	4,6	2,9	11,2	2,4	1,4p	1,3
	Females	4,5p	4,5p	5	6	5,3	1,2	5,5p	4,2	0,8	8,9	3,4b	4,5	5,2	1,7	3,7	4,5	1,2p	3,2	3,2	1,9	1,4	11,4	4,2	3,4	3,3	12,3	1,9	1p	0,7
2006	Total	3,6p	3,6p	4,2	5	3,9	0,8	4,7p	2,8	1,4	4,8	1,8	4p	3,4	0,9	2,5	2,5	1,4p	3,4	2,9	1,7	1,3	7,8	3,8	4,2	2,9	10,2	1,9	1,1	1,2
	Males	3,3p	3,2p	3,7	4,8	3,1	0,7	4,4p	3,1	1,8	2,6	1,2	3,7p	2,6	0,7	3	2,5	1,2p	3,3	3,1	1,6	1,3	7,1	3,3	4,7	2,4	9,4	2,1	1,2	1,5
	Females	4p	4p	4,9	5,2	4,9	0,9	5,2p	2,6	0,9	8	2,8	4,3p	4,5	1,2	1,9	2,4	1,6p	3,4	2,5	1,8	1,3	8,6	4,4	3,6	3,5	11,2	1,8	0,9	0,8
2007	Total	3.1	3.0	3.8	4.1	2.8	0.6	4.7	2.3	1.4	4.1	1.7	3.3	2.9	0.7	1.6	1.4	1.2	3.4	2.7	1.3	1.2	4.9	3.8	3.2	2.2	8.3	1.6	0.9	1.3
	Males	2.8	2.8	3.3	3.7	2.1	0.5	4.8	2.9	1.8	2.2	1.1	3.1	2.2	0.8	1.9	1.4	1.2	3.3	2.8	1.2	1.0	4.6	3.2	3.6	1.8	7.4	1.7	0.9	1.6
	Females	3.3	3.3	4.3	4.5	3.6	0.7	4.7	1.7	0.9	7.0	2.5	3.6	3.9	0.7	1.2	1.3	1.1	3.6	2.4	1.4	1.4	5.4	4.5	2.7	2.7	9.3	1.4	0.8	0.9

Source : Eurostat - Labour Force Survey, Annual averages

p = provisional value u = unreliable or uncertain data b= break in data series

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)

	EU27	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
2010	25,9	26,1	25,3	21,8	25,0	31,2	25,0	16,7	28,2	24,4	25,8	31,0	18,0	25,2	23,2	21,1	24,2	21,2	22,8	26,0	19,0	26,6	21,3	23,9	17,0	25,7	27,8	24,7
2020	31,1	30,6	31,1	31,1	31,9	35,3	29,2	20,2	32,8	27,4	32,8	35,5	22,3	28,1	26,0	24,2	30,3	31,3	30,7	29,2	27,2	30,7	25,7	31,2	23,9	36,8	33,7	28,6
2030	38,0	37,6	36,3	35,7	37,9	46,2	34,4	24,6	38,5	34,3	39,0	42,5	27,4	34,6	34,7	30,8	34,1	39,1	40,0	38,1	36,0	36,6	30,3	40,8	32,3	43,9	37,4	33,2
2040	45,4	42,3	43,6	42,7	42,7	54,7	39,0	30,6	48,3	46,4	44,0	54,1	30,8	40,7	42,8	36,3	40,1	41,7	46,8	46,0	41,3	44,6	40,8	49,4	40,0	45,1	40,8	36,9
2050	50,4	43,9	55,4	54,8	41,3	56,4	47,2	40,4	57,0	58,7	44,7	59,2	37,7	51,2	51,1	37,8	50,8	49,8	45,6	48,3	55,7	53,0	54,0	59,4	55,5	46,6	41,9	38,0
2060	53,5	45,8	63,5	61,4	42,7	59,1	55,6	43,6	57,1	59,1	45,2	59,3	44,5	64,5	65,7	39,1	57,6	59,1	47,2	50,7	69,0	54,8	65,3	62,2	68,5	49,3	46,7	42,1

Source : Eurostat - EUROPOP2008 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
	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
Children (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, 2007 (percentage of total population)

	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
- Single adults, no children	13	15		9	22	18	14	8	7	6	15	12	5	10	11	12	9	7	16	15	9	6	7	8	18	20	14
of which:																										:	
- Single men	5	7		4	10	7	5	4	2	2	6	5	2	3	3	5	3	3	7	6	3	2	2	2	8	9	6
- Single women	8	8		6	11	11	9	4	5	4	9	7	3	7	8	7	7	4	9	9	6	4	5	7	11	10	7
																										:	
- Under 65	7	9		5	15	12	8	4	4	3	8	6	3	5	6	8	5	3	11	9	4	2	3	3	12	12	8
- 65 and over	5	6		4	7	6	6	4	4	3	6	6	2	5	5	4	5	4	5	6	5	4	4	5	6	7	6
- Single parents	5	6		4	7	6	7	8	2	2	5	3	2	5	6	4	5	2	4	4	3	3	3	3	5	8	8
- 2 adults below 65, no children	13	15		14	18	16	11	10	9	10	16	9	8	10	9	12	11	9	17	13	8	9	8	7	19	16	17
- 2 adults, at least one aged 65+, no children	11	10		9	10	13	9	7	12	9	11	12	9	9	9	9	9	8	10	9	7	11	8	7	10	10	11
- 3 or more adults, no children	12	9		15	3	7	10	12	23	23	5	18	13	13	10	11	14	20	7	13	13	18	19	17	5	2	11
- 2 adults, 1 child	12	11		12	10	12	15	10	10	13	13	13	10	14	16	13	12	11	11	11	12	17	11	9	12	11	10
- 2 adults, 2 children	18	16		21	19	15	14	15	25	20	24	19	26	13	17	25	16	17	20	15	15	16	19	17	16	19	16
- 2 adults, 3 or more children	7	11		5	10	6	6	14	3	3	7	5	10	5	7	7	9	8	12	8	7	4	5	8	12	10	8
- 3 or more adults, with children	10	7		11	2	6	14	17	10	14	4	11	16	21	16	8	15	18	5	12	25	17	19	24	3	4	7

EU aggregates based on available country data

Source : Eurostat - European Labour Force Survey

Context 6a: General government debt - General government consolidated gross debt as a percentage of GDP

