COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 5.2.2010
SEC(2010) 98 final

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 2010

Supporting document

COM(2010)25 final
SEC(2010)99

TABLE OF CONTENTS

1. SCOPE AND OUTLINE OF THE REPORT

This supporting document was prepared by the Commission services to accompany the 2010 Joint Report on Social Protection and Social Inclusion [Commission proposal: COM(2010) xx]. It provides an assessment of the social situation in the 27 Member States, with special emphasis on the impacts of the economic crisis and Member States' responses to it. Against this background, and in addition to more general topical discourse, specific aspects of social protection and social exclusion of long-standing concern are explored; the sustainability and adequacy of pensions; homelessness and housing exclusion; and the effectiveness and efficiency of healthcare spending.

As this was not a year for formal cyclical reporting by Member States on Social Protection and Social Inclusion, the document draws largely upon material and analysis produced for the Social Open Method of Coordination (Social OMC) under the aegis of the Social Protection Committee (SPC). In 2009, the SPC carried out important work to improve understanding of the context and nature of the policies and reforms that will be needed for successful recovery leading to a sustainable and inclusive social market economy. In the spring and autumn, two reports reviewed the social impact of the crisis and the policy responses of the Member States. The report on *Growth, Jobs and Social Progress* looked back at ten years of the Lisbon Strategy and sought to draw lessons on how the social dimension of the strategy for 2020 could be strengthened (see box at the end of chapter 2). Learning from the experience of Member States in past downturns, the report also points to the long-term challenges that will accompany recovery. Member States' specific reporting on their strategies to fight homelessness and housing exclusion brings a timely focus on a key dimension of social exclusion that has become more acute in the crisis. The SPC adopted a new update of the report on theoretical replacement rates of future pensions. The health chapter is based on previous Joint Reports in this area as well as WHO and OECD work (including the 2008 Joint EC/OECD conference on improving the efficiency of health systems). It also draws on recent Czech presidency conferences on this topic and the 2007 Luxembourg seminar on the rational use of resources in the health sector.

There is a detailed table of contents, but in summary the report is organised as follows. Section 2 contains an overview of the social situation in the Member States, including the effects of the crisis. It considers the importance of social protection and the need to preserve adequate but sustainable protection. It also looks at public perceptions of poverty and separately considers pensions, healthcare and long-term care. Section 3 surveys Member States' policy responses to the crisis and looks at the need for strong policies for inclusion, activation, social services, and minimum incomes both during and beyond the crisis. Section 4 covers the role of the European Social Fund and the European Globalisation Adjustment Fund. Section 5 considers homelessness and housing exclusion in more depth. Finally, section 6 looks at healthcare expenditure, section 7 the sustainability and adequacy of pensions; and section 8 matters of governance.

2. THE SOCIAL SITUATION IN THE EU-27

2.1. The social impact of the crisis

As the EU was been hit by the most severe global recession in decades, strong policy intervention has focused on recovery with automatic stabilisers playing a major role in absorbing the shock and in mitigating the economic and social consequences of the crisis. However, the human costs of the crisis are difficult to evaluate fully as yet. Despite the prospect of economic recovery, the full impact of the crisis on labour markets and public finances is still unfolding and there are risks of jobless recovery.

2.1.1. *Forecast 2009-2010*

The latest economic forecast published by the Commission on 3 November 2009 points to the first signs of economic recovery. The dramatic fall in EU GDP has come to an end. GDP in the European Union is projected to fall by 4.1 % in 2009 and to grow again by 0.7 % in 2010 and 1.6 % in 2011. However, the full impact of the crisis on labour markets and public finances is still to emerge. Looking ahead, employment is expected to contract by about 2.3 % in 2009 and by a further 1.2 % in 2010, resulting in nearly 8 million job losses over the two years, in contrast to the net job creation of 9½ million during 2006-2008. Unemployment is likely to reach 10.3 % in 2010, and social expenditure may rise from 27.5 % to 30.8 % of GDP between 2007 and 2010.

Public finances have also been hit hard. The total EU government deficit is projected to triple this year (from 2.3 % of GDP in 2008 to 6.9 % in 2009) and to rise further in 2010 to 7.5 %. This deterioration follows in part from the working of automatic stabilisers, not least on the revenue side and from the discretionary measures taken to support the economy.

The scope, magnitude and effects of the crisis vary greatly among the EU Member States. According to the Commission forecast, all Member States but Poland (+1.2 % in 2009) will experience a fall in GDP in 2009, with estimates ranging from -18 % in Latvia and Lithuania to -0.7 % in Cyprus. Gradual recovery is expected for 2010, as GDP growth is expected to turn positive again in two thirds of the EU countries. Among the five largest EU economies, real GDP is expected to contract this year by about -5 % in Germany, -4.7 % in Italy, -4.6 % in the United Kingdom, -3.7 % in Spain, and -2.2 % in France. Of these countries, Germany, France, Italy and the UK are expected to return to positive growth in 2010.

2.1.2. *Labour market trends*

At EU level, employment growth has come to a standstill, with the employment rate contracting in the second quarter of 2009 to reach 64.8 % in the EU-27 as against 66 % one year before. Unemployment rates increased from 6.7 % in March 2008 to reach 9.5 % in November 2009 and could go up to 10.3 % in 2010 if policies and labour market behaviour remain unchanged.

At national level, the impact of the crisis varies greatly. Between the second quarter of 2008 and the second quarter of 2009 employment contracted in most EU countries. It fell considerably – by 4pp or more – in Ireland, Spain and the three Baltic States, but remained stable in Germany, Luxembourg, the Netherlands and Poland.

In some Member States, the rise in unemployment has been especially stark. In Spain it reached 19.4% in November 2009, as against 9.5% in March 08. During the same period it also more than doubled in Ireland (12.9% as against 5.2%), in Estonia (15.2% as against 4%), Lithuania (14.6% as against 4.3%) and Latvia (22.3% as against 6.1%).

Some categories of workers have been particularly hit by the crisis, including the young, the low skilled, employees on temporary contracts, EU mobile workers, migrants and the elderly. Youth unemployment rate reached 21.4% in the EU27 in November 2009 compared with 14.7% at the end of 2007. Since the start of the crisis, the unemployment rate of non-EU workers grew faster than for other workers and reached 18.18.9% in the third quarter of 2009, as against 13.6% one year before.

Data available from a few Member States show that the number of workers with **flexible working time arrangements** varies greatly across countries. In Belgium, 185 000 workers were on reduced time in August 2009 as against 120 000 one year before. In Ireland the number of workers on reduced working time rose from 20 880 in Q3 2007 to 89 250 in Q3 2009. In Austria, similar schemes covered 62 000 workers in June 2009, up from 8 800 in December 2008 (falling to below 40 000 workers in September 2009). In Bulgaria, 20 000 workers have come under a similar scheme since its launch in January 2009. In **Germany**, short-time working was dramatically expanded to cover more than **1.4 million in June 2009**, compared with 50 000 one year before. The results of such differences in scope and magnitude can be seen in the differences in the impact of large GDP drops on unemployment. In Germany, in particular, the significant drop in GDP led only to a moderate increase in unemployment (from 7.2% in August 2008 to 7.6% in November 2009). Luxembourg also notes that the sustained promotion of part time work arrangements may have contained the growth in unemployment rates observed in the last quarter of 2008 and limited the number of unemployed.

2.1.3.   Take-up of benefits

The direct impact of the recession is apparent in the growing number of unemployment benefit recipients during 2008 and into the third quarter of 2009. The crisis has had no clear impact on the percentage of older workers claiming early retirement benefits, apart from upward trends reported in May 2009 in LT, PL and EL.

Table 2.1a: Countries that have reported significant increases in <u>unemployment benefits</u> claimant since the outset of the crisis

AT: +32.6% between 09-08 and 09-09	ES: +46% between 08-08 and 08-09
BE: +7.6% between 08-08 and 08-09	IE: +80% between 09-08 and 09-09
BG: +27.8% between 07-08 and 07-09	FR: +18% between 07-08 and 07-09
CZ: +80% between 08-08 and 08-09	LV: + 98.7% between 12-08 and 09-09
DK: +85% between Q4-08 and Q2-09	LT: +216% between 09-08 and 09-09
DE: +6% between 09-08 and 09-09	LU: +37% between 08-08 and 08-09
EE: +188% between 08-08 and 08-09	

Source: SPC/ISG questionnaire on the social impact of the crisis

The impact in terms of social assistance claimants became clear in the second and third quarters of 2009 (See Table 2.1b). The pressure on last-resort schemes depends both on how

early the crisis hit the different countries, and on the varying coverage and duration of unemployment schemes. Claimant numbers continued to increase in the countries first hit or most affected by the crisis. Pressure on last resort schemes has also started increasing significantly (by more than 10%) in another five countries. In Denmark and Slovakia, this surge followed a period of strong decline. In Hungary, Poland[1], and the UK the percentage dropped slightly.

Table 2.1b: Countries that have reported significant increases in the claimants of social assistance since the outset of the crisis

Countries already reporting a surge in social assistance claimants in spring 2009
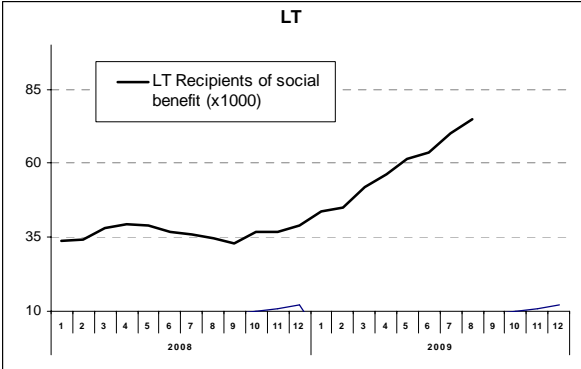
AT: +10.6% between Q3-08 and Q3-09,
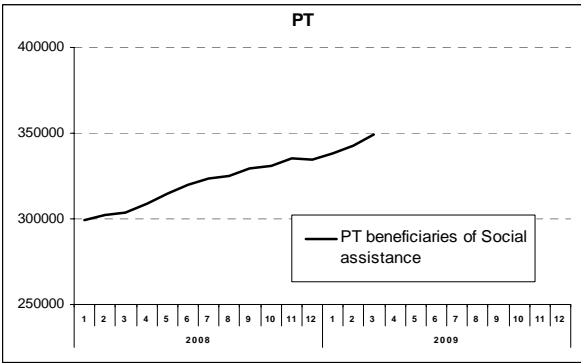
Countries reporting a surge in social assistance claimants in the autumn 2009
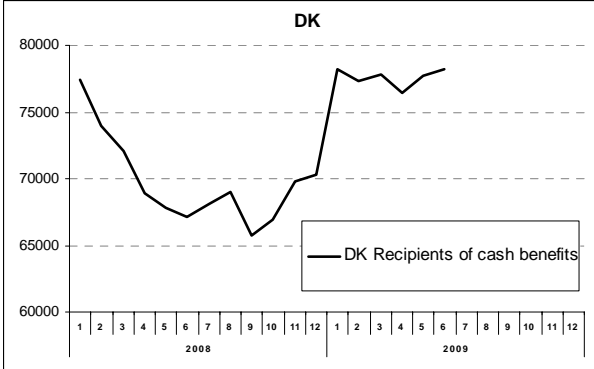
CZ: +11% between February 08 and February 09

CY: +15% between 2008 and September 2009

---

[1]   The reason of social benefits dropping in Poland can be unchanged income criteria for social benefits since 2006 while during last few years the income of Polish households have been noticeably risen (there is particularly observed earnings increase).
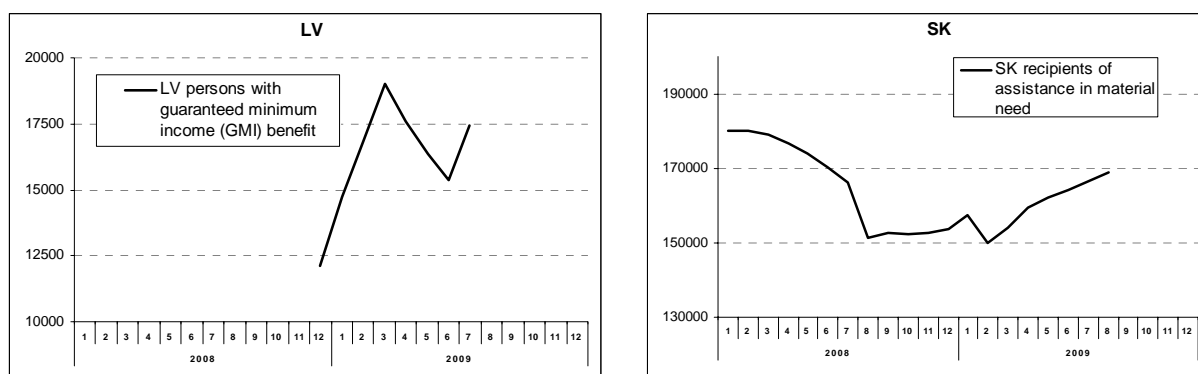
Source: SPC/ISG questionnaire on the social impact of the crisis

2.1.4. *Housing*

The impact of the crisis on housing markets and the housing situation of people varied greatly across the EU. **Housing prices have continued to fall** in Ireland (-18% between Q1-08 and Q1-09), Spain (-8.34 between Q2-08 and Q2-09), and LV (-10% between Q1-08 and Q1-09), NL (-5.6% between August 08 and August 09) and FI (-1.5% between Q2-08 and Q2-09). In the United Kingdom, prices have started recovering after the initial fall observed in 2008 (+7% between January and September 09). **Rents** have increased more than general inflation in BG (+66% between Q2-08 and Q2-09), LV (+23%), and the Netherlands (+2.9%). Increases in the number of **non-performing housing loans** were recorded in Belgium, and Latvia.

The number **of housing repossessions has increased** in Denmark (+46.3% in 2009), Spain (+126% in 2008), Greece (+17% in 2008), Ireland (+30% between June 08 and June 09), the Netherlands (+14.5% between June 08 and June 09) and the United Kingdom (from 10000 in Q2-08 to 11400 in Q2-09). This indicates the potential severity of the crisis, even though repossessions still concern limited numbers of mortgage holders (e.g. 1594 mortgage holders in Denmark, 58686 in ES, 0.38% of mortgage holders in the UK).

In addition, the consequences of repossessions on families vary greatly across Member States, depending on the support mechanisms in place when people lose their homes. The number of beneficiaries of specific support schemes to renters has increased in IE (+41% between Q2-08 and Q2-09) and PT (+40% between June 08 and June 09 even though it concerns a limited number of families benefiting from the Social Integration Income: 21381) as well as the number of beneficiaries of schemes to support mortgage holders in IE: (+144% between Q2-08 and Q2-09). Finally, the **requests and waiting time for social housing have increased** in Ireland, Luxembourg and the UK.

2.1.5. *Over-indebtedness*

Over-indebtedness can be monitored through administrative data on applications for loan arrangements or the number of 'non-performing' loans. Worsening over-indebtedness of households was initially reported in Greece, Latvia, Lithuania, Austria and Portugal. New evidence shows that over-indebtedness and applications for loan arrangements are now increasing in Belgium, Bulgaria, Luxembourg, Austria and (to a minor extent) Portugal. These increases also partly reflect long-term trends in the consumption pattern of households.

According to the spring report, **debts linked to utility bills** have also increased in Lithuania and Latvia. In Latvia, for example, unpaid bills for heating energy at the end of the heating season amounted to 15.8 million *lats*, which is about 66.3 % higher compared to the previous heating season, when debts amounted to 9.5 million *lats*. At the beginning of the 2009 heating season, total unpaid heating bills in Latvia came to 1.63 million lats, about 54 % higher than in 2008. Over-indebtedness has increased in FR and HU, and difficulties in accessing credit are reported in LT and PL.

2.2. Poverty and the crisis in public perception: main results from EU wide opinion polls

According to a Flash Eurobarometer conducted in early July for the European Commission, citizens' perceptions are that the economic crisis has had a serious impact on their lives. Although primarily viewed in this way in some of the southern and eastern European countries, the crisis has also made a deep impression in previously economically sound countries, such as Ireland. Overall, about one fifth of Europeans say their households are facing financial difficulties and a similar percentage say that, on occasion, they have had no money to settle ordinary bills or to buy food in the last 12 months. A quarter of EU citizens expect the situation to get worse in the coming year, while just over half foresee no change and about one in six think that things will improve. The proportion of Danish, Finnish and Swedish citizens who are optimistic about both the present situation and future economic prospects is greater than in the other EU Member States.

Another Eurobarometer survey, carried out in September 2009, sheds some light on the many facets of poverty and social exclusion in the context of the crisis. The survey examined, among other things, people's awareness of the extent of poverty within the European Union, the perceived personal and societal reasons behind poverty, who is thought to be most at risk, if people feel somehow threatened by the possible prospect of poverty, how poverty may prevent people from taking full advantage of society, as well as how easy or difficult they perceive access to financial services to be. People's perception of the urgency of government action to combat poverty is also examined, together with the level of administration felt to be mainly responsible for taking action.

EU citizens are strongly aware of the problem of poverty and social exclusion in today's society: three out of four Europeans (73 %) feel that poverty in their country is widespread. However, the extent to which poverty is seen as widespread differs greatly from country to country. In Bulgaria, Hungary, and Romania 90 % or more of citizens perceive it to be widespread. Conversely, fewer than four in ten think that poverty is widespread in Denmark (31 %), Cyprus (34 %) and Sweden (37 %).

High unemployment (52 %) and insufficient wages and salaries (49 %) are the most widely perceived 'societal' **explanations for poverty**, together with insufficient social benefits and pensions (29 %) and the excessive cost of decent housing (26 %). Meanwhile, a lack of education, training or skills (37 %), as well as 'inherited' poverty (25 %) and addiction (23 %) are the most widely perceived 'personal' reasons behind poverty.

Over half of Europeans (56 %) believe that **the unemployed are most at risk of poverty**, while 41 % believe that the elderly are most vulnerable, and 31 % see those with a low level of education, training or skills as most at risk. Other social categories considered most vulnerable by Europeans are people in precarious employment, people with disabilities, and those suffering from some form of long-term illness.

Close to nine out of ten Europeans (87 %) believe that **poverty hampers people's chances** of gaining access to decent housing, while eight out of ten feel that being poor limits access to higher education or adult learning, and 74 % believe that it damages their chances of finding a job. A majority of Europeans (60 %) believe that access to a decent basic school education is affected, and 54 % believe that the ability to maintain a network of friends and acquaintances is limited by poverty.

While the majority of Europeans do not report difficulties in gaining access to financial services, the picture for the most vulnerable is very different. 70 % of the **unemployed** in the EU find it difficult to get a mortgage according to the survey results, as against 49 % of the general population. A further 58 % of unemployed people, compared with an EU average of 34 %, have problems getting loans, and 47 % find it difficult to get a credit card (the EU average is 27 %). 72 % of Europeans who have difficulties making ends meet find it difficult to get a mortgage, 64 % find it difficult to get a loan, and 55 % find it difficult to get a credit card.

On average, 89 % of Europeans say that **urgent action is needed by their national governments** to tackle poverty. Across Europe, 53 % feel that their national governments are primarily responsible for combating poverty. Even if Europeans do not regard the European Union as primarily responsible for combating poverty, its role is nonetheless seen as important by many (28 % see it as 'very important', and 46 % 'somewhat important').

2.3.   Situation of the Member States' before the crisis: the role of social protection in addressing inequalities and poverty

2.3.1.   At the outset of the crisis the situation of Member States varied greatly

As highlighted above, not all Member States were in the same situation when hit by the crisis. In particular, the size and structure of social protection varied greatly, as illustrated in Figure 2.1. Generally, richer countries spend a larger share of their GDP on social protection, and periods of economic growth had allowed many governments in the EU to devote more resources to social policy intervention. The structure of social protection expenditure shows that old-age pensions and sickness and healthcare benefits represent the bulk of spending in all EU Member States, and have also been the areas where most reforms have taken place. Social protection plays a redistributive role over the life-cycle, insuring people against social risks and helping reduce poverty.

Figure 2.1 Expenditure on social protection benefits - gross, by function, in % of GDP — 2007
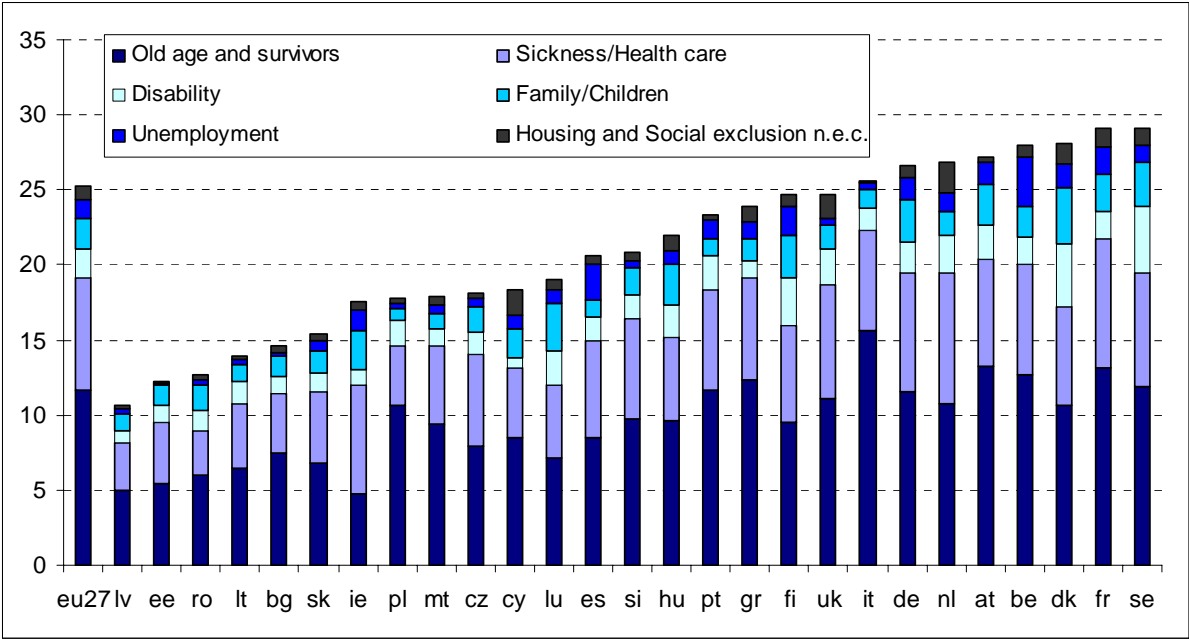
Source: Eurostat – ESSPROS 2007

2.3.2. *Risk of poverty vary greatly across the EU*

In 2008, 17% of the EU population was at risk of poverty, living on less than 60% of the national median income. The aggregate figure hides marked differences across Member States, ranging from 9-12% in the Czech Republic, the Netherlands, Slovakia, Denmark, Hungary, , Austria, , Slovenia and Sweden to 20-26% in Spain, Greece, Lithuania, Bulgaria Romania and Latvia. However, being at risk of poverty relates to very different living standards across the EU, as illustrated by the large differences in the levels of poverty thresholds apparent in figure 2.2 (right axis). Even when corrected for differences in the cost of living, poverty thresholds are five times higher in the UK at the top of the ranking after Luxembourg (which is clearly an outlier) than in the two countries at the bottom (Romania and Bulgaria).

Figure 2.2: At-risk-of-poverty rate and illustrative value of the at-risk-of-poverty thresholds (single adult household); 2008
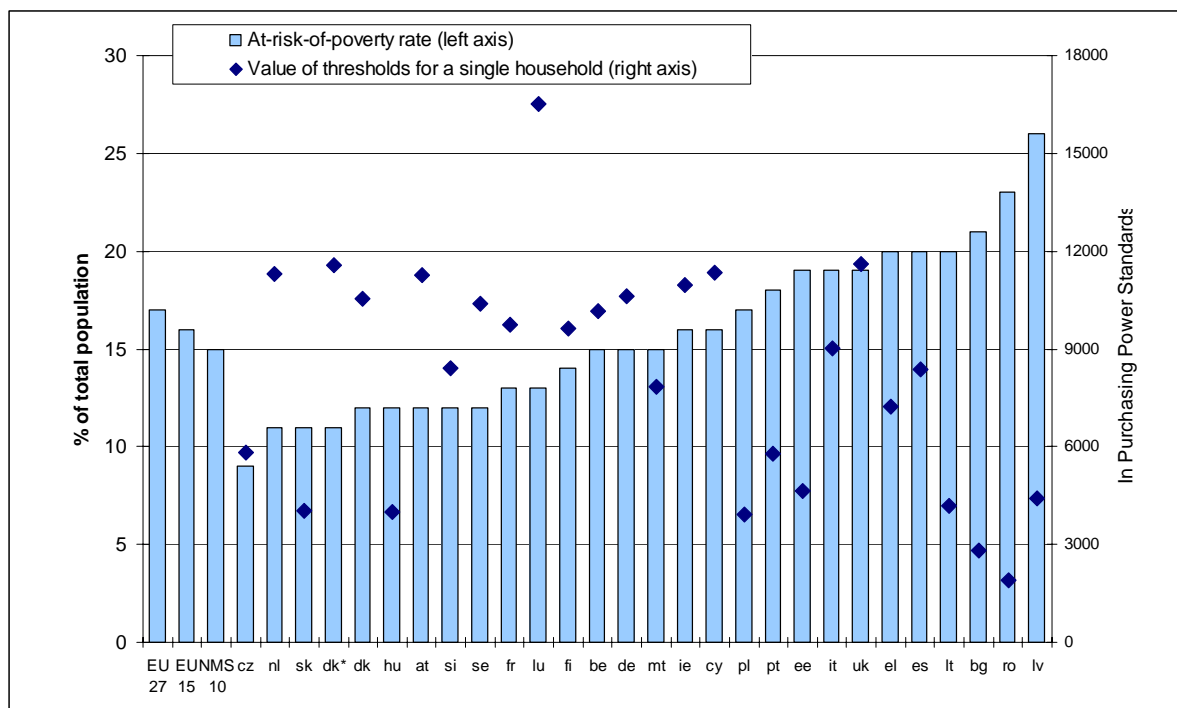
Source: EU-SILC (2008). dk*: values including imputed rent[2]

Over the last decades a shift in poverty risks was observed from the elderly towards younger people. Child poverty remained stable or increased in many EU countries with some exceptions (CZ, EE, IE, LT, PL - see figure 2.4), while poverty risks generally decreased for the elderly as a consequence of the maturing of pension systems (including reforms of minimum pensions). Today, both children and the elderly[3] face a risk-of-poverty of 20% and 19% against 17% for the overall population. However, age patterns of poverty differ across countries.

---

[2]   Two values are presented for Denmark, with and without imputed rent. See footnote below and methodological note in annex.

[3]   To evaluate the relative position of older people, only monetary income (notably deriving from pensions) is taken into account. The wealth of pensioners, in particular house ownership (and associated imputed rents), private savings, private pensions, or specific housing supplements which have a strong effect on the income distribution of pensioners, are not taken into account, nor are other non-monetary benefits (free healthcare, transport, etc.). For this reason, the poverty risk of older people may be somewhat overestimated. The possibility to include imputed rent in the definition of income will be examined by the ISG in the coming years.

Figure 2.3: At-risk of poverty rate by age group, 2008
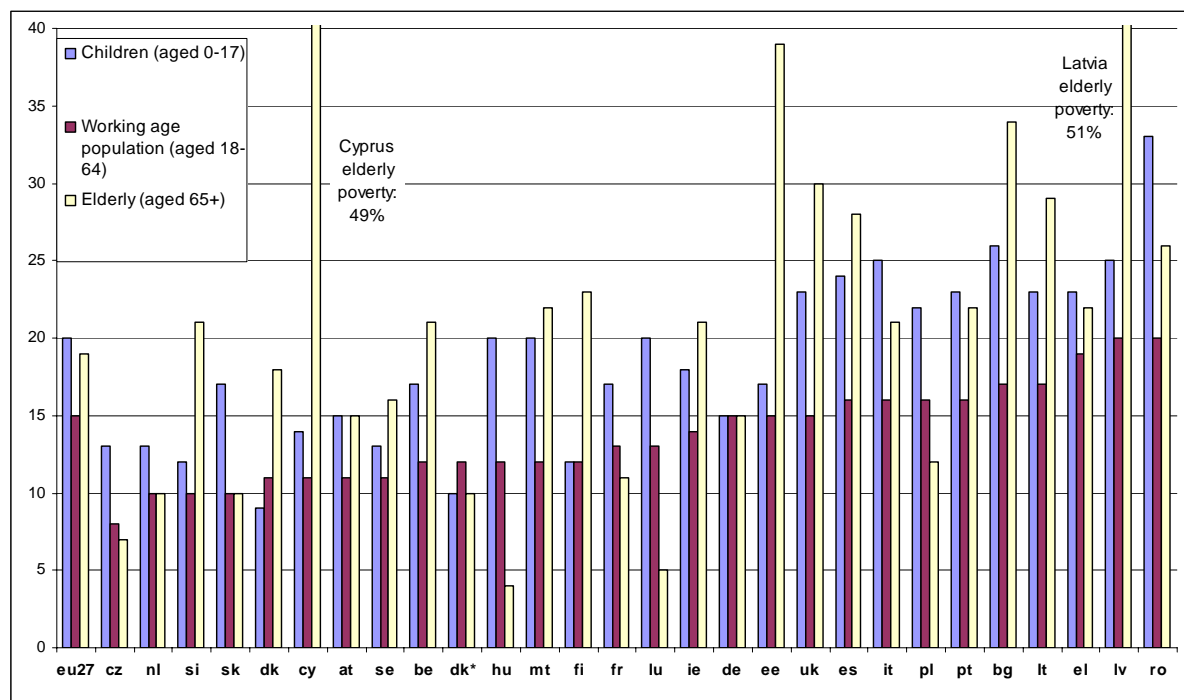
Source: EU-SILC (2008). dk*: values including imputed rent

2.3.3. *Poverty trends across countries and age groups*

As the 2008 SILC data becomes available it is now possible to observe first evolutions in at-risk-of-poverty rates. Figure 2.4 presents the evolution of the at-risk-of poverty rate for the EU-25 and 25 Member States separately. The analysis excludes Romania and Bulgaria for which EU-SILC comparable data are only available starting from 2007. It has to be kept in mind that at-risk-of-poverty rates figures are subject to confidence intervals of 1 percentage point at the most aggregated level, and therefore changes over time are only meaningful for changes of more than 2 to 3 percentage points (depending on the breakdown). At EU-25 level, the at-risk-of poverty rate remained at 16% between 2005 and 2008, at 16%, and over the period both children and the elderly experienced risks of poverty by 3 percentage points higher than the overall population, with child poverty increasing slightly from 19% to 20% in 2008.

This overall stability at EU level hides great diversity. When looking at the old Member States (EU-15) and the Member States who joined in 2004 (NMS10) separately, the data shows that in the EU-15 the elderly (65+) are at higher risk of poverty than both children and working age population (20% against respectively 18% and 15%). This relation remained stable over the period. On the contrary, in the NMS10 they experienced much lower risks of poverty in 2005 than children and the working age population (8% against 25% and 17% respectively). This reflects partly the age orientation of social protection in these countries where pensions used to appear relatively generous compared to weak support to families with children. During the period, the relative situation of children and the elderly evolves rapidly, with the child at-risk-of-poverty rate dropping by 5 percentage points and the elderly risk of poverty rate increasing by 4 percentage points.

In most of the old EU-15 Member States, the risk of poverty remained rather stable for all age groups. Exceptions are in Germany, Finland and Sweden where it increased for all age groups, while in Greece and France it increased for children while it was decreasing the elderly. Ireland, and to lesser degree Portugal are the only countries to have reduced the risk of poverty for all age groups between 2005 and 2008.

This first insight in recent trends calls for further analysis, especially of the reforms that were implemented in EU countries during the period. The supporting document to the Joint Report 2009 contains interesting elements drawn from the National Strategy Reports 2008-2010 and the SPC report on minimum income provision for the elderly[4] that could support this analysis, but would need further elaboration. It lists new measures taken in the area of child poverty, and it provides information on the recent evolution of pension systems that could help explaining the strong trends observed for both children and the elderly in some countries.

Large increases in the at-risk-of poverty rate of the elderly have been observed in a number of Member States, especially in those that have experienced strong economic growth, accompanied by a strong increase in wages in the years before the crisis. Further analysis would be needed to fully understand the deterioration of the relative situation of the elderly in these countries. However, there are indications that where pensions were indexed to prices and not to wages, at-risk-of poverty rates for the elderly have increased dramatically. In some MS, however, some of the impacts of reforms to improve minimum income pensions and reduce poverty rates may have been dampened by faster increases in the income of the working age population (e.g. ES, CY, FI and UK). In some cases, an improvement of the relative income situation of the elderly may have resulted from a strengthening of pension benefits (e.g. IE). This illustrates that the type of indexation of benefits can significantly influence the evolution of the relative income position of the elderly over time compared to the working age population. This applies specifically to minimum income pensions which play an important role in averting poverty in old age.

Figure 2.4: At-risk-of-poverty rate, total and by broad age groups, by country; 2005-08
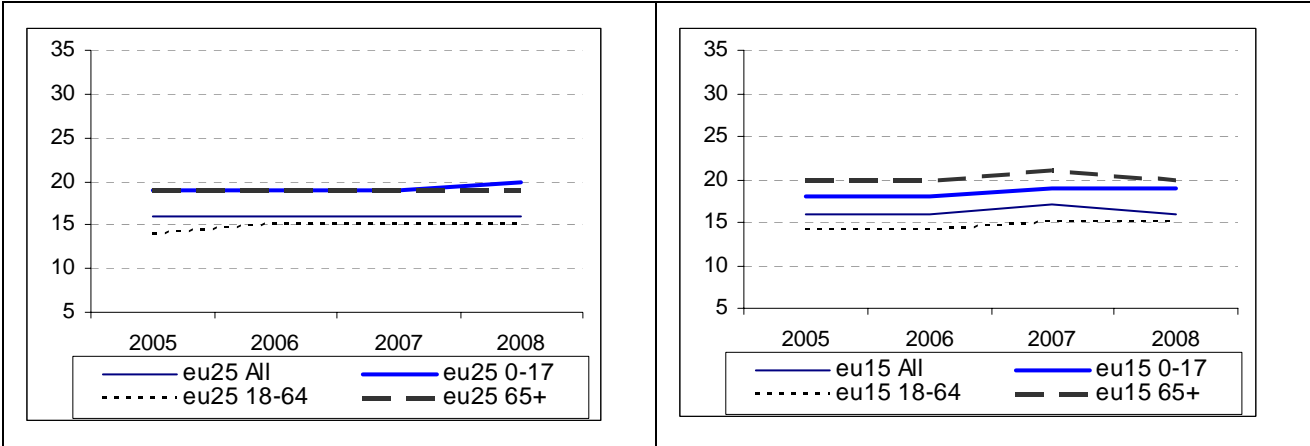
Figure 2.4: At-risk-of-poverty rate, total and by broad age groups, by country; 2005-08

Figure 2.4: At-risk-of-poverty rate, total and by broad age groups, by country; 2005-08

EN   **EN**
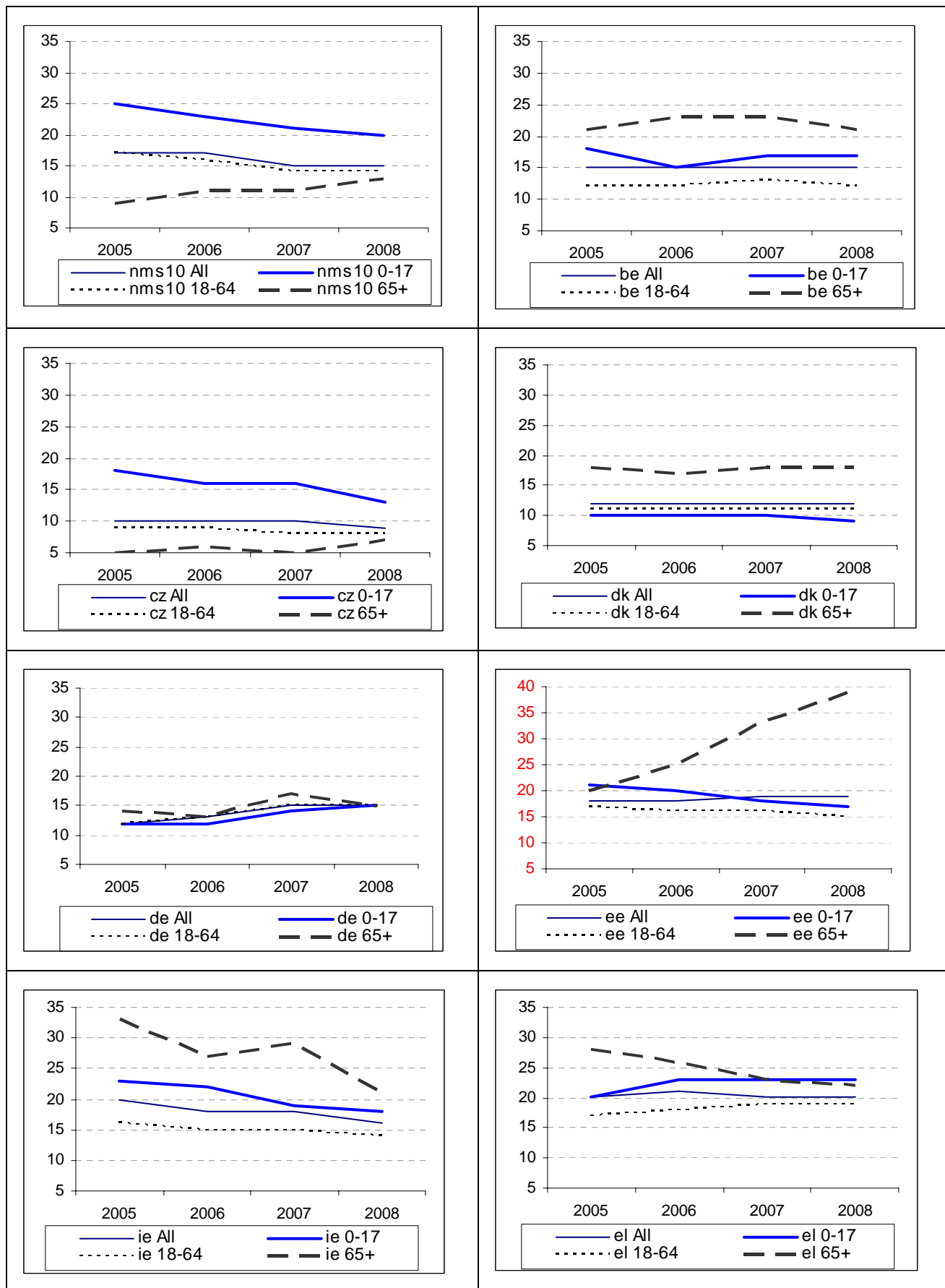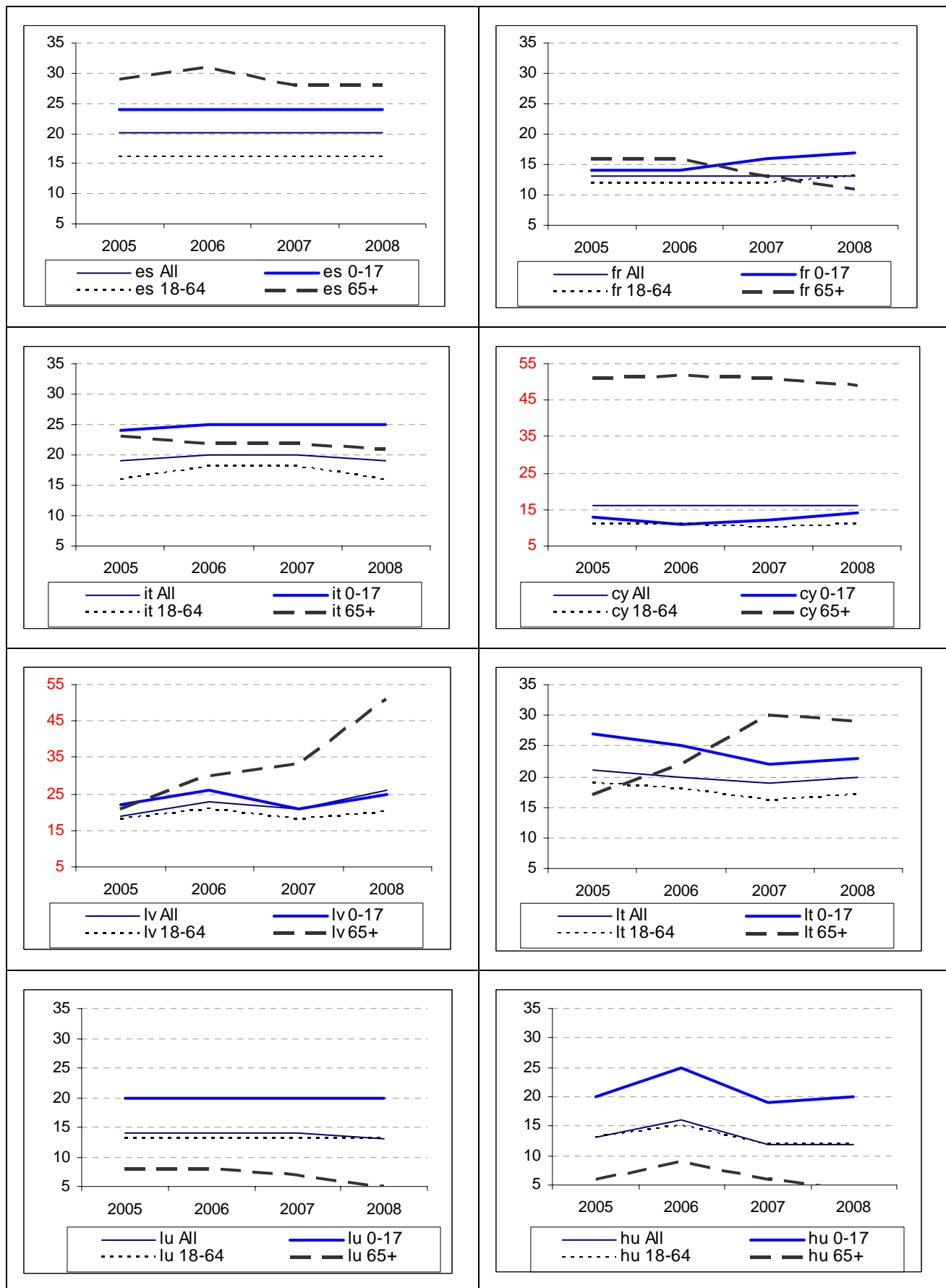
**Figure 2.4: At-risk-of-poverty rate, total and by broad age groups, by country; 2005-08**
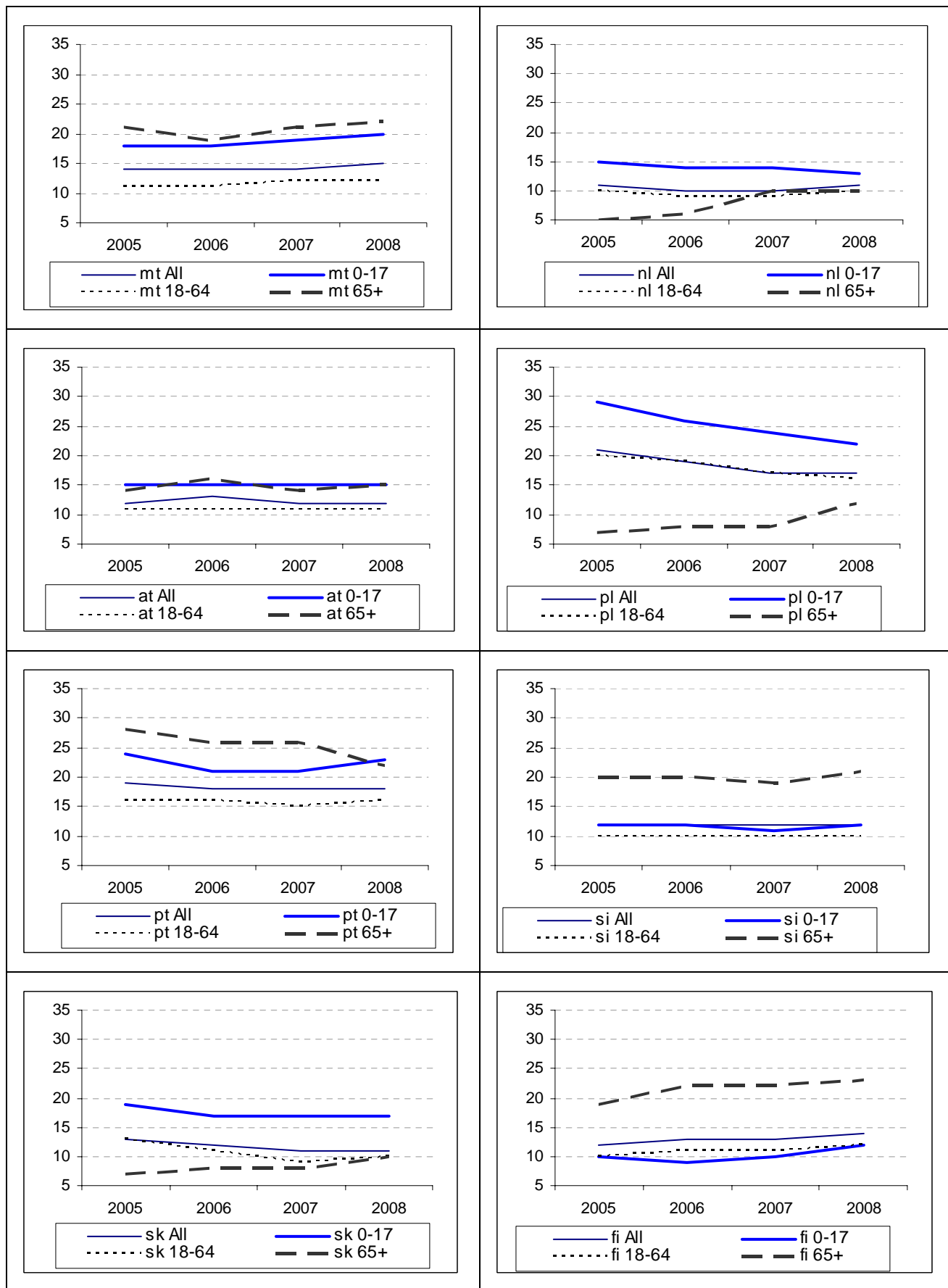
Figure 2.4: At-risk-of-poverty rate, total and by broad age groups, by country; 2005-08
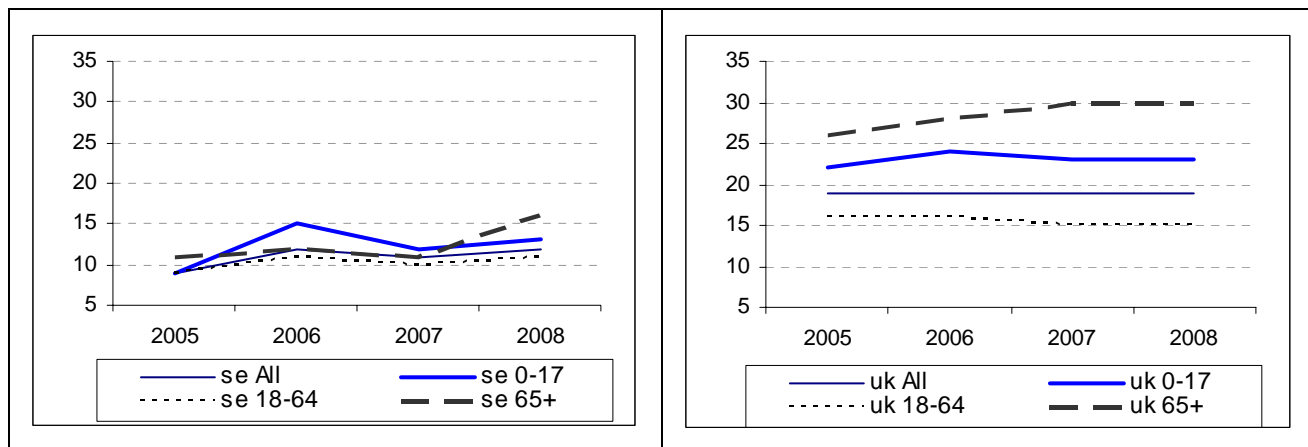

Source: EU-SILC

2.3.4.   Living standards vary greatly across the EU

Material deprivation rates complement the picture given through the at-risk of poverty rates by providing an estimate of the proportion of people whose living conditions are severely affected by a lack of resources. The material deprivation rate provides a headcount of the number of people who cannot afford to pay their rent, mortgage or utility bills, keep their home adequately warm, face unexpected expenses, eat meat or proteins regularly, go on holiday, or cannot afford to buy a television, a washing machine, a car or a telephone[5].

17% of Europeans live in these difficult conditions. However, in Bulgaria, Latvia, Hungary, Poland and Romania more than 30% of people are affected. The material deprivation rate complements the at-risk of poverty rate by reflecting the differences in living standards across the EU, as it,, depends as much on the level of development of the country as on the social policies operating redistribution. These disparities in material deprivation rates reflect the large differences in GDP per capita that remain between EU countries. This emphasizes that the fight against poverty in the EU will benefit from a greater economic growth as well as from greater territorial cohesion within the EU.

---

[5]   The indicator recently adopted by the social protection committee measures the percentage of the population that cannot afford at least 3 of the 9 items quoted above.

Figure 2.5: At-risk-of poverty and material deprivation rates (%) and at-risk-of-poverty thresholds (€PPS per year for a single household); 2008
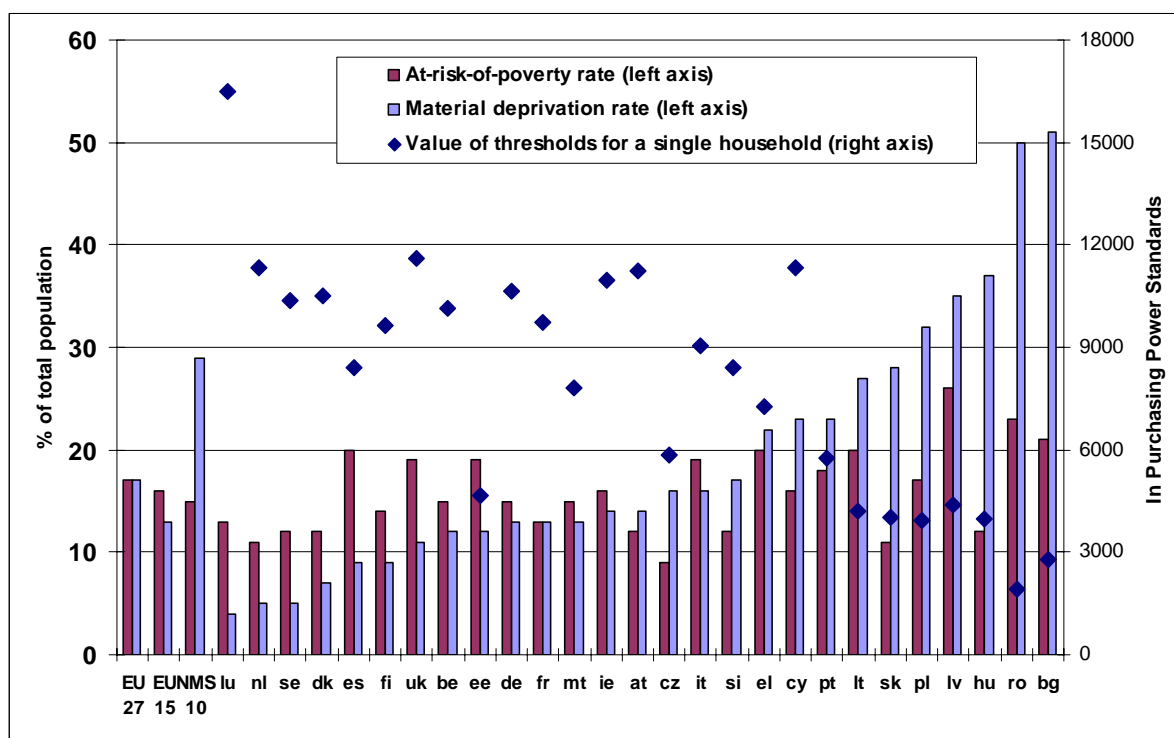
Source: EU-SILC (2008). Material deprivation data for Denmark refers to 2007

2.3.5. The evolution of inequalities and poverty in the last decade

The design of the tax-benefit system is crucial in determining the way and extent to which it affects income inequalities and redistributes resources to the poor. Important features include the progressivity of taxes and benefits and the degree of targeting and conditionality of benefits, which can create disincentive effects, if badly designed. Available evidence highlights the large variation across Member States in net cash support for low-income households. EU data show that social transfers other than pensions effectively reduce poverty risks but the degree to which they do so varies substantially across Member States (ranging from a poverty reduction effect of 50% or more in some countries to one of 17% or less in others). This largely reflects differences in the size of expenditure, which varies from 12% to 30% of GDP, but the composition of expenditure, the quality of interventions, and, more broadly, the efficiency and effectiveness of social protection also play an important role.

Figure 2.6 – Impact of social transfers (excluding pensions) on the at-risk-of-poverty rate for the total population (percentage reduction), 2007
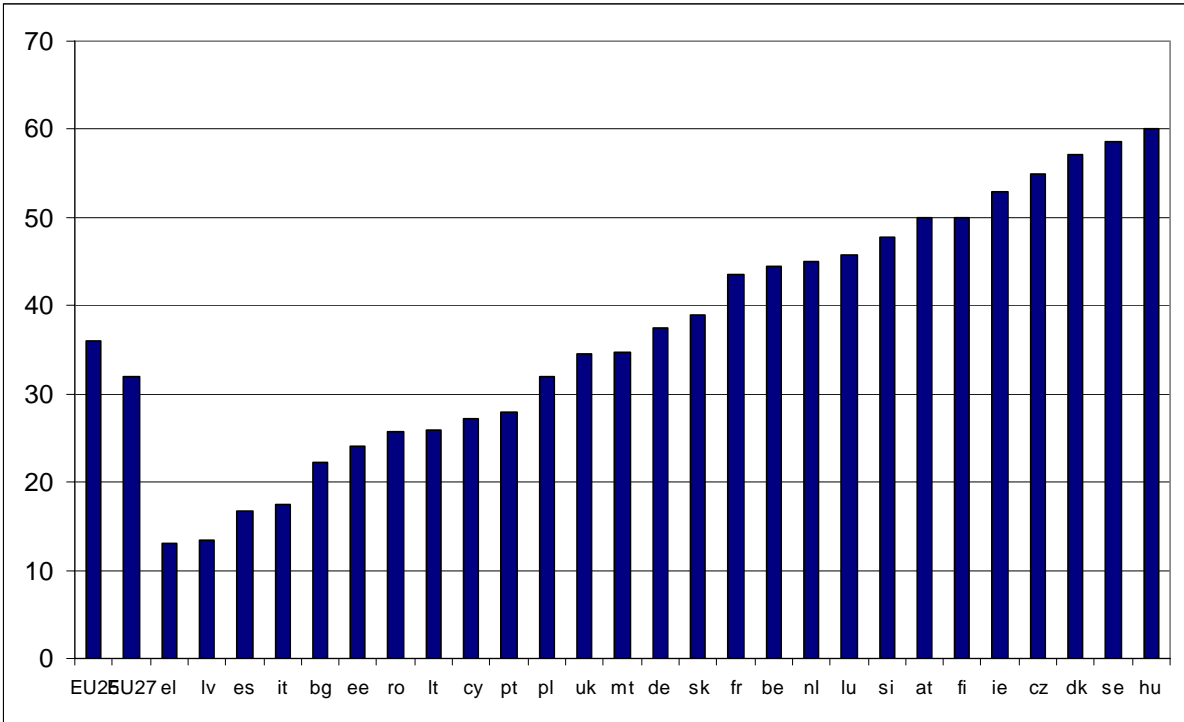
Source: EU-SILC 2008

Despite the clear redistributive effect of social protection, inequalities have often increased and poverty and social exclusion remain a major issue in most EU countries. **Most increases in inequalities** happened between the mid-1980s and the mid-1990s. Over the last 10 years inequalities have remained stable in most countries, but a few stand out as exceptions. Behind these overall developments, divergent trends were observed at different levels of the income distribution. In most countries, top incomes grew relatively faster than middle incomes. In some countries, low incomes caught up with median incomes, while in other countries inequalities also widened at the bottom of the distribution.

According to national sources gathered by the OECD, **relative poverty risks** increased in most Member States between the mid-1980s and the mid-1990s and in most cases they either increased or remained stable between the mid-1990s and the mid-2000s. Fully comparable EU data available for the last three years confirm the stability of relative poverty, but at the same time show that living standards improved in the new Member States, as measured by **material deprivation rates (Figure 2.7)[6]**.

---

[6] See also SPC report on "Growth, Jobs and Social Progress: a contribution to the evaluation of the social dimension of the Lisbon Strategy", 2009

Figure 2.7: Trends in poverty rates and material deprivation, Total population - 2005-2008
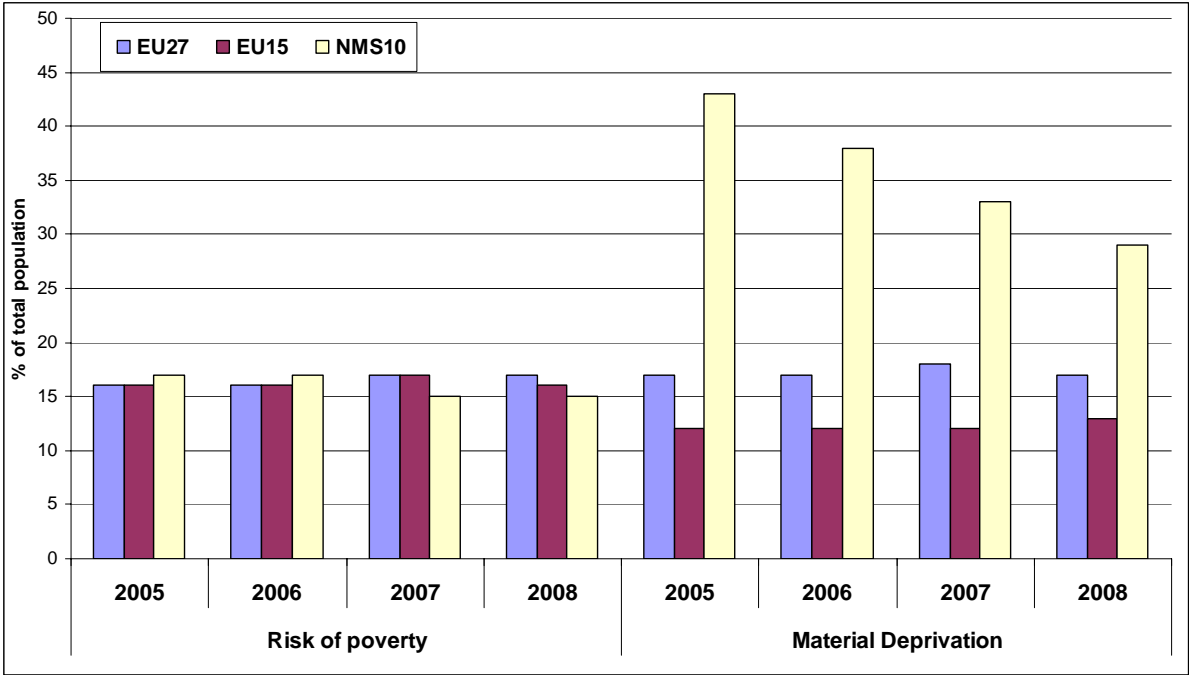

Source: EU-SILC (2008, 2007, 2006, 2005); Without BG and RO

2.4. Employment growth doesn't automatically lead to a reduction of poverty

Significant progress has been made in **raising employment rates across Europe** - especially for women - and also in reversing negative trends such as the decline in the participation of older workers. Indeed, unemployment rates fell significantly in the EU (from 8.7% in 2000 to 7.1% in 2007) while the increased participation of older workers and of women as second earners (notably through the availability of part-time work) has helped to improve the income of many households.

The experience of this decade has confirmed that **having a job remains the best safeguard against poverty and exclusion**, since the poverty risk faced by unemployed working age adults is more than five times higher than those in work (44% against 8%), and the inactive (other than retired) face a risk-of-poverty that is three times higher than that of the employed (27% against 8%).

Figure 2.8: At-risk-of-poverty rate of the unemployed and of the inactive (not retired) vs. people employed, people aged 18+, 2008
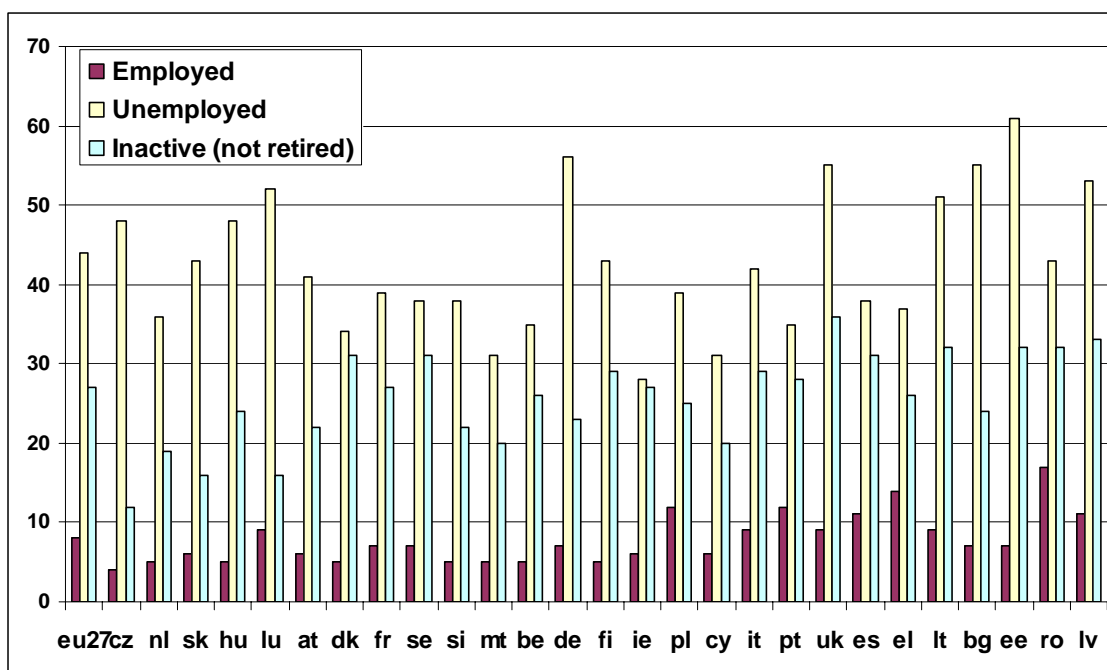
Source: EU-SILC 2008

However, having a job is not always a guarantee against the risk of poverty and the **working poor** represent one third of the working age adults at-risk-of-poverty. In 2008, 8% of the people in employment were living under the poverty threshold. This figure has not improved since 2005. In-work poverty is linked to employment conditions such as low pay, low skills, precarious employment or under-employment.

Figure 2.9: In-work poverty, overall and by type of contract, people in employment aged 18+, 2008
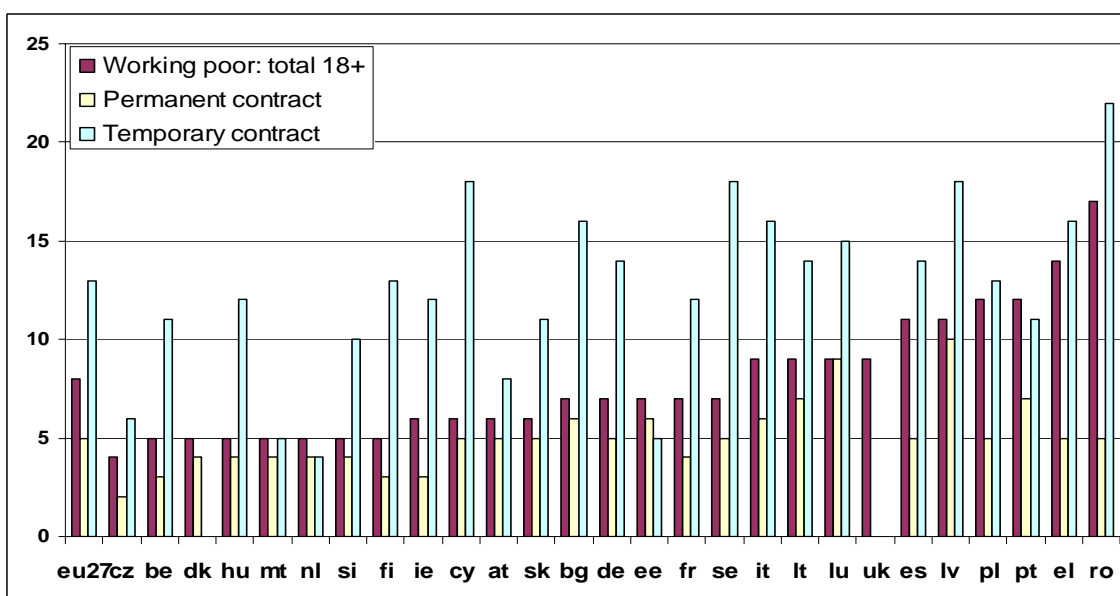
Since 2000, the rise in temporary work (see Figure 2.10), part-time work (including involuntary part-time working) along with sometimes stagnating wages has increased the number of individuals with low yearly earnings. These trends have particularly affected women and the young. In addition, evidence shows that **workers working part-time or on temporary contracts are generally paid less per hour** *after controlling for differences in education and experience*, **and for many, these jobs are not stepping stones towards better jobs**.

Figure 2.10: Increase in the share of workers on temporary contracts, by age 2000-2008, EU27
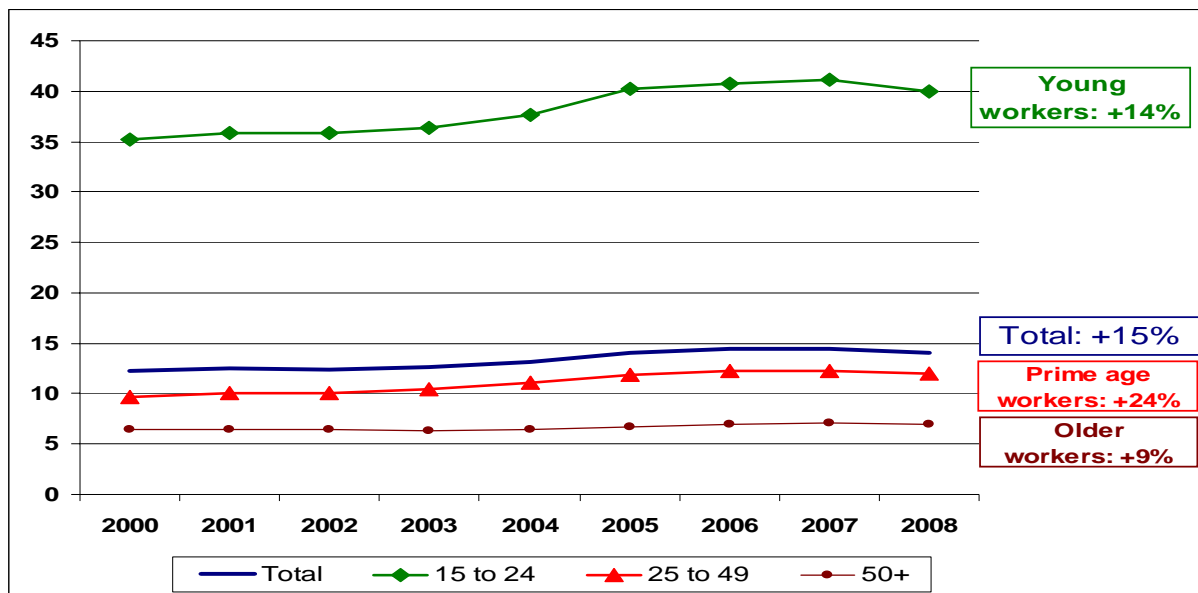
Source: EU - Labour Force Survey

In-work poverty is also related to **low work intensity** in the household, i.e. where there are too few adults in the household working, or working enough, to make a living (too few hours or only part of the year). Among these, single and lone parent households not working full time, as well as one-earner families face the highest risks of poverty.

The last decade has also seen the persistence of **groups of people who remain outside or on the margins of the labour market**, often facing multiple barriers to entry (including low skills, care responsibilities, age, migrant background, disability and other discriminatory factors, etc.). The worst-off are those households in which nobody works. In 20082008 in the EU27, 9.2% of adults of working age and 9.2% of children were living in jobless households as against 10.1% and 10.2% in 2001. The crisis is likely to increase the number of families having to rely entirely on social benefits. In 2008, the percentage of children in jobless households has already started to increase significantly in Ireland (13.1% against 11.5% in 2007), Spain (6.5% up from 5.3%), Italy (6.7% up from 5.8%), Lithuania (9.9% up from 8.5%), and Hungary (14.6% up from 13.9).