	EU-27	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
2000	61,7	107,8	74,3	18,5	51,7	59,7	5,2	37,7	101,8	59,2	56,7	109,2	58,8	12,3	23,7	6,4	54,2	55,9	53,8	66,4	36,8	50,4	24,7	26,8	50,3	43,8	53,6	41,0
2001	60,8	106,5	67,3	25,1	47,4	58,8	4,8	35,5	102,9	55,5	56,2	108,8	60,7	14,0	23,1	6,5	52,1	62,1	50,7	67,0	37,6	52,9	26,0	27,4	48,9	42,3	54,4	37,7
2002	60,2	103,4	53,6	28,5	46,8	60,3	5,6	32,2	101,5	52,5	58,2	105,7	64,6	13,5	22,3	6,5	55,8	60,1	50,5	66,4	42,2	55,5	25,0	28,1	43,4	41,3	52,6	37,5
2003	61,8	98,6	45,9	30,1	45,8	63,8	5,5	31,1	97,8	48,7	62,9	104,4	68,9	14,6	21,1	6,2	58,1	69,3	52	65,4	47,1	56,9	21,5	27,5	42,4	44,3	52,3	38,7
2004	62,2	94,3	37,9	30,4	43,8	65,6	5	29,4	98,6	46,2	64,9	103,8	70,2	14,9	19,4	6,3	59,4	72,1	52,4	64,8	45,7	58,3	18,8	27,2	41,4	44,1	51,2	40,6
2005	62,7	92,1	29,2	29,8	36,4	67,8	4,5	27,3	98,8	43,0	66,4	105,9	69,1	12,4	18,4	6,1	61,7	69,9	51,8	63,7	47,1	63,6	15,8	27	34,2	41,3	50,9	42,3
2006	61,3	87,8	22,7	29,6	30,5	67,6	4,3	24,7	95,9	39,6	63,6	106,9	64,6	10,7	18	6,6	65,6	63,9	47,4	62	47,7	64,7	12,4	26,7	30,4	39,2	45,9	43,4
2007	58,7	83,9	18,2	28,9	26,2	65,1	3,5	24,8	94,8	36,2	63,9	104,1	59,5	9,5	17	7	65,8	62,2	45,7	59,5	44,9	63,6	12,9	23,4	29,4	35,1	40,4	44,2
2008	*59,8*	*86,5*	*13,8*	*26,6*	*21,1*	*64,3*	*4,2*	*31,6*	*93,4*	*37,5*	*65,4*	*104,1*	*48,2*	*12,3*	*17,5*	*14,1*	*65,4*	*63,1*	*48,2*	*57,4*	*43,7*	*64,3*	*13,4*	*21,8*	*28,8*	*31,6*	*34,7*	*50,1*
2009	*60,9*	*86,1*	*10,6*	*26,4*	*21,1*	*63,2*	*5*	*39,2*	*92,2*	*41,1*	*67,7*	*104,3*	*44,7*	*17,7*	*20*	*14,6*	*66*	*63,2*	*47*	*57,1*	*43,4*	*65,2*	*15,4*	*21,1*	*29*	*30,2*	*33,8*	*55,1*
2010	*61,8*	*85,6*	*7,9*	*26,3*	*20,1*	*61,9*	*6,1*	*46,2*	*91,9*	*44,4*	*69,9*	*103,8*	*41,3*	*23*	*23,3*	*14,5*	*66,2*	*63,1*	*45,9*	*56,9*	*42,9*	*66,6*	*17,1*	*20,1*	*29,3*	*29,8*	*32,4*	*60,3*

Source: Eurostat - General Government data (2000 to 2007) and ECFIN forecasts (2008-2009)

Context 6b: Projected evolution of debt levels up to 2050 (in % of GDP)

Programme scenario

	EU-25**	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	63	93,3	:	30,5	35,8	67,7	4,8	27,6	107,5	43,2	66,8	106,4	70,3	11,9	18,7	6,2	58,4	74,7	52,9	62,9	42.5	63,9	:	29,1	34,5	41,1	50,3	42,8
2010	61	72	:	30	18	64	0	17	90	30	60	97	57	9	16	10	61	65	46	54	45	65	:	27	31	25	34	42
2030	79	31	:	43	23	37	-25	37	18	33	41	32	42	26	22	74	51	16	70	23	-33	64	:	65	16	26	-3	44
2050	180	83	:	188	98	65	-82	157	-56	198	66	1	172	92	76	240	155	-58	176	18	-163	208	:	270	66	96	-1	114

2005 budget scenario

2010	55	74	:	43,2	14,4	73,6	0,9	13,6	96,9	25,7	69,2	108,9	64,3	13	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
2030	33	52	:	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	195,4	:	68,5	66,8	7,9	8	90,1
2050	76	129	:	320,3	-135,5	232,4	-117	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.

** aggregates exclude Greece

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) - 2006

	EU-27	EU-25	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
Sickness, health care	29.2p	29.2p	25,7	26	34,4	21,6	29.1p	31,2	41,1	28,7	31.2p	29.9p	26.8p	25,7	29.1p	32.1p	25,4	29	28,4	31.8p	25,5	20,4	29,2	34,8	32.1p	31.0p	26,2	26.0p	31.8p
Disability	7.5p	7.5p	6,4	9,1	8,6	14,9	6.2p	9,5	5,4	4,7	7.3p	6.1p	5.9p	3,9	7.3p	10.7p	13,2	9,6	6,3	8.5p	8,2	9,3	10	7,4	8.5p	8.7p	12,7	14.9p	8.7p
Family and children	8.0p	8.0p	7,1	7,4	7,6	13,1	11.1p	12,1	14,7	6,2	5.7p	8.6p	4.5p	10,8	10.2p	9.0p	16,9	13	6,3	5.8p	10,4	4,4	5,1	8,9	8.6p	7.8p	11,6	9.8p	6.1p
Unemployment	5.6p	5.6p	11,9	2,2	3,2	7,2	6.3p	0,9	7,6	4,6	12.5p	6.9p	2.0p	6,1	3.7p	1.9p	4,9	3,1	3,4	5.0p	5,8	3	5,5	2,7	3.0p	3.5p	8,5	5.5p	2.4p
Old age and survivors benefits	46.2p	46.2p	47	52,9	43,1	37,9	44.3p	45,2	27,4	51,3	41.3p	44.3p	60.5p	46,1	48.3p	44.8p	36,7	42,2	52,8	41.4p	48,6	61,2	49,1	45	45.4p	45.3p	37,8	40.2p	44.7p
Housing and social exclusion	3.6p	3.6p	2	2,5	3,1	5,3	3.0p	1	3,8	4,5	2.0p	4.3p	0.3p	7,4	1.4p	1.6p	2,9	3,1	2,8	7.5p	1,5	1,8	1,2	1,2	2.5p	3.6p	3,2	3.6p	6.3p

e: Eurostat estimate; p: provisional

Context 7b: Social protection benefits by group of functions (as a percentage of GDP) - 2006