Figure 2.11 EU-27 - Employment and unemployment rates and shares of children and adults (aged 18-59 and not students) living in jobless households; 2001-0808 — %
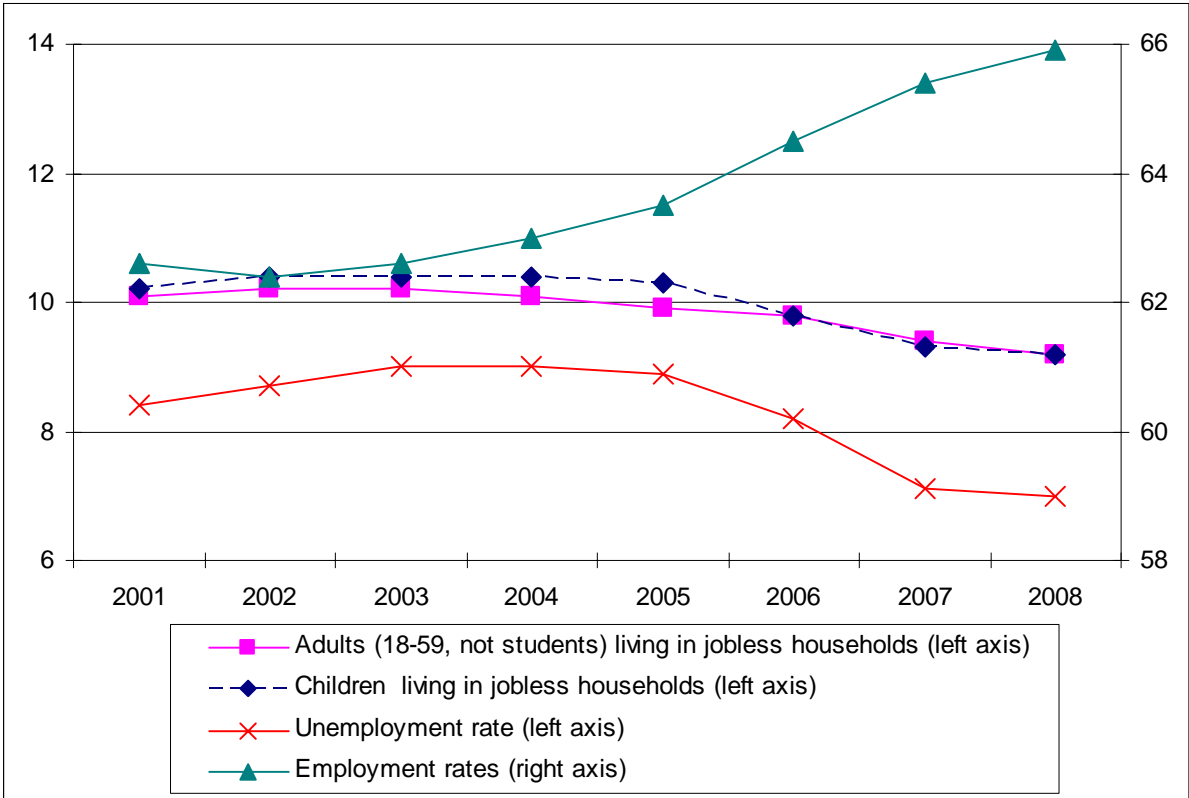
Source: EU Labour Force Survey

National experiences from past crises show that long-term unemployment or inactivity tend to persist long after recovery has set in. In some countries, increasing numbers of people are moving onto long-term sickness and disability benefits or early retirement schemes. Of these people, many are likely never to enter or return to the labour market. Some short-term responses to sudden increases in unemployment can exacerbate these trends and should therefore be avoided.

2.5. The adequacy and sustainability of pension systems

How does the income of the elderly compare to the rest of the population? Currently, pension systems have significantly reduced poverty among older people, though the risk of poverty is higher older people than for the general population and, on average, people aged 65+ have an income which is around 83% of the income for younger people, ranging from 54% in Latvia to more than 100% in Hungary. However, single elderly women still face a much higher risk of poverty than single men.

Figure 2.12: Relative income of the elderly: median income of people aged 65+ as a ratio of the income of people aged 0-64, 2008
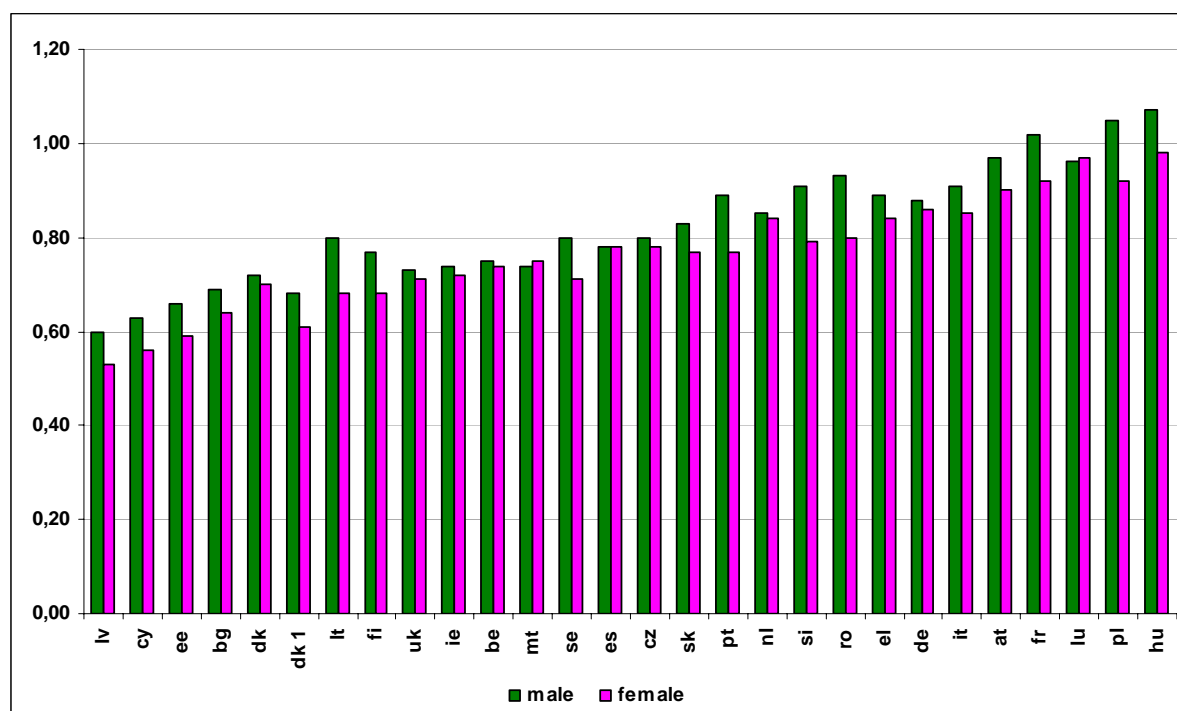
Source: SILC (2008) Income reference year 2007; except for UK (income year 2008) and for IE (moving income reference period 2007-2008).
Note: To evaluate the relative position of older people, only monetary income (notably deriving from pensions) is taken into account. The wealth of pensioners, in particular house ownership (and associated imputed rents) and private savings, which have a strong effect on the income distribution of pensioners, are not taken into account, nor are other non-monetary benefits (free healthcare, transport, etc.). The possibility to include imputed rent in the definition of income will be examined by the ISG in the coming years.

One of the ways to ensure both the sustainability of pension systems and an adequate level of income for pensioners is 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.

The future adequacy and sustainability of pensions can be assessed using theoretical replacement rates. They show how changes in pension rules can affect pension levels in the future. A look at the link between theoretical replacement rates and the evolution of pension expenditure shows that developments in pension promises can involve a heavy future cost in the light of an ageing society, if labour market patterns remain constant. Put more simply, a country with an ageing population which aims to maintain the same replacement rate will inevitably need to devote more resources to pensions. The burden of this could be dampened by increasing the size of available resources, either by increasing employment and/or capital, or minimising administration costs.

Future levels of pensions in relation to earnings (income replacement levels) will depend on different factors, notably the pace of accrual of pension entitlements (which is linked to developments in the labour market), the maturation of pension schemes and the effect of reforms. However, most Member States are in a situation where reforms of statutory schemes will lead to a decrease of replacement rates at given retirement ages. This most probably

reflects of reforms that have lowered future benefit levels at a fixed retirement age in order to cope with increasing longevity and the expenditure this would otherwise entail[7]. As a result many Member States have also increased incentives to work longer. Measures include increasing retirement age, flexible retirement options, increasing contributory periods needed for a full pension, and designing work incentives into pension schemes. These offer ways and means to bring effective retirement age into line with expected increases in life expectancy.

---

[7]   Given that the employment rate has risen, more people will be entitled to pensions in their own right – and thus for instance the need to have high replacement rates for a husband to support his wife in old age has been reduced. It is also important to point out that more people are surviving to receive state pensions and they are receiving them for longer – so while on a year-on-year basis they might be getting lower pensions, when looking at the overall transfer during retirement they might be getting more than previous generations.

Table 2.2: Change in theoretical replacement rates for a worker with average earnings retiring at 65 after 40 years, 2006-2046

	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), 2046	Occupational and supplementary pensions	Type of Occupational or Supplementary Scheme (DB or DC), 2046	Statutory pensions, 2006	Occupational and Voluntary pensions, 2006	Statutory pensions (or in some cases Social Security): Current (2006) and Assumed (2046)	Occupational and voluntary pensions: Estimate of current (2006)	Occupational and voluntary pensions: Assumption (2046)	Evolution of statutory pensions expenditures between 2007 and 2045 (source EPC/AWG)***
BE	4	5	0	DB	5	DC	100	55	16.36	NA	4.25	4,8
BG	15	15	15	DB and DC	/		NA	/	NA	/		2,9
CZ	-21	-16	-16	DB	/		100	/	28	/		1,8
DK	7	20	-10	DB	30	DC	100	78	0.9	8.8	12.7	0,8
DE	1	2	-9	DB	11	DC	90	70	19.5	NA	4	1,7
EE	11	9	9	DB and DC	/		100	/	22	/		0,8
EL	-7	-12	-12	DB	/		NA	/	20	/		8,6
ES	-12	-9	-9	DB	/		89	/	28.3	/		5,9
FR	-17	-16	-16	DB	/		100	/	20	/		1,3
IE	-11	-10	-2	DB	-9	DC	100	55	9.5	10-15	10	3,1
IT	3	-3	-17	DB and NDC	14	DC	100	22(M)/17(F)*	33	5.7	6.91	1,6
CY	14	11	11	DB	/		100	/	16.6	/		6,2
LV	-12	-11	-11	NDC and DC	/		100	/	20	/		2,8
LT	-3	1	1	DB and DC	/		89	/	26	/		4,3
LU	0	-1	-1	DB	/		92	/	24	/		11,1
HU	5	13	13	DB and DC	/		100	/	26.5	/		3,9
MT	-9	-8	-8	DB	/		100	/	30	/		4,7
NL	6	11	2	DB	10	DB	100	91	7	9.8	11.5 -12.5	4,3
AT	5	1	1	DB	/		100	/	22.8	/		1,6
PL	-19	-16	-16	NDC and DC	/		77	/	19.52	/		-0,7
PT	-20	-20	-20	DB	/		81	/	33	/		1,3
RO	52	39	39	DB and DC	/		NA	/	29	/		7,7
SI	2	-4	-4	DB	/		100	/	24.35	/		6,9
SK	2	1	1	DB and DC	/		100	/	28.75	/		2,2
FI	-11	-12	-12	DB	/		100	/	21.6	/		4,2
SE	-13	-13	-11	NDC and DC	-2	DC	100	90	17.2	4.5	4.5	1,8
UK	-4	-2	-3	DB	0	DC	100	53 (M)/56(F)	19.85% (17.25%)	9	8	1,8

Source: ISG calculations done using the OECD APEX model or national models, EPC/AWG projections

*Note: Figures as of June 2008

**Note: Contribution rates used for statutory schemes and also any occupational or private schemes included in the base case, thus providing indicators for the representativeness of the base case. Contribution rates correspond to overall contribution rates as a share of gross wages (for 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 of the breakdown is 10 % from the employee, 10 % from the employer and 10 % from the state. For PL this corresponds to old-age contributions (19.52 % of wages) and disability and survivor's contributions (13% of wages). For PT this corresponds to a general estimate (ratio between overall contributions and aggregate wages declared to social security). In Portugal the TRR will fall partly due to the introduction of the sustainability factor related to life expectancy. It should be noted that the actual pension cuts resulting from the sustainability factor have been lower than previously expected in the 2006 projections. ***Note: AWG projections figures include funded tiers of statutory schemes and statutory early retirement schemes

However, as the work histories required for a full pension are being extended it is important to protect vulnerable groups and cater for career breaks which should not be unduly penalised in the pension system. While the most vulnerable groups are often protected by minimum income provision (see Figure 2.3 above for risk-of-poverty among the elderly), persisting labour market differences between men and women translate into income inequalities in old age. Member States have legislated to equalise pension eligibility ages for men and women to help ensure that women can have a decent retirement income. Furthermore, care burdens, which still mainly fall on women, and the way they result in lower pensions, are being monitored, and an increasing number of countries are beginning to give pension entitlements for care-related absences from the labour market.

Figure 2.13: Accumulated 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 or 3 year career break for childcare compared with no break
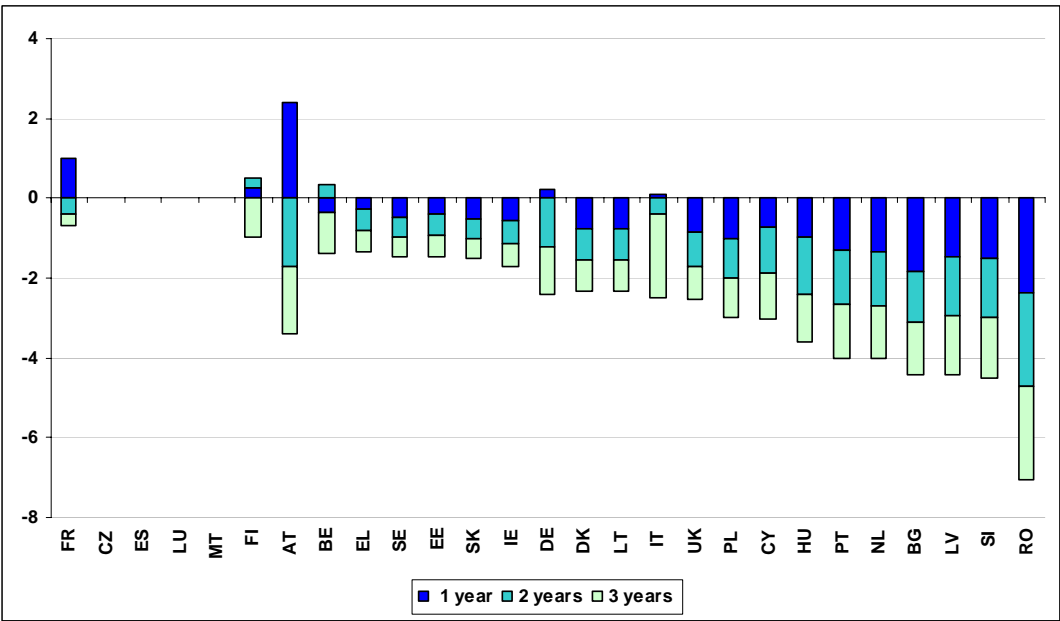
Source: SPC/ISG
Note: the values for CZ, ES, LU and MT are equal to 0 and should not be interpreted as missing.

Given the current economic downturn and increasing unemployment, protecting the pension entitlements of future pensioners during periods of unemployment is also an emerging feature in most pension systems across the EU. The risk of unemployment is well covered by public pension schemes in many Member States. Nevertheless, it is definitely less true for funded pensions and the preservation of pension entitlements during unemployment is typically less generous than for periods of child care. However, it is important to monitor such protection of pension entitlements together with the effects on work incentives in order to prevent becoming a new dependency traps.

Figure 2.14. Accumulated 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 or 3 year career break due to unemployment compared with no break*
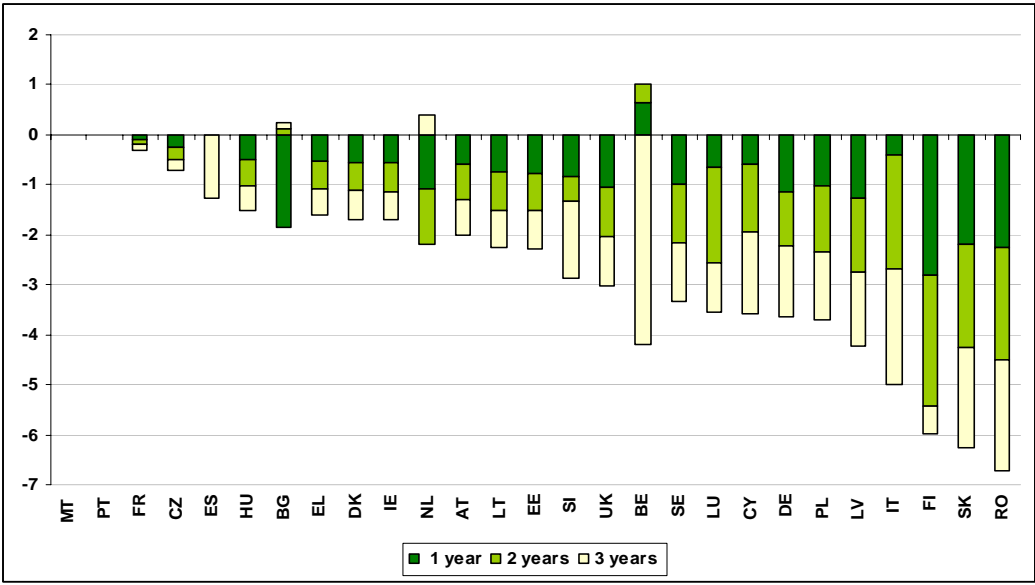
Source: SPC/ISG* The unemployment break is assumed to take place in the years just prior to old age retirement which is assumed here to be the statutory retirement age for men. Note: the values for MT and PT are equal to 0 and should not be interpreted as missing.

2.6.   Health care and long-term care: ensuring sustainability and access to quality services for all

The availability, affordability and quality of health and long-term care systems can strongly contribute to ensuring healthy, independent living and improving labour market participation and productivity. However, there are inequalities in health between and within countries. Between EU Member States there is a 14 year gap in life expectancy at birth for men and an 8 year gap for women. Within Member States differences in life expectancy at birth between lowest and highest socioeconomic groups can reach 10 years for men and 6 years for women.[8]

Spending on health and long-term care represents a significant share of GDP and is on a secular rise. There is a growing share of GDP spent on healthcare in view of ageing, technological development, growing patient expectations and increased risky behaviour (for example, alcohol abuse or obesity in children and young adults). This trend is yet more marked, if combined with low economic growth, low labour market participation and high unemployment which limit increases in revenues. Hence, improving the value for money of healthcare systems through enhancing effectiveness, efficiency and priority setting have been deemed an urgent task.

Member States are in very different positions to face these challenges. In fact, there are substantial differences in health outcomes and health expenditure across the EU, with those reporting lower life expectancy (Bulgaria, Romania, the Baltic states, Hungary) also reporting

---

[8]   Communication from the Commission: Solidarity in Health. Reducing health inequalities in the EU, COM(2009)567/4.

the lowest total health expenditure as a percentage of GDP (Figure 2.15). In many of these countries, out-of-pocket expenditure is a large part of total expenditure (by EU standards), making health care more difficult to access for those who need it most. (Figure 2.16).

Figure 2.15: Total expenditure on healthcare and life expectancy in the EU Member States
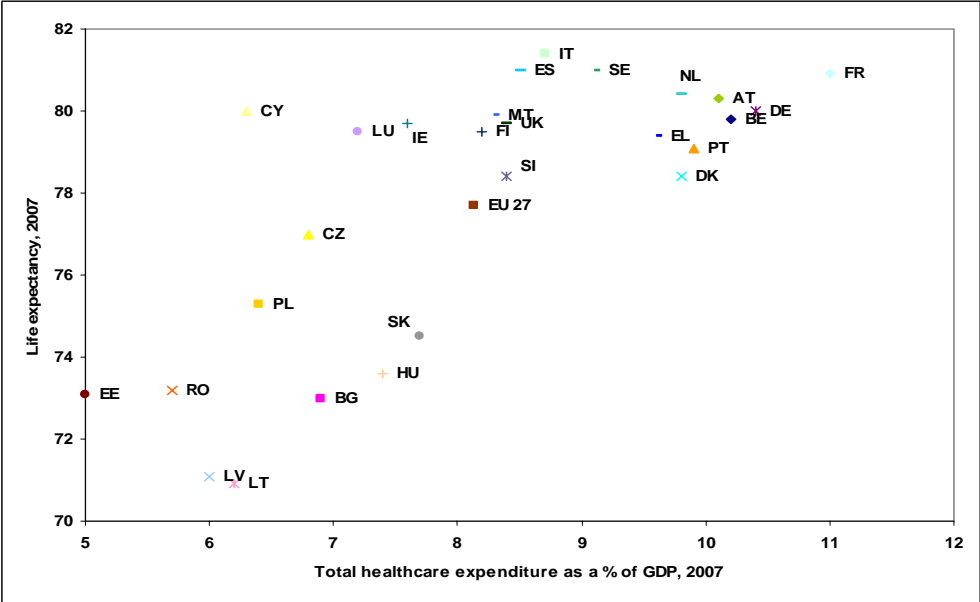
Source: Life expectancy - EUROSTAT 2006 for FR and IT, 2007 for the rest of the EU MS, Total healthcare expenditure as a % of GDP - OECD health data 2007 and WHO health data 2006 for the non-OECD EU MS

Figure 2.16: Out-of-pocket expenditure on healthcare and life expectancy in the EU Member States
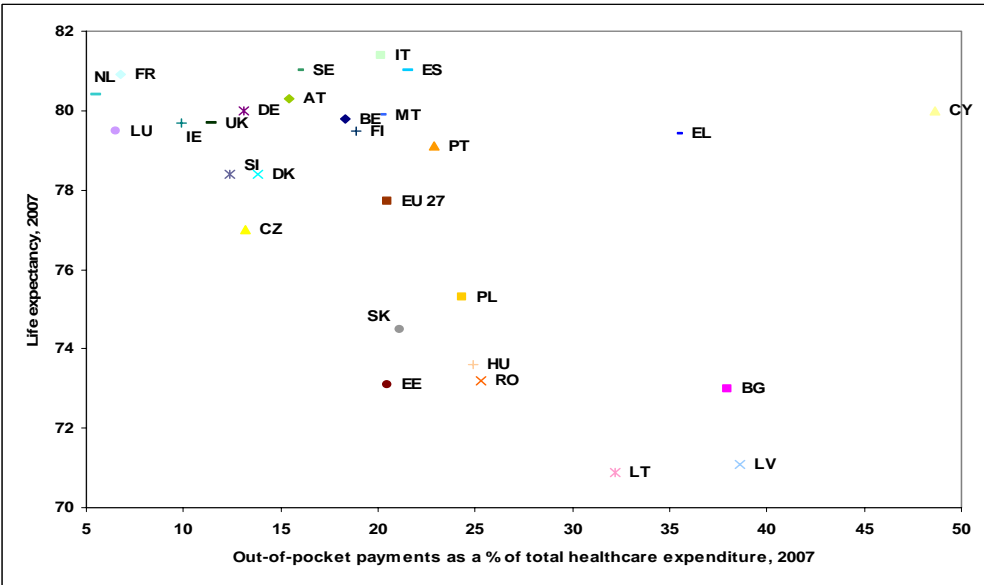
Source: Life expectancy - EUROSTAT 2006 for FR and IT, 2007 for the rest of the EU MS; Out-of-pocket payments as a % of total healthcare expenditure - OECD health data 2007 and WHO health data 2005 for the non-OECD EU MS

The current crisis can place an additional economic constraint in countries where the health and social care sector is already under-resourced, social protection expenditure (as percentage of GDP) is low and the financial situation of households is poor (Baltic States, Romania, Bulgaria in terms of public expenditure) or in countries which have just recently faced a macroeconomic stabilisation programme and where the financial situation of households is reduced (Hungary).

The impact of the economic crisis was felt strongly in some new Member-States (Estonia, Latvia, Lithuania, Romania, Hungary), as well as in older and richer ones (United Kingdom, Ireland and Spain). However, the health care sectors in the new Member-States are more vulnerable to economic crisis than in the UK, Ireland and Spain because the total health expenditure as a proportion of GDP is low (5% in Estonia, 5.5% in Romania, 5.9% in Lithuania, 6.4% in Latvia as compared to 8.4% in United Kingdom, Spain, Hungary, 7.5% in Ireland) and the out-of-pocket payments as a proportion of the total health expenditure are high (38.6% in Latvia, 32.2% in Lithuania, 25.3% in Romania, 22.6% in Hungary, 20.5% in Estonia as compared to 11.9% in UK, 12.4% in Ireland and 21.5% in Spain).

Therefore, the role of private funding in adjusting for public health funding deficits remains a particular concern especially in the newer Member-States, as several of them have increased the amount of out-of-pocket payments.

2.7.   Social protection over the economic cycle

Social protection systems can play a crucial role as automatic stabilisers and sustain the productive capacity of the economy. In some countries, however, there are significant weaknesses and gaps in social safety nets. In others with mature social protection systems to cushion the impact of the crisis, financial sustainability is questioned in the long run. Countries faced with major public finance deficits are left with little room for manoeuvre to address the social consequences of the crisis. This is of particular concern for those who also have weaker levels of protection (e.g. Lithuania, Latvia, Romania). Mapping the at-risk-of-poverty rate of the total population against total social protection expenditure as a percentage of GDP gives a first indication of the importance of social security expenditure in reducing social vulnerability, and also the efficiency of social protection systems in reducing poverty. The graph below also illustrates the different situations faced by Member States at the onset of the economic crisis.

Figure 2.17: Total social protection expenditure and at-risk-of-poverty rate of the total population in EU Member States
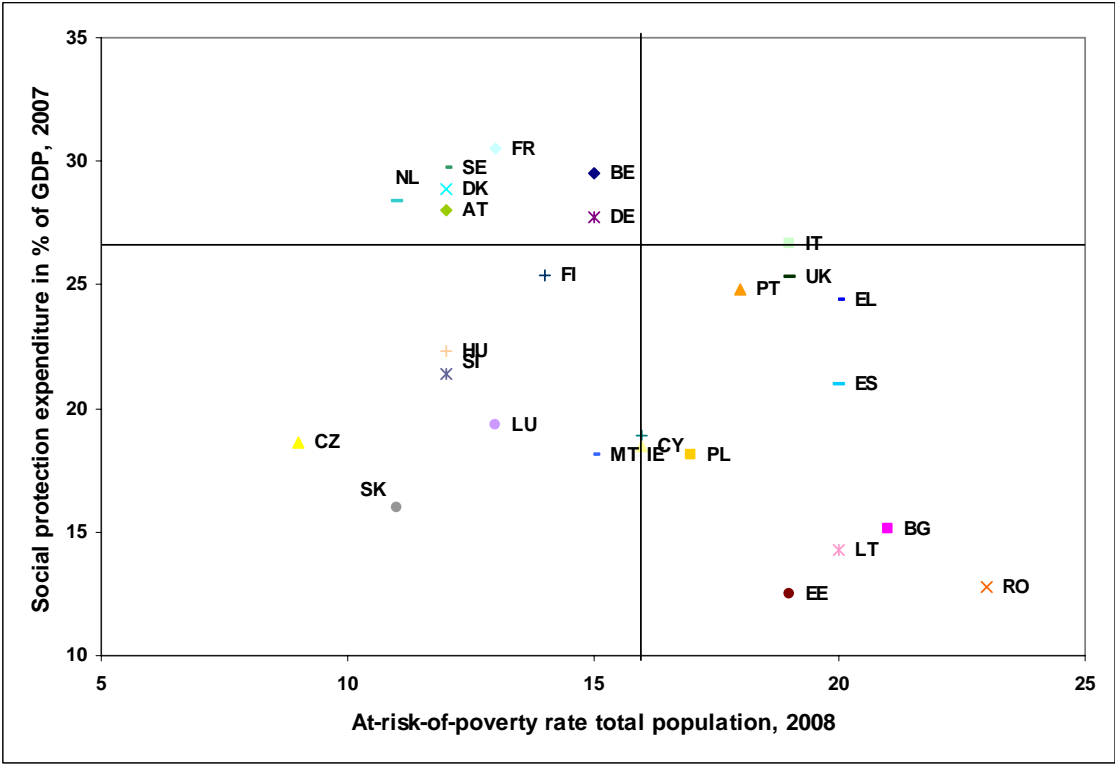
Source: ESSPROS 2007, EU-SILC 2008
Note: The horizontal and perpendicular lines depict the EU averages of the variables

An analysis of the evolution of social spending and public deficits against the economic cycle can illustrate to what extent social spending is counter-cyclical, both in good times and bad. Ideally, increases in social protection expenditure should be seen as part of a recovery package, rather than a permanent feature, thus acting as an automatic stabiliser.

The ratio of social protection expenditure as a share of GDP declined during the periods of rapid growth in the second half of 1990s, after having increased sharply in the early 1990s when growth rates were very low. In recent years, a trend can be observed towards increased resources devoted to social protection from general government budgets. Promoting labour market participation in addition to improving the fairness, efficiency and effectiveness of social spending will be crucial for all countries. This will help to ensure counter-cyclicality to promote economic growth and to address fiscal imbalances.

Figure 2.18: Expenditure on social protection benefits since 1994 in the EU in relation to the fiscal situation, % of GDP
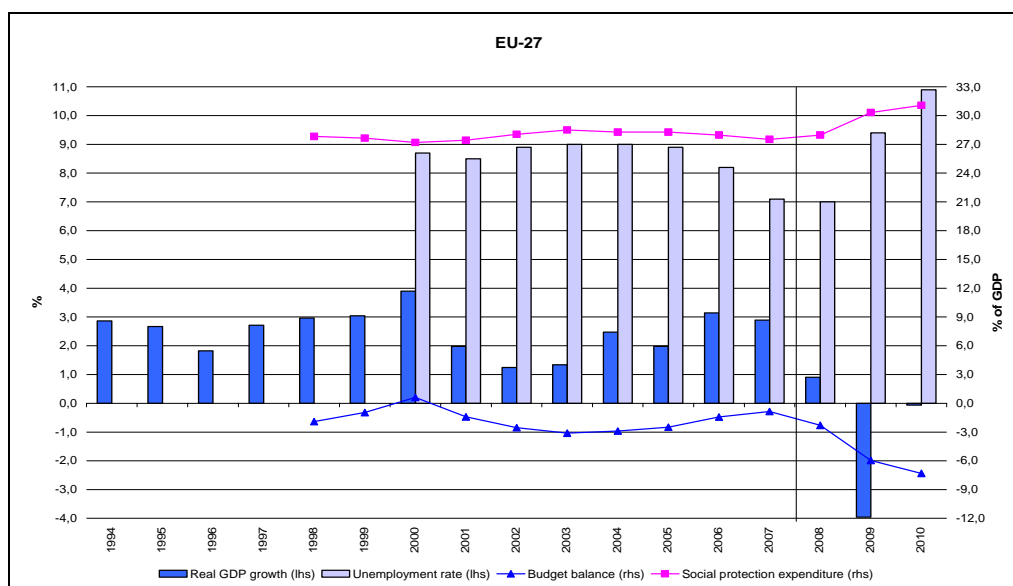
Source: AMECO database[9]

Analysis shows that Member States have taken steps to **reshape social protection systems** so that they encourage activity and inclusion. However, it is also clear that for social protection systems to function well, their modernisation needs to be accompanied by effective strategies for growth and more and better jobs.

---

[9]   The AMECO database is based on National Accounts.

In this extract from AMECO the sum of "Social transfers in kind" and "Social benefits other than social transfers in kind" in accordance with European System of Accounts 1995 (ESA95) has been used. Generally speaking the results for total expenditure on social protection is somewhat lower than in ESSPROS. For details on the main differences compared with the European System of Integrated Social Protection Statistics (ESSPROS) in the way social benefits in cash and kind are distinguished please refer to Manual on sources and methods for the compilation of COFOG Statistics, page 65-66, Eurostat,

http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-RA-07-022/EN/KS-RA-07-022-EN.PDF

'Growth, Jobs and Social Progress': a contribution to evaluating the social dimension of the Lisbon Strategy

The report on *Jobs, Growth and Social Progress* was adopted by the Social Protection Committee (SPC) on 14 September 2009. It is a contribution to discussions on the future shape of the EU's Growth and Jobs Strategy and looks at the way economic, employment and social policies interact. It was prepared by the SPC, which brings together experts representing each Member State together with the European Commission. The report investigates the extent to which past economic and employment growth has contributed to greater social cohesion, as well as the extent to which the modernisation of social protection systems has supported this growth.

The report shows that Europeans can count on sound social protection systems. Not only has social protection greatly contributed to mitigating the worst social consequences of the economic and financial crisis, it has also undergone profound modernisation, in line with the overall Lisbon strategy.

However, social protection is not enough to limit or prevent poverty and exclusion. Having a job remains the best safeguard against poverty and exclusion, thus confirming and important stance of the Lisbon Strategy. Yet, this report clearly shows that the virtuous circle of participation in employment and living out of poverty has not always functioned in the last decade. Serious obstacles still face the most vulnerable groups, such as the low-skilled, lone-parent families, or migrants. In addition, recent developments have shown that more attention needs to be paid to the interaction between flexible labour markets and quality of work, notably in relation to its impact on the gender dimension. As a consequence, while the emphasis should still be on promoting growth and jobs, fighting child poverty, engaging closely in active inclusion and more generally fighting labour market segmentation and encouraging job quality will have crucial importance.

The task of modernising social protection is not over: quite the contrary. Building on previous achievements, reforms should be further pursued and fully articulated with growth and employment strategies. The consolidation of pension reforms will require further efforts to promote longer working lives, which in turn makes a strong case for fighting health inequalities and improving health and safety at work.

## 3. RESPONDING TO THE CRISIS AND PREPARING FOR RECOVERY

The crisis has highlighted great diversity within the EU. Its scope, magnitude and effects vary. Large drops in GDP have triggered dramatic rises in unemployment in some countries, while it has been contained in others. The capacity of EU welfare systems to address the rising demand for social security also varies. Some Member States have major gaps in their safety nets, and not all governments have the financial room for manoeuvre to let automatic stabilisers operate fully.

3.1. First evaluation of policy responses

Members State policy responses vary in scale and emphasis. A Commission estimate (Figure 2.1) shows that spending on overall recovery measures ranges from less than 1% of GDP in Hungary, Lithuania, Bulgaria and Greece to more than 3.5% in Spain, Finland and Germany. Figure 1 also illustrates the different emphases placed by Member States on the various types of measures: some countries predominantly investing in support for households, others in labour market measures, and yet others devoting large shares of their spending to investment expenditure.

According to the Commission's autumn forecast, as a result of automatic stabilisers and discretionary measures to reinforce social benefits, social expenditure in the EU is expected to increase by 3.2 percentage points of GDP between 2007 and 2010 (Figure 2). The forecast rise ranges from less than 1 pp in Bulgaria, Hungary and Slovakia to 6 pp or more in Estonia, Ireland, Latvia and Lithuania.

Figure 3.1: Overview of the composition of recovery measures in EU Member States' recovery plans – Discretionary stimulus (aggregate over 2009-10)[10]
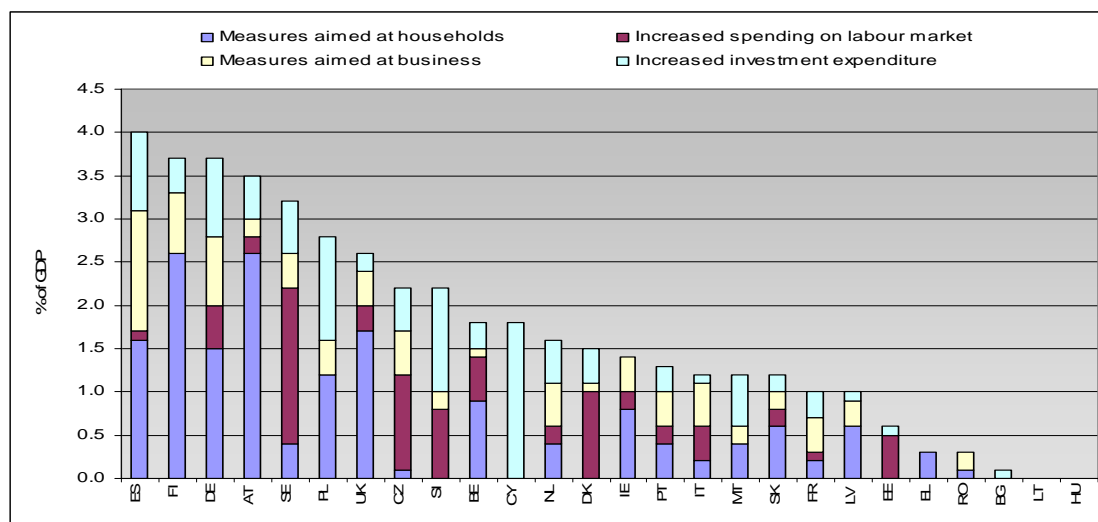
Source: Commission services – European Economy Occasional papers N°51 July 09 "The EU's response to support the real economy during the economic crisis: an overview of Member States' recovery measure". – Table 2 on page 16.

---

[10] The figure for Poland might be overestimated, e.g. including the impact of the announced *Social Solidarity Fund* which was rejected later on.

Figure 3.2: Expected increase in social expenditure between 2007 and 2010, pp of GDP
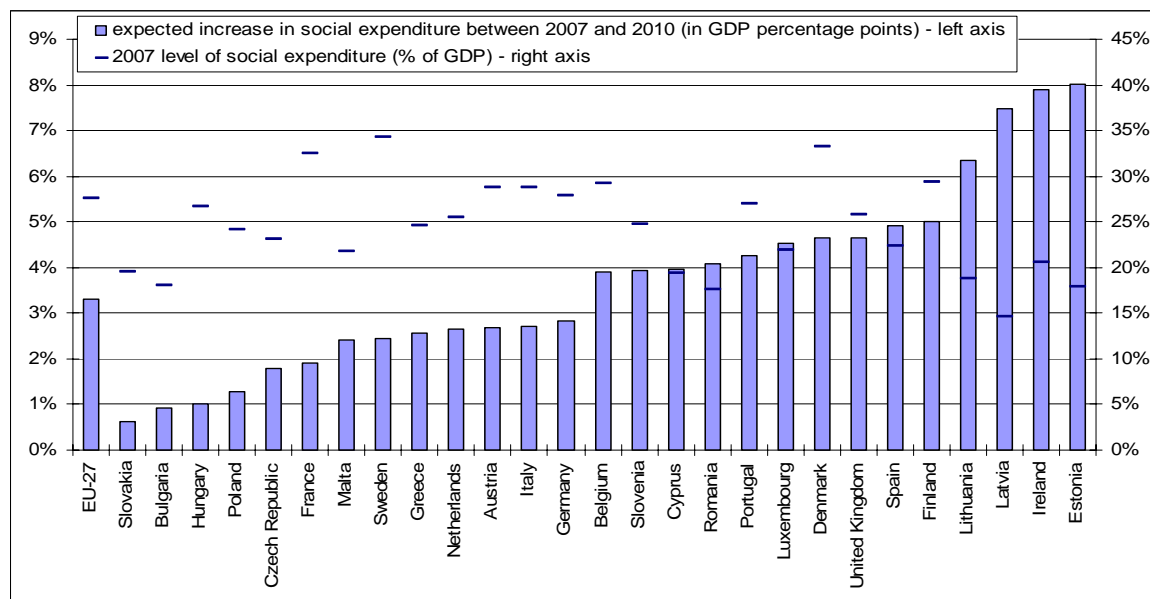
Source: EC Economic Forecast Autumn 2009 (AMECO database)

3.1.1. *First evaluation of the impact of automatic stabilisers*

The last year has illustrated the key role played in Europe by automatic stabilizers in cushioning the impact of the crisis. As highlighted in the SPC report on "Growth, Jobs and Social Progress" a number of estimates for large European countries based on past experiences have shown that the capacity for stabilization of public finances in European countries varies. According to these macro estimates 15% to 35% of economic fluctuations are smoothed by automatic stabilizers, depending on Member State[11]. In general, most components of social protection expenditures increase more quickly than GDP in periods of economic downturn, and more slowly than GDP in economic recovery. But, while unemployment expenditures are clearly among the most sensitive to changes in the economic conditions, the variability of social protection expenditures also reflects changes in other types of expenditures (with significant variations between Member States covered).

More recently, a working paper by the Institute of Labour (IZA)[12] provides an illustration of the various impacts of automatic stabilizers across EU countries[13]. The model estimates the relative contribution of taxes and benefits to disposable income stabilization and demand stabilization. It points to the limited role of unemployment benefits stabilization in some EU Member States (see Table 1).

The results suggest that in the event of a large unemployment shock (e.g. a 5 pp increase in the unemployment rate), automatic stabilisers in the EU would absorb 48 % of the shock (only 34 % in the US), with benefits having an important income stabilisation effect (19 % in the EU and only 7 % in the US). However, there is considerable heterogeneity within the EU, as illustrated in Table 3.1. These results suggest that social transfers, in particular on the revenue side and also on unemployment insurance, play a key role in the stabilisation of disposable incomes and household demand. According to the OECD Economic Outlook (2009), when seen in relation to the impact of discretionary fiscal measures implemented during the crisis, the scale of the operation of automatic stabilisers is such that, for the OECD countries as a whole, the net fiscal stimulus they provide in 2009 is estimated to exceed the discretionary fiscal action currently planned by governments by a factor of 2½.

Table 3.1 - income and demand stabilization in case of unemployment shock*

	income stabilization (% of shock absorption)			
	FEDTax	SIC	Benefits	Tax and benefits
SE	19.7	2.9	45.8	68.5
DK	24.3	8.3	38.2	70.7
FR	7.6	19	31.7	58.2
PT	22.5	9.4	30.6	62.5
AT	20	16.7	30.3	67
LU	14.7	9	29.6	53.3
BE	25.7	12.4	27.6	65.7
DE	23.1	14.5	26.8	64.5
FI	22.4	5	26.7	54.1
NL	10.3	13.1	23.9	47.2
EURO	16.6	12.9	21	50.4
EU	17.2	12.1	18.9	48.2
UK	19.4	6.1	18.6	44.1
IE	20.7	3.6	18.2	42.5
EL	12.6	13.7	11.9	38.3
ES	12.7	6.4	9.1	28.3
IT	18.3	10.1	7.6	35.9
US	21.5	5.1	7.1	33.7
SI	17.5	21.6	5.4	42.5
HU	22.7	19	4.7	46.4
PL	15.1	17	-2.7	29.5
EE	17.8	2.2	-3.2	16.8

* Unemployment shock refers to an increase in the unemployment rate by five percentage points.
** FEDTax: taxes, SIC: Social Insurance Contributions.
Source: Dolls et al (2009), Automatic Stabilizers and Economic Crisis: US vs. Europe, IZA Discussion Papers 4310, Institute for the Study of Labor (IZA) based on the micro-simulation model EUROMOD

3.2.   Overview of main policy measures taken in response to the crisis

Most Member States continue to strengthen their **policy responses** to the economic slowdown, in line with national reform programmes and the National Strategy Reports. As labour market conditions have continued to worsen in the second and third quarters of 2009, many Member States have strengthened and consolidated the set of **labour market measures** they had adopted at an early stage. These measures aim to preserve employment, support activation and promote re-integration in the labour market, while anticipating and managing the adverse impact of restructuring. New or reinforced measures focus on **flexible working**

time arrangements, which are seen as effective means to maintain people in employment in response to short term shocks, as well as a way to further enhance active labour markets and ease labour taxation.

Member States have also further enhanced their **measures to support people's income**. Two countries have adopted comprehensive packages to reinforce their safety nets. New measures have especially been taken to strengthen **unemployment benefits** while paying attention to avoiding disincentives to get back to work. Member States have also reinforced **minimum income schemes** especially in countries where they appeared weak under the increased pressure created by the crisis.

Member States also report on the specific support provided to groups at risk, notably **youth**, families with **children** and the disabled. Some Member States also report on measures to ensure equal opportunities between **women** and men.

A few Member States have taken further measures to avoid and stem the direct consequences of the financial crisis for individuals and families. These include measures to **protect mortgage holders** against repossession (e.g. renegotiation of mortgages for the unemployed), to address over-indebtedness, or to create incentives for banks to **give access to credit** to individuals, including people on low income.

The current economic and financial crisis may have a severe impact on the **healthcare sector** in several EU Member States, on both the supply and demand sides. On the supply side, the economic and financial crisis may lead to reduced funding for health and long-term care services as a result of budget cuts and lower tax revenues, while the demand for health and long-term care services may increase as a result of a combination of factors contributing to worsening health among the general population.

The health impact of the rapid deterioration in public finances is likely to be fully felt only at the end of this year, when budgets for 2010 will be discussed. In view of the levels of public debt, it is more than likely that the fiscal 'room to manoeuvre' will further reduce. The deterioration in public finances and consequent shrinking of fiscal resources could force governments to adopt drastic adjustment and austerity measures.

For countries whose health system is financed through general tax revenues, decreases in GDP and economic outputs may result in significant reductions in public revenue for health. Alternatively, for countries that rely predominantly on wage-related contributions to health insurance funds, increases in unemployment are likely to constrain revenues earmarked for health.

Several Member States have included measures within their recovery packages to mitigate the impact of the economic crisis on health care, in the following areas *i)* **investing in health infrastructure,** *ii)* **providing additional funding to the healthcare sector,** *iii)* **restructuring and reorganising the healthcare system**.

Some Member States have allocated funding to the construction of new healthcare centres or the upgrading of the existing health infrastructure as a means to boost employment in the construction sector, although these measures were not initially considered as a part of an economic recovery plan.

Furthermore, many Member States have adopted measures to reduce the impact of the economic crisis on health care by securing sufficient funds for the healthcare sector during the crisis, improving the utilisation of existing resources within the healthcare sector and ensuring the protection of patients' rights and entitlements.

The measures taken by some Member States in order to restructure and reorganise the healthcare sector are aimed at using resources in the most productive and efficient way, re-defining priorities (so as to reallocate funds and distribute any surpluses to other fields that appear to have higher deficits), and reorienting and reorganising healthcare services, in an attempt to respond effectively to the increased demand for healthcare services in the context of the economic crisis.

However, a few Member States have not introduced specific health-related measures to cope with the economic crisis, either because their health systems have not yet been directly affected by the crisis or because health care is not regarded as a key element in re-launching economic growth.

Regarding the longer-term impact of the crisis on **pension schemes**, and social security schemes in general, many countries observe that the effects of the crisis are still hard to predict. At present, the bulk of pensions in payment are delivered by public PAYG schemes on which the crisis in financial markets has no direct effect. By contrast, the book values of the assets held by pension funds have fallen significantly and real issues of solvency could emerge if markets take long to recover. But, apart from in a few Member States, this would primarily affect the incomes of future pensioners in the medium to long term. Most Member States therefore regard their pension systems as quite resilient. However, if the crisis deepens and continues for several years, even PAYG systems will be affected as unemployment and lower growth reduce revenues from taxes and social contributions and weaken public finances.

In their replies to the October 2009 questionnaire, most countries indicate that it is still **too early to fully evaluate the social impact of the measures they have taken in response to the crisis**. However, some countries report on stock-taking exercises performed by government to evaluate the take-up of specific measures (e.g. number of benefit recipients, number of workers having participated in activation measures) or the impact of measures to preserve or create jobs. A few countries have commissioned independent ex-post or ex-ante evaluations of their overall recovery packages.

The preparation of their 2010 budgets is the occasion for Member States to review the measures originally taken in the light of constraints on public finances. This review should also highlight the need to balance the burden of the policy responses across different levels of government.

One year into the crisis, more Member States report a stronger emphasis on provisions to ensure **budgetary discipline**. This is because of very high constraints on public finances, and/or the need to preserve the long-term sustainability of public finances in general and social protection in particular. In addition to the two countries who had already reported on this aspect in spring 2009, a number of others are planning or have recently adopted '**austerity' packages** of different sorts. These packages include reforms of the public sector (e.g. redundancies and reduced wages for state employees), tax increases (especially VAT), etc.

As welfare systems continue to play their role of automatic stabilisers, social protection expenditure is projected to rise. However, their capacity to address the rising demand for social security varies greatly across Member states, and not all Member States have the financial room for manoeuvre to let automatic stabilisers operate fully. The review of public finances and the preparation of the 2010 budgets have led some Member States to adopt fiscal consolidation packages that may weaken the effects of previous recovery measures aimed at preserving employment and/or sustaining demand. In the long run, however, their aim is to ensure sound public finances and thereby support macroeconomic stability and future growth.

3.3.   The need for effective and efficient social inclusion policies during and after the crisis

While the economy is expected to return to a 0.7% growth in 2010, labour demand is likely to remain weak for a while and past experience suggests that the social consequences of the downturn will persist. **Unemployment** in the EU reached 9.5% in November 09, and could reach 10.3% in 2010. The rate is more than double for **young workers** (21.4%) and **migrants** (18.18.9%).

The loss of family income caused by unemployment deeply affects all those who depend on it. Clearly this includes **children and other dependants**. Cuts in the provision of social services may also affect families with children. **Young people** still in education or seeking to enter the labour market may also affected both by the drop in their parents income, on which they often depend and by the lack of job opportunities. The maturing of pensions systems in recent decades has helped reducing poverty risks for the **elderly** in many parts of the EU. However, the crisis threatens the development of adequate pensions where elderly poverty remains very high and has highlighted risks in privately managed schemes.

The crisis is also likely to affect **those furthest from the labour market**, whether inactive or long-term unemployed. Even before the crisis, the low-skilled, people with disabilities or mental health problems, and migrants — particularly women — had limited access to training and other enabling services. Recent efforts to boost employability for all may be undermined by the lack of jobs and increased pressure on training and employment services. Maintaining decent living standards for all is not only crucial to ensure that people can live in dignity, but is also necessary to sustain their employability and learning capacity. Overall, the crisis has shown that most Europeans can rely on some of the most **effective safety nets** in the world. However, there are gaps across countries and population groups.

The effectiveness of **unemployment benefits** varies greatly across and within countries depending on their coverage, duration, conditionality and replacement rates. Some workers are better covered than others. Young workers with short contributory records and some of the self-employed may not be entitled to unemployment benefits, while workers on part-time or temporary contracts often benefit from a lower level of protection than other workers.

Reforms to strengthen incentives to work have tightened eligibility criteria, or reduced the level or duration of benefit entitlements. Together with a greater emphasis on activation measures, these reforms have contributed to an overall reduction in long-term unemployment. However, they have not always managed to reduce **long-term welfare dependency**. Even though several Member States have prolonged benefit durations and relaxed eligibility rules

in response to the crisis, the pressure on **last-resort schemes** is likely to increase, as unemployment benefits run out for more and more people.

The report 'Growth, Jobs and Social Progress' warns that past crises have shown that long-term unemployment or inactivity tend to persist long after recovery has set in. This partly reflects increasing numbers of people moving into long-term sickness and disability benefits or early retirement schemes. Long-term unemployment and periods of inactivity also affect people's employability through skill depreciation, discouragement, and in some cases a lack of integration in society as a whole.

3.4.   Supporting the integration of the most excluded in the labour market and in society as whole: the role of activation and access to services

Adequate income support is crucial for people's ability to live in dignity (see section 3.5), but it should also be complemented with policies aimed at helping them back on the labour market and participate fully in society. Active labour market policies and ambitious life long learning strategies have an important role to play in fighting poverty and social exclusion.

The SPC report on "Growth, Jobs and Social Progress" reviews recent trends in a number of policy fields that promoted in the context of the Lisbon Strategy to support greater labour market participation among the inactive and the unemployed and help low wage workers to get better jobs. It shows that both spending and participation in active labour market measures, including training, have improved overall in the last years. However, more needs to be done to ensure that such policies **reach all categories of workers**, including the low skilled, the young and the elderly, migrants and the disabled.

Participation in **life-long learning** has improved overall in the EU-27 from 7.1% of people aged 25-64 in 2000 to 9.6% in 2008. However, great disparities remain across countries, with participation rates among the 25-64 age group varying from 3% or less in RO, BG, HU and EL to more than 30% in DK and SE. The participation rates of the unemployed have increased but were still only around 8.5% in 2008. After an increase in early 2000, the participation rates of the inactive stagnated and stood at 6.9% in 2008. The main issue of concern is **the very low rates and slow progress in the participation of low-skilled workers**, which stood at 3.8% in 2008 (as against 2.8% in 2000). Furthermore, the percentage of early school-leavers was still high at 15.2% in the EU in 2007, as against 17.2% in 2000. Moreover, the overall progress hides the poor performance of a number of countries like BE, DK, DE, EE, ES, FR, AT and SK, where no or very little progress was made.

Labour market policy (LMP) expenditure decreased from 0.51% of GDP to 0.47% between 2005 and 2007, partly reflecting declining unemployment rates. LMP expenditure per person wanting to work also stagnated during that period. There was also a slight shift from spending on passive measures to spending on active measures[14]. Spending on active measures per person wanting to work increased from 1472 PPS in 2005 to 1739 PPS in 2007, while spending on 'passive' measures per person wanting to work declined from 3931 PPS to

---

[14]   'Passive measures' include income support (8) and early retirement schemes (9); 'active measures' include training (2), job rotation and job sharing (3), employment incentives (4), supported employment and rehabilitation (5), direct job creation (6), and start-up incentives (7).

3770 PPS in 2007. The decline was mainly driven by the decline in income replacement spending, while spending on early retirement (8% of total passive spending) remained the same. Further analysis would be needed to identify the factors behind the relative decrease in income maintenance spending (changes in the design of benefits, reduced benefits, etc). (See point 3.6)

The lack of enabling services has also been identified as an obstacle to participation in the labour market, especially for women with care responsibilities. It is also a compounding factor in child poverty. Member States' efforts to increase **child care provision** have helped to increase the number of children in formal care arrangements from 25% in 2005 to 30% in 2007 for children below the age of 2. Very large differences persist between Member States, with rates ranging from 2% in CZ, PL and SK to more than 40% in BE, DK, NL and SE. In many countries the provision of child care is mainly on a part-time basis, which can hamper labour market participation for lone parents in particular. Furthermore, in the same period the share of persons with care responsibilities declaring that they are inactive or working part-time due to the lack of care services increased from 26.7% in 2006 to 29.8% in 2008.

More generally, adequate and individualised social and employment services play a key role in addressing the structural barriers to participation in the labour market and in society as a whole. Labour market policies alone are not sufficient to support the integration of the most vulnerable in society and into the labour market: the personal, family and social hurdles they face should also be addressed by quality social and health services.

3.5. Income support: the specific role of minimum income schemes

3.5.1. Minimum income schemes in the context of Active Inclusion

The **Active Inclusion Strategy**[15] provides an integrated framework within which the multidimensional nature of poverty and social exclusion can appropriately be tackled, and as such it is fully supported by the Member States. **Adequate income support is a key pillar of the strategy**. Its aim is to ensure a dignified life to those – either fit or unfit to work – that are not endowed with sufficient resources to live in a manner compatible with human dignity, consistently with the 1992 Council Recommendation[16] that called on Member States to recognise such a basic right.

In the context of the adequate income support strand of the strategy, **the focus here is on minimum income (MI) schemes for working-age people** across EU Member States.[17]

---

[15]   The European Commission adopted on 3 October 2008 a Recommendation on the active inclusion of people excluded from the labour market providing common principles and practical guidelines for the Active Inclusion Strategy – a comprehensive integrated strategy linking together adequate income support, inclusive labour markets and access to quality services. It was endorsed by the Council on 17 December 2008, and by the European Parliament in its Resolution of 6 May 2009.

[16]   Council Recommendation 92/441/EEC.

[17]   The analysis presented in Sections 3.4.1 and 3.4.2 relies heavily on the work conducted by the EU Network of national independent experts on social inclusion, and particularly on the Synthesis Report drawn from their work (Frazer H. and E. Marlier (2009) "Minimum income schemes across EU Member States. Synthesis Report"). The Synthesis Report covers 26 out of the 27 Member States as a final report for LU was not available when the report was finalised. However, LU is included in the Tables in the Synthesis Report's Annex on "Main characteristics of MI schemes and their relationship with national social protection systems". The national experts' reports and their overview are available

[18]These are schemes that provide cash benefits aimed at ensuring a minimum standard of living to individuals and their dependants having no, or insufficient, other means of financial support (including contributory cash benefits and support from other family members). As stated by Figari, Haux, Matsaganis and Sutherland (2009),[19] the level of income provided to a person through a MI scheme is the minimum level of income deemed acceptable for that type of person by the social protection system in the country concerned.

MI schemes are to be considered as "schemes of last resort". They provide a safety net, aimed at preventing destitution to people that are not eligible for social insurance benefits or whose entitlement to such benefits has expired. In this sense, **they play an even more important role in a context of crisis**, and the more so, the more long-lasting the economic downturn. Indeed, many of the national independent experts part of the EU Network on social inclusion[20] note that the rise in unemployment brought about by the financial and economic crisis has already had an impact on social assistance (SA) schemes.[21]

Almost all EU countries have some form of MI scheme *at the national level*, while those Member States that do not have one, like Italy, have some sort of schemes at the regional or local level. The schemes are generally conceived as a short-term form of assistance (though formally not time-limited in most Member States). They are means-tested and funded through the tax system (i.e. non-contributory). They mainly target people out of work but some Member States have extended their scope to provide in-work income support. The institutional features of MI schemes across EU countries are considered in the next Section. The following two Sections focus respectively on non-take up and benefit adequacy and work incentives.

3.5.2.   Institutional features of minimum income schemes in EU countries

Substantial differences exist across Member States in the way MI schemes are designed. In terms of comprehensiveness of the schemes (i.e. the extent to which MI schemes are non-categorical, thus generally applying to the low-income population and not only to specific

---

from: http://www.peer-review-social-inclusion.eu/network-of-independent-experts/2009/minimum-income-schemes.

[18]   The work on MI presented in this document is meant to be as the first step in the direction of more detailed analytical work on Active Inclusion. As such, it only touches upon a specific issue mainly linked to adequate income support, but also partly to inclusive labour markets. The third pillar of active inclusion (access to quality services) is of course as important as the other two but is left to future investigation.

[19]   Figari F., T. Haux, M. Matsaganis and H. Sutherland (2009) "The effects of Minimum Income schemes on the working-age population in the European Union",SSO Research Note 5(2009).

[20]   The EU Network of National Independent Experts on Social Inclusion assists the European Commission in monitoring and evaluating the situation with regard to poverty and social exclusion and the policies that are relevant in this respect in the Member States and candidate Member States. Twice a year, the experts produce a report on their respective countries concerning a specific subject that is being examined in the context of the EU social inclusion process. Once a year, the experts produce an independent (non-governmental) assessment of an official policy document (social inclusion strand of the National Strategy Report on Social Protection and Social Inclusion or an official reply to an SPC questionnaire on a specific topic). The Network Core Team produces synthesis reports, bringing together the main results of the analysis across countries. For more information on the network and its work, see: http://www.peer-review-social-inclusion.eu/network-of-independent-experts.

[21]   SA schemes represent the broader category including MI benefits together with other types of benefits like housing benefits, child benefits and unemployment assistance benefits. In what follows we will make it explicit whether considerations and findings apply to SA schemes more generally rather than specifically to MI schemes (to which we refer whenever not differently specified).

subgroups), the work of the EU Network experts pinpoints to the existence of four "broad" groups of countries with different institutional features. A first group of Member States (AT, BE, CY, CZ, DE, DK, FI, NL, PT, RO, SI, SE) is characterised by **relatively simple and comprehensive MI schemes**, generally open to those lacking sufficient resources to live in dignity. A smaller group of countries (EE, HU, LT, LV, PL, SK) has **simple and non-categorical MI schemes accompanied by more restricted eligibility conditions**. A third group (ES, FR[22], IE, MT, UK) is characterised by a **complex set of different and often categorical schemes** that sometimes overlap one with the other but generally cover most of those with insufficient resources. Finally, there is a small group of countries having **limited, partial or piecemeal arrangements** only covering narrow categories of people.

In general, eligibility conditions (commonly related to age, nationality, residence, lack of financial resources and availability for work) vary significantly. Consistently, **large cross-country variation in coverage**[23] **of MI schemes is observed** – as evident also from Figure 3.3 reporting EUROMOD[24] simulations on the poor working-age individuals (not in full-time education) living in assessment units entitled and not entitled to MI.[25] [26] **In some Member States there are people on very low incomes that still have no access to MI schemes.** Some groups, like the homeless, refugees and asylum seekers, are often left uncovered even in the countries with the more comprehensive schemes.

---

[22]   This has improved with the introduction of the RSA in 2009

[23]   People are considered as "covered" by one or more MI schemes if they meet all the eligibility conditions and are therefore entitled to receive benefits.

[24]   EUROMOD is a tax-benefit micro-simulation model currently covering 19 EU countries (EU-15 plus EE, HU, PL and SL). Cash benefits, direct taxes and social contributions are calculated by the model on the basis of tax-benefit policy rules in place in the different countries. Market incomes, as well as instruments that are not simulated, are taken from the data. Results derived from the model are therefore based on simulated, rather than recorded, disposable income. Baseline results from EUROMOD rely on the assumption of full take up (i.e. all eligible individuals or households receive the benefits they are entitled to) (see Paulus A., F. Figari and H. Sutherland (2008) "The effects of taxes and benefits on income distribution in the EU" Chapter 7 in SSO Monitoring Report 2008). The assumption of full take up allows focusing the analysis here on the issue of non-entitlement among poor households.

[25]   EUROMOD simulations presented here are run with the version of the model currently available, which uses 2001, 2003 and 2005 tax-benefit policy rules depending on the country. This of course means that changes in national tax-benefit policy rules intervened after the reference year are not reflected in the results. It will be possible in the future to repeat the analysis with updated policy rules. The new version of the model using 2008 policy rules for 9 EU countries will be available as from February 2010. By February 2012 EUROMOD will be upgraded to use 2010 policy rules for all 27 Member States (project financed under a three-year Framework Partnership Agreement between DG EMPL and the University of Essex).

[26]   When interpreting EUROMOD results, one should also keep in mind that asset tests affecting eligibility to some MI schemes are not considered (except in cases where information on assets is relatively reliable and asset tests are critical, like for the UK). Among the other conditions of entitlement, information on availability for work and citizenship is not always available (Figari et al., 2009).

Figure 3.3 – Working-age (16-64) individuals below the poverty line (at 60% of the median) by minimum income entitlement status (policy years 2001, 2003, 2005)
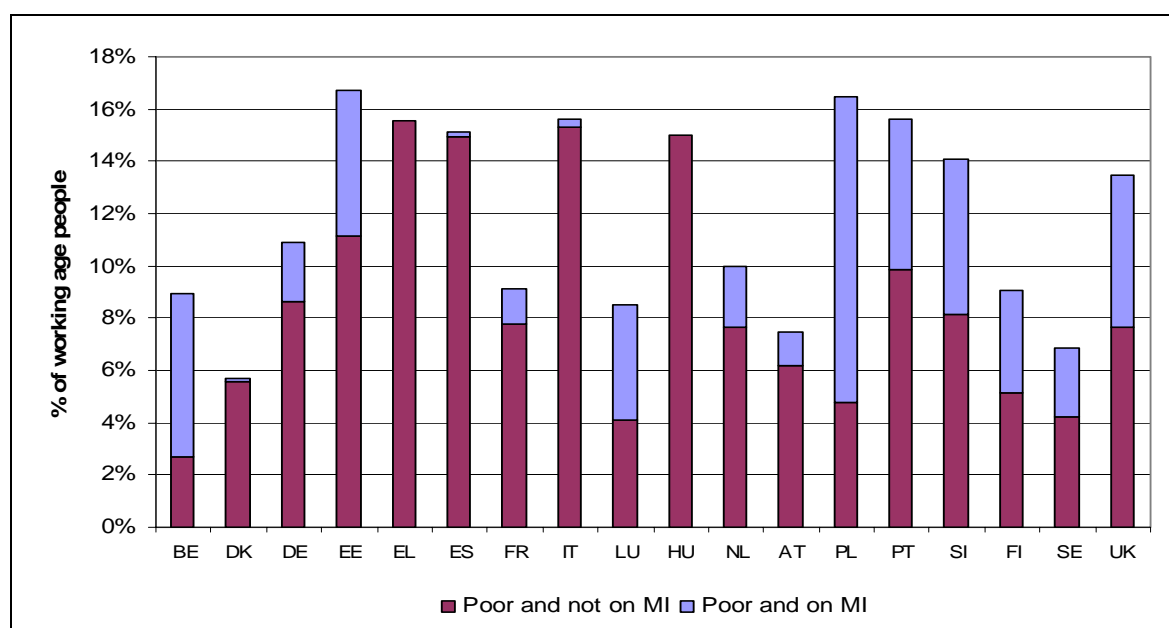
Note: MI schemes are defined here as to include the benefits listed as "Minimum resources: general non-contributory minimum" in the Mutual Information System on Social Protection (MISSOC) database.[27] [28] Tax-benefit policy rules refer to 2001 for DK, FR, SE; to 2003 for BE, DE, IT, LU, NL, AT, PT, FI, UK; to 2005 for EE, EL, ES, HU, PL, SI.[29] Figures for FR do not take into account the (time-limited) earnings disregards linked to the MI scheme (RMI). MI schemes cannot be simulated for IT and ES, where the schemes are administered at the regional level and variation across regions is too large. For these two countries MI receipt information from national surveys is therefore used. The sample size of poor working-age individuals living in assessment units entitled to MI benefits is small in DK, ES and AT. Results for these three countries should be treated with caution.
Source: Figari, Haux, Matsaganis and Sutherland (2009)

In terms of trends, many Member States display a clear move towards **tightened eligibility conditions**. Conditionality has been generally increased and **availability for work** has commonly become a more stringent requirement for people who are fit to work. Sanctions are often associated with the failure to comply with the requirement of availability for work, and might lead to reductions in benefit amounts and to the loss of the right to SA benefits in more

---

[27] The specific MI schemes considered are "droit à l'integration sociale" for BE; "kontanthjælp and starthjælp" for DK; "Sozialhilfe" for DE; "toimetulekutoetus" for EE; "renta minima de inserción" (regional scheme) for ES; "revenu minimum d'insertion" for FR; "minimo vitale/reddito minimo" (regional scheme) for IT; "revenu minimum garanti" for LU; "algemene bijstand" for the NL; "Sozialhilfe" for AT; "poloc spoleczna" for PL; "rendimento social de insercao" for PT; "denarna socialna pomoč" for SI; "toimeentulotuki" for FI; "ekonomiskt bistand" for SE; "income support" for the UK; no *general* MI scheme for EL and HU (EUROMOD cannot represent the discretion left to the local level in some systems).

[28] For each country the main characteristics of the MI scheme, as from MISSOC, are summarised in Table A2, Appendix 1, in Figari et al. (2009).

[29] Though modelled in the current version of EUROMOD, IE is excluded from this analysis. The decision is linked to the assumption of full take-up used in EUROMOD, which applies also to those other benefits to which MI operates as a top-up. This generates an over-estimation of such other benefits leading to an under-estimation of MI entitlement. This applies particularly to IE that has therefore been excluded from the analysis (Figari et al., 2009).

extreme cases. There is also a trend towards a stronger link between income support through MI schemes and **activation measures**.

While the focus of the analysis here is on MI schemes, it is anyway important to highlight that in many Member States MI benefit recipients receive **additional assistance for specific needs**, like housing benefits, contributions for fuel costs and child benefits (this can be seen, for instance, from Figure 3.4 on the composition of disposable income for households with working-age individuals in the poorest decile of the population obtained using EUROMOD). Though not formally classified as "guaranteed MI benefits", these additional benefits in fact contribute to the level of income that is actually guaranteed to people supported by MI schemes.

Figure 3.4 – Components of disposable income of households with working-age individuals in the poorest 10% of the population (policy years 2001, 2003, 2005)
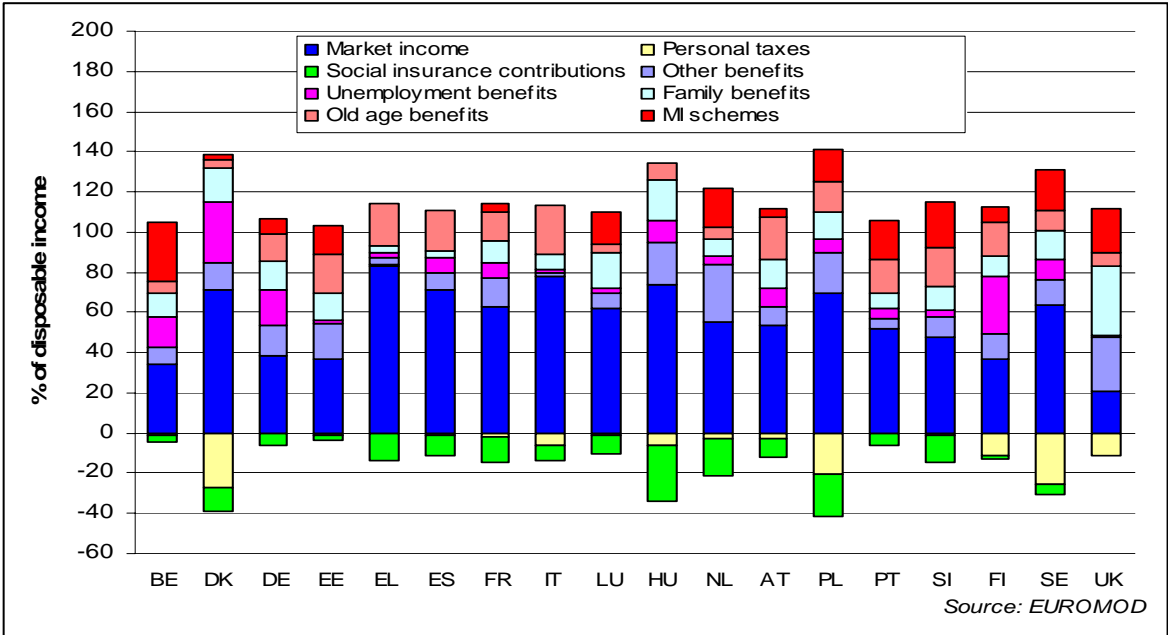
Note: Tax-benefit policy rules refer to 2001 for DK, FR, SE; to 2003 for BE, DE, IT, LU, NL, AT, PT, FI, UK; to 2005 for EE, EL, ES, HU, PL, SI. Source: Figari, Haux, Matsaganis and Sutherland (2009)

In most Member States MI schemes are designed as schemes applying to the country as a whole, while delivery is delegated to the local authorities. But there are a few Member States, like Austria and Hungary, where responsibility for policy decisions on SA benefit levels and eligibility conditions is partly delegated to regional/local governments. At the local level the EU Network experts note that the introduction of "one-stop-shop" type of arrangements in a number of Member States has represented an important innovation to ensure effective coordination in the delivery of various schemes.