	EU-27	EU-25	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 expenditure*	26,9p	27,0p	30,1	15,0	18,7	29,1	28,7p	12,4	18,2	24,2	20,9p	31,1p	26,6p	18,4	12,2p	13,2p	20,4	22,3	18,1	29,3p	28,5	19,2	25,4	14,0	22,8p	15,9p	26,2	30,7p	26,4p
Social protection benefits	25,8p	26,0p	28,7	14,5	18,1	28,3	27,6p	12,2	16,9	23,6	20,4p	29,2p	25,7p	18,1	11,9p	12,8p	20,0	21,8	17,9	27,5p	27,6	18,8	23,8	13,7	22,2p	15,3p	25,4	30,0p	25,9p
Sickness/Health care	7,5p	7,6p	7,4	3,8	6,2	6,1	8,0p	3,8	7,0	6,8	6,4p	8,7p	6,9p	4,6	3,5p	4,1p	5,1	6,3	5,1	8,7p	7,1	3,8	6,9	4,8	7,1p	4,7p	6,6	7,8p	8,2p
Disability	1,9p	1,9p	1,8	1,3	1,5	4,2	1,7p	1,2	0,9	1,1	1,5p	1,8p	1,5p	0,7	0,9p	1,4p	2,6	2,1	1,1	2,3p	2,3	1,7	2,4	1,0	1,9p	1,3p	3,2	4,5p	2,2p
Family/Children	2,1p	2,1p	2,0	1,1	1,4	3,7	3,1p	1,5	2,5	1,5	1,2p	2,5p	1,2p	1,9	1,2p	1,1p	3,4	2,8	1,1	1,6p	2,9	0,8	1,2	1,2	1,9p	1,2p	2,9	2,9p	1,6p
Unemployment	1,4p	1,5p	3,4	0,3	0,6	2,0	1,7p	0,1	1,3	1,1	2,6p	2,0p	0,5p	1,1	0,4p	0,2p	1,0	0,7	0,6	1,4p	1,6	0,6	1,3	0,4	0,7p	0,5p	2,2	1,6p	0,6p
Old age and survivors	11,9p	12,0p	13,5	7,7	7,8	10,7	12,2p	5,5	4,6	12,1	8,4p	12,9p	15,5p	8,3	5,7p	5,7p	7,3	9,2	9,5	11,4p	13,4	11,5	11,7	6,2	10,1p	6,9p	9,6	12,1p	11,6p
Housing and Social exclusion n.e.c.	0,9p	0,9p	0,6	0,4	0,6	1,5	0,8p	0,1	0,6	1,1	0,4p	1,2p	0,1p	1,3	0,2p	0,2p	0,6	0,7	0,5	2,0p	0,4	0,3	0,3	0,2	0,6p	0,6p	0,8	1,1p	1,6p
Administration costs	0,8p	0,8p	1,0	0,4	0,6	0,8	1,0p	0,2	1,3	0,6	0,5p	1,3p	0,7p	0,3	0,3p	0,4p	0,3	0,5	0,2	1,5p	0,5	0,4	0,5	0,2	0,5p	0,6p	0,8	0,7p	0,5p
Other expenditure	0,2p	0,2p	0,4	0,1	0,0	:	0,1p	:	0,0	0,0	0,0p	0,6p	0,2p	0,1	0,1p	0,0p	0,1	:	:	0,4p	0,4	0,0	1,0	0,0	0,0p	0,0p	:	0,0p	0,0p

* including administrative costs; e: Eurostat estimate; p: provisional

Context 8a: Adults aged 18-59 living in jobless households by household types, 2006, in % of total number of adults living in jobless households

	EU27	EU25	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
Alone without children	23,1	24,1	32,2	15,3	23,2	:	38,5	31,8	:	19,0	11,5	30,3	18,2	15,2	19,0	26,7	33,3	15,9	12,1	41,9	36,0	14,3	14,3	11,5	29,4	11,8	48,5	:	27,2
Alone with child(ren)	10,3	10,9	14,9	3,9	12,9	:	12,1	12,0	:	3,6	5,6	10,7	3,4	11,8	5,4	10,7	6,1	6,2	10,6	11,7	5,6	7,9	6,2	3,8	5,5	4,0	3,1	:	23,5
Couple without children	22,0	22,1	25,2	19,5	24,0	:	22,5	15,5	:	28,1	14,4	28,9	19,4	30,3	13,6	6,9	31,4	21,9	17,9	24,4	24,4	21,9	22,3	21,0	27,6	19,1	25,3	:	16,6
Couple with child(ren)	15,6	15,0	9,6	19,6	14,5	:	17,4	13,5	:	10,2	20,3	15,3	15,0	18,3	15,8	12,0	12,2	19,4	26,7	14,0	16,3	14,9	14,1	24,3	9,6	16,8	11,2	:	15,4
Other households without children - total	20,0	19,8	11,5	22,0	19,4	:	6,9	19,0	:	33,7	37,7	10,8	34,5	20,9	30,0	30,2	12,7	23,8	28,4	7,6	13,2	25,2	33,5	21,5	23,6	26,2	11,0	:	12,0
- without elderly (65+)	9,5	9,5	6,3	8,9	8,3	:	3,6	4,1	:	13,3	13,8	5,4	16,1	10,4	8,6	9,0	7,1	10,6	11,6	4,8	5,9	12,2	12,7	11,0	11,6	12,4	3,5	:	7,1
- with at least 1 elderly (65+)	10,4	10,4	5,2	13,1	11,2	:	3,3	14,9	:	20,4	23,9	5,4	18,4	10,5	21,4	21,2	5,6	13,2	16,8	2,8	7,3	13,0	20,8	10,5	12,0	13,8	7,5	:	4,9
Other households with child(ren) - total	8,9	8,1	6,5	19,7	5,9	:	2,6	8,2	:	5,5	10,6	4,1	9,4	3,5	16,2	13,4	4,3	12,8	4,4	0,4	4,5	15,8	9,7	17,9	4,3	22,1	0,9	:	5,3
- without elderly (65+)	6,9	6,4	5,6	13,6	4,6	:	2,3	3,6	:	3,6	7,3	3,5	7,8	2,3	12,6	6,0	3,5	10,7	3,0	0,2	3,5	11,6	7,1	11,3	3,7	18,7	0,7	:	4,6
- with at least 1 elderly (65+)	2,1	1,7	0,9	6,1	1,2	:	0,2	4,6	:	1,9	3,3	0,6	1,6	1,2	3,6	7,4	0,8	2,2	1,4	0,2	1,0	4,1	2,6	6,6	0,5	3,5	0,2	:	0,7
Total number in 1000	19386,3	17763	799,9	482,1	437,256		581,56	44,4749		467,909	233,7121	3486,4	2912,8	20,3106	87,6593	126,44	17,52665	640,3	15,38	217,5	406,1	2835	337,8	1142	84,94	305,3	276,7		3427,1

Source : Eurostat - European Labour Force Survey 2006, Spring results. Annual averages for FI.

Context 8b: Children aged 0-17 living in jobless households by household types, 2006, in % of total number of children living in jobless households

	EU27	EU25	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
Alone with child(ren) - no elderly	44,6	47,5	61,6	15,8	50,8	:	45,0	48,3	:	30,0	26,8	47,2	21,8	56,8	26,8	38,9	49,7	23,2	41,9	57,8	28,2	34,7	33,2	12,9	40,5	12,4	23,2	:	66,5
Alone with child(ren) - at least 1 elderly	0,4	0,3	0,0	1,2	0,3	:	0,2	10,7	:	1,2	0,8	0,3	0,2	1,1	0,0	1,1	0,7	0,1	1,2	0,0	0,2	0,2	1,4	0,6	0,0	0,0	0,0	:	0,3
Couple with child(ren) - total	39,9	38,4	25,4	50,1	35,9	:	48,4	25,6	:	52,5	49,5	44,8	59,2	38,7	41,8	24,6	41,1	52,5	46,4	40,9	58,1	35,7	39,3	58,2	47,8	51,8	73,4	:	26,1
- without elderly (65+)	38,8	37,3	24,8	47,9	35,7	:	48,0	25,6	:	46,2	45,5	43,3	57,5	37,6	36,7	23,0	35,9	51,9	45,5	39,8	56,4	34,7	36,9	57,2	47,3	51,3	72,8	:	25,4
- with at least 1 elderly (65+)	1,1	1,1	0,6	2,2	0,2	:	0,4	0,0	:	6,3	4,0	1,5	1,7	1,1	5,2	1,6	5,2	0,6	0,9	1,0	1,7	0,9	2,4	1,1	0,5	0,5	0,5	:	0,7
Other households with child(ren) - no elderly	15,1	13,7	13,1	32,9	13,1	:	6,4	15,4	:	16,2	22,8	7,7	18,9	3,4	31,3	35,5	8,6	24,2	10,5	1,3	13,5	29,3	26,1	28,2	11,7	35,8	3,4	:	7,0
- without elderly (65+)	10,5	9,9	11,5	19,9	10,2	:	5,8	5,0	:	7,2	15,5	6,0	13,0	1,1	25,8	11,7	6,0	19,3	6,0	0,6	9,2	18,7	15,9	15,8	5,7	28,9	2,3	:	5,7
- with at least 1 elderly (65+)	4,6	3,9	1,5	13,0	2,9	:	0,7	10,3	:	9,0	7,3	1,7	5,8	2,3	5,5	23,7	2,6	5,0	4,5	0,7	4,2	10,7	10,2	12,5	6,0	7,0	1,1	:	1,3
Total number in 1000	7036,67	6438	289,6	189,76	148,0428	59,58677	203,751	18,92742	117,92024	67,10845	63,63202	1261,13	523,48	7,01462	27,52685	36,5547	3,60966	247,037	8,075	69,681	112,52	854,32	85,391	409,05	12,074	129,1	53,446	0	2038,4

Source : Eurostat - European Labour Force Survey 2006, Spring results. Annual averages for FI.

Context 9a. Unemployment traps, 2006

For unemployed persons (previous work at 67% of Average Wage, 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 AW	50	67	50	67	50	67	50	67
BE	86%	83%	75%	77%	72%	73%	76%	75%
CZ	66%	63%	62%	62%	84%	69%	74%	73%
DK	94%	91%	85%	91%	73%	89%	97%	94%
DE	79%	76%	97%	87%	97%	85%	91%	90%
EE	64%	64%	64%	64%	61%	61%	64%	64%
IE	93%	77%	-13%	12%	97%	88%	61%	53%
EL	68%	57%	83%	66%	86%	69%	57%	49%
ES	78%	80%	75%	80%	75%	79%	79%	82%
FR	80%	81%	89%	86%	89%	85%	81%	79%
IT	64%	72%	59%	63%	59%	61%	78%	71%
CY	63%	61%	35%	72%	91%	82%	77%	72%
LV	86%	88%	100%	100%	100%	100%	83%	85%
LT	82%	79%	78%	76%	92%	77%	82%	79%
LU	86%	88%	92%	86%	104%	102%	80%	86%
HU	77%	78%	74%	79%	88%	78%	74%	78%
MT	70%	61%	80%	64%	85%	68%	35%	34%
NL	96%	86%	77%	83%	92%	87%	72%	76%
AT	70%	67%	78%	72%	93%	81%	76%	76%
PL	98%	82%	81%	99%	100%	89%	81%	71%
PT	79%	82%	86%	87%	94%	85%	83%	85%
SI	87%	94%	84%	83%	100%	86%	92%	84%
SK	40%	44%	29%	35%	39%	30%	47%	49%
FI	84%	76%	84%	85%	89%	92%	77%	74%
SE	92%	87%	91%	91%	100%	95%	87%	87%
UK	78%	68%	66%	72%	74%	78%	44%	41%

Context 9b. Inactivity Trap at 67% of AW, 2005

Total increase in effective tax burden with and without childcare costs, Lone parents and two-earner couples with two children

	Lone Parents with two children, no childcare	Lone Parents with two children, with childcare	Two-earner Couple with 2 children, no childcare	Two-earner Couple with 2 children, with childcare
% of gross earnings in new job				
BE	74	76	49	56
CZ	69	84	36	51
DK	85	94	54	67
DE	84	90	52	65
IE	57	123	23	90
EL	16	20	16	26
FR	93	100	29	51
LU	71	77	24	37
HU	45	45	50	63
NL	79	81	37	58
AT	73	81	54	83
PL	64	72	43	51
PT	66	68	23	32
SK	56	73	64	81
FI	70	75	50	63
SE	64	69	30	41
UK	70	85	23	88

Transitions from labour-market inactivity to a full-time low-wage job (67% of AW). Person assumed to be aged 40 with 22 years of employment, children aged two and three. For couples the % of AW relates to 1 spouse only. Assumes full-time centre based care while in work and no childcare costs while out of work. Benefits available only on a temporary basis immediately following the transition into work are not taken into account.

Source: Joint Commission -OECD project using tax-benefit Models

Notes:

AETR = 1 - (change in net income / change in gross income). AETRx% is that part of additional gross earnings that is "taxed away" when moving from unemployment (full-time with previous earnings of x% AW) to full time employent (with current earnings of x% AW). AETRs are measure at the household level and take into account increasing taxes and contributions as well as reduced benefits.

Weekly working hours are 0/40 for the out-of-work/in-work situations.

Results do not take into account national minimum wage legislation. As a result, the "33%" and "50%" scenarios may in fact not be relevant for employees covered by minimum wage rules.

For one earner couple households the first spouse is inactive with 0 earnings. The 'x%' therefore relate to the second spouse only.

For two-earners couple households the first spouse's earnings are held fixed at 67% of AW. The 'x%' therefore relate to the second spouse only.