3.5.3.   *The non-take up of benefits: estimated extent, causes and policy-relevant consequences*

While coverage of MI schemes is defined on the basis of eligibility criteria, the take up of benefits refers to the share of people entitled to benefits (i.e. covered by the schemes) that

actually are in receipt of benefits. **Coverage and take-up rates do not necessarily coincide**,[30] and indeed the limited and fragmented available evidence shows a large to very large gap between the two. Contributions in the literature highlight that people entitled to benefits might actually not receive them due to the following reasons (Hernanz, Malherbet and Pellizzari, 2004):[31]

(1)   relatively high **"information costs"** for potential claimants (i.e. efforts required to obtain and understand information) with regard to benefit regulations (including the existence of the benefit itself and the eligibility criteria) and the related application procedures, with "information costs" being higher, the more complex the design of the scheme and the procedures;

(2)   **"administrative costs"** related to the duration of the administrative process and to uncertainties with regard to the outcome of the application, which may discourage potential claimants from applying;

(3)   **pecuniary determinants** affecting the (rational) cost-benefit calculation to claim for benefits, related to benefit levels being too low and/or the expected duration of benefit receipt to be too short to offset the costs of claiming in terms of time and efforts (this might explain non-take up in situations of less extreme need);

(4)   **social and psychological costs** related to the perception of SA support and the fear of stigmatisation refraining people from claiming;

(5)   **errors in evaluation procedures and discretionary assessment** of applications (not based on objective clearly established criteria) leading to the rejection of applications by eligible people (these factors might be exacerbated by the insufficient number of social workers processing the applications).

Evidence on take up is currently very fragmented, limited in terms of country coverage and referred to different (mostly not recent) years and different benefit schemes for different countries. In the EU, the UK is the only country where official estimates of take-up rates have been published (by the Department for Work and Pensions) for various benefits, including Income Support, since 1997 (the last estimates being referred to 2007-08). The message to be drawn from the available (though not recent) evidence is anyway clear: **non-take up is indeed substantial and requires research efforts** on the side of the academic community **and attention on the side of policy-makers**, though over the last years measures to tackle this key issue have been put in place at national level, as explained below.

The traditionally quoted OECD paper by Hernanz et al. (2004) reports estimates of take up for SA and housing benefits ranging between 40% and 80%. A recently completed EUROMOD

---

[30]   In an "'ideal world" where all people entitled to benefits actually receive them, coverage and take-up rates would of course be identical. In the real world "frictions" of different nature (see the rest of the Section) characterising both the stage of delivery of the schemes and the stage of claiming for benefits generate incomplete take-up so that take-up rates end up being smaller, or much smaller, than coverage rates.

[31]   Hernanz V., F. Malherbet and M. Pellizzari (2004) "Take-up of welfare benefits in OECD countries: a review of the evidence" OECD Social, Employment and Migration Working Papers DELSA/ELSA/WD/SEM(2004)2.

project (AIM-AP)[32] has provided additional evidence on take up for some EU countries and different types of social benefits. With regard to countries for which SA more generally or MI schemes more specifically were analysed, the project led to the following take-up estimates (Matsaganis, Paulus and Sutherland, 2008):[33]

– Austria: 44% by caseload (i.e. numbers of individuals/households claiming benefits) and 52% by expenditure (i.e. amount of benefit claimed) for SA ("Hilfe zur Sicherung des Lebensunterhalts") in 2003 (Fuchs, 2007);[34]

– Finland: between 50% and 60% for SA ("Toimeentulotuki") by working-age families between 1996 and 2003 (with a declining rate over the period) (Bargain et al., 2007);[35]

– Germany: 33% by caseload and 43% by expenditure for SA in 2002 (Frick et al., 2007);[36]

– Netherlands: between 72% and 81% for SA (ABW) (Vrooman et al., 1994);[37]

– Portugal: between 70% and 75% for the Social Integration Income (RSI) in 2009 (Rodrigues, 2009);[38]

– UK: between 78% and 88% by caseload and between 85% and 93% by expenditure for Income Support in 2007-08 with a decrease in caseload take up by about 1% since 2006-07 and by at least 4% since 1997-98, though the latter piece of evidence is not certain due to high and increasing modelling bias (DWP, 2009).

The available evidence therefore suggests that **take up of SA benefits is far from complete and even significantly low in many EU countries**. Moreover, compared to the past take up seems to have declined, at least in some EU countries for which data are available. **The risk of non-take up might also be greater for some groups than for others**, as highlighted by the EU Network experts (Frazer and Marlier, 2009). For instance, in Belgium non-take up is estimated to be greater for women, couples, individuals with educational attainment below the second stage of secondary studies and the 16-24 age cohort. In the UK, people that do not take up Income Support tend to be slightly older than those that take it up (with a larger share of people aged 50-59) and more likely to be owner-occupiers in terms of tenure type, to have

---

[32]   The Accurate Income Measurement for the Assessment of Public Policies was a programme (started in 2006 and finished in 2009) funded by the European Commission under the Sixth Framework Programme. The programme aimed at improving the comparability, scope and applicability of tools, methods and data for the measurement of income and the analysis of the effects of policies on inequality, poverty and social inclusion. It involved 11 universities and research institutes in various EU countries   (http://www.iser.essex.ac.uk/research/euromod/research-and-policy-analysis-using-euromod/aim-ap).

[33]   Matsaganis M., A. Paulus and H. Sutherland (2008) "The take up of social benefits" SSO Research Note 6(2008).

[34]   Fuchs M. (2007) "Social assistance – No, thanks? Empirical analysis of non-take up in Austria 2003" EUROMOD Working Paper No. EM4/07.

[35]   Bargain O., H. Immervoll and H.Viitamäki (2007) "How tight are safety nets in Nordic countries? Evidence from Finnish register data" IZA Discussion Paper 3004.

[36]   Frick J.R. and O. Groh-Samberg (2007) "Estimating the size and determinants of benefit non-take up in Germany" Deutsches Institut für Wirtschaftsforschung, Berlin.

[37]   Vrooman J.C. and K.T.M. Asselberghs (1994) "De gemiste bescherming, niet-gebruik van sociale zekerheid door bestaansonzekere huishoudens" COSZ/Sociaal en Cultureel Planbureau, Rijswijk.

[38]   Rodrigues C.F. (2009) "Impacto do RSI na distribução do rendimento e exclusão" European Seminar "Social Integration Income – RSI a right to social integration", Lisbon March 2009.

other incomes, to share their household with other benefit units and to live in a household below 60% of median income *before housing costs*[39] (DWP, 2009). Some of the EU Network experts, the Austrian for instance, underline the fact that **non-take up can vary significantly by region within a country** (Frazer and Marlier, 2009).

There are several reasons why it is important for policy-makers to better understand the extent and causes of non-take up and to identify appropriate policy responses. Firstly, **low take up distorts the intended effects of social benefits** (Matsaganis et al., 2008). If only a fraction of those that are supposed to benefit from a welfare programme are reached, this clearly reduces the chance for the programme to achieve its objectives (Hernanz et al., 2004). Secondly, when not claiming a benefit is (at least partly) involuntary, due, for instance, to lack of information, **non-take up generates disparities of treatment between individuals** (those that are informed and those that are not) **that were supposed to be treated equally by the welfare programme** (Hernanz et al., 2004). Moreover, if information on benefit programmes is not "randomly distributed" but rather more available to certain groups within the eligible population, the disparities of treatment implied by non-take up end up being particularly harmful to those people that are relatively more in need for assistance.

The policy-relevant consequences of non-take up clearly emerge also in Matsaganis et al. (2008), where EUROMOD is used to study the effects of non-take up of SA schemes in some EU countries.[40] Simulation results pinpoint to the following effects (see Table 3.2):[41]

(1)   non-take up lowers the capacity of SA benefits to reduce the aggregate poverty gap.[42] Incomplete take up reduces poverty gap efficiency by over a half in PL, by around one third in SE and PT, and by a tenth in the UK.

(2)   **non-take up has a significant negative effect on SA effectiveness at reducing the at-risk-of-poverty rate**. Simulation results show that incomplete take up leads to an increase in the poverty rate by 0.5 points in the UK, by 0.7 points in SE and by 2.8 points in PL. Moreover, the negative effects on poverty rates are stronger, the lower the poverty line considered, thus the more we move towards the bottom of the income distribution (see estimates for the 60%, 50% and 40% thresholds in Table 3.2).

(3)   **non-take up increases the poverty gap** (expressed as the average gap between poor households' incomes and the poverty line as a proportion of disposable income) by 9-16% in PT and the UK, by 34% in SE and by 64% in PL.

Again these findings show that non-take up is to be considered a matter of concern and its monitoring is particularly relevant. As anticipated, the relevance of the issue has been recognised by the Member States that have generally put in place **measures to increase take up**. These have mainly consisted of **simplification of procedures** to apply for benefits, as well as **measures to better inform potential beneficiaries** about their entitlement and

---

[39]   The difference becomes negligible after including housing costs (DWP, 2009).
[40]   The schemes considered in the four countries for which results are reported here below are: Pomoc Społeczna in PL, Rendimento Mínimo Garantido/Rendimento Social de Inserção in PT, Ekonomiskt Bistånd/Socialbidrag in SE, and Income Support in the UK.
[41]   The policy year considered is 2001 for all countries but Poland, for which 2005 is used.
[42]   The aggregate poverty gap is given by the sum, over the whole sample of poor households, of the differences between the poverty threshold (at 60% of median equivalised household disposable income) and the pre-transfer household disposable income.

application procedures. For instance, the EU Network expert for Ireland highlights that strategies to increase take up have focussed especially on information campaigns through a variety of media and formats. For the Netherlands, the experts note that "municipalities promote the use of existing income facilities. This is for instance done by writing directly to people entitled to these facilities, by publishing articles in local newspapers and by giving information at locations such as playgrounds and schools. Furthermore, the procedures to apply for support will be simplified and by means of data-linking non-applicants will be identified..". The already mentioned "**one-stop shops**" introduced in a number of Member States have also contributed to increasing take up by informing people applying for one benefit about their eventual entitlement to other benefits.

Table 3.2 – The effects of non-take up of SA benefits among working-age individuals[43]
(poverty line at 60% of median equivalised household disposable income - unless stated otherwise - *under complete take up*; all values in %)
(policy years 2001, 2005)

	Poland	Portugal	Sweden	UK
A. Poverty gap efficiency				
Complete take up	49.9	22.4	48.7	59.9
Incomplete take up	23.5	16.1	33.3	54.0
Proportional change	-53	-28	-32	-10
B. At-risk-of-poverty rate at 60% of median				
Complete take up	13.0	15.4	8.8	14.6
Incomplete take up	15.8	15.4	9.5	15.1
Proportional change	22	0	8	4
C. At-risk-of-poverty rate at 50% of median				
Complete take up	5.4	10.1	4.3	7.2
Incomplete take up	9.2	10.1	5.7	8.0
Proportional change	69	0	31	10
D. At-risk-of-poverty rate at 40% of median				
Complete take up	2.6	4.2	2.5	2.8
Incomplete take up	5.4	4.6	3.7	3.7
Proportional change	107	9	47	30
E. Poverty gap				
Complete take up	2.9	3.7	2.2	3.2
Incomplete take up	4.8	4.0	2.9	3.7
Proportional change	64	9	34	16

Source: Matsaganis, Paulus and Sutherland (2008)

---

[43] As already said, baseline results from EUROMOD rely on the assumption of full take up. In Matsaganis et al. (2008) a methodology is applied to simulate also the case with incomplete take up. The take-up rate is set equal to an estimate derived from external sources and the number of beneficiaries within the eligible population is set to match the estimated take-up rate. Eligible people not claiming their benefits are selected randomly. Random draws are repeated 1000 times (100 times for Poland) and average values are calculated and presented as simulation results.

3.5.4. *Minimum income schemes: the issues of adequacy and work incentives*

The 2008 European Commission Communication on the active inclusion of people excluded from the labour market [44] already underlined that in most Member States and with regard to most family types **SA benefits alone are not sufficient to lift people out of poverty risk**. This emerged from OECD calculations on net income of social assistance recipients using tax-benefit models (as reported in European Commission, 2008)[45] and has been confirmed by the EU Network of national independent experts. A review and discussion of differences in methodologies and measures of adequacy is beyond the scope of this brief analysis but is already scheduled in the context of the work on Active Inclusion, and included in the 2010 work-programme of the Social Protection Committee Indicators Sub-Group.

The EU Network experts also highlight the fact that **MI schemes play an important role in reducing poverty intensity, though the extent** to which they do so **varies greatly across Member States**. This shows up also in simulation results obtained for 15 EU countries using EUROMOD (Figari et al., 2009).Figure 3.5 represents the median poverty gaps[46] for working-age individuals (not in full-time education) below the poverty line (at 60% of the median) before and after receiving MI benefits. The median poverty gap for people entitled to benefits is indeed reduced through MI benefits in all countries, though with a substantial cross-country variation. The effect is stronger in BE, the NL and SE and smaller in ES, EE, AT, PL and FI. Figure 3.5 also shows that in all countries the median poverty gap is larger for working-age individuals entitled to MI (before receiving it) than for individuals that are not entitled to it. This suggests that MI schemes are indeed targeting the poorest working-age individuals in all countries, despite the fact that, as mentioned above, in some Member States people with very low incomes are still left with no access to the schemes due to low coverage.

Mechanisms for up-rating MI benefits over time are also important to ensure adequacy. Many of the EU Network experts note **a tendency towards deterioration of benefit adequacy with respect to general living standards, with the benefits "losing ground" relative to wage increases over time** (which reflects the more general downward trend – observed by Nelson, 2009[47] – for social assistance benefits standardised for wage increases between 1990 and 2005). This is often linked to the **lack of clear systems and procedures for regular up-rating of the MI level** (see Frazer and Marlier, 2009, and the country reports produced by the EU Network of independent experts for the country-specific institutional details on this).

---

[44]   COM(2008) 639 final.

[45]   European Commission (2008) "Social protection and social inclusion 2008: EU indicators" Commission Staff Working Document.

[46]   The poverty gap is expressed as the distance between the household equivalised income and the poverty line as a proportion of the poverty line.

[47]   Nelson K. (2009) "Social assistance and minimum income protection in the EU: vulnerability, adequacy, and convergence" Luxembourg Income Study Working Paper No. 511.

Figure 3.5 – Median poverty gap of working-age individuals below the poverty line (at 60% of the median) by MI entitlement status (before and after receiving MI benefits) (policy years 2001, 2003, 2005)
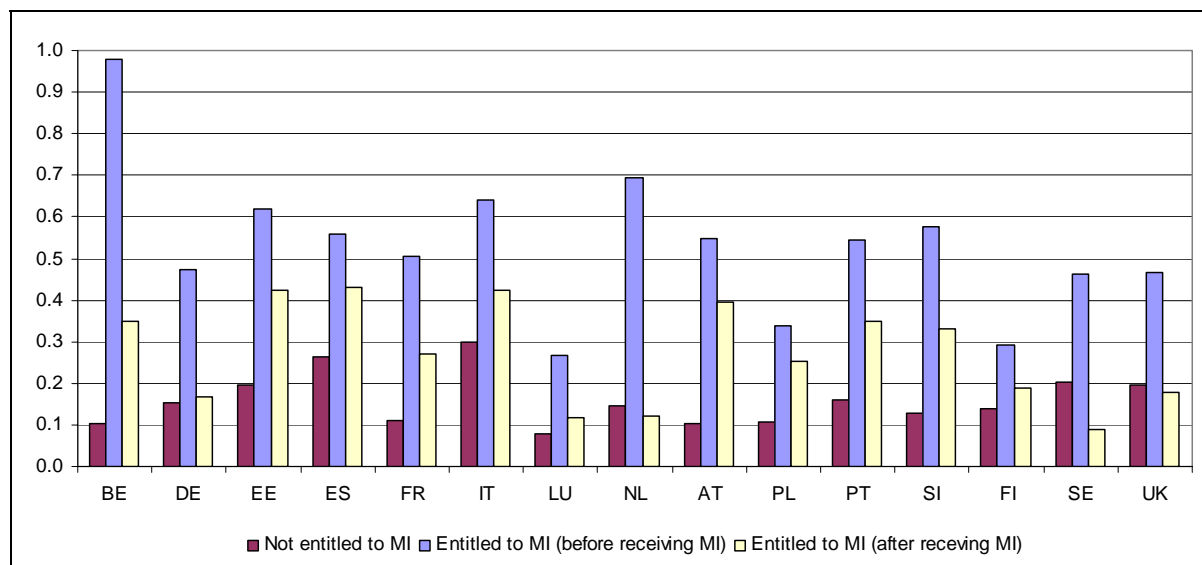
Note: MI schemes are defined here as to include the benefits listed as "Minimum resources: general non-contributory minimum" in the Mutual Information System on Social Protection (MISSOC) database. Tax-benefit policy rules refer to 2001 for FR, SE; to 2003 for BE, DE, IT, LU, NL, AT, PT, FI, UK; to 2005 for EE, ES, PL, SI. Figures for FR do not take into account the (time-limited) earnings disregards linked to the MI scheme (RMI). MI schemes cannot be simulated for IT and ES, where the schemes are administered at the regional level and variation across regions is too large. For these two countries MI receipt information from national surveys is therefore used. The sample size of working-age individuals below the poverty line entitled to MI benefits is small in DK, ES and AT. DK has been dropped while the results for the remaining countries should be treated with caution.

Source: Figari, Haux, Matsaganis and Sutherland (2009)

For many Member States designing MI schemes in such a way not to negatively impact on incentives to take up work represents a key concern. Attention has been increasingly devoted to designing the schemes so as to **avoid creating unemployment and inactivity traps, as well as low wage traps** for people in work and in receipt of MI benefits. In this sense, based on the assessment of the tax-benefit reforms aimed at making work pay conducted by the European Commission in February 2009,[48] policy interventions adopted by the Member States include reductions in the tax wedge (direct labour taxation plus social security contributions) on lower wages, increases in minimum wages, the introduction of in-work benefits and the review of the design of out-of-work benefits including social assistance.

The above mentioned European Commission study shows that between 2001 and 2007 the largest improvements in terms of reducing unemployment traps were achieved by FR, SK, FI, SE, BE and DK for all household types. The introduction of in-work benefits contributed to reducing unemployment traps in FR, SK, IE and FI, while a contribution in this sense was provided by measures to reduce the tax wedge on low wages in FR, FI, BE and PL. Increased earnings disregards helped reducing the financial disincentives to work in FR and FI.

---

[48]   European Commission (2009) "Recent reforms of the tax and benefit systems in the framework of flexicurity" European Economy Occasional Papers 43, Feb 2009.

Inactivity traps were also considerably reduced between 2001 and 2007 in a number of countries. In particular, this was the case for one-earner couples with children at a low wage level in FR, SE, AT, ES, FI, CZ and SK. The reduction was mainly due to changes in social assistance schemes, followed, for instance, by the introduction of in-work benefits as in SK and SE. Targeted reductions in inactivity traps for certain family types were achieved also in HU (for two-earner couples with and without children), the UK (for one-earner couples), IT (for two-earner couples with and without children) and IE (for two-earner couples without children and single parents with children). Based on recent data (2007), reductions in inactivity traps have been recorded in particular for FR, LV and SE. This was driven by changes in social assistance schemes in FR and LV and by the introduction of in-work benefits in SE.

Specific factors characterising the design of MI schemes **that might bring about disincentives to take up work** are identified by the EU Network experts (Frazer and Marlier, 2009). These include:

(4) **high benefit withdrawal rates** (also with regard to secondary benefits providing access to key services like medical care and childcare);

(5) **lack of systematic mechanisms to adjust the value of earnings disregards**[49] over time so as to avoid their erosion;

(6) **regulations on refund of benefits** on the part of former beneficiaries.

In the context of the work on Active Inclusion, a more detailed review of the existing evidence and further analytical work on the relationship between minimum income protection and incentives to take up work will be conducted with the Social Protection Committee Indicators Sub-Group.

4. THE USE OF THE EUROPEAN SOCIAL FUNDS TO SUPPORT SOCIAL OBJECTIVES DURING THE CRISIS AND IN THE LONG TERM

The European Union mobilises significant financial resources to fight poverty and social exclusion and to promote the policy objectives agreed in the Social OMC. Here, the European Social Fund (ESF) is the single most important financial instrument at the disposal of the EU. The ESF accounts for almost 10 % of the € 120 billion annual EU budget, and will spend over € 75 billion in total between 2007 and 2013. In the period 2007–2013, the ESF will invest over € 75 billion in creating jobs, promoting social inclusion, fighting discrimination and strengthening institutional capacity.

As described in greater depth in the 2008 Joint Report on Social Protection and Social Inclusion, Member States have designed strategies to create more and better jobs and to promote social inclusion and cohesion in the 117 'operational programmes' planned according to their specific situations and needs.

---

[49] Earnings disregards are the part of income that is not taken into account when assessing whether eligibility conditions are met by the applicants.

Fighting poverty and social exclusion through ESF interventions primarily takes two forms. Firstly, the ESF can target social exclusion explicitly. Such actions tend to be curative in nature and are aimed at people already suffering from social exclusion. Some €10 billion (12.4% of the total funding over 2007-2013) can be spent on this type of action.

Secondly, ESF actions aim to prevent or reduce poverty and exclusion through early intervention. In particular, measures to help invest in skills and knowledge, but also to improve workers' adaptability or fight early school-leaving, belong to this second type of intervention. No matter which form of intervention is used, however, the bulk of ESF spending helps prevent or reduce social exclusion.

The two approaches outlined above involve a broad range of target groups and policy areas. In the period 2007–2013, the European Social Fund will focus on the social inclusion of disadvantaged people, in particular by improving their opportunities for integration in the labour market. In addition, the ESF also supports employability measures, the social economy, access to vocational training, and life-long learning. Gender mainstreaming, the promotion of equal opportunities and anti-discrimination measures are also supported. As far as pensions are concerned, the ESF aims to promote longer working lives by keeping older workers in employment. Finally, throughout the programming period, many operational programmes will make a significant contribution to health and long-term care by focusing on key personnel employed in this labour-intensive sector.

The operational programmes for the 2007–2013 programming period were developed in a period of increasing employment and stable growth, but the overall economic context in which they now operate has changed fundamentally. Economic growth plummeted in 2009 and the situation in the labour market has deteriorated significantly. For many disadvantaged persons, the result is further vulnerability and isolation from the labour market. Social protection and inclusion systems now face the enormous challenge of ensuring that the crisis does not disproportionately affect those citizens most in need.

The unemployed are the group requiring most urgent action. Many Member States focus their ESF interventions on this group in order to help them maintain their employability and find a new job as quickly as possible. In addition, the number of persons at risk of losing their jobs has also increased. Therefore, an equally urgent issue is to prevent unemployment. Many measures supported by the ESF therefore seek to keep people in employment, albeit often with shorter working hours, and prepare for the upcoming recovery by investing in their skills and qualifications.

In a context of rising unemployment, falling revenues and increasing scarcity of resources, the ESF can provide stable, predictable and available financial support. In their response to the crisis, Member States and the European Union have made use of the financial instruments at their disposal, such as the ESF, by re-adjusting their operational programmes, where necessary, and fine-tuning them to their emerging needs.

Member States' responses to the crisis also reflect the will not to lose sight of the most vulnerable. While efforts to give people furthest from the labour market a realistic chance of finding a job are by nature more time-consuming, the way operational programmes are implemented shows that combating the crisis in the short term and addressing long-term

priorities and actions in support of vulnerable groups are not mutually exclusive, with many Member States maintaining their efforts to help those facing structural barriers in accessing the labour market.

The following chapter looks at ESF-supported actions responding to the most urgent needs prompted by the crisis and at the longer-term aim of cushioning the impact of the crisis on the most vulnerable. The chapter also sets out how the Commission and the Member States have adjusted their instruments to respond to the crisis, by modifying, simplifying or making them more effective. Finally, the chapter describes some recent actions supported by the European Globalisation Fund to help maintain the social inclusion of workers losing their jobs.

4.1. ESF support for social protection and inclusion: actions responding to the crisis

As part of their immediate responses to the crisis in the areas of social inclusion and protection, Member States have used the ESF to enhance support for the unemployed, to prevent further rises in unemployment and to strengthen the social inclusion of vulnerable groups.

Member States have used four main approaches to mobilise ESF resources to counter the effects of the crisis, which can be described as follows:

- Support for the unemployed

- Preventing the risk of unemployment

- Social inclusion of vulnerable groups

- Simplifying ESF implementation arrangements to better respond to the crisis

4.1.1. Support for the unemployed

As mentioned earlier, the current economic crisis has had a significant impact on unemployment. Given the well-known link between poverty and unemployment, a key policy objective is to ensure that unemployed people benefit from active measures as soon as possible, in terms of new employment where it exists, the updating of old skills or the acquisition of new ones. The objective is to ensure that people do not lose their link with the labour market and become long-term unemployed, thereby increasing their chances of financial and social exclusion. The following section details some of the ways in which Member States have used the ESF to support the unemployed.

To better focus ESF spending on certain areas, **Poland** has introduced anti-crisis measures mainly under the Adaptability and ALMP priorities of the operational programme (OP), which play the principal role in mitigating the impact of the crisis. Some specific measures (amounting to €156.5 million in 2009) include subsidies to increase the geographical mobility of employees by covering the costs of transport and settling down in other places, funds for retraining qualified redundant employees (for instance from the service sector), or financial support for business start-ups by employees losing their jobs as a result of lay-offs. Similarly, additional ESF funds have been allocated to support self-employment for the unemployed in **Slovenia**.

Ireland has introduced a number of new active measures that may receive ESF co-funding, such as a work experience scheme (including for graduates), an increase in the number of tertiary education places for the unemployed, a doubling of the monthly capacity of the public employment service (PES), and a significantly increased number of short-term training places.

In **the UK**, the devaluation of the sterling against the euro since 2008 has resulted in additional ESF funding in England amounting to £ 179 million. This additional funding is being used to help those most affected by the economic downturn. Of this, £ 79 million has been allocated to provide extra help for the unemployed to make a successful return to work, focusing on people who have been on jobseekers allowance for 6 months (and therefore at risk of long-term unemployment) and other disadvantage unemployed people from day 1 of unemployment at Jobcentre Plus. In addition, the introduction of the 'Training for Success' programme in Northern Ireland will assist young people in acquiring the required skills and qualifications to get work.

In **Greece**, the creation of 12 new employment centres (KPA) and the renovation of another 38 will help address the needs of those recently made unemployed. 122 350 unemployed had benefited from active employment measures up to March 2008, through participation in co-financed projects such as 'new employment posts', 'work experience', 'promotion of new employers' and so forth, targeting particular groups and different sectors.

Portugal has strengthened measures to address the unemployed, such as qualification actions, professional training, professional internships for young people with high qualifications, double certification training, and consulting schemes for enterprises. Special attention is given to measures to help create jobs, including self-employment, entrepreneurship and professional internships, and an effort has been made to increase the implementation rate of these measures. Participation by unemployed people in useful social activities is promoted by the OP, aiming to help unemployed people retain contact with the labour market, avoid long-term unemployment, and increase their purchasing power.

4.1.2. *Preventing the risk of unemployment*

Since unemployment is so strongly linked to poverty, it is important that rising unemployment is tackled — especially the drift towards long-term unemployment. Many ESF actions taken by Member States have been designed with a view to preventing further rises in unemployment and people falling into social exclusion and poverty.

Germany has responded to the crisis by adapting its short-term allowance scheme (Kurzarbeitergeld) to the new situation on the labour market. The principle is 'better retrained than redundant' ('Qualifizieren statt entlassen'). In particular, the maximum duration for receiving the short-term allowance has been extended from 6 to 24 months. Furthermore, the government seeks to encourage employers and employees to use the period of short-time work to organise training courses. If such a course is organised, the public employment service pays, as a financial incentive, 100 % of the social security costs. The ESF can be used as a source for co-financing the training courses and the short-term allowance.

Similarly, in **the Czech Republic**, an ESF co-financed budget of € 125 million has been allocated to schemes subsidising the wages and training costs of employees whose companies are forced to reduce their working hours. The two short-term working schemes, 'Train

yourself!' and 'Training is a chance', enable companies to obtain reimbursement of the training costs and salaries for their employees for the time they spend on training. Their implementation is managed by the labour offices or directly by the Ministry of Labour.

The **Hungarian** OP co-funded by the ESF supports a similar scheme, combining reduced working time with training, for micro, small and medium-sized enterprises. A scheme for larger companies is also envisaged. In **Slovenia**, the obligatory training of employees temporarily waiting for work is also co-financed by the ESF. Another example of this approach is **Austria** which has changed its OP to extend the group of potential beneficiaries to **employees in short-time working ("Kurzarbeit")** (before the change training for older workers was eligible). Similarly, the initial focus of **Finland's** OPs was mainly on employed people and the weakest groups in the labour market. Since the financial crisis, however, funding has also targeted the increasing number of workers who have just become unemployed.

The **Italian** government has widened the scope of some unemployment benefits (indennità di disoccupazione in deroga). Extra funds from national resources and ESF regional operational programmes have been allocated to such unemployment benefits and to active labour market policies (ALMPs) for the period 2009-2010, focusing on the needs of redundant workers or on those temporarily laid off due to demand fluctuations or firm restructuring. These new provisions complement national unemployment benefit programmes: the workers are involved in labour market reactivation programmes run by public employment services and employment agencies and the target groups benefit from personalised training paths or are given training vouchers.

The Netherlands has modified its OP with a view to combating youth unemployment. A national Action Plan on Youth Unemployment was presented in May 2009. The measures include creating extra apprenticeships and traineeships and stimulating regional cooperation between all actors (municipalities, social partners, schools, PES) able to contribute to participation possibilities for young people up to the age of 27. The activities qualifying for support are those covered by the national Action Plan, and include education, training, guidance, working/learning combinations, traineeships, apprenticeships, etc.

In **Spain,** the ESF contributes to a number of actions, focusing both on the short term (responding to lay-offs) and on the long term (supporting sustainable economic growth), such as reinforced personalised guidance and support, skills development and local needs, the promotion of occupational and geographical mobility, and the concentration of support on the most vulnerable. Over a long-term perspective, the ESF provides reinforced support to emerging sectors (identification of future occupational and skills requirements) and to human capital and education actions (combating early school drop-out).

France has reinforced the priorities for strengthening the ability of workers and companies to adapt to economic change, ensuring access to employment for job seekers through training for qualifications, and providing support for the most vulnerable (general introduction of the 'active solidarity income' — Revenu de Solidarité Active (RSA)). In addition, it was decided to extend temporarily the ESF support for training activities by crisis-affected companies with more than 250 employees (whereas the OP targets mainly SMEs).

4.1.3. Social inclusion of vulnerable groups

In the current global economic downturn, the role of the ESF in supporting the most vulnerable has never been more critical. The ESF is contributing to the efforts made by the Member States in a number of actions aimed at ensuring that vulnerable groups are not disproportionately hit by the crisis. Most ESF OPs try to ensure a coordinated response to the needs of those furthest from the labour market, including actions to promote access to employment and sustainability, the social inclusion of disadvantaged persons, and human capital development.

In **Cyprus,** the OP co-financed by the ESF provides for a series of interventions to increase labour supply (especially of women and young people) and strengthen the social inclusion of vulnerable groups, while also supporting the development of human resources and the adaptability of workers and enterprises. As a result, there is a high degree of complementarity between the actions planned under the ESF and the Prevention Action Plan put in place by the government in response to the crisis. A large number of interventions under the Prevention Action Plan (such as promoting new employment opportunities for vulnerable persons, skills upgrading, vocational training, work experience and subsidised job placements, along with upgrading and expanding the activities of the public employment services to better respond to the needs of the unemployed and the vulnerable) are expected to be supported by the ESF.

In the **UK,** part of the additional ESF funding (resulting from the devaluation of sterling against the euro) has been allocated to increasing the support that Jobcentre Plus provides to disadvantaged groups such as ex-offenders, refugees, homeless people, people with drug or alcohol problems, people leaving residential care, lone parents, people with disabilities, etc., thus strengthening activation and prevention.

Romania has set up a national pre-financing system for programmes co-financed by the ESF. This system gives greater support to social inclusion projects, for which 40 % pre-financing (instead of 30 %) has been set aside.

In Greece, an important objective is to further restructure the public employment centres (KPA) by converting them into 'one-stop shops' able to implement stronger active policies for disadvantaged groups. More precisely, support for strengthening the social inclusion of at-risk groups includes actions to improve the attendance of vulnerable groups in secondary education (Roma, migrants, minorities) and to reduce early school-leaving and promote achievement through all-day schools, learning support programmes for immigrants, the establishment of intercultural schools, 'second chance' schools and adult education centres, and the use of new technologies in the learning process.

4.1.4. Simplifying ESF implementation arrangements to respond to the crisis

In their response to the crisis, Member States have also made use of the flexibility offered by the ESF to cushion the impact of the crisis on the most vulnerable by adjusting their operational programmes, modifying them where necessary and using the simplification tools proposed by the Commission to improve the effectiveness of the ESF.

Many Member States have used the opportunity to review their operational programmes to adapt them to the changing economic context. Concerning the refocusing of strategies

supported by the ESF and the fine-tuning of programmes, it is worth noting that a number of changes to OPs and implementing arrangements have been made. Member States have amended the selection criteria, modified the strategic indicators to take account of emerging needs and, in some cases, reallocated funding between categories and priorities.

In **Poland**, some changes have been made to the **selection criteria** — such as ensuring participation in ESF projects for those employed in sectors particularly affected by the crisis. Simplified implementation arrangements are envisaged by the authorities, including fast-tracking for project selection — especially for labour market and adaptability measures.

In order to better respond to the crisis, **Latvia** has reviewed the priorities set in the ESF OP. The OP 'Human Resources and Employment' has been revised substantially in response to the challenges faced by Latvia due to the financial and economic crisis. The main change is the re-allocation of resources to Priority 3 'Promotion of Employment and Health at Work' (€22 million) and Priority 4 'Promotion of Social Inclusion' (€16 million). New measures include a local employment emergency programme, short-term working combined with training, and retraining of teachers in the context of education reform.

In the **UK,** the Wales/Convergence OP has transferred €41 million from priority 1 'For young people' to the 'Employability' priority. Similarly, the Irish ESF OP was revised in 2009 to better respond to the crisis by focusing more on support for the unemployed. This involves transferring some resources from Priority II 'Increasing Participation and Reducing Inequality in the Labour Force' to Priority I 'Increasing Activation of the Labour Force'.

In **Portugal**, the ESF programme has been modified to mitigate the impact of the crisis. Under priority 5 'Support for entrepreneurship and transition into active life', new measures have been introduced to support the maintenance of jobs in enterprises in a sound financial situation but facing falling world demand, mainly by training workers. Another modification involves promoting the employability of unemployed people and social welfare beneficiaries by supporting their participation in useful social activities. Priority 6 'Citizenship, Inclusion and Social Development' has received an additional €37.1 million from the Portuguese government in order to boost public investment in the social sector.

4.2.   ESF support for social protection and inclusion: long-term actions

Despite the crisis, the ESF co-funded programmes will continue with long-term social inclusion actions to strengthen social cohesion. In the current programming period, some Member States are using the ESF to implement multidisciplinary actions to respond to more complex social challenges. These actions cover different fields such as education, employment or social inclusion in a holistic manner. The experiences to date show that ESF support mobilises and triggers effects from different policy fields which would otherwise not have come about. The catalytic effect generated by the ESF on the ground leads to the streamlining of multidisciplinary actions, thus overcoming fragmented policy-making and combining different interventions into a single comprehensive approach.

- **In Slovakia**, the ESF co-finances the complex (comprehensive) local development strategies for marginalised Roma communities. These strategies have been allocated almost €179 million for the programming period 2007-2013. They require at least one

investment project (ERDF) and one non-investment project (ESF). The call for proposals has already been published and will remain open until the end of January 2010. Eligible activities under six operational programmes include building infrastructure (educational, social and tourist, plus settlement regeneration), supporting employment growth and social inclusion, raising the educational level of communities, innovation and technology transfers, health promotion, and waste management.

- In **Germany** an ESF co-funded programme (BIWAQ[50]) has been launched to address the multiple problems arising in deprived neighbourhoods due to social and economic change. Its starting point is the fact that economic and social deficiencies are usually concentrated in specific neighbourhoods where structural deficiencies in buildings and dwellings, inadequate infrastructures, high unemployment rates, low incomes, lack of skills or education and, as a result, poor employment opportunities are creating tensions in these communities, including tensions between different ethnic groups. BIWAQ is closely linked to a more comprehensive policy initiative called the 'Social City'[51], which is based on an integrated approach cutting across various fields of action. Under the BIWAQ programme, public bodies, private entities and partnerships (such as businesses, education or training providers, schools, clubs or associations) may receive funding for projects within the areas covered by the 'Social City' programme. The content of the BIWAQ projects must have a connection with the development strategies adopted by urban and local authorities under the 'Social City' programme, thereby following its integrated approach. BIWAQ projects target both the mainstream segments of society and persons with an immigrant background and aim to promote social inclusion and community life in neighbourhoods. BIWAQ focuses on (1) helping the long-term unemployed back to work; (2) providing young people with training and integrating them into the labour market; (3) facilitating the transition from school to work; and (4) strengthening the local economy.

- As part of the **Spanish** regional OP for Cataluña, the regional government has singled out 80 particularly deprived neighbourhoods in the region for intervention under the ESF Programme 'Employment in the Neighbourhoods'. One of them is the Barrio de La Mina (a particularly deprived area in Barcelona). This area received ESF co-financing under the Catalonia OP Objective 3 in 2000-2006. The success of the project prompted its mainstreaming in the OP 2007-2013. The project comprises an ad hoc consortium bringing together all relevant actors to jointly manage actions (urban planning, social inclusion, training, etc.). Main 'innovative' features: strengthening and recognition of local governments as main actors in employment and local development policies; a 'Charter of Services' for local governments, integrating all active employment policies into a single project; a change of approach from sectoral implementation of policies to territorial implementation; and strengthened cooperation between regional/local administrations.

- In **Ireland**, the ESF helps promote equality in tertiary education by increasing the participation rates of students with disabilities, students from disadvantaged backgrounds, including from the Roma community, ethnic minorities and mature 'second-chance' students, through the 'Third Level Access' measure. The Fund for Students with a

---

[50] BIWAQ stands for '*Bildung, Wirtschaft, Arbeit im Quartier*' (education, economy, work in the neighbourhood).

[51] This programme is an urban development programme which targets neighbourhoods with development priority. The Social City (*Soziale Stadt*) was launched in 1999 to counteract the increasing social and spatial segregation of urban communities.

Disability, part of the Third Level Access fund, provides grants for the provision of services and purchase of equipment for students with serious sensory, physical and/or communicative disabilities. ESF co-financing is also used to provide targeted aids such as transport, sign-language assistance/interpreters and personal assistants. The Student Assistance Fund, which aims to assist students who might otherwise, because of financial reasons, suffer severe hardship or be unable to continue their tertiary studies, is also an integral part of tertiary access funding. Assistance under the Student Assistance Fund covers rent, books/course materials and living expenses. Expenses financed under the Fund for Students with Disabilities include transport, personal assistance, and equipment.

- In the **UK**, the ESF-funded project Seeing the Potential, which is run by the Royal National Institute of Blind People (RNIB), assists blind and partially-sighted people to prepare for work — through training or work placements — and secure and sustain paid or voluntary employment. The project operates by regularly meeting with clients to assist with exploring employment options and identifying vacancies, creating a CV, and providing assistance with application forms and cover letters.

4.3.   The European Globalisation Adjustment Fund (EGF)

The EU Structural Funds, in particular the European Social Fund (ESF), support the anticipation and management of change through activities with a strategic and long-term perspective, such as life-long learning. In contrast, the European Globalisation Adjustment Fund (EGF) provides one-off, time-limited individual support geared to helping workers who have become redundant as a result of globalisation.

The EGF exists to support workers who lose their jobs as a result of changing global trade patterns or the current economic and financial crisis. When a large enterprise shuts down or a factory is relocated to a country outside the EU, or a whole sector loses many jobs in a region, the EGF can help the redundant workers to find new jobs as quickly as possible. A maximum amount of € 500 million per year is available to the EGF to finance such interventions.

The advent of the current recession, with its greater demands and challenges, called for a strengthened response, and the EGF was modified in 2009 to enable it to respond more flexibly to the requirements of redundant workers. Some aspects of the EGF were modified specifically for the expected duration of the crisis, including:

– The addition of the crisis itself as a qualifying condition. Where previously evidence of changing world trade patterns had to be provided, applications made by the end of 2011 can be justified by redundancies caused by the crisis.

– For applications introduced before the end of 2011 the intervention rate has been increased to 65 %, rather than the normal 50 %. This means less strain on national budgets, so more workers can be assisted.

One of the key principles of the EGF is that assistance should be provided as quickly as possible in order to keep the workers in the labour market. Active labour market policy measures can be eligible for EGF funding from the moment of redundancy, which may occur several months before the decision on such funding has been taken by the EU's budgetary authority.

The EGF specifically encourages measures aimed at disadvantaged or older workers to help them reintegrate into the labour market, in order to make up for the disadvantage that their age may constitute in the eyes of potential employers or the extra training they may require after many years in the same job or the same sector. In several EGF cases Member States have proposed actions specifically for workers over 45 or over 50, aiming to keep them in active employment. Where necessary, this assistance can include wage subsidies and public works employment.

Other EGF cases have targeted workers with low basic education levels. Both Portugal and Ireland have proposed measures to help redundant workers overcome obstacles resulting from low basic education levels, through provision of targeted education and the recognition and certification of experience gained.

Another area of disadvantage that the EGF tackles is geographical remoteness. The case of Perlos in Eastern Finland showed that the collapse of the biggest employer in the region may threaten the whole area with depopulation. By helping the workers to acquire new skills locally and to find new jobs or start their own businesses, the EGF helped to ensure a brighter outlook for the region, and to keep the younger population there.

5. THE IMPORTANCE AND EXTENT OF HOMELESSNESS AND HOUSING EXCLUSION

5.1. Housing vulnerability: the importance of housing in the context of the current economic crisis

The link between the housing market and the economic crisis differs between Member States, both in terms of the role of housing as a factor behind the economic crisis and the consequences of the crisis for the housing situation of EU citizens. This complex picture is at least partly due to the different structure of housing markets and their legal and policy frameworks. The labour and credit markets constitute the most obvious connection between housing and the broader economy.

Employment in the construction sector, which increased in the vast majority of Member States between 2000 and 2007 with the housing boom, was one of the worst affected by the economic crisis. In turn, employment losses in the economy at large have had a further negative impact on housing markets and increased the risks of becoming homeless. Concerning the credit market, the vulnerability of households to fluctuating and often over-inflated house prices and to uncertain financial markets has increased in the last ten years: mortgage debt as a percentage of household income has increased in most Member States, reaching over 100 % in PT, ES, SE, the UK and IE and over 200 % in DK and NL.

The potential severity of the crisis and its impact on the housing situation of EU citizens are illustrated by the following examples based on national data[52]. Significant increases in the number of **non-performing housing loans** have been recorded in Belgium, Estonia (+ 215 % in 2008 and a further 40 % increase in the first quarter of 2009), Greece, Ireland, Lithuania and Latvia. The number **of repossessions has also increased** in Denmark (+100 % in 2008

---

[52] See the Joint assessment by the SPC and the European Commission of the social impact of the crisis and of policy responses (doc. SPC/0911/1).

and +46.3% in 2009), Spain (+126% in 2008), Greece (+17% in 2008), Ireland (+30% between June 2008 and June 2009), and the United Kingdom (from 10000 in Q2-2008 to 11400 in Q2-2009). The number of beneficiaries of specific support schemes for tenants has increased in IE (+41% between Q2-2008 and Q2-2009) and HU (+5% between 04-2008 and 04-2009), while the number of beneficiaries of schemes to support mortgage holders also rose in IE: +144% between Q2-2008 and Q2-2009. Finally, the **applications and waiting times for social housing have increased** in Ireland, Luxembourg and the UK.

The consequences of the economic crisis on households vary greatly across Member States, depending on the support mechanisms in place and the policies introduced to counteract the effects of the downturn. In particular, Member States have reacted with measures to **protect mortgage holders**, such as housing loan subsidies (EL, IT, NL, PL[53], IE, SK and the UK), state guarantees for mortgage loans and tax reforms (ES, HU, PT and LU), the possibility to renegotiate and postpone mortgage payments and making repossessions more difficult (EL, ES, IT and LT); and **investment in housing and regeneration**, including accommodation for the homeless and measures to improve energy efficiency (DE, ES, FR, IE, LV, LU, MT, AT, PT and the UK). More general measures introduced to **strengthen income support** are also important to help people cope with the worsening conditions in the labour market.

5.2. Housing exclusion –- an important challenge for the EU population at large and particularly for those at risk of poverty[54]

A decent home is an essential need and access to **affordable** and **quality** housing is one of the main determinants of people's well-being and social participation. Indeed, according to a recent Eurobarometer survey, for 26% of EU citizens the fact that decent housing is too expensive is the social factor that best explains why people are poor. This is why the Charter of Fundamental Rights provides for the right to housing assistance so as to ensure a decent existence for all who lack sufficient resources. Housing support and social housing are also recognised as essential services in supporting active inclusion policies[55].

Housing affordability is an important challenge considering that housing costs represent a significant proportion of people's income. On average in the EU the share of housing costs in total disposable income, net of housing allowances, is 19%, reaching over 20% in CZ, PL, SK, EL and the UK and over 25% in DK and NL. The issue of affordability is particularly problematic for the at-risk-of-poverty population: in the EU as a whole, the impact of housing costs is more than twice as important for the poor as for the non-poor population (33% vs 17%) and this ratio is over 2.5 in FI, AT, FR, CY, SI, LU and SE, where poor people spend three times more on housing, relatively to their income, than non-poor people.

---

[53]   The public support for mortgage holders is created as interest-free loan and it is offered only to unemployed persons whose have lost their jobs after 1st July 2008. During one year the state covers the mortgage rate of registered unemployed person (who applies for such support) up to a. 300 EUR monthly. After 2-years the support is finished and the mortgage holders have to, during 8 years, pay back (monthly) amount of this support.

[54]   For further analysis on homelessness and housing exclusion, see also the 2009 Social Situation Report at: http://ec.europa.eu/social/main.jsp?catId=675&langId=en

[55]   See the Commission Recommendation on active inclusion [2008/867/EC] paragraph 4(c), Council Conclusions of 17.12.2008 paragraph 29 and the European Parliament resolution of 6.05.2009 (A6-0263/2009).

**Fig. 5.1: Share of housing costs in total household income net of housing allowances —
2007**
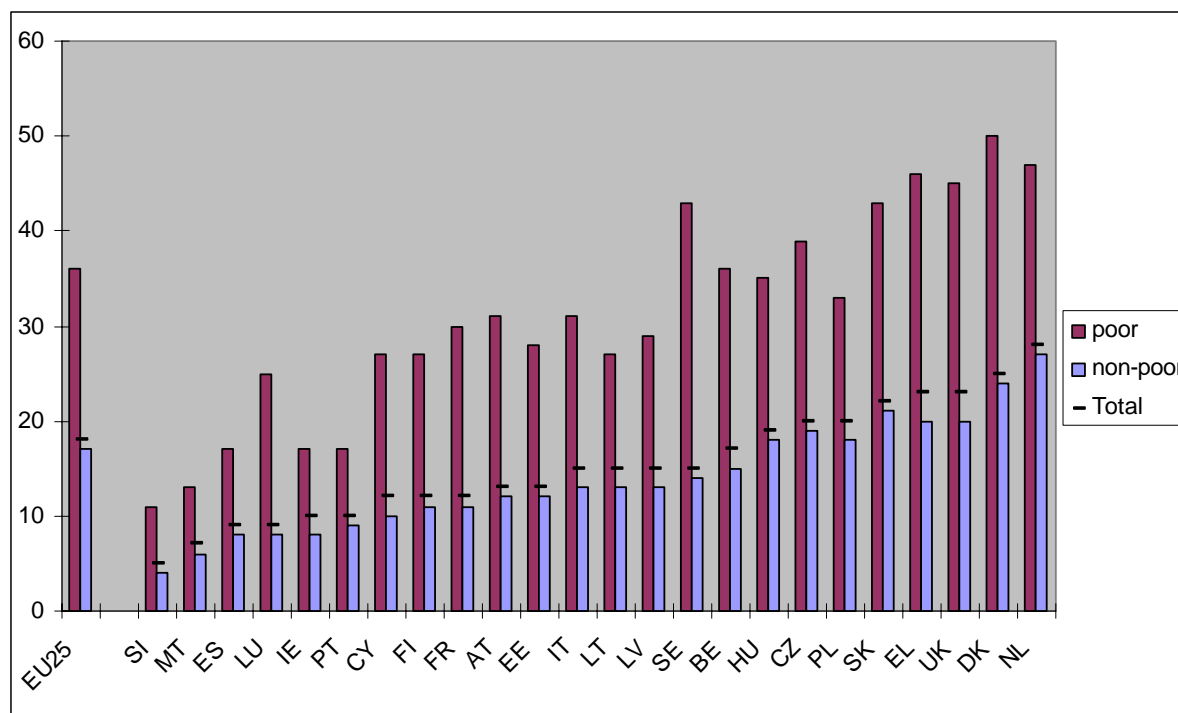
Source: EUROSTAT; EU-SILC 2007
Notes: data on DE omitted because key components of the housing cost variable are missing.

The impact of housing costs on household income is also particularly important for households in more densely urbanised areas, for single households with or without children (around 28 %) and for tenants (27 %).

Housing costs are on average the most important single expenditure item relative to income. For a significant part of the population housing costs account for over 40 % of disposable income, which can significantly reduce the capacity of the household to adequately cope with all the other needs besides accommodation, even if the relevance of a relatively high housing cost burden on household welfare obviously depends on the level of household income. Approximately 13 % of the EU population is affected by <u>housing costs overburden</u>, but the figure is 39 % for the at-risk-poverty population as against 7 % for the non-poor — more than a five-fold difference. Indeed, the difference is over 10 times in CY, SE, LT, AT and EL and over 20 times in LU.

Furthermore, in Member States such as SK, DK, NL, EL and BG over 50 % of the at-risk-of-poverty population faces an excessive housing cost burden. This represents an important challenge in terms of increased risks for social and housing exclusion. It also points to the importance of housing affordability as a fundamental element in improving the living standards of people at risk of poverty.

Fig. 5.2: Housing costs overburden rate — 2007
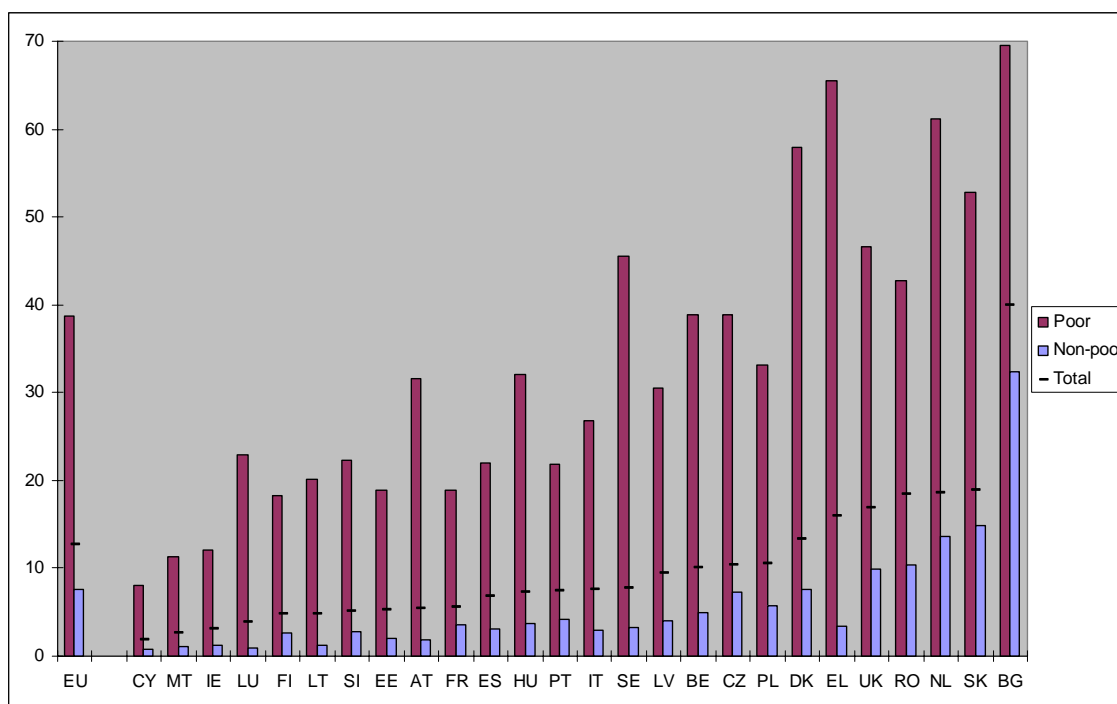
Note: share of the population living in a household where housing costs (net of housing allowances) represent more than 40 % in the total household income (net of housing allowances). Data on DE omitted because key components of the housing cost variable are missing.
Source: EUROSTAT; EU-SILC 2007

Despite the fact that those at risk of poverty tend to spend more, in relative terms, on housing, they live in worse housing conditions. Over 27 % of low-income people lives in <u>overcrowded accommodation</u>[56], as opposed to 15 % of the rest of the population. The overcrowding rate for the at-risk-of-poverty population is over 50 % in SK, LV, LT, RO, BG, CZ, HU and over 68 % in PL. If single households are excluded[57], the overcrowding rate is reduced by 2 percentage points in SE and 3 in FI, but it increases by 2 in EE, IT, LV, PL, SK and 3 in BG, HU, LT and RO.

---

[56]   The dwelling is considered overcrowded if one the criteria mentioned below is not fulfilled:
- one room for the household;
    - one extra room for each couple;
    - one extra room for each single person aged 18+;
    - one extra room - for two single people of the same sex between 12 and 17 years of age;
    - one extra room - for each single person of different sex between 12 and 17 years of age;
    - one extra room - for two people under 12 years of age.

[57]   According to the definition of overcrowding, single-people households living in one-room flats are classified as overcrowded. However, this type of accommodation can range from large inner city lofts to small, inadequate bed-sits; without information on the size of the dwelling it is difficult to properly assess the situation. Also, the lack of a separate living-room can have different impacts on the capacity of the individual to invite people and socialize at his or her place according to the different social and cultural norms. For these reasons, data on overcrowding is published with and without single-person households.

Fig. 5.3: Overcrowding rate by poverty status — 2007
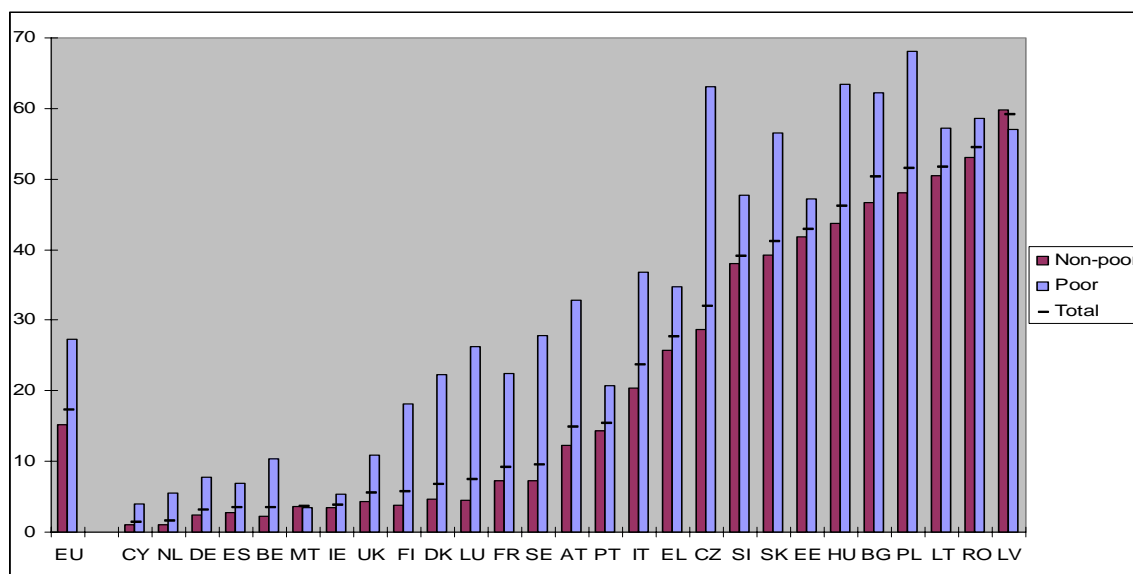
Source: EUROSTAT; EU-SILC 2007

Apart from overcrowding, low-income households also tend to live in poorer quality accommodation. The share of the at-risk-of-poverty population affected by at least one of the housing deprivation factors is 38% in the EU as a whole, and over 50% in EE, LV, PL, LT, BG and RO. This compares with 22% for the non-poor population.

Fig. 5.4a: Share of the population affected by at least one housing deprivation factor — 2007
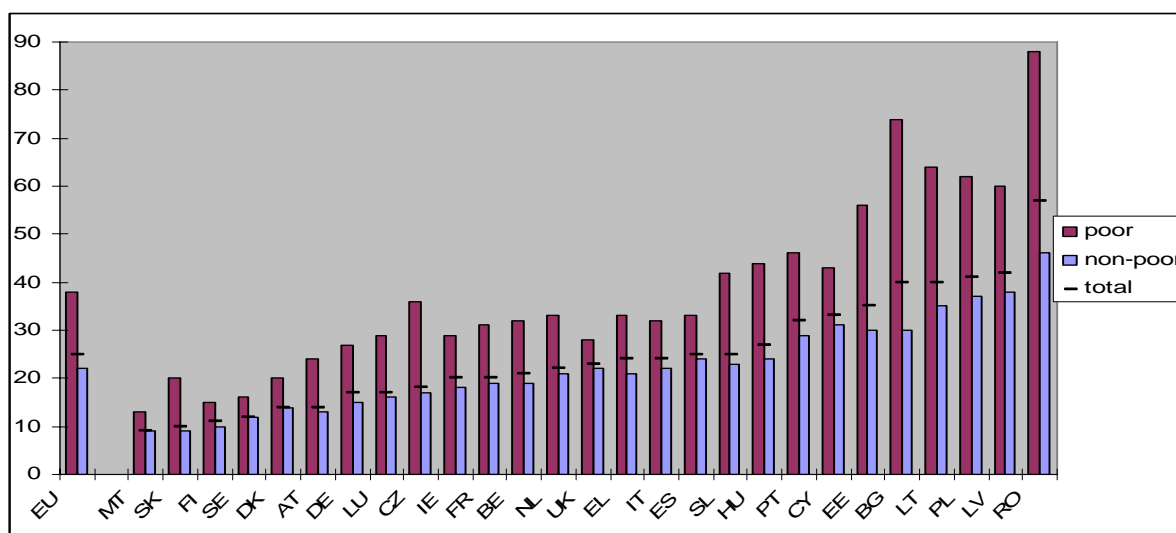
Note: housing deprivation factors are: damp walls, leaking roof or rot in windows; no bath or shower in the dwelling; no indoor flushing toilet for the sole use of the household; dwelling too dark.
Source: EUROSTAT; EU-SILC 2007.

Figure 5.4b: Material deprivation for the 'Housing' dimension, by item - 2007

	Total				
	Leaking roof, damp walls, floors or foundation, or rot in window frames of floor	Lack of bath or shower in dwelling	Lack of indoor flushing toilet for sole use of household	Dwelling too dark	Lacking no item
eu27	18	4	4	8	75
be	14	1	1	9	79
bg	15	20	34	10	60
cz	16	1	1	4	82
dk	11	1	0	5	86
de	13	1	1	4	83
ee	22	18	15	7	65
ie	15	1	1	9	80
gr	19	1	3	8	76
es	18	0	0	10	75
fr	14	1	1	8	80
it	21	0	0	8	76
cy	30	1	1	6	67
lv	26	22	20	12	58
lt	25	18	20	11	60
lu	15	0	1	5	83
hu	19	5	6	10	73
mt	5	0	0	4	91
nl	18	0	0	5	78
at	9	1	2	6	86
pl	37	7	6	9	59
pt	20	4	3	17	68
ro	29	42	44	8	43
si	17	1	1	10	75
sk	6	1	3	4	90
fi	5	1	1	5	89
se	6	1	0	7	88
uk	15	0	1	11	77

Source: EUROSTAT; EU-SILC 2007
Note: housing deprivation items are: damp walls, leaking roof or rot in windows; no bath or shower in the dwelling; no indoor flushing toilet for the sole use of the household; dwelling too dark.

The indicators presented above mainly concern two aspects of housing exclusion that lead to homelessness, namely inadequate and insecure accommodation. Being without a roof or without a house and having to live in emergency shelters or in temporary accommodation is of course the most extreme form of homelessness and indeed poverty and social exclusion. The lack of a commonly agreed framework at EU level to define and quantify homelessness, along the lines of the ETHOS definition[58], for example, remains one of the main obstacles to a

---

[58] The European Typology of Homelessness and housing exclusion (ETHOS) was developed by FEANTSA (the European Federation of National Organisations Working with the Homeless - http://www.feantsa.org/code/en/hp.asp) as a means of improving understanding and measurement of homelessness in Europe, and to provide a common "language" for transnational exchanges on homelessness. This typology was launched in 2005 and is used for different purposes - as a framework for debate, for data collection purposes, for policy purposes, monitoring purposes, and in the media.

proper assessment of this problem. Definitions of homelessness and housing exclusion (HHE) vary widely across Member States. There are a small number of Member States that have broad definitions of HHE that either correspond directly to the ETHOS definition or cover very similar categories (DE, DK, LU, NL, SE, UK), while some have partial coverage of ETHOS categories (BE, FR, HU, PT), some have a narrow definition (CZ, ES, FI, IE, PL, SK) and others have no standardised definition at all (AT, BG, CY, EE, EL, IT, LT, LV, MT, RO, SI).

The lack of clear definitions or the use of very narrow definitions can make it difficult to establish a definitive picture of those experiencing homelessness and housing exclusion and its causes. The national data available on rough sleepers and houseless people show a mixed picture, with the situation improving in certain Member States (UK, IE, NL and DE), but deteriorating in others (RO, LT, CZ, HU and SK). In particular, homelessness has emerged as an issue after transition in post-communist countries due to limited public budget support for housing developments for the low-income population and the shortage of affordable flats following privatisation of the public housing stock.

ETHOS – European typology on homelessness and housing exclusion

			Operational Category		Living Situation	Generic Definition
Conceptual Category	ROOFLESS	1	People Living Rough	1.1	Public space or external space	Living in the streets or public spaces, without a shelter that can be defined as living quarters
		2	People in emergency accommodation	2.1	Night shelter	People with no usual place of residence who make use of overnight shelter, low threshold shelter
	HOUSELESS	3	People in accommodation for the homeless	3.1	Homeless hostel	Where the period of stay is intended to be short term
				3.2	Temporary Accommodation	
				3.3	Transitional supported accommodation	
		4	People in Women's Shelter	4.1	Women's shelter accommodation	Women accommodated due to experience of domestic violence and where the period of stay is intended to be short term
		5	People in accommodation for immigrants	5.1	Temporary accommodation / reception centres	Immigrants in reception or short term accommodation due to their immigrant status
				5.2	Migrant workers accommodation	
		6	People due to be released from institutions	6.1	Penal institutions	No housing available prior to release
				6.2	Medical institutions[9]	Stay longer than needed due to lack of housing
				6.3	Children's institutions / homes	No housing identified (e.g by 18th birthday)
		7	People receiving longer-term support (due to homelessness)	7.1	Residential care for older homeless people	Long stay accommodation with care for formerly homeless people (normally more than one year)
				7.2	Supported accommodation for formerly homeless people	
	INSECURE	8	People living in insecure accommodation	8.1	Temporarily with family/friends	Living in conventional housing but not the usual or place of residence due to lack of housing
				8.2	No legal (sub)tenancy	Occupation of dwelling with no legal tenancy Illegal occupation of a dwelling
				8.3	Illegal occupation of land	Occupation of land with no legal rights
		9	People living under threat of eviction	9.1	Legal orders enforced (rented)	Where orders for eviction are operative
				9.2	Re-possession orders (owned)	Where mortgagor has legal order to re-possess
		10	People living under threat of violence	10.1	Police recorded incidents	Where police action is taken to ensure place of safety for victims of domestic violence
	INADEQUATE	11	People living in temporary / non-conventional structures	11.1	Mobile homes	Not intended as place of usual residence
				11.2	Non-conventional building	Makeshift shelter, shack or shanty
				11.3	Temporary structure	Semi-permanent structure hut or cabin
		12	People living in unfit housing	12.1	Occupied dwellings unfit for habitation	Defined as unfit for habitation by national legislation or building regulations
		13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding	Defined as exceeding national density standard for floor-space or useable rooms

Source: FEANTSA – the European Federation of National Organisations Working with the Homeless
(http://www.feantsa.org/code/en/pg.asp?Page=484)

5.3.   The overall policy response — comprehensive strategies and better governance[59]

5.3.1.   Comprehensive strategies are key to fighting homelessness and housing exclusion.

Homelessness and housing exclusion have been identified as an issue of concern by almost all Member States. This greater awareness amongst Member States is also due to the increasing focus given to the issue of HHE in recent years by the Social OMC. Transnational studies and exchanges have helped to enhance mutual learning and encourage increased efforts in a number of countries[60].

A growing number of Member States have adopted **comprehensive strategies** to fight homelessness and housing exclusion, either at national (IE, PT, UK, DK, FI, NL and FR) or regional/local level (SE, DE and ES). This has helped to push the agenda forward, improve coordination in policy design and implementation and identify more financial resources. In general, strategies are more effective with specific **targets,** including: prevention (both in terms of preventing evictions and follow-up of individuals discharged from public institutions); ending the most severe forms of homelessness (such as rough sleeping, in line with the European Parliament Resolution[61]); reducing the duration of homelessness (in particular the time spent in emergency and temporary accommodation); improving the quality of services and accommodation for homeless people; and improving the supply of affordable housing.

In several countries (e.g. DE, ES, IE, LU, NL, PL, PT and CY), there is a high and/or growing emphasis on **prevention**, which has proved to be the most effective and least costly way of combating homelessness. It has also received renewed attention as Member States respond to the economic crisis. Prevention tends to be of two types: firstly, initiatives to reduce the number of evictions and, secondly, increased efforts to help people leaving institutions gain access to suitable housing. There are examples of comprehensive strategies targeting specific risk groups, such as people released from prison (BE, DK, NL, UK and FI) or children leaving care (PL, MT).

In many Member States, there is more emphasis on providing temporary accommodation than on actual prevention. There is also a trend towards building other support services around the provision of temporary accommodation. However, some Member States have successfully moved beyond temporary/crisis accommodation to developing more comprehensive progression policies to help people move from temporary accommodation to supported accommodation and/or into more permanent housing such as social housing (e.g. FI).

For people already affected by homelessness and housing exclusion, two broad approaches can be identified in the EU: the **'staircase approach'**, leading the homeless step-by-step up the housing ladder from emergency accommodation to permanent, independent living; and the

---

[59]   The next two sections are also based on the analysis of the Member States' contributions by the network of Independent Experts on Social Inclusion (http://www.peer-review-social-inclusion.eu/network-of-independent-experts).

[60]   For a wealth of information on homelessness and housing exclusion, see the website of FEANTSA (the European Federation of National Organisations Working with the Homeless) which is supported by PROGRESS (http://www.feantsa.org/code/en/hp.asp).

[61]   Declaration of the European Parliament on ending street homelessness (2009/C 259 E/04) published on the Official Journal of 29.10.2009, C 259 E/19.

'housing first' approach, offering individuals stable housing as a first priority. The latter approach has often proved to be more effective where there is an adequate housing supply for low-income people. However, 'housing first' does not mean 'housing only', and to ensure sustainable integration, homeless people often require support beyond housing. This has prompted several Member States to introduce socially supported accommodation, combining independent living with health and social support[62].

5.3.2. *Improved governance as an important tool to make strategies more effective*

Policies to fight homelessness and housing exclusion are the responsibility of different ministries at national level and different levels of government. Typically, national government is responsible for planning and overall policy design, while responsibility for delivery is devolved to local and/or regional authorities.

For this reason, inter-ministerial coordination is essential, and is being improved in several Member States, especially those with a comprehensive strategy, where steering committees have also been established to coordinate the efforts of all actors involved. However, fragmented responsibilities often represent one of the main challenges for the effective design of integrated policies. At the same time, the lack of capacity and resources at local level is one of the main problems in implementing such policies.