9c. Inactivity traps, 2006

For inactive persons entering work at 2 different wage levels1, 2006

	Single person, no children		Lone parent		One-earner couple, 2 children		Two-earner couple, 2 children	
moving to % of AW	50	67	50	67	50	67	50	67
BE	66%	65%	75%	71%	68%	65%	42%	47%
CZ	62%	53%	62%	62%	84%	69%	49%	48%
DK	104%	88%	90%	84%	90%	92%	65%	63%
DE	73%	68%	97%	87%	97%	85%	50%	50%
EE	46%	40%	46%	40%	61%	52%	25%	25%
IE	93%	77%	-13%	12%	97%	88%	33%	32%
EL	16%	18%	16%	16%	16%	16%	16%	18%
ES	48%	44%	62%	54%	62%	52%	18%	20%
FR	66%	62%	79%	73%	89%	81%	21%	25%
IT	14%	22%	-10%	-1%	-17%	-8%	40%	42%
CY	68%	52%	56%	75%	126%	96%	6%	6%
LV	61%	54%	100%	100%	100%	100%	45%	41%
LT	39%	37%	64%	55%	85%	71%	19%	22%
LU	80%	67%	88%	69%	82%	89%	16%	20%
HU	44%	43%	51%	49%	69%	61%	5%	13%
MT	71%	62%	81%	64%	86%	69%	35%	34%
NL	98%	85%	77%	74%	93%	88%	41%	44%
AT	70%	64%	78%	70%	93%	81%	25%	30%
PL	67%	59%	50%	75%	68%	66%	52%	50%
PT	41%	37%	58%	55%	58%	57%	18%	20%
SI	71%	73%	84%	75%	100%	86%	68%	63%
SK	28%	29%	35%	34%	47%	38%	22%	24%
FI	84%	72%	62%	64%	89%	92%	31%	32%
SE	92%	77%	65%	63%	100%	95%	29%	30%
UK	78%	68%	66%	72%	74%	78%	40%	38%

Notes:

AETR = 1 - (change in net income / change in gross income). AETRx% is that part of additional gross earnings that is "taxed away" when moving from inactivity (without entitlements to unemployment benefits) to full time employent (with current earnings of x% AW). AETRs are measure at the household level and take into account increasing taxes and contributions as well as reduced benefits.

Weekly working hours are 0/40 for the out-of-work/in-work situations.
Results do not take into account national minimum wage legislation. As a result, the "33%" and "50%" scenarios may in fact not be relevant for employees covered by minimum wage rules.
For one earner couple households the first spouse is inactive with 0 earnings. The 'x%' therefore relate to the second spouse only.
For two-earners couple households the first spouse's earnings are held fixed at 67% of AW. The 'x%' therefore relate to the second spouse only.

Context 9d. Low wage traps - 2006

METR as wage increases by 33% of the AW wage level from two starting low wages

	from 33 to 67% of AW				*from 67 to 100% of AW*			
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
BE	58%	52%	47%	58%	56%	56%	50%	55%
CZ	31%	43%	53%	24%	29%	55%	50%	29%
DK	82%	74%	92%	49%	51%	61%	59%	43%
DE	50%	66%	65%	51%	55%	54%	51%	54%
EE	25%	25%	19%	25%	25%	25%	25%	25%
IE	54%	-34%	77%	23%	30%	84%	57%	30%
EL	20%	16%	16%	20%	41%	41%	41%	41%
ES	26%	19%	17%	26%	29%	27%	25%	29%
FR	64%	96%	111%	37%	35%	25%	23%	33%
IT	34%	-2%	-11%	40%	38%	52%	49%	38%
CY	6%	93%	91%	6%	15%	15%	15%	15%
LV	32%	100%	100%	32%	32%	40%	65%	32%
LT	30%	30%	52%	30%	30%	30%	30%	30%
LU	50%	58%	110%	29%	42%	30%	18%	36%
HU	32%	35%	32%	32%	59%	64%	67%	59%
MT	24%	60%	30%	33%	43%	39%	39%	32%
NL	71%	49%	77%	41%	46%	56%	58%	46%
AT	37%	41%	62%	37%	45%	45%	45%	45%
PL	66%	94%	79%	35%	35%	57%	58%	35%
PT	22%	54%	56%	25%	35%	35%	55%	35%
SI	67%	50%	73%	34%	58%	89%	54%	43%
SK	24%	24%	28%	35%	30%	30%	18%	30%
FI	61%	62%	100%	33%	43%	55%	60%	43%
SE	55%	53%	89%	34%	36%	50%	39%	36%
UK	58%	85%	85%	33%	33%	56%	60%	33%

Notes:

For one earner couple households the second spouse's earnings are varied while the first spouse's earnings are held fixed at 0% AW (inactive).

For two earner couple households the second spouse's earnings are varied while the first spouse's earnings are held fixed at 67% AW.

[1] In computing METRs, weekly working hours are increased by the same fraction as earnings, i.e., it is assumed that hourly earnings remain at weekly AW / 40.

[2] In computing METRs, working hours are held constant at 40, i.e., earnings above 100% AW are a result of increasing hourly earnings rather than working hours.

Context 10: Net income of social assistance recipients as % of the at-risk of poverty rate threshold for 3 jobless households types, 2006

	LT	SK	PT	MT	EE	HU	ES	LV	CZ	BE	PL	LU	CY	FR	SI	AT	DE	FI	SE	DK	UK	IE	NL
single	0,3	0,5	0,5	0,5	0,5	0,5	0,6	0,6	0,6	0,7	0,7	0,8	0,8	0,8	0,8	0,8	0,9	1,0	1,1	1,1	1,2	1,2	1,3
lone parent, 2 children	0,7	0,6	0,7	0,4	0,6	0,9	0,6	1,3	0,8	0,9	0,9	0,8	0,8	0,8	1,0	0,9	1,2	0,9	0,9	1,0	1,2	1,0	1,1
couple with two children	0,7	0,5	0,8	0,3	0,5	0,9	0,4	1,1	0,8	0,6	0,7	0,7	0,7	0,7	0,9	0,8	1,1	0,9	0,8	0,9	1,0	1,0	0,9

Source : Joint EC-OECD project using OECD tax-benefit models, and Eurostat.

Context 11: At-risk-of-poverty rate before social transfers by gender and selected age groups

Before all social transfers except old-age and survivors' benefits

		EU27	EU25	BE	BG(1)	CZ	DK	DK(2)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO(1)	SI	SK	FI	SE	UK
Total population	Total	25ps	26p	28	17i	20	27	28p	25p	25	33	24	24	26	24	21	27	26	23	29	22	21	25	27	24	24p	23	18	29	28	30
	Men	24ps	24p	26	15i	19	26	27p	24p	23	31	23	23	25	23	19	25	24	23	30	21	20	23	27	24	24p	21	18	27	26	28
	Women	26ps	27p	29	19i	21	29	29p	26p	27	35	25	25	27	25	23	29	27	24	29	22	22	26	26	25	24p	25	19	31	30	32
Children aged 0-17 years		33ps	33p	31	21i	31	24	24p	30p	28	39	27	29	36	32	20	30	29	33	44	29	25	36	35	27	34p	25	27	31	33	40
People aged 18-64 ye	Total	24ps	24p	26	15i	19	27	27p	25p	21	29	22	21	24	22	15	24	22	23	29	19	20	23	27	22	21p	21	17	28	27	25
	Men	23ps	23p	25	15i	18	25	26p	24p	21	27	21	20	23	21	13	23	22	22	29	17	18	22	28	21	22p	20	17	27	26	23
	Women	25ps	25p	28	15i	20	28	29p	27p	22	31	22	22	26	23	18	25	23	24	28	21	22	24	26	23	20p	22	17	29	28	27
People aged 65 years	Total	23ps	24p	27	20i	12	34	37p	18p	36	42	28	31	18	24	55	37	34	10	11	23	17	17	12	29	21p	30	13	31	23	38
	Men	20ps	20p	24	10i	9	34	34p	15p	23	37	24	29	17	20	50	25	18	9	7	26	15	12	9	27	15p	23	6	26	12	34
	Women	26ps	26p	29	27i	14	35	39p	21p	42	47	31	33	19	27	59	43	41	10	13	21	19	21	13	31	25p	35	17	35	31	41

Source: SILC 2007, Income data 2006; except for UK, income year 2007 and for IE moving income reference period (2006-2007); (1) BG National HBS 2006, income data 2006 and RO National HBS 2007, income data 2007; (2) with imputed rent data 2006 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

Context 12 already in 2.1

1. Employment rate gap by country of birth, 2005, 2006, 2007 annual averages

	Employment rate gap between persons born inside and outside the country			Employment rates by country of birth									Distribution of the population aged 15-64 by country of birth								
				2005			2006			2007			2005			2006			2007		
	2005	2006	2007	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25	Born in the country	Born in another EU25 country	Born outside the EU25
BE	12,5	12,5	12,7	62,7	57,5	44,2	62,7	56,2	45,2	63,5	57,9	45,2	87,1	5,8	7,1	86,5	6,1	7,5	88,4	5,2	6,5
BG	:	-2,4	2,1	:	:	:	58,6	:	61,8	61,7	:	61,0	:	:	:	:	:	:	:	:	:
CZ	3,4	4,8	-2,3	64,9	59,0	67,2	65,4	58,3	65,2	66,1	61,2	71,4	98,1	1,4	0,6	98,1	1,3	0,6	99,1	0,3	0,6
DK	13,6	14,5	16,0	76,9	72,2	60,1	78,4	70,8	61,5	78,8	74,8	59,6	93,1	1,8	5,1	93,2	1,8	5,0	90,6	1,9	7,5
DE *	14,4	14,9	14,8	67,5	65,5	47,0	69,1	66,3	48,1	70,9	68,2	49,6	89,5	3,4	7,0	89,7	3,5	6,8	89,7	3,6	6,7
EE	-5,3	-4,7	-5,9	63,7	64,1	69,3	67,4	64,9	72,6	68,6	75,4	74,4	85,6	0,9	13,5	85,7	0,9	13,5	86,2	0,6	13,1
IE	:	:	:	:	:	:	68,2	:	:	68,4	:	:	:	:	:	:	:	:	:	:	:
EL	-6,4	-6,6	-5,1	59,6	55,0	67,9	60,5	55,5	68,8	60,9	58,2	67,5	92,0	1,2	6,9	92,5	1,0	6,5	92,3	1,2	6,4
ES	-6,8	-6,9	-4,6	62,5	64,2	70,2	63,8	65,7	71,6	64,9	69,9	69,4	88,0	1,9	10,1	86,4	2,0	11,7	84,9	4,0	11,1
FR	7,9	7,5	7,3	64,1	63,5	53,5	64,7	65,4	54,0	65,5	64,6	55,8	88,4	3,1	8,5	89,0	3,0	8,0	88,5	3,1	8,3
IT	:	-7,3	-7,8	:	:	:	57,9	58,9	66,4	58,0	64,9	66,2	:	:	:	92,4	1,3	6,3	92,0	2,1	5,9
CY	-2,2	-1,6	-0,6	68,1	57,4	75,8	69,3	62,1	75,3	70,8	64,8	75,2	82,9	5,1	12,0	82,7	5,6	11,7	82,3	6,4	11,2
LV	-4,2	-6,0	-5,0	62,8	56,1	68,4	65,7	(62,1)	72,7	67,7	(69,4)	73,1	88,0	1,4	10,7	89,4	1,0	9,6	87,8	1,3	10,9
LT	-5,1	-6,7	-6,4	62,4	:	68,7	63,3	73,2	69,7	64,7	72,3	70,9	(96,3)	(0,2)	(3,5)	95,9	0,4	3,8	95,9	0,4	3,8
LU	-9,4	-8,9	-11,9	59,8	70,7	60,0	60,0	71,2	55,3	59,2	72,9	60,0	59,7	34,6	5,8	59,6	34,4	6,0	58,3	35,6	6,0
HU	-5,8	-3,4	-7,6	56,8	53,1	64,5	57,3	(53,5)	62,4	57,2	(65,7)	62,6	98,2	0,3	1,5	98,3	0,3	1,3	98,5	1,1	0,4
MT	-4,1	-0,5	-3,4	53,7	(48,9)	61,9	54,8	56,1	54,9	55,5	55,8	60,2	95,3	1,5	3,2	95,4	1,7	3,0	95,5	1,4	3,1
NL	14,5	14,2	13,2	75,2	70,2	58,5	76,2	72,5	59,5	77,7	73,1	62,2	86,9	2,5	10,7	87,0	2,5	10,5	87,1	2,7	10,3
AT	7,7	8,2	7,7	69,9	65,3	61,0	71,6	67,8	61,6	72,7	(69,4)	63,0	83,7	4,7	11,5	83,0	4,9	12,1	82,8	5,4	11,7
PL	22,9	19,1	21,7	52,9	29,8	30,1	54,6	36,2	35,0	57,1	30,7	38,7	99,4	0,3	0,4	99,5	0,2	0,3	99,6	0,2	0,2
PT	-5,4	-4,3	-5,8	67,1	65,1	74,5	67,6	:	72,9	67,3	:	73,7	92,9	1,5	5,6	92,6	1,6	5,8	92,3	1,6	6,1
RO	(-1.9)	:	(-4.3)	57,6	:	:	58,8	51,9	:	58,8	67,7	(62,4)	:	:	:	:	:	:	:	:	:
SI	-1,3	-0,2	-0,2	65,9	59,4	67,9	66,6	51,3	68,4	67,8	64,1	68,2	92,1	0,6	7,2	92,5	0,7	6,7	91,9	0,5	7,6
SK	6,4	4,3	-5,6	57,8	49,0	61,6	59,5	54,8	(57,5)	60,7	67,7	(60,9)	99,1	0,7	0,2	99,3	0,6	0,1	99,5	0,4	0,1
FI	11,7	9,2	6,8	68,8	65,4	50,8	69,7	69,4	53,7	70,5	74,8	55,8	96,9	1,3	1,8	96,7	1,4	1,9	96,6	1,4	2,0
SE	13,8	13,5	13,1	74,3	71,8	54,8	75,1	72,5	56,9	76,2	72,7	58,9	86,4	4,6	9,0	85,1	4,6	10,3	84,7	4,7	10,6
UK	7,7	5,9	5,6	72,5	72,1	62,2	72,2	75,1	63,1	72,0	75,4	62,8	88,9	3,0	8,2	88,2	3,1	8,7	87,4	3,7	9,0
EU-27	4,6	2,7	2,6	64,8	65,6	58,2	64,7	66,6	60,4	65,6	68,6	60,8	91,1	2,4	6,4	91,3	2,2	6,4	91,0	2,6	6,4
EU-25	5,1	3,1	3,0	65,2	65,6	58,2	65,1	66,6	60,4	66,1	68,6	60,8	90,6	2,6	6,8	90,8	2,4	6,9	90,4	2,8	6,8
EU-15	7,2	4,7	4,5	67,4	66,2	57,9	66,7	67,1	60,2	67,4	68,8	60,5	88,9	3,1	8,0	89,3	2,7	7,9	88,8	3,2	7,9

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.