In several Member States (BE, DE, DK, ES, FI, HU, IE, MT, PL, PT and the UK) there appears to be a strong or increasing tendency to involve key stakeholders in the planning, delivery and monitoring of services. However, stakeholder participation is not promoted enough in some Member States and, in most, the direct involvement of people experiencing homelessness and housing exclusion remains quite limited.

Three elements prove to be particularly useful in improving governance in the area of homelessness and housing exclusion where responsibilities are shared between different levels of government and NGOs: *leadership* by the main public authority in charge of homelessness and housing exclusion policies; *participation* and consultation of relevant stakeholders in policy design and implementation; and *consensus* on the agreed strategy.

5.4. Causes of homelessness and housing exclusion and instruments

5.4.1. *Several factors causing homelessness and housing exclusion – need for a joint policy response to tackle them.*

Homelessness and housing exclusion are particularly complex phenomena. They are caused by a number of different factors and in turn affect several socio-economic outcomes, such as people's health and well-being, social participation, employability, and consequently income[63]. Broadly speaking, the causes of homelessness and housing exclusion can be

---

[62] On social and supported housing-related services, see the study by the Network of Local Authority Observatories on active inclusion (http://www.eurocities-nlao.eu/) supported by PROGRESS.

[63] See also the study for the European Commission coordinated by the University of York on "Housing exclusion: welfare policies, housing provision and labour markets".

grouped into three broad categories, even though multiple reasons often coexist and reinforce each other[64].

- *Structural*, such as low income, debt, worklessness and shortages of adequate and affordable housing.

- *Personal*, such as relationships and family breakdown, violent and abusive relationships, disabilities and mental illness, substance dependency.

- *Institutional*, such as discharge from institutions (foster and state care, prison, armed forces, hospitals). Housing exclusion can also be brought about by discrimination and lack of legal status, affecting some ethnic minorities and migrants.

The changing profile of the homeless population also points to new categories of people becoming more vulnerable due to the current social and economic environment and institutional settings. The first group consists of *those at the margins of the labour market*: either those in low-paid, poor-quality jobs who find it difficult to find adequate and affordable housing, or those in precarious, short-term employment, who move in and out of the lower end of the labour market and thus find it difficult to afford relatively high housing costs or even access the rental market. In particular, many *young people face specific challenges* in finding adequate housing. With the youth unemployment rate being on average in the EU more than double that of the overall population, a disproportionate number of young people face challenges when establishing their family and set up their own households. There are also higher numbers of young people on a temporary contract or in part-time employment compared to the rest of the population[65], which impacts a person's possibility to own or rent a home.

The second group consists of *migrant and mobile workers* who find themselves in precarious employment, on low incomes and often without a supportive social network. Several Member States have found this group to be growing in the population affected by HHE, including vulnerable migrants, refused asylum seekers, illegal immigrants, economic migrants and ethnic minorities, especially the Roma (CZ, IE, CY, MT, PL, PT, and the UK)[66].

5.4.2.   Measures to tackle homelessness

The causes of HHE are being tackled with two sets of measures:

− **Support for individuals**, where social policy instruments such as social assistance benefits and quality social services play a key role

---

[64]   On the complexities of multiple deprivation, see the PROGRESS funded mutual learning project "CONNECTIONS – social inclusion at city level" (http://www.connectionsprogress.eu/home) and in particular the Vienna and Oslo peer reviews.

[65]   See the EU Youth Report 2009, pp 34-35 (http://ec.europa.eu/youth/news/doc/new_strategy/youth_report_final.pdf). See also the PROGRESS funded mutual learning project "European cities against child poverty" (http://www.againstchildpoverty.com/index.php) and the FP7 CSEYHP project: "Combating Social Exclusion among Young Homeless Populations" (http://www.movisie.nl/118836/eng/).

[66]   On the issue of housing and migration, see the results of the mutual learning project "Building inclusion – access to housing and inclusion in Europe" supported by the PROGRESS programme (http://buildinginclusion.oberaxe.es/en/home/index).

Despite the weight of housing costs in total disposable income, especially for the population at risk of poverty, expenditure on **housing-related benefits** remains very limited in most Member States: only in DE, DK, FR and the UK does it exceed 0.5% of GDP. In countries such as BG, EE[67], IT, LT, PT and SI, expenditure on housing-related benefits is almost insignificant relative to GDP. Housing-related benefits have remained almost unchanged since the beginning of the decade, with the only exceptions being a fairly significant reduction in EL and a marked increase in DE and SK.

Fig. 5.5: Social protection expenditure as % of GDP: housing function (cash benefits)
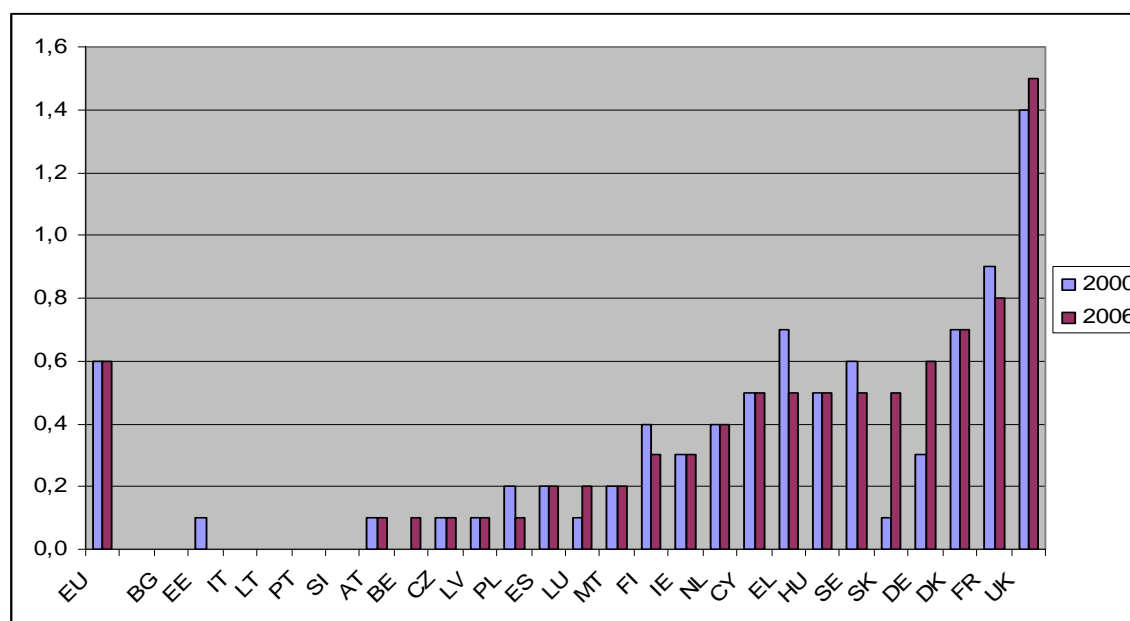
Source: EUROSTAT; ESSPROS

Homeless people often face multiple disadvantages. There is a growing emphasis in several Member States on developing integrated approaches to homelessness which go beyond just issues of accommodation and look at access to employment, income support and access to services such as health and **social services** — in other words, approaches that adopt an *active inclusion* approach[68]. In several countries, however, there appears to be a complete absence of any integrated approach.

Likewise, several Member States emphasise that the homeless can benefit from social services such as employment, health, care, and social assistance services on the same basis as other vulnerable groups. However, this is often not sufficient, as several obstacles may in practice impede actual access. Also, in a significant minority of Member States homeless people appear to have very limited access to such services.

---

[67]   In Estonia, housing costs are taken into account in the calculation of the subsistence benefit.
[68]   See the Commission Recommendation on active inclusion [2008/867/EC] published in the Official Journal of 18.11.2008 (L. 307/11).

Improving the supply of adequate and affordable housing, in particular social and public housing

Social and public housing[69] emerges as a key element in HHE strategies and is often the most important solution for homelessness, especially for persons and families who can manage their housing situation with normal economic and social support. A very widespread problem is that there is excess demand for public housing and relatively long waiting lists. Tenant purchasing polices have reduced the existing stock of housing in some cases (UK), while deregulation and priority for private housing have been factors in other cases. Several Member States are increasing the volume of housing with a specific focus on social housing (IE, BE, UK, FI, FR, IT, MT, EE), although this does not always meet demand. In some countries, private housing has been prioritised and the construction of social and/or public housing has been decreasing. The deregulation of the housing market has also reduced the supply in some countries.

The **quality** of housing stock varies widely across the EU. Inadequate housing standards are an issue for a significant number of Member States, especially for several of the newer Member States where the housing stock was in great part built during the communist period. Several countries have introduced policies to set standards and improve the quality of housing. These include offering *financial incentives and support* to property owners to provide high-quality accommodation, such as financial bonuses, advantageous loans or advances for modernisation and renovation and tax deductions. *Regulation and the setting of minimum standards* is another approach used to ensure the quality of housing. Measures used by Member States to improve the stock of permanent accommodation include: increased monitoring and regulation of the privately rented sector; setting minimum standard requirements for the quality of housing (e.g. safety, health, usefulness, energy saving); and setting minimum space standards. Some countries have introduced regulations to define overcrowding or inadequate housing at national, regional and local levels in legal and regulatory frameworks (UK, IT, RO, LU, FI). However, in some countries with highly devolved systems, the setting and enforcement of standards varies from region to region (DE, ES). There is also a growing emphasis in several Member States (e.g. IE, IT, LU, PT, RO, UK) on improving the regulation and oversight of temporary accommodation and related services with a view to increasing standards.

The Commission proposal that housing intervention to help marginalised communities should be eligible for ERDF support can open the way for the structural funds to make an important contribution towards such objectives in the convergence regions.

There are efforts in a number of Member States to develop or extend instruments to improve the **affordability** of housing. These include: housing benefit / means-tested housing allowances (BE, DE, FI, LU, PL, UK, IE); rent allowance guarantees (NL); and regulations governing rents (AT, BE and IE), mortgage tax reliefs (BE), and the sale of houses under market value (NL).

Housing and urban regeneration programmes, together with planning instruments, can directly improve the living standards of local communities and help people to access adequate housing. Urban regeneration programmes are a common feature in many cities across the EU,

---

[69]   See also the website of CECODHAS, the European Liaison Committee for Social Housing (http://www.cecodhas.org/).

and focus investment on areas with a high concentration of socially vulnerable groups in order to improve the quality of housing, tackle social problems and ensure lower rents in local areas[70]. In a context of increased social diversification and relocation of economic activities, these polices are particularly important for increasing the functional and social mix of EU cities. There are several interesting examples of countries where policies to increase the social mix to avoid developing high concentrations of disadvantaged residents are part of mainstream planning and housing policy (DK, DE, FI, LU and the UK). As well as other specific areas, some programmes focus on the social excluded communities, such as the Roma.

5.5. Monitoring and evaluation

The need to develop or improve ways of collecting statistical data to improve the understanding of homelessness and housing exclusion in the various Member States is widely recognised. The lack of data is at least partly responsible for the lack of a consistent and robust **information and evaluation strategy** in most Member States. The Peer Review on "Counting the homeless – improving the basis for planning assistance" that took place in Vienna, Austria in November 2009 concluded that the EU must reinforce cooperation in this field and encourage political will in Member States to enhance data collection and develop corresponding monitoring systems[71].

The 2011 Census represents a unique opportunity to produce invaluable baseline figures in the field of homelessness. At EU level, steps forward in the measurement of homelessness and housing exclusion have been achieved with the adoption by Member States of the common indicators on housing costs and overcrowding presented in section 5.2 and with the PROGRESS supported project MPHASIS[72].

Some Member States report the absence, at all administrative levels, of statistical data on homelessness and housing exclusion (BG, CY, EL and SI). In these countries, such gaps are filled to some extent by the work of NGOs or other players (e.g. the Council of Europe in BG). Censuses carried out every decade or so also play a role in this respect, which is all the more important in the absence of any other systematic and scientific data collection process.

The absence of any monitoring of homelessness also means that any policies in place to address the issue are impossible to assess using agreed, quantified and measurable standards.

In Germany, some individual Länder have been collecting data on homelessness, sometimes for many decades, but this has not resulted in any global overview, and there are no nationwide statistics on the issue.

In a few other Member States, there is no systematic monitoring or evaluation, and the overall understanding of the issue is sketchy (AT, CZ, IT, RO, SK). NGOs have also carried out more or less coordinated research on monitoring and evaluation in an attempt to fill the current knowledge gaps.

---

[70] On HHE in cities and urban regeneration, see also the website of EUROCITIES, the network of major European cities (http://www.eurocities.eu/main.php) and in particular the 'Inclusive Cities' programme supported by PROGRESS.

[71] See the Peer Review programme website: http://www.peer-review-social-inclusion.eu/peer-reviews.

[72] For detailed results of MPHASIS ("Mutual Progress on Homelessness Through Advancing and Strengthening Information Systems") see: http://www.trp.dundee.ac.uk/research/mphasis/index.html.

Some projects have also been launched in a number of Member States to establish formal monitoring of the situation of the homeless, and thus a countrywide database, but are still at the preliminary or teething stage (EE, MT, PT).

In BE, the situation varies depending on the region, but the federal authorities are making efforts to improve statistical knowledge at countrywide level, backed by a federal department, set up in 1998, to fight poverty. Data collection is still incomplete, but is being assisted by the work of agencies such as Strada in Brussels. In Flanders, the CAW is obliged to submit registration data on homeless people to the administration every year.

In Sweden, there is no regular reporting system for monitoring homelessness, but national surveys are carried out approximately every five years. Some government agencies have been tasked with developing statistics, and to improve knowledge of different methods to facilitate access by homeless people to the regular housing market.

However, the most common pattern is a multi-level or multi-party system for documenting the situation of homeless people, for example in Hungary, Ireland, Lithuania, the Netherlands, Poland, Spain, Finland and the UK. The role played by social services is not negligible in this respect, as they tend to be the ultimate source of data on homelessness.

The nature and operation of these multi-level or multi-party documentation systems varies among the Member States. In Hungary, for instance, there is a network of regional bureaus that collect data daily on the available capacities of the institutions concerned. However, no countrywide up-to-date data are available on the topic, though efforts are being made to put this information into one comprehensive database.

In Finland, the Housing Finance and Development Centre is responsible at national level for gathering monitoring data on homelessness. Quantitative trends in homelessness are monitored and assessed annually by means of a questionnaire that is sent out to every local authority in the country.

Ireland's new homeless strategy has set specific performance indicators for each of its six strategic aims, in an attempt to improve data availability and comparability. In the UK, national reporting is based on returns from local authorities under the homelessness legislation. The information on statutory homelessness is collated by central government in all four jurisdictions.

6. EFFECTIVENESS AND EFFICIENCY IN THE HEALTH SECTOR: SOME CONSIDERATIONS AT A TIME OF ECONOMIC CRISIS

The current economic and financial crisis makes more evident and urgent the need to improve the effectiveness and efficiency of health care. The crisis may impact the health sector negatively on both the demand and supply sides. The demand for health and long-term care may increase as a result of a deterioration in health determinants (e.g. higher unemployment, reduced income) and thus health status. On the supply side, the economic crisis may lead to a reduction in the funding available for health and long-term care as a result of rising deficits and lower contributions and tax revenues. Member States are in very different positions to face these challenges: there are large differences in health outcomes and health expenditure across the EU, with in general those countries reporting lower expenditure on health and especially lower public expenditure on health also reporting lower health status (e.g. lower life expectancy).

The crisis places budget constraints on all countries, which will be particularly felt in those where the health sector is already under-resourced, social protection is least developed and households are poorer. In previous short and small recessions, and so far in the current downturn, expenditure on health has worked as an automatic stabiliser and a recovery tool in many countries, though not all. If, as forecast, this economic crisis is to continue for some time, and given the large government deficits observed, the near future will bring a period of budgetary constraints. This may translate into stronger prioritisation and even budget cuts across the public sector, including the health sector.

In addition, large socio-economic gaps in health (translating into premature and avoidable mortality and disease), which persist despite the large increases in expenditure, and which may increase as a result of the economic crisis, call for greater effectiveness in healthcare delivery.

Thus, increasing the effectiveness and efficiency of health care will likely be common goals in the years to come. In searching for policies to achieve these goals, Member States can benefit from pooling their knowledge and exchanging their experiences and information.

Indeed, the effectiveness and efficiency of health spending is a long-standing concern in many Member States. Spending on healthcare and the provision of services absorbs a large share of total resources in the economy, in particular public expenditure. Health-related expenditure is the second biggest component of social protection expenditure in public budgets. Furthermore, the ratio of total health expenditure to gross domestic product has increased over time and continues to grow. Data show a recent slowdown in expenditure growth, but pressures on health spending are likely to continue given the emerging challenges of ageing, technology development and growing expectations.

A rising share of resources devoted to healthcare systems, together with a more equitable distribution of these resources, i.e. more widely available, affordable, higher-quality health care, has been associated with a considerable improvement in the health status of the EU population in recent decades (increasing likelihood of detecting and treating diseases, avoiding mortality, ensuring independent living and reducing health inequalities between and within Member States). Good health contributes to economic prosperity through improving

labour market participation and productivity and increasing participation in other societal activities. High levels of population health and an increase in Healthy Life Years[73] are crucial in the context of an ageing population, to allow for longer working lives and secure higher employment, productivity and competitiveness. Nonetheless, increasing health-related expenditure and strong expenditure pressures have also given rise to general apprehension, increased efficiency concerns, and calls for improving the value for money of funds allocated to the health sector.

This chapter is based on previous Joint Reports on social protection and social inclusion and on EU level Ageing-related and EU level healthy ageing and health workforce related work, as well as work by the OECD (including the 2008 Joint EC/OECD conference on improving health systems efficiency) and the WHO. It also draws on recent CZ presidency conferences on this topic and the 2007 LU seminar on the rational use of resources in the health sector.

6.1. Why more effectiveness and efficiency in health care is needed

6.1.1. Health expenditure analysed[74]

In general, **total expenditure on health represents a significant share of EU Member States' financial resources** (Figure 6.1), as measured by GDP, although it varies across EU Member States from 5% in EE to 11% in FR. BE, DE and AT also spend more than 10% of GDP on health, with PT (9.9) and DK (9.8) following suit. At the other extreme, RO, LT, CY, PL, and LV spend less than 6.5% of GDP. On average (population-weighted), EU Member States spend about 9% of GDP on health, including both public and private expenditure (with the EU-15 population-weighted average reaching 9.5% of GDP). A large part of this expenditure is from public sources (EU average of 75%): more than 60% in all Member States, except for CY (43% in 2005), more than 70% in 19 Member States and more than 80% in 6 Member States, including LU with 90% (Figure 6.1). Total expenditure on health per capita is also sizeable, though it varies across Member States, from around less than 500 Purchasing Power Standard (PPS) unit in RO to more than 4000 PPS in LU (Figure A1 in the Annex).

Time series data (Figure 2) show that **over the past decade total expenditure on health has increased by about 1 pp of GDP in the EU-27** (population-weighted average). The same trend (increasing share of health expenditure as % of GDP) has been seen in the vast majority of individual Member States since 1980 (Figure A2 in the Annex) and, for those countries for which data are available, over the past 50 years (Table A1 in the Annex). Also, total expenditure on health per capita (PPP) has consistently increased over time (Figure 3).

---

[73] http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm

[74] The figures based on time series of health expenditure used here should be considered with caution, since there have been methodological breaks in the computation of the relevant underlying data at certain points of time, notably the introduction of the System of Health Accounts (SHA) in many countries.

Figure 6.1

Total expenditure on health as % of GDP (breakdown between private and public expenditure). 2007 or latest available
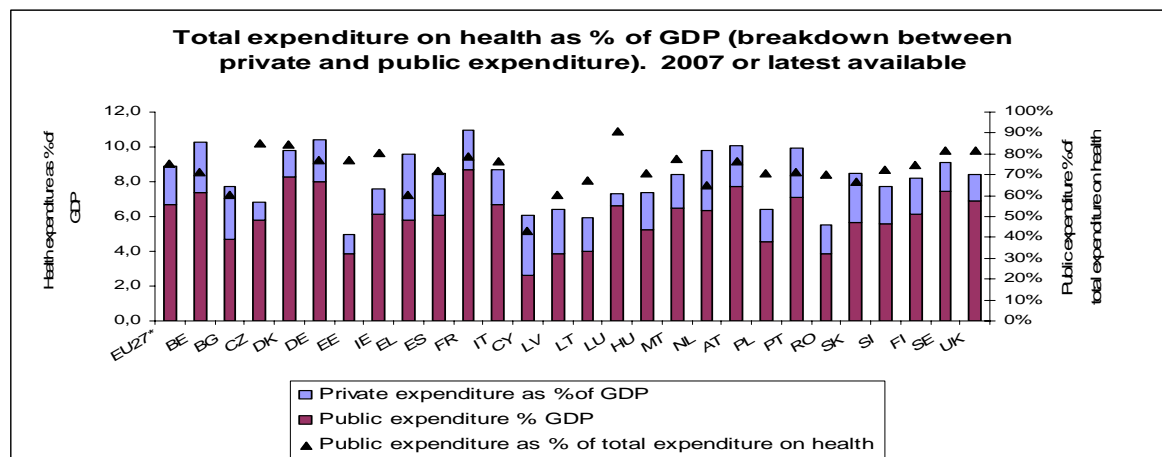
Source: OECD Health data and WHO Health for All databases, EU-27* standing for the population-weighted average of the latest values available: BG, EE, CY, LV, LT, MT, RO and SI for 2005 and PT and LU for 2006, others for 2007 — EC computations.

Time series data (Figure 6.2) show that **over the past decade total expenditure on health has increased by about 1 pp of GDP in the EU-27** (population-weighted average). The same trend (increasing share of health expenditure as % of GDP) has been seen in the vast majority of individual Member States since 1980 (Figure A2 in the Annex) and, for those countries for which data are available, over the past 50 years (Table A1 in the Annex). Also, total expenditure on health per capita (PPP) has consistently increased over time (Figure 6.3).

Figure 6.2 and 6.3
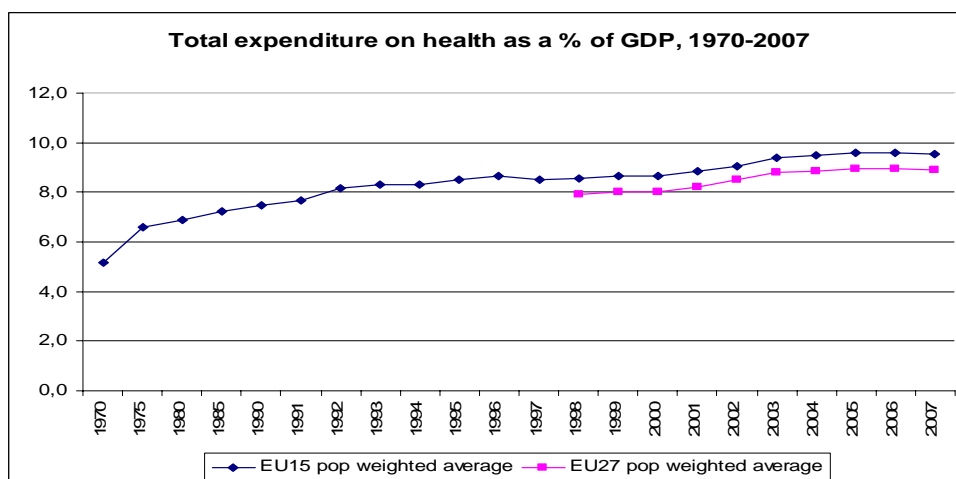
Total expenditure on health as a % of GDP, 1970-2007

Source: Eurostat, OECD Health data, WHO Health for All databases and EC computations.

Figure 6.3

Total expenditure on health per capita PPS, 1970-2007
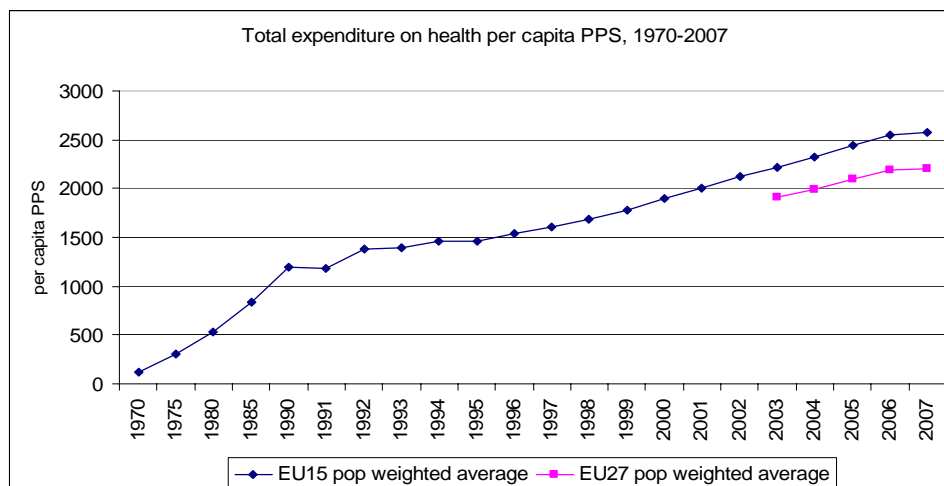
Source: Eurostat, OECD Health data and EC computations.

The data in Figure 6.2 suggest, however, different periods of health expenditure growth. The fastest health expenditure growth (compared to GDP growth) was observed — on average for the EU-15 — up to the early 90s. Health expenditure still grew faster than GDP throughout the 1990s and early 2000s, but has remained a roughly constant share of GDP in recent years.

The reason for these results, looking at the time series available for individual countries (Figures A3 in the Annex), is that the growth rates for total health expenditure are in general higher than GDP growth rates for most countries and years. They are significantly higher the further back in time one goes. Total expenditure on health increased fast in the 1960s and 1970s (annual growth rates higher than 15 %). Then from the 1990s onwards, growth rates in the EU-15 countries decreased to become more similar to GDP growth rates, though still higher. In the new Member States for which longer time series are available, some convergence between GDP growth and health expenditure growth is observed in recent years, after very high health expenditure growth during the 1990s and in the early 2000s. A look at the last 10 years of data shows that while total expenditure on health is in general higher in 2008 than in 1998 (Figure 6.4 and Figures A3 in the Annex), health expenditure growth and GDP growth have been converging during recent years, with some countries even showing a reduction in total expenditure on health as a percentage of GDP.

Figures A3 also provide interesting information on what can happen to health expenditure and its growth in periods of economic downturn. Looking at SE and FI for example, the downturns in the early 2000s saw health expenditure growth increase and peak compared to the general trend of decreasing expenditure growth, while the economic crisis of the early 1990s resulted in negative health expenditure growth rates in line with the negative GDP growth rates. In times of economic crisis, therefore, health spending has reacted in opposing ways: either following the downward trend in the whole economy or working counter-cyclically[75].

---

[75]   The Research Note '*Recession and health in Europe: what to expect?*' (European Observatory on the Social Situation and Demography) finds that economic downturns in the 27 EU countries from 1970 to

Figure 6.4

Total expenditure on health as % of GDP, 1997-2007

Legend: 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007
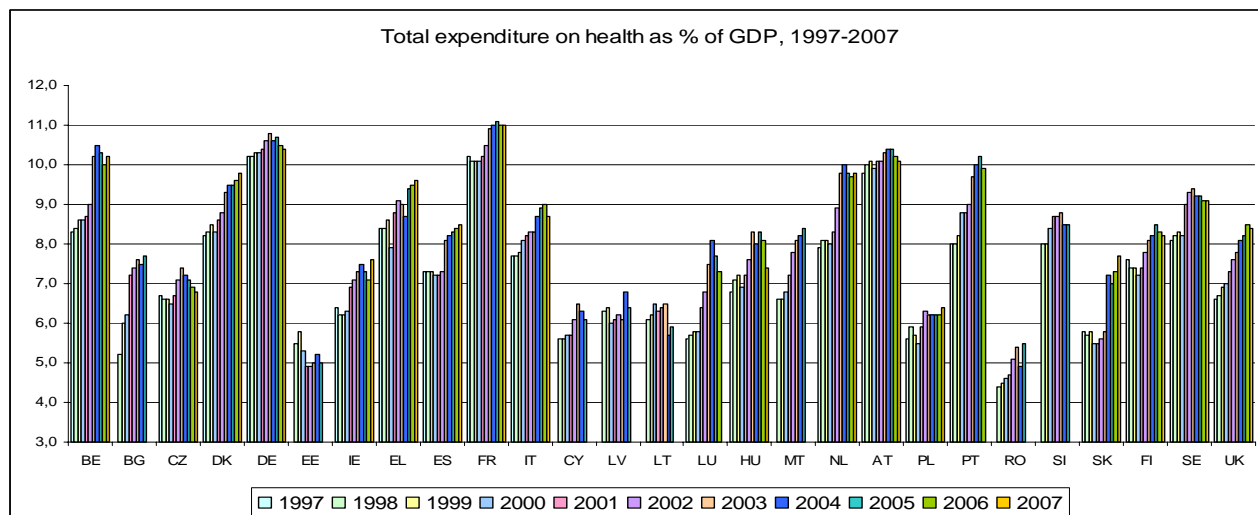
Source: OECD Health data and WHO Health for All databases

Given that public expenditure is the main driver of total health expenditure, **public expenditure on health as a percentage of GDP has followed a similar overall pattern** to that of total health expenditure as a percentage of GDP (Figure 5 compared to Figure 2, and Figures A4 and A5 and Table A2 in the Annex). Over the last four decades, public expenditure on health as a percentage of GDP appears to have increased fast until the early 1990s, increased less fast throughout the 1990s, and remained more or less constant in more recent years.

Looking at the evolution of public expenditure as a percentage of total expenditure on health in individual Member States (Figures A6 in the Annex), it can be seen that in some countries (DK, FR, LU, AT) the share of public expenditure has been fairly constant over the last two decades, while in others it has increased (PT, IE) or conversely fallen initially before increasing again in the past decade. In all, **public expenditure accounts for a significant share of total expenditure on health (75 % on average for the EU)**. It thus competes with other areas (e.g. education) for public resources, which also explains the **emphasis on improving effectiveness and efficiency in the health sector**.

2007 had no significant effect on healthcare spending (in per capita terms and as a percentage of GDP), based on a variety of indicators for recession (including fluctuations in GDP and unemployment and taking account of time lags).

Figure 6.5

Public expenditure on health as a % of GDP, 1970-2007
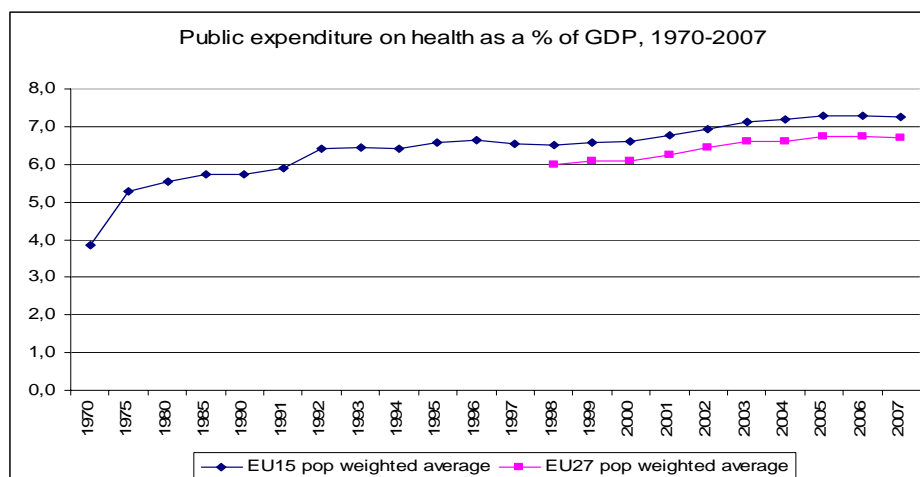
Source: OECD Health data and WHO Health for All databases and EC computations

Importantly, there is considerable evidence[76] that higher total health expenditure per capita leads to lower mortality, lower infant mortality and higher life expectancy, as shown in simple form by Figure 6. Furthermore, Figure A7 in the Annex also shows that countries with different levels of health expenditure (in per capita terms or as a percentage of GDP) have similar outcomes and that countries with similar expenditure levels have different outcomes, at least in terms of life expectancy.

Figure 6.6
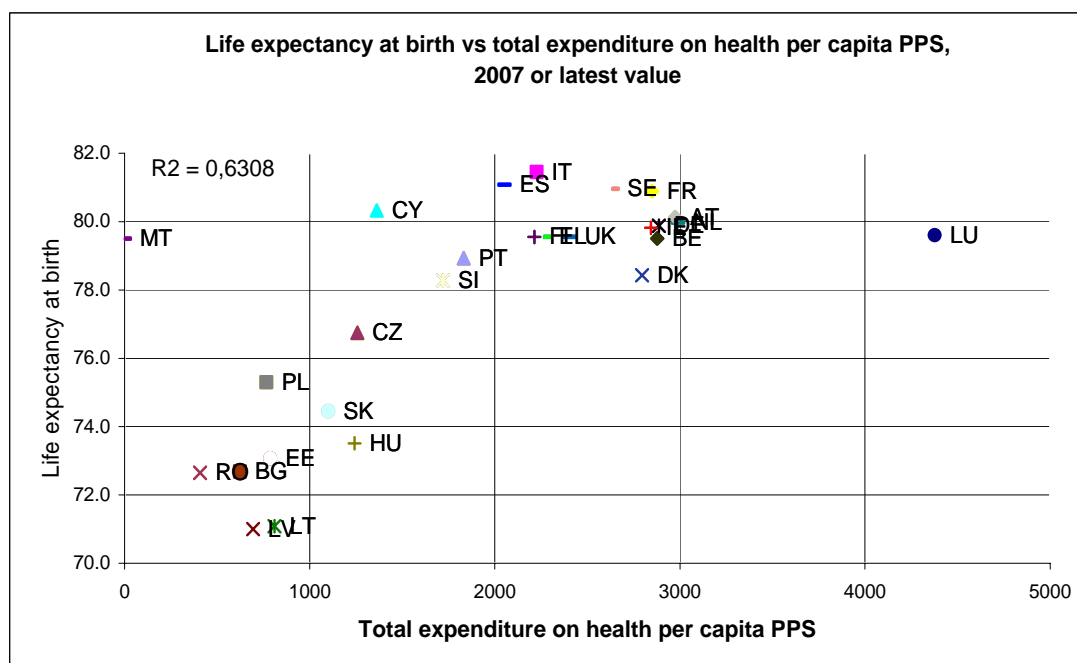
Source: Eurostat, OECD Health data and EC computations

---

[76]   For a short review, see the Joint Report on Social Protection and Social Inclusion 2007.

It may be noted that countries with lower life expectancy at birth and lower health expenditure (as a percentage of GDP or per capita) are also those with higher inequities in access to care and health status.[77] Hence, **some countries may be investing too little** in this sector. While they may have to spend more on health, it is as important for them to ensure that what is spent and any **additional amounts spent make an effective and efficient contribution to health**.

In sum, the consistent increase in total expenditure on health, the fact that a significant part of that expenditure is public, and indications that there may be scope for improvement give rise to some uneasiness about the size and growth of health expenditure and thus prompt **calls for health systems to obtain good value for money (through greater effectiveness and efficiency)**.

6.1.2. Pressures on healthcare spending

Levels of spending depend on a combination of factors: a) factors affecting demand for care, such as general health status of the population and thus the need for care, population age structure and income levels, plus organisational (e.g. cost-sharing) and cultural (e.g. self-care) factors, and b) supply-side factors such as the availability and distribution of services, the physician/nurse mix, cultural, organisational and institutional factors including wages and remuneration methods, gate-keeping, market regulation, diffusion of high-cost technology, or administrative costs. These are summarised in Figure 6.7.

Figure 6.7
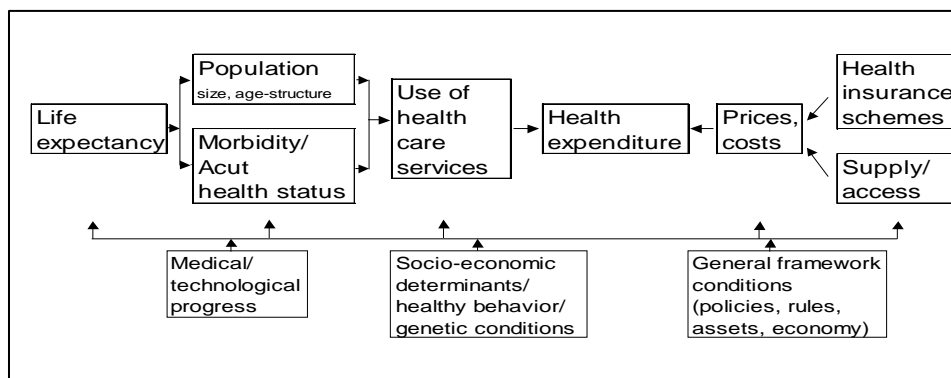
Source: 2007 AHEAD — Ageing, health status and determinants of health expenditure project

In this context, it is worth describing in more detail some **important challenges to the system that emphasise the need to look more closely at the effectiveness and efficiency of resources allocated to health**.

One of these challenges is **population ageing**. This translates into more people living longer (Figure 8 and Figures A8 and A9 in the Annex), notably a higher proportion of people aged 65+ and especially those aged 80+. Between 2008 and 2060 the EU-27 population aged 65 and over is projected to increase from less than 20 % to about 30 % of the population, and the 'very old' (80+) will be the fastest growing segment of the population. Ageing can bring with

---

[77]   Impact assessment accompanying the Communication 'Solidarity in Health: Reducing health inequalities in the EU' SEC(2009) 1396.

it new patterns of morbidity including <u>multi-morbidity</u> (multiple chronic diseases, disability and dependency) presenting themselves <u>over a long period of time</u>. Evidence shows that the need and demand for health care is strongly and positively correlated with age: health deteriorates with age (Figure 9) and correspondingly, expenditure profiles increase with age (Figure A10 in the Annex). This means that there will be higher pressure to provide <u>more and substantially different care</u> than with a younger population structure. Moreover, while the demand for formal auxiliary medical and support care is likely to increase as a result of ageing, the number of informal carers (family and relatives) may fall as a result of changing family structures, mobility, and work patterns. Consequently, as expenditure rises with old age, if age-disease patterns remain unchanged, expenditure levels will increase. According to the 2009 EPC/EC projections, EU public health expenditure will increase by 1.7 percentage points of GDP by 2060 due to population ageing, i.e. a 25 % increase with respect to current spending (Table 1).

However, research (e.g. 2009 EPC/EC Ageing Report, 2007 AHEAD) shows that the impact of ageing on expenditure can be mitigated by improving the health status of the elderly. Hence, a **healthier ageing population is crucial to control expenditure growth**. Indeed, the age-related projections estimate that the impact of demographic change (costs increasing by 1.7 % of GDP) is more than halved if people live longer but the onset of disease is also later. Moreover, age-utilisation relationships are affected by the cultural and institutional factors of each country, helping explaining the gaps in per capita spending at older ages between EU Member States.

Figure 6.8. Projected changes in population structure in % for selected years, EU27
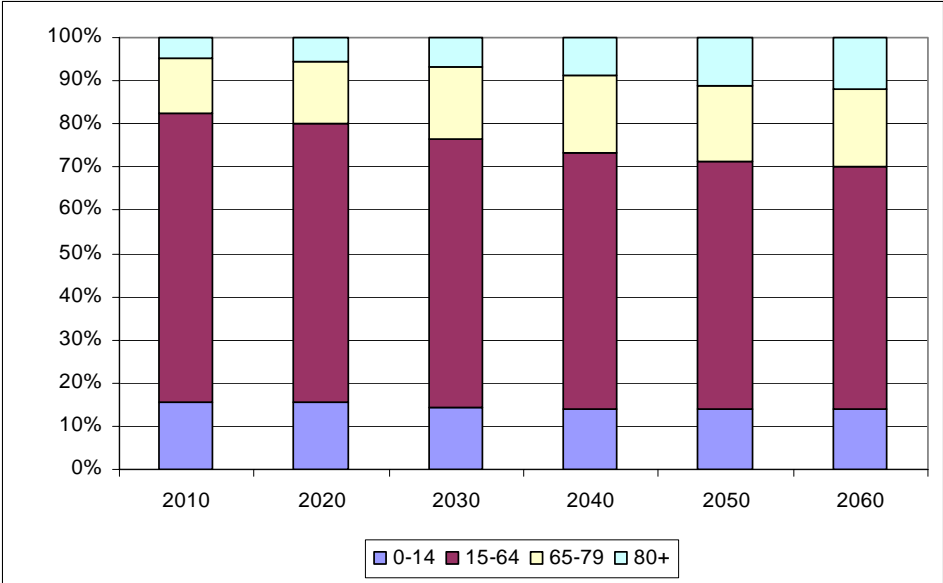
Source: Eurostat, EUROPOP2008 (EUROstat POpulation Projections 2008-based) convergence scenario; 2009 EPC/EC Ageing report

Figure 6.9. Health status by age, 2007

Self-reported general health, limitations in daily activities, and long-standing illness in the EU, by age group
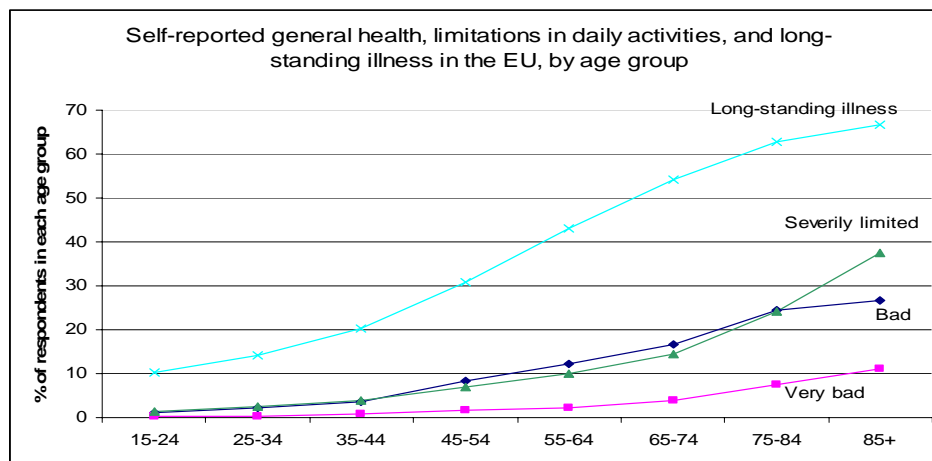
Source: Eurostat

A related challenge is to ensure the availability of a **health workforce** able to respond to future needs. Thus, ageing can have other negative implications, such as <u>reducing the supply of staff</u> and increasing staff wages, thus resulting in higher production costs. Across Europe, between 1995 and 2000, the number of physicians under the age of 45 dropped by 20%, while the number aged 45 and over went up by over 50% (European Commission Green Paper on the health workforce[78]). For nurses, average ages are rising: in five Member States nearly half the nurses are aged 45 and over. It is predicted that the retirement of the baby boomers will affect the health sector by reducing staff numbers at such a rate that there will be insufficient numbers of younger people coming into the system to replace them. The health sector, a labour-intensive sector, currently provides employment for about 10% of the EU workforce, and approximately 70% of healthcare budgets is spent on salaries and other charges related directly to employment (Green Paper). As current staff approach retirement age, sufficient new and younger recruits are needed to replace them. In addition to staff ageing, health-related jobs may not be attractive to new generations, and several countries are faced with the migration of their health professionals to richer countries. As increased numbers of staff may take time to materialise, in view of the duration of medical and other training, we need to ensure an **effective and efficient workforce** in the meantime[79].

---

[78]   See http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf.
[79]   The development of robust human resource strategies to improve recruitment and retention will be one of the most important issues for employers in the health and care sectors. Such strategies could range from raising awareness of careers among school and university leavers, running return-to-practice campaigns with support for updating of skills and opportunities to work flexibly, and introducing schemes to attract and retain older workers or those needing to change careers after redundancy.

Table 6.1 The projected costs of ageing: pure demography scenario

	Level 2007	Change 2007-2060 % points of GDP	%	Level 2060
BE	7.6	1.5	19	9.1
BG	4.7	0.7	15	5.4
CZ	6.2	2.3	37	8.5
DK	5.9	1.2	20	7.1
DE	7.4	2.0	27	9.4
EE	4.9	1.2	25	6.2
IE	5.8	2.0	34	7.8
EL	5.0	1.5	30	6.4
ES	5.5	1.8	32	7.3
FR	8.1	1.4	17	9.5
IT	5.9	1.2	21	7.1
CY	2.7	0.9	32	3.6
LV	3.5	0.7	19	4.1
LT	4.5	1.2	27	5.7
LU	5.8	1.3	23	7.1
HU	5.8	1.7	30	7.5
MT	4.7	3.8	80	8.5
NL	4.8	1.1	23	6.0
AT	6.5	1.7	27	8.2
PL	4.0	1.3	33	5.4
PT	7.2	2.2	30	9.4
RO	3.5	1.4	40	4.9
SI	6.6	1.9	29	8.6
SK	5.0	2.3	46	7.3
FI	5.5	1.4	25	6.9
SE	7.2	0.9	13	8.1
UK	7.5	2.2	29	9.7
NO	5.6	1.6	29	7.3
EU27	6.7	1.7	25	8.4
EU15	6.9	1.7	25	8.6
EU12	4.7	1.5	33	6.2
EA	6.7	1.6	23	8.3

Source: 2009 EPC/EC, Ageing Report

In addition to potentially increasing demand, ageing reduces the relative size of the working population (Figure 10) and thus poses a challenge to governments to ensure sufficient revenues for the health sector from shrinking tax bases/contributions.

Figure 6.10. Labour force projections, 2007-2060, percentage change in population aged 15-64
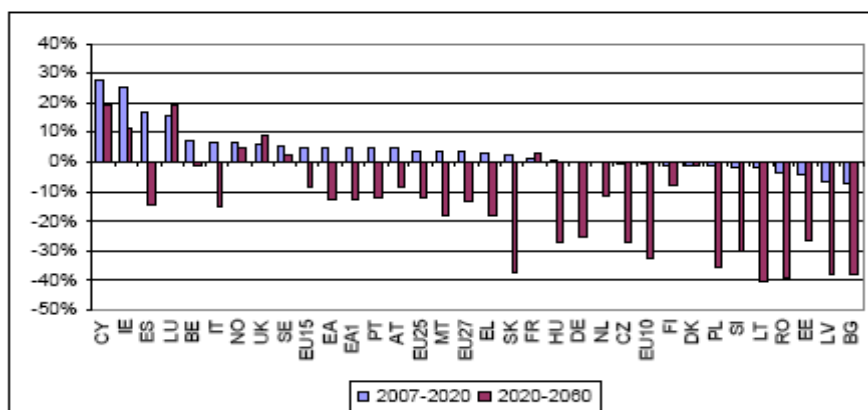
Source: EPC/EC 2009 Ageing Report

Another pressure on healthcare expenditure comes from **technological development**[80]. While this can bring about less intrusive and cheaper treatments (day case instead of in-patient surgery), it contributes to raising expenditure by providing ways to cure or control hitherto untreatable diseases through new and often expensive interventions, albeit also often less intrusive and with fewer side-effects. Thus, technology creates a supply-induced demand for services (diagnosis, prevention and treatment). In addition, health staff need to be trained to use it. The 2009 EPC/EC age-related projections (2009 EPC/EC Ageing Report) suggest that between 2% and 3% of yearly growth in healthcare spending can be ascribed to non-demographic and non-income factors such as technology. Nevertheless, the potential for ICT technology and process innovation to improve access, quality and coordination of care, as well as cost predictability and control should be kept in mind. There is growing evidence of this potential[81] and even if field implementation seems to be lagging behind expectations and potential, this area should be given adequate attention in the future.

In what relates to health professionals, ICT have the potential to reliably free the doctors and nurses from most of the administrative burden, saving their valuable time for health-enhancing activities, something especially important in the present and coming times of health personnel shortages (as mentioned above).

Part of the progress in medical technology is the development of new pharmaceuticals. Member States point to a significant growth in pharmaceutical expenditure and the diffusion of new medicines as one of the financial pressures they face. There is evidence (2008 EC/OECD conference) that, although pharmaceutical expenditure accounts on average for a relatively minor share of national spending on health (less than a fifth of total health expenditure), it increased faster than total health expenditure and GDP between 1980 and 2005. Also, the public sector is the primary source of financing (60% of total pharmaceutical expenditure on average in the OECD), although private expenditure is greater for pharmaceuticals than for other types of care. On average, pharmaceutical expenditure constitutes a growing share of total health expenditure (Figure 11). However, there are important differences across Member States: some show a constant share over recent decades while others, notably the Nordic countries and a number of new Member States, show a growing share. There are also wide differences in pharmaceutical expenditure per capita (Figure A11 in the Annex) between Member States. These reflect different practices in relation to market regulation, pricing, reimbursement, coverage, distribution, prescribing and dispensing of pharmaceuticals, thus constituting a suitable area for information and best practice exchange.

---

[80]   Technology here stands for more than just equipment or ICT as it includes pharmaceuticals and other types of medical interventions.

[81]   http://www.oecd.org/document/42/0,3343,en_2649_33929_38311850_1_1_1_1,00.html

Figure 6.11. Pharmaceutical expenditure as % of total expenditure on health
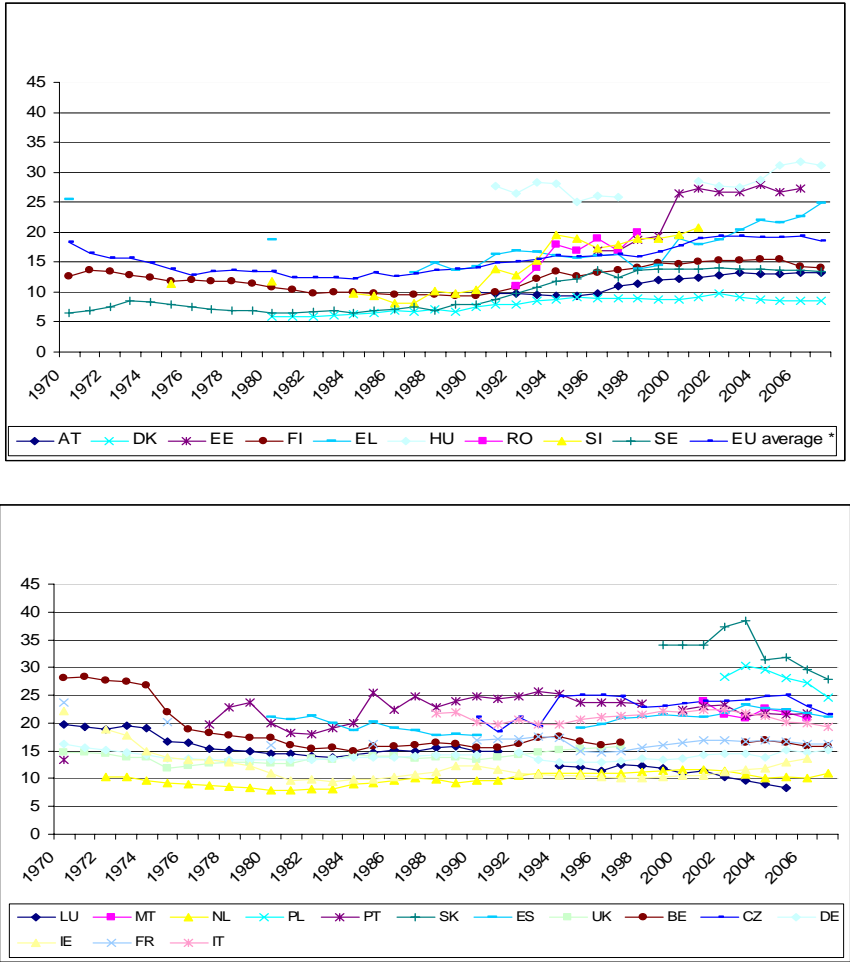
Source: WHO Health for All database

Growing expectations, broadly related to education, income, family structures and/or access to information, also play an important role in increasing demand for and supply of care. In general, countries with a higher GDP per capita tend to spend more on health (Figure 12). The 2009 EPC/EC Ageing Report projects significantly higher public health spending (additional 0.6 percentage points of GDP) once income elasticity of demand exceeds unity (1.1 converging to 1 by the end of the projection period). The desire for greater choice of provider and care setting, tailor-made treatment, access to a new and wider range of technologies, and the enforcement of patient rights are some of the pressures policy-makers have to balance against existing resources. Indeed, while people want more and modern care and free choice as patients, often as contributors they wish to pay lower taxes, contributions or user charges. As for public health and patient empowerment, ICT allows web 2.0 tools to harness the potential of social marketing and networks for public health, health promotion and lifestyle changes.

In addition, there are **emerging risks to health** from risk behaviour / unhealthy life-styles that can lead to a higher incidence and prevalence of chronic diseases. Lack of exercise, unhealthy diet, obesity (see Figure A12 in the Annex), excessive drinking and high rates of smoking, notably in young age groups, are associated with a higher incidence and prevalence of cardiovascular and respiratory diseases, diabetes, etc. In addition, there continue to be

significant outbreaks of communicable diseases such as TB, and the prevalence of HIV/AIDS is of strong concern. These result in an unnecessary burden of disease on societies and on health budgets.

Figure 6.12

Total expenditure on health per capita vs GDP per capita, 2007 or latest year available
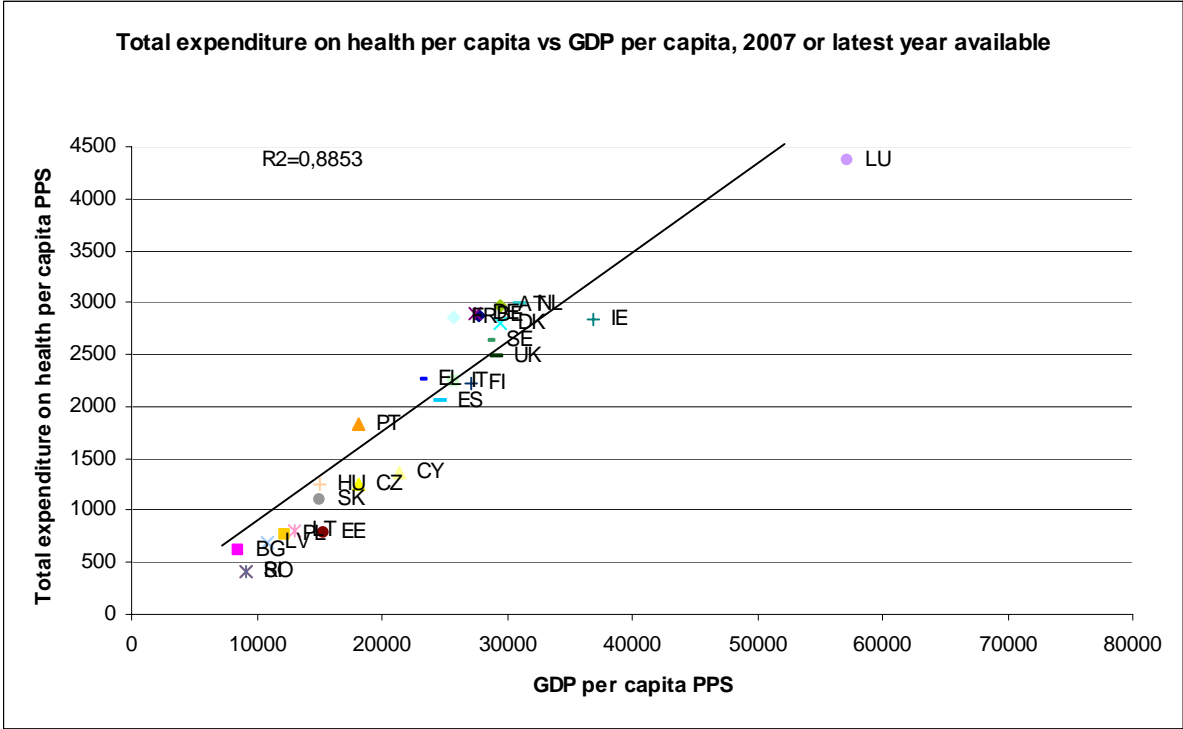
Source: Eurostat, OECD Health data and EC computations

Large and widening health inequalities between and within Member states (e.g. a 14-year gap in life expectancy at birth for men and an 8-year gap for women between Member States and differences of 10 years for men and 6 years for women in life expectancy at birth between the lowest and highest socio-economic groups) indicate that not everyone has benefited in the same way from the increase in health expenditure and the greater availability of medical care as well as the economic progress that delivers better health through more and better jobs and better living conditions. Barriers to accessing care (including health promotion, disease prevention, treatment and rehabilitation) have been identified, including lack of health insurance, direct financial costs of care, geographical disparities in provision, waiting times, lack of information, discrimination, language barriers, health literacy and socio-cultural expectations in relation to life and care use. Premature and avoidable mortality and morbidity are an economic burden to society as they are detrimental to employment, productivity and growth. Avoidable ill-health places an economic burden on health care systems and unnecessary pressure on public budgets. Reducing unnecessary and premature death and disease can make a contribution to meeting the Lisbon goals of employment and growth and achieving Europe's full potential for prosperity. Hence, such **large gaps in health call for greater effectiveness of healthcare delivery, public health prevention and a rethinking of priorities in this sector**.

6.1.3. *The current economic and social situation*

The current downturn will impact on the demand for health care and on available resources. Hence it is crucial to understand where potential effectiveness and efficiency gains can be made and where greater value for money may be attained in the health sector.

6.1.3.1. Potential effects of the economic crisis on health status

Research shows that higher public expenditure on health is related to lower mortality (Brenner, 2009; figures above), so significant **reductions in spending on life-saving interventions will increase mortality.** However, data relating changes in mortality to periods of economic recession are scarce and somewhat contradictory. Some perhaps counterintuitive findings come from the US and Europe, where recession has been accompanied by falling all-causes mortality rates, although an increase in suicide rates is generally observed (Brenner, 2007). Those findings have been observed for recent, relatively short periods of recession and may be unlikely in a more sustained and deeper downturn. Moreover, mortality is an extreme event and often depends on a complex matrix of determinants acting over a long time. It would perhaps be more intuitive to look at morbidity, and especially mental ill health, when searching for the health consequences of an economic crisis. In addition, while rapid and deep social and economic changes will have consequences for the health of the population, the extent and distribution of these consequences are likely to vary depending on the development and coverage of social safety nets, the resilience and robustness of the health sector, as well as policy responses in the fields of social security and health care.

For example, in the early 1990s, FI experienced a severe economic recession, during which the unemployment rate increased from 3.4% in 1990 to 18.4% in 1994 and long-term unemployment rose to 27%. However, life expectancy at birth for men (Figure 13) remained stable or improved slightly among the adult population while infant mortality declined from 6.3 deaths per 1 000 live births in 1986 to 4 in 1994. This may be explained by the fact that a developed welfare system comprising wide social safety nets and a health care system offering universal coverage provided comprehensive protection. Nevertheless, the crisis did have a health impact especially in terms of mental health, with an increase in sleeping and anxiety problems (see e.g. Figure A13 in the Annex for SE).

Several new Member States experienced a crisis in the early-1990s or mid-1990s during the transition to democracy and to a market economy: high unemployment and inflation and a drop in GDP were observed, albeit to different extents. It can be observed that the rise in unemployment and the drop in GDP during that transition period could be associated with increased mortality and reduced life expectancy, in particular for men. For some countries life expectancy did not increase during transition, while for others it actually decreased and has taken some time to return to pre-transition levels.

Figures 6.13. Life expectancy at birth for men, 1985-2007, for FI and SE and for those countries that have undergone the economic and political transition from a planned to a market economy
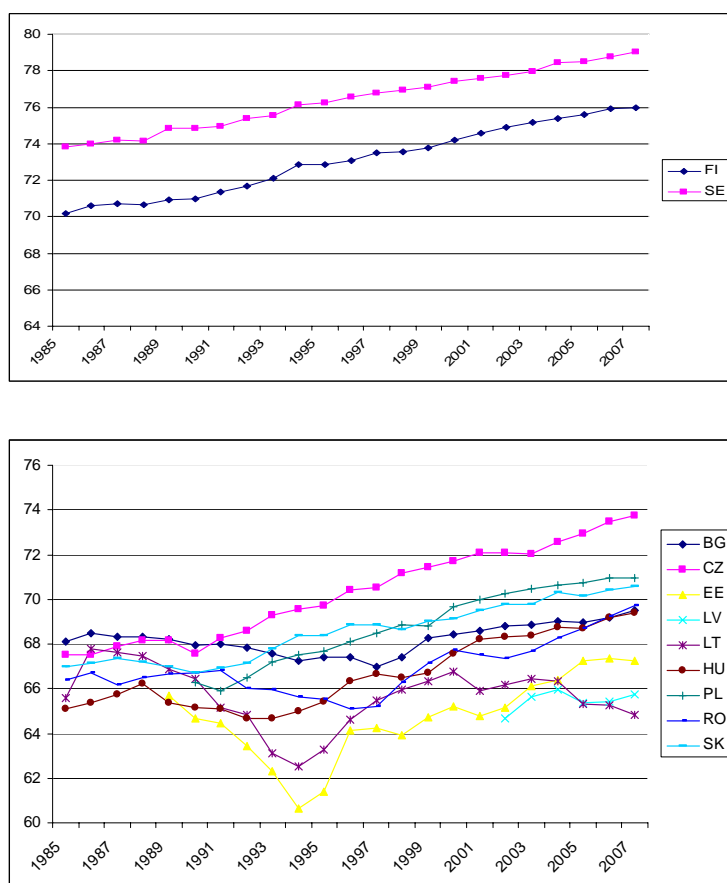
Source: Eurostat

Fluctuations in the **unemployment rate** are more closely associated with short-term changes in health than any other economic indicator. A study has shown that every 1% rise in unemployment rates is associated with a 0.79% rise in suicides of those aged 65 and less and a 0.79% rise in homicides (Stuckler, D. et al., 2009). A study of the correlation between **unemployment** and **mortality** in Britain during the recession period in the 1970s and 1980s showed that the unemployed had a mortality rate 20%-25% higher than the average for their respective socioeconomic group (Marmot, 2009).

The unemployment rate is also found to be a significant risk factor for morbidity. In addition to increasing alcohol or substance abuse and malnutrition, unemployment (and the associated lower income and financial distress) is also found to be an important risk factor in cardiovascular disease and **mental health** (distress, depression, anxiety, psychosomatic symptoms, etc.). Moreover, the negative effect of unemployment on mental health is stronger in countries with a weak level of social protection and unequal income distributions. Not only unemployment is detrimental to health. Even **job insecurity** has a negative impact on health (Bilbao Agency, 2007). A meta analysis (Sverke et al., 2002) has revealed a significant negative correlation between job insecurity and poorer mental health. The relationship has been confirmed by longitudinal studies (Ferrie et al., 2003) showing that job insecurity should be treated as a cause of worsening mental health.

6.1.3.2. Potential effects of the economic crisis on the healthcare sector

Reductions in **public expenditure** on health may also affect the **composition of health spending**. Where governments report cuts, they suggest that salaries will be maintained, but that savings will be made in infrastructure and equipment. However, some governments may choose to increase the health and social protection budget, as has actually happened in previous instances of recession. As a result, health spending in some of the countries affected by economic downturns has fallen, while in other countries it has been maintained or even increased.

Private expenditure on health care may fall as a result of the drop in household disposable income. In contrast to public spending, **private out-of-pocket expenditure** usually tends to decline in a recession, particularly if services are available at lower cost in the public sector. The reduction in household income caused by currency devaluation, inflation, unemployment, wage reduction or other factors can affect the ability of families to pay for health care. Recourse to cost-sharing and out-of-pocket payments for health care may be avoided or reduced by turning to government-subsidised and not-for-profit health care providers in times of crisis. As a result of the **lower demand for private care and the** consequent **transfer of demand to the public sector** the overall quality of care may decline, if public services are not adequately equipped to cope. This problem will affect all countries where publicly funded services are under pressure.

Some governments choose to increase cost-sharing. Decreasing public health spending, increased costs of treatment, and reduced family income and/or insurance coverage will **affect the use of health services**. For patients, price increases (in the form of official user charges and co-payments, payment for medicines or informal payments) may deter less well-off patients from seeking the necessary care as it becomes unaffordable. However, it may be possible to control the rise in the costs of care for patients through generic substitution or public subsidies.

Where recession is accompanied by inflation and devaluation of domestic currencies**,** the prices of imported medicines, raw materials and medical equipment can increase.

In sum: EU health systems have to balance increasing demands on services, and the need to respond to people's health needs, with restricted or even diminishing financial resources. The fact that similar health expenditure levels may be associated with different outcomes has raised some political discussion on whether there could be effectiveness and efficiency gains to be made within the sector and in addressing the social determinants of health. Different financing and organisational arrangements may be more or less able to control such expenditure pressures (2007 Joint Report; OECD 2005). Differences in expenditure levels and price structures raise questions in relation to financing and delivery structures and policy priorities (e.g. health promotion, disease prevention and rehabilitation versus treatment). The search for ways to raise effectiveness and efficiency is therefore ongoing.

6.2. Improving effectiveness and efficiency in the health sector: a look at a number of areas

The last decade has seen increasing debate on ways to improve health system performance and value for money and thus enhance longer-term sustainability. The following sections review some possible strategies to improve effectiveness and efficiency and what they entail.

6.2.1. Encouraging the use of primary care

Encouraging the use of primary care instead of direct use of specialist care while strengthening referral systems from primary to other types of care is one of the health policy reforms that are being implemented or planned by EU Member States to improve resource use in this sector. This is done by enforcing a compulsory referral system with a gate-keeping role for primary care physicians and via financial incentives (i.e. higher reimbursement if a patient follows a referral system from primary to other types of care).

In the last decade, policy makers in many Member States have changed the way they see primary care. While some Member States had a primary care-led system with patients first visiting a primary care physician who would then refer the patient to specialist services (referral and gate-keeping role), in many others free choice and direct access to specialists, with a strong emphasis on curative hospital-based care, were part of normal service delivery. Primary care remained peripheral, sometimes seen as a synonym for lower-quality care with patients failing to register or visit a primary care physician and using specialist and hospital care directly through overuse or unnecessary use of emergency departments. In more recent times, the growing focus on addressing observed healthcare delivery deficiencies (improving access and quality) and improving value for money in the health sector (efficiency) has shifted attention to primary care and its potential role in achieving these improvements (2008 WHO World Health Report; 2007 PROGRESS workshop on 'Policy options for promoting rational resource use in the areas of health care and long-term care').

Primary care is to be the first point of access to the health system under normal circumstances. The primary care physician (also called 'general practitioner' or 'family doctor') examines the patient and decides whether he/she should then visit a specialist. Stronger primary care aims to avoid patients organising or having to organise their care path through the system, leading to disparities in access, lack of coordination and continuity of care (quality), duplication of procedures and use of unnecessary and more expensive diagnostic and curative hospital care, resulting in health and financial costs for both the patient and the system. A focus on primary care will also improve access to health promotion and disease prevention to avoid or postpone the onset of disease and ensure its early diagnosis, thus bringing about savings in the sector.

Figure 6.14. General practitioners per 100 000 inhabitants

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
BE	168.9	170.8	173.7	175.1	177.2	176.2	176.4	175.9	173.3	170.3	170.9
BG						67.5	68.6	69.1	67.8	66.8	
CZ	48.3	48.3	49.0	51.2 (b)	52.5	52.2	51.4	51.3	51.2		
DK	61.5	63.5	64.1	71.9	72.1	72.2	71.5	75.3	74.6	74.4	
DE	109.6	108.0	106.4	106.6	106.2	105.1	104.2	102.4	97.4	99.2	
EE	56.3	64.5	80.8	88.2	85.4	92.7	95.5	100.2	99.8		105.3
IE								62.2	68.3	69.9	
EL	27.8	27.9	29.8	27.7	26.5	28.5	31.9	33.9	35.5		
ES											
FR	161.6	161.3	159.6	161.1	162.0	162.8	163.8	164.5	164.6	164.1	
CY				37.4							
LV	16.0	20.2	33.4	40.6	41.0	43.8	45.0	52.9	54.7	55.7	54.7
LT	7.5	8.3	15.6	21.3	27.9	36.0	43.0	48.2	50.5	52.6	
LU	71.2	72.5	73.9	74.3	77.2	75.2	74.7	76.6			
HU	65.3	66.1	65.9	66.0	66.0	66.1	66.1	65.6	65.4	65.2	
MT											77.7
NL	44.7	45.0	45.5	45.5	45.5	45.6	45.6	46.1	46.4		
AT	131.0	134.4	132.8	134.6	137.4	139.9	141.1	143.3	146.0	150.5	153.3
PL							11.9	13.3	14.3	15.2	
PT	43.0	43.4	43.7	44.2	44.5	44.7	44.9	45.6			
RO									65.8	80.9	
SI	16.7	20.3	19.8	19.7	19.4	19.0	19.2	26.7	26.2	26.0	
SK	8.5	36.5	41.5	43.2	44.0	43.6	43.2	43.2	36.9	36.3	
FI	33.2	34.5	36.3	37.7	38.7	39.7	40.6				
SE	49.8	51.4	52.0	52.8	54.6	56.0	57.0	57.7	58.9	60.2	
England				71.1	71.8	72.5	74.8	76.9	79.0		

Source: Eurostat

However, reforms to improve health system efficiency (as well as accessibility and quality of care) through greater use of primary care imply a change in its scope, its delivery and its financing. While greater use of primary care is indeed a more efficient option for care delivery because it ensures more adequate care, avoids unnecessary care (as primary care doctors compared to patients acting alone have more and better information on the type of care needed following a referral) and postpones the need for care, this entails a wider range of tasks for primary care physicians and nurses, including health promotion and disease prevention activities. Reforms are also encouraging group rather than individual practices, and sometimes a common budget, so that primary care centres act as purchasers of other types of care for their patients. Primary care providers will also act as the care guide or coordinator for their patients.

Expanding the scale and scope of primary care appears to bring satisfaction to both patients and primary care providers. For patients, the expansion of primary care services, especially if this translates into a better geographic distribution of services, may mean easier access to a wider range of services provided in a more personal and continuous basis over a lifetime, with more time given to the patient. For primary care physicians, a wider range of responsibilities and tasks renders primary care more interesting and rewarding.

For primary care to improve value for money in the system, one nevertheless has to look at the number of primary care physicians available (Figure 14), the set of services included in primary care and the financial incentives for primary care providers, much like in other parts of the health sector, so that these factors do not run counter to referral and gate-keeping goals.

6.2.2.   Care coordination

Care coordination can be defined as policies that help ensure care is more coherent both within and across care settings and over time. It is about making health care systems more

attentive to the needs of individual patients and ensuring they get access to appropriate care but at less cost (EC/OECD conference, 2008). By ensuring a coherent care path, coordination can be of great importance to the most disadvantaged groups, who often lack continuous follow-up in terms of preventive or early care and end up relying on late or emergency care instead. Care coordination is particularly pertinent in the context of ageing and the attendant multi-morbidity and chronic diseases, which result in greater use of many different types of both medical and support care at the same time. Care coordination is thus about ensuring that patients access care that is appropriate and of a high quality (i.e. safe, effective and responsive to the needs and preferences of patients), and is provided in the most cost-efficient or cost-effective manner (effectiveness, efficiency and thus sustainability).

Currently, independent care settings and budgets, specialisation of medical knowledge, lack of communication and mutual professional esteem, and even rivalry between professionals have led to fragmentation of care (between primary and secondary or tertiary care, between medical and support/social care). Patients may not always receive the care they should, when they should, or where it is best provided. Further, there can be high levels of medical error. Belated care, often in emergency departments, as well as overuse or unnecessary care, duplication of procedures, and conflicting medical recommendations represent a double burden for patients (negative impact on their health status and their income) and the system (e.g. increased costs/expenditure). Good coordination of care can reduce the need for hospital stays, the unnecessary use of emergency care and the duplication of procedures (in particular expensive and invasive diagnostic procedures).

Primary care providers are often seen as best placed to be the guide or coordinator, although at present referral systems from primary to other types of care do not function perfectly: patients do not register with or visit family doctors, who lose track of patients once they move to hospital or institutional settings due to lack of referral back to the family doctor.

Policies conducive to coordination include: a) improved use of ICT as a key tool to link the healthcare "silos" and allow information to follow the patient, including electronic health records or software that follows the patient's path through several episodes of care; b) reconfiguring provider structures, in particular to include more elements of multi-disciplinarity (multi-disciplinary teams in care practices); c) incentives to care providers (e.g. elements of remuneration explicitly linked to care coordination) and skills development in chronic disease management, communication with patients and networking; d) implementation of targeted disease programmes; and e) addressing administrative barriers (e.g. through pooling resources from health and social sectors and addressing lack of mutual esteem and recognition between different medical professions). Communication across the various parts of the health sector is fundamental to avoid fragmentation and rivalry between medical professions and types of care.

6.2.3.   *Reforming in-patient care and enhancing outpatient care*

Health policy reforms to improve value for money in the health system also encompass reforms in the specialist and hospital care areas. These often call for changes in medical knowledge and medical technology to enable, for example, less invasive medical (diagnostic, surgical) interventions. This can in turn shorten stays in in-patient care or render them unnecessary through the use of day case surgery, thus allowing for more intensive use of existing beds and staff. More use of day case surgery is an appealing solution to reduce

overall costs in the health sector by cutting hospital costs (which often make up a large part of total expenditure in the sector), and many countries have been encouraging it. Looking at Figure 15, a wide variation across EU countries in terms of hospital activity, measured by hospital inpatient average length of stay (ALOS), can be observed. In addition to data comparability issues, variations can be due to various factors associated with quality and financial considerations. They include patient registration practices as hospital cases, historical medical practices, absence of clinical guidelines, lack of referral back to primary care, lack of alternative follow-up care at home, lack of long-term care at home or community so that long-term care patients are treated in hospital, but also disincentives to reduce in-patient care and length of stay, such as overcapacity or remuneration/budgetary systems that make in-patient procedures more financially attractive to providers. In addition, the implementation of day case surgery and a general reduction of ALOS should be accompanied by monitoring mechanisms to follow up its impact including adverse effects on health outcomes.

Figure 6.15. Average length of in-patient stay (in days), all causes excluding births

	2000	2001	2002	2003	2004	2005	2006	2007	2008
BE	7.7	7.5	7.4	7.7	7.6	7.5	7.4	7.3	
BG						8.3	7.5	7.2	
CZ			10.3	10.2	10.2	10.9	10.7	10.6	
DK	6.3	6.2	6.1	5.9			5.4	5.3	
DE	10.1	9.8	9.7				10.2	10.2	
EE									
IE	6.4	6.4	6.4	6.4	6.4	6.5	6.3	6.2	
ES	8.8	7.7	7.7	7.7	7.2	7.1	7.0		
FR	6.0	6.0	6.1	6.0	5.9	5.9	5.8	5.8	
IT				7.6	7.6	7.6	7.7		
CY	6.4	6.5	6.4	6.0	6.3	6.0	5.9	6.2	
LV						9.6			8.8
LT		10.6	10.3	10.0	10.1	10.1	10.0	9.9	
LU	7.5	7.4	7.5	7.2	7.3	7.3	7.4	7.3	
HU					8.1	8.0	7.9	7.9	
MT					5.4	5.4		4.8	4.9
NL			8.0	7.6	7.2	6.9	6.7	6.4	
AT				10.0	9.5	9.0	8.9	9.0	
PL				7.2	6.8	8.4	8.1	8.0	
PT						6.7			
RO								7.8	
SI					7.9	7.9	7.7	7.7	
SK	9.9	9.5	9.0	8.8	8.7	8.4	8.3		
FI			12.9	12.7	12.5	12.5	12.7		
SE	6.8	6.7	6.7	6.5	6.4	6.4	6.4		
UK	10.8	10.6	10.0	9.3		8.7	8.8	8.1	

Source: Eurostat. Please note that caution is needed in interpreting the table results as it includes all causes (including psychiatric care) rather than just acute care, fact that can increase the figures for ALOS. In addition, there are differences across countries in the way they report on ALOS for different types / functions of care considered.

Measures to increase efficiency also include the division and concentration of tasks between hospitals in a defined health region. The idea is to concentrate certain types of services in fewer hospitals to improve capacity use, while often also improving the quality of those services. For certain services, concentration may go as far as having a very few centres of excellence serving the entire population. Division and concentration of tasks does require good coordination and communication structures between primary and secondary care and between the various hospitals.

6.2.4.   Pharmaceuticals

Spending on pharmaceuticals has risen rapidly in the last two decades. Pharmaceutical expenditure accounts for about 1.5 % of GDP, and although a relatively minor share of spending by OECD countries on health — on average less than a fifth of total health expenditure — the share has been increasing over the past 20 years, at an average rate of 5.7 % per year, faster than other types of health care, in GDP terms as well (2008 EC/OECD conference). The public sector is the primary source of financing for pharmaceuticals, accounting on average for 60 % of total pharmaceutical expenditure in OECD countries, while another large part comes directly from households. Moreover, there are also large differences in pharmaceutical expenditure per capita (Figure A10 in the Annex), which may reflect different practices in market regulation, pricing, reimbursement, coverage, distribution, prescribing and dispensing of pharmaceuticals, and different objectives (affordable access, cost-containment, encouraging of industry production and R&D). Hence the growing concerns expressed.

In this sector, a trade-off is often identified between: a) obtaining greater value for money given a limited public budget; and b) promoting future innovation (long-run perspective), which involves high costs for the development of new drugs. Innovation creates new care opportunities, some of which may replace old, more invasive and expensive practices in the long run but will require considerable funding in the short run, which will have to come from the sale of current branded and patented drugs. Therefore, policy makers need to identify policies that can induce savings in the short run without hindering innovation.

Countries have been using price regulation to set maximum prices for patented drugs and/or reference pricing (the maximum price reimbursed by public insurance for non-patented drugs, typically an average of the prices of drugs in each therapeutic group with perhaps a certain percentage margin below that average). The patient then pays the difference in price. Price regulation can induce the desired patient behaviour and control expenditure, but some drawbacks need to be taken into account. Indeed, producers can use the reference price for all drugs or slightly adjust the definitions of drugs to obtain a higher price premium. Price limits are also based on a set of other factors, including the importance and leverage of the pharmaceutical sector in the country. Price regulation based on external benchmarking (looking at the price of a same drug in other countries with similar economic and geographic characteristics) can induce manufacturers to launch products first in countries with no regulation at the entry point in order to set the industry price as an example. As a consequence, such measures should be coupled with other policies.

One way to increase the cost-efficiency of pharmaceuticals is to encourage generic substitution. A number of Member States have been doing this for some time, but for others there is a large scope for improvement. The use of generics can be encouraged through prescribing guidelines (defining positive or negative lists of publicly reimbursed drugs, encouraging doctors to prescribe by active element and pharmacists to sell the cheapest medicine that matches the prescription) and through user charges (higher reimbursement for generic drugs). Prescribing guidelines and financial incentives can be used to influence the demand for pharmaceuticals overall. They can be coupled with information campaigns.

Another policy is to see if there are opportunities for efficiency gains in the distribution chain (looking at existing practices in reimbursing pharmacies, the number and location of

pharmacies, the number of pharmacists, opening hours, etc.) and see if these encourage higher prices and higher sales.

Yet another is to use economic evaluation and thus information on the relative cost-effectiveness and cost-utility of products in the definition of prices and reimbursement schemes (and cost-sharing) for pharmaceuticals, while ensuring that the rewards for innovation are consistent with the value of the benefits offered. Economic evaluation is not commonly used for health policy decisions in many countries, and there is large room for improvement.

In addition, governments can seek to establish price-volume agreements or even confidential rebates when value-based prices cannot be established, as pharmaceutical firms may be more willing to negotiate an overall budget for a large set of medicines than to negotiate the unit price of each medicine. They can also explore the possibility for risk sharing in the case of new medicines, to reduce the financial risk presented by new medicines when information on their cost and their expected effect on health outcomes is insufficient. This can involve the pharmaceutical company and the purchaser authority agreeing on the expected benefits of the drug, with the company then paying part of the health service costs if the drug fails to fulfil expectations. Such agreements can allow new, expensive drugs to be covered.

Some countries (UK and ES) are experimenting with profit regulation to control the amount of profit drug companies may keep on their sales to the National Health Service so as to keep the public costs of purchasing drugs down to a reasonable level.

6.2.5. *Greater use of Information and Communication Technologies (ICTs) / e-Health[82] solutions but also more economic assessment of technology*

Technological development can bring about less intrusive and cheaper treatments, thus facilitating the above changes in the primary and secondary care sectors (e.g. greater use of day case surgery). In addition, the lack of communication among different care providers and between providers and patients has been identified as an obstacle to healthcare access and associated with quality deficits. The resulting lack of care coordination translates into additional financial costs.

Both better information and better systems for information transfer are needed to improve health monitoring, access to health care and the quality and sustainability of health systems. eHealth can also allow for additional access points to health information and to the health system (health portals; online health services, e.g.: *NHS direct*), providing more information to patients. This support to health literacy can encourage health promotion and lifestyle changes, as well as patient empowerment.

Currently, health systems are not sufficiently employing ICTs or are doing so without sufficient concern for interoperability, thus fragmenting health information flows. This reduces the ability to systematically record and report inputs, processes, outputs and outcomes as well as the ability to develop and use evidence-based guidelines.

---

[82]   **e-Health** is the generic name given to a group of powerful ICT-based tools used for the benefit of patients and/or health systems.

ICT and e-Health solutions have the potential to improve the collection and storage of multiple sources of data (electronic records, registries, and administrative data) and the linkages between them as well as enhance information exchange, while abiding with data protection and privacy law.

eHealth can allow for better care coordination by allowing for information to seamlessly follow the patient as s/he navigates through the health system. This can directly improve patient safety (for instance, by alerting to possible medicine interactions or avoiding unnecessary and harmful procedures) while also helping to control costs. E-prescribing can support compliance with protocols, avoid interaction between drugs or confusion between patients, dosages or times of application, and support generic prescription (and thus control costs). ICT and e-Health can also help fight against counterfeiting and mislabelling. They can also be key instruments to reduce the administrative burden on staff and to free the valuable time of health professionals for core care activities, something of great importance in a context of workforce shortages.

Introducing such system-wide information systems is complex (e.g. cultural barriers, resistance to change the legal and reimbursement frameworks, etc) and can be expensive in the short term, even if the expected gains may outweigh the costs. It requires commitment by all stakeholders and staff involvement and a longer-term, system-wide approach. It requires training and incentives for staff to use the systems implemented. In general, the objectives are to promote a coordinated and deeper engagement in e-Health and to promote mainstreaming, acceptance and take-up by involving health professionals and patients in national e-Health strategies and deployment in a way that reduces inequality, not adds to it. Moreover, given greater patient mobility, the aim is to promote the (cross-border) interoperability of e-Health systems.

6.2.6. *Health Technology Assessment*

Technological development can increase expenditure by creating new treatment opportunities. The issue of the health system's financial ability to pay for these new treatments versus patients' high expectations of benefiting from new technology at an affordable price has led to calls for greater use of economic assessment and evaluation of technology (Health Technology Assessment — HTA[83]), including a cost-effective and cost-utility analysis to decide if a certain care intervention or drug should be included in the publicly funded or reimbursed basket of care and to what extent, notably in comparison to other interventions or drugs.

There is growing pressure from stakeholders requesting evidence that public money is spent wisely for the benefit of patients, the public purse, service providers and innovators. HTA is thus being more and more debated but there is a wide variation across EU countries and the tool is still not commonly used by policy makers. HTA is in fact a daunting exercise. There are different approaches to the definition of costs, outcomes and thresholds. Hence, it may

---

[83] According to EUnetHTA (European network for Health Technology Assessment), 2003, HTA is a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, and robust manner. It therefore helps to inform the formulation of safe, effective health policies that are patient-focused and seek to achieve best value.

yield different results that may not be totally generalisable or transferable. It is a multidisciplinary field and requires skilled scientists and the creation of committees. In addition, there may be societal and ethical issues involved. Building on a number of previous actions and projects, the Commission and Member States are currently working on a joint initiative aimed at increasing cooperation, sharing information and developing the same core methods in the area of HTA.

6.2.7. Incentives for users and providers

6.2.7.1. Financial incentives for patients: user charges

From the point of view of system efficiency and financial sustainability, user charges have two roles: 1) to raise revenues for the sector and 2) send signals to patients to combat moral hazard (overuse or unnecessary use of care because it is free at the point of use). Most EU countries rely heavily on public funding, so user charges play only a small part in financing the system. Moreover, in countries that rely more on user charges, many citizens take out complementary insurance to cover those charges (actually rendering citizens less sensitive to charges and their role in counteracting moral hazard). In most cases the revenue is not large, and in some cases is outweighed by the collection costs. Hence, user charges have not been very successful in raising additional financing, and mostly function to encourage the better use of services as in 2), although their impact is limited when complementary insurance is available.

Charges have been accompanied by intense political discussion because of the potential negative impact on the solidarity and equity of the system, i.e. in reducing care use among those who need it, especially the more vulnerable and less well-off. Consequently, a practice of small charges combined with a number of payment exemptions (based on age, income and chronic disease) has developed. Existing evidence does indeed suggest that charging can and does reduce utilisation[84]. While this may not have major health consequences for most of the population, it has important negative consequences for the health of those with low incomes and poor health (who need health services more often). Hence, if not properly designed, charges can have financial and health consequences for some groups of the population and thus contribute to the socio-economic health inequalities observed.

Therefore, the role of user charges needs to be carefully rethought. They may be unavoidable for financing the system given the already high expenditure and the growing demand and expenditure pressures discussed previously. However, if they are to play their two roles effectively it is crucial to design them so as to minimise the negative impact on access to care for the most vulnerable while maximising efficiency gains.

One suggestion is that authorities should define a minimum care package of a sufficiently high quality so that all citizens are willing to contribute to its financing, thus ensuring broad, publicly funded provision. This package will be fully covered by public financing and determined, where possible, using cost-effectiveness criteria. Building on this initial high-quality package, charges (co-payments, co-insurance and deductibles) will be introduced to an increasing extent to encourage appropriate behaviour (e.g. generics rather than branded products, primary care rather than direct visits to specialists and hospitals, preventive rather

---

[84] "Achieving better value for money in health care", OECD 2009.

than curative care). Some charges should not be covered by complementary insurance to ensure that they encourage desirable behaviour. At the same time a system of exemptions for the poor or chronically ill needs to be in place to avoid under-use of care.

6.2.7.2. Non-financial incentives for users: patient choice and involvement

Recent years have also seen an increased emphasis on patient empowerment/involvement/choice and satisfaction. When introducing choice, one needs to think about its design (at which stage, how choice is allowed) and its objective. Patients' ability to choose providers can lead to increased patient satisfaction, and fits in with the goal of improved well-being and the notion that the health sector works for the patient. However, it may result in overall increased expenditure with no general clinical improvements. If properly designed, choice at certain stages in the care delivery process may encourage the development of alternative providers and thus contribute to enhancing efficiency. Some countries where provider choice was typically restricted have introduced some degree of choice in various stages of the process: choice of the primary care physician, albeit with some geographic and time limitations, or choice of hospital following referral by a primary care physician.

Choice is nevertheless constrained by the level of information patients possess about their rights and the quality of care offered, and is thus often influenced by age and social background. It is also dependent on the number of alternative providers. Proximity considerations also weigh heavily in the decision to search for care elsewhere.

6.2.7.3. Remuneration of physicians and hospitals and benchmarking

Labour unit costs vary across countries in part due to different remuneration systems. Such systems include fee-for-service (income equal to the number of services provided times the price of each service), capitation (income based on the number of patients enrolled with each physician, often risk-adjusted to the types of patients enrolled) and salary (fixed income independent of the number of patients and services provided). Each system provides different incentives for physicians. A fee-for-service system may be associated with supply-induced demand and the lack of care coordination, especially if associated with free choice of physician. Capitation or salary systems may, in contrast, result in under-use of services and longer waiting times. As a result, several Member States are now implementing a combination of systems, with, for example in the context of primary care, a capitation system plus fee-for-service for health promotion and disease prevention services. In others, the fee-for-service system is regulated and a list of standard tariffs is published by the authorities.

Many countries have introduced an element of activity-based or case-based remuneration in the payment structure of hospital services. These are usually based on diagnosis-related groups (DRGs), a way of categorising patients according to diagnosis and intensity of resources required and thus an attempt to establish a comparable structure of hospital costs. In addition, there is greater use of prospective budgeting for hospitals (payments fixed in advance of the provision of services), often based on potential patient case-mix and a set of healthcare need criteria. Some countries use global prospective budgets.

Some Member States are supplementing the above mechanisms with the measurement of hospital efficiency, hospital benchmarking and ranking (measuring performance of organisations according to specified standards and comparing them using the results) on the

basis of efficiency and other criteria as a means to induce each hospital to evaluate its practices and search for improvements.

Evidence suggests that changes in hospital budgeting and hospital performance measurement and benchmarking have induced changes in hospital care delivery to achieve cost savings. The overall results appear to be positive, especially if the changes are well-communicated to providers, if they encourage learning from other providers, and if approached from a rewarding rather than a punishing perspective. Nevertheless, there are also reports of miscoding of patients under more costly DRGs to obtain greater hospital revenue or rejecting costly patients. Efficiency gains from performance measurement and benchmarking may also not have been as high as expected, while in some cases hospitals may have focused on those dimensions of care that are being measured to the detriment of other important dimensions. Moreover, performance measurement and benchmarking have to be adjusted for patient case-mix and need criteria as well as the availability and quality of equipment (old vs new hospitals).

Some non-EU countries also use or are planning to use user charges for drug companies to raise revenue and pay for the technology assessment of their new drugs.

6.2.7.4. Non-financial incentives for physicians: training and motivation

The development of robust human resource strategies to improve recruitment and retention will be one of the most important issues for policy makers in the health sector. Such strategies could range from raising awareness of careers among school and university leavers, running return-to-practice campaigns with support for updating of skills and providing opportunities to work flexibly, and schemes to attract and retrain older workers or those needing to change careers after redundancy.

6.2.7.5. Competition

The healthcare market is one where several market imperfections are observed. There are information asymmetries between patients and providers and between insurers/purchasers and providers about health status and the care needed and provided, allowing for principal-agent problems to develop and raising issues of supply-induced demand. There are other information gaps, such as patients being cost-unaware as to how care is financed and delivered, thus raising issues of possible excess demand and consumption. There are also practical and regulatory constraints on the entry and exit of providers such as restrictions on access to training for staff, economies of scale and scope in the provision of many services, and the fact that, from society's point of view, providers and purchasers cannot just fail and vanish from the market leaving a gap in the provision of needed, life-saving services. In addition, health-related education and training have the characteristics of public goods and there is substantial R&D in the sector. Moreover, the objectives associated with healthcare provision are not necessarily those of efficiency but also those of solidarity, universality, and equity of access and outcomes.

In this context, competition in the healthcare market may imply higher costs than a non-competitive market due to the need to regulate, monitor, audit and control (notably through competition and quality authorities) and the complex mechanisms that need to be in place to obtain the required information to attain the other objectives associated with health care.

On the other hand, policy makers and researchers in recent times have expressed their concerns that sole reliance on non-market mechanisms may also be undesirable, as it can give rise to opportunistic behaviour and inefficiency. Hence, several countries are looking at the scope for promoting more rational use of resources by using market-type mechanisms such as increased competition, notably in certain sub-markets, or procedures to improve efficiency.

Two types of competition are being explored. The first is <u>competition between healthcare insurers,</u> i.e. competition to provide to each patient a set of services for a specific time period, a recent development in some social health insurance systems. What is observed in EU Member States, however, is not the extreme case of an unregulated market where patients pay a premium related to their risk and preferred benefit package. What is found is enhanced competition between insurers in a regulated environment (e.g. NL, BE, DE) where insurance is mandatory, there is a community-rated premium that all insurers must offer for a minimum defined care package, insurers cannot refuse applications, and there is competition on extra benefits or side-benefits of the package and along some quality dimensions. There is a risk-adjustment mechanism among insurers, and sometimes regulations for high-risk patients, to avoid cream-skimming and ensure a level playing field.

The second is competition between providers, or <u>competition for collective health services,</u> a more common mechanism, whereby a purchaser concludes a block contract with a provider for the delivery of a set of specified services. The separation between purchasers and providers in various national health systems in the EU is intended to create strategic purchasers who would choose between providers to achieve cost reductions. Negotiation/bargaining and contracting have often been based on benchmarking. Research indicates that contracting has delegated responsibility in previously very hierarchical settings, allowing for the involvement of lower-level managers in decision-making. Contracting has also made providers more responsive to the priorities of purchasers and national health strategies. It has induced changes in provision patterns (from in-patient to out-patient care and the adoption of cost-effective interventions) and cost reductions have been observed.

In conclusion, there may be room for greater competition among insurers/purchasers and providers and greater use of market-type mechanisms in sub-markets or for certain procedures that may encourage greater cost efficiency in the health sector. However, one must not underestimate the regulatory challenge and the considerable costs of the administrative machinery needed to create and sustain competition in health markets while also ensuring coverage and quality of care. The extent of the <u>information</u> needed is very large in terms of population structure and health status, to allow for risk-adjustment mechanisms, as well as in terms of care costs, prices, and market structure. Imprecise information and thus risk-adjustment leads to cream-skimming of patients. On the other hand, if many high-risk patients seek particular insurers and risk-adjustment is not properly designed, then a race to the bottom ensues, i.e. insurers start offering a lower quality of care for those patients (e.g. care for chronic conditions). This then requires the definition and control of minimum standards. In addition, the efficiency gains may be smaller if there is under-competition between insurers and patients are allowed to choose providers.

The gains associated with greater competition between providers also depend on a number of factors: the nature and scope of the services contracted, the contract process used, the duration of the contract, the population covered, and the definition of price and quality criteria. In some sub-markets this competition may not be realistic if there are economies of scope and

scale and few providers. Moreover, if a purchaser wishes to ensure integrated care then it may wish to contract with a larger provider offering a wider range of services, therefore strongly limiting its choice. Contracting requires information and data collection on many variables such as unit costs, prices, length of stay, etc. Imperfect information may have negative effects on unmeasured dimensions of the care provided. Finally, the contract type (global budgets vs. case-based DRG payments) provides different incentives to providers.

EU Member States differ in their institutional and market capacity and thus their ability to pursue such avenues. As some of these mechanisms have been introduced only recently in some countries, it is important to follow up the results achieved, in terms of efficiency gains, by those actively engaged in these policies.

6.2.8. Encouraging effective health promotion and disease prevention

As highlighted, if people are healthier for longer the pressure on expenditure and public expenditure in particular is lower. A range of health promotion and disease prevention activities (e.g. vaccination, screening for certain types of cancer) are considered effective and cost-effective in improving population health outcomes by avoiding disease and mortality and through early diagnosis and treatment (often less costly) and thus higher survival chances. However, expenditure on health promotion and disease prevention is still a minor part of total health expenditure (Figure 6.16). Nevertheless other policy areas may contain prevention measures that are not reflected in health-related budgets.

To enhance health promotion and disease prevention, some countries have introduced direct personal financial incentives for people to prevent illness and promote their health. These include financial disincentives to smoke or drink alcohol (especially spirits) through high taxation of these products. Other mechanisms include age regulation for the sale of alcohol and smoking bans in public places. These are often coupled with publicly reimbursed support schemes for quitting smoking. Some countries are considering higher taxes on soft drinks. Others prescribe physical exercise as a treatment or give financial incentives to do so (vouchers). Financial incentives are also given to pregnant women to eat a healthy diet and follow pre-natal care or for patients to comply with their medication. As mentioned above, some countries provide additional fee-for-service remuneration to physicians to perform health promotion and disease prevention activities. In addition, many national authorities have implemented projects to improve healthy eating and exercise in schools. More research is needed to understand the cost-effectiveness of several of these schemes.

Figure 6.16. Public expenditure on health promotion and disease prevention as a share of total current expenditure on health

	2003	2004	2005	2006
Belgium	1,34	1,72	3,62	3,53
Bulgaria	3,5	3,6	2,84	3,13
CzechRepublic	1,75	1,75	1,46	1,84
Denmark	2,44	2,51	2,29	2,32
Germany	2,84	2,86	2,86	2,95
Estonia	2,16	1,51	1,83	1,94
Ireland	2,5	:	:	:
Greece	:	:	:	:
Spain	2,2	2,21	2,21	2,25

France	1,45	1,41	1,47	1,58
Italy	0,7	0,6	0,6	0,6
Cyprus	0,5	0,44	0,46	0,51
Latvia	:	:	0,24	:
Lithuania	:	1,78	1,74	1,26
Luxembourg	0,72	0,75	1,09	:
Hungary	3,32	2,97	2,89	2,76
Malta	:	:	:	:
Netherlands	2,73	2,43	2,37	2,54
Austria	1,66	1,78	1,67	1,66
Poland	3,24	1,54	1,78	1,79
Portugal	1,3	1,22	1,18	1,16
Romania	5,28	6,92	6,63	5,9
Slovenia	2,86	2,94	2,83	2,8
Slovakia	1,7	1,9	1,3	1,9
Finland	3,05	3,11	3,29	3,24
Sweden	2,46	2,4	1,56	2,66
UnitedKingdom	:	:	:	:

Source: OECD Health data and Eurostat

6.3. Conclusions

Health expenditure absorbs an important and growing share of GDP and the public share is sizeable. Pressures on health spending are likely to continue. Ageing, technology development and growing expectations, together with large socio-economic inequalities in health and the current economic crisis (causing increased ill-health and budget deficits), call for greater value for money through increased effectiveness and efficiency. This may imply restructuring of the way health care is organised and delivered. A number of paths have been suggested, including a restructuring of primary and secondary care, greater care coordination, more intensive and interoperable use of ICT and e-Health solutions, a proper assessment of current pharmaceutical policies, greater use of health technology assessment, a re-engineering of remuneration systems and financial incentives for both providers and users of care more generally, the development of non-financial incentives, and the use of market-type mechanisms. The combination and design may be different across countries, and indeed some of the above measures may be more suitable for some than for others depending on their institutional and market capacities.

Efforts to improve effectiveness and efficiency should aim to promote health, prevent morbidity and ensure access for all to high-quality care that is sustainable. Short-term strategies must be well-linked to long-term strategies. They should also be linked to policies outside the health sector. Health and consequently the need for care are determined by a wide range of factors, including education, income, working and living conditions, and the environment. Hence, attention to health in all policies can improve health and thus the sustainability of health systems.

Despite these first clues to greater effectiveness and efficiency, more information and assessment is needed regarding many of these tools. Moreover, the list set out above is by no means exhaustive. In searching for policies to achieve these goals Member States can benefit from pooling knowledge and exchanging experiences and information. In this context, there is a need to investigate the various aspects of the functioning of national health systems. The

Commission will work with Member States to identify areas where a potential for improving health performance exists and support the development of national strategies to reduce health inequalities.

7. LONG-TERM IMPLICATIONS OF THE CRISIS FOR THE SUSTAINABILITY AND ADEQUACY OF PENSIONS

Over the last 15 years consecutive waves of Member State reforms in response to the challenge of ageing have markedly altered pension systems and pension scheme designs across the Union. For almost 10 of these years, the EU has sought to underpin this process by providing a framework for policy learning with common objectives conducive to the planning, implementation and assessment of such reforms through the Lisbon process and the Social OMC. With the introduction of the euro, the fiscal framework in the EU – the Stability and Growth Pact – has been strengthened, including the need for pursuing structural reforms e.g. in the field of pensions that contribute to long-term fiscal sustainability. As the first decade of Lisbon is coming to a close, it is time to take stock of the progress made. However, with the financial crisis and the economic downturn, Member States also have to revisit achievements and re-assess core responses in the light of the short- and longer-term impacts on the various elements in their pension systems.

This chapter presents a first explorative analysis of the outcome of reforms, the immediate impacts of the crisis, and the longer-term implications of the crisis for pensions. As an initial mapping exercise, it aims to set out some of the main issues that will be subject to a more thorough examination in the joint work of the Social Protection and the Economic Policy Committees in 2010.

Key findings and messages can be summarised as follows:

A first examination of crisis impacts shows that while budgetary restrictions have led to cuts in pension payments in a few countries (e.g. LV, LT, HU), in most Member States current pensioners have so far been among those least affected by the crisis. But as schemes are changing, future pensioners will be more exposed. Importantly, crisis setbacks and the likelihood of lower growth have thrown the rapidly approaching ageing challenge into sharper focus and put the adequacy/sustainability balance sought over a decade of reforms under new pressure.

Strong trends in reforms towards a greater role for pre-funding and defined-contribution formulas will increase sensitivities to volatilities in financial markets, including the present downturn. The wide variation in the losses and capacities of funded schemes to absorb the shock demonstrates that differences in design, regulation and investment strategies matter. To achieve longer-term adequacy and sustainability, lessons need to be learned and greater security for pension savers achieved.

The closer links introduced between benefits and contributions in many public PAYG schemes likewise have made pension entitlements more sensitive to developments in labour markets and benefits will not only depend on the willingness to work but also be contingent on opportunities for more complete and longer work careers.

7.1. Outcomes of pension reforms prior to the crisis

7.1.1. *The financial resilience of pension schemes and the adequacy of pensions*

In the joint European Commission (DG ECFIN) and Economic Policy Committee (Ageing Working Group) 2009 Ageing Report from the spring 2009 and the SPC report on Theoretical Replacement Rates adopted this summer, Member States provided some major assessments of their success in achieving sustainable and adequate pensions. From scenarios based on trajectories for present and coming reforms to pension systems and assumptions about continued growth and increasing employment rates, it would seem that sustainability (in terms of the public budget impact of ageing-induced extra pension costs) has markedly improved over the last decade. In fact, a challenge in some Member State systems in terms of pension policy (i.e. notwithstanding the need to eventually implement a fiscal exit strategy and reduce the high budget deficits currently prevailing in a large majority of MS) would be to secure sufficient future adequacy.

The compelling factor behind most pension reforms has been the need to ensure sustainable finances in pension systems in the long run as the population ages. Changes in the old-age dependency ratio would result in public pension expenditure in the EU-27 to increase from 10.1% of GDP in 2007 to 18.8% in 2060. However, Member States have implemented reforms that address to a large extent this increase. As a result of these reforms and a projected increase in employment rates among the population aged 15-64 from 65.5% in 2007 to 69.9% in 2060,[85] public pension expenditure is forecast to reach only 12.5% of GDP in 2060.[86]

In response to the longevity challenge, we see that due to many pension reforms, the relative level of annual pensions will decrease over the next forty years, given a forty year career.[87] That said, in many cases policymakers have tightened eligibility rules for full pensions and extended pensionable ages to encourage longer working lives as people live longer. There has also been a move toward greater pre-funding of pensions as a method for moving some of the payment burden forward to current working generations, but also as a method of reaping eventual gains from growing financial markets, which traditional PAYG systems do not do.

Pension policy responses by Member States to the ageing challenge have combined three broad types of reform measures: (1) encouraging/enabling more people to work more and longer, (2) greater pre-funding of pensions, and (3) decline in the accrual of annual pension rights, all else being equal.

7.1.2. *More people working more and longer*

The first policy response has three elements: more people working; people working more; and people working longer. Although all elements have seen progress to varying degrees, the most

---

[85]   In the same time participation rates of older workers (55-64) are projected to increase from 47.5% in 2007 to 62.5% in 2060.

[86]   Ageing Report 2009

[87]   *Updates of current and prospective theoretical pension replacement rates 2006-2046*, SPC, July 2009. One must keep in mind that very few individuals in Member States were ever entitled to the theoretical replacement rates, as average career lengths are currently much lower than 40 years in many EU countries.

significant improvement has been seen in increasing employment rates in general and in particular among women and older workers.

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 off for a group of countries where the employment rate for older workers is around 30%. The general increase in employment rates 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. Post 2000, the improvement in the employment rate for older workers has been markedly better than that for both people of prime working age (25-54) and youth (15-24). In addition, most Member States experienced a higher increase in the employment rate for older women than for older men between 2001 and 2007.[88]

Figure 7.1 Employment rates of older workers (55-64) in the EU-15 (1992-2008) and EU-27 (1997-2008)
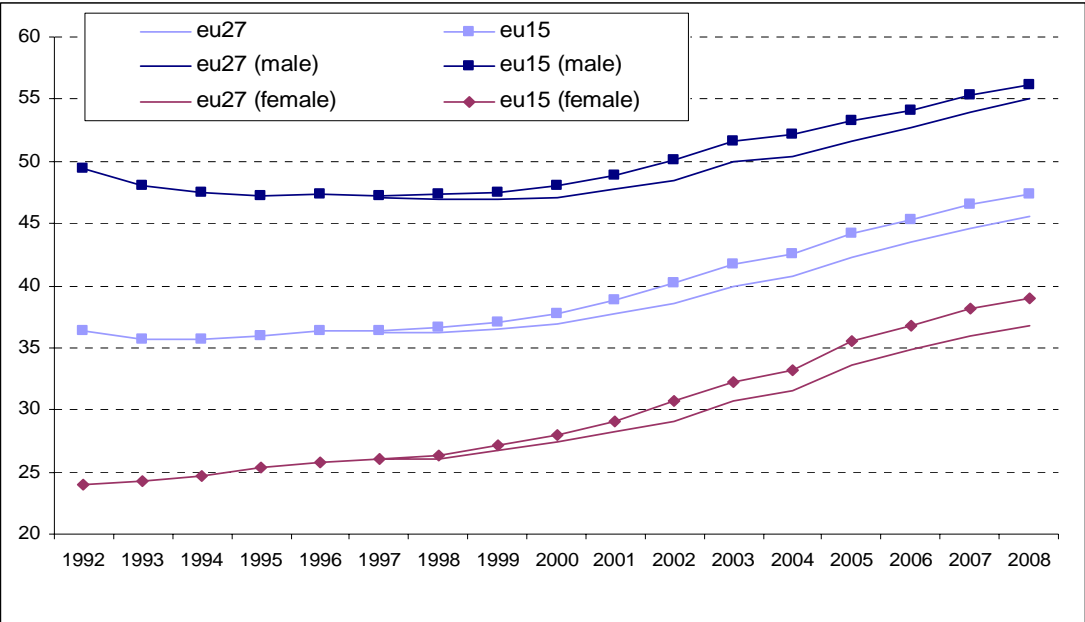
Source: Eurostat

Recent improvements in the employment rates of older workers should not hide the fact that the employment rates of older men have declined substantially since 1970, when life expectancy was much lower than today. In 1970 there were more employed men aged 55-69 than today and more women aged 65-69. In contrast, the employment rates of women aged 25-54 increased substantially by at least 25 pp.[89] Attracting more people into the labour market in the future will thus require reversal of the decline in the employment of older people (especially men) observed after 1970 and boosting of the trend towards increasing female employment.

---

[88]   More detailed analysis can be found in the chapter 2 "Active ageing and labour market trends for older workers", *Employment in Europe 2007* Report.

[89]   *Ibidem*

Figure 7.2 Employment rates by gender in the EU-15, 1970 and 2008
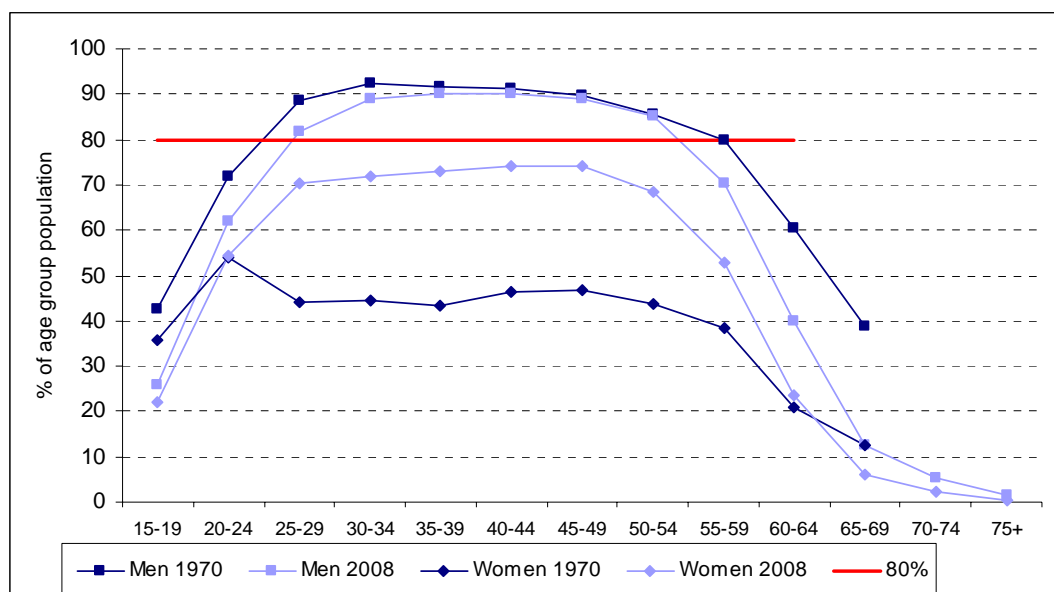
Source: OECD Stat base

General policies fostering economic growth and jobs together with societal changes (such as structural changes in the skill, gender and sectoral composition of older workers) have clearly formed the backdrop to much of recent progress particularly in terms of more people working more. But pension reforms have certainly underpinned developments through changes in design and incentives embedded in pension schemes. These include:

Increasing pensionable ages — i.e. the ages at which retirement benefits can be accessed, or accessed without any actuarial reductions (for instance in the UK, DE, DK before 2030, HU, MT, SI and — for women — AT), abolishing or restricting early retirement options (for instance in BE, DK, ES, LV, LT, PL) and examining critically other routes out of work prior to formal retirement, such as disability and incapacity schemes.

Improving flexible retirement options, allowing and encouraging people to continue working, perhaps in a reduced capacity, and supplementing to pensions for people who choose to defer taking them.

Increasing the link between actual contributions (number of contributions, period they are made over and their level) and eventual pension income. Due to their nature, funded pensions — both defined-benefit (DB) and defined-contribution (DC) - tend to have such links and notional defined-contribution (NDC) schemes (as in SE, IT, PL, LV) are also designed in this way. But increasingly other public pension designs (e.g. AT, DE, ES, FR, PT) also have features where longer working lives feed into higher pensions.

Linking pension benefit calculation and/or indexation of benefits to changes in longevity or dependency ratios. Many pension reforms (e.g. SE, IT, PL, DE, FI, FR, AT) have already introduced such mechanisms. While these measures may have little impact on retirement decisions, they can (if allowed to operate as intended) reduce pension benefits in relation to earnings and contribute to better alignment of expenditures with revenue.

Outlawing and reducing age discrimination in work places and labour markets at both EU and national levels.

7.1.3. *Greater pre-funding of pensions*

Greater pre-funding, in one form or another, has been a popular policy response by Member States to the demographic challenge. However, it is important to note that pay-as-you-go (PAYG) is and will remain the most important element in overall pension provision for most European citizens.

In macro-economic terms, pre-funding is about bringing forward some of the costs of the demographic shift to distribute them over a longer period and over different generations. Greater pre-funding can have various important implications for risk sharing, diversity, solidarity, personal responsibility, credibility and efficiency, with these impacts varying depending on the pre-funding mechanism chosen.

The three main approaches to pre-funding are:

Increasing the role of funded pensions schemes (on a compulsory, quasi-compulsory or voluntary basis)
setting up a national reserve fund (more or less explicitly ear-marked to help smooth the demographic impacts on PAYG schemes)
paying down national debt (with a more or less explicit link to smoothing demographic impacts)

Hybrid schemes combining the best features of traditional designs

A key trend in reforms has been a much larger role in future pension systems for privately managed, fully funded schemes. Yet it would be a gross simplification to say that changes have primarily entailed a shift from public to private and PAYG to funded schemes. In fact, reforms have brought several genuine innovations into scheme design. Whether through big-bang paradigmatic changes or a sequence of parametric reforms, Member States have to a large extent developed *new hybrid designs*. Typically, they have sought to incorporate the better features that used to distinguish public from private and PAYG from funding schemes. Through transformative NDC designs (e.g. SE, IT, PL) or simply by significantly strengthening the links between contributions and benefits, a number of statutory, public PAYG systems (e.g. DE, ES, FR, PT) now emulate the individual accounts and actuarial connections hitherto only found with private, fully funded schemes. The aim is to provide similarly strong and transparent incentives to work and contribute, while avoiding the difficulties of funding schemes such as the double payment problem and investment risks. Likewise, typical weaknesses of private funded schemes in terms of social protection, such as low, fragmented and discretionary coverage, have been overcome in pioneering Member States through the semi-compulsory extension of occupational schemes (e.g. NL, SE, DK and recently UK), making private scheme coverage mandatory (e.g. BG, EE, LT, LV, HU, PL, SE, SK, RO), or subsidies for lower-income groups in voluntary private pension savings schemes (e.g. DE). New occupational schemes also tend to be designed so they present far fewer barriers to labour market mobility (e.g. DK, SE & UK) than traditional schemes.

The majority of Member States have expanded the role of pre-funding, by setting up national reserve funds to smooth ageing effects on PAYG schemes, expanding existing or introducing new occupational and voluntary schemes, or — most importantly — shifting part of former PAYG contributions to mandatory funded schemes under private management.

Over the last ten years, a number of Member States have set up new funded pension schemes of the latter kind. These are defined-contribution (DC) schemes and the vast majority form part of the compulsory social security system (BG, EE, LT, LV, HU, PL, SE, SK, RO). In some countries, however, reforms currently under way (e.g. DK and most recently the UK)

involve a national quasi-compulsory occupational pension scheme set up with employer involvement. It is important to note that occupational pensions are not compulsory in many Member States, which raises concerns of coverage when looking at the overall pensions of individuals. Another different approach seen in various Member States involves encouraging voluntary individual DC pensions. In CZ and DE, on the back of generous targeted incentives, a significant increase in the importance of such voluntary schemes is expected.

Figure 7.3 Gross replacement rates of occupational and statutory funded pensions in 2006 and 2046 in selected Member States
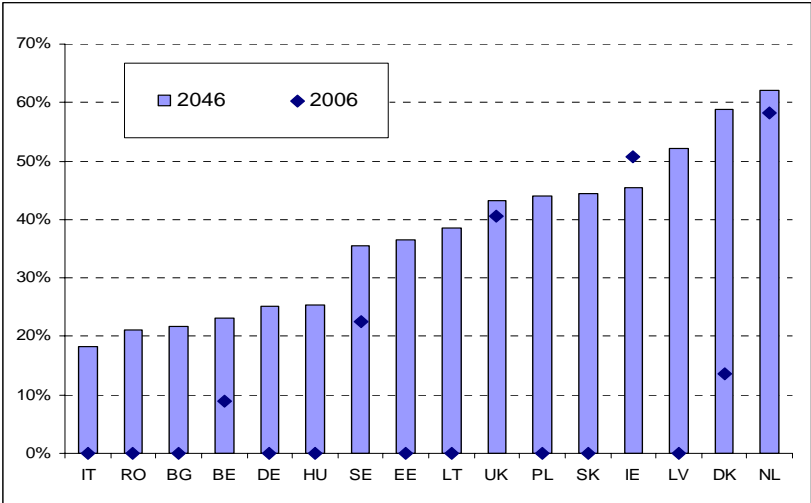
Source: ISG 2009 report on Theoretical Replacement Rates
Note: Data available only for a number of Member States

Figure 7.4 Ratio of expenditure on mandatory occupational and mandatory private pensions to expenditure on social security pensions[90]
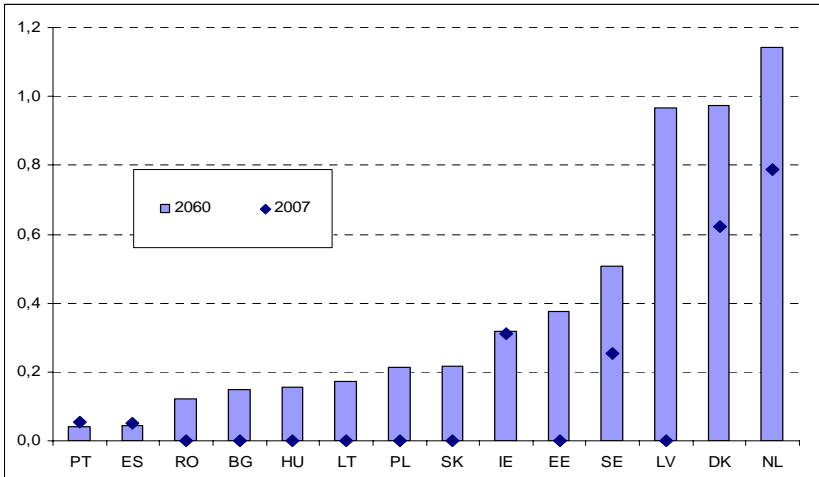
Source: own calculations on the basis of Ageing Report 2009, data not available for all MS, voluntary private pensions are not included

---

[90]   Values for Figure 7.4 are calculated by comparing numbers from tables extracted from the EU 2009 Ageing Report: A 57 (expenditure on <u>occupational</u> pensions as percentage of GDP) and A 58 (expenditure on <u>private</u> mandatory pensions as percentage of GDP) with numbers in table A53 (gross social security pension expenditure as percentage of GDP).

Similarly, a number of Member States have set up reserve funds more or less explicitly intended to help smooth the impact of the demographic challenge on PAYG pension schemes. These vary considerably in size, explicit purpose and controls, and their true test will come over the long term. In some countries, the reserve funds have not yet accumulated substantial assets (less than 10% of GDP, e.g. BE, EE, ES, FR, IE, NL), while in others they have become quite sizeable (e.g. LU, SE, FI), ranging from just over 20% of GDP in LU to almost 30% of GDP in SE in 2007. In other Member States the funds may not be purely pension funds but social protection or demographic funds (e.g. UK, LT, CY, PL, PT).

A final option for moving some of the costs of the demographic change forward is for countries to pay down national debt (e.g. BE, DK). However, few of the countries using this route have been able to make explicit links between particular actions to reduce national debt and the financing of future pensions.

Contrary to this increasing role for funded pension schemes, funded occupational defined-benefit (DB) schemes, which have traditionally been important in NL, UK, IE, SE and DK are in many cases in decline (notably in UK and IE). Facing the same demographic pressures as statutory PAYG schemes, DB schemes are undergoing major changes. In particular, they are increasing pensionable ages and in many cases shifting to funded defined-contribution (DC) schemes, where the investment and longevity risk lies to a greater extent with members rather than the scheme. Nonetheless the overall story of how pension systems are changing as a result of reforms is one of increased pre-funding compared to today.

7.1.4.   Changes in the relative level of public pensions

Strengthening of the link between contributions and the accrual of benefit rights means that the same contributions as in the past will give people less annual pension. But given increasing longevity, this annual reduction does not necessarily imply a lower overall transfer paid out over the retirement period. Moreover, the drop in the value of annual pension will be reduced as more people will be getting pensions in the future (e.g. more women).

Given the projected reduction in working age population, the same level of contributions cannot continue to fund these increased pensions, and to avoid constant increases Member States have sought other ways to rebalance their systems. Reducing the replacement rates at a given age of retirement is one way to return to a more sustainable balance between contributions and total pension paid over (longer average) retirements. Another way is to continue to pay the same annual pension but to increase the age at which it is first payable in line with longevity increases. Most countries combine these approaches.

In funded defined-contribution (DC) schemes actuarial adjustments occur automatically. The pension fund accumulated will have to cover more or less years of retirement depending on when a person retires and how long they can expect to live on average, so the amount they will receive annually will vary accordingly. This is made most overt (and individual longevity and investment risks are most reduced) when the payout phase is via annuities. The adjustments inherent in individual DC schemes are no doubt one reason why they have been a popular policy response.

For pay-as-you-go (PAYG) pensions, other options have been considered. One approach is to move from having one fixed pensionable age with a fixed annual pension, to give people choices based on actuarial fairness. Here, people who choose to delay taking their pension will receive a higher annual amount when they do in fact take it up. Equally, people who opt

to take their pension earlier will receive a lower pension, reflecting the fact it will on average be paid for more years.

Another approach is to build global (as opposed to individual-choice) adjustment mechanisms into public pension schemes. These are designed to stabilise pension systems through automatic adjustments (e.g. SE, FI, PL, DE) or periodically required reviews and adjustments (e.g. AT, IT, FR). They intend to reflect changes in one or more factors such as longevity (e.g. in SE, FI, IT, PT), the support ratio (e.g. in DE), reserve fund performance (e.g. SE) or general economic performance (e.g. in FI, SE). The effects vary from increases in contribution rates (e.g. DE), lower (or even negative) indexation of benefits (e.g. FI, SE) and lower accrual rates (e.g. PT), to increases in pensionable ages (e.g. in DK).

Such mechanisms at least ensure that the adjustments needed are put on the agenda. But it is always easier to set up such mechanisms than to allow them to fully operate when they are triggered.

The overall decline in the relative level of pension benefits at a given retirement age emerging from reforms has given rise to questions whether key improvements in the overall financial sustainability of systems have been obtained at the cost of adequacy. While this calls for further investigation, as adequacy is a multi-level, contextual concept, it would be safe to say that greater sustainability has been secured by introducing a greater element of conditionality into future pension provision. Obtaining replacement rates similar to those of the recent past will require people to work substantially more and longer and in many cases people will also have to increase their contributions to voluntary pension savings schemes.

Box X. The adequacy of pension systems

The **adequacy** of pension systems and the way it can be measured can be viewed in terms of the two main objectives of pensions, as posited by economic thinking:

1) Pension systems aim to provide all individuals income security in old age. As some people may be poor over a lifetime and unable to save enough during working life to ensure income security in old age, one of the stated key objectives of public pension systems is precisely to *relieve poverty*. There should therefore be programmes that reduce the risk of poverty in old age, by providing minimum adequate levels of pension income.

For the OMC, elderly poverty is basically measured relative to that of the working age population. The main indicators used are at-the-risk-of-poverty rate and the relative income of the elderly. These together give us a picture of the efficiency of minimum income pensions in providing adequate income security for the elderly.

2) Pensions are also a mechanism for *consumption smoothing*. During their retired lives people have to consume real goods and services, just as during their working years. Thus 'adequate' pension income allows for smoothing the consumption path over time, through the productive middle years and then the retired years. This also implies that 'adequacy' has to take into account the need to retain the value of income over time (i.e. indexation) so as to keep constant the *real* value of a person's pension.

In order to account for the second dimension in the definition of adequacy, the OMC indicators look at measures of replacement income, i.e. the extent to which pension systems enable workers to preserve their previous living standards when moving from employment to retirement and the relative income of the elderly. The main indicator is the aggregate replacement ratio. However, this only looks at pensions currently in payment. But given the long-term implications of pension reforms, theoretical replacement rates are useful as an additional analysis tool. This gives us the possibility to look at the adequacy of the replacement income provided by pension systems for theoretical cases. It also allows us to stress-test this adequacy by assuming macroeconomic shocks such as the change in rate of returns for funded pensions or by assuming career-breaks for individuals, for example in the case of unemployment.

These indicators may not be exhaustive in the analysis of pension adequacy, and future work can seek to identify new measurements as developments in data sources and modelling tools improve. This can also provide possibilities to look at the adequacy and sustainability of pensions more cohesively.

7.1.5. *More interdependent schemes make for more complicated pension systems*

Implicit in the greater role for pre-funded components is the move **towards multi-tier** systems, whether by expanding existing rudimentary tiers or by introducing new statutory, occupational or voluntary tiers. This has made systems more complicated and greatly raised the need for transparency, information and even financial education. Where individuals before could rely on single systems to provide for them they will in the future be required to make a lot of decisions and adapt their working lives to obtain sufficient pension rights for an adequate pension package.

Despite these caveats, the many innovative features in pension systems as a result of reforms have put the **majority of Member States on a sound course** towards achieving a better balance between financial, labour market and social protection concerns in their pension systems.

7.2. First effects of the crisis

The European economy is subject to fluctuations in the economic cycle. It stagnated in 2002-2003, to rebound again in 2004. Growth came to a halt in 2008 as the world entered one of the direst financial and economic crises in years. <u>EU-27 GDP is projected to fall by 4.1% in 2009</u>, even if the economy started to grow again in the third quarter of the year.

Current pensioners have so far been among those least affected by the crisis. With steady incomes and low inflation they have been fairly well cushioned. Thanks to improvements in recent growth years even pensioners with minimum pensions have fared somewhat better than before. People retiring now or in the near future are also unlikely to be much affected. With a few Member States as stark exceptions, this is the situation for pensioners across the Union.

The main reason for this is that current pensioners overwhelmingly draw their pensions from public (pre-reform) PAYG systems and established most of their pension rights before reforms began to take effect. Notwithstanding the trend towards a larger role for funded schemes, benefits from such schemes still generally play only a marginal role in pensioner income. In the few countries where this type of income is already important, benefits furthermore tend to be of the defined-benefit type where the investment risk is borne by the scheme. Thus, current pensioner income is not so sensitive to the short-term ups and downs of financial markets. Moreover, even though reductions in contribution revenues immediately weaken public pension scheme finances in most countries, it would still take a longer weakening of overall public finances before pensioners could conceivably be affected through lower indexing of benefits. Current pensioners are therefore also not particularly affected by the impact of the crisis on the labour market.

7.2.1. *Occupational pensions schemes in deficit*

Defined-benefit (DB) occupational pension schemes take on the investment risk, so in the shorter term people in general will get the pension they expect. Going forward some impacts will be felt as funded DB pension schemes that are in deficit as a result of falls in investments

seek to restore their funding balance. The crisis has caused most DB funds to move into deficit, due not only to falls in the value of investments but also to changes in the market interest rates used to translate future liabilities into today's money terms.

Member State reactions to the problems with funded schemes have in the short term been pragmatic. National pension supervisory authorities have aimed to allow pension funds more flexibility than normal. For instance, **Irish** pension funds were given more time to submit funding status reports and recovery plans in the hope that markets would become more stable, making the planning process easier and more robust. The normal maximum period allowed for recovery from deficits has been extended (e.g. IE, NL) and greater use has been made of existing flexibility, as in the UK's scheme-specific funding regime. This allows the impacts to be spread over a longer period, thus smoothing the impact of the crisis and hopefully allowing any recovery in markets to assist in a return to full funding. In **Denmark**, a financial stability package for pensions has been implemented to ensure market stability and prevent the forced sale of mortgage bonds owned by pension funds and substantial losses for pension savers. Regulators and the insurance and pension industry have agreed to temporary changes in the standards by which the solvency of funds is calculated to avoid funds locking in their losses by being forced to sell assets in the currently depressed markets. The double aim is to avoid destabilisation of the mortgage bond market and substantial losses for pension savers.

Dialogue between social partners is often a key element behind the recovery plans, as they involve attempts to share the impacts not only over time but also between different interests. A greater sharing of risks between scheme members and employers may be needed if the decline in DB provision is to be halted and such schemes are to have a viable future. In **the Netherlands,** the existing risk-sharing mechanisms have been used to lower or freeze indexation of benefits and/or increases in contribution levels. This shares the impacts between employers and pension scheme members, whether still working or retired. These mechanisms and the increase in permitted recovery periods aim to avoid the need for any last-resort adjustment of actual benefits. In contrast, **the UK**, with its legal obligation on employers to support their pension schemes, has seen increasing demands on employers to make extra contributions to schemes. In some cases, ad hoc negotiations between employers and employees have led to some burden sharing with scheme members (e.g. higher employee contributions, lower benefits).

7.2.2. *Market exposure of future pensioners in the DC schemes*

Defined-contribution (DC) pension schemes leave the investment risk entirely with the scheme member, so the impact of falls in investments is felt directly. On the other hand, DC plan members can benefit from any investment out-performance, unlike DB members.

DC-funded pensions can be statutory, occupational and voluntary, and all three are expected to see some growth in at least some Member States. Currently, statutory DC-funded schemes are found in the majority of new Member States (BG, EE, HU, LT, LV, PL, RO, SK — see table below) together with SE and IT. A number of Member States have DC occupational pension schemes, notably UK, IE, SE and DK, although others including NL, BE and CY also

have some provision of this type. Voluntary DC provision is really only of importance in IE, UK, CZ and particularly DE, on the back of the strongly incentivised Riester pensions.[91]

Statutory DC schemes will grow as transitional arrangements switch some elements of provision from PAYG to funded statutory DC schemes. For occupational DC schemes, growth will stem largely from a switch from DB to DC provision. Individual voluntary DC provision is normally encouraged by tax incentives and typically used to top up other pension income. Only modest, if any, growth is expected in this type of provision.

Fortunately, the crisis came at a time when DC provision was less important than it will be in future. People with DC provision who are some way from retirement may have time for investment falls to recover at least partially. For those close to retirement the impact can be real, leading to less affluent, or possibly delayed, retirement.

For those countries that have opted for an important role for funded DC provision of whatever type, the questions seem to be:

– how to control the risk for the individual;

– how to give people a realistic idea about what can be obtained;

– how to consider for which income and career profiles these schemes are an appropriate solution; and

– how to ensure the payout phase matches the original purpose of pension savings as efficiently as possible.

In relation to the capacity to bear risk, the question is also whether mandatory schemes in particular should make provision to protect against too much volatility. This could be done by guaranteeing the principal and some minimal rate of return, but it could be very costly and possibly create incentives for excessive risk-taking if the guarantee carries no price to the scheme operators. Another more likely solution consists in gradually lowering the investment risk as people get closer to retirement age (so-called 'life-styling' or 'life-cycling' investment strategies). Not all mandatory schemes contain such options at the moment. Attempts to reduce the reliance of pension funds on more volatile assets by setting limits on the value of shares in portfolios can be also observed, but the timing of such reforms (low value of more risky assets when the crisis hit) is questionable.

The choice between investment strategies with different potential rates of return and levels of risk leads to questions as to the accuracy of information. In statutory schemes where there was a choice between continuing in PAYG schemes or moving part of the contributions to the new funded scheme, people often opted for a defined-contribution scheme even if it was questionable whether this was indeed the best solution for them. And regarding the choice of pension funds and investment strategies, evidence suggests that many people went for riskier options than would have been justified given their earning capacity and the length of their working life. These choices were driven by the information people received at the time. Rates of return observed in the past and the positive growth expectations for central and eastern

---

[91] It is important to remind that Riester pensions are not pure DC schemes because they do not leave the investment risk entirely with scheme members. Financial institutions are obliged to offer to their customers a guarantee of maintenance of nominal value of capital.

European countries obviously played a role. But so did the fact that nobody told people that a sudden decline in asset values could occur. Hence, access to unbiased information is of key importance and not only in defined-contribution schemes. Additional information provided by non-partisan organisations such as consumer NGOs could help people make the right choices. Introducing limited-risk default options designed to be a reasonable choice for most people would likewise help.

The 2009 Joint Report on Social Inclusion and Social Protection stressed that Member States should give careful consideration to <u>the proportion of overall pension income expected to come from defined-contribution schemes</u> and whether such schemes would be sufficiently appropriate for all groups in the population. This is often not the case for less well-off people and for those with shorter or atypical employment careers. People in this situation would typically be better served by pay-as-you-go schemes, as they would not be able to accumulate sufficient benefits or absorb the inherent risks.

<u>The payout phase in DC pension design</u> often appears to be an afterthought when it should be central to the scheme, especially where it will form an important element of overall pension provision. A poorly designed payout phase means money supposedly saved to provide retirement income leaks out of the pension system to be used for other purposes such as bequests. This is a problem unique to DC pensions. PAYG and DB schemes and their inherent cross-subsidies between those who live for longer or shorter periods in retirement ensure that all resources are used to provide pensions. DC schemes with their increased sense of personal ownership also bring with them the risk of money being used for non-pension purposes. Allowing this with badly designed payout phases means poorer retirements or greater costs to compensate for the leakage. The closest match to the payout outcomes from PAYG and DB pensions is provided by annuity-based DC schemes. Ensuring the payout phase is well thought out and clearly explained before people join schemes reduces the likelihood of difficulties later.

An important advantage of DC schemes over DB plans is that they have a less distortionary impact on the labour market. Mobile workers who change their jobs can be often better off in terms of their pension outcome with one DC fund rather than with multiple small DB entitlements. DC schemes do not discourage job mobility to extent that DB schemes can do.

7.2.3. The problem of double payment in mandatory DC schemes

BG, EE, LT, LV, HU, PL, SE, SK, and RO have introduced mandatory or quasi-mandatory funded pension provision during the last 11 years. <u>The situation in these countries is, however, diverse.</u> We can observe differences according to the time of implementation of reform (from 1998 in HU to 2008 in RO), relative maturity of DC schemes (first partial cohorts retired in 2009 in PL, but will retire only in 2023 in RO), the importance of pension contributions feeding into DC schemes (contributions ranging from 5% of gross wages in BG to 9% in SK), existence of phasing-in arrangements (e.g. gradual increase in contribution levels in LV and RO, and transitional arrangements in LT, PL, or SK), and the character of the scheme (mandatory for cohorts under a certain age in BG, LV, or PL, and mandatory for those who decided to opt in on voluntary basis, e.g. in LT). More detailed information on DC schemes in central and eastern Europe can be found in the table below.

Table 7.1 Pension systems in selected Member States[92]

Country	% Wage to funded scheme	Proportion of total contribution to funded scheme	Year funded scheme started	Participation in funded scheme	Year funded participants retire
Bulgaria	5%	**21.7%**	2002	Mandatory <42	Full cohorts in **2023**
Estonia	6%	**20.0%**	2002	Voluntary	Partial cohorts by **2012**
Hungary	8%	**23.9%**	1998	Mandatory for new entrants; voluntary for all others	Partial cohorts by **2013**; full cohorts by **2045**
Latvia	2% increasing to 6%	**6% increasing to 24.0%**	2001	Mandatory <30, voluntary 30-49	Partial cohorts by **2013**; full cohorts by **2033**
Lithuania	5.5%	**22.0%**	2004	Voluntary	Partial cohorts by **2014**
Poland	7.3%	**26.1%**	1999	Mandatory <30; voluntary 30-50	Partial cohorts of women by **2009** and men by **2014**; full cohorts of women by **2029** and men by **2034**
Romania	2%, increasing to 6%	**6.7%**	2008	Mandatory <35; voluntary 36-45	Partial cohorts of women by **2023** and men by **2028**; full cohorts of women by **2033** and men by **2038**
Slovak Republic	9%	**31.3%**	2005	Voluntary for all	Partial cohorts by **2020**

Source: Regional Bank Staff

A common feature for Member States that have introduced statutory DC schemes is the need to shoulder net transition costs. 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). Other strategies have included increasing total contribution rates to pension schemes, using revenues from privatising state enterprises, or shifting part of the cost to current pensioners, e.g. through the introduction of less favourable indexation rules, or to future beneficiaries of the PAYG schemes[93].

The reforms usually made participation in the funded scheme mandatory for younger generations, while people nearing retirement were excluded, and intermediate cohorts had the choice to join or not. In some Member States (e.g. LT, HU, PL, SK), however, the net transition costs turned out to be higher than anticipated, as the numbers of workers who moved to the mixed PAYG-funded system considerably exceeded official estimates.

Bringing forward costs by increasing pre-funding has placed strains on Members States' fiscal positions, and the current economic situation provides a serious stress test of the viability of

---

[92] Relevant EU countries extracted from World Bank Human Development Network paper "The Financial Crisis and Mandatory Pension Systems in Developing Countries Short- and medium-term responses for retirement income systems" http://siteresources.worldbank.org/INTPENSIONS/Resources/395443-1121194657824/PRPNote-Financial_Crisis_12-10-2008.pdf

[93] According to the 2008 SPC study "Privately Managed Funded Pension Provision and their Contribution to Adequate and Sustainable Pensions", pp.18-19.

such arrangements. Facing a growing fiscal gap, some <u>Member States have decided to limit the relative burden of pre-funding</u> future pension expenditure by reducing the proportion of social security contributions diverted to mandatory DC schemes (e.g. EE, LT, LV, SK, RO).

In **Estonia,** all compulsory contributions to the DC scheme have been cancelled from 1 June 2009 until 31 December 2010. Scheme members can restart their contributions on a voluntary basis in 2010. The government's intention is that contributions will be partially resumed in 2011 (with a 2% state and 1% member share) and will reach their original level only in 2012 (4% plus 2%). In **Lithuania**, social insurance contributions to the DC pension schemes have been reduced temporarily from 5.5% to 2% by 2012. They will be increased again to 6% after 2012 for a minimum of 3 years. In **Latvia,** part of contributions to the mandatory funded DC scheme has been diverted to feed the PAYG NDC scheme. Contribution rates to the funded pillar are being reduced: in 2009 from 8% to 2%; in 2010 from 9% to 2%; in 2011 from 10% to 4%; in 2012 and subsequent years from 10% to 6%. In **Romania,** the government has suspended legal provisions that would have seen contributions to the mandatory DC scheme rise from 2% to 2.5% of employees' gross salary this year. **Slovakia** has allowed workers to opt out of the funded scheme and return to the PAYG scheme for the second time in 2008, and the DC scheme will be optional for all new entrants to the labour market. In **Poland,** the government is discussing a reduction in contributions to the DC scheme from 7.3% to 3% of gross wages and to divert the difference to the PAYG scheme. Another solution under consideration of the government is to revise the way in which public debt is calculated by excluding the debt resulting from transfers to the funded pension scheme.

Shifting part of contributions from funded schemes to PAYG schemes helps to reduce the aggregate savings rate, so can be treated as an <u>anti-cyclical measure</u>. However, there are also arguments against decreasing the pre-funding burden. The <u>inflow of contributions to funded schemes is reduced when prices of assets are low</u> and offer greater growth prospects. This might imply a decline in the expected rates of return. While it is understandable that public authorities see the need to adjust their mandatory private funded schemes, one should not forget that <u>pension systems need stability over the long term</u> if they are to have the necessary credibility among citizens. Hence, transparency and long-term planning are important.

7.2.4.   *Distribution of the burden of the crisis in PAYG systems between different generations*

PAYG schemes also have not been immune to the crisis. <u>The effect of the crisis on different cohorts of pensioners varies</u> depending on how much future pension systems will differ from the current arrangements. In most Member States, most retired cohorts today obtain their pensions under pre-reform rules providing for guaranteed pension levels. Younger cohorts in reformed schemes may be affected to some extent depending on the design of the scheme.

<u>Member States in the majority of cases are keeping their promises towards current pensioners</u>, even at the expense of soaring public debts that will add to the costs of ageing and increase future burdens on the current working age population. <u>LV and LT are exceptions</u> here as they are recording the deepest fall in GDP in the EU in 2009 (both economies are expected to contract by 18%)[94] and current pensioner cohorts have also had to bear the burden of economic adjustment.

---

[94]   European Economic Forecast of Autumn 2009.