2. Distrbution of the population by age and country of birth

	2005									2006									2007								
	Born in the country			Born in another EU25 country			Born in another country outside the EU25			Born in the country			Born in another EU27 country			Born in another country outside the EU25			Born in the country			Born in another EU27 country			Born in another country outside the EU25		
	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	15-24	25-49	50-64	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	19,4	52,8	27,8	10,3	53,1	36,6	13,5	67,0	19,5	19,0	52,5	28,5	11,4	52,8	35,8	14,6	66,1	19,2
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	18,6	51,8	29,6	8,4	49,5	42,1	13,8	70,5	15,7	18,4	51,8	29,8	11,1	49,7	39,1	12,2	71,9	15,8
DK	16,7	52,6	30,6	12,1	55,7	32,3	16,8	68,9	14,3	17,1	52,2	30,7	12,3	56,1	31,6	20,0	64,1	16,0	17,0	51,6	31,4	13,8	55,0	31,2	19,2	63,6	17,2
DE	17,7	53,7	28,7	13,3	59,4	27,3	19,5	61,2	19,3	18,4	53,8	27,8	:	:	:	:	:	:	18,4	53,2	28,4	:	:	:	:	:	:
EE	25,6	52,0	22,4				3,4	47,8	48,8	26,0	51,6	22,3	:	49,1	41,5	2,9	46,7	50,5	25,8	52,3	21,9	:	51,1	42,8	2,5	43,8	53,7
IE	23,3	52,8	23,9	16,5	68,8	14,7				22,5	53,1	24,4	:	:	:	:	:	:	21,9	53,3	24,7	:	:	:	:	:	:
EL	17,1	55,0	27,9	19,2	66,9	13,9	18,4	67,4	14,2	16,8	55,1	28,0	15,8	70,3	13,9	18,5	68,7	12,7	16,2	55,1	28,7	15,3	68,6	16,2	17,5	69,4	13,1
ES	17,6	56,8	25,7	7,8	69,4	22,8	19,6	71,3	9,1	16,9	56,6	26,6	13,7	69,0	17,3	18,3	72,9	8,8	16,5	56,1	27,4	13,3	72,6	14,1	17,6	72,0	10,4
FR	20,5	53,0	26,5	6,4	50,2	43,4	10,7	56,6	32,8	20,5	52,5	27,0	5,5	51,2	43,3	10,6	56,7	32,7	20,4	52,0	27,6	7,2	48,5	44,3	10,1	58,5	31,5
IT										15,7	55,2	29,0	11,8	73,3	14,9	15,1	74,0	10,9	15,7	55,0	29,3	10,5	75,1	14,4	14,5	73,6	11,9
CY	19,5	53,4	27,1	14,2	61,1	24,8	16,9	72,0	11,1	19,6	53,3	27,1	15,4	62,1	22,5	14,6	74,6	10,8	18,7	53,5	27,8	15,3	60,6	24,2	15,4	74,2	10,4
LV	25,2	52,6	22,2	11,3	38,7	50,0	3,4	45,3	51,3	25,0	52,3	22,7	:	42,3	52,4	4,1	46,1	49,9	25,3	52,5	22,2	(6.1)	40,7	53,2	4,2	46,3	49,5
LT	23,2	53,2	23,5				5,7 u	55,4	39,0	23,5	53,0	23,5	:	(72.4)	:	(6.8)	51,5	41,7	23,7	52,8	23,5	:	(59.3)	:	(5.9)	52,2	42,0
LU	21,5	52,2	26,4	9,7	64,9	25,3	14,8	70,4	14,7	21,7	51,0	27,3	9,4	64,8	25,8	15,6	64,9	19,5	21,7	51,7	26,5	9,6	65,9	24,5	16,1	66,3	17,6
HU	18,8	52,1	29,2	12,2 u	40,9	46,9	12,0	63,9	24,1	18,5	51,6	29,9	11,9	61,1	27,0	16,2	59,4	24,5	18,4	51,7	29,9	10,4	62,3	27,3	20,0	58,7	21,3
MT	22,5	50,4	27,1							22,6	50,3	27,1	:	(58.5)	:	(22.1)	67,6	:	22,8	49,8	27,4	:	(57.5)	:	(22.2)	66,7	:
NL	18,4	52,7	28,9	8,9	60,8	30,3	13,1	66,2	20,7	18,6	52,2	29,2	10,2	60,7	29,2	13,2	65,3	21,5	18,7	51,6	29,7	11,2	59,7	29,2	12,4	65,0	22,6
AT	18,4	55,0	26,6	12,0	55,9	32,1	16,2	62,5	21,3	18,6	54,9	26,6	10,4	59,6	30,0	16,2	62,2	21,6	18,6	54,5	26,8	11,0	61,7	27,2	15,6	62,2	22,2
PL	22,6	51,7	25,7				5,8 u	27,6	66,6	22,2	51,3	26,5	:	(25.0)	71,4	(10.6)	33,0	56,5	21,5	51,0	27,5	:	(18.5)	74,3	:	35,1	57,9
PT	18,6	54,3	27,2	22,3	70,5	7,2	15,4	72,2	12,3	18,1	54,3	27,6	18,2	76,6	5,2	15,4	70,6	14,0	17,6	54,3	28,1	16,5	79,1	4,4	14,1	70,6	15,3
RO										21,6	53,2	25,2	:	:	:	:	:	:	21,3	53,0	25,7	:	:	:	:	(77.2)	:
SI	20,2	54,0	25,8	6,3 u	53,1	40,6 u	5,0	58,0	37,0	19,6	53,9	26,5	(6.7)	53,9	(39.4)	6,1	55,2	38,7	19,3	53,8	26,9	:	61,6	(34.3)	5,1	53,3	41,5
SK	23,0	53,2	23,8							22,3	53,0	24,7	(9.2)	46,8	43,9	:	:	:	22,0	52,9	25,1	:	39,7	55,2	:	68,6	:
FI	18,1	50,0	32,0	24,1	61,0	14,8	22,1	64,6	13,3	18,0	49,4	32,5	17,8	70,9	11,4	23,9	61,7	14,4	18,3	48,8	33,0	13,4	73,7	12,9	23,0	60,6	16,3
SE	19,7	49,8	30,5	4,8	48,3	46,9	18,7	63,6	17,7	20,0	49,5	30,5	4,6	48,8	46,6	18,5	62,0	19,6	20,5	49,2	30,3	5,1	47,7	47,2	18,8	61,0	20,2
UK	19,4	52,3	28,3	15,8	59,5	24,7	14,4	64,8	20,8	19,4	51,9	28,7	18,2	60,9	21,0	14,1	64,9	21,0	19,6	51,2	29,2	19,0	61,9	19,1	14,0	65,6	20,3
										:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
EU-27	19,3	53,2	27,5	11,2	57,4	31,4	15,6	63,4	21,0	19,1	53,2	27,7	11,7	61,0	27,3	14,4	65,5	20,0	18,9	52,8	28,2	12,3	61,7	26,0	14,1	65,8	20,2
EU-25	19,3	53,3	27,5	11,2	57,4	31,4	15,6	63,4	21,0	18,9	53,2	27,9	11,7	61,0	27,3	14,4	65,5	20,0	18,8	52,8	28,4	12,3	61,7	26,0	14,1	65,8	20,2
EU-15	18,7	53,6	27,8	11,3	58,1	30,5	16,0	63,9	20,1	18,2	53,6	28,2	11,8	61,6	26,6	14,8	66,1	19,1	18,2	53,2	28,7	12,4	62,3	25,3	14,4	66,3	19,3