Pension benefits for current pensioners in **Latvia** have seen an overall 10% reduction (70% for working pensioners) since the 1st of July 2009. According to the judgment of the Constitutional Court (21 December 2009), these deductions will be removed from 1st February 2010 and deductions for the time period 1st July 2009 to 1st February 2010 will be reimbursed to pensioners. The amount of early retirement benefit has also been decreased. Nevertheless, given the collapse in the labour market, the number of early retirement and disability pensions increased considerably in 2008 and especially in 2009. Moreover, there will be no indexation of pensions in 2009 and 2010, and from 2011 price indexation will be applied (the previous method also considered wages).

In **Lithuania**, social security schemes are facing huge pressures from decreasing income and increasing numbers of unemployed. Seeking to stabilize an increase of the deficit of the State and the State Social Insurance Fund budgets and to ensure timely payments of social security benefits, a reduction of social security benefits (social insurance pensions, state pensions and other social benefits) was introduced since 1st January (temporarily until 2012). They are reduced progressively according to income received (pensions and labour income). On average old age pensions are lowered by 5%. Pensions for working old age pensioners will be reduced proportionally to their insured income received, with a maximum reduction of 70%.

7.2.5. *Shrinking contribution base in PAYG schemes*

It is the economic crisis, rather than the financial crisis that precipitated it, that is affecting PAYG pensions. The sustainability of PAYG pensions ultimately depends on the strength of the underlying economy, so fewer people working and paying contributions, lower economic growth and higher levels of national debt all weigh down on PAYG schemes. At least over the short term the effects are very limited. Where they occur, impacts may take the form of lower indexation (e.g. EE, LV), higher contributions (e.g. CY, LV, RO) or delayed reforms.

The strength of PAYG pensions is that they are resilient to shocks in the short term, and these impacts can be smoothed and shared over long periods.

The majority of Member States have preferred to accept increased deficits in their social security schemes, so that automatic stabilisers can play their role. Anti-cyclical behaviour in social spending is an important part of supporting an economy in recession. This is one of the factors contributing to ballooning general government deficits and a dramatic increase in the level of gross general government debt in the EU, from 58.7% of GDP in 2007 to 83.7% of GDP in 2011.[95]

In order to limit the increase in public debt some countries have decided to deplete their reserve funds (e.g. IE, LV) whereas in others this is being considered (e.g. PL). While in LV the reserve fund partially covers the deficit of the social security system, the reserve fund in IE was used as a means to help solve the effects of the crisis in the banking sector. While this can be considered an effective use of resources in times of constraint, it is important to consider the long-term demographic pressures on the pension system. The use of funds earmarked for pensions can also lead to a loss of social confidence and acceptance for the pension system.

---

[95]   European Economic Forecast, Autumn 2009, European Commission, p. 208.

7.2.6.   The effects of the crisis on automatic mechanisms in PAYG systems

While automatic mechanisms enhance the transparency of a pension system, they do so only if they are allowed to be activated. Automatic adjustment and indexing rules boost the transparency and credibility of a system only if the triggers are allowed to function.

Most automatic mechanisms have not yet been applied in practice, and experience from 2006-2008 shows that it is critical to monitor the functioning of these mechanisms, some of which are close to activation given the financial and economic pressures on pension systems as a result of the crisis. Prior to the crisis a few countries had already taken political decisions to postpone automatic adjustments. Changing the regulations before the adjustments are to be activated may damage their credibility.

In **Italy,** the automatic updating of life-expectancy projections for annuity calculations has been delayed. In **Germany,** pension benefits have been temporarily increased beyond what would have been allowed by the automatic adjustment mechanism, which aim to balance contributions and federal subsidies against pension expenditure during the year. A part of the increase in pension benefits resulted from the so called 'sustainability factor' which takes into account the demographic imbalances between the working population and the retired. Positive change in the relation between the working population and the retired triggers an increase in pension benefits.

The activation of the automatic adjustment mechanism in DE would require contribution rates to be raised. Whiles there is a cap of 20% on contribution rates, this can be balanced with a decrease in pension indexation. In 2002 to 2005, contribution rates would have had to be increased to over 20% or pension indexation would have had to be suspended. However, this was alleviated by the introduction of the 'Riester factor' in the adjustment mechanism, which takes into account the increase in total contributions outside the statutory system.

In **Sweden**, the fall in financial markets has triggered the adjustment mechanism. The activation of the mechanism reduces the indexation of pensions and earned pension entitlements, and depends on the calculation of a surplus or deficit in the system. This calculation is regulated by law. The Swedish government has recently decided to re-evaluate the calculation performed for the balancing mechanism and the proposal that has been decided by the Swedish parliament is one that smoothens out the volatility of the buffer funds by incorporating a three year moving average of their values into the calculation of the balance rather than the current annual value of the funds. This will have the effect of sharing the burden of the financial downturn over more years. This strategy may increase the anti-cyclical nature of the mechanism.

Box X. The role of pension systems as automatic stabilisers

Social protection systems can respond in different ways to the downturn in the economic cycle. On the one hand, anti-cyclical behaviour in public spending, especially on social expenditure, is an important part of bringing an economy out of recession, since social protection expenditure constitutes a large part of total expenditure. The role of social protection expenditure as an automatic stabiliser is to attenuate the consequences of economic shocks on the level of activity (i.e. by maintaining consumer incomes and thereby promoting demand). In that sense, given that pension spending is the biggest item of social protection expenditure, it is evident that it can play a crucial role as an anti-cyclical automatic stabiliser to sustain and re-boost the economy. The strength of the automatic stabiliser depends on the marginal propensity to consume of the group to which the benefit goes. Pensioners, a priori, should tend to consume their income as they have less incentives to save. On the other hand, at a time of crisis, as GDP contracts, government budget balances are often strained, and cutbacks in pensions or indexation due to growing budget deficits are also observed.

Both types of pension policies have been observed in the current crisis. Some countries have held back the indexation of pensions (e.g. EE), postponed planned pension payments (e.g. HU) or cut pension benefits (e.g. LT) to cope with their fiscal consolidation concerns. Other countries have increased pension benefits, typically by increasing minimum pensions (e.g. ES, FR, FI, BG) or by increasing the indexation of pension payments beyond the normally applied rules (e.g. PT, FI).

The responsiveness of pension systems to the business cycle is determined by the current capacity of public budgets to protect people. In that sense, Member States are in very different positions to face the crisis. Countries with more balanced budgets can afford to apply a higher degree of counter-cyclicality at a time of crisis as compared with countries where the consolidation of fiscal budgets is the major concern. Countries with mature pension systems and balanced budgets will thus have more budgetary room for manoeuvre at the onset of a recession and will be in a better position to protect the most vulnerable and those most affected by a downturn. In contrast, countries faced with major public finance imbalances are left with little room for manoeuvre to address the social consequences of the crisis.

7.2.7. *Conclusion*

Funded pension schemes have been more immediately and directly impacted by the financial crisis. Falls in the value of investments feed through into deficits in definend-benefit pension schemes and into lower individual pension fund accounts. How these then impact on actual pension incomes for individuals depends on how quickly and to what extent investments recover and what mechanisms are in place to mitigate and share investment risk.

Pay-As-You-Go (PAYG) pensions are also impacted. Ultimately, the economy determines what is affordable for PAYG pensions. Lower growth, fewer people in work to pay for those already retired and increases in national debt all weigh down on PAYG pension systems. The impact on individual pension income depends on how quickly countries return to growth and higher employment rates, what adjustment mechanisms are in place and what further reform measures are necessary to ensure PAYG schemes are sustainable in the long term.

The demographic challenge remains key, and the crisis has added to this challenge. Indeed, the financial crisis may have put into sharper focus underlying structural issues regarding the sustainability of pension systems. These issues may previously have been masked by expectations of returns on funded pension schemes or anticipated levels of economic growth and employment rates which may now seem over-optimistic.

The financial crisis and the economic downturn have outlined the need for ensuring the resilience of reformed systems in terms of ensuring sustainable financing and providing adequate pensions, both in the short and long term. Financial losses in pre-funded schemes can affect the solvency of these schemes and thus their ability to pay out pensions. The inherent risk of lower returns for future pensions in defined-contribution schemes has also been brought into sharper focus. In PAYG schemes, where the contribution base provided by the working population is key, the damage caused by long-term unemployment to the sustainability of these systems has been highlighted. At the same time, as eligibility rules are tightened in reforms, the effect of long career breaks on future pensions also becomes significant.

Though none of the present and future pension systems in the Member States have been designed to withstand a financial crisis and an economic downturn of this magnitude, they seem to have performed relatively well. However, pension reforms and resulting pension promises have been predicated on scenarios of steady economic growth and continued increases in employment.

Adjustments to all kinds of pension schemes may therefore be necessary to ensure their long-term health. But one of the few positives that can be taken from the crisis is that it may give the necessary impetus for further reforms, in particular to encourage and enable more people to work more and longer.

7.3. Long-term implications of the crisis

There is a marked uncertainty regarding economic growth over the medium and long term. The recession could have implications for the growth potential of the EU economy. On the demand side, deteriorating labour market conditions could constrain consumption in the medium term. The supply side of the economy could be also affected.[96]

Trend growth in the next few years could be lower than projected in the pre-crisis scenarios. This would have implications for the future adequacy and sustainability of pensions.

7.3.1. Will long-term sustainability of pensions be affected?

The long-term nature of pensions gives them a certain resilience to economic shocks, as there is usually time for the systems to recover. Long transitional periods in pension reforms also tend to protect the pensions of those in or close to retirement today. However, the length of the shock and the financial situation of the system when the shock hits crucially affect how the system can handle the payment burden in the short and long term. Pension reforms have been based on certain assumptions of growth and returns on paid contributions. If pension systems are unable to handle the effects of lower than expected returns or a narrower contribution base due to unemployment, this could ultimately affect the adequacy of benefits. However, a system that cannot pay out adequate pensions is not sustainable in the long run, as its social or even political credibility will decrease.

Member States have let pension systems play the role of automatic stabilisers in the current crisis. However, anti-cyclicality should be maintained when recovery sets in, so that social protection systems are sustainable in the long run. This often implies politically difficult decisions. Meanwhile, automatic adjustment mechanisms in pension schemes may tend to be activated in a pro-cyclical rather than anti-cyclical manner, which needs to be monitored or adjusted.

In the event of protracted low growth Member States will be faced with the difficult task of adjusting social security expenditure to levels that reflect the trend growth rate of the economy and are affordable in the long run. According to an initial assessment by the Ageing Working Group, if trend growth is permanently affected, expenditure on public pensions in the EU in 2060 is projected to increase to 13.6% of GDP instead of 12.5%.[97]

7.3.2. Long-term adequacy of pensions in light of the crisis

Over the coming decades the sensitivity of pensioner incomes to the economic situation will change significantly as a consequence of the reforms presented at the beginning of this chapter. The share of funded pensions in the income packages of future pensioners is set to increase markedly. At the same time, the bulk of funded schemes will be of the defined-contribution type where investment risks are moved to pension savers. In addition, the

---

[96]   For further discussion see *Sustainability Report 2009*, p. 48.
[97]   Ageing Report 2009, pp. 185-187.

reduced pensions from public PAYG schemes will increasingly be calculated on life-time earnings-related contributions. On present trends, only those with very long careers and largely unbroken contributory records will obtain rights to a full (maximum) pension. Adequacy will therefore not just depend on the ability of workers to respond positively to the new work incentives in pension systems. It will also be contingent on the ability of labour markets to deliver sufficient opportunities for prolonging average careers.

The effects of the crisis on pensions being paid from statutory PAYG systems are often indirect. The EU labour market is contracting and an unemployment rate of over 10% is projected for the EU in 2010 and 2011. The effect of high unemployment on pensions is two-fold. <u>Higher unemployment, along with slower productivity and wage growth, affects both the tax and contributory base of pension systems,</u> reducing the revenues that pension systems rely on. Furthermore, <u>long-term unemployment can negatively affect the accruals of pension entitlements</u>, having an adverse affect on individual pensions.

The figure 2.12 presents the impact of a career break due to unemployment lasting one, two or three years on future pension income, measured in theoretical replacement rates. In a number of Member States, pension income can be reduced by an equivalent of more than 5% of wages due to a three-year unemployment break.

It is thus vital to monitor the length of the period of unemployment and actively promote a return to the labour market. Past crises have often resulted in older workers, a relatively vulnerable group on the labour market in the best of times, being prematurely pushed out of the labour market. Given the demographic challenges that PAYG systems are yet to face, it is important that Member States reduce the risk of older workers being forced into early exit pathways from the labour market, including, early retirement, unemployment and disability schemes.

7.3.3. *Increases in pensionable ages*

Long-term risks for the sustainability and adequacy of pensions can be limited if more people work more and longer. Member States realise that, in addition to the need to ease future expenditure pressures due to population ageing, they will have to increase efforts to reduce the swollen public debts due to the current crisis. Discussions on increasing the pensionable age are under way in a number of Member States.

In **Latvia,** the government intends to increase the retirement age from 62 to 65 by 2021. In **Hungary**, the retirement age will be gradually raised from 62 to 65 by 2022. In the **Netherlands**, the government has proposed that the pensionable age should rise to 66 years in 2020 and to 67 years in 2025. There would be special provision for people who began their careers very young and those who worked in physically demanding jobs. In **Slovenia,** the government has disclosed a plan to increase the retirement age from the current 61 for women and 63 for men to 65 for both by 2020. Early pensions would be accessible from the age of 60 instead of 58. In **Romania,** the government is considering an increase in the retirement age from 58 to 60 for women and from 63 to 65 for men by 2014.

The crisis can be used as an opportunity to carry out necessary reforms and to give an impetus to politically difficult decisions. If increases in retirement age are to be successful, they need to be coupled with other measures that give older workers the opportunity to return to the labour market, e.g. offering flexible retirement options, monitoring whether wage differentials

between younger and older workers do not push out older workers from the labour market, changing the habits of employers, or outlawing discrimination on the grounds of age.

7.3.4. *Increases in pensionable age for DB schemes in agreement with social partners*

Just as with PAYG schemes, increased longevity is a major challenge to funded DB schemes and early retirement schemes, where comparatively young pension eligibility ages look increasingly unaffordable. Increases in pensionable age would require more or less formal agreements with social partners, usually at company or sector level.

7.3.5. *Risks linked to the exposure of future pensioners to market outcomes*

It is important to ensure that projected long-term rates of return on DC pension funds are reliable and take into account fluctuations in financial markets. The new statutory DC schemes have often been introduced in boom times and on the basis of upbeat economic assumptions.

DC plan members are not only exposed to falls in financial markets, but unlike DB scheme members, can benefit from any investment out-performance. Nevertheless, the possibility of obtaining high replacement rates has to be considered in the long term (so there is a question of how far financial markets can outperform the real economy) and discussed against risks of volatility.

The crisis has exposed the vulnerability of funded schemes to volatility in financial markets and highlighted the need for policymakers, regulators and supervisors to promote more prudent management of people's retirement savings. With losses ranging from 15% to 35%, and with an even greater variation in the capacity to absorb the shock, differences in pension fund designs and investment strategies clearly matter. From the variation in impacts across the Union important lessons can be drawn about how funded schemes can be improved and greater security for pension savers achieved. Accordingly a new agenda is emerging for necessary changes to funded designs and for speedy completion of the unfinished parts of the new mandatory schemes (e.g. concerning more secure default options, life-styling, charge capping, and rules for annuitisation and the pay-out phase). Achieving this will be an important part of rebuilding public confidence in funded, privately managed pensions.

7.4. Policy implications

The longer-term challenge of ageing is no longer such a distant scenario. Over the next decade the working age population will begin to shrink. Indeed, the setbacks from the crisis and the likelihood of lower growth have thrown this into sharper focus. The balance between adequacy and sustainability — the object of a decade of pension reforms — is under pressure from the financial and economic crisis. Increases achieved in employment rates for older workers must now be defended against rising unemployment. Recovery packages have secured the ground for a thriving economy to supply the income that can pay for pensions. But they have also reduced the hard-won public finance improvements intended to provide room for extra expenditure to address ageing and this lost ground will have to be regained.

7.4.1. *Shorter-term implications for current schemes*

In general, current systems for those retiring now have coped quite well. A key issue to monitor is the resilience of DB pension schemes and the mechanisms designed to protect

scheme members when schemes are underfunded. Box x below raises a few specific key shorter-term policy questions that Member States may want to consider depending on the mix of pension schemes in their system.

Box X. Shorter-term policy questions for specific types of pensions

There are a number of short-term policy questions Member States may wish to consider, depending on the type(s) of pension schemes in their particular system:

Defined-contribution (DC) pensions

A key issue is providing good information so that individuals have a realistic understanding of the rates of return and the inherent risks of DC provision both in general and to avoid the risk of hasty actions locking in losses during downturns. More flexibility in the timing of the start of the payout phase may also need to be considered to avoid investment losses being locked in during the transition phase.

Defined-benefit (DB) pensions

Short-term flexibility may be necessary, such as on recovery plans, to smooth impacts. Adjustment mechanisms designed to share risk (e.g. potential changes to the indexation of benefits) may need to be allowed to operate fully for the long-term good. In the absence of formal risk-sharing arrangements, there may also be merit in encouraging ad hoc employer/employee negotiations to agree burden sharing, where necessary, to keep DB schemes open. In Member States with insurance-style fall-back arrangements close monitoring of such arrangements is important, to ensure they remain robust. Where there are neither adjustment mechanisms nor insurance style fall back arrangements, there is a need to urgently address DB pension security over the long term.

PAYG pensions

Reserve funds designed to cope with demographic pressures need to remain credible. Clear ring-fencing supported by public and political sentiment, as well as by rules, may help. Drawing on pension reserve funds in difficult times for other purposes reduces their credibility and needs to be carefully explained. Similarly, where public pension schemes have automatic adjustment mechanisms in place to support sustainability, any interference with the automatic outcome can reduce their credibility and social acceptance and needs careful explanation.

7.4.2.   *Medium/long-term implications of the crisis*

In the future an increasing share of pension income is expected to be provided by DC pension systems. This is due to two factors. One is the longstanding shift from DB to DC occupational pension provision as employers find the costs and risks of DB increasingly unpalatable. The other is the introduction of new DC pension schemes often partly replacing PAYG pensions, as in many new Member States. Box Y below raises a few specific longer term policy questions that Member States may want to consider, depending on the current mix of pension schemes in their overall system and how this is expected to change in the future. What is, however, a common challenge for all Member States and a long-term implication of the crisis is to increase overall employment rates and employment rates of older workers.

Box Y. Longer-term policy questions for specific types of pensions

There are a number of longer-term policy questions Member States may wish to consider, depending on the type(s) of pension schemes in their particular system:

DC pensions

Careful consideration should be given to the appropriate maximum proportion of overall pension income expected to come from DC pensions, particularly for the less well-off, who may be less able to absorb the inherent risks. And the greater the proportion of DC provision the more important it is that the mainstream investment choices for DC schemes should mitigate investment risk and volatility close to retirement (such as by taking lifestyling/lifecycling approaches or introducing minimum guarantee schemes). The payout phase needs to be properly worked out and explained from the outset to minimise leakage of pension savings for other purposes (e.g. bequests), otherwise the efficiency of DC pension savings can be seriously compromised. Charges need to be kept as low as economically viable and consideration has to be given to intervention to achieve this where market failure is apparent. Good information for individuals which clearly explains the risks and manages expectations is important both for individual decision-making on saving and retirement issues and for long-term public support for such schemes.

DB pensions

To have a long-term future as an important element of pension provision, some DB schemes may need to consider developing more formal risk sharing arrangements. For individuals, DB provision typically offers much less risk than DC pensions. But putting too much risk on employers instead encourages them to close schemes, so a sharing of risks may be more a viable long term approach that benefits all stakeholders. There may also be a need to examine whether there are underlying structural issues in some DB schemes, which may need addressing via specific changes, for instance to retirement ages. There may also be merit in considering the role of DB pension schemes in the macro economy and whether such schemes could be made more anti-cyclical, while recognising that the issues are complex.

PAYG pensions

The financial crisis adds to the challenges to the long-term sustainability of PAYG pension systems and its impact will need to be closely monitored. Where underlying structural issues are revealed, further action may be needed along the lines of a long-term strategy combining working longer, reducing public debt and pension reform. In particular, further measures to support employment in general and to provide opportunities for older workers pushed out of employment to return to the labour market may be called for. Public spending, of which pensions is a key part, has an important role in supporting economic recovery via its anti-cyclical role. Government budget balances are often strained, however, which highlights the issue of how to finance this expenditure. Although often politically difficult, it is therefore important to consider developing this anti-cyclical behaviour in social spending even as the economy enters a boom.

Current pension systems for those retiring today have so far stood up reasonably well to the major stress test of the financial crisis. However, there are still some lessons emerging for current systems, perhaps especially so for the design of pension systems in future. The crisis has demonstrated the interdependence of the various pension pillars within each Member State and underlined that pension funds are an important part of the financial system. It has also highlighted the importance of common EU approaches to solvency and social adequacy. Pension systems were of course already under pressure from the demographic ageing in Europe. The crisis has added to this pressure, and brought into sharper focus underlying structural issues that pension systems are facing. With different expectations for economic growth and investment performance, these issues are now surfacing and the crisis may offer the impetus and political opportunity to see through difficult reforms.

8.   GOVERNANCE

The crisis has emphasised the value of policy coordination under the Social OMC and provides a further incentive to exploit fully its potential. Since the autumn of 2008, the Social Protection Committee has engaged in a **joint exercise on monitoring the social impact of the crisis**. Member States have provided fresh information on emerging social problems and on new policy measures. This information has been collected, analysed, and presented to the Council. The exercise has also entailed **in-depth examination of specific social policy challenges in the context of the crisis,** such as minimum income schemes and funded pensions. Overall, the exercise has provided new opportunities for **mutual learning** and **exchange of best practice**. It has increased the awareness and understanding of common challenges.

The need to react swiftly to the crisis has led many Member States to reinforce their capacity to detect social problems and to intensify cooperation among social and institutional actors. Most Member States have endeavoured to **enlarge their knowledge base** on the social impact of the crisis, using administrative data or specific monitoring tools, including new surveys. Steps have been taken to improve the timeliness of social statistics drawn from EU SILC or the LFS.

As mentioned before, some Member States have commissioned ex ante impact evaluations of recovery packages (i.e. assessment of the likely impact of proposed measures before they are decided). Given that pressure aimed at limiting public expenditures is to be expected in most of the Member States in the coming years, the development of an **adequate ex ante social impact assessment capacity in the context of integrated impact assessment arrangements** should be encouraged. Strengthening such 'social' component can contribute to more effective and efficient social policy measures. Applied to non social policy measures, it can contribute to avoiding unintended negative social impacts and to better exploiting possibilities for positive synergies (mainstreaming). In this respect, the Social OMC can be used as a forum for exchanging know how between the Member States and between the Member States and the European Commission. The latter has recently taken initiatives to strengthen its own capacity to assess social impacts.

Countries that can rely on well-established **governance arrangements and practices** have benefited from the engagement and mobilisation of stakeholders. Local authorities, social partners, and NGOs are on the front line of the crisis. Social partners have often played a key role in designing and implementing short-term labour market measures to maintain people in jobs. Local authorities and NGOs across Europe have had to meet increased demand for social benefits and services while often seeing their own revenues squeezed. Cooperation and coordination among all these actors has been an invaluable asset.

In preparation for the EU strategy post-2010, the Social Protection Committee has established a Task Force to review the experience of the last decade. The **Task Force Report** — *Growth Jobs and Social Progress* — shows that the benefits of growth have not always been evenly distributed, and that poverty and social exclusion remain a major issue in most EU countries, although with substantial differences across Europe.

Drawing on the lessons of the crisis and of ten years of the Lisbon strategy, there will be a need to foster sustainable growth along with job creation and social cohesion and systematically assess progress of social outcomes, including gender equality. To this end, reinforcing the Social OMC and increasing its effectiveness and visibility is essential.

An integrated vision for an exit strategy from the crisis and a return to long-term growth in an inclusive social market economy entails continued modernisation of social protection to deliver the dual objectives of adequacy and sustainability. This will be crucial for improving the functioning and social outcomes of labour markets, thus ensuring the optimal use of our human resources through opportunities and access for all. Employment and social policies must continue to be central to the growth and employment agenda in the next decade.

The start of the post-2010 strategy coincides with the **European Year for combating poverty and social exclusion**. Raising awareness, reinforcing partnerships between actors and reaching out to new actors will help to generate new impetus. The European Year 2010 should lead the EU and Member States to strongly reaffirm the commitment made ten years ago to make a decisive impact on the eradication of poverty and social exclusion.

9. ANNEXES

9.1. Indicators

9.1.1. 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[98]. Source: EU-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: EU-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: EU-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: EU-SILC.

3. Healthy life expectancy Number of years that a person at birth, at 45, and at 65 is still expected to live in a healthy condition (also called disability- free life expectancy). To be interpreted jointly with life expectancy. Source: EUROSTAT.

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[99]. 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) (2007-2020; 2007-2060).

http://ec.europa.eu/economy_finance/publications/publication14994_en.pdf (Table A 134 – The cost of ageing overview)

---

[98] **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.

[99] Students aged 18-24 who live in households composed solely of students are not counted in either the numerator or denominator.

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.

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 subject to adjustment in the future.

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: EU-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[100] (distinguishing between 'wage and salary employment plus self-employment' and 'wage and salary employment' only) and who are at risk of poverty.

This indicator needs to be analysed according to personal, job and household characteristics. It should also be analysed in comparison with the poverty risk faced by the unemployed and the inactive. Source: EU-SILC.

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[101] 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.

---

[100] 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.

[101] 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).

9.1.2. Context information

The overarching indicators have to be assessed in the light of key context information and by referring to past, and where relevant, future trends. The list of context information is indicative and leaves room to other background information that would be most relevant to frame and understand better the national socio-economic context.

Context 1: Growth rate of GDP volume - percentage change over previous year**.** Source: Eurostat, Annual national accounts; forecast for 2009, 2010, 2011.

Context 1: GDP per capita in Purchasing Power Standards (PPS) - (EU-27 = 100) Source: Eurostat, Annual national accounts; forecast for 2009, 2010, 2011.

Context 2a: Employment rate (% of population aged 15-64) - Source: Eurostat - Labour Force Survey, Annual averages.

Context 2b: Unemployment rate (% of labour force aged 15+**)** - Source: Eurostat - LFS adjusted series, Annual average.

Context 2c: Youth unemployment rate (% of labour force aged 15-24) - Source: Eurostat - LFS adjusted series, Annual average.

Context 2d: Long-term unemployment rate by gender, selected years (% of the labour force 15+**)** - Source: Eurostat - Labour Force Survey, Annual averages.

Context 4: Old age dependency ratio (current and projected) - ratio between the total number of people aged 65 and over and the number of persons of working age (from 15 to 64). Source: Eurostat - EUROPOP2008 Trend scenario - baseline variant.

Context 5a: Distribution of households by age and household type (private/institutional). Source: Eurostat Census data collection 2000-01.

Context 5b: Population living in private households by household type, 2008 (percentage of total population). Source: EU-SILC.

Context 6a: General government debt - General government consolidated gross debt as a percentage of GDP. Source: Eurostat - General Government data (2000 to 2009) and ECFIN forecasts (2010-2011).

Context 6b: Projected evolution of debt levels up to 2050 (in % of GDP). 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). Source: Eurostat ESPROSS.

Context 7b: Social protection benefits by group of functions (as a percentage of GDP). Source: Eurostat ESPROSS.

Context 8a: Adults aged 18-59 living in jobless households by household types. Source: Eurostat - European Labour Force Survey 2008, Annual results.

Context 8b: Children aged 0-17 living in jobless households by household types. Source: Eurostat - European Labour Force Survey 2008, Annual results.

Context 9a - Unemployment traps, 9b - Inactivity Trap at 67% of Average Wage, 9c - Inactivity traps. Source: Joint Commission -OECD project using tax-benefit Models.

Context 10: Net income of social assistance recipients as % of the at-risk of poverty rate threshold for 3 jobless households types. This indicator refers to the income of people living in households that only rely on "last resort" social assistance benefits (including related housing benefits) and for which no other income stream is available (from other social protection benefits – e.g. unemployment or disability schemes – or from work). The aim of such an indicator is to evaluate if the safety nets provided to those households most excluded from the labour market are sufficient to lift people above the risk-of-poverty threshold. This indicator is calculated on the basis of the tax-benefit models developed jointly by the OECD and the European Commission. It is only calculated for Countries where non-categorical social benefits are in place and for 3 jobless household types: single, lone parent, 2 children and couple with 2 children. This indicator is especially relevant when analysing MWP indicators. Source: Joint EC-OECD project using OECD tax-benefit models, and Eurostat.

Context 11: At-risk-of-poverty rate before social transfers by gender and selected age groups. This indicator is meant to compare the observed risk of poverty with a hypothetical measure of a risk of poverty in absence of all social transfers (other than pensions) all things being kept equal. In particular, household and labour market structure are kept unchanged. This measure does not take into account other types of transfers that have an impact on household disposable income such as transfers in kind and tax rebates.Source: EU-SILC.

Context 12: Change in Theoretical replacement Rates for a worker retiring at 65 after 40 years. Change in the theoretical level of income from pensions at the moment of take-up related to the income from work in the last year before retirement for a hypothetical worker (base case), percentage points, 2004-2050, with information on the type of pension scheme (DB, DC or NDC) and changes in the public pension expenditure as a share of GDP, 2004-2050. This information can only collectively form the indicator called Projected theoretical replacement ratio. Results relate to current and projected, gross (public and private) and total net replacement rates, and should be accompanied by information on representativeness and assumptions (contribution rates and coverage rate, public and private). Specific assumptions agreed in the ISG. For further details, see 2006 report on Replacement Rates. Source: ISG and AWG

9.1.3.   New indicators adopted in the field of social inclusion:

In 2009, the Social Protection Committee adopted new indicators for the monitoring of social inclusion objectives in the field of material deprivation and housing.

1. Material deprivation rate: Share of population living in households lacking at least 3 items among the following 9 items: The household could not afford: i) to face unexpected expenses, ii) one week annual holiday away from home, iii) to pay for arrears (mortgage or rent, utility bills or hire purchase instalments), iv) a meal with meat, chicken or fish every second day, v) to keep home adequately warm, or could not afford (even if wanted to): vi) a washing machine, vii) a colour TV, viii) a telephone, ix) a personal car.

2. Depth of material deprivation: Unweighted mean of the number of items lacked by the population concerned out of the nine items retained for the definition of the "material deprivation" indicator (see above, indicator SI-P8).

In July 2009, 2 secondary indicators and 2 context information were adopted in the field of housing, but further work, including further improvement of the quality of the data is needed before a primary indicator can be identified.

3. Housing costs: Percentage of the population living in a household where total housing costs (net of housing allowances) represent more than 40% of the total disposable household income (net of housing allowances).

Housing costs include mortgage interest payments (net of any tax relief) for owners and rent payments, gross of housing benefits for renters, housing benefits for rent free households. They also include structural insurance, mandatory services and charges (sewage removal, refuse removal, etc.), regular maintenance and repairs, taxes, and the cost of utilities (water, electricity, gas and heating). They do not include capital repayment for mortgage holders.

Housing allowances include rent benefits[102] and benefits to owner-occupiers[103].

4. Overcrowding: Percentage of people living in an overcrowded household

- All households[104].

- excluding single households.

The person is considered as living in an overcrowded household if the household doesn't have at its disposal at least:

- one room for the household;
- one room for each couple;
- one room for each single person aged 18+;
- one room - for two single people of the same sex between 12 and 17 years of age;
- one room - for each single person of different sex between 12 and 17 years of age;
- one room - for two people under 12 years of age..

5. Housing deprivation by item:

Percentage of the population deprived of each housing deprivation item, and by number of items. *The following housing deprivation items are considered: - Leaking roof, damp walls/floors/foundations, or rot in window frames or floors; - no bath or shower in the dwelling; - no indoor flushing toilet for the sole use of the household; - Dwelling too dark.*

Breakdowns: sex, age (0-17; 18-64; 65+); for the 4 items only: poor/non-poor.

---

[102] Rent benefit: a current means-tested transfer granted by public authority to tenants, temporarily or on a long-term basis, to help them with rent costs.

[103] Benefit to owner occupier: a means-tested transfer by public authority to owner-occupiers to alleviate their current housing costs; in practice, often help with mortgage reimbursements.

[104] The calculation includes single households and considers them as deprived if they live in a studio with a bedroom not separated from the living room. This calculation based on all households should systematically be used if the overcrowding criteria is analysed together with other housing quality criteria.

6. Share of housing costs in total disposable household income: Median of the distribution among individuals of the share of housing costs (net of housing allowances) in total disposable income (net of housing allowances)
- median for the total population
Breakdowns: sex, age (0-17; 18-64; 65+); poor/non-poor; degree of urbanisation

9.2. Data sources

9.2.1. Indicators of income and living conditions: EU-SILC

EU-SILC data are available for 25 EU countries since 2005, Bulgaria and Romania have launched SILC in 2006. The EU-SILC instrument has been launched on the basis of the Regulation (EC) No 1177/2003 of the European Parliament and of the Council of 16 June 2003 concerning Community statistics on income and living conditions. Commission Regulation (EC) No 1983/2003 of 7 November 2003, implementing Regulation (EC) No 1177/2003 of the European Parliament and the Council concerning Community statistics on income and living conditions (EU-SILC) as concerns the lists of target primary variables established a common framework for the systematic production of Community statistics on income and living conditions. In addition to those regulations mentioned above there are various other implementing regulations, concerning e.g. definitions and updates, fieldwork aspects and imputation procedures and quality reports as well as annual regulations setting down lists of secondary target variables. In June 2006, the Social Protection Committee adopted a new set of common indicators for the social protection and social inclusion process.

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 other non-monetary income components: the value of goods produced for own consumption[105] and non-cash employee income. These components, together with imputed rent data are available for all countries from the SILC (2007) exercise onwards; Eurostat is currently assessing the quality and comparability of these components. In 2010, the Indicator's Sub-Group of the

---

[105] 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.

Social Protection Committee will discuss the possible inclusion of each of them in the definition of income underlying the OMC indicators.

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 if the information was collected in 2006. EU aggregates are computed as population-weighted averages of available national values.

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.

9.2.2. *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.

9.2.3. *Age-related expenditure projections*

Long-term budgetary projections were prepared in 2009 by the Economic Policy Committee and the European Commission (DG ECFIN) — see European Policy Committee and European Commission (2009), 'The 2009 Ageing Report: Economic and budgetary projections for the EU-27 Member States (2008-2060)', European Economy 2/2009

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-2008. 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.

9.3. Annex to part 6 on Health

Figure A1

Total expenditure on health per capita PPS, 2007 or latest available
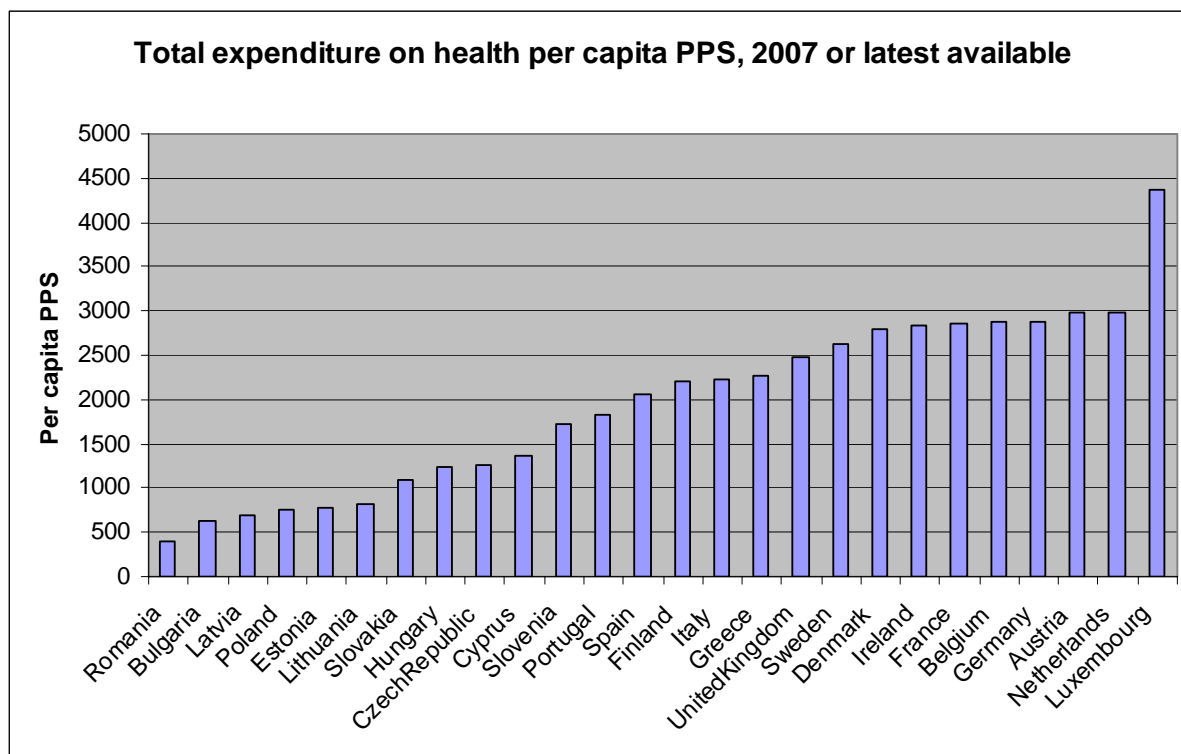
Source: Eurostat for all, except Ireland, Greece, Italy and UK. Source for these four Member States: OECD Health data. Malta: non available.

Figure A2
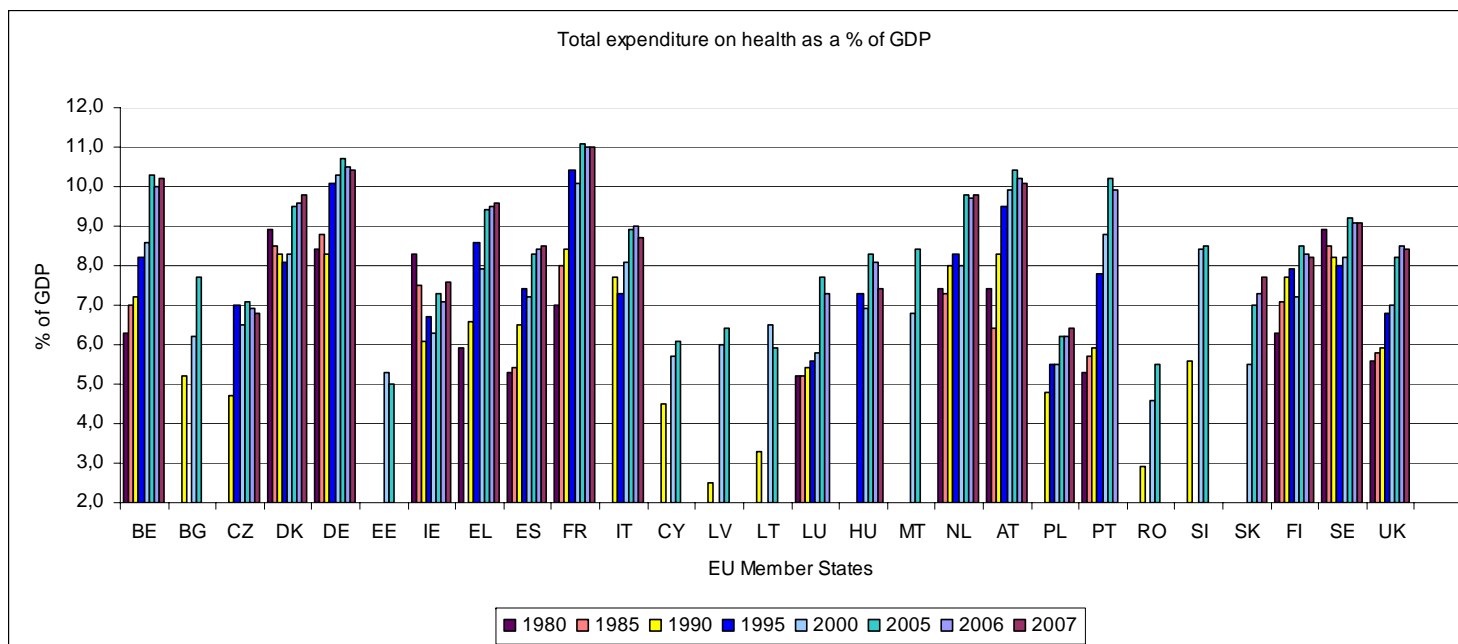
Source: OECD Health data and WHO Health for All databases

Table A1: Total expenditure on health as a percentage of GDP, 1960-2007

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
BE			3,9	5,6	6,3	7,0	7,1	7,3	7,3	7,2	7,2	7,6	7,7	7,9	7,7	8,2	8,4	8,3	8,4	8,6	8,6	8,7	9,0	10,2	10,5	10,3	10,0	10,2
BG											5,2									6	6,2	7,2	7,4	7,6	7,5	7,7		
CZ											4,7	4,9	5,1	6,7	6,9	7,0	6,7	6,7	6,6	6,6	6,5	6,7	7,1	7,4	7,2	7,1	6,9	6,8
DK				8,7	8,9	8,5	8,2	8,5	8,6	8,5	8,3	8,2	8,3	8,6	8,4	8,1	8,2	8,2	8,3	8,5	8,3	8,6	8,8	9,3	9,5	9,5	9,6	9,8
DE			6,0	8,4	8,4	8,8	8,7	8,8	8,9	8,3	8,3		9,6	9,6	9,8	10,1	10,4	10,2	10,2	10,3	10,3	10,4	10,6	10,8	10,6	10,7	10,5	10,4
EE																			5,5	5,8	5,3	4,9	4,9	5	5,2	5		
IE	3,7	4,0	5,1	7,3	8,3	7,5	7,4	7,1	6,7	6,3	6,1	6,5	7,0	6,9	6,9	6,7	6,5	6,4	6,2	6,2	6,3	6,9	7,1	7,3	7,5	7,3	7,1	7,6
EL		5,4			5,9			6,6	5,9	6,5	6,6	6,4	7,0	7,9	8,6	8,6	8,6	8,4	8,4	8,6	7,9	8,8	9,1	9,0	8,7	9,4	9,5	9,6
ES	1,5	2,5	3,5	4,6	5,3	5,4	5,3	5,4	6,0	6,2	6,5	6,7	7,1	7,4	7,3	7,4	7,5	7,3	7,3	7,3	7,2	7,2	7,3	8,1	8,2	8,3	8,4	8,5
FR	3,8	4,7	5,4	6,4	7,0	8,0					8,4	8,6	8,9	9,3	9,3	10,4	10,4	10,2	10,1	10,1	10,1	10,2	10,5	10,9	11,0	11,1	11,0	11,0
IT									7,3	7,3	7,7	7,9	8,0	7,9	7,6	7,3	7,4	7,7	7,7	7,8	8,1	8,2	8,3	8,3	8,7	8,9	9,0	8,7
CY											4,5									5,6	5,6	5,7	5,7	6,1	6,5	6,3	6,1	
LV											2,5								6,3	6,4	6	6,1	6,2	6,1	6,8	6,4		
LT											3,3								6,1	6,2	6,5	6,3	6,4	6,5	5,7	5,9		
LU			3,1	4,3	5,2	5,2	5,0	5,5	5,3	5,2	5,4	5,1	5,4	5,5	5,3	5,6	5,7	5,6	5,7	5,8	5,8	6,4	6,8	7,5	8,1	7,7	7,3	
HU												7,0	7,5	7,6	8,1	7,3	7,0	6,8	7,1	7,2	6,9	7,2	7,6	8,3	8,0	8,3	8,1	7,4
MT																			6,6	6,6	6,8	7,2	7,8	8,1	8,2	8,4		
NL			7,0	7,4	7,3	7,4	7,6	7,6	7,9		8,0	8,2	8,4	8,5	8,3	8,3	8,2	7,9	8,1	8,1	8,0	8,3	8,9	9,8	10,0	9,8	9,7	9,8
AT	4,3	4,6	5,2	6,9	7,4	6,4	6,7	6,8	6,8	7,0	8,3	8,4	8,7	9,3	9,6	9,5	9,5	9,8	10,0	10,1	9,9	10,1	10,1	10,3	10,4	10,4	10,2	10,1
PL											4,8	6,0	6,1	5,8	5,5	5,5	5,9	5,6	5,9	5,7	5,5	5,9	6,3	6,2	6,2	6,2	6,2	6,4
PT			2,5	5,1	5,3	5,7	6,3	6,2	6,4	5,9	5,9	6,4	6,6	6,9	7,0	7,8	8,0	8,0	8,0	8,2	8,8	8,8	9,0	9,7	10,0	10,2	9,9	
RO											2,9									4,4	4,5	4,6	4,7	5,1	5,4	4,9	5,5	
SI											5,6									8	8	8,4	8,7	8,7	8,8	8,5	8,5	
SK																		5,8	5,7	5,8	5,5	5,5	5,6	5,8	7,2	7,0	7,3	7,7
FI	3,8	4,8	5,5	6,2	6,3	7,1	7,2	7,3	7,1	7,1	7,7	8,8	9,0	8,2	7,7	7,9	8,0	7,6	7,4	7,4	7,2	7,4	7,8	8,1	8,2	8,5	8,3	8,2
SE			6,8	7,5	8,9	8,5	8,3	8,3	8,2	8,2	8,2	8,0	8,2	8,4	8,0	8,0	8,2	8,1	8,2	8,3	8,2	9,0	9,3	9,4	9,2	9,2	9,1	9,1
UK	3,9	4,1	4,5	5,4	5,6	5,8	5,8	5,9	5,8	5,8	5,9	6,3	6,8	6,8	6,9	6,8	6,8	6,6	6,7	6,9	7,0	7,3	7,6	7,8	8,1	8,2	8,5	8,4

Source: OECD Health data and WHO Health for All databases

Figures A3: GDP growth rates versus growth rates of total expenditure on health [106]

---
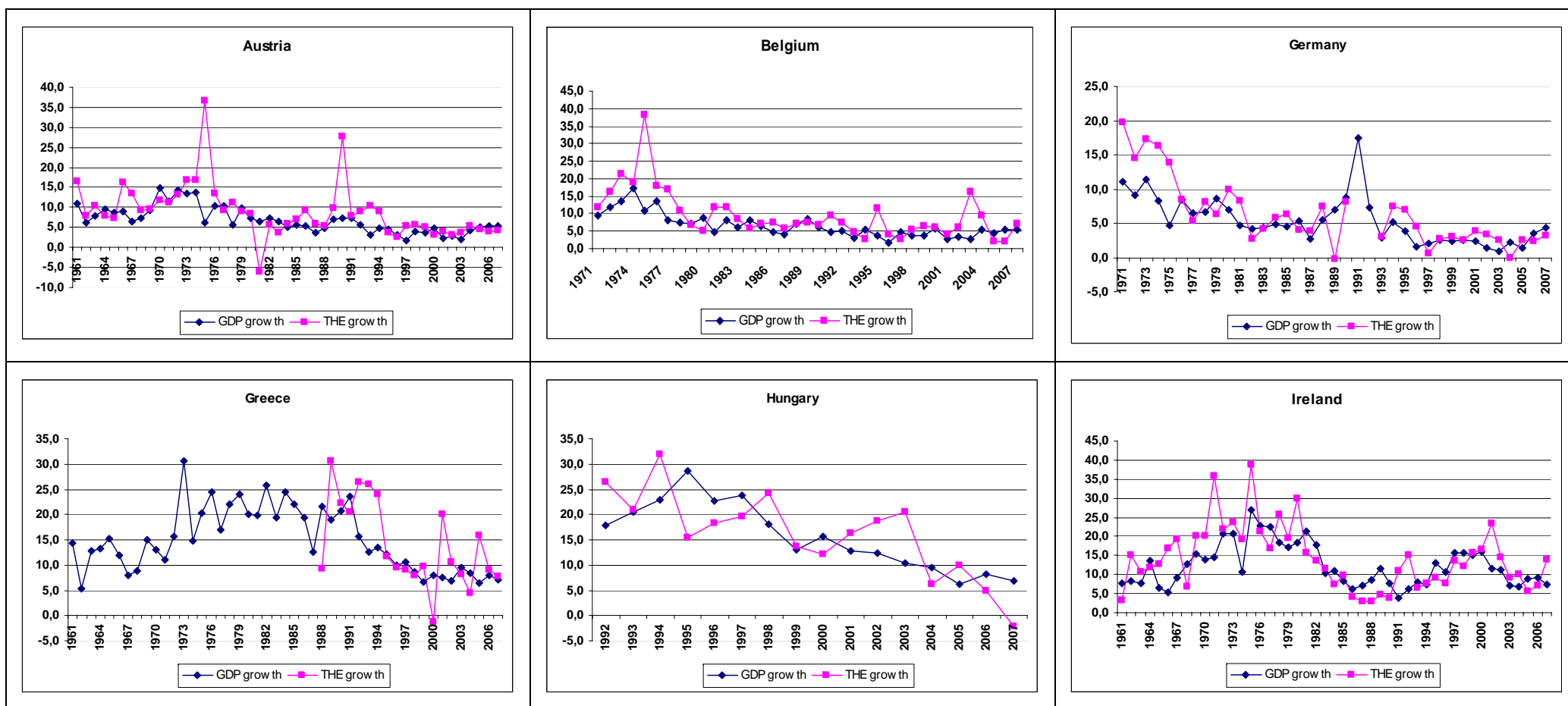
[106]   The relevant information (i.e. total health expenditure in absolute values) is not readily available for the eight Member States missing in these graphs, or is just available for very short time series.
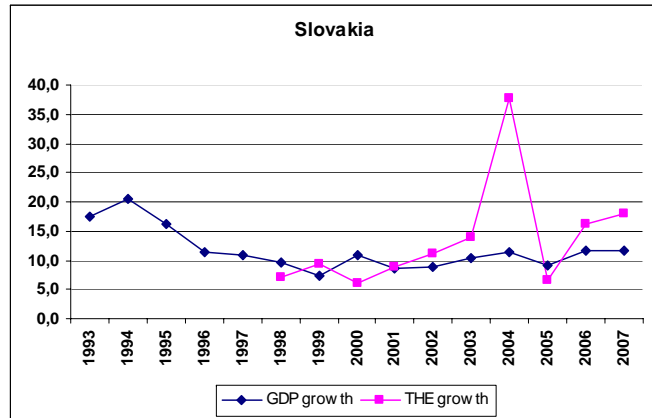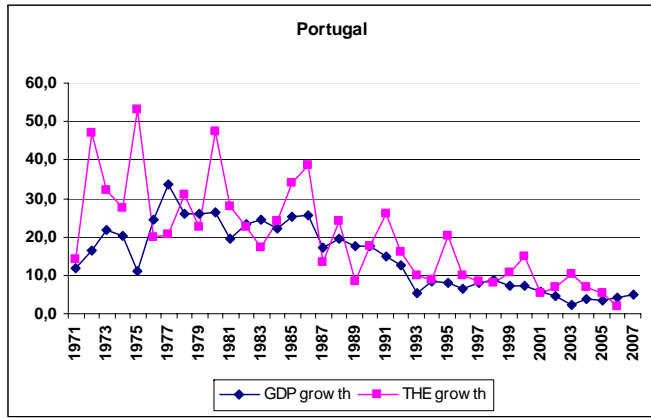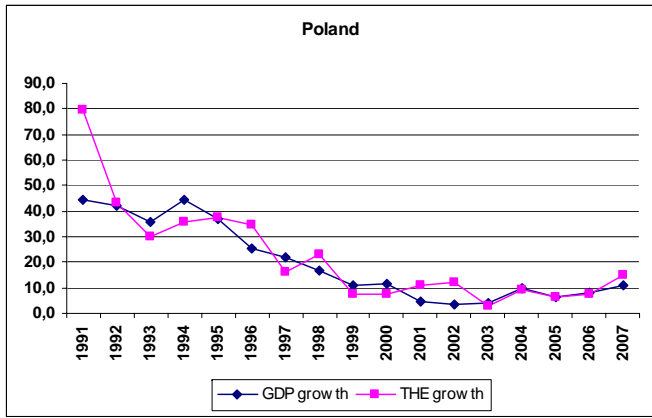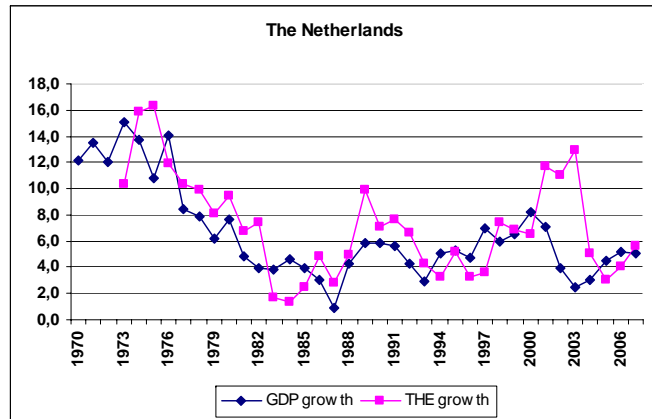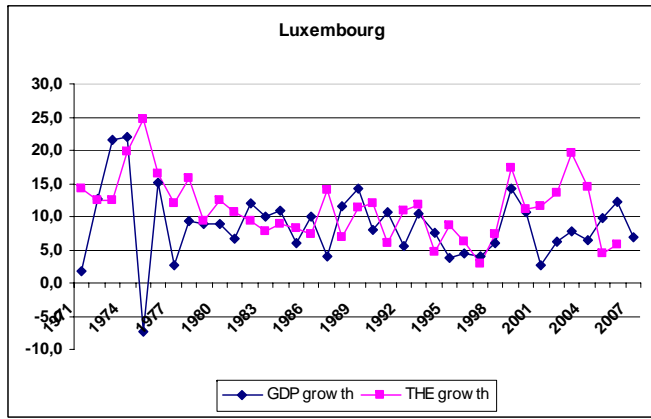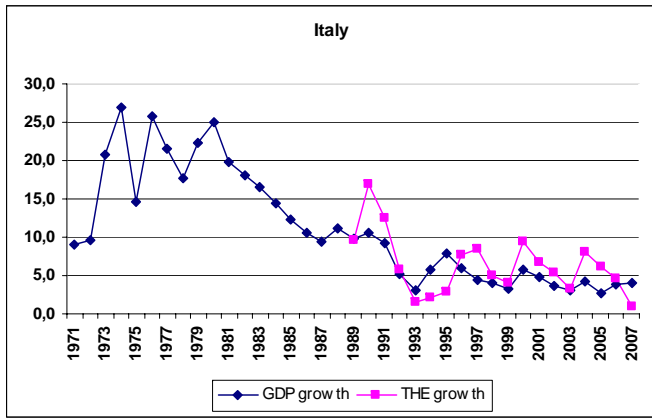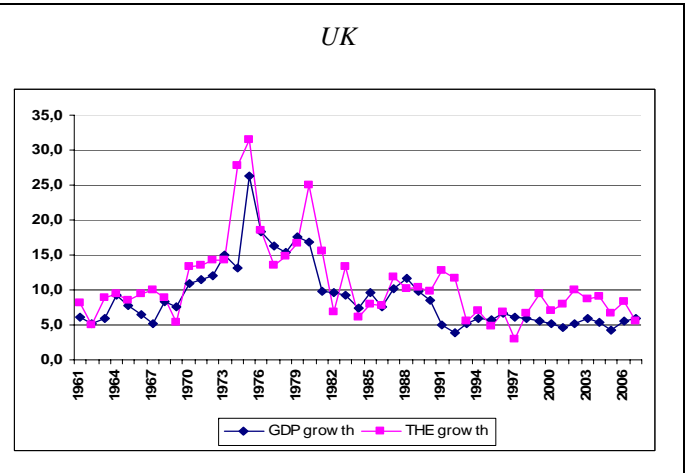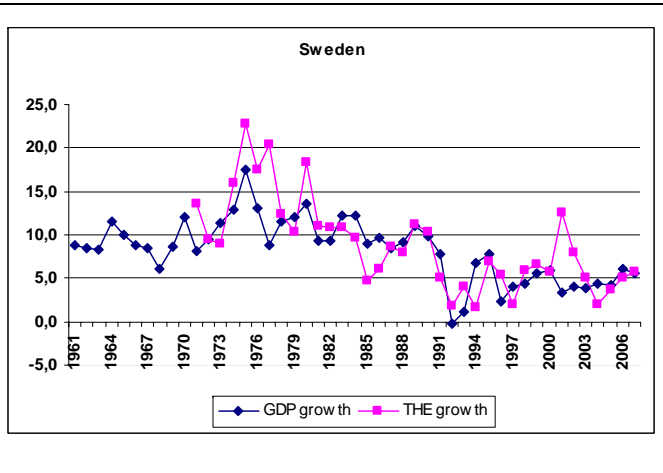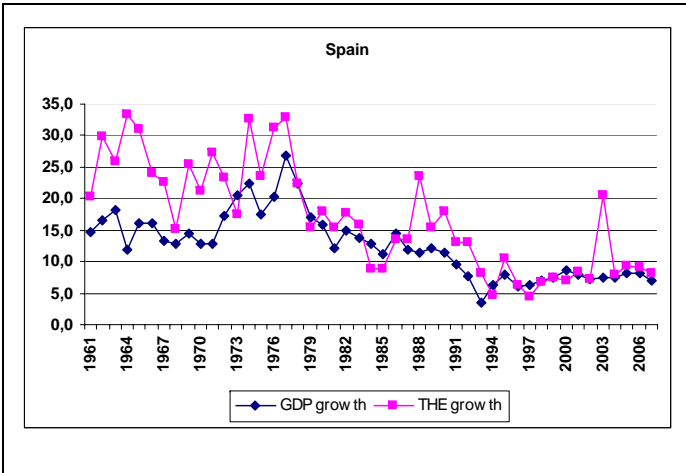
Italy — GDP growth / THE growth (1971–2007)

Luxembourg — GDP growth / THE growth (1971–2007)

The Netherlands — GDP growth / THE growth (1970–2006)

Poland — GDP growth / THE growth (1991–2007)

Portugal — GDP growth / THE growth (1971–2007)

Slovakia — GDP growth / THE growth (1993–2007)

Source: OECD Health data, WHO Health for All databases and EC computations

Figure A4

Public expenditure on health as % of GDP, 1997-2007

Source: OECD Health data and WHO Health for All databases
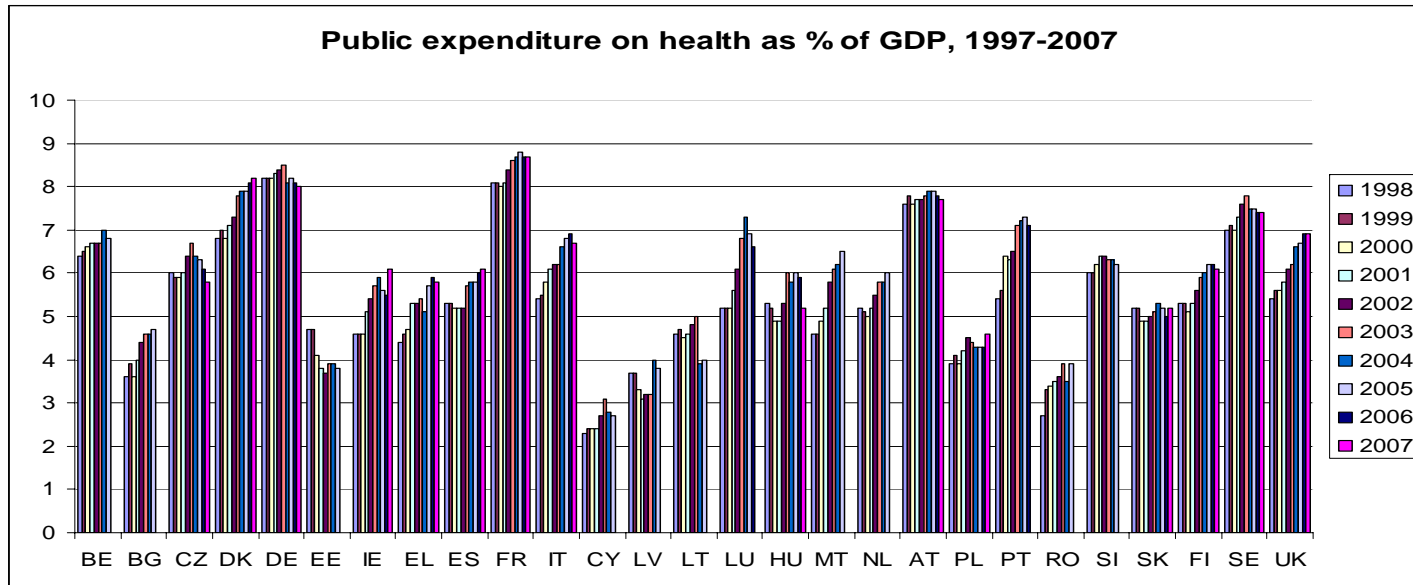
Figure A5

Public expenditure on health as % of GDP, 1980-2007
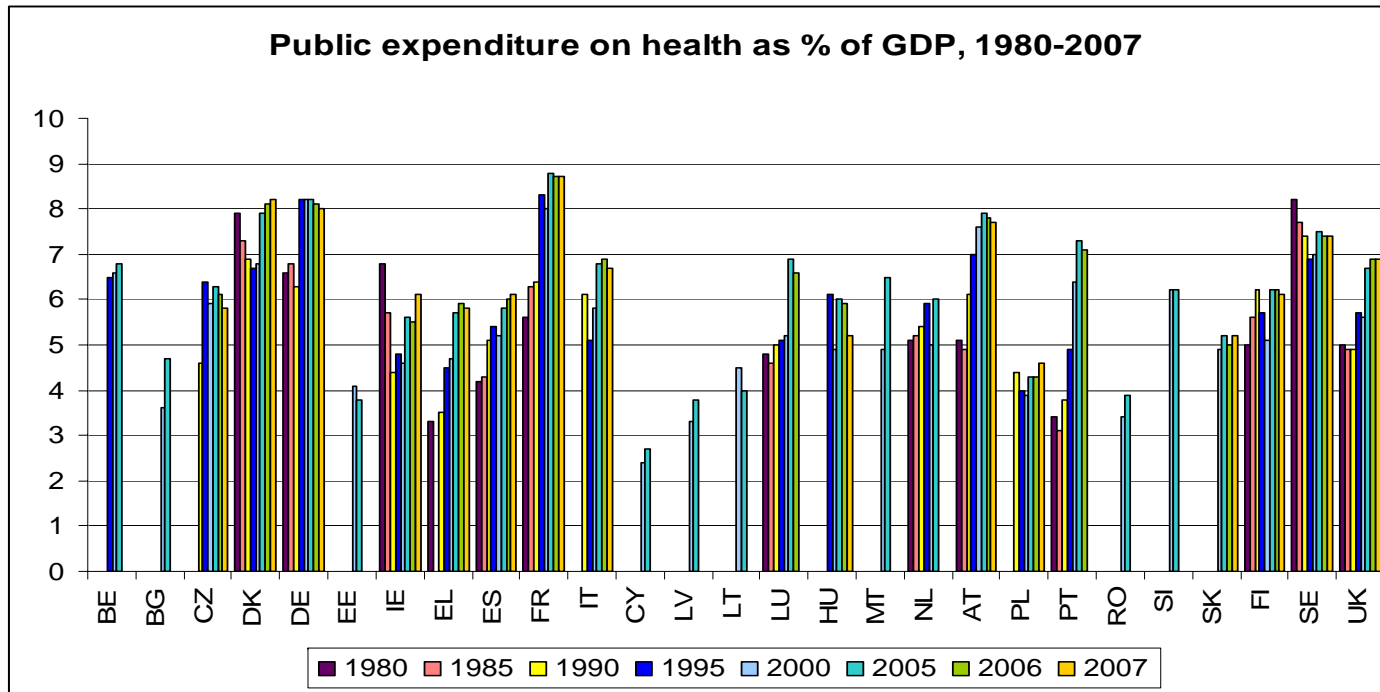
Source: OECD Health data and WHO Health for All databases

Table A2: Public expenditure on health as a % of GDP, 1960-2007

	1960	1965	1970	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
BE																6,5	6,7		6,4	6,5	6,6	6,7	6,7	6,7	7	6,8		
BG																			3,6	3,9	3,6	4	4,4	4,6	4,6	4,7		
CZ											4,6	4,8	4,9	6,4	6,5	6,4	6,1	6	6	5,9	5,9	6	6,4	6,7	6,4	6,3	6,1	5,8
DK				7,5	7,9	7,3	6,9	7,1	7,3	7,1	6,9	6,9	6,9	7,1	6,9	6,7	6,8	6,7	6,8	7	6,8	7,1	7,3	7,8	7,9	7,9	8,1	8,2
DE			4,4	6,6	6,6	6,8	6,7	6,8	6,9	6,3	6,3		7,8	7,7	7,9	8,2	8,5	8,3	8,2	8,2	8,2	8,3	8,4	8,5	8,1	8,2	8,1	8
EE																			4,7	4,7	4,1	3,8	3,7	3,9	3,9	3,8		
IE	2,8	3,1	4,1	5,8	6,8	5,7	5,6	5,2	4,8	4,6	4,4	4,7	5	5,1	5	4,8	4,7	4,7	4,6	4,6	4,6	5,1	5,4	5,7	5,9	5,6	5,5	6,1
EL		2,3				3,3		4	3,2	3,6	3,5	3,4	3,8	4,3	4,3	4,5	4,5	4,5	4,4	4,6	4,7	5,3	5,3	5,4	5,1	5,7	5,9	5,8
ES	0,9	1,3	2,3	3,6	4,2	4,3	4,2	4,3	4,7	4,8	5,1	5,2	5,5	5,7	5,5	5,4	5,4	5,3	5,3	5,3	5,2	5,2	5,2	5,7	5,8	5,8	6	6,1
FR	2,4	3,4	4,1	5	5,6	6,3					6,4	6,6	6,8	7,1	7,1	8,3	8,3	8,1	8,1	8,1	8	8,1	8,4	8,6	8,7	8,8	8,7	8,7
IT									5,7	5,7	6,1	6,3	6,2	5,9	5,6	5,1	5,2	5,4	5,4	5,5	5,8	6,1	6,2	6,2	6,6	6,8	6,9	6,7
CY																			2,3	2,4	2,4	2,4	2,7	3,1	2,8	2,7		
LV																			3,7	3,7	3,3	3,1	3,2	3,2	4	3,8		
LT																			4,6	4,7	4,5	4,6	4,8	5	3,9	4		
LU			2,8	4	4,8	4,6	4,5	5,1	4,9	4,8	5	4,8	5	5,1	4,9	5,1	5,2	5,2	5,2	5,2	5,2	5,6	6,1	6,8	7,3	6,9	6,6	
HU											6,3	6,6	6,6	7,1	6,1	5,7	5,5	5,3	5,2	4,9	4,9	5,3	5,8	6	5,8	6	5,9	5,2
MT																			4,6	4,6	4,9	5,2	5,8	6,1	6,2	6,5		
NL				4,8	5,1	5,2	5,1	5,2	5,1	5,3	5,4	5,6	6,1	6,2	6,1	5,9	5,4	5,4	5,2	5,1	5	5,2	5,5	5,8	5,8	6		
AT	3	3,2	3,3	4,8	5,1	4,9	5,1	5,2	5,2	5,2	6,1	6,1	6,4	6,9	7,2	7	7	7,4	7,6	7,8	7,6	7,7	7,7	7,8	7,9	7,9	7,8	7,7
PL											4,4	4,5	4,6	4,3	4	4	4,3	4	3,9	4,1	3,9	4,2	4,5	4,4	4,3	4,3	4,3	4,6
PT			1,5	3	3,4	3,1	3,3	3,2	3,4	3,1	3,8	4	3,9	4,4	4,4	4,9	5,2	5,3	5,4	5,6	6,4	6,3	6,5	7,1	7,2	7,1		
RO																			2,7	3,3	3,4	3,5	3,6	3,9	3,5	3,9		
SI																			6	6	6,2	6,4	6,4	6,3	6,3	6,2		
SK																		5,3	5,2	5,2	4,9	4,9	5	5,1	5,3	5,2	5	5,2
FI	2,1	3,2	4,1	4,8	5	5,6	5,7	5,8	5,6	5,7	6,2	7,1	7,2	6,3	5,8	5,7	5,8	5,5	5,3	5,3	5,1	5,3	5,6	5,9	6	6,2	6,2	6,1
SE			5,8	6,8	8,2	7,7	7,4	7,4	7,3	7,3	7,4	7,1	7,1	7,4	7	6,9	7,1	6,9	7	7,1	7	7,3	7,6	7,8	7,5	7,5	7,4	7,4
UK	3,3	3,5	3,9	4,9	5	4,9	4,9	4,9	4,8	4,8	4,9	5,3	5,7	5,8	5,8	5,7	5,7	5,3	5,4	5,6	5,6	5,8	6,1	6,2	6,6	6,7	6,9	6,9

Source: OECD Health data and WHO Health for All databases

Figures A6: Public expenditure as % of total expenditure on health, 1960-2007

Source: OECD Health data and WHO Health for All databases

Figure A7

Life expectancy at birth vs total expenditure on health as % of GDP, 2007 or latest available

$y = 1,5045x + 65,266$
$R2 = 0,5439$
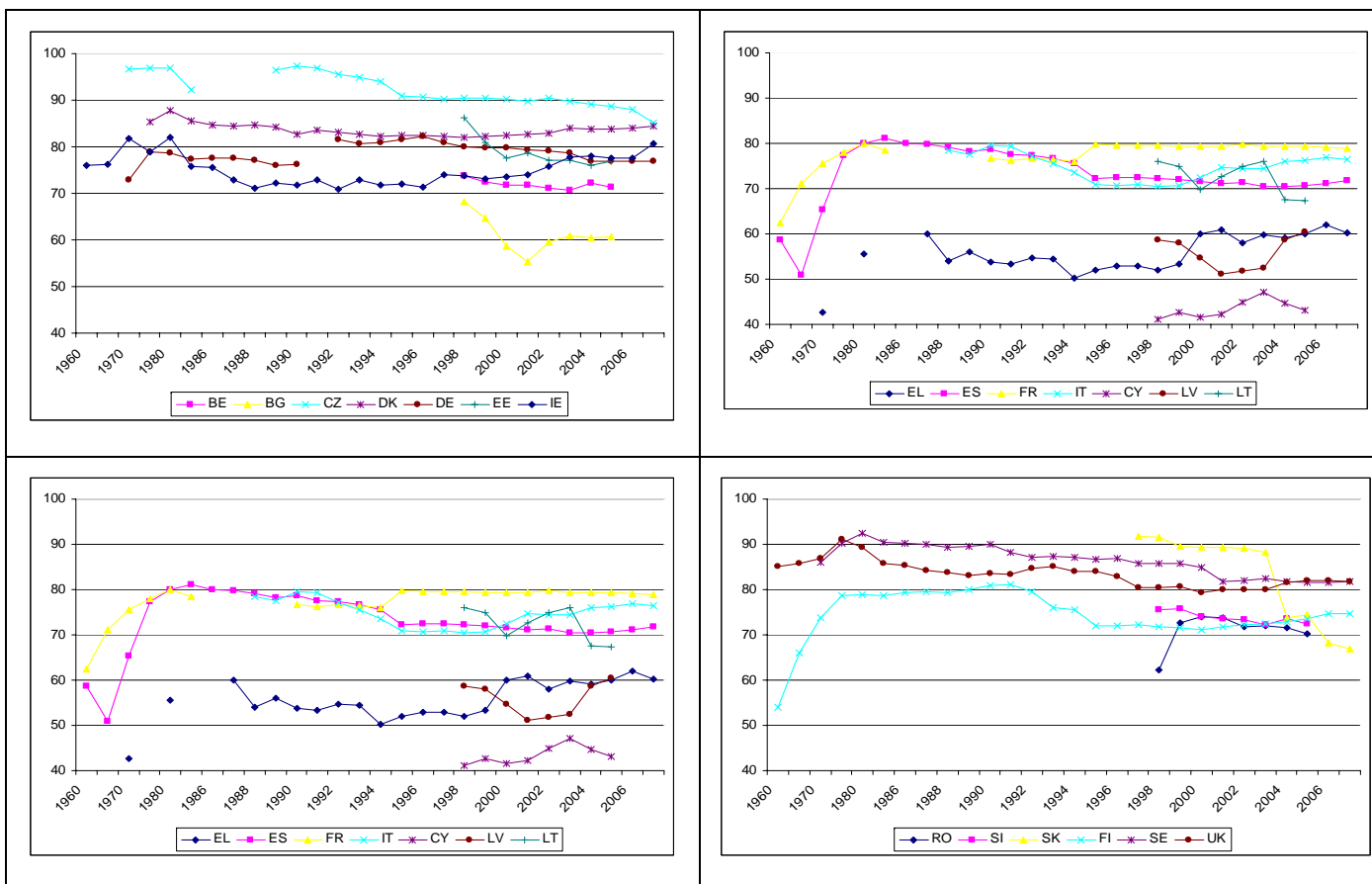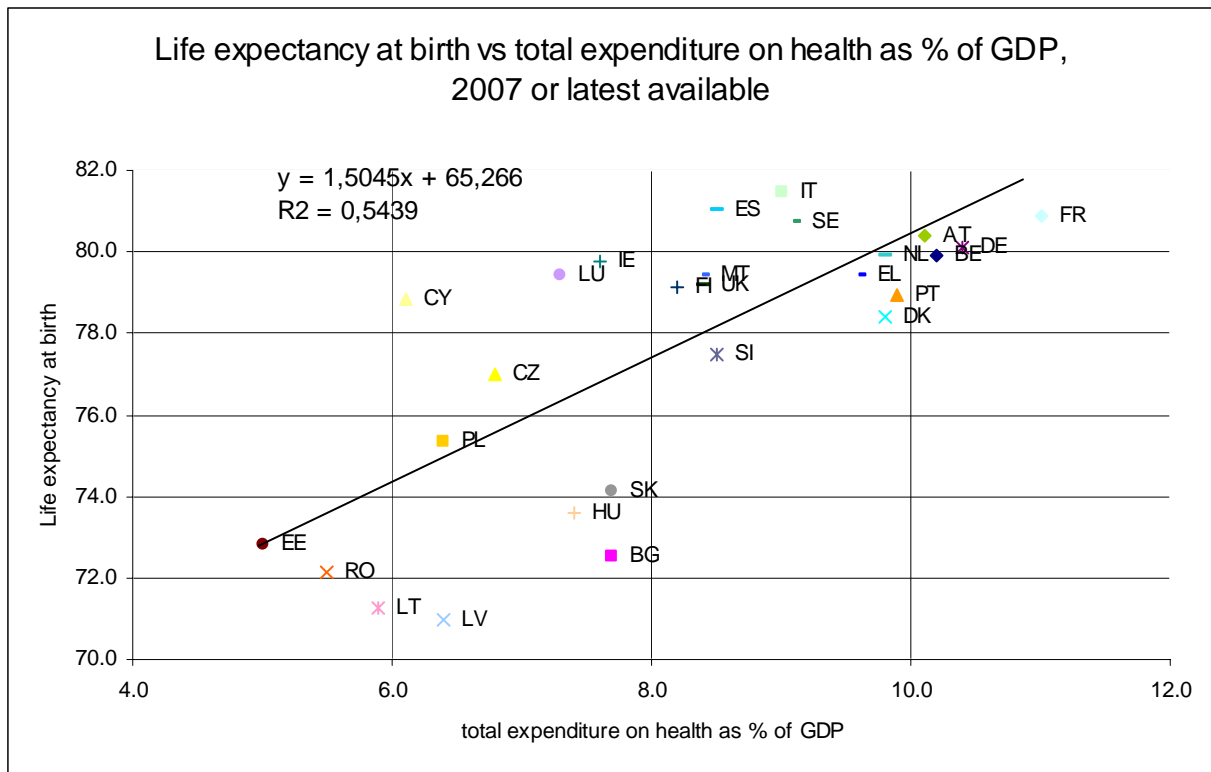
Source: Eurostat data, OECD Health data, WHO Health for All database and EC computations

Figures A8a

Projected life expectancy at birth, males
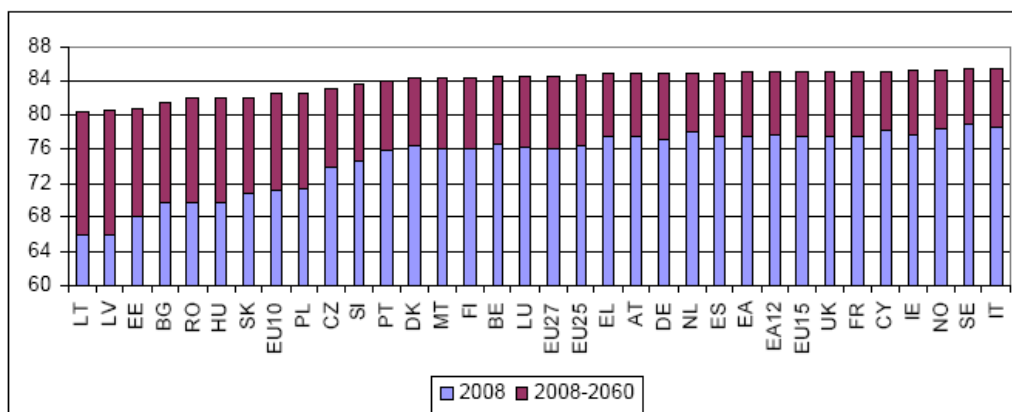
Projected life expectancy at 65, males
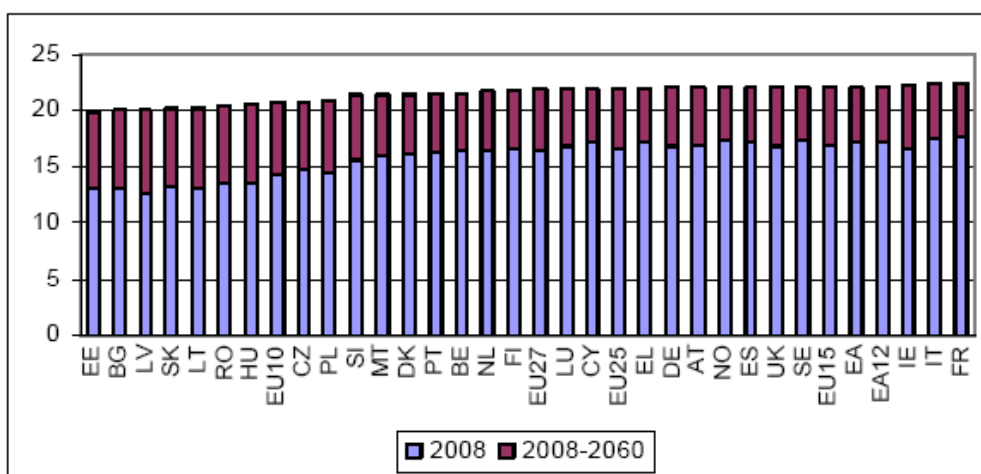
Source: Eurostat, EUROPOP2008 convergence scenario; 2009 EPC/EC Ageing Report

Figures A8a

Projected life expectancy at birth, female (in years)
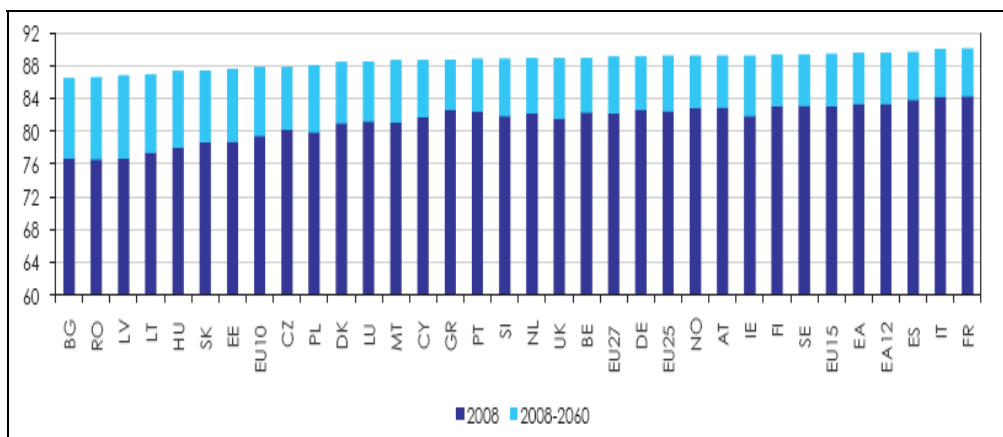
Projected life expectancy at 65, women (in years)
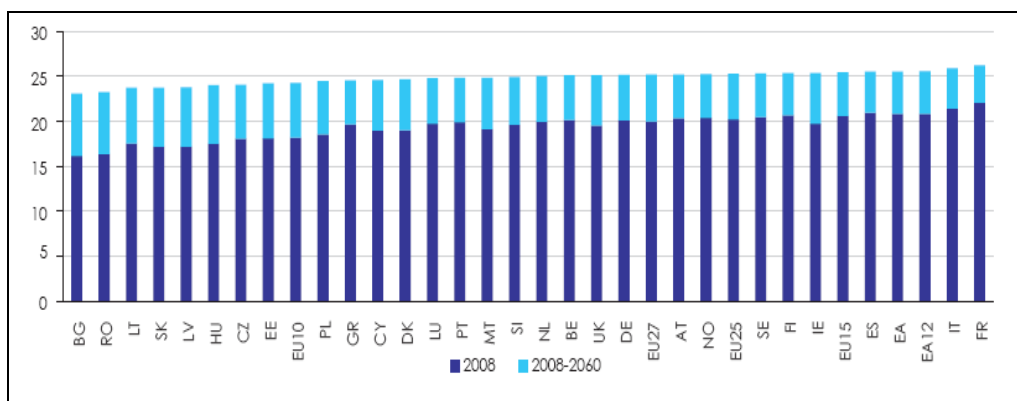
Source: Eurostat, EUROPOP2008 convergence scenario; 2009 EPC/EC Ageing Report

Figures A9: Population pyramids 2008 and 2060, EU27
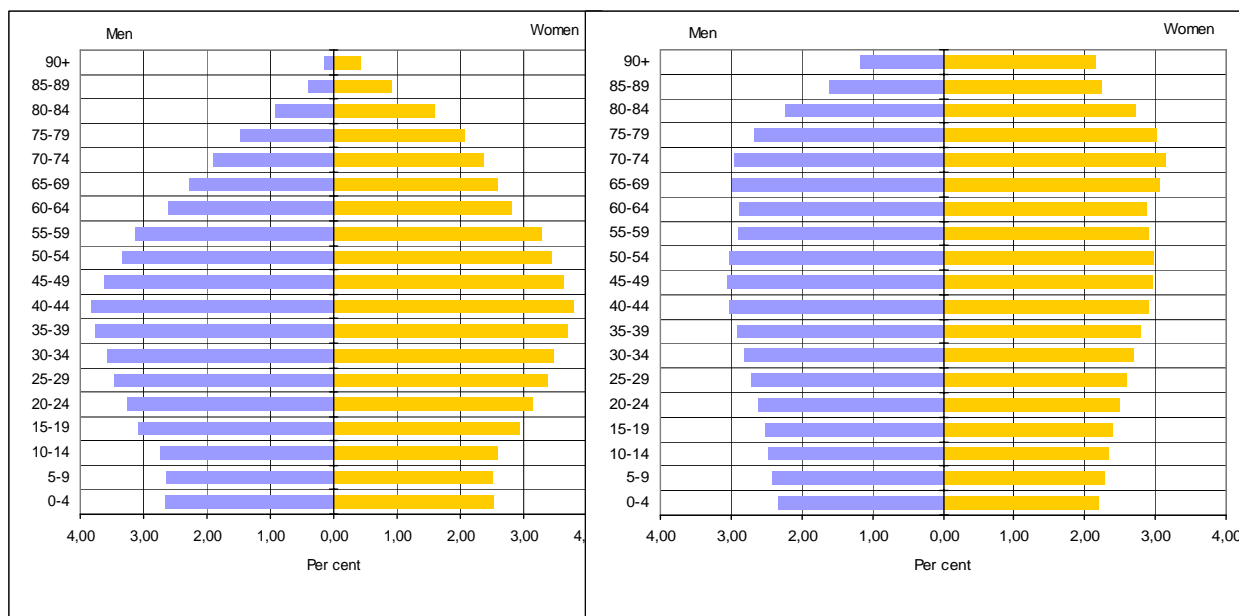
Source: Eurostat, EUROPOP 2008 convergence scenario

Figure A10 Age-related expenditure profiles
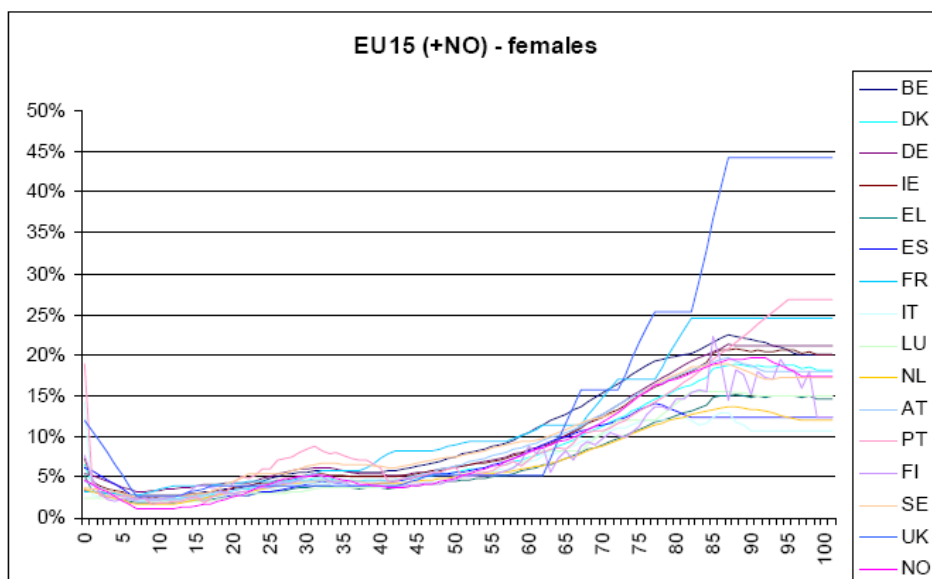
Source: EPC/EC 2009 Ageing Report

Figure A11. Pharmaceutical expenditure per capita PPS, 2007 or latest available

Total pharmaceutical expenditure per capita PPS
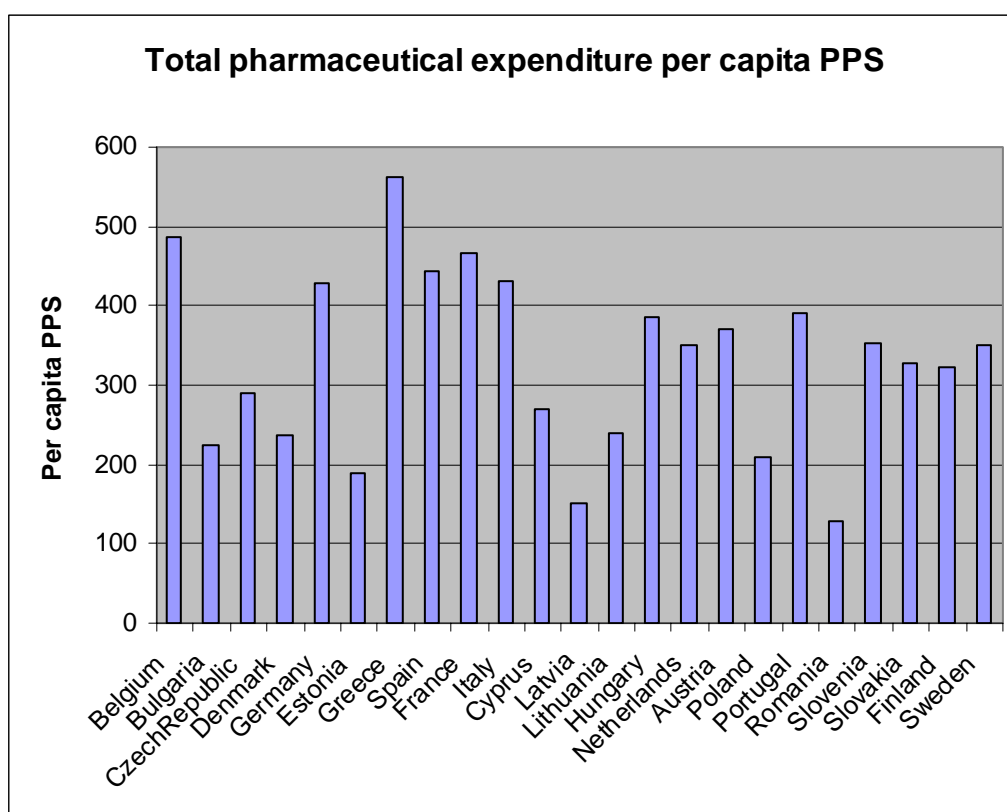
Source: Eurostat and WHO Health for All database

NB. It should be noted that in some Member States pharmaceutical expenditures in hospitals are not properly separated from the total of hospital expenditure.

Figure A12

Obesity rates (% of the population that is obese)
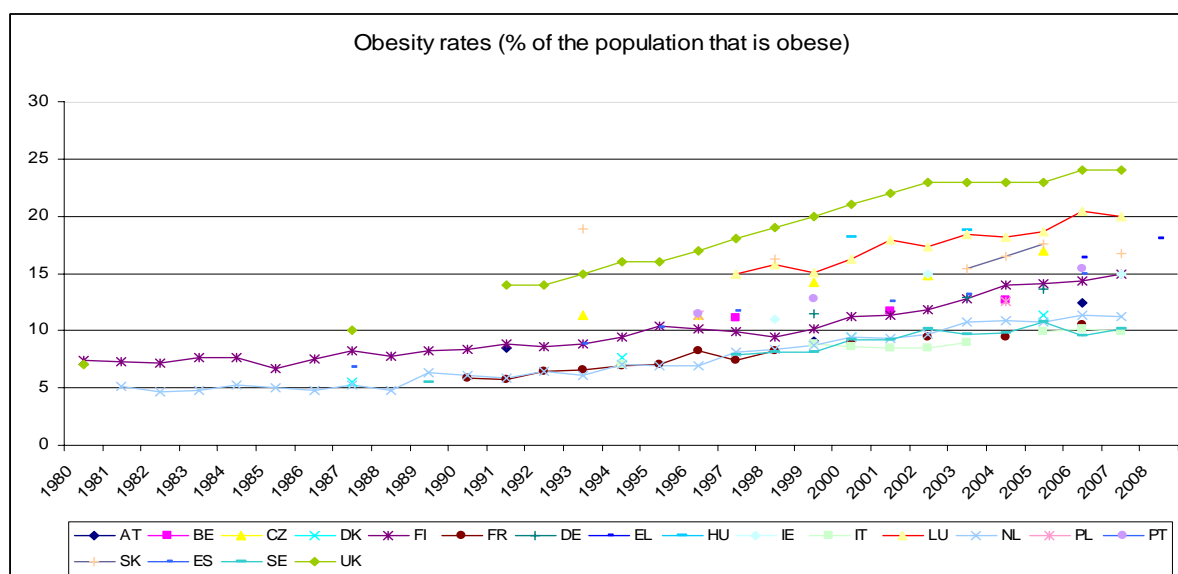
Source: OECD Health data

Figure A13. Sleeping and anxiety problems in SE (% of the population) in the early 2000s
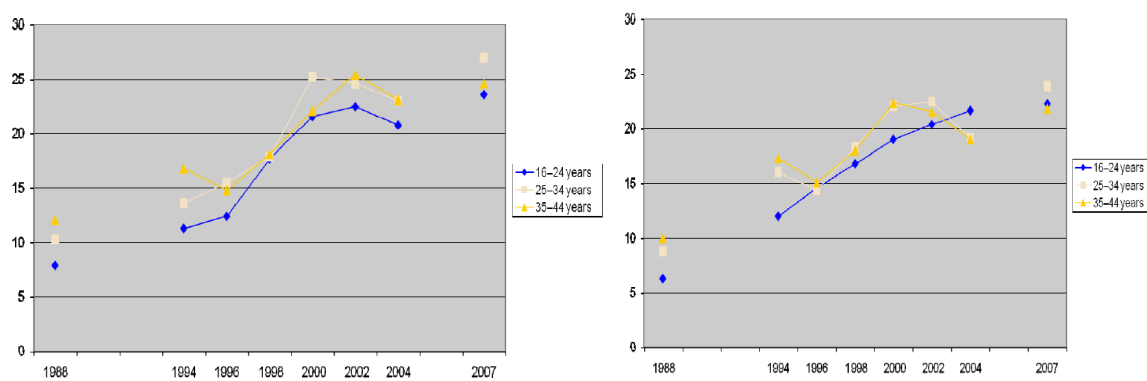
Source: Ministry of Health and Social Affairs, Sweden. See at
http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/ev_20090427_co06_en.pdf

9.4. Statistical tables

1a. At-risk-of-poverty rate by age and gender, 2008

		EU27	EU25	BE	BG	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
Total population	Total	17p	16p	15	21	9	12	11	15	19	16	20	20	13b	19	16	26	20	13	12	15	11	12	17	18	23	12	11	14	12	19p
	Men	16p	15p	14	20	8	12	11	14	16	15	20	18	13b	17	14	23	18	13	12	14	11	11	17	18	22	11	10	13	11	18p
	Women	17p	17p	16	23	10	12	12	16	22	16	21	21	14b	20	18	28	22	14	12	15	11	13	17	19	24	14	12	14	13	20p
Children aged 0-17	Total	20p	19p	17	26	13	9	10	15	17	18	23	24	17b	25	14	25	23	20	20	20	13	15	22	23	33	12	17	12	13	23p
People aged 18-64	Total	15p	15p	12	17	8	11	12	15	15	14	19	16	13b	16	11	20	17	13	12	12	10	11	16	16	20	10	10	12	11	15p
	Men	14p	14p	11	16	7	11	13	15	15	13	18	15	12b	15	9	19	16	12	12	10	10	10	17	15	20	11	9	13	11	14p
	Women	15p	15p	13	18	9	11	12	16	15	14	19	17	13b	18	13	20	17	14	12	13	10	12	16	17	20	10	10	11	11	16p
People aged 65+	Total	19p	19p	21	34	7	18	10	15	39	21	22	28	11b	21	49	51	29	5	4	22	10	15	12	22	26	21	10	23	16	30p
	Men	16p	16p	20	27	3	17	8	12	25	19	21	25	10b	17	43	45	17	5	3	24	10	12	9	19	21	12	4	16	10	28p
	Women	22p	21p	22	39	10	19	11	18	46	23	24	30	12b	24	54	54	36	6	5	20	9	17	13	24	30	28	13	28	21	33p

1a. At-risk-of-poverty threshold (illustrative values), EUR and PPS, 2008

	EU27	EU25	BE	BG	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO[1]	SI	SK	FI	SE	UK
EUR '- One-person household	:	:	10788	1303	3638	14497	15917	10953	3328	13760	6480	7753	10538b	9382	10022	2899	2502	18550	2639	5743	11694	11406	2493	4878	1173	6535	2875	11800	12178	13119p
'- Two adults with two dep. ch	:	:	22654	2736	7640	30443	33426	23001	6989	28896	13608	16282	22130b	19702	21046	6088	5253	38955	5542	12061	24557	23953	5235	10243	2462	13724	6038	24779	25573	27550p
PPS '- One-person household	:	:	10146	2801	5828	10529	11561	10627	4652	10949	7249	8391	9734b	9033	11335	4403	4196	16505	3993	7831	11314	11248	3915	5768	1907	8395	4040	9632	10377	11609p
'- Two adults with two dep. ch	:	:	21307	5881	12239	22110	24277	22317	9770	22993	15223	17622	20441b	18969	23804	9245	8811	34660	8385	16446	23760	23620	8221	12113	4005	17629	8484	20228	21792	24380p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008)
(1) Including imputed rent data 2007. See methodological note for an explanation
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available b= break in data series

1b. Relative median at-risk-of-poverty gap by age and gender, 2008

		EU27	EU25	BE	BG	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Total population	Total	22p	21p	17	27	18	18	22	23	20	19	25	24	18b	23	17	29	26	17	17	18	15	15	21	23	32	19	18	16	18	21p
	Men	23p	22p	18	27	21	19	25	24	24	20	24	25	19b	23	16	27	29	15	18	19	14	16	21	22	33	21	21	17	20	21p
	Women	21p	21p	17	27	15	17	19	21	19	18	25	23	17b	23	17	30	25	18	17	18	17	15	20	23	32	19	17	14	17	21p
Children aged 0-17	Total	22p	21p	18	40	21	19	22	19	24	20	26	26	15b	24	14	29	28	17	17	17	13	16	22	26	39	16	24	16	18	19p
People aged 18-64	Total	24p	23p	19	30	19	25	26	25	27	21	26	26	21b	26	15	30	31	17	18	18	17	17	21	24	32	20	19	19	23	22p
	Men	25p	24p	20	29	22	30	30	27	29	21	26	27	23b	25	14	29	31	14	18	20	17	20	22	23	33	22	22	20	24	24p
	Women	23p	23p	19	30	17	20	23	24	25	21	26	26	20b	26	16	30	29	20	18	17	18	16	21	24	31	18	18	18	23	21p
People aged 65+	Total	18p	17p	14	18	8	8	8	17	15	8	21	19	12b	19	19	27	17	15	10	20	14	14	14	18	23	20	9	11	11	21p
	Men	17p	17p	15	14	7	7	9	18	13	12	20	21	11b	16	18	21	12	15u	10u	19	12	14	13	17	23	18	8u	10	13	18p
	Women	18p	18p	13	20	8	8	8	17	16	6	23	17	13b	20	20	30	18	15u	10	20	16	14	14	18	23	21	10	12	11	21p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008) [1] with imputed rent data 2007 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available b= break in data series
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	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
S80/S20	Total	5p	4,8p	4.1	6.5	3.4	3.6	3.6	4.8	5	4.5	5.9	5.4	4,2b	5.1	4.1	7.3	5.9	4.1	3.6	4	4	3.7	5.1	6.1	7	3.4	3.4	3.8	3.5	5.6p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008); [1] with imputed rent data 2007 (see methodological note).
Notes: i See explanatory text (Eurostat website) p = provisional value s = Eurostat estimate u = unreliable or uncertain data (:) = data not available b= break in data series
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) 1997-2008

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
life expectancy at birth - males	**eu27**	:	:	:	:	:	74.5	74.6	75.2	75.4	75.8	:	:
life expectancy at 45 - males	**eu27**	:	:	:	:	:	31.9	31.9	32.5	32.6	32.9	:	:
life expectancy at 65 - males	**eu27**	:	:	:	:	:	15.9	15.9	16.4	16.5	16.8	:	:
Healthy Life Years at birth - males	**eu27**	:	:	:	:	:	:	:	:	:	:	61,60e	:
life expectancy at birth - females	**eu27**	:	:	:	:	:	80.9	80.8	81.5	81.5	82.0	:	:
life expectancy at 45 - females	**eu27**	:	:	:	:	:	37.3	37.2	37.8	37.8	38.2	:	:
life expectancy at 65 - females	**eu27**	:	:	:	:	:	19.5	19.4	19.9	20.0	20.4	:	:
Healthy Life Years at birth - females	**eu27**	:	:	:	:	:	:	:	:	:	:	62,30e	:
life expectancy at birth - males	**eu25**	:	:	:	:	:	75.0	75.1	75.7	75.9	76.3	:	:
life expectancy at 45 - males	**eu25**	:	:	:	:	:	32.3	32.3	32.8	32.9	33.3	:	:
life expectancy at 65 - males	**eu25**	:	:	:	:	:	16.1	16.1	16.6	16.7	17.1	:	:
Healthy Life Years at birth - males		:	:	:	:	:	:	:	:	60.8	61.6	:	:
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	:	:
Healthy Life Years at birth - females	**eu25**	:	:	:	:	:	:	:	:	62.1	62.1	:	:
Disability free life expectancy at birth - males	**eu15**	:	:	63,2e	63,5e	63,6e	64,3e	64,5e	:	:	:	:	:
Disability free life expectancy at birth - females	**eu15**	:	:	63,9e	64,4e	65,0e	65,8e	66,0e	:	:	:	:	:

Source: Eurostat - Demography; e: estimate

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**BE**	74.2	74.4	74.4	74.6	75.0	75.1	75.3	76.0	76.2	76.6	77.1	:
Life expectancy at 45 - males	**BE**	31.6	31.7	31.8	32.0	32.3	32.3	32.5	33.0	33.1	33.6	34.0	:
Life expectancy at 65 - males	**BE**	15.2	15.3	15.5	15.6	15.9	15.8	16.0	16.4	16.6	17.0	17.3	:
Healthy Life Years at birth - males	**BE**	66.5	63.3	66.0	65.7	66.6	66,9(e)	67,4(e)	58,4(bi)	61.7	62.8	63.3	
Life expectancy at birth - females	**BE**	80.7	80.7	81.0	81.0	81.2	81.2	81.1	81.8	81.9	82.3	82.6	:
Life expectancy at 45 - females	**BE**	37.2	37.3	37.4	37.5	37.7	37.5	37.3	38.0	38.0	38.5	38.8	:
Life expectancy at 65 - females	**BE**	19.5	19.6	19.7	19.8	19.9	19.7	19.6	20.2	20.2	20.7	21.0	:
Healthy Life Years at birth - females	**BE**	68.3	65,4(e)	68.4	69.1	68.8	69,0(e)	69,2(e)	58,10(bi)	61.9	62.8	63.7	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**BG**	67.0	67.4	68.3	68.4	68.6	68.8	68.9	69.0	69.0	69.2	69.5	69.8
Life expectancy at 45 - males	**BG**	26.3	26.4	27.2	27.0	27.2	27.3	27.3	27.5	27.2	27.3	27.5	27.9
Life expectancy at 65 - males	**BG**	12.3	12.5	12.9	12.7	13.0	13.0	13.0	13.2	13.1	13.2	13.3	13.5
Healthy Life Years at birth - males	**BG**	:	:	:	:	:	:	:	:	:	:	:	:
Life expectancy at birth - females	**BG**	73.8	74.6	75.0	75.0	75.4	75.5	75.9	76.2	76.2	76.3	76.7	77.0
Life expectancy at 45 - females	**BG**	31.7	32.2	32.5	32.4	32.8	32.9	33.1	33.4	33.3	33.5	33.7	34.0
Life expectancy at 65 - females	**BG**	14.7	15.1	15.4	15.3	15.6	15.7	15.9	16.2	16.1	16.3	16.4	16.7
Healthy Life Years at birth - females	**BG**	:	:	:	:	:	:	:	:	:	:	:	:

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**CZ**	70.5	71.2	71.5	71.7	72.1	72.1	72.0	72.6	72.9	73.5	73.8	74.1
Life expectancy at 45 - males	**CZ**	28.1	28.6	28.8	29.0	29.3	29.3	29.2	29.7	29.9	30.4	30.7	30.9
Life expectancy at 65 - males	**CZ**	13.2	13.5	13.7	13.8	14.0	13.9	13.8	14.2	14.4	14.8	15.1	15.3
Healthy Life Years at birth - males	**CZ**	:	:	:	:	:	62,8(p)	:	:	57,9(bi)	57.8	61.3	
Life expectancy at birth - females	**CZ**	77.6	78.2	78.3	78.5	78.6	78.7	78.6	79.2	79.3	79.9	80.2	80.5
Life expectancy at 45 - females	**CZ**	34.1	34.5	34.5	34.8	34.8	34.9	34.7	35.3	35.3	36.0	36.2	36.5
Life expectancy at 65 - females	**CZ**	16.7	17.1	17.1	17.3	17.3	17.3	17.2	17.6	17.7	18.3	18.5	18.8
Healthy Life Years at birth - females	**CZ**	:	:	:	:	:	63,3(p)	:	:	59,90(bi)	59.8	63.2	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	DK	73.6	74.0	74.2	74.5	74.7	74.8	75.0	75.4	76.0	76.1	76.2	76.5
Life expectancy at 45 - males	DK	30.9	31.1	31.3	31.6	31.7	31.8	32.0	32.4	32.8	32.8	33.0	33.3
Life expectancy at 65 - males	DK	14.6	14.9	15.0	15.2	15.2	15.4	15.6	15.9	16.1	16.2	16.5	16.6
Healthy Life Years at birth - males	DK	61.6	62.4	62.5	62.9	62.2	62,8(e)	63,0(e)	68,3(bi)	68.4	67.7	67.4	
Life expectancy at birth - females	DK	78.6	79.0	79.0	79.2	79.3	79.4	79.8	80.2	80.5	80.7	80.6	81.0
Life expectancy at 45 - females	DK	35.0	35.4	35.2	35.5	35.6	35.6	35.9	36.4	36.6	36.8	36.6	37.1
Life expectancy at 65 - females	DK	18.0	18.3	18.1	18.3	18.3	18.2	18.5	19.0	19.1	19.2	19.2	19.5
Healthy Life Years at birth - females	DK	60,7(e)	61,3(e)	60.8	61.9	60.4	61,0(e)	60,9(e)	68,80(bi)	68.2	67.1	67.4	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	DE	74.1	74.6	74.8	75.1	75.6	75.7	75.8	76.5	76.7	77.2	77.4	77.6
Life expectancy at 45 - males	DE	31.4	31.7	32.0	32.2	32.5	32.6	32.7	33.3	33.4	33.8	34.0	34.2
Life expectancy at 65 - males	DE	15.2	15.4	15.6	15.8	16.1	16.2	16.2	16.7	16.9	17.2	17.4	17.6
Healthy Life Years at birth - males	DE	61,9(e)	62,1(e)	62,3(e)	63,2(e)	64,1(e)	64,4(e)	65,0(e)	:	55(bi)	58.5	58.8	
Life expectancy at birth - females	DE	80.5	80.8	81.0	81.2	81.5	81.3	81.3	81.9	82.0	82.4	82.7	82.7
Life expectancy at 45 - females	DE	36.9	37.1	37.3	37.5	37.6	37.5	37.5	38.0	38.1	38.5	38.7	38.6
Life expectancy at 65 - females	DE	19.1	19.3	19.4	19.6	19.8	19.6	19.6	20.1	20.1	20.5	20.7	20.7
Healthy Life Years at birth - females	DE	64,3(e)	64,3(e)	64,3(e)	64,6(e)	64,5(e)	64,5(e)	64,7(e)	:	55,10(bi)	58.0	58.4	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	EE	64.2	63.9	64.7	65.2	64.8	65.2	66.1	66.4	67.3	67.4	67.2	68.7
Life expectancy at 45 - males	EE	24.9	24.2	25.0	25.1	24.8	25.2	25.6	25.7	26.2	26.2	26.2	27.2
Life expectancy at 65 - males	EE	12.5	12.2	12.5	12.6	12.6	12.7	12.7	13.0	13.1	13.2	13.1	13.6
Healthy Life Years at birth - males	EE	:	:	:	:	:	:	:	49,8(bi)	48.0	49.4	49.5	
Life expectancy at birth - females	EE	75.9	75.4	76.0	76.2	76.4	77.0	77.1	77.8	78.1	78.6	78.8	79.5
Life expectancy at 45 - females	EE	33.3	32.9	33.5	33.5	33.7	33.9	34.1	34.6	35.0	35.1	35.5	36.0
Life expectancy at 65 - females	EE	16.8	16.5	17.0	17.0	17.3	17.3	17.4	17.8	18.0	18.3	18.5	18.9
Healthy Life Years at birth - females	EE	:	:	:	:	:	:	:	53,30(bi)	52.2	53.7	54.6	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**IE**	73.4	73.4	73.4	74.0	74.5	75.2	75.9	76.4	77.3	77.4	77.4	77.5
Life expectancy at 45 - males	**IE**	30.7	30.9	30.8	31.5	31.9	32.4	33.0	33.4	34.1	34.2	34.3	34.5
Life expectancy at 65 - males	**IE**	14.0	14.2	14.1	14.6	15.0	15.4	15.9	16.2	16.8	16.8	17.1	17.2
Healthy Life Years at birth - males	**IE**	63.2	64.0	63.9	63.3	63.3	63,5(e)	63,4(e)	62,5(bi)	62.9	63.2	62.7	
Life expectancy at birth - females	**IE**	78.7	79.1	78.9	79.2	79.9	80.5	80.8	81.4	81.7	82.2	82.1	82.3
Life expectancy at 45 - females	**IE**	35.2	35.5	35.3	35.7	36.4	36.9	37.0	37.6	37.9	38.2	38.1	38.4
Life expectancy at 65 - females	**IE**	17.6	17.8	17.6	18.0	18.5	18.9	19.2	19.6	19.9	20.3	20.1	20.4
Healthy Life Years at birth - females	**IE**	:	:	67.6	66.9	66.5	65,9(e)	65,4(e)	64,30(bi)	64.1	65.0	65.3	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**EL**	75.4	75.4	75.5	75.5	76.0	76.2	76.5	76.6	76.8	77.2	77.1	77.7
Life expectancy at 45 - males	**EL**	32.9	32.8	32.9	32.8	33.2	33.4	33.5	33.7	34.0	34.3	34.2	34.6
Life expectancy at 65 - males	**EL**	16.2	16.2	16.2	16.1	16.5	16.6	16.7	16.9	17.1	17.5	17.4	17.8
Healthy Life Years at birth - males	**EL**	66.4	66.5	66.7	66.3	66.7	66,7(e)	66,7(e)	63,7(bi)	65.7	66.3	65.9	
Life expectancy at birth - females	**EL**	80.4	80.3	80.5	80.6	81.0	81.1	81.2	81.3	81.6	81.9	81.8	82.4
Life expectancy at 45 - females	**EL**	36.8	36.7	36.8	36.8	37.2	37.2	37.2	37.5	37.8	37.9	37.9	38.3
Life expectancy at 65 - females	**EL**	18.4	18.3	18.4	18.4	18.7	18.8	18.7	19.0	19.2	19.4	19.4	19.8
Healthy Life Years at birth - females	**EL**	68.7	68.3	69.4	68.2	68.8	68,5(e)	68,4(e)	65,20(bi)	67.2	67.9	67.1	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**ES**	75.2	75.3	75.3	75.8	76.2	76.3	76.3	76.9	77.0	77.7	77.8	78.0
Life expectancy at 45 - males	**ES**	32.8	32.8	32.7	33.2	33.4	33.5	33.5	34.0	34.0	34.6	34.6	34.7
Life expectancy at 65 - males	**ES**	16.4	16.2	16.2	16.7	16.9	16.9	16.8	17.3	17.3	17.9	17.8	18.0
Healthy Life Years at birth - males	**ES**	65.5	65.2	65.6	66.5	66.0	66,6(e)	66,8(e)	62,5(bi)	63.2	63.7	63.2	
Life expectancy at birth - females	**ES**	82.3	82.4	82.4	82.9	83.2	83.2	83.0	83.7	83.7	84.4	84.3	84.3
Life expectancy at 45 - females	**ES**	38.8	38.7	38.7	39.2	39.4	39.4	39.2	39.9	39.7	40.4	40.4	40.4
Life expectancy at 65 - females	**ES**	20.5	20.4	20.3	20.8	21.0	21.0	20.8	21.5	21.3	22.0	22.0	21.9
Healthy Life Years at birth - females	**ES**	68.2	68.2	69.5	69.3	69,2(e)	69,9(e)	70,2(e)	62,50(bi)	63.1	63.3	62.9	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**FR**	:	74.8	75.0	75.3	75.5	75.7	75.8	76.7	76.7	77.3	77.6	:
Life expectancy at 45 - males	**FR**	:	32.4	32.6	32.9	33.0	33.1	33.1	33.9	33.9	34.4	34.6	:
Life expectancy at 65 - males	**FR**	:	16.5	16.6	16.8	17.0	17.0	17.0	17.7	17.7	18.2	18.4	:
Healthy Life Years at birth - males	**FR**	60.2	59.2	60.1	60.1	60.5	60,4(e)	60,6(e)	61,2(bi)	62.0	62.7	63.1	
Life expectancy at birth - females	**FR**	:	82.6	82.7	83.0	83.0	83.0	82.7	83.8	83.8	84.5	84.8	:
Life expectancy at 45 - females	**FR**	:	39.1	39.2	39.4	39.4	39.3	39.0	40.1	40.0	40.7	41.0	:
Life expectancy at 65 - females	**FR**	:	21.2	21.2	21.4	21.5	21.4	21.1	22.1	22.0	22.7	23.0	:
Healthy Life Years at birth - females	**FR**	63.1	62.8	63.3	63,2(e)	63.3	63,7(e)	63,9(e)	64,10(bi)	64.3	64.1	64.2	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**IT**	75.8	76.0	76.5	76.9	77.1	77.4	77.1	77.9	78.0	78.5	:	:
Life expectancy at 45 - males	**IT**	33.0	33.1	33.5	33.8	34.0	34.2	34.0	34.7	34.8	35.2	:	:
Life expectancy at 65 - males	**IT**	16.2	16.2	16.5	16.7	16.9	17.0	16.8	17.5	17.4	17.9	:	:
Healthy Life Years at birth - males	**IT**	68.0	67.9	68.7	69.7	69.8	70,4(e)	70,9(e)	68,4(bi)	65.7	64.7	62,8(e)	
Life expectancy at birth - females	**IT**	82.0	82.1	82.6	82.8	83.1	83.2	82.8	83.8	83.6	84.2	:	:
Life expectancy at 45 - females	**IT**	38.4	38.4	38.8	39.0	39.2	39.3	38.8	39.9	39.6	40.1	:	:
Life expectancy at 65 - females	**IT**	20.2	20.3	20.5	20.7	21.0	21.0	20.6	21.6	21.3	21.8	:	:
Healthy Life Years at birth - females	**IT**	71.3	71.3	72.1	72.9	73,0(e)	73,9(e)	74,4(e)	70,70(bi)	66.5	64.1	62(e)	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**CY**	74.9	74.7	76.0	75.4	76.6	76.4	76.9	76.6	76.8	78.4	77.9	78.5
Life expectancy at 45 - males	**CY**	32.8	32.4	33.5	32.8	33.9	33.7	33.8	33.7	34.2	35.1	34.9	35.4
Life expectancy at 65 - males	**CY**	15.7	15.3	16.5	15.9	16.8	16.3	16.5	16.6	16.8	17.4	17.4	17.9
Healthy Life Years at birth - males	**CY**	:	:	:	:	:	:	68.4	:	59,5(bi)	64.3	63.0	
Life expectancy at birth - females	**CY**	80.0	79.8	79.9	80.1	81.4	81.0	81.3	81.9	80.9	82.2	82.2	83.1
Life expectancy at 45 - females	**CY**	36.5	36.2	36.6	36.6	37.6	37.4	37.4	37.8	37.6	38.1	38.4	38.9
Life expectancy at 65 - females	**CY**	18.2	18.0	18.3	18.3	19.2	19.0	19.1	19.4	19.1	19.5	19.6	20.4
Healthy Life Years at birth - females	**CY**	:	:	:	:	:	:	69.6	:	57,90(bi)	63.2	62.7	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**LV**	:	:	:	:	:	64.7	65.6	65.9	65.4	65.4	65.8	67.0
Life expectancy at 45 - males	**LV**	:	:	:	:	:	24.9	25.3	25.4	25.0	24.9	25.2	26.1
Life expectancy at 65 - males	**LV**	:	:	:	:	:	12.5	12.6	12.6	12.5	12.7	12.8	13.0
Healthy Life Years at birth - males	**LV**	:	:	:	:	:	:	:	:	50,6(bi)	50.5	50.9	
Life expectancy at birth - females	**LV**	:	:	:	:	:	76.0	75.9	76.2	76.5	76.3	76.5	77.8
Life expectancy at 45 - females	**LV**	:	:	:	:	:	33.5	33.2	33.7	33.8	33.5	33.7	34.6
Life expectancy at 65 - females	**LV**	:	:	:	:	:	17.0	16.8	17.1	17.2	17.3	17.2	17.9
Healthy Life Years at birth - females	**LV**	:	:	:	:	:	:	:	:	53,10(bi)	52.2	53.7	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**LT**	65.5	66.0	66.3	66.8	65.9	66.2	66.4	66.3	65.3	65.3	64.9	66.3
Life expectancy at 45 - males	**LT**	26.0	26.2	26.4	26.7	26.2	26.1	26.2	26.1	25.3	25.1	24.8	25.8
Life expectancy at 65 - males	**LT**	13.2	13.3	13.4	13.7	13.5	13.3	13.3	13.4	13.0	13.0	12.9	13.4
Healthy Life Years at birth - males	**LT**	:	:	:	:	:	:	:	:	51,2(bi)	52.4	53.4	
Life expectancy at birth - females	**LT**	76.6	76.7	77.0	77.5	77.6	77.5	77.8	77.7	77.3	77.0	77.2	77.6
Life expectancy at 45 - females	**LT**	34.1	34.1	34.5	34.8	34.7	34.6	34.8	34.7	34.3	34.2	34.4	34.6
Life expectancy at 65 - females	**LT**	17.3	17.4	17.6	17.9	17.9	17.8	18.1	17.9	17.6	17.6	17.9	18.1
Healthy Life Years at birth - females	**LT**	:	:	:	:	:	:	:	:	54,30(bi)	56.1	57.7	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**LU**	74.0	73.7	74.4	74.6	75.1	74.7	74.8	76.0	76.7	76.8	76.7	78.1
Life expectancy at 45 - males	**LU**	31.2	31.2	31.8	32.0	32.5	32.3	31.9	33.1	33.4	33.5	33.3	34.6
Life expectancy at 65 - males	**LU**	14.8	15.2	15.3	15.5	16.0	15.9	15.3	16.5	16.7	17.0	16.4	17.4
Healthy Life Years at birth - males	**LU**	:	:	:	:	:	:	:	59,1(bi)	62.2	61.0	62.2	
Life expectancy at birth - females	**LU**	80.0	80.8	81.4	81.3	80.7	81.5	80.9	82.4	82.3	81.9	82.2	83.1
Life expectancy at 45 - females	**LU**	36.7	37.3	37.5	37.7	37.4	37.7	37.0	38.5	38.4	38.0	38.1	39.0
Life expectancy at 65 - females	**LU**	19.2	19.5	19.9	20.1	19.7	20.1	18.9	20.5	20.4	20.3	20.3	21.0
Healthy Life Years at birth - females	**LU**	:	:	:	:	:	:	:	60,20(bi)	62.1	61.8	64.6	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**HU**	66.7	66.5	66.7	67.6	68.2	68.3	68.4	68.7	68.7	69.2	69.4	70.0
Life expectancy at 45 - males	**HU**	25.4	25.3	25.3	26.0	26.4	26.4	26.3	26.6	26.4	26.8	26.9	27.3
Life expectancy at 65 - males	**HU**	12.5	12.6	12.5	13.0	13.2	13.2	13.0	13.4	13.3	13.7	13.7	14.0
Healthy Life Years at birth - males	**HU**	:	:	:	:	:	:	53,5(p)	:	52(bi)	54.2	55.0	
Life expectancy at birth - females	**HU**	75.5	75.6	75.6	76.2	76.7	76.7	76.7	77.2	77.2	77.8	77.8	78.3
Life expectancy at 45 - females	**HU**	32.7	32.8	32.6	33.2	33.5	33.6	33.5	33.8	33.8	34.3	34.3	34.7
Life expectancy at 65 - females	**HU**	16.3	16.4	16.2	16.8	17.0	17.0	16.9	17.3	17.2	17.7	17.8	18.1
Healthy Life Years at birth - females	**HU**	:	:	:	:	:	:	57,8(p)	:	53,90(bi)	57.0	57.6	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**MT**	75.2	74.9	75.3	76.2	76.6	76.3	76.4	77.4	77.3	77.0	77.5	77.1
Life expectancy at 45 - males	**MT**	32.1	32.0	32.1	32.7	33.4	33.0	33.2	34.1	33.8	33.6	34.4	34.3
Life expectancy at 65 - males	**MT**	14.6	14.6	15.0	15.1	15.7	15.3	15.6	16.3	16.2	16.1	16.7	17.0
Healthy Life Years at birth - males	**MT**	:	:	:	:	:	65,1(p)	:	:	68,5(bi)	68.1	69.0	
Life expectancy at birth - females	**MT**	80.1	80.0	79.4	80.3	81.2	81.3	80.8	81.2	81.4	81.9	82.2	82.3
Life expectancy at 45 - females	**MT**	36.6	36.3	35.9	36.5	37.0	37.3	36.9	37.4	37.5	37.7	38.5	38.4
Life expectancy at 65 - females	**MT**	18.4	18.1	17.8	18.5	18.7	19.1	18.7	19.1	19.4	19.5	20.3	20.1
Healthy Life Years at birth - females	**MT**	:	:	:	:	:	65,7(p)	:	:	70,10(bi)	69.2	70.8	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**NL**	75.2	75.2	75.4	75.6	75.8	76.0	76.3	76.9	77.3	77.7	78.1	78.4
Life expectancy at 45 - males	**NL**	32.0	32.0	32.1	32.3	32.6	32.7	32.9	33.5	33.8	34.2	34.5	34.8
Life expectancy at 65 - males	**NL**	15.1	15.1	15.2	15.4	15.6	15.6	15.8	16.3	16.4	16.8	17.1	17.4
Healthy Life Years at birth - males	**NL**	62.5	61.9	61.6	61.4	61.9	61,7(e)	61,7(e)	:	65(bi)	65.0	65.7	
Life expectancy at birth - females	**NL**	80.7	80.8	80.5	80.7	80.8	80.7	81.0	81.5	81.7	82.0	82.5	82.5
Life expectancy at 45 - females	**NL**	37.0	37.1	36.9	37.0	37.1	37.0	37.2	37.7	37.9	38.1	38.6	38.5
Life expectancy at 65 - females	**NL**	19.3	19.4	19.2	19.3	19.4	19.4	19.5	19.9	20.1	20.3	20.7	20.7
Healthy Life Years at birth - females	**NL**	61.4	61,1(e)	61.4	60.2	59.4	59,3(e)	58,8(e)	:	63,10(bi)	63.2	63.7	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**AT**	74.1	74.5	74.9	75.2	75.7	75.8	75.9	76.4	76.7	77.2	77.4	77.8
Life expectancy at 45 - males	**AT**	31.4	31.7	32.0	32.4	32.8	32.8	32.9	33.4	33.6	34.0	34.2	34.5
Life expectancy at 65 - males	**AT**	15.2	15.4	15.7	16.0	16.3	16.3	16.4	16.8	17.0	17.3	17.5	17.7
Healthy Life Years at birth - males	**AT**	62.2	63.4	63.6	64.6	64.2	65,6(e)	66,2(e)	58,1(bi)	57.8	58.4	58.4	
Life expectancy at birth - females	**AT**	80.7	81.0	81.0	81.2	81.7	81.7	81.5	82.1	82.2	82.8	83.1	83.3
Life expectancy at 45 - females	**AT**	37.0	37.3	37.3	37.5	37.9	37.8	37.7	38.2	38.4	38.8	39.0	39.3
Life expectancy at 65 - females	**AT**	19.1	19.4	19.4	19.6	20.0	19.8	19.7	20.2	20.3	20.7	21.0	21.1
Healthy Life Years at birth - females	**AT**	:	:	:	68.0	68.5	69,0(e)	69,6(e)	60,20(bi)	59.6	60.8	61.1	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**PL**	68.5	68.9	68.8	69.6	70.0	70.3	70.5	70.6	70.8	70.9	71.0	71.3
Life expectancy at 45 - males	**PL**	27.1	27.4	27.3	27.9	28.1	28.4	28.4	28.5	28.7	28.8	28.8	29.1
Life expectancy at 65 - males	**PL**	13.2	13.4	13.3	13.6	13.7	13.9	13.9	14.2	14.3	14.5	14.6	14.8
Healthy Life Years at birth - males	**PL**	:	:	:	:	:	62.5	:	:	61(bi)	58.2	57.4	
Life expectancy at birth - females	**PL**	77.0	77.4	77.5	78.0	78.4	78.8	78.8	79.2	79.3	79.7	79.8	80.0
Life expectancy at 45 - females	**PL**	33.9	34.2	34.3	34.7	35.0	35.3	35.3	35.6	35.8	36.1	36.2	36.4
Life expectancy at 65 - females	**PL**	16.8	17.1	17.1	17.5	17.7	18.0	18.0	18.4	18.5	18.8	19.0	19.1
Healthy Life Years at birth - females	**PL**	:	:	:	:	:	68.9	:	:	66,60(bi)	62.5	61.3	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**PT**	72.2	72.4	72.6	73.2	73.5	73.8	74.2	75.0	74.9	75.5	75.9	76.2
Life expectancy at 45 - males	**PT**	31.0	31.1	31.3	31.6	31.9	31.9	32.0	32.6	32.5	32.9	33.1	33.3
Life expectancy at 65 - males	**PT**	14.9	15.0	15.0	15.4	15.7	15.7	15.7	16.3	16.1	16.6	16.8	16.9
Healthy Life Years at birth - males	**PT**	59.3	59.1	58.8	60.2	59.5	59,7(e)	59,8(e)	55,1(bi)	58.4	59.6	58.3	
Life expectancy at birth - females	**PT**	79.3	79.6	79.7	80.2	80.5	80.6	80.6	81.5	81.3	82.3	82.2	82.4
Life expectancy at 45 - females	**PT**	36.3	36.4	36.5	36.9	37.1	37.2	37.0	37.9	37.6	38.5	38.4	38.6
Life expectancy at 65 - females	**PT**	18.4	18.5	18.5	18.9	19.1	19.2	19.0	19.7	19.4	20.2	20.2	20.3
Healthy Life Years at birth - females	**PT**	60.4	61.1	60.7	62.2	62.7	61,8(e)	61,8(e)	52,00(bi)	56.7	57.6	57.3	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	RO	65.2	66.3	67.1	67.7	67.5	67.4	67.7	68.3	68.7	69.2	69.7	69.7
Life expectancy at 45 - males	RO	25.8	26.4	26.9	27.3	27.0	26.7	26.8	27.3	27.4	27.7	28.1	28.0
Life expectancy at 65 - males	RO	12.7	13.0	13.0	13.4	13.3	12.9	13.1	13.3	13.4	13.6	13.9	14.0
Healthy Life Years at birth - males	RO	:	:	:	:	:	:	:	:	:	:	60.4	
Life expectancy at birth - females	RO	73.3	73.8	74.2	74.8	74.9	74.7	75.0	75.5	75.7	76.2	76.9	77.2
Life expectancy at 45 - females	RO	31.8	32.1	32.3	32.7	32.7	32.4	32.7	33.1	33.1	33.5	33.9	34.2
Life expectancy at 65 - females	RO	15.3	15.5	15.5	15.9	16.0	15.7	15.8	16.2	16.2	16.5	16.9	17.2
Healthy Life Years at birth - females	RO	:	:	:	:	:	:	:	:	:	:	62.4	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	SI	71.1	71.3	71.8	72.2	72.3	72.6	72.5	73.5	73.9	74.5	74.7	75.5
Life expectancy at 45 - males	SI	29.0	29.1	29.3	29.7	29.8	30.0	29.8	30.7	31.1	31.6	31.8	32.4
Life expectancy at 65 - males	SI	14.0	13.9	14.1	14.2	14.5	14.5	14.3	15.0	15.2	15.9	15.9	16.4
Healthy Life Years at birth - males	SI	:	:	:	:	:	:	:	:	56,3(bi)	57.6	58.7	
Life expectancy at birth - females	SI	79.1	79.2	79.5	79.9	80.4	80.5	80.3	80.8	80.9	82.0	82.0	82.6
Life expectancy at 45 - females	SI	35.5	35.6	35.8	36.2	36.5	36.6	36.5	37.0	37.1	38.0	38.1	38.5
Life expectancy at 65 - females	SI	18.0	18.1	18.3	18.7	19.0	19.0	18.8	19.4	19.3	20.1	20.2	20.5
Healthy Life Years at birth - females	SI	:	:	:	:	:	:	:	:	59,90(bi)	61.0	62.3	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	SK	68.9	68.6	69.0	69.2	69.5	69.8	69.8	70.3	70.2	70.4	70.6	70.8
Life expectancy at 45 - males	SK	27.0	26.9	27.1	27.2	27.3	27.5	27.6	28.0	27.8	28.0	28.1	28.5
Life expectancy at 65 - males	SK	12.9	12.8	13.0	12.9	13.0	13.2	13.2	13.3	13.3	13.3	13.6	13.8
Healthy Life Years at birth - males	SK	:	:	:	:	:	:	:	:	54,9(bi)	54.3	55.4	
Life expectancy at birth - females	SK	76.9	77.0	77.4	77.5	77.7	77.7	77.7	78.0	78.1	78.4	78.4	79.0
Life expectancy at 45 - females	SK	33.7	33.8	34.0	34.1	34.1	34.3	34.3	34.5	34.5	34.8	34.9	35.3
Life expectancy at 65 - females	SK	16.5	16.6	16.8	16.7	16.8	16.9	16.9	17.1	17.1	17.3	17.5	17.8
Healthy Life Years at birth - females	SK	:	:	:	:	:	:	:	:	56,40(bi)	54.4	55.9	

3. Disability free Life expectancy (+ Life expectancy at 0, 45, 65) by country, 1995-2008 Source: Eurostat – Demography database

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**FI**	73.5	73.6	73.8	74.2	74.6	74.9	75.2	75.4	75.6	75.9	76.0	76.5
Life expectancy at 45 - males	**FI**	31.0	31.0	31.2	31.7	32.0	32.1	32.3	32.6	32.8	33.1	33.2	33.7
Life expectancy at 65 - males	**FI**	15.0	15.0	15.2	15.5	15.7	15.8	16.2	16.5	16.8	16.9	17.0	17.5
Healthy Life Years at birth - males	**FI**	55.5	55.9	55.8	56.3	56.7	57,0(e)	57,3(e)	53,1(bi)	51.7	52.9	56.7	
Life expectancy at birth - females	**FI**	80.7	81.0	81.2	81.2	81.7	81.6	81.9	82.5	82.5	83.1	83.1	83.3
Life expectancy at 45 - females	**FI**	37.0	37.3	37.5	37.5	37.8	37.8	38.0	38.6	38.8	39.2	39.2	39.3
Life expectancy at 65 - females	**FI**	19.1	19.3	19.5	19.5	19.8	19.8	20.0	20.7	21.0	21.2	21.3	21.4
Healthy Life Years at birth - females	**FI**	57.6	58.3	57.4	56,8(e)	56.9	56,8(e)	56,5(e)	52,90(bi)	52.4	52.7	58.0	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**SE**	76.8	76.9	77.1	77.4	77.6	77.8	78.0	78.4	78.5	78.8	79.0	:
Life expectancy at 45 - males	**SE**	33.4	33.6	33.8	34.1	34.2	34.3	34.5	34.9	34.9	35.2	35.4	:
Life expectancy at 65 - males	**SE**	16.3	16.4	16.5	16.8	16.9	16.9	17.1	17.5	17.4	17.7	17.9	:
Healthy Life Years at birth - males	**SE**	62.1	61.7	62.0	63.1	61.9	62,4(e)	62,5(e)	62(bi)	64.2	67.1	67.5	
Life expectancy at birth - females	**SE**	82.0	82.1	82.0	82.0	82.2	82.2	82.5	82.8	82.9	83.1	83.1	:
Life expectancy at 45 - females	**SE**	38.1	38.2	38.0	38.0	38.2	38.1	38.5	38.8	38.8	39.0	39.0	:
Life expectancy at 65 - females	**SE**	20.1	20.2	20.1	20.2	20.2	20.1	20.4	20.7	20.7	20.9	20.8	:
Healthy Life Years at birth - females	**SE**	60.0	61,3(e)	61.8	61.9	61.0	61,9(e)	62,2(e)	60,90(bi)	63.1	67.1	66.6	

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth - males	**UK**	74.7	74.8	75.0	75.5	75.8	76.0	76.2	76.8	77.1	77.3	77.6	:
Life expectancy at 45 - males	**UK**	31.8	32.0	32.1	32.6	32.9	33.1	33.2	33.8	34.0	34.3	34.6	:
Life expectancy at 65 - males	**UK**	15.1	15.3	15.4	15.8	16.1	16.2	16.3	16.8	17.0	17.4	17.6	:
Healthy Life Years at birth - males	**UK**	60,9(e)	60,8(e)	61,2(e)	61,3(e)	61,1(e)	61,4(e)	61,5(e)	:	63,2(bi)	65.0	64,8(e)	
Life expectancy at birth - females	**UK**	79.7	79.8	79.9	80.3	80.5	80.6	80.5	81.0	81.2	81.7	81.8	:
Life expectancy at 45 - females	**UK**	36.1	36.2	36.2	36.7	36.9	36.9	36.8	37.3	37.4	38.0	38.0	:
Life expectancy at 65 - females	**UK**	18.5	18.6	18.6	19.0	19.2	19.2	19.1	19.4	19.6	20.1	20.2	:
Healthy Life Years at birth - females	**UK**	61,2(e)	62,2(e)	61,3(e)	61,2(e)	60,8(e)	60,9(e)	60,9(e)	:	65,00(bi)	65.1	66,2(e)	

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

		EU27	EU25	BE	BG	CZ	DK	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SL	SK	FI	SE	UK
2000	total	17,6e	17,2e	13.8	:	:	11.7	14.6	15.1	:	18.2	29.1	13.3	25.1	18.5	:	16.5	16.8	13.9	54.2	15.4	10.2	:	43,6p	22.9	:	:	9,0i	7.3	18.2
	female	15,5e	15,0e	11	:	:	10.4	14.9	11,0u	:	13.6	23.2	11.9	21.7	13.9	:	12.8	17.6	13.4	56.1	14.1	10.7	:	36,3p	22	:	:	6,5i	5.8	17.5
	male	19,6e	19,3e	16.4	:	:	12.8	14.4	19.4	:	22.9	35	14.8	28.5	25	:	20	15.9	14.4	52.5	16.6	9.6	:	50,9p	23.8	:	:	11,5i	8.7	18.8
2004	total	16.1	15.7	13,1b	21.4	6.3	8.8	12.1	13.1	13.1	14.7	32	12.8	22.3	20.6	14.7	10,5b	12.7	12.6	42,1b	14.1	9,5i	5,6b	39,4p	22,4b	4,3u	6.8	10,0i	9.2	12,1i
	female	13.8	13.3	10,8b	20.6	6.6	7.1	11.9	7,8u	10	11.3	25.1	10.8	18.3	14.9	9.5	8,6u	12.7	11.5	39,8b	11.7	8,8i	3,9b	31,0p	21,1b	2,5u	6.3	7,5i	7.8	11,2i
	male	18.4	18.1	15,4b	22.2	6.1	10.5	12.2	18.6	16	18.1	38.7	14.7	26.5	27.2	19.8	12,4u	12.6	13.6	44,3b	16.4	10,2i	7,3b	47,7p	23,7b	6,0u	7.3	12,5i	10.6	13,0i
2005	total	15.8	15.5	12.9	20.4	6.2	8.7	13,5b	13.4	12.5	13.6	30,8b	12.2	22	18,2b	14.4	8.1	13.3	12.5	38.9	13.5	9.1	5.3	38,8p	19.6	4,9u	6.3	10,3i	10,8b	11.6
	female	13.7	13.3	10.5	20.3	6.3	6.9	13,7b	:u	9.5	9.7	24,9b	10.3	18.2	10,4b	10.4	5,6u	9.6	11.3	35.5	11.1	8.7	3.7	30,7p	19.1	3,2u	5.9	8,2i	9,7b	10.6
	male	17.8	17.6	15.3	20.6	6.1	10.5	13,3b	17,1u	15.4	17.6	36,6b	14.1	25.8	27,2b	18.2	10,7u	17	13.7	42.1	15.9	9.6	6.8	46,7p	20.1	6,5u	6.7	12,4i	11,9b	12.6
2006	total	15.5	15.4	12.6	17.3	5.1	9.1	13.6	13.5	12.1	15.5	30.5	12.4	20.6	14.9	14.8	8.2	14	12.6	39.9	12.6	9.8	5.4	39,1p	17.9	5.6	6.6	9,7i	12,4p	11.3
	female	13.4	13.1	10	17	4.9	7.7	13.3	:u	9	10.8	24	10.6	17.1	8.2	10.4	5,8u	10.4	11.4	36.8	10.1	9.7	3.9	31,3p	18	4,0u	5.8	7,8i	11,3p	10.2
	male	17.6	17.6	15.1	17.7	5.4	10.5	13.9	19,8u	15.3	20.2	36.7	14.4	23.9	22.5	18.9	10,5u	17.6	13.8	42.8	15.1	10	6.9	46,6p	17.8	7,1u	7.3	11,8i	13,5p	12.3
2007	total	15.1	14.9	12.1	14.9	5.2	12,5b	12.5	14.4	11.6	14.6	31	12.6	19.7	12.5	15.1	7.4	12.5	11.4	38.3	11.7	10.7	5	36,9p	17.3	4,1u	6.5	9,1i	11,4p	16,6b
	female	13	12.7	10.3	14.7	4.7	9,1b	11.8	:u	8.4	10.6	25.2	10.3	16.4	6.8	10.1	5,1u	8,4u	10.1	34.9	9.3	10.1	3.8	30,4p	17.4	2,2u	5.8	7,2i	10,0p	15,6b
	male	17.1	17.1	13.9	15.2	5.7	15,7b	13.1	21.7	14.7	18.6	36.6	15.1	22.9	19.5	20	9,6u	16.6	12.6	41.3	14	11.4	6.2	43,1p	17.1	5,8u	7.2	11,2i	12,6p	17,6b
2008	total	14.9	14.8	12	14.8	5.6	11.5	11.8	14	11.3	14.8	31.9	11.8	19.7	13.7	15.5	7.4	13.4	11.7	39	11.4	10.1	5	35,4p	15.9	5,1u	6	9,8i	11,1p	17
	female	12.9	12.6	10.6	15.5	5.4	9.2	11.2	8,2u	8	10.9	25.7	9.8	16.7	9.5	10.7	4,7u	10,9u	10.9	36.1	8.8	9.8	3.9	28,6p	16	2,6u	4.9	7,7i	9,9p	15.6
	male	16.9	17	13.4	14.1	5.8	13.7	12.4	19.8	14.6	18.5	38	13.8	22.6	19	20.2	10,0u	15.8	12.5	41.7	14	10.4	6.1	41,9p	15.9	7,2u	7.1	12,1i	12,3p	18.3

Source: Eurostat, Labour Force Survey u = data lack reliability due to low sample size / : = not available or unreliable data / b = break / p = provisional

The results for SE are provisional from 2005 as some revisions are foreseen for the variable on educational attainment and on the variable measuring participation in education and training

Due to changes in the survey characteristics or the transition to annual averages after the year 2000, data lack comparability with former years in DE and CY (from 2005)

EN

EN

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)

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	SI	SK	FI	SE	UK
2001	Children	10,1e	10,0e	11.9	19.6	7.8	:	9.6	11.5	32.1	5.5	6.6	9.5	6.9	3.4	11.3	:	3.3	13.7	7.4	5.8	3.8	:	3.8	8	3.8	9.8	:	:	17
	Adults (18-59)																													
	Total	10,2e	10,1e	13.3	17.7	7.8	:	9.8	11.3	13.4	9.4	7.5	10.2	10.4	5	13.1	11.4	6.6	13.2	7.6	6.9	7.8	13.6	4.4	9.4	8.1	10.1	:	:	11.2
	Men	8,9e	8,8e	11.1	17.1	6.2	:	9	11.4	9.6	7	6.7	8.8	8.7	3.5	12.4	11.5	5.3	12	5.6	5.4	6.1	12.8	3.7	8.5	7	9.6	:	:	9.1
	Women	11,5e	11,4e	15.5	18.3	9.4	:	10.7	11.2	17.2	11.7	8.3	11.5	12.1	6.4	13.6	11.4	8.1	14.4	9.6	8.4	9.4	14.4	5.1	10.3	9.2	10.6	:	:	13.3
2002	Children	10,2e	10,0e	13.1	19.4	7.7	5.7	10.3	11	11.1	5.3	6.5	9.1	7	3.2	10.1	8.1	3.6	14.4	7.8	5.8	3.7	:	4.3	10,7b	3.6	11.6	:	:	17.4
	Adults (18-59)																													
	Total	10,4e	10,2e	14	17.1	7.3	8.4	10.3	10.5	8.8	9.4	7.5	10.1	10	5.2	10.3	8.9	7.1	13	7.9	6.8	7.3	15	4.8	11,8b	8.2	10.5	:	:	11.2
	Men	9,1e	8,9e	11.7	16.8	5.5	7.9	9.7	10.7	7.5	7.1	6.8	8.8	8.4	4.1	8.6	8.7	5.5	11.7	6	6.3	5.9	14.1	4.1	10.4	7.1	10	:	:	9
	Women	11,6e	11,4e	16.4	17.5	9.1	8.8	10.9	10.3	10	11.7	8.2	11.4	11.6	6.4	10.1	9.1	7.9	14	9.6	8	8.8	15.9	5.4	12,9b	9.2	11.1	:	:	13.3
2003	Children	10,2e	10,1e	13.2	17.9	8.6	5.7	11.1	8.4	11.8	4.6	6.2	9	6.9	2.6	8.1	7.5	3.9	13	8.8	6.8	4.1	:	4.7	10.3	3.9	11.8	5.7	:	17.1
	Adults (18-59)																													
	Total	10,4e	10,2e	14.4	15.9	7.7	9.4	10.9	10.2	9.1	9	7.3	10.1	9.6	5.1	8.8	8.2	7.5	11.7	8.5	7.8	6.8	15	5.3	11.5	8.8	10.3	11	:	11
	Men	9,2e	9,0e	12.4	15.5	5.8	8.8	10.3	10.8	7.7	6.8	6.7	8.9	8.1	4.1	8.6	8.1	6.5	11	6.7	6.5	5.4	14	4.7	10.4	7.9	9.6	11.6	:	8.9
	Women	11,5e	11,4e	16.3	16.2	9.7	10	11.5	9.7	10.4	11.3	8	11.3	11.2	5.9	8.9	8.3	9	12.5	10.4	9.1	8.1	16	5.9	12.6	9.7	11	10.3	:	13
2004	Children	10,1e	9,9e	13	16.5	9.1	6	11.4	8.7	11.8	4.7	6.2	8.9	5,9b	2.7	8.1	7.1	3.4	13.1	9.2	7.1	5,2b	:	4.4	12.2	3.5	12.7	5.7	:	16.4
	Adults (18-59)																													
	Total	10,4e	10,2e	13.8	14.4	8	9.4	11.1	9.7	8.6	9.1	7.2	10.2	9,4b	5.1	8.1	7.8	7.1	12	8.8	7.9	8,2b	15.5	5.3	11.8	7.7	10.5	11.1	:	11
	Men	9,3e	9,2e	11.6	14	6.3	9.2	10.8	10.3	7.2	6.8	6.6	9	8,1b	4	8	7.9	5.7	11.2	7	6.6	6,8b	14.5	4.9	11	7	9.8	11.2	:	9
	Women	11,4e	11,3e	16	14.8	9.7	9.5	11.4	9.1	10	11.3	7.9	11.3	10,8b	6.2	8.2	7.7	8.5	12.8	10.8	9.1	9,5b	16.5	5.7	12.6	8.5	11.2	10.9	:	12.9
2005	Children	9,9e	9,7e	12.8	15.7	8.2	5.7	11,0b	8.8	11.9	4.2	5,6b	8.8	5.9	3.6	8	6.1	2.7	14.1	9.1	6.7	5.9	:	4.6	11.3	3.1	13.9	6.6	:	16.5
	Adults (18-59)																													
	Total	10,3e	10,1e	13.7	13.7	7.4	8.6	11,0b	8.6	8.3	8.9	6,6b	10.3	9.8	5.3	8.5	6.8	6.7	12.3	8.2	7.9	8.4	14.8	5.7	11.3	7.1	10.3	10.5	:	10.9
	Men	9,2e	9,1e	11.7	13.3	5.9	8.4	10,7b	9.7	6.9	6.7	6,1b	9.2	8.4	4.3	8.7	7.1	5.4	11.5	6.3	6.8	7.3	13.5	5.3	10.3	6.4	9.6	11	:	8.9
	Women	11,3e	11,2e	15.7	14.1	8.9	8.7	11,2b	7.5	9.8	11.1	7,1b	11.5	11.1	6.2	8.3	6.6	8.1	13	10.1	9.1	9.4	16	6.1	12.2	7.8	11	10	:	12.8
2006	Children	9.8	9.7	12.7	15	8.1	5	10.6	6.9	11.2	3.9	5.3	9.3	5.7	3.9	7.1	6.8	3.7	13.7	9.3	6.4	6	11.1	4.6	10.3	3.4	12.1	4.9	:	16.5
	Adults (18-59)																													
	Total	9.8	9.7	13.6	12.1	7.2	7.7	10.5	6.6	7.8	8.1	6.3	10.5	9.5	5.2	6.7	6.9	7.1	11.8	7.9	7.4	7.6	13.2	5.8	10.3	7.4	9.5	9.5	:	10.8
	Men	8.8	8.7	11.8	11.6	5.7	7.1	10.2	6.5	6.5	6	5.8	9.4	8.1	4.3	6.9	7.3	5.4	10.8	6	6.1	6.5	11.9	5.2	9.3	6.4	8.8	10.1	:	8.8
	Women	10.9	10.8	15.4	12.6	8.6	8.3	10.8	6.6	9.2	10.3	6.8	11.6	10.9	6.1	6.6	6.6	8.9	12.7	9.8	8.6	8.7	14.4	6.3	11.2	8.5	10.1	9	:	12.7
2007	Children	9.4	9.3	12	12.8	8	5.3	9.6	7.2	11.5	3.9	5.3	8.8	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	9.3	9.2	12.3	10.2	6.5	8.1	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	8.2	8.1	10.6	10.1	4.9	7.6	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	10.3	10.3	13.9	10.3	8.1	8.5	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
2008	Children	9.2	9.2	11.3	11	7.4	3.3	9.3	6.8	13.1	3.6	6.5	8.5	6.7	3.9	7.6	9.9	3.6	14.6	8.7	4.8	5.3	8.2	4.7	9.9	2.6	8.6	4.1	:	16.4
	Adults (18-59)																													
	Total	9.2	9.1	12	9	6	6.8	9	6.2	9.2	7.5	7.4	9.8	9.6	4.9	6.4	9	7.9	12.5	8.1	5.9	7	10.1	5.5	10.5	6.4	7.5	8.1	:	10.7
	Men	8.2	8.1	10.4	8.7	4.5	6.4	8.6	6.6	8.1	5.7	7.2	8.8	8.3	4.7	6.2	9.1	7.2	11.5	6.5	4.9	6	8.7	5.2	9.6	5.7	7	8.3	:	8.9
	Women	10.1	10.1	13.6	9.4	7.6	7.2	9.4	5.8	10.3	9.3	7.7	10.8	10.9	5.2	6.5	9	8.6	13.4	9.8	6.9	8	11.5	5.8	11.5	7.1	8.1	7.8	:	12.5

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

Due to changes in the survey characteristics, data lack comparability with former years in BG (from 2001), LV and LT (from 2002), RO (from 2002), LU (from 2003), HU (from 2003) and AT (from 2004: implementation of a continuous survey covering all weeks of the reference quarter).