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.

3. Distribution of the 15-64 by sex and country of birth

	2005						2006						2007					
	Born in the country		**Born in another EU25 country**		**Born outside the EU25**		**Born in the country**		**Born in another EU25 country**		**Born outside the EU25**		**Born in the country**		**Born in another EU25 country**		**Born outside the EU25**	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
BE	49,5	50,5	51,6	48,4	50,8	49,2	49,2	50,8	46,1	53,9	48,2	51,8	49,1	50,9	47,2	52,8	47,4	52,6
BG	50,5	49,5			55,4 u	44,6 u	48,4	51,6	41,7	58,3	37,8	62,2	48,4	51,6	41,8	58,2	46,6	53,4
CZ	49,9	50,1	49,6	50,4	45,8	54,2	48,9	51,1	45,8	54,2	47,4	52,6	48,9	51,1	44,4	55,6	48,5	51,5
DK	49,3	50,7	45,2	54,8	55,7	44,3	49,8	50,2	50,4	49,6	44,3	55,7	49,8	50,2	43,3	56,7	46,9	53,1
DE	49,8	50,2	47,5	52,5	49,1	50,9	48,8	51,2	52,7	47,3	51,2	48,8	48,8	51,2	52,6	47,4	51,1	48,9
EE	51,6	48,4	52,7	47,3	57,1	42,9	47,4	52,6	35,8	64,2	38,0	62,0	47,4	52,6	33,4	66,6	38,5	61,5
IE	49,8	50,2	48,1	51,9	48,3	51,7	49,7	50,3	:	:	:	:	49,8	50,2	:	:	:	:
EL	50,1	49,9	62,0	38,0	49,2	50,8	49,1	50,9	35,0	65,0	50,1	49,9	49,2	50,8	39,9	60,1	51,4	48,6
ES	49,4	50,6	53,2	46,8	50,1	49,9	49,4	50,6	48,5	51,5	49,4	50,6	49,5	50,5	49,7	50,3	49,0	51,0
FR	50,5	49,5	53,2	46,8	51,0	49,0	48,7	51,3	46,3	53,7	48,6	51,4	48,7	51,3	45,4	54,6	49,3	50,7
IT							48,7	51,3	36,4	63,6	49,6	50,4	48,7	51,3	40,4	59,6	49,8	50,2
CY	50,1	49,9	53,3	46,7	60,6	39,4	50,0	50,0	45,9	54,1	39,3	60,7	50,1	49,9	43,7	56,3	39,8	60,2
LV	51,2	48,8	57,2	42,8	56,5	43,5	46,8	53,2	46,5	53,5	40,5	59,5	47,1	52,9	43,0	57,0	39,5	60,5
LT	51,7	48,3			53,9	46,1	46,8	53,2	54,9	45,1	42,7	57,3	46,7	53,3	49,1	50,9	42,7	57,3
LU	49,2	50,8	49,6	50,4	53,4	46,6	51,2	48,8	50,4	49,6	46,3	53,7	50,5	49,5	51,2	48,8	44,9	55,1
HU	51,1	48,9	56,3	43,7	53,3	46,7	47,4	52,6	41,6	58,4	44,3	55,7	47,4	52,6	44,0	56,0	42,8	57,2
MT	49,7	50,3	53,0 u	47,0 u	47,7	52,3	49,7	50,3	51,8	48,2	44,9	55,1	49,7	50,3	43,2	56,8	48,9	51,1
NL	49,3	50,7	56,1	43,9	50,1	49,9	49,8	50,2	41,9	58,1	49,3	50,7	49,8	50,2	44,1	55,9	48,5	51,5
AT	49,8	50,2	57,5	42,5	50,5	49,5	48,8	51,2	43,0	57,0	49,5	50,5	48,9	51,1	43,2	56,8	49,6	50,4
PL	50,5	49,5	46,8	53,2	53,8	46,2	48,3	51,7	43,8	56,2	37,6	62,4	48,2	51,8	46,4	53,6	37,1	62,9
PT	50,5	49,5	52,1	47,9	52,4	47,6	48,4	51,6	48,0	52,0	48,1	51,9	48,5	51,5	47,5	52,5	47,6	52,4
RO							48,7	51,3	58,0	42,0	65,7	34,3	48,7	51,3	63,4	36,6	54,8	45,2
SI	49,2	50,8	54,9	45,1	49,0	51,0	48,9	51,1	45,1	54,9	51,8	48,2	49,0	51,0	38,3	61,7	53,2	46,8
SK	50,3	49,7	53,3	46,7	53,9	46,1	48,6	51,4	46,4	53,6	37,2	62,8	48,6	51,4	43,1	56,9	53,2	46,8
FI	49,7	50,3	48,3	51,7	53,8	46,2	48,8	51,2	51,2	48,8	43,9	56,1	48,8	51,2	53,2	46,8	46,3	53,7
SE	48,9	51,1	53,0	47,0	50,5	49,5	50,9	49,1	44,7	55,3	49,4	50,6	51,0	49,0	45,5	54,5	48,8	51,2
UK	50,6	49,4	53,1	46,9	51,6	48,4	48,9	51,1	46,4	53,6	48,4	51,6	48,8	51,2	47,4	52,6	48,5	51,5
EU-27	50,1	49,9	51,6	48,4	50,6	49,4	48,8	51,2	47,0	53,0	49,0	51,0	48,8	51,2	47,4	52,6	49,0	51,0
EU-25	50,1	49,9	51,6	48,4	50,6	49,4	48,8	51,2	47,0	53,0	49,0	51,0	48,8	51,2	47,4	52,6	49,0	51,0
EU-15	50,0	50,0	51,6	48,4	50,5	49,5	48,9	51,1	47,1	52,9	49,4	50,6	49,0	51,0	47,5	52,5	49,4	50,6

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.