Source : Eurostat, Labour Force Survey

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/publications/publication14994_en.pdf   (Table A 134 – The cost of ageing overview)

	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
2007	23.1	26.5	16.6	17.9	24.8	23.6	14.3	17.2	22.1	19.3	28.4	26	15.4	13.2	15.8	20	21.6	18.2	20.5	26	20.5	24.5	13.1	22.5	15.2	24.2	24.2	24.2
Change 2007 - 2020	0.5	1.7	-0.1	-0.7	2.6	0	0.2	1.4	1.9	1.4	0.9	0.3	1.3	-0.7	-0.7	1.2	-0.3	2.3	2.1	0.3	-2.7	0.8	2	1.8	-0.7	3	-0.3	0.8
Change 2007 - 2060	4.7	6.9	3.7	5.5	2.6	4.8	0.4	8.9	15.9	9	2.7	1.6	10.8	0.4	5.4	18	4.1	10.2	9.4	3.1	-2.4	3.4	10.1	12.1	5.2	6.3	2.6	5.1

7a. Relative median income ratio of people aged 65+ (relative to the complementary age group 0-64) (%), 2008

	EU27	EU25	BE	BG	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Relative median income ratio (65+/0-Total 64)	0,84p	0,85p	0.74	0.66	0.79	0.7	0.65	0.87	0.62	0.73	0.86	0.78	0,96b	0.88	0.58	0.54	0.71	0.97	1	0.75	0.84	0.92	0.97	0.83	0.85	0.84	0.79	0.71	0.75	0,71p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008); (1) with imputed rent data 2007 (see methodological note).
 : = not available or unreliable data / b = break / p = provisional / e: estimate
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.

7b. Aggregate replacement ratio (%), 2008

		EU27	EU25	BE	BG	CZ	DK	DK[1]	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL[2]	AT	PL	PT	RO	SI	SK	FI	SE	UK[2]
Aggregate replacement ratio (Pensions 65-74 /Earnings 50-59)	Total	0,49p	0,5p	0.45	0.34	0.51	0.41	0.41	0.44	0.45	0.43	0.41	0.48	0,66b	0.51	0.32	0.3	0.44	0.58	0.59	0.44	0.43	0.68	0.56	0.51	0.49	0.44	0.54	0.48	0.59	0,41p
	Men	0,53p	0,53p	0.44	0.37	0.48	0.38	0.38	0.47	0.37	0.4	0.48	0.53	0,69b	0.58	0.37	0.25	0.45	0.54	0.6	0.47	0.48	0.65	0.65	0.65	0.54	0.5	0.54	0.47	0.62	0,42p
	Women	0,49p	0,49p	0.47	0.36	0.55	0.44	0.44	0.48	0.55	0.54	0.44	0.47	0,58b	0.39	0.36	0.34	0.46	0.59	0.6	0.45	0.51	0.69	0.53	0.49	0.45	0.4	0.55	0.48	0.55	0,44p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008); (1) with imputed rent data 2007 (see methodological note).
 : = not available or unreliable data / b = break / p = provisional / e: estimate
EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.
(2) Pensions from individual insurance private plans are not included, if included ratio for NL and UK would be higher

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 2008

	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
1st quintile	6.6	1.4	41.6	1	0.4	7.1	14.2	5.3	10	0.1	3.6	9.2	9.2	26.2	10.2	1.4	5.2	1.2	0.4	1	10.6	18.7	20.7	0.4	3.9	1	4.1	1.2
2nd quintile	4.6	0	19.6	0.6	0.2	4.9	9.4	2.1	6.9	0	1.8	6	4.8	13.8	7.8	0.3	3.7	1.5	0.3	0.7	8.7	11.7	16.9	0.2	1.2	1	3.7	1.6
3rd quintile	3.2	0.3	14.6	1.1	0.5	2.8	7.5	2.7	5.7	0.2	0.8	3.5	2.4	11.1	6.9	0.1	2.2	0.7	0.5	0.9	6.5	9.6	13.1	0.1	0.8	0.3	3.3	1.4
4th quintile	2.5	0	10.2	0.5	0.1	2.3	6.8	1.4	4.1	0.2	0.6	3.1	1.9	8	6.6	0.5	1.6	0.7	0.1	0.3	5.6	7.3	8.4	0.2	0.6	0.2	2.9	1.5
5th quintile	1.6	0	8.1	0.6	0.1	1.2	8	0.9	1.1	0.2	0.2	1.9	0.4	4.9	5	0.3	0.9	0.1	0.3	0.4	4.8	2.3	3.2	0	0.5	0.1	2.1	1.4

Source: SILC(2008)
* 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), 2008

		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	12p	13p	15	:	6	11	8	13	5	10	19	16	12b	18	9	7	5	14	9	11	8	13	8	17	:	9	5	11	8	15p
	Men	12p	13p	14	:	6	11	9	13	6	10	18	15	11b	17	8	7	5	13	10	11	8	12	9	17	:	8	5	11	8	14p
	Women	13p	14p	16	:	6	11	8	14	5	10	19	17	13b	20	11	7	5	15	9	12	8	14	8	18	:	10	5	11	9	16p
Children aged 0-17	Total	15p	16p	17	:	10	9	8	13	6	12	21	20	16b	24	7	8	7	20	14	15	9	16	12	21	:	8	9	9	8	17p
People aged 18-64	Total	11p	12p	13	:	6	11	10	14	6	10	17	13	12b	16	6	7	5	13	9	9	7	11	8	15	:	8	4	10	8	12p
	Men	11p	12p	11	:	5	11	10	13	6	9	17	13	11b	15	5	6	6	13	9	8	7	11	9	14	:	8	5	11	9	11p
	Women	12p	13p	14	:	6	11	10	14	5	10	18	14	12b	17	7	7	5	14	10	10	8	12	8	16	:	7	4	9	8	13p
People aged 65+	Total	14p	15p	22	:	3	16	3	13	3	9	20	21	9b	20	32	8	2	6	3	17	7	16	4	19	:	17	2	17	9	23p
	Men	12p	13p	21	:	1	14	3	11	1	10	19	20	8b	17	27	4	2	5	2	18	7	12	3	17	:	9	1	12	6	20p
	Women	15p	16p	22	:	4	17	4	15	4	9	22	22	10b	23	36	10	2	6	4	16	7	18	4	21	:	22	2	21	11	25p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008); [1] BG, RO (:) data not available; [2] with imputed rent (see methodological note).
: = not available or unreliable data / b = break / p = provisional / e: estimate
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	36.2	35.8	22.9	:	37.1	52.0	37.7	50.2	41.7	39.0	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	63.0	49.0
	male	47.0	46.6	32.1	:	53.2	61.3	47.2	62.0	60.2	56.0	52.6	32.5	41.4	:	48.1	54.4	35.2	27.0	:	47.5	40.5	41.5	62.9b	59.5	31.8	39.1	38.4	66.1	59.1
	female	26.1	25.5	14.0	:	22.9	42.0	28.3	41.6	23.1	23.5	18.8	24.4	15.0	:	27.5	28.3	15.5	9.6	:	20.3	17.1	24.1	38.0b	44.5	16.1	9.4	34.1	60.0	39.2
2000	total	36.9	36.6	26.3	20.8	36.3	55.7	37.6	46.3	45.3	39.0	37.0	29.9	27.7	49.4	36.0	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	50.7
	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	56.0	32.3	35.4	42.9	67.8	60.1
	female	27.4	26.9	16.6	10.3	22.4	46.6	29.0	39.0	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	41.7
2002	total	38.5	38.7	26.6	27.0	40.8	57.9	38.9	51.6	48.0	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	68.0	53.4
	male	48.4	48.8	36.0	37.0	57.2	64.5	47.3	58.4	65.0	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	24.0	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	40.7	41.0	30.0	32.5	42.7	60.3	41.8	52.4	49.5	39.4	41.3	37.8	30.5b	49.9	47.9	47.1	30.4	31.1	31.5	45.2	28.8b	26.2	50.3	36.9	29.0	26.8	50.9	69.1	56.2
	male	50.4	50.8	39.1	42.2	57.2	67.3	50.7	56.4	65.0	56.4	58.9	41.7	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	31.8	21.1	24.2	29.4	53.3	33.0	49.4	33.7	24.0	24.6	34.2	19.6b	30.0	41.9	39.3	22.2	25.0	11.5	33.4	19.3b	19.4	42.5	31.4	17.8	12.6	50.4	67.0	47.0
2006	total	43.5	43.6	32.0	39.6	45.2	60.7	48.4	58.5	53.1	42.3	44.1	38.1	32.5	53.6	53.3	49.6	33.2	33.6	29.8	47.7	35.5	28.1	50.1	41.7	32.6	33.1	54.5	69.6	57.3
	male	52.7	52.8	40.9	49.5	59.5	67.1	56.4	57.5	67.0	59.2	60.4	40.4	43.7	71.6	59.5	55.7	38.7	41.4	49.4	58.0	45.3	38.4	58.2	50.0	44.5	49.8	54.8	72.3	66.0
	female	34.9	35.0	23.2	31.1	32.1	54.3	40.6	59.2	39.1	26.6	28.7	35.8	21.9	36.6	48.7	45.1	27.8	27.1	10.8	37.2	26.3	19.0	42.8	34.5	21.0	18.9	54.3	66.9	49.0
2007	total	44.6	44.8	34.4	42.6	46.0	58.6	51.5	60.0	53.8	42.4	44.6	38.2	33.8	55.9	57.7	53.4	32.0	33.1	28.5	50.9	38.6	29.7	50.9	41.4	33.5	35.6	55.0	70.0	57.4
	male	53.9	54.1	42.9	51.8	59.6	64.9	59.7	59.4	67.9	59.1	60.0	40.4	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	35.9	36.1	26.0	34.5	33.5	52.4	43.6	60.5	39.6	26.9	30.0	36.0	23.0	40.3	52.4	47.9	28.6	26.2	11.6	40.1	28.0	19.4	44.0	33.6	22.2	21.2	55.0	67.0	48.9
2008	total	45.6	45.7	34.5	46.0	47.6	57.0	53.8	62.4	53.6	42.8	45.6	38.2	34.4	54.8	59.4	53.1	34.1	31.4	29.2	53.0	41.0	31.6	50.8	43.1	32.8	39.2	56.5	70.1	58.0
	male	55.0	55.0	42.8	55.8	61.9	64.3	61.8	65.2	66.0	59.1	60.9	40.5	45.5	70.9	63.1	60.2	38.7	38.5	46.4	63.7	51.8	44.1	58.5	53.0	44.7	56.7	57.1	73.4	67.3
	female	36.8	36.9	26.3	37.7	34.4	49.8	46.1	60.3	41.0	27.5	31.1	36.0	24.0	39.4	56.7	47.8	29.3	25.7	12.5	42.2	30.8	20.7	43.9	34.4	21.1	24.2	55.8	66.7	49.0

b= break in data series / : = data not available
Source: Eurostat - Labour Force Survey, Annual averages.

11. In work at-risk-of-poverty rate after social transfers by gender (Age 18+), 2008

		EU27	EU25	BE	BG	CZ	DK	DK(1)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
	Total	8p	8p	5	7	4	5	6	7	7	6	14	11	7b	9	6	11	9	9	5	5	5	6	12	12	17	5	6	5	7	9p
In work	Men	9p	8p	4	8	3	6	6	6	6	7	16	12	7b	11	6	11	9	9	6	6	5	6	12	12	19	6	6	5	7	8p
	Women	8p	8p	5	7	4	4	5	7	9	6	12	9	6b	6	7	11	10	10	4	2	5	6	10	11	15	4	5	5	6	9p

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008);[1] with imputed rent data 2007 (see methodological note).
 : = not available or unreliable data / b = break / p = provisional / e: estimate
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	75.5
	Male	77.2	77.5	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	82.9
	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	68.2
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	75.3
	Male	76.8	77.4	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	82.4
	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	69.8	70.3	66.7	62.1	70.4	79.8	74.3b	70.1	70.8	66.8	69.7b	70.0	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	75.4
	Male	77.3	77.9	73.9	67.0	78.4	83.6	80.6b	73.6	80.6	79.2	80.9b	75.3	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	82.0
	Female	62.4	62.8	59.5	57.3	62.4	75.9	68.0b	66.9	60.8	54.5	58.3b	64.8	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	70.3	70.7	66.5	64.5	70.3	80.6	75.3	72.4	71.8	67.0	70.8	69.9	62.7	73.0	71.3	67.4	66.7	62.0	57.6	77.4	73.7	63.4	73.9	63.6	70.9	68.6	75.2	78.8	75.7
	Male	77.6	78.1	73.4	68.8	78.3	84.1	81.3	75.8	81.5	79.1	81.3	75.0	74.6	82.7	76.2	70.5	75.3	68.7	78.1	83.9	80.5	70.1	79.5	70.7	74.9	76.4	77.1	81.2	82.3
	Female	63.0	63.4	59.5	60.2	62.3	77.0	69.3	69.3	61.9	55.0	60.2	64.9	50.8	63.8	66.7	64.6	58.2	55.5	36.5	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	70.0	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	74.8	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	63.3	63.7	60.4	62.1	61.5	76.4	70.1	68.7	63.3	54.9	61.4	65.3	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
2008	Total	70.9	71.4	67.1	67.8	69.7	80.8	76.5	74.0	72.0	67.1	72.6	70.1	63.0	73.6	74.4	68.4	66.8	61.5	58.8	79.3	75.0	63.8	74.2	62.9	71.8	68.8	76.0	79.3	75.8
	Male	78.0	78.4	73.3	72.5	78.1	84.4	82.1	78.3	80.7	79.1	81.8	74.8	74.4	82.0	78.6	71.4	74.7	68.3	76.9	85.3	81.4	70.9	79.5	70.6	75.8	76.4	77.9	81.7	82.4
	Female	63.9	64.3	60.8	63.1	61.0	77.1	70.8	70.1	63.1	55.1	63.2	65.6	51.6	65.7	70.5	65.5	58.7	55.0	40.2	73.3	68.6	57.0	68.9	55.2	67.5	61.3	73.9	76.9	69.4

Source : Eurostat - Labour Force Survey, Annual averages.

b= break in data series / : = data not available

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	13.0	:	7.9	:	5.8	:	5.4	-	:	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	12.1	:	8.7	6.9	5.6	:	6.0	-	:	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	5.9
2005	11.9	:	8.4	7.2	5.5	:	5.6	-	:	4.3	8.3	7.2	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	7.4	16.0	-	-	-	-	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

: not available; - not applicable or real zero or zero by default

Source : Eurostat - Labour Force Survey, Annual averages

14. Total health expenditure per capita PPS

	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		1219	:	503	1387	1588	:	709	766	783	1301	1221	:	:	:	:	:	:	1272	1453	261	561	:	:	:	1227	1433	864
1991		1353	:	492	1447	:	:	805	794	866	1412	1339	:	:	:	:	520	:	1380	1562	314	669	:	:	:	1367	1437	955
1992		1442	:	520	1524	1808	:	922	890	941	1508	1393	:	:	:	:	563	:	1468	1677	335	735	:	:	:	1379	1483	1057
1993		1454	:	690	1594	1792	:	934	977	976	1575	1379	:	:	:	:	565	:	1505	1786	334	771	:	:	:	1252	1493	1087
1994		1485	:	733	1667	1911	:	1003	1102	999	1627	1382	:	:	:	:	637	:	1543	1923	337	800	:	:	:	1233	1496	1165
1995		1553	:	754	1569	1907	:	1009	1059	1000	1762	1289	:	:	:	1602	553	:	1508	1858	344	868	:	:	:	1242	1463	1131
1996		1628	:	777	1676	2032	:	1084	1102	1058	1831	1366	:	:	:	1686	558	:	1578	1932	405	945	:	:	:	1315	1577	1216
1997		1683	:	788	1761	2062	:	1192	1158	1110	1902	1477	:	:	:	1686	580	:	1638	2065	425	1014	:	:	381	1373	1612	1272
1998	1516	1748	:	793	1863	2127	:	1284	1184	1184	1977	1566	:	:	:	1784	654	:	1759	2202	479	1036	:	:	381	1426	1697	1335
1999	1604	1883	:	812	1973	2243	:	1406	1270	1255	2073	1626	:	:	:	2063	701	:	1884	2336	496	1150	:	:	354	1513	1843	1452
2000	1713	2071	:	854	2071	2326	:	1572	1262	1338	2214	1787	:	:	:	2224	742	:	2035	2459	507	1314	:	:	371	1614	1989	1596
2001	1813	2133	:	929	2165	2411	:	1827	1507	1405	2334	1901	:	:	:	2350	833	:	2194	2468	551	1346	:	:	397	1689	2154	1720
2002	1924	2295	:	1021	2304	2510	:	2023	1680	1492	2497	1900	:	:	:	2634	952	:	2421	2613	626	1417	:	:	440	1833	2305	1873
2003	1906	2663	526	1131	2393	2609	566	2131	1715	1705	2524	1920	1250	:	:	3853	1099	:	2607	2707	633	1542	323	1497	486	1867	2400	1964
2004	1992	2786	547	1167	2571	2660	639	2318	1762	1791	2623	2020	1247	:	623	4229	1116	:	2773	2860	680	1611	368	1565	670	2030	2494	2153
2005	2091	2832	600	1217	2639	2804	696	2371	1971	1899	2766	2123	1301	694	697	4377	1205	:	2876	2894	717	1759	405	1647	954	2127	2487	2255
2006	2195	2877	624	1258	2795	2887	786	2500	2122	2052	2849	2227	1363	:	810	:	1243	:	2990	2975	767	1832	408	1719	1101	2213	2635	2404
2007	2205	:	:	:	:	:	:	2844	2265	:	:	2232	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	2486

Source: OECD health data and Eurostat

AMECO PPS

Context 1: Growth rate of GDP volume - 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	10.0	9.4	4.5	5.0	3.9	3.7	5.0	6.9	3.3	8.4	4.9	:	3.9	3.7	4.3	3.9	2.4	4.4	1.4	5.1	4.4	3.9
2006	3.2	3.2	2.8	6.3	6.8	3.4	3.2	10.0	5.4	4,5(p)	4.0	2.2	2.0	4.1	12.2	7.8	5.6	4.0	3.5	3.4	3.5	6.2	1.4	7.9	5.8	8.5	4.9	4.2	2.9
2007	2.9	2.8	2.9	6.2	6.1	1.7	2.5	7.2	6.0	4,5(p)	3.6	2.3	1.6	5.1	10.0	9.8	6.5	1.0	4.0	3.6	3.5	6.8	1.9	6.3	6.8	10.6	4.2	2.5	2.6
2008	0.8	0.7	1.0	6.0	2.5	-0.9	1.3	-3.6	-3.0	2,0(p)	0.9	0.4	-1.0	3.6	-4.6	2.8	0.0	0.6	2.1	2.0	2.0	5.0	0.0	7.3	3.5	6.2	1.0	-0.2	0.5
2009f	-4.1	-4.1	-2.9	-5.9	-4.8	-4.5	-5.0	-13.7	-7.5	-1.1	-3.7	-2.2	-4.7	-0.7	-18.0	-18.1	-3.6	-6.5	-2.2	-4.5	-3.7	1.2	-2.9	-8.0	-7.4	-5.8	-6.9	-4.6	-4.6
2010f	0.7	0.7	0.6	-1.1	0.8	1.5	1.2	-0.1	-1.4	-0.3	-0.8	1.2	0.7	0.1	-4.0	-3.9	1.1	-0.5	0.7	0.3	1.1	1.8	0.3	0.5	1.3	1.9	0.9	1.4	0.9
2011f	1.6	1.6	1.5	3.1	2.3	1.8	1.7	4.2	2.6	0.7	1.0	1.5	1.4	1.3	2.0	2.5	1.8	3.1	1.6	1.6	1.5	3.2	1.0	2.6	2.0	2.6	1.6	2.1	1.9

Source : Eurostat, Annual national accounts; forecast for 2009, 2010, 2011

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	105.0	126.1	27.8	68.5	131.6	118.5	45.0	130.9	84.1	97.4	115.4	116.9	88.8	36.7	39.3	243.7	55.3	83.6	134.3	131.4	48.3	78.0	26.1	79.8	50.1	117.2	126.7	119.0
2006	100	103.9	117.7	36.5	77.0	124.2	116.1	65.1	145.5	93,0p	104.6	108.8	104.2	90.7	51.6	55.3	272.2	63.2	76.8	131.2	124.4	51.9	76.4	38.4	87.6	63.4	115.0	121.1	120.3
2007	100	103.7	115.7	37.7	80.1	121.3	115.8	68.8	148.1	92,8p	105.0	108.5	103.4	93.6	55.7	59.3	275.2	62.6	76.4	132.2	122.8	54.4	75.6	41.6	88.6	67.7	118.0	122.8	116.7
2008	100	103.4	115.1	41.3	80.3	120.1	115.6	67.4	135.4	94,3p	102.6	107.9	102.0	95.8	57.3	61.9	276.3	64.4	76.3	134.0	123.3	56.4	76.0	48.0	90.9	72,2e	117.2	120.0	116.2
2009f	100	:	115.6	38.3	78.0	114.4	112.7	58.7	132.7	95.4	101.0	107.3	96.0	94.3	46.3	51.6	260.5	59.8	77.6	128.5	122.4	57.9	74.6	43.1	87.1	67.8	109.4	116.0	113.7
2010f	100	:	115.1	38.0	78.2	115.6	113.8	58.5	130.2	94.5	99.0	107.7	96.0	93.3	44.6	49.8	259.8	59.4	77.3	128.0	122.9	58.8	74.5	43.3	87.9	68.8	109.7	117.0	113.5
2011f	100	:	114.5	38.8	78.7	115.9	114.3	60.1	131.6	93.4	97.9	107.3	95.6	92.4	45.1	50.6	257.9	60.4	76.9	127.8	122.7	59.8	74.1	43.9	88.2	68.8	109.7	117.8	113.3

Source: Eurostat, Annual national accounts; forecast for 2009, 2010, 2011

f = forecast / : = not available or unreliable data / b = break / p = provisional / e: estimate

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
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	71.2
	male	70.8	71.3	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	77.8
	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	64.7
2002	total	62.4	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	71.4
	male	70.4	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	77.7
	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	63.0	63.4	60.3	54.2	64.2	75.7	65.0	63.0	66.3	59.4	61.1	63.8	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	71.7
	male	70.4	71.0	67.9	57.9	72.3	79.7	70.8	66.4	75.9	73.7	73.8	69.5	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	77.9
	female	55.6	55.8	52.6	50.6	56.0	71.6	59.2	60.0	56.5	45.2	48.3	58.3	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	63.5	64.0	61.1	55.8	64.8	75.9	66,0b	64.4	67.6	60.1	63,3b	63.7	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	70.8	71.4	68.3	60.0	73.3	79.8	71,3b	68.2	76.9	74.2	75,2b	69.2	69.9	79.2	66.1	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	77.7
	female	56.3	56.6	53.8	51.7	56.3	71.9	60,6b	62.1	58.3	46.1	51,2b	58.4	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	65.8
2006	total	64.5	64.8	61.0	58.6	65.3	77.4	67.5	68.1	68.6	61.0	64.8	63.7	58.4	69.6	66.3	63.6	63.6	57.3	53.6	74.3	70.2	54.5	67.9	58.8	66.6	59.4	69.3	73.1	71.6
	male	71.6	72.1	67.9	62.8	73.7	81.2	72.8	71.0	77.7	74.6	76.1	68.9	70.5	79.4	70.4	66.3	72.6	63.8	73.3	80.9	76.9	60.9	73.9	64.6	71.1	67.0	71.4	75.5	77.5
	female	57.3	57.6	54.0	54.6	56.8	73.4	62.2	65.3	59.3	47.4	53.2	58.6	46.3	60.3	62.4	61.0	54.6	51.1	33.4	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	64.3	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	64.8	74.8	81.0	74.7	73.2	77.4	74.9	76.2	69.2	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	59.7	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
2008	total	65.9	66.3	62.4	64.0	66.6	78.1	70.7	69.8	67.6	61.9	64.3	64.9	58.7	70.9	68.6	64.3	63.4	56.7	55.3	77.2	72.1	59.2	68.2	59.0	68.6	62.3	71.1	74.3	71.5
	male	72.8	73.2	68.6	68.5	75.4	81.9	75.9	73.6	74.9	75.0	73.5	69.6	70.3	79.2	72.1	67.1	71.5	63.0	72.5	83.2	78.5	66.3	74.0	65.7	72.7	70.0	73.1	76.7	77.3
	female	59.1	59.4	56.2	59.5	57.6	74.3	65.4	66.3	60.2	48.7	54.9	60.4	47.2	62.9	65.4	61.8	55.1	50.6	37.4	71.1	65.8	52.4	62.5	52.5	64.2	54.6	69.0	71.8	65.8

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
2000	Total	8.7	8.6	6.9	16.4	8.7	4.3	7.5	12.8	4.3	11.2	11.1	9.0	10.1	4.9	13.7	16.4	2.2	6.4	6.7	2.8	3.6	16.1	4.0	7.3	6.7	18.8	9.8	5.6	5.4
	Males	7.8	7.6	5.6	16.7	7.3	3.9	7.5	13.8	4.4	7.4	7.9	7.5	7.8	3.2	14.4	18.6	1.8	7.0	6.4	2.2	3.1	14.4	3.2	8.0	6.5	18.9	9.1	5.9	5.9
	Females	9.8	9.9	8.5	16.2	10.3	4.8	7.5	11.7	4.2	17.1	16.0	10.8	13.6	7.2	12.9	14.1	2.9	5.6	7.4	3.6	4.3	18.2	5.0	6.5	7.0	18.6	10.6	5.3	4.8
2002	Total	8.9	8.8	7.5	18.2	7.3	4.6	8.4	10.3	4.5	10.3	11.1	8.6	8.6	3.6	12.2	13.5	2.6	5.8	7.5	2.8	4.2	20.0	5.1	8.6	6.3	18.7	9.1	6.1	5.1
	Males	8.3	8.1	6.7	18.9	6.4	4.3	8.8	10.8	4.7	6.8	8.1	7.7	6.7	2.9	13.3	14.2	2.0	6.2	6.6	2.5	4.0	19.2	4.2	9.2	5.9	18.6	9.1	6.4	5.7
	Females	9.7	9.7	8.6	17.3	9.0	5.0	7.9	9.7	4.1	15.7	15.7	9.7	11.5	4.5	10.9	12.7	3.5	5.4	9.3	3.1	4.4	21.0	6.1	7.9	6.8	18.7	9.1	5.8	4.5
2004	Total	9.1	9.1	8.4	12.1	8.3	5.5	9.8	9.7	4.6	10.5	10.6	9.3	8.0	4.7	10.4	11.4	5.0	6.1	7.4	4.6	4.9	19.0	6.7	8.1	6.3	18.2	8.8	7.7	4.7
	Males	8.5	8.4	7.5	12.6	7.1	5.1	10.3	10.4	4.9	6.6	8.0	8.4	6.4	3.6	10.6	11.0	3.6	6.1	6.6	4.3	4.5	18.2	5.9	9.1	5.9	17.4	8.7	7.9	5.1
	Females	9.8	9.9	9.5	11.5	9.9	6.0	9.1	8.9	4.1	16.2	14.3	10.3	10.5	6.0	10.2	11.8	6.8	6.1	9.0	4.8	5.4	20.0	7.7	6.9	6.9	19.2	8.9	7.5	4.2
2005	Total	8.9	9.0	8.5	10.1	7.9	4.8	10.7	7.9	4.4	9.9	9.2	9.3	7.7	5.3	8.9	8.3	4.6	7.2	7.2	4.7	5.2	17.8	7.7	7.2	6.5	16.3	8.4	7.7	4.8
	Males	8.3	8.3	7.6	10.3	6.5	4.4	11.2	8.8	4.6	6.1	7.1	8.4	6.2	4.3	9.1	8.2	3.6	7.0	6.4	4.5	4.9	16.6	6.8	7.8	6.1	15.5	8.2	7.8	5.2
	Females	9.6	9.8	9.5	9.8	9.8	5.3	10.1	7.1	4.0	15.3	12.2	10.3	10.0	6.5	8.7	8.3	6.0	7.4	8.9	5.1	5.5	19.2	8.8	6.4	7.1	17.2	8.6	7.7	4.3
2006	Total	8.2	8.2	8.3	9.0	7.2	3.9	9.8	5.9	4.5	8.9	8.5	9.2	6.8	4.6	6.8	5.6	4.6	7.5	7.1	3.9	4.8	13.9	7.8	7.3	6.0	13.4	7.7	7.1	5.4
	Males	7.6	7.5	7.4	8.7	5.8	3.3	10.2	6.2	4.6	5.6	6.3	8.4	5.4	4.0	7.4	5.8	3.6	7.2	6.3	3.5	4.3	13.0	6.6	8.2	4.9	12.3	6.9	6.9	5.8
	Females	8.9	9.0	9.3	9.3	8.9	4.5	9.5	5.6	4.2	13.6	11.6	10.1	8.8	5.4	6.2	5.4	6.0	7.8	8.7	4.4	5.2	14.9	9.1	6.1	7.2	14.7	8.1	7.3	4.9
2007	Total	7.1	7.2	7.5	6.9	5.3	3.8	8.4	4.7	4.6	8.3	8.3	8.4	6.1	4.0	6.0	4.3	4.2	7.4	6.4	3.2	4.4	9.6	8.1	6.4	4.9	11.1	6.9	6.2	5.3
	Males	6.6	6.6	6.7	6.5	4.2	3.5	8.5	5.4	4.9	5.2	6.4	7.8	4.9	3.4	6.4	4.3	3.4	7.1	5.9	2.8	3.9	9.0	6.7	7.2	4.0	9.9	6.5	5.9	5.6
	Females	7.8	7.9	8.5	7.3	6.7	4.2	8.3	3.9	4.2	12.8	10.9	9.0	7.9	4.6	5.6	4.3	5.1	7.7	7.5	3.6	5.0	10.4	9.7	5.4	5.9	12.7	7.2	6.5	5.0
2008	Total	7.0	7.1	7.0	5.6	4.4	3.3	7.3	5.5	6.0	7.7	11.3	7.8	6.7	3.6	7.5	5.8	4.9	7.8	5.9	2.8	3.8	7.1	7.7	5.8	4.4	9.5	6.4	6.2	5.6
	Males	6.6	6.6	6.5	5.5	3.5	3.0	7.4	5.8	7.1	5.1	10.1	7.3	5.5	3.1	8.0	6.1	4.1	7.6	5.6	2.5	3.6	6.4	6.6	6.7	4.0	8.4	6.1	5.9	6.1
	Females	7.5	7.6	7.6	5.8	5.6	3.7	7.2	5.3	4.6	11.4	13.0	8.4	8.5	4.2	6.9	5.6	5.9	8.1	6.6	3.0	4.1	8.0	9.0	4.7	4.8	10.9	6.7	6.6	5.1

Source: Eurostat - LFS adjusted series, Annual average
p = provisional value / 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
2000	Total	17.4	17	16.7	33.7	17.8	6.2	7.5	23.9	6.9	29.1	24.3	19.6	27	10.1	21.4	30.6	6.6	12.4	13.7	5.7	5.3	35.1	8.6	20	16.3	36.9	21.4	10.5	12.2
	Males	16.6	16.1	14.5	36.1	18.5	6.6	8.8	23.8	6.8	21.5	18.1	17.6	23.1	6.9	21.2	32.3	6	13.6	14.9	4.9	4.7	33.4	6.2	22.2	14.6	39.7	21.1	11	13.2
	Females	18.2	18.1	19.5	30.7	17	5.7	6.2	24.1	7.1	38.1	32.5	21.9	31.9	13	21.6	28.3	7.2	10.8	12.3	6.5	6	37.1	11.6	17.2	18.3	33.8	21.6	9.9	11
2002	Total	18	17.5	17.7	37	16.9	7.4	9.1	17.6	8.5	26.8	24.2	19.3	23.1	8.1	22	22.4	7	12.7	17.1	5	6.7	42.5	11.6	23.2	16.5	37.7	21	16.6	12
	Males	17.9	17.3	17.2	40.1	16.6	7.3	11.4	14.3	9.2	19.9	19.2	17.8	19.4	7.9	20.4	22.6	5.8	13.2	17.6	5.2	6.4	41.9	9.8	24.3	15	39.5	21.2	17.7	13.7
	Females	18.1	17.8	18.3	33.2	17.2	7.5	6.7	22.5	7.6	35.3	31.1	21.1	27.8	8.3	24.2	22.2	8.6	11.9	16.7	4.8	7.1	43.3	13.9	21.8	18.6	35.5	20.9	15.5	10.2
2004	Total	18.5	18.3	21.2	25.8	21	8.2	11.9	21.7	8.9	26.9	23.9	20.6	23.5	10.5	18.1	22.7	16.4	15.5	16.8	8	9.7	39.6	15.3	21.9	16.1	33.1	20.7	21.5	12.1
	Males	18.4	18	20.2	27	22.2	8.9	13.7	21.2	9.3	19.1	19.4	19.9	20.6	9.4	16	22.5	12	16.2	16.3	7.9	9.3	37.7	13.5	24.2	13.9	34.7	22	22.5	13.3
	Females	18.7	18.6	22.4	24.3	19.5	7.4	10	22.4	8.5	36.3	30.1	21.5	27.2	11.6	21.3	22.9	21.5	14.4	17.4	8.1	10.2	41.9	17.6	18.9	19.2	31	19.4	20.6	10.7
2005	Total	18.3	18.2	21.5	22.3	19.2	8.6	14.2	15.9	8.6	26	19.7	21.1	23.9	13	13.6	15.7	14.3	19.4	16.2	8.2	10.3	36.9	16.1	20.2	15.9	30.1	20.1	22.9	12.8
	Males	18.3	18.1	21	23.4	19.3	8.6	15.8	16.6	9.1	18.7	16.7	20	21.5	11.9	11.8	15.9	12.3	19.6	16.6	8	10.7	35.7	13.6	21.6	14.5	31	20.6	23	14.4
	Females	18.4	18.4	22.1	21	19.1	8.6	12.4	14.9	8	34.8	23.4	22.4	27.4	14.2	16.2	15.3	16.9	19	15.8	8.4	9.9	38.3	19.1	18.4	17.8	28.8	19.5	22.8	11.1
2006	Total	17.1	16.9	20.5	19.5	17.5	7.7	12.8	12	8.6	25.2	17.9	22.1	21.7	10.5	12.2	9.8	15.8	19.1	16.5	6.6	9.1	29.8	16.3	21.4	13.9	26.6	18.7	21.6	14
	Males	16.9	16.7	18.8	18.9	16.6	7.9	14.2	10	9.1	17.7	15	20.9	19.1	9.9	9.9	10	16.3	18.6	17.8	6.1	8.9	28.3	14.5	22.3	11.6	26.4	19	21.1	15.7
	Females	17.4	17.3	22.6	20.3	18.7	7.5	11.3	14.7	8.1	34.7	21.6	23.7	25.3	11.2	14.7	9.6	15.2	19.8	14.9	7.1	9.3	31.6	18.4	20.2	16.8	27	18.4	22.1	12
2007	Total	15.3	15.2	18.8	15.1	10.7	7.9	11.1	10	9	22.9	18.2	19.6	20.3	10.1	10.7	8.2	15.6	18	13.8	5.9	8.7	21.7	16.6	20.1	10.1	20.3	16.5	19.3	14.3
	Males	15.1	14.9	17.1	14.5	10.6	8.2	12.2	12.1	9.9	15.7	15.2	18.9	18.2	10.7	11.2	7	13.7	17.6	15.7	5.6	8.3	20	13.5	21.1	9.4	20.4	16.4	18.9	15.8
	Females	15.6	15.5	20.9	15.9	11	7.5	10	7.1	8	32.1	21.9	20.3	23.3	9.5	10	10	18.2	18.6	11.6	6.2	9.1	23.8	20.3	18.7	11.2	20.2	16.6	19.8	12.5
2008	Total	15.4	15.4	18	12.7	9.9	7.6	9.9	12	12.7	22.1	24.6	19.1	21.2	8.8	13.1	13.4	17.3	19.9	11.9	5.3	8	17.3	16.4	18.6	10.4	19	16.5	20.3	15
	Males	15.6	15.5	17.3	13.7	9.8	6.9	10.7	12.6	15.3	17	23.7	19.2	18.9	8.4	13.2	12.6	13.4	19.1	13.6	5.4	7.9	15.2	13.3	18.8	9.9	18.5	17.1	19.8	17
	Females	15.3	15.2	18.7	11.4	9.9	8.4	9	11.3	9.8	28.9	25.8	19	24.7	9.3	13.1	14.6	21.9	20.9	9.8	5.2	8.2	19.9	20.2	18.3	11.3	19.8	15.8	20.8	12.7

Source: Eurostat - LFS adjusted series, Annual average
p = provisional value / 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
2000	Total	4	3.9	3.7	9.4	4.2	0.9	3.8	5.9	1.6	6.2	4.6	3.5	6.3	1.2	7.9	8	0.5	3.1	4.5	0.8	1	7.4	1.7	3.8	4.1	10.3	2.8	1.4	1.4
	Males	3.5	3.4	3.1	9.5	3.5	0.8	3.7	6.7	2.1	3.5	2.8	2.8	4.8	0.5	8.3	9.4	0.5	3.5	4.5	0.6	0.9	6	1.4	4	4.1	10.3	2.8	1.7	1.9
	Females	4.6	4.6	4.6	9.2	5.2	1.1	4	5	1	10.1	7.4	4.3	8.4	2.2	7.5	6.5	0.5	2.5	4.5	1	1.2	9.1	2	3.5	4.2	10.2	2.7	1	0.9
2002	Total	4	3.9	3.7	12	3.7	0.9	4	5.4	1.3	5.3	3.7	3	5.1	0.8	5.5	7.2	0.7	2.5	3.2	0.7	1.1	10.9	1.8	4,6b	3.5	12.2	2.3	1	1.1
	Males	3.6	3.4	3.2	12.5	3	0.7	4.1	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	9.8	1.4	4,8b	3.5	11.9	2.5	1.2	1.4
	Females	4.5	4.4	4.3	11.4	4.6	1	4	4.5	0.8	8.6	5.9	3.4	6.9	1	4.6	6.8	0.8	2.2	2.5	0.9	1.2	12.3	2.2	4,4b	3.6	12.5	2	0.8	0.7
2004	Total	4.2	4.1	4.1	7.2	4.2	1.2	5.5	5	1.6	5.6	3.4	3.8	4,0b	1.2	4.6	5.8	1	2.7	3.4	1.6	1,4b	10.3	3	4.8	3.2	11.8	2.1	1.2	1
	Males	3.8	3.7	3.7	7.3	3.4	1.1	5.7	5.6	2	3	2.2	3.3	2,9b	0.9	4.8	5.5	0.8	2.8	3.6	1.5	1,3b	9.6	2.6	5.5	3.1	11.3	2.3	1.4	1.2
	Females	4.6	4.5	4.7	7.1	5.3	1.3	5.2	4.4	1	9.4	5	4.2	5,5b	1.6	4.3	6.2	1.3	2.6	3	1.6	1,4b	11.1	3.5	3.8	3.4	12.4	2	1	0.6
2005	Total	:	:	4.4	6	4.2	1.1	5,7b	4.2	1.5	5.1	2,2b	3.8	3.9	1.2	4.1	4.3	1.2	3.2	3.3	1.9	1.3	10.3	3.7	4	3.1	11.7	2.2	:	1
	Males	:	:	3.9	6.1	3.4	1.1	6,0b	4.2	1.9	2.6	1,4b	3.4	2.9	0.8	4.4	4.2	1.2	3.2	3.4	1.9	1.3	9.3	3.2	4.6	2.9	11.2	2.4	:	1.3
	Females	:	:	5	6	5.3	1.2	5,3b	4.2	0.8	8.9	3,4b	4.3	5.2	1.8	3.7	4.5	1.2	3.2	3.4	1.9	1.4	11.4	4.3	3.4	3.3	12.3	2	:	0.7
2006	Total	3.7	3.7	4.2	5	3.9	0.8	5.5	2.9	1.4	4.8	1.8	3.9	3.4	0.9	2.5	2.5	1.4	3.4	2.8	1.7	1.3	7.8	3.9	4.2	2.9	10.2	1.9	1.1	1.2
	Males	3.5	3.4	3.7	4.8	3.1	0.7	5.7	3.2	1.8	2.6	1.2	3.6	2.6	0.7	3	2.5	1.3	3.3	3	1.6	1.3	7.1	3.4	4.7	2.5	9.4	2.1	1.2	1.5
	Females	4	4	4.9	5.3	4.9	0.9	5.3	2.6	0.9	8.1	2.8	4.2	4.5	1.1	1.9	2.5	1.6	3.4	2.4	1.8	1.3	8.6	4.5	3.6	3.5	11.2	1.8	1	0.8
2007	Total	3.1	3	3.8	4.1	2.8	0.6	4.7	2.3	1.4	4.1	1.7	3.4	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	0.8	1.3
	Males	2.8	2.8	3.3	3.7	2.1	0.6	4.8	2.8	1.7	2.2	1.1	3.2	2.2	0.8	1.9	1.4	1.3	3.3	2.8	1.2	1	4.6	3.2	3.6	1.8	7.5	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	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
2008	Total	2.6	2.6	3.3	2.9	2.2	0.5	3.8	1.7	1.6	3.6	2	2.9	3.1	0.5	1.9	1.2	1.6	3.6	2.5	1	0.9	2.4	3.7	2.4	1.9	6.6	1.2	0.8	1.4
	Males	2.4	2.4	3	2.7	1.7	0.4	3.9	2	2.2	2.1	1.4	2.8	2.4	0.5	1.9	1	1.2	3.6	2.6	0.9	0.9	2	3.2	2.9	1.6	5.8	1.3	0.8	1.7
	Females	2.8	2.8	3.7	3.1	2.8	0.5	3.7	1.4	0.9	6	2.9	3	4.1	0.5	1.9	1.4	2.1	3.7	2.5	1	0.9	2.8	4.2	1.8	2.1	7.6	1.1	0.7	0.9

Source : Eurostat - Labour Force Survey, Annual averages

: = not available or unreliable data / b = break / p = provisional / e: estimate

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

EN

EN

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	:	99.6	99.6	-	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, 2008 (percentage of total population)

	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
- Single adults, no children	13	13	15	6	10	23	19	15	8	8	7	15	12	6	10	10	12	9	7	16	15	9	6	7	7	9	19	18	13
of which:																													
- Single men	6	6	7	2	4	11	9	5	4	3	3	7	5	2	3	3	5	3	3	7	7	3	2	3	3	2	8	8	6
- Single women	8	8	8	4	6	12	10	10	4	5	4	9	7	3	7	7	7	6	4	9	9	6	5	5	5	6	11	10	7
- Under 65	8	8	9	2	5	16	13	9	4	4	3	10	6	3	5	5	8	5	3	11	10	4	2	3	3	4	12	11	7
- 65 and over	5	6	6	4	5	7	6	7	4	4	3	6	6	3	5	5	4	5	4	5	6	5	4	4	4	5	7	7	6
- Single parents	4	4	6	2	4	7	5	6	8	1	2	5	3	3	5	5	4	4	3	4	4	2	3	2	3	2	5	7	7
- 2 adults below 65, no children	13	14	15	9	14	18	16	13	11	9	11	16	9	8	9	9	12	12	8	17	13	9	9	8	7	7	20	18	17
- 2 adults, at least one aged 65+, no children	11	11	10	9	10	10	14	10	8	12	9	11	12	10	8	9	9	9	9	10	10	7	12	8	9	7	10	11	11
- 3 or more adults, no children	12	12	8	20	15	2	7	9	12	24	22	7	17	14	15	13	10	14	22	6	13	15	19	14	18	18	4	3	9
- 2 adults, 1 child	12	12	11	11	12	10	12	15	10	10	13	12	13	10	14	15	13	13	11	10	11	12	16	13	10	10	11	11	11
- 2 adults, 2 children	17	17	13	10	20	19	15	15	17	25	21	18	30	11	18	26	16	16	20	15	15	16	14	22	17	16	18	17	
- 2 adults, 3 or more children	7	7	15	2	5	10	7	6	14	3	3	11	5	7	5	7	7	13	8	7	4	6	7	7	11	10	9		
- 3 or more adults, with children	11	10	7	32	11	2	5	11	14	10	13	6	11	13	24	17	8	16	18	5	12	25	16	27	17	24	4	4	8

EU aggregates based on available country data
Source: SILC 2008

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	61.8	107.6	74.3	18.5	51.7	59.7	5.1	37.7	101.8	59.2	57.3	109.2	58.8	12.3	23.7	6.4	55.0	55.9	53.8	66.4	36.8	50.4	24.6	26.8	50.3	43.8	53.6	41.0
2001	60.9	106.3	67.3	25.1	47.4	58.8	4.8	35.5	102.9	55.5	56.9	108.8	60.7	14.0	23.1	6.5	52.0	62.1	50.7	67.0	37.6	52.9	25.7	27.4	48.9	42.3	54.4	37.7
2002	60.3	103.2	53.6	28.5	46.8	60.3	5.6	32.2	101.5	52.5	58.8	105.7	64.6	13.5	22.3	6.5	55.6	60.1	50.5	66.4	42.2	55.5	24.9	28.1	43.4	41.3	52.6	37.5
2003	61.7	98.3	45.9	30.1	45.8	63.8	5.5	31.0	97.3	48.7	62.9	104.4	68.9	14.6	21.1	6.2	58.4	69.3	52.0	65.4	47.1	56.9	21.5	27.5	42.4	44.4	52.3	38.7
2004	62.1	93.9	37.9	30.4	44.5	65.6	5.0	29.4	98.6	46.2	64.9	103.8	70.2	14.9	19.4	6.3	59.1	72.5	52.4	64.8	45.7	58.3	18.7	27.2	41.4	44.2	51.2	40.6
2005	62.7	92.1	29.2	29.7	37.1	68.0	4.6	27.6	100.0	43.0	66.4	105.8	69.1	12.4	18.4	6.1	61.8	70.2	51.8	63.9	47.1	63.6	15.8	27.0	34.2	41.8	51.0	42.2
2006	61.3	88.1	22.7	29.4	31.3	67.6	4.5	25.0	97.1	39.6	63.7	106.5	64.6	10.7	18.0	6.6	65.6	63.6	47.4	62.2	47.7	64.7	12.4	26.7	30.5	39.3	45.9	43.2
2007	58.7	84.2	18.2	29.0	26.8	65.0	3.8	25.1	95.6	36.1	63.8	103.5	58.3	9.0	16.9	6.6	65.9	62.0	45.5	59.5	45.0	63.6	12.6	23.3	29.3	35.2	40.5	44.2
2008	61.5	89.8	14.1	30.0	33.5	65.9	4.6	44.1	99.2	39.7	67.4	105.8	48.4	19.5	15.6	13.5	72.9	63.8	58.2	62.6	47.2	66.3	13.6	22.5	27.7	34.1	38.0	52.0
2009F	*73.0*	*97.2*	*15.1*	*36.5*	*33.7*	*73.1*	*7.4*	*65.8*	*112.6*	*54.3*	*76.1*	*114.6*	*53.2*	*33.2*	*29.9*	*15.0*	*79.1*	*68.5*	*59.8*	*69.1*	*51.7*	*77.4*	*21.8*	*35.1*	*34.6*	*41.3*	*42.1*	*68.6*
2010F	*79.3*	*101.2*	*16.2*	*40.6*	*35.3*	*76.7*	*10.9*	*82.9*	*124.9*	*66.3*	*82.5*	*116.7*	*58.6*	*48.6*	*40.7*	*16.4*	*79.8*	*70.9*	*65.6*	*73.9*	*57.0*	*84.6*	*27.4*	*42.8*	*39.2*	*47.4*	*43.6*	*80.3*
2011F	*83.7*	*104.0*	*15.7*	*44.0*	*35.2*	*79.7*	*13.2*	*96.2*	*135.4*	*74.0*	*87.6*	*117.8*	*63.4*	*60.4*	*49.3*	*17.7*	*79.1*	*72.5*	*69.7*	*77.0*	*61.3*	*91.1*	*31.3*	*48.2*	*42.7*	*52.7*	*44.1*	*88.2*

Source: Eurostat - General Government data and ECFIN forecasts / F = forecast

177

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

	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
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) - 2007

	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	29,1p	29,2p	26.5	27.1	33.9	23	29,8p	33.4	41.1	28.1	31,2p	29,9p	26,1p	25,2p	29,7p	30,7p	26	25.5	29.2	32,5p	26	22.1	28.3	23.8	32,1p	30,8p	26.3	26,1p	30,6p
Disability	8,1p	8p	6.6	8.3	8.1	15	7,7p	9.3	5.5	4.9	7,6p	6,1p	6p	3,7p	7p	10,4p	12.3	9.6	6.3	9,1p	8	9.6	10	10	7,8p	8,5p	12.6	15,3p	9,8p
Family and children	8p	7,9p	7.1	8.6	9.2	13.1	10,6p	11.6	14.7	6.2	6p	8,5p	4,7p	10,8p	11p	8,7p	16.6	12.8	5.9	6p	10.2	4.5	5.3	13.2	8,7p	10p	11.6	10,2p	6p
Unemployment	5,1p	5,1p	11.7	2	3.5	5.6	5,8p	1.2	7.7	4.5	11,7p	6,1p	1,8p	4,8p	3,3p	1,9p	4.9	3.4	2.8	4,3p	5.3	2.2	5.1	2.2	2,3p	3,6p	7.8	3,8p	2,1p
Old age and survivors benefits	46,2p	46,2p	45.3	51.4	43.9	38.1	43,1p	43.8	27.4	52	41,3p	45,3p	61,1p	46,7p	46,8p	47p	37.3	43.9	52.4	40,2p	48.9	60.2	50	47.3	46,7p	43,8p	38.5	41p	44,9p
Housing and social exclusion	3,6p	3,6p	2.8	2.5	1.4	5.1	2,9p	0.8	3.6	4.3	2,2p	4,2p	0,3p	8,7p	2,3p	1,3p	2.9	4.8	3.3	7,8p	1.5	1.4	1.2	3.5	2,4p	3,3p	3.2	3,8p	6,5p

e = Eurostat estimate / p = provisional

Context 7b: Social protection benefits by group of functions (as a percentage of GDP) - 2007

	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*	26.2	26.4p	29.5	15.1	18.6	28.9	27.7p	12.5	18.9	24.4	21.0p	30.5p	26.7p	18.5p	11.0p	14.3p	19.3	22.3	18.1	28.4p	28.0	18.1	24.8	12.8	21.4p	16.0p	25.4	29.7p	25.3p
Social protection benefits	25.2p	25.4p	28.0	14.6	18.0	28.1	26.7p	12.3	17.6	23.8	20.5p	29.0p	25.5p	18.1p	10.7p	13.9p	19.0	21.9	17.9	26.8p	27.1	17.8	23.4	12.6	20.8p	15.4p	24.6	29.0p	24.8p
Sickness/Health care	7.4p	7.4p	7.4	3.9	6.1	6.5	8.0p	4.1	7.2	6.7	6.4p	8.7p	6.7p	4.6p	3.2p	4.3p	4.9	5.6	5.2	8.7p	7.1	3.9	6.6	3.0	6.7p	4.7p	6.5	7.6p	7.6p
Disability	2.0p	2.0p	1.8	1.2	1.5	4.2	2.0p	1.1	1.0	1.2	1.6p	1.8p	1.5p	0.7p	0.7p	1.4p	2.3	2.1	1.1	2.5p	2.2	1.7	2.3	1.3	1.6p	1.3p	3.1	4.4p	2.4p
Family/Children	2.0p	2.0p	2.0	1.3	1.7	3.7	2.8p	1.4	2.6	1.5	1.2p	2.5p	1.2p	2.0p	1.2p	1.2p	3.2	2.8	1.1	1.6p	2.8	0.8	1.2	1.7	1.8p	1.5p	2.9	3.0p	1.5p
Unemployment	1.3p	1.3p	3.3	0.3	0.6	1.6	1.5p	0.1	1.4	1.1	2.4p	1.8p	0.5p	0.9p	0.3p	0.3p	0.9	0.8	0.5	1.2p	1.4	0.4	1.2	0.3	0.5p	0.6p	1.9	1.1p	0.5p
Old age and survivors	11.7p	11.7p	12.7	7.5	7.9	10.7	11.5p	5.4	4.8	12.4	8.5p	13.1p	15.6p	8.5p	5.0p	6.5p	7.1	9.6	9.4	10.8p	13.3	10.7	11.7	6.0	9.7p	6.8p	9.5	11.9p	11.1p
Housing and Social exclusion n.e.c.	0.9p	0.9p	0.8	0.4	0.3	1.4	0.8p	0.1	0.6	1.0	0.5p	1.2p	0.1p	1.6p	0.2p	0.2p	0.6	1.1	0.6	2.1p	0.4	0.3	0.3	0.4	0.5p	0.5p	0.8	1.1p	1.6p
Administration costs	0.8p	0.8p	1.0	0.4	0.6	0.8	1.0p	0.1	1.3	0.6	0.5p	1.2p	0.7p	0.3p	0.2p	0.4p	0.3	0.4	0.2	1.3p	0.5	0.3	0.5	0.2	0.4p	0.6p	0.8	0.6p	0.5p
Other expenditure	0.2p	0.2p	0.5	0.1	0.0	:	0.1p	:	0.0	0.0	0.1p	0.2p	0.5p	0.1p	0.1p	0.0p	0.0	:	:	0.3p	0.4	0.0	0.9	0.0	0.1p	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, 2008, 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	26.5	27.5	33.3	17.3	25.7	:	43.0	34.0	19.4	21.5	14.7	31.0	18.2	9.9	24.6	37.3	33.6	14.5	15.7	45.0	37.8	15.8	14.2	10.9	27.3	13.3	51.8	:	27.5
Alone with child(ren)	10.2	10.7	13.7	4.4	14.5	:	10.3	12.4	18.2	3.2	4.8	11.7	4.0	8.0	9.1	11.2	5.5	6.5	7.8	14.1	5.9	7.6	6.8	2.9	4.0	4.6	3.7	:	23.3
Couple without children	19.9	19.9	23.1	19.9	23.3	:	19.1	9.5	11.4	26.9	15.5	26.8	17.3	26.5	12.0	10.9	32.8	21.4	21.0	22.1	23.8	25.2	23.4	20.3	32.4	18.3	22.8	:	14.0
Couple with child(ren)	15.7	15.4	10.7	13.4	11.7	:	14.6	12.1	21.2	11.0	21.3	14.1	17.5	18.3	11.0	11.8	11.7	18.7	18.2	11.5	12.0	13.0	14.1	22.8	6.7	14.5	11.5	:	16.3
Other households without children - total	19.7	19.4	12.5	28.4	19.1	:	9.3	27.4	20.8	32.6	31.9	12.2	33.5	33.0	32.5	21.6	11.6	25.2	28.1	5.9	16.8	26.3	32.0	22.5	25.0	30.2	9.3	:	13.5
- without elderly (65+)	9.5	9.2	7.6	13.7	7.7	:	4.8	7.8	13.0	13.1	11.4	6.7	16.3	25.4	8.3	8.4	7.1	12.1	12.1	3.4	7.6	11.6	10.4	12.7	12.3	14.5	3.2	:	8.1
- with at least 1 elderly (65+)	10.3	10.2	4.8	14.7	11.4	:	4.5	19.6	7.8	19.5	20.5	5.4	17.2	7.6	24.2	13.2	4.5	13.1	16.1	2.4	9.3	14.8	21.6	9.8	12.7	15.7	6.0	:	5.5
Other households with child(ren) - total	7.9	7.0	6.8	16.5	5.7	:	3.6	4.7	8.9	4.7	11.7	4.3	9.5	4.3	10.8	7.2	4.8	13.6	9.2	1.5	3.5	12.1	9.4	20.6	4.7	18.9	0.9	:	5.4
- without elderly (65+)	6.0	5.4	5.8	12.4	4.1	:	3.2	2.0	7.8	3.0	7.9	3.4	7.7	2.7	5.1	4.2	3.9	10.7	6.2	1.2	2.8	8.2	5.8	13.6	3.5	15.5	0.9	:	4.9
- with at least 1 elderly (65+)	1.9	1.6	1.1	4.2	1.6	:	0.5	2.8	1.1	1.7	3.8	0.9	1.8	1.6	5.7	2.9	0.9	3.0	2.9	0.3	0.7	3.8	3.6	7.0	1.2	3.4	0.0	:	0.5

Source: Eurostat - European Labour Force Survey 2008, Annual results.

: = not available or unreliable data / b = break / p = provisional / e = estimate

Context 8b: Children aged 0-17 living in jobless households by household types, 2008, 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	45.7	47.9	57.7	23.4	57.3	:	46.9	56.1	49.9	27.7	23.5	51.5	22.4	43.1	36.9	50.7	35.1	25.7	39.0	63.0	37.6	37.7	34.5	8.4	32.7	20.1	27.5	:	66.3
Alone with child(ren) - at least 1 elderly	0.4	0.3	0.4	1.1	0.3	:	0.4	0.4	0.1	0.7	0.8	0.2	0.2	0.0	7.8	1.5	1.2	0.3	0.0	0.4	0.8	0.5	1.2	1.2	0.0	0.0	0.0	:	0.1
Couple with child(ren) - total	40.0	39.1	29.6	39.7	30.8	:	45.2	28.6	37.3	53.4	48.7	41.2	59.1	46.1	26.6	29.2	37.5	51.0	42.3	34.4	50.9	31.9	44.8	57.3	44.7	39.3	71.0	:	26.8
- without elderly (65+)	38.9	38.2	28.5	34.7	29.6	:	44.5	27.9	36.9	49.3	47.1	40.2	58.1	43.8	21.0	27.8	35.4	50.5	40.7	33.3	49.9	31.0	40.6	55.5	44.3	39.1	70.0	:	26.1
- with at least 1 elderly (65+)	1.1	1.0	1.1	5.0	1.3	:	0.7	0.6	0.4	4.0	1.7	1.0	1.0	2.4	5.5	1.4	2.1	0.5	1.6	1.1	1.0	0.9	4.1	1.8	0.4	0.3	1.0	:	0.7
Other households with child(ren) - no elderly	14.0	12.6	12.3	35.9	11.6	:	7.5	14.9	12.7	18.3	27.0	7.1	18.3	10.8	28.7	18.6	26.1	23.0	18.7	2.2	10.7	30.0	19.5	33.1	22.6	40.5	1.5	:	6.8
- without elderly (65+)	9.4	8.7	9.8	25.4	8.1	:	5.4	4.3	10.7	8.8	14.7	5.7	13.0	7.4	13.8	10.2	21.4	16.8	11.8	1.5	7.2	16.1	8.9	17.9	14.5	31.4	1.5	:	5.9
- with at least 1 elderly (65+)	4.6	4.0	2.5	10.4	3.6	:	2.1	10.6	2.0	9.5	12.3	1.4	5.3	3.5	15.0	8.4	4.7	6.1	6.9	0.7	3.5	13.9	10.6	15.2	8.0	9.1	0.0	:	0.9

Source: Eurostat - European Labour Force Survey 2008, Annual results.

: = not available or unreliable data / b = break / p = provisional / e = estimate

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	0.7	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	CZ	DK	DK(1)	DE	EE	IE	EL	ES	FR	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	RO	SI	SK	FI	SE	UK
Total population	Total	25(p)	25(p)	27	27	20	28	27	24	25	34	23	24	23(b)	23	22	30	27	24	30	23	20	24	25	25	31	23	18	28	29	29(p)
	Men	24(p)	24(p)	26	26	19	26	25	23	22	32	22	23	23(b)	22	20	28	25	23	31	22	19	23	25	24	30	21	18	26	27	27(p)
	Women	26(p)	26(p)	28	29	21	29	29	25	27	36	24	25	23(b)	25	24	32	29	24	30	24	21	26	25	25	32	25	19	29	30	31(p)
Children aged 0-17 years		33(p)	32(p)	32	31	30	22	22	31	26	40	26	29	34(b)	32	20	32	32	34	47	32	23	36	33	30	43	23	27	30	34	39(p)
People aged 18-64 years	Total	23(p)	23(p)	26	22	19	28	28	25	20	31	22	21	22(b)	21	16	24	24	23	30	20	20	23	25	23	27	21	17	26	27	24(p)
	Men	22(p)	22(p)	25	22	17	26	26	24	19	30	21	20	21(b)	20	15	23	24	23	30	18	19	22	26	22	27	21	17	26	26	22(p)
	Women	24(p)	24(p)	27	23	20	29	29	26	20	33	22	22	23(b)	22	18	25	25	24	30	21	21	24	24	24	27	21	17	26	28	26(p)
People aged 65 years and over	Total	23(p)	22(p)	25	41	14	36	31	16	41	38	27	31	13(b)	23	53	53	32	8	10	26	16	17	15	25	30	33	15	31	26	38(p)
	Men	20(p)	19(p)	24	35	11	32	27	14	27	32	24	28	12(b)	20	46	47	19	8	7	26	15	13	11	22	23	26	8	23	16	33(p)
	Women	26(p)	25(p)	26	46	17	39	34	18	49	42	29	32	14(b)	26	58	56	39	8	11	25	16	20	17	27	35	37	19	36	33	42(p)

Source: SILC 2008, Income data 2007; except for UK, income year 2008 and for IE moving income reference period (2007-2008); (1) with imputed rent data 2007 (see methodological note).

: = not available or unreliable data / b = break / p = provisional / e: estimate

EU Aggregates: Eurostat estimates are obtained as a population size weighted average of national data